

Clinical Step Working Guide

Steps 6-7: Willingness

For SUD and mental health counselors

Step Six

"Were entirely ready to have God remove all these defects of character."

The step of willingness—preparing to release the patterns that no longer serve.

Step Seven

"Humbly asked Him to remove our shortcomings."

The step of humility—actively requesting help to become who we're meant to be.

Clinician Resources

Understanding Steps Six and Seven deeply allows you to support patients through the vulnerable process of character transformation—the bridge between insight and lasting change. Remember: willingness is the key, humility is the posture.

Recommended Reading

Alcoholics Anonymous "Big Book" - Chapter 6: "Into Action" (pp. 76-84)

Clinical Training

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

Step Six: Foundation

Understanding "entirely ready" and the nature of character defects

The Meaning of "Entirely Ready"

OVERVIEW

Step Six states: "Were entirely ready to have God remove all these defects of character." The key phrase is "entirely ready"—not "partially willing" or "somewhat open to." This step asks for complete willingness, which is fundamentally different from complete ability. Your patients don't need to be perfect; they need to be willing to pursue perfection in character.

KEY POINTS FOR CLINICIANS

- "Entirely ready" is about willingness, not capability
- This step is about internal preparation, not external action
- Patients often confuse readiness with results
- Willingness can exist alongside fear and doubt
- Being "entirely ready" is a decision, not a feeling
- The step doesn't ask patients to remove defects themselves—only to be ready

CLINICAL INSIGHT

Many patients get stuck because they interpret "entirely ready" as meaning they must feel ready or confident. Help them understand that willingness is a choice made in the face of fear, not the absence of fear. A patient who says "I'm scared but willing" is more ready than one who says "I'll do it when I feel ready."

THE PATIENT EXPERIENCE

What patients often think: "I can't be entirely ready because I still have doubts. I still want to hold onto some of these behaviors. Does that mean I'm failing?" The truth is: ambivalence is normal. Willingness doesn't require the absence of resistance.

CLINICAL REFLECTION

How do you distinguish between a patient's genuine unreadiness versus fear masquerading as unreadiness? What does "entirely ready" look like in clinical practice?

CLINICAL EXERCISE / ASSESSMENT TOOL

Readiness assessment questions:

- "On a scale of 1-10, how willing are you to change [specific defect]? What would move you one point higher?"
- "What would you lose if this character defect were removed? What would you gain?"
- "What's the difference between not being ready and being afraid to be ready?"
- "If you woke up tomorrow and this defect was gone, what would be different?"

ACTION STEP FOR YOUR PRACTICE

In your next session, help a patient distinguish between willingness and confidence. Explore whether their resistance is about capability or willingness.

Character Defects vs. Human Nature**OVERVIEW**

A critical distinction in Step Six is understanding what constitutes a "defect of character" versus normal human emotions and drives. Fear, for example, is not a defect—it's a survival mechanism. But fear that controls decisions, paralyzes action, or drives harmful behaviors has become defective. The defect is in the degree and application, not the emotion itself.

KEY POINTS FOR CLINICIANS

- Defects are often healthy traits taken to unhealthy extremes
- The problem is usually degree, not the trait itself
- Self-preservation becomes selfishness when it harms others
- Caution becomes fear when it prevents living
- Self-confidence becomes pride when it blocks growth
- Patients need help seeing the spectrum, not just the extremes

CLINICAL INSIGHT

Patients often feel they must eliminate entire aspects of themselves, which creates resistance and shame. Help them understand they're seeking balance, not elimination. The goal isn't to become fearless (that would be dangerous) but to have fear that is proportionate and doesn't control their lives.

THE PATIENT EXPERIENCE

Patients may say: "But my anger has protected me. My distrust kept me safe. If I get rid of these, I'll be vulnerable." They're not wrong—these traits did serve a purpose. The clinical work is helping them develop healthier versions of these protective mechanisms.

CLINICAL REFLECTION

How do you help patients distinguish between healthy self-protection and dysfunctional character defects? Where is the line between normal human traits and defects?

CLINICAL EXERCISE / ASSESSMENT TOOL

Spectrum exploration exercise:

- "Describe a time when [trait] served you well."

- "Describe a time when the same trait caused problems."
 - "What's the difference between those two situations?"
 - "What would a balanced version of this trait look like?"
 - "Who do you know that demonstrates healthy [caution/anger/self-interest]?"
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ACTION STEP FOR YOUR PRACTICE

Create a simple spectrum diagram with a patient showing the healthy middle ground between deficiency and excess for one of their identified character defects.

The Role of Step Four and Five in Step Six

OVERVIEW

Step Six doesn't exist in isolation—it builds directly on the work of Steps Four and Five. In Step Four, patients conducted a searching and fearless moral inventory. In Step Five, they admitted these to themselves, God, and another person. Step Six asks them to become willing to release what they've discovered. The progression is: identify, admit, then become willing to change.

KEY POINTS FOR CLINICIANS

- Step Six requires the foundation of honest self-examination (Step 4)
- Public acknowledgment (Step 5) reduces the power of secrets
- Patients can't be ready to release what they haven't identified
- The emotional relief of Step 5 often creates openness for Step 6
- Rushing through 4 and 5 creates shaky ground for 6
- Return to earlier steps if Step 6 seems blocked

CLINICAL INSIGHT

If a patient is struggling with Step Six, the issue may actually be incomplete Step Four or Five work. Perhaps they minimized certain defects, held back during their Fifth Step, or never truly acknowledged certain patterns. Sometimes the clinical intervention is going back, not pushing forward.

THE PATIENT EXPERIENCE

After completing Step Five, many patients feel relief—sometimes even euphoria. They may believe the hard work is done. Step Six asks them to stay engaged, to not rest on the laurels of confession. "I told someone my worst secrets— isn't that enough?" No, acknowledgment isn't change.

CLINICAL REFLECTION

How do you assess whether a patient's Step Four and Five work was thorough enough to support genuine Step Six readiness? What signs indicate incomplete earlier work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Step progression assessment:

- "In your Step Four, what patterns emerged that surprised you?"
 - "During your Step Five, was there anything you held back or minimized?"
 - "Looking at your inventory now, what stands out as most important to address?"
 - "How did sharing your inventory change your relationship to these defects?"
 - "What defects do you still have trouble admitting, even to yourself?"
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ACTION STEP FOR YOUR PRACTICE

Review a patient's Step Four inventory with them specifically looking for minimization patterns or gaps that might be blocking Step Six readiness.

Why Step Six is the "Forgotten Step"

OVERVIEW

Step Six is often called the "forgotten step" because it can seem anticlimactic. There's no list to make (like Step 4), no dramatic confession (like Step 5), no amends to plan (like Steps 8-9). It's an internal step of preparation—becoming willing. Many patients (and clinicians) rush through it, missing its profound importance as the bridge between insight and transformation.

KEY POINTS FOR CLINICIANS

- Step Six is preparation for transformation, not transformation itself
- Internal steps are easy to minimize or skip
- Willingness must precede the asking (Step 7)
- Rushing this step often leads to superficial change
- The Big Book dedicates little space to it—easily overlooked
- This is where many patients stall without recognizing it

CLINICAL INSIGHT

In treatment settings especially, there can be pressure to "complete" steps quickly. But Step Six cannot be completed in an afternoon group session. It requires honest self-examination about willingness—which parts of themselves patients are truly ready to release, and which they're still clutching. This takes time.

THE PATIENT EXPERIENCE

Patients may say: "I did Step Six—I read it and I'm willing. Can we move on to Seven?" This surface-level engagement misses the depth Step Six requires. True willingness involves confronting what patients will lose when defects are removed, not just what they'll gain.

CLINICAL REFLECTION

How do you create space for patients to genuinely engage with Step Six without rushing? How do you know when willingness is genuine versus performed?

CLINICAL EXERCISE / ASSESSMENT TOOL

Deep willingness exploration:

- "For each character defect identified, rate your willingness 0-100%"
 - "For any rated below 80%, what makes you hesitant?"
 - "What would it cost you to be entirely willing?"
 - "What's the worst thing that could happen if this defect were removed?"
 - "Are you willing to be made willing?"
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ACTION STEP FOR YOUR PRACTICE

Slow down your Step Six work with patients. Create a structured process for examining willingness toward each major character defect rather than treating it as a single decision.

The Paradox of Powerlessness and Action

OVERVIEW

Step Six presents a paradox central to recovery: patients must become entirely ready (an act of will) to have something removed (acknowledging they can't remove it themselves). This is the same paradox as Step One—admitting powerlessness while taking action. Patients don't remove their own defects; they prepare themselves to have them removed.

KEY POINTS FOR CLINICIANS

- The patient's job is willingness, not willpower
- Removal is not self-improvement through effort
- This challenges the American "self-made" mythology
- Recovery requires effort AND surrender simultaneously
- Patients prepare; something else transforms
- This paradox is clinically important—it relieves pressure while maintaining responsibility

CLINICAL INSIGHT

Many patients interpret Step Six as another self-improvement project: "I'll try harder to be less angry, less fearful, less selfish." This is not the step's intent. The step asks for willingness to have defects removed, implicitly acknowledging patients cannot remove them through willpower alone. This is actually liberating.

THE PATIENT EXPERIENCE

Patients often ask: "If I can't remove my own defects, what's the point of being willing?" The answer: willingness creates openness. A closed door can't be walked through. The patient opens the door; they don't carry themselves through it.

CLINICAL REFLECTION

How do you help patients understand the balance between responsibility (becoming willing) and surrender (not trying to transform themselves through sheer effort)?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exploring the paradox:

- "What have you tried to change about yourself through willpower? How did that work?"
 - "What's the difference between trying hard to be different and being open to becoming different?"
 - "If effort alone could change you, would you still have this problem?"
 - "What does it mean to be willing without being in control?"
 - "How might letting go of control actually be more effective than gripping tighter?"
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ACTION STEP FOR YOUR PRACTICE

Help a patient identify areas where they've exhausted willpower attempts at change. Use these examples to illustrate the Step Six principle of willingness without self-reliant effort.

Step Seven: Foundation

Understanding humility and the process of asking for help

The Meaning of Humility

OVERVIEW

Step Seven states: "Humbly asked Him to remove our shortcomings." The key word is "humbly." Humility is one of the most misunderstood concepts in recovery. It does not mean humiliation, self-deprecation, or weakness. True humility is an accurate assessment of self—neither inflated nor deflated. It's seeing oneself clearly, limitations and strengths alike.

KEY POINTS FOR CLINICIANS

- Humility is not humiliation or low self-esteem
- Humility is accurate self-perception—no more, no less
- Pride and shame are both forms of distorted self-view
- Humble people can acknowledge strengths without arrogance
- Humble people can acknowledge weaknesses without self-attack
- Humility requires courage—seeing oneself clearly is hard

CLINICAL INSIGHT

Many patients with substance use disorders oscillate between grandiosity and self-loathing—sometimes within the same conversation. Neither represents humility. Clinical work here involves helping patients develop stable, accurate self-perception that can hold both their value and their limitations.

THE PATIENT EXPERIENCE

Patients may resist humility because they confuse it with the shame they're already drowning in: "I already know I'm worthless—I don't need more of that." This reveals the misunderstanding. Humility would actually mean: "I have worth AND I have serious character flaws that need addressing."

CLINICAL REFLECTION

How do you distinguish healthy humility from toxic shame in your patients? How do you help patients develop accurate self-perception?

CLINICAL EXERCISE / ASSESSMENT TOOL

Humility assessment:

- "Describe yourself accurately—both strengths and limitations"
- "Do you tend more toward self-inflation or self-deflation?"
- "What would it mean to accept yourself as you actually are—flaws and all?"
- "How is acknowledging your shortcomings different from beating yourself up?"
- "Can you name three strengths without minimizing and three weaknesses without catastrophizing?"

ACTION STEP FOR YOUR PRACTICE

Practice balanced self-assessment with a patient, helping them articulate both genuine strengths and genuine limitations without sliding into either grandiosity or shame.

The Act of Asking

OVERVIEW

Step Seven involves asking—actively requesting help in removing shortcomings. This is fundamentally different from passively hoping things will change. Asking requires vulnerability, acknowledgment of need, and trust that the request will be heard. For many patients, asking for help is itself a profound challenge that cuts against years of self-reliance.

KEY POINTS FOR CLINICIANS

- Asking is active, not passive
- Asking acknowledges need and limitation
- Asking requires vulnerability—many patients avoid this
- Asking is relational—it implies someone is listening
- Asking is different from demanding or expecting
- The willingness to ask is often the bigger change than the request itself

CLINICAL INSIGHT

Patients who have survived addiction often developed fierce independence as a coping mechanism. Asking for help—truly asking, not manipulating—may be foreign to them. The act of genuinely asking, with humility and without expectation of control over the outcome, is often the first real spiritual act for many patients.

THE PATIENT EXPERIENCE

Patients often say: "I don't ask anyone for anything—I've learned not to depend on people." This self-sufficiency was adaptive in their history but is now a barrier. Learning to ask—without manipulation, demand, or certainty—is profound character change in itself.

CLINICAL REFLECTION

How comfortable are your patients with genuine asking? What's their history with asking for help? How do you model or teach healthy asking?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exploring the act of asking:

- "When was the last time you genuinely asked for help without expecting a specific outcome?"

- "What makes asking hard for you?"
 - "What's the difference between asking and demanding?"
 - "Who in your life would you be willing to ask for help?"
 - "What would it mean to ask for help with your character defects?"
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ACTION STEP FOR YOUR PRACTICE

Assign a patient one genuine ask this week—something small but meaningful. Process their experience: What came up before, during, and after asking?

Shortcomings vs. Character Defects: Is There a Difference?

OVERVIEW

Step Six refers to "defects of character" while Step Seven refers to "shortcomings." Some view these as interchangeable; others see important distinctions. Regardless of interpretation, the progression from Six to Seven involves movement: from identifying defects (Four), admitting them (Five), becoming willing to release them (Six), to actively requesting their removal (Seven).

KEY POINTS FOR CLINICIANS

- Some view defects and shortcomings as synonyms; others see distinction
- One interpretation: defects are the patterns; shortcomings are specific behaviors
- Another: shortcomings are defects seen through the lens of humility
- The language shift may indicate transformation in the patient's perspective
- What matters clinically: movement from identification to action
- The vocabulary is less important than the patient's engagement with the process

CLINICAL INSIGHT

Don't get caught up in semantic debates with patients. What matters is whether they're engaging genuinely with the process of character change. If a patient is arguing about word definitions, explore what they might be avoiding by focusing on semantics.

THE PATIENT EXPERIENCE

Some patients obsess over the "right" interpretation: "Am I doing this correctly? What's the exact difference?" This intellectualization can be a defense against the vulnerability of actual change. Gentle redirection toward experience over analysis often helps.

CLINICAL REFLECTION

Do you have a clinical perspective on the defects/shortcomings distinction? How do you handle patients who get stuck on program semantics?

CLINICAL EXERCISE / ASSESSMENT TOOL

Moving past semantics:

- "Whether we call them defects or shortcomings, what are you most ready to work on?"
 - "Instead of defining these perfectly, describe how [specific pattern] shows up in your life"
 - "What matters more to you: understanding the terminology or changing the behavior?"
 - "If you woke up tomorrow with this removed, would you care what it was called?"
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ACTION STEP FOR YOUR PRACTICE

If you encounter a patient stuck on terminology, gently redirect to experiential work. What specific change are they seeking? That's what matters.

The Seventh Step Prayer

OVERVIEW

The traditional Seventh Step Prayer in AA is: "My Creator, I am now willing that you should have all of me, good and bad. I pray that you now remove from me every single defect of character which stands in the way of my usefulness to you and my fellows. Grant me strength, as I go out from here, to do your bidding. Amen." Understanding this prayer helps clinicians understand what patients are being asked to do.

KEY POINTS FOR CLINICIANS

- The prayer acknowledges both good and bad in the person
- It requests removal of defects that block usefulness—purpose-focused
- It asks for strength to act differently going forward
- The prayer is surrender and commitment combined
- It models humility, willingness, and service orientation
- Patients can adapt language to their beliefs while keeping the spirit

CLINICAL INSIGHT

For patients who struggle with traditional religious language, help them extract the core elements: acknowledgment of the full self, willingness to release what blocks growth, orientation toward being useful to others, and request for strength to change. These elements can be expressed in many ways.

THE PATIENT EXPERIENCE

Some patients embrace the prayer fully; others struggle with "My Creator" or "your bidding." Both responses are valid starting points. The question is: Can the patient authentically engage with the core request—help me become who I need to be to be useful?

CLINICAL REFLECTION

How do you help patients engage with the Seventh Step Prayer when they have religious resistance? What adaptations have you seen work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Prayer deconstruction and reconstruction:

- "What resonates with you in this prayer? What doesn't?"
 - "If you were to write your own version, what would you say?"
 - "What's the core request being made here?"
 - "Could you make this request in your own words?"
 - "What would it mean to truly pray something like this and mean it?"
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ACTION STEP FOR YOUR PRACTICE

Have a patient write their own version of a Step Seven prayer/intention in language that feels authentic to them while maintaining the core elements.

The Process of Removal: What to Expect

OVERVIEW

Patients often expect dramatic, instantaneous removal of character defects after Step Seven—like a spiritual surgery. Reality is usually different. Character defects are often removed gradually, sometimes through circumstances that provide opportunity to choose differently. The removal is often a process of diminishing power rather than complete elimination.

KEY POINTS FOR CLINICIANS

- Removal is typically gradual, not instantaneous
- Defects may lose power rather than disappear entirely
- Progress is often "two steps forward, one step back"
- Life provides circumstances to practice new responses
- Some defects require ongoing vigilance throughout recovery
- The change is often noticed retrospectively: "I used to react differently"

CLINICAL INSIGHT

Set realistic expectations. Patients who expect instant transformation often become discouraged. Help them recognize that a defect's grip loosening—having a moment of pause before reacting angrily, for instance—is evidence of change. The miracle is often subtle.

THE PATIENT EXPERIENCE

Patients may say: "I prayed for my anger to be removed and I still got angry. This doesn't work." They need help recognizing: Did you notice your anger faster? Did it last as long? Did you act on it the same way? Changes in intensity, duration, and behavioral response are all evidence of progress.

CLINICAL REFLECTION

How do you help patients recognize gradual progress when they're expecting dramatic change?
What markers of progress do you point to?

CLINICAL EXERCISE / ASSESSMENT TOOL

Progress recognition:

- "Think of a time recently when [defect] showed up. Compare it to a year ago—any differences?"
 - "What would a 10% improvement in this area look like? Have you seen that?"
 - "Do you catch yourself faster than you used to?"
 - "Is the defect controlling your behavior less, even if you still feel it?"
 - "Who else might have noticed changes you can't see yourself?"
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ACTION STEP FOR YOUR PRACTICE

Create a simple tracking system with a patient to monitor subtle progress on one character defect—frequency, intensity, duration of episodes, speed of awareness.

Character Defects Explored

Deep dive into common defects and their clinical presentations

Fear: The Root Defect

OVERVIEW

The Big Book identifies fear as the root of most character defects: "This short word somehow touches about every aspect of our lives. It was an evil and corroding thread; the fabric of our existence was shot through with it." Understanding fear as foundational helps clinicians see the common root beneath seemingly diverse presenting problems.

KEY POINTS FOR CLINICIANS

- Fear underlies most other character defects
- Anger is often fear in disguise (fear of being hurt, controlled, exposed)
- Dishonesty stems from fear of consequences, rejection, or vulnerability
- Control is fear of uncertainty and helplessness
- People-pleasing is fear of abandonment or disapproval
- Addressing root fears often improves multiple surface defects

CLINICAL INSIGHT

When working with any character defect, consider asking: "What fear drives this?" A patient who presents with anger problems may need to address underlying fears of vulnerability or loss of control. Treating the anger without addressing the fear may produce limited results.

THE PATIENT EXPERIENCE

Patients often don't recognize their own fear. Anger feels powerful; fear feels weak. Helping patients see that their aggressive, controlling, or manipulative behaviors are actually fear-driven can be both challenging and liberating. "I'm not mean—I'm terrified."

CLINICAL REFLECTION

How often do you trace presenting character defects back to underlying fears? How do patients typically respond when you suggest fear as the root cause?

CLINICAL EXERCISE / ASSESSMENT TOOL

Fear root exploration:

- "When you feel [anger/need to control/urge to lie], what would happen if you didn't act on it?"
- "What's the worst thing that could happen if you let go of [defect]?"
- "What are you protecting yourself from when you [engage in defective behavior]?"
- "If you felt completely safe, would you still need to [behavior]?"
- "What scared you before you got angry?"

ACTION STEP FOR YOUR PRACTICE

With a patient's presenting character defect, work backward to identify underlying fears. Develop interventions that address both the surface behavior and root fear.

Resentment: The Number One Offender**OVERVIEW**

The Big Book states: "Resentment is the number one offender. It destroys more alcoholics than anything else." Resentment is re-feeling old hurts, carrying grievances, maintaining victim identity, and keeping score of wrongs. It's drinking poison expecting the other person to die. Clinicians must understand its grip and its function.

KEY POINTS FOR CLINICIANS

- Resentment is holding onto past hurts—re-feeling them repeatedly
- It provides a sense of moral superiority and justified victimhood
- Resentment often feels protective but is actually self-destructive
- It blocks intimacy, peace, and spiritual growth
- Resentment is strongly linked to relapse
- Letting go of resentment is not the same as condoning the wrong

CLINICAL INSIGHT

Resentment serves a function—it protects against vulnerability, provides identity, and maintains distance from painful emotions like grief or fear. Patients won't release resentments until they have better ways to meet these needs. Simply telling them to "let go" without addressing the function is ineffective.

THE PATIENT EXPERIENCE

Patients often cling to resentments because releasing them feels like: admitting the wrong was okay, letting the offender "win," losing their identity as the wronged party, or having to feel the original pain. None of these are true, but they feel true.

CLINICAL REFLECTION

How do you help patients distinguish between healthy processing of harm and toxic resentment?
How do you address the secondary gains of holding resentments?

CLINICAL EXERCISE / ASSESSMENT TOOL

Resentment examination:

- "Who or what do you think about with anger that happened more than a month ago?"

- "What does holding this resentment do for you? Against you?"
 - "What would you lose if you let this go?"
 - "Does the person you resent know or care that you're carrying this?"
 - "What emotion is under the resentment—grief? Fear? Betrayal?"
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ACTION STEP FOR YOUR PRACTICE

Help a patient identify one resentment they carry and explore its function. What need does it meet? What would releasing it require?

Self-Centeredness: The Core Issue

OVERVIEW

The Big Book suggests that "selfishness—self-centeredness! That, we think, is the root of our troubles." This doesn't mean patients are bad people who only think about themselves. It means their perception is organized around self: How does this affect me? What will I get? What might I lose? This self-referential filtering distorts relationships and reality.

KEY POINTS FOR CLINICIANS

- Self-centeredness is perception organized around self, not selfishness per se
- Even "selfless" behaviors can be self-centered (approval-seeking)
- Active addiction requires massive self-focus to maintain
- Self-centeredness isolates—others exist only in relation to self
- Service to others is the antidote, not just trying to think less about self
- Recognizing self-centeredness is itself a form of progress

CLINICAL INSIGHT

Self-centeredness in addiction often developed as survival. When managing active addiction, intense self-focus is required just to function. This conditioning doesn't disappear with sobriety. Recovery involves gradually expanding awareness to genuinely include others.

THE PATIENT EXPERIENCE

Patients may resist the "selfish" label: "I've given everything to my family! I'm not selfish!" Help them see the distinction: self-centeredness is about perception and motivation, not just behavior. Someone can "sacrifice" for family while still being centrally focused on their own anxiety, image, or need to be needed.

CLINICAL REFLECTION

How do you help patients see their self-centeredness without shaming them? How do you distinguish between healthy self-care and unhealthy self-centeredness?

CLINICAL EXERCISE / ASSESSMENT TOOL

Self-centeredness awareness:

- "When you did [seemingly generous act], what were you hoping to get or avoid?"
 - "How often do you consider others' needs when they don't affect you?"
 - "When someone shares a problem, does your mind go to how it affects you?"
 - "Can you celebrate someone else's success without comparing to yourself?"
 - "What percentage of your thoughts are about yourself, honestly?"
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ACTION STEP FOR YOUR PRACTICE

Gently explore self-referential thinking with a patient. Help them see that self-centeredness is about perception, not moral failing, and that awareness is the first step to change.

Dishonesty: More Than Lying**OVERVIEW**

Dishonesty in character defect terms extends far beyond outright lying. It includes denial, minimization, rationalization, omission, exaggeration, impression management, self-deception, and all the ways patients distort reality to protect themselves. Active addiction requires elaborate dishonesty systems to maintain.

KEY POINTS FOR CLINICIANS

- Dishonesty includes self-deception, not just deceiving others
- Denial is a form of dishonesty with self
- Omission and minimization are dishonesty
- Addiction requires and reinforces dishonesty
- Honesty is a practice, not just a decision
- Rigorous honesty is a recovery lifestyle, not just avoiding lies

CLINICAL INSIGHT

By the time patients enter treatment, dishonesty has become automatic—a first response rather than a conscious choice. They may lie even when truth would serve them better. Recovery requires rebuilding honesty as a default, which takes time and practice.

THE PATIENT EXPERIENCE

Patients often don't recognize their dishonesty because it's automatic. They've been telling their story a certain way for so long, the distortions feel like truth. Gentle reality testing, without judgment, helps them see patterns they've normalized.

CLINICAL REFLECTION

How do you address dishonesty patterns without damaging the therapeutic relationship? How do you help patients recognize self-deception?

CLINICAL EXERCISE / ASSESSMENT TOOL

Honesty inventory:

- "When was the last time you told a 'small' lie? What were you protecting?"
 - "What truths about yourself do you avoid thinking about?"
 - "Who do you present a false version of yourself to? Why?"
 - "What would people be surprised to learn about you?"
 - "Where in your life do you routinely exaggerate or minimize?"
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ACTION STEP FOR YOUR PRACTICE

Help a patient identify one area where dishonesty is habitual. Explore the function: What does the dishonesty protect against? What would honesty risk?

Control: The Illusion of Safety

OVERVIEW

The need for control is a character defect rooted in fear—specifically, fear of what will happen if control is relinquished. Patients may control through manipulation, anger, micromanagement, withdrawal, or pleasing. The method varies; the underlying drive is the same: managing anxiety by managing external circumstances.

KEY POINTS FOR CLINICIANS

- Control is an attempt to manage anxiety by managing environment
- Multiple methods: anger, manipulation, withdrawal, people-pleasing
- Control provides illusion of safety but prevents intimacy
- Need for control often increases when internal life is chaotic
- Letting go of control is central to Steps 1-3 and 6-7
- Control frequently appears as "help" or "concern"

CLINICAL INSIGHT

Control often presents as something positive: "I just want to help," "I'm just organized," "I care about getting things right." Help patients see when legitimate care crosses into controlling behavior driven by their own anxiety rather than genuine concern for others.

THE PATIENT EXPERIENCE

Patients often don't see themselves as controlling: "I just have high standards," "I'm trying to help my family," "If I don't do it, it won't get done right." The controlling person usually sees themselves as responsible, not controlling.

CLINICAL REFLECTION

How do you help patients see their controlling patterns without triggering defensiveness? Where do you see control masquerading as care in your clinical work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Control inventory:

- "What happens in your body when things don't go as planned?"
 - "How do you react when someone does something differently than you would?"
 - "What areas of life do you absolutely need to manage?"
 - "What would happen if you let go of control in [specific area]?"
 - "Do you offer help or impose help? How do others experience your helpfulness?"
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ACTION STEP FOR YOUR PRACTICE

Identify a patient's primary control strategy. Explore the anxiety underneath and what they fear would happen if they loosened their grip.

Pride: The Obstacle to Growth

OVERVIEW

Pride in the Step Six/Seven context isn't healthy self-esteem—it's an inflated self-image that blocks growth. Pride says "I already know," "I don't need help," "I'm different/special," "I can handle this myself." Pride is the wall that prevents humility and keeps patients isolated from the help they need.

KEY POINTS FOR CLINICIANS

- Pride is inflated self-perception, not healthy confidence
- Pride blocks learning, help-seeking, and vulnerability
- "Terminal uniqueness"—I'm different from other addicts—is pride
- Pride often masks deep insecurity
- Pride and shame frequently coexist—flip sides of the same coin
- Pride says "I know"; humility says "I'm learning"

CLINICAL INSIGHT

Pride and shame often alternate in patients: grandiosity and self-loathing both represent distorted self-perception. The patient who says "I'm the worst" may be as pride-bound as one who says "I'm special"—both are making themselves exceptional, unable to be one among many.

THE PATIENT EXPERIENCE

Patients may resist identifying as "proud" because they feel terrible about themselves. Help them see that pride isn't about feeling good—it's about inflated self-focus. "I'm uniquely broken" is as

much pride as "I'm uniquely gifted."

CLINICAL REFLECTION

How do you help patients recognize pride when it masquerades as shame? How do you address "terminal uniqueness"?

CLINICAL EXERCISE / ASSESSMENT TOOL

Pride identification:

- "In what ways do you see yourself as different from other people in recovery?"
 - "When was the last time you admitted you were wrong—easily and genuinely?"
 - "How do you respond when someone offers help you didn't ask for?"
 - "Do you believe the normal rules apply to you?"
 - "What would you never want others to see you struggle with?"
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ACTION STEP FOR YOUR PRACTICE

Explore "terminal uniqueness" with a patient—the ways they believe they're different from others in recovery. What function does this belief serve?

People-Pleasing: The Quiet Defect

OVERVIEW

People-pleasing often isn't recognized as a character defect because it looks like virtue—being nice, accommodating, easy-going. But compulsive people-pleasing is fear-driven: fear of rejection, conflict, abandonment, or disapproval. It's dishonest (hiding true feelings), controlling (managing others' perceptions), and ultimately self-centered (focused on managing own anxiety).

KEY POINTS FOR CLINICIANS

- People-pleasing appears virtuous but is fear-driven
- It involves chronic dishonesty about true thoughts and feelings
- People-pleasers often harbor significant hidden resentment
- It blocks authentic relationships—others only know the mask
- Can enable others' dysfunction to avoid conflict
- Recovery requires learning to tolerate others' displeasure

CLINICAL INSIGHT

People-pleasers often present as ideal patients—agreeable, cooperative, saying what they think you want to hear. This very compliance can block genuine therapeutic work. Gently challenge agreement; look for authentic voice beneath accommodation.

THE PATIENT EXPERIENCE

People-pleasers often don't see the problem: "What's wrong with being nice? I just don't like conflict." Help them see the cost: chronic exhaustion, hidden resentment, no one really knowing them, inability to set boundaries, relationships built on false foundations.

CLINICAL REFLECTION

How do you identify people-pleasing in therapeutic relationships? How do you help patients see the dysfunction beneath apparent niceness?

CLINICAL EXERCISE / ASSESSMENT TOOL

People-pleasing inventory:

- "When was the last time you said yes when you meant no?"
- "Who in your life really knows what you think and feel?"
- "How do you feel when someone is disappointed in you?"
- "What resentments are you carrying from things you agreed to but didn't want?"
- "If you were completely honest for one day, what would change?"

ACTION STEP FOR YOUR PRACTICE

Identify a people-pleasing patient. In session, practice authentic disagreement or honest expression of a preference. Process the anxiety that arises.

Defects as Survival

Understanding why patients are attached to their defects

Character Defects as Adaptive Survival Strategies

OVERVIEW

Most character defects developed as survival strategies. They were solutions before they were problems. The anger that's destructive today protected a vulnerable child. The control that isolates now provided safety in chaos. Understanding defects as once-adaptive helps clinicians approach them with compassion rather than judgment—and helps patients release them.

KEY POINTS FOR CLINICIANS

- Most defects began as adaptive responses to difficult circumstances
- What was survival in childhood becomes dysfunction in adulthood
- Defects are often "loyal soldiers" that don't know the war is over
- Understanding the origin doesn't excuse the behavior but contextualizes it
- Patients need new strategies before they can release old ones
- Honoring what defects once provided helps patients let go

CLINICAL INSIGHT

When you explore the origins of a character defect, patients often connect to genuine grief—for the circumstances that required such adaptations, for the parts of themselves sacrificed to survive. This grief work can unlock willingness that shame never could.

THE PATIENT EXPERIENCE

Patients often feel deep shame about their defects: "What's wrong with me?" Reframing helps: "This is what you learned to do to survive. It worked then. It's not working now. We can learn new ways." This honors their history while opening space for change.

CLINICAL REFLECTION

How do you explore the adaptive origins of character defects with patients? How does understanding origin impact willingness to change?

CLINICAL EXERCISE / ASSESSMENT TOOL

Adaptive origin exploration:

- "When did you first learn to [defective behavior]? What was happening in your life?"
- "How did this behavior help you survive or cope at the time?"
- "What was it protecting you from?"
- "If a child developed this behavior in those circumstances, would it make sense?"
- "What would you say to that child about why they needed this?"

ACTION STEP FOR YOUR PRACTICE

Take one of a patient's character defects through this reframe: When did it start? What did it solve? What did it cost? What's it costing now?

Why Patients Resist Releasing Defects

OVERVIEW

Even patients who genuinely want recovery resist releasing character defects. This isn't perversity or lack of motivation—these defects feel essential. They've been identity, protection, coping mechanism. Asking someone to release a character defect can feel like asking them to release a part of themselves. Understanding this resistance is crucial for clinical effectiveness.

KEY POINTS FOR CLINICIANS

- Defects often feel like identity—"I am an angry person"
- Defects provide perceived protection even if dysfunctional
- Familiarity of dysfunction can feel safer than unknown of change
- Releasing defects surfaces the original pain they defended against
- Patients may fear they'll be vulnerable or weak without defects
- Resistance is information, not obstruction

CLINICAL INSIGHT

Resistance to releasing character defects is diagnostically useful. What a patient clings to most tightly often points to their deepest wounds and fears. The defect they "can't imagine living without" is probably protecting something extremely vulnerable.

THE PATIENT EXPERIENCE

Patients may say: "But if I'm not angry, people will walk all over me." "If I'm not guarded, I'll get hurt again." "If I stop controlling, everything will fall apart." These fears are real to them. Dismissing them won't help; exploring them will.

CLINICAL REFLECTION

How do you work with resistance to character change? What does resistance tell you about the patient's underlying fears?

CLINICAL EXERCISE / ASSESSMENT TOOL

Resistance exploration:

- "What would you be giving up if this defect were removed?"
- "What's the worst thing that could happen if you changed this?"

- "What identity would you lose?"
 - "If you imagine not having this defect, what feelings come up?"
 - "What does this defect protect you from that you don't have another way to handle?"
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ACTION STEP FOR YOUR PRACTICE

When a patient shows resistance to addressing a specific defect, get curious rather than confrontational. What is the resistance protecting?

Building Replacement Skills Before Releasing Defects

OVERVIEW

Patients cannot simply "stop" character defects without alternative coping strategies. If anger has been the primary response to feeling threatened, the patient needs new tools for safety before anger can be released. This is why behavioral skills training (DBT skills, communication training, boundary work) often accompanies Step Six/Seven work.

KEY POINTS FOR CLINICIANS

- Nature abhors a vacuum—removing without replacing fails
- New skills must be in place before old defenses can be dropped
- This is where clinical treatment adds to 12-step work
- DBT skills, communication training, trauma work support character change
- Skills need practice before they're available under stress
- Premature removal of defenses without skills creates vulnerability

CLINICAL INSIGHT

The 12-step program focuses on spiritual readiness; clinical treatment can focus on skill-building. These complement each other. A patient spiritually willing to release anger but with no alternative responses to threat will struggle. Teach skills alongside spiritual growth.

THE PATIENT EXPERIENCE

Patients feel more willing to release defects when they have alternatives: "I don't have to stop protecting myself—I'm learning better ways to protect myself." This reframe reduces the terror of character change.

CLINICAL REFLECTION

What skills do your patients need to develop in order to release specific character defects? How do you sequence skill-building with Step work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Skills mapping:

- "When [defect] is removed, what will you do instead?"
 - "What skills do you need to handle situations that currently trigger [defect]?"
 - "Who handles [situations] well without using [defect]? What do they do?"
 - "What's a small step you could practice this week?"
 - "Let's role-play: How could you respond to [trigger] without [defect]?"
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ACTION STEP FOR YOUR PRACTICE

For a patient working on Step Six, identify the practical skills they'll need to replace one character defect. Begin teaching and practicing those skills.

The Identity Crisis of Character Change

OVERVIEW

When character defects have been central to identity for decades, releasing them can trigger an identity crisis. "Who am I if I'm not the angry one, the helper, the strong one, the victim?" This disorientation is normal and expected. Patients need support through the ambiguous middle—no longer who they were, not yet who they're becoming.

KEY POINTS FOR CLINICIANS

- Long-held defects become fused with identity
- Character change can feel like death of self
- Identity ambiguity is disorienting and can increase anxiety
- Patients may mourn who they were, even if dysfunctional
- New identity emerges through action, not insight
- This transition requires significant support and patience

CLINICAL INSIGHT

The identity disruption of character change is often underestimated. Patients may feel lost, empty, or depressed even as they're making progress. Normalize this: "You're in between selves right now. This is part of the process, not a sign of failure."

THE PATIENT EXPERIENCE

Patients may say: "I don't know who I am anymore." "I feel like I'm losing myself." "Everyone expects me to be the old me but I don't want to be that anymore." These are signs of growth, not regression, even though they feel destabilizing.

CLINICAL REFLECTION

How do you support patients through identity transition? How do you help them tolerate the ambiguity between old and new selves?

CLINICAL EXERCISE / ASSESSMENT TOOL

Identity transition support:

- "Who were you before [defect] became central to your identity?"
 - "What parts of yourself exist independent of [defect]?"
 - "Who do you want to become? What values would guide that person?"
 - "What's it like to be in between—not the old you, not yet the new you?"
 - "How can you be patient with yourself during this transition?"
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ACTION STEP FOR YOUR PRACTICE

Help a patient articulate their emerging identity—who they're becoming, not just who they're leaving behind. Create space for the grief of transition.

The Patient Experience

What patients actually experience during Steps Six and Seven

Fear of Change vs. Fear of Staying the Same

OVERVIEW

Patients at Steps Six and Seven often exist in tension between two fears: the fear of what change will require and the fear of what staying the same will cost. Understanding this tension helps clinicians navigate ambivalence. The goal isn't to eliminate fear but to help patients choose which fear to move toward.

KEY POINTS FOR CLINICIANS

- Both change and stagnation carry legitimate fears
- Fear of change: unknown, vulnerability, loss of identity/defenses
- Fear of staying same: continued suffering, progressive deterioration
- The question isn't "Are you scared?" but "Which fear will you face?"
- Ambivalence is normal—both fears coexist
- Movement often comes when fear of same exceeds fear of change

CLINICAL INSIGHT

Motivational interviewing techniques are helpful here: developing discrepancy between current behavior and desired values, exploring both sides of ambivalence, supporting self-efficacy. The clinician doesn't push change but helps patients clearly see both options.

THE PATIENT EXPERIENCE

Patients feel stuck between impossible choices: "Change is terrifying. But I can't keep living like this either." Validating both fears often provides relief: "Of course you're ambivalent—both options are scary. The question is which fear you're willing to move toward."

CLINICAL REFLECTION

How do you work with the dual fears of change and stagnation? What tips the balance for your patients?

CLINICAL EXERCISE / ASSESSMENT TOOL

Dual fear exploration:

- "What scares you most about changing [defect]?"
- "What scares you most about NOT changing?"
- "If nothing changes, where will you be in 5 years?"
- "If you change, what's the best possible outcome?"
- "Which fear are you willing to face to have the life you want?"

ACTION STEP FOR YOUR PRACTICE

Use a decisional balance exercise with a patient: Four quadrants—benefits of changing, costs of changing, benefits of not changing, costs of not changing.

Shame and Character Defect Work

OVERVIEW

Steps Six and Seven require patients to look closely at their character defects and ask for help with them—which can trigger profound shame. Shame says: "These defects prove I'm bad." Patients may deflect, minimize, or disconnect from the work to manage shame. Clinicians must create safety for honest examination without shame spiral.

KEY POINTS FOR CLINICIANS

- Character defect work surfaces shame: "I'm defective"
- Shame leads to hiding, minimization, or abandoning the work
- Distinguish between guilt (I did wrong) and shame (I am wrong)
- Shame blocks the vulnerability Steps Six and Seven require
- Self-compassion is essential for honest self-examination
- Clinician attitude is crucial—acceptance allows honest exploration

CLINICAL INSIGHT

Your non-shaming stance is therapeutic. When you can discuss a patient's character defects matter-of-factly—neither minimizing nor catastrophizing—you model that these can be looked at without the world ending. This reduces shame enough for real work.

THE PATIENT EXPERIENCE

Patients often interpret character defect language as confirmation of worthlessness: "See, I knew I was horrible." Reframe: "These are patterns you learned, not who you are. Everyone has character defects. Yours are showing up. That's actually good news—now we can work on them."

CLINICAL REFLECTION

How do you create a shame-safe environment for character defect work? How do you help patients separate defects from identity?

CLINICAL EXERCISE / ASSESSMENT TOOL

Shame reduction strategies:

- "What's the difference between having character defects and being a bad person?"
- "Who do you respect that also has character defects?"

- "What would you say to a friend who was judging themselves this harshly?"
 - "Can you examine these patterns with curiosity rather than judgment?"
 - "What if these defects are problems to be solved rather than proof of your badness?"
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ACTION STEP FOR YOUR PRACTICE

Monitor your own reactions when patients share character defects. Does your expression or tone convey shame? Practice matter-of-fact acceptance.

The Experience of Becoming Willing

OVERVIEW

Becoming "entirely ready" is often a gradual process, not a single moment of decision. Patients may cycle through resistance, partial willingness, avoidance, and deeper willingness multiple times. Understanding willingness as a process rather than event helps clinicians and patients be patient with the journey.

KEY POINTS FOR CLINICIANS

- Willingness is typically gradual, not instantaneous
- Patients may be willing about some defects, not others
- Willingness fluctuates—readiness ebbs and flows
- "Willing to be willing" is a valid starting point
- Forcing willingness is counterproductive
- Each defect may require its own willingness journey

CLINICAL INSIGHT

Patients don't need to be 100% willing about all defects to do meaningful work. Start with where there is willingness. Success with one defect often increases willingness toward others. Trying to force comprehensive willingness usually backfires.

THE PATIENT EXPERIENCE

Patients may feel they're failing if they're not "entirely ready" for everything: "I should be further along by now." Normalize the process: "You're becoming more ready over time. Willingness isn't all-or-nothing. Being willing to be willing counts."

CLINICAL REFLECTION

How do you assess and track willingness across different character defects? How do you work with partial willingness?

CLINICAL EXERCISE / ASSESSMENT TOOL

Willingness mapping:

- Rate willingness 0-100% for each major character defect
 - "For ones below 50%, what would need to change to increase willingness?"
 - "For ones above 70%, what's making you more ready?"
 - "Which one feels most possible to start with?"
 - "If you can't be fully willing, can you be willing to explore?"
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ACTION STEP FOR YOUR PRACTICE

Create a willingness inventory with a patient. Identify the defect with highest willingness and start there rather than trying to address everything simultaneously.

The Paradox of Receiving Help

OVERVIEW

Step Seven asks patients to ask for help—to receive rather than achieve. For many, receiving is harder than giving. They've built identity around self-sufficiency, helping others, not needing anyone. Asking for and receiving help may be the most radical aspect of Step Seven work.

KEY POINTS FOR CLINICIANS

- Many patients are better at giving than receiving
- Self-sufficiency is often a defense against vulnerability
- Asking for help requires trust that others can and will help
- Receiving challenges beliefs like "I don't deserve help"
- Healthy interdependence is the goal, not dependence or independence
- The ability to receive is a character asset, not weakness

CLINICAL INSIGHT

The patient who resists receiving help in therapy is showing you their Step Seven work. Their therapeutic relationship practice becomes Step Seven practice: Can they receive your input, accept your care, let you help without immediately reciprocating or deflecting?

THE PATIENT EXPERIENCE

Patients may say: "I don't want to be a burden." "I should be able to handle this myself." "I hate feeling needy." Help them see: "Receiving help is a skill. It requires trust and vulnerability. It's actually the harder thing to do."

CLINICAL REFLECTION

How do you help patients learn to receive? How does resistance to receiving show up in the therapeutic relationship?

CLINICAL EXERCISE / ASSESSMENT TOOL

Receiving practice:

- "What makes receiving harder than giving for you?"
 - "What beliefs come up when someone offers help?"
 - "When was the last time you let someone help you without immediately repaying?"
 - "What would it mean to need others? Is that acceptable?"
 - "Can you practice receiving in this room? Let me help without deflecting?"
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ACTION STEP FOR YOUR PRACTICE

Notice deflection patterns when patients receive help, validation, or care. Gently name the pattern and invite them to try receiving without reciprocating or minimizing.

What Patients Need from Clinicians During Steps Six and Seven**OVERVIEW**

Patients doing Step Six and Seven work need specific things from clinicians: safety to explore without shame, help seeing blind spots, skill-building to replace defects, patience with the process, and modeling of humility. Understanding what patients need helps clinicians show up effectively.

KEY POINTS FOR CLINICIANS

- Safety: Non-shaming space for honest self-examination
- Insight: Help seeing patterns and blind spots
- Skills: Practical tools to replace defective patterns
- Patience: Understanding that character change is slow
- Modeling: Clinician demonstrating humility and growth
- Connection: Supportive relationship through the difficult work

CLINICAL INSIGHT

Your role is not to remove character defects—neither you nor the patient can do that through effort alone. Your role is to support the process: helping with identification, building willingness, teaching skills, and being a steady presence through the transformation.

THE PATIENT EXPERIENCE

Patients need to know their clinician believes they can change, will not shame them, and will stay engaged through the messy middle. They don't need a clinician who has arrived; they need one who models ongoing growth.

CLINICAL REFLECTION

What do your patients need most from you during Steps Six and Seven? How do you provide safety, insight, and skills while respecting the spiritual nature of the work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Needs assessment:

- "What do you need from me during this process?"
 - "What would help you feel safe enough to be honest about your defects?"
 - "How can I best support you without doing the work for you?"
 - "What would make this harder? What should I avoid?"
 - "How will you let me know if something I do isn't helping?"
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ACTION STEP FOR YOUR PRACTICE

Explicitly ask a patient what they need from you during their character work. Let them know you're a resource, not the source of transformation.

Spiritual Barriers

Working with resistance to spiritual concepts

Working with "The God Problem"

OVERVIEW

Steps Six and Seven reference God directly: "ready to have God remove" and "Humbly asked Him." Many patients struggle with this language due to religious trauma, atheism, agnosticism, or simply discomfort with spiritual concepts. Clinicians need strategies to help patients engage with these steps despite theological objections.

KEY POINTS FOR CLINICIANS

- Religious trauma is common in SUD populations
- Atheism/agnosticism don't preclude recovery
- The program emphasizes "God as we understood Him"—personalized conception
- What matters is connection to something beyond self
- Patients can use Higher Power, universe, group, truth, etc.
- Pushing specific theology creates unnecessary barriers

CLINICAL INSIGHT

Help patients find what works for them. Some connect to the group as Higher Power. Some find meaning in love, truth, nature, or conscience. The key is finding something that: is beyond individual ego, can be trusted, and provides guidance. The specific name matters less than the function.

THE PATIENT EXPERIENCE

Patients may say: "I can't do this because I don't believe in God." Help them explore: "What's something bigger than yourself that you could trust? It doesn't have to be supernatural. What represents wisdom, connection, or guidance to you?"

CLINICAL REFLECTION

How do you help patients with spiritual resistance engage with Steps Six and Seven? What conceptions of Higher Power have you seen work for skeptical patients?

CLINICAL EXERCISE / ASSESSMENT TOOL

Higher Power exploration:

- "Set aside the word 'God'—what's bigger than you that you could trust?"
- "What has helped you when your own thinking wasn't working?"
- "Where do you find guidance when you're stuck?"
- "What represents wisdom or truth to you?"
- "If you imagined the wisest, most loving presence, what would it be like?"

ACTION STEP FOR YOUR PRACTICE

Help a spiritually resistant patient articulate their own conception of Higher Power that they can authentically connect with during Steps Six and Seven.

Religious Trauma and Step Work

OVERVIEW

Many patients have been harmed by religious institutions or individuals using God-language. They may have experienced spiritual abuse, religious control, or church-based shaming. Steps Six and Seven can trigger this trauma. Clinicians must recognize religious trauma and help patients distinguish between harmful religion and helpful spirituality.

KEY POINTS FOR CLINICIANS

- Religious trauma creates strong negative associations with God-language
- Spiritual abuse often involved shame and control
- Patients may need trauma work before spiritual engagement
- The 12-step conception of God is often different from abusive religion
- Distinguishing between institution and spirituality is important
- Patients set the pace for spiritual reconnection

CLINICAL INSIGHT

Don't push patients to "get over" religious trauma to do step work. Acknowledge the validity of their injuries. Help them see that what hurt them may not represent what the steps are pointing toward. But let them approach spiritual concepts at their own pace.

THE PATIENT EXPERIENCE

Patients with religious trauma may feel triggered, skeptical, or angry when Steps Six and Seven come up: "This is just another system trying to control me." Their resistance is self-protection. Honor it while gently exploring what healthy spirituality might look like.

CLINICAL REFLECTION

How do you assess for religious trauma in your patients? How do you help traumatized patients engage with spiritual content in the steps?

CLINICAL EXERCISE / ASSESSMENT TOOL

Religious history exploration:

- "What was your experience with religion growing up?"
- "How was God talked about in your family or community?"

- "Have religious people or institutions hurt you?"
 - "What would a loving, non-controlling spiritual presence be like?"
 - "What would need to be different for spiritual concepts to feel safe?"
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ACTION STEP FOR YOUR PRACTICE

Screen for religious trauma in patients struggling with Steps Six and Seven. Determine if trauma work needs to precede or accompany spiritual step engagement.

Perfectionism and "Entirely Ready"

OVERVIEW

Patients with perfectionism may approach Step Six obsessively: "I have to be ENTIRELY ready. I have to identify EVERY defect. I have to do this PERFECTLY." This perfectionism is itself a character defect blocking the step. Help patients see that perfectionism applied to Step Six undermines its intent.

KEY POINTS FOR CLINICIANS

- Perfectionism turns Step Six into another impossible standard
- "Entirely ready" doesn't mean perfectly ready
- Progress, not perfection, is the actual goal
- Perfectionism creates paralysis, not readiness
- The perfectionist approach to steps misses the point
- Perfectionism may be one of the defects to become willing about

CLINICAL INSIGHT

The perfectionist patient trying to do Steps Six and Seven "perfectly" is demonstrating the exact defect the steps address. Gently name this paradox: "You're trying to perfectly become imperfectly human. What if 'good enough' is actually the goal?"

THE PATIENT EXPERIENCE

Perfectionists may feel they can never be ready "enough": "I'm not entirely ready because I still have some resistance. I must be failing." Help them see: "Resistance is normal. Ambivalence is human. You don't need perfect willingness to move forward."

CLINICAL REFLECTION

How do you identify perfectionism operating in Step work? How do you help patients release the need to do recovery "right"?

CLINICAL EXERCISE / ASSESSMENT TOOL

Perfectionism in step work:

- "What would 'good enough' readiness look like?"
 - "What if 'entirely' means 'to the best of your current ability'?"
 - "Is perfectionism itself a defect you're working on?"
 - "What would it be like to do this step imperfectly?"
 - "How is trying to do this perfectly actually keeping you stuck?"
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ACTION STEP FOR YOUR PRACTICE

Identify if perfectionism is blocking a patient's Step Six work. Reframe "entirely ready" as current-capacity willingness, not perfect willingness.

The Action of "Asking"

OVERVIEW

Step Seven requires asking—but what does that mean practically? For patients uncomfortable with prayer, the asking can feel foreign. Help patients understand that asking can take many forms: prayer, meditation, intention-setting, conscious acknowledgment, verbal commitment, written declaration, or simply open-hearted desire.

KEY POINTS FOR CLINICIANS

- Asking can be prayer, meditation, intention, or declaration
- The form matters less than the sincerity
- Some patients speak to God; others set intentions
- Writing, speaking aloud, or silent reflection all count
- The key is conscious, humble acknowledgment of need
- Regular practice of asking reinforces the orientation

CLINICAL INSIGHT

Help patients find their authentic way of asking. A patient who writes a letter to their Higher Power is asking. A patient who sits in silent openness is asking. A patient who attends a meeting and silently acknowledges need is asking. Don't impose a single form.

THE PATIENT EXPERIENCE

Patients may feel awkward: "I don't know how to pray. I feel stupid talking to someone I'm not sure is there." Normalize the awkwardness: "Many people feel that way. What matters is the sincere intention, not the polished form."

CLINICAL REFLECTION

What forms of asking have you seen patients use successfully? How do you help patients find authentic spiritual practice?

CLINICAL EXERCISE / ASSESSMENT TOOL

Finding authentic asking:

- "What would feel natural to you—writing, speaking, sitting in silence?"
 - "If you were to express your willingness, how would you do it?"
 - "What would it mean to ask without knowing if anyone is listening?"
 - "Could you try speaking your intention aloud, even if it feels awkward?"
 - "What practice could you commit to daily, even for just a minute?"
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ACTION STEP FOR YOUR PRACTICE

Help a patient create their own Step Seven practice—a form of asking that feels authentic to them. Practice it together in session if appropriate.

Clinical Applications

Translating Step Six & Seven understanding into clinical practice

Integrating Steps Six and Seven with Clinical Treatment

OVERVIEW

Steps Six and Seven address character change—which is also a clinical goal. The spiritual process and clinical work complement each other: clinical treatment provides assessment, insight, skills, and support; the program provides spiritual framework and community. Clinicians can enhance Step work without replacing it.

KEY POINTS FOR CLINICIANS

- Clinical and 12-step work complement, not compete
- Clinical treatment adds: assessment, skills, trauma work, insight
- 12-step adds: spiritual framework, community, peer support
- Clinicians can facilitate Step work without leading it
- Skills training supports character change process
- Avoid either over-reliance on 12-step or dismissing it

CLINICAL INSIGHT

Your role isn't to be their sponsor or lead their Step work. Your role is to provide clinical support that enhances the process: identifying underlying issues, building skills, processing trauma, offering insight, and providing consistent support. Let the program do what it does; you do what you do.

THE PATIENT EXPERIENCE

Patients benefit from both: "My sponsor helps me work the steps, but my therapist helps me understand why I'm stuck and gives me tools to practice." The combined approach is more effective than either alone.

CLINICAL REFLECTION

How do you integrate 12-step work with clinical treatment? How do you collaborate with sponsors without overstepping?

CLINICAL EXERCISE / ASSESSMENT TOOL

Integration planning:

- "How is your Step work going? Where do you need support?"
- "What clinical skills might help with your character defect work?"
- "What does your sponsor focus on? What could we add here?"
- "How can therapy support your spiritual growth without replacing it?"
- "What would comprehensive support look like?"

ACTION STEP FOR YOUR PRACTICE

Coordinate with patient about their 12-step work. Identify specific ways clinical treatment can support Steps Six and Seven without duplicating sponsor role.

Differentiating Character Defects from Mental Health Symptoms

OVERVIEW

Not everything that looks like a character defect is one. Irritability might be depression. Withdrawal might be anxiety. Impulsivity might be ADHD. Clinicians must differentiate between character issues and treatable mental health conditions. Treating a patient's depression as a spiritual problem—or their character issue as purely medical—both fail.

KEY POINTS FOR CLINICIANS

- Many mental health symptoms resemble character defects
- Depression, anxiety, ADHD, trauma can all mimic defects
- Proper assessment prevents spiritual bypass of medical issues
- Also prevents medicalizing genuine character issues
- Co-occurring conditions are common—both may be present
- Treatment should address both mental health and character

CLINICAL INSIGHT

A patient's "anger problem" might be partly PTSD hyperarousal. Their "selfishness" might be partly depression's self-focus. Their "inability to commit" might be partly ADHD. Full clinical assessment ensures you're addressing all the right issues.

THE PATIENT EXPERIENCE

Patients may feel confused: "Is this a spiritual problem or a mental health problem?" Often it's both: "You have anxiety that benefits from treatment AND you've developed character patterns around managing that anxiety. We work on both."

CLINICAL REFLECTION

How do you differentiate character defects from mental health symptoms? How do you address both without spiritual bypass or over-medicalization?

CLINICAL EXERCISE / ASSESSMENT TOOL

Differential assessment:

- Complete mental health screening for patients in early recovery
- "When did this pattern start? Before or after substance use?"

- "Is this pattern constant or does it fluctuate with mood?"
 - "Have medications ever changed this pattern?"
 - Track symptoms separately from character patterns
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ACTION STEP FOR YOUR PRACTICE

For patients working on Steps Six and Seven, ensure adequate mental health assessment. Identify what requires clinical treatment versus character work.

Using Character Defects in Treatment Planning

OVERVIEW

The character defects identified in Step work can inform clinical treatment planning. If a patient identifies fear as their root defect, anxiety-focused interventions make sense. If control is central, DBT skills might help. Aligning clinical work with Step-identified issues increases relevance and engagement.

KEY POINTS FOR CLINICIANS

- Step Four inventory reveals key targets for clinical work
- Character defect themes can guide intervention selection
- Fear-dominant: anxiety interventions, exposure work
- Control-dominant: acceptance strategies, DBT skills
- Resentment-dominant: forgiveness work, cognitive restructuring
- Alignment between clinical work and Step work improves outcomes

CLINICAL INSIGHT

When patients have done Step Four work, they've already done substantial self-assessment. Use this. Ask to see their inventory (if appropriate), or have them summarize themes. This information can directly inform your treatment focus.

THE PATIENT EXPERIENCE

Patients appreciate when clinical work connects to their recovery work: "My therapist is helping me with the exact things I identified in my inventory. It all fits together." This coherence increases engagement.

CLINICAL REFLECTION

How do you use Step work information in treatment planning? How do you align clinical interventions with character defect themes?

CLINICAL EXERCISE / ASSESSMENT TOOL

Treatment alignment:

- "What themes emerged from your Step Four inventory?"
 - "Which character defect is causing the most problems currently?"
 - "What clinical skills might help with [specific defect]?"
 - "How can we make our work here support your Step Six and Seven process?"
 - Map clinical interventions to specific defect patterns
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ACTION STEP FOR YOUR PRACTICE

Review a patient's Step Four themes and align one clinical intervention specifically with their identified character defect pattern.

Group Therapy and Steps Six and Seven

OVERVIEW

Group therapy provides unique opportunities for Steps Six and Seven work: mutual identification, feedback about blind spots, practice ground for new behaviors, and community support for change. Groups can address character defects that individual therapy might miss because the defects show up in relationship.

KEY POINTS FOR CLINICIANS

- Groups reveal character defects that individual work might miss
- Peers can offer feedback individuals resist from clinicians
- Mutual identification reduces shame about defects
- Groups provide practice arena for new patterns
- Community support enhances willingness to change
- Group process can mirror 12-step fellowship dynamics

CLINICAL INSIGHT

A patient's people-pleasing, control, dishonesty, or isolation show up immediately in group. "How you do anything is how you do everything." Group therapy makes character patterns visible and provides a laboratory for practicing change.

THE PATIENT EXPERIENCE

Patients often learn more about their defects from group feedback than self-reflection: "I had no idea I came across as controlling. Multiple people said the same thing. I couldn't dismiss that."

CLINICAL REFLECTION

How do you use group therapy to support character defect work? What character issues become visible in group that might not appear in individual treatment?

CLINICAL EXERCISE / ASSESSMENT TOOL

Group for character work:

- Design groups specifically addressing character defect themes
 - Create structured feedback opportunities
 - Use group dynamics as material: "What's happening right now?"
 - Process how members' defects interact
 - Practice new behaviors with group support
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ACTION STEP FOR YOUR PRACTICE

Consider how group therapy could enhance a patient's Steps Six and Seven work. What defects would benefit from group feedback or practice?

Tracking Progress in Character Change

OVERVIEW

Character change is gradual and hard to measure. Patients often don't recognize their own progress. Clinicians can help by tracking specific, measurable indicators: frequency of defect-driven behavior, intensity of reactions, recovery time after slips, range of situations handled differently.

KEY POINTS FOR CLINICIANS

- Character change is gradual and easy to miss
- Specific, behavioral indicators help track progress
- Frequency, intensity, duration, recovery time are measurable
- Self-report plus external feedback gives fuller picture
- Celebrating progress reinforces change
- Tracking maintains motivation during slow periods

CLINICAL INSIGHT

Create simple tracking systems: "How many times this week did you notice the urge to [defect] but chose differently?" "On a scale of 1-10, how intense was your anger?" "How long did it take you to calm down?" These concrete measures reveal progress patients might miss.

THE PATIENT EXPERIENCE

Patients often feel they're not changing: "I still get angry." Help them see: "You used to explode; now you remove yourself. You used to stay angry for days; now it's hours. You used to deny it; now you see it. That's progress."

CLINICAL REFLECTION

How do you track character change progress? What indicators do you use? How do you help patients recognize incremental improvement?

CLINICAL EXERCISE / ASSESSMENT TOOL

Progress tracking:

- "How often did [defect behavior] occur this week vs. last month?"
 - "When it happened, how intense was it? How long did it last?"
 - "Did you notice it faster than usual?"
 - "Did you try any new responses? How did they work?"
 - Track patterns over time with simple rating scales
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ACTION STEP FOR YOUR PRACTICE

Create a simple tracking tool with a patient for one character defect: frequency, intensity, awareness speed, new response attempts. Review weekly to show progress.

Clinical Pitfalls

Common mistakes clinicians make with Steps Six and Seven

Rushing Steps Six and Seven

OVERVIEW

In treatment settings with time pressure, there's temptation to rush through Steps Six and Seven. "You've identified your defects. Are you willing to change? Great, you did Steps Six and Seven." This superficial treatment misses the profound internal work these steps require and sets patients up for later struggle.

KEY POINTS FOR CLINICIANS

- Steps Six and Seven cannot be completed in a single session
- Depth of willingness takes time to develop
- Rushing creates superficial change that doesn't last
- Treatment center time pressure can undermine quality step work
- Better to do deep work on partial willingness than superficial work on full
- These steps are returned to throughout recovery

CLINICAL INSIGHT

If your treatment setting pressures rapid step completion, advocate for depth over speed. A patient who deeply engages with willingness about one defect has done better work than one who superficially addresses all of them. The steps are returned to; initial depth matters more than initial breadth.

THE PATIENT EXPERIENCE

Patients may perform completion without genuine engagement: "I did the steps—can I go home now?" Slow down: "Let's not just check boxes. Let's actually engage with what these steps are asking."

CLINICAL REFLECTION

What pressures in your setting push rapid step completion? How do you create space for genuine engagement despite time constraints?

CLINICAL EXERCISE / ASSESSMENT TOOL

Depth assessment:

- "Walk me through how you engaged with Step Six"
- "Which defects are you genuinely willing to release? Which not so much?"
- "What's the hardest part of becoming willing?"
- "If this feels quick and easy, we might be missing something"
- "These steps deserve more than a quick yes"

ACTION STEP FOR YOUR PRACTICE

Examine your treatment setting's approach to Steps Six and Seven. Advocate for depth over speed. Build in ongoing return to these steps throughout treatment.

Confusing Character Defects with Personality

OVERVIEW

Character defects are patterns that can change; personality is more stable. Clinicians sometimes frame defects as fixed: "You're just an angry person." "That's just who you are." This fatalistic framing undermines the hope inherent in Steps Six and Seven—that people can change.

KEY POINTS FOR CLINICIANS

- Character defects are mutable; personality is more stable
- Framing defects as fixed undermines hope for change
- Patients often believe their defects are "just who they are"
- Steps Six and Seven assert that change is possible
- Distinguishing between "I am" and "I do" creates space for change
- Even longstanding patterns can shift with willingness and help

CLINICAL INSIGHT

Watch your language. "You're controlling" is different from "You use controlling behavior." "You're a liar" is different from "You have a pattern of dishonesty." The second framing suggests change is possible; the first suggests it isn't.

THE PATIENT EXPERIENCE

Patients often say: "I've always been this way. I can't change." Challenge this gently: "These are patterns you've practiced for a long time. They feel like you. But they're things you do, not who you are. Things we do can change."

CLINICAL REFLECTION

Do you ever frame character defects as fixed personality? How does your language create or limit space for change?

CLINICAL EXERCISE / ASSESSMENT TOOL

Language of changeability:

- Reframe "I am" statements to "I do" statements
- "When did this pattern start? There was a you before this pattern"
- "What would you be if this pattern changed? Who is under it?"

- "Have you ever acted differently? That's evidence of changeability"
 - Avoid diagnostic labels that suggest permanence
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ACTION STEP FOR YOUR PRACTICE

Review how you talk about character defects with patients. Ensure your language conveys that these are patterns that can change, not fixed traits.

Shaming Patients About Their Defects

OVERVIEW

Character defect work requires naming problematic patterns. But there's a difference between honest identification and shaming. Shaming patients about their defects reinforces the shame that often drove addiction in the first place. Non-shaming confrontation is a clinical skill to develop.

KEY POINTS FOR CLINICIANS

- Identifying defects is necessary; shaming about them is harmful
- Shame reinforces hiding and blocking genuine work
- Tone, timing, and framing determine whether feedback shames
- Patients are already shame-prone about defects
- Non-shaming confrontation says "this pattern AND you're worth changing it"
- Clinician stance should be curiosity and acceptance, not judgment

CLINICAL INSIGHT

Your attitude when discussing defects matters enormously. If you can discuss character defects with the same tone you'd use discussing a medical condition—matter-of-fact, compassionate, treatment-oriented—patients can engage without collapsing into shame.

THE PATIENT EXPERIENCE

Patients are exquisitely attuned to judgment. They've judged themselves harshly for years. They need clinicians who can see their defects clearly without disgust. "My therapist knows all my worst traits and still treats me with respect."

CLINICAL REFLECTION

How do you provide honest feedback about character defects without shaming? How do you maintain warmth while naming difficult patterns?

CLINICAL EXERCISE / ASSESSMENT TOOL

Non-shaming feedback:

- Focus on pattern, not person: "I notice this pattern" vs. "You always do this"
 - Include context: "Given your history, this makes sense"
 - Express confidence: "And you can develop different patterns"
 - Check in: "How does it feel to hear this?"
 - Maintain warm tone throughout
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ACTION STEP FOR YOUR PRACTICE

Practice non-shaming confrontation. Identify a defect pattern you need to name with a patient. Plan language that's honest but not shaming.

Ignoring the Spiritual Dimension

OVERVIEW

Some clinicians, uncomfortable with spirituality, try to do Steps Six and Seven work in purely clinical terms. But these are fundamentally spiritual steps—about willingness, surrender, humility, and asking for help. Stripping the spiritual dimension makes them self-improvement projects, which isn't what they are.

KEY POINTS FOR CLINICIANS

- Steps Six and Seven are inherently spiritual, not just behavioral
- Purely clinical approach misses the surrender dimension
- Self-improvement through effort is not the same as these steps
- Spiritual doesn't mean religious—but it is transcendent
- Clinicians can support spiritual work without imposing beliefs
- Ignoring spirituality may leave patients without full recovery tools

CLINICAL INSIGHT

You don't have to be religious to support spiritual work. You can help patients engage with something beyond themselves, practice humility, and develop willingness without pushing any particular belief system. The clinical skill is supporting their spiritual process, not leading it.

THE PATIENT EXPERIENCE

Patients in clinical treatment who also do 12-step work want both: clinical skills and spiritual support. "My therapist doesn't have to pray with me, but I want them to understand why I pray."

CLINICAL REFLECTION

What's your comfort level with the spiritual dimensions of Steps Six and Seven? How do you support spiritual work without imposing or avoiding?

CLINICAL EXERCISE / ASSESSMENT TOOL

Supporting spiritual process:

- "How is your spiritual practice supporting this work?"
 - "What role does your Higher Power play in your character change?"
 - "How do you experience asking for help with your defects?"
 - "What does surrender mean to you practically?"
 - Don't avoid the spiritual; don't impose your beliefs
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ACTION STEP FOR YOUR PRACTICE

Reflect on your comfort with spiritual content. If you tend to avoid it, practice asking patients about their spiritual experience with Steps Six and Seven.

Expecting Immediate Results

OVERVIEW

Steps Six and Seven are often followed by... more struggle with the same defects. Patients (and clinicians) may expect that sincere willingness and humble asking will produce rapid change. Usually it doesn't. Character change is typically gradual, uneven, and requires ongoing return to these steps.

KEY POINTS FOR CLINICIANS

- Character change is usually gradual, not dramatic
- Defects may diminish rather than disappear
- Return to defects is normal, not failure
- The steps are practiced repeatedly throughout recovery
- Progress is often visible only in retrospect
- Expecting instant change sets patients up for discouragement

CLINICAL INSIGHT

Manage expectations. Patients who expect to be different people after Step Seven often become discouraged. Help them understand: "These steps open you to change. The change itself unfolds over time. You'll return to these steps many times."

THE PATIENT EXPERIENCE

Patients may feel they've failed: "I did Step Seven and I still got angry this week." Reframe: "The step wasn't about eliminating anger overnight. It was about opening yourself to change. Are you noticing your anger faster? That's how it starts."

CLINICAL REFLECTION

What expectations do you hold about pace of character change? How do you help patients tolerate the slow unfolding of transformation?

CLINICAL EXERCISE / ASSESSMENT TOOL

Managing expectations:

- "What do you expect to be different after Step Seven?"
- "Character change is usually gradual—more like learning an instrument than flipping a switch"
- "You'll probably still struggle with these defects. The question is: are you struggling differently?"
- "How will you maintain willingness when change is slow?"
- Set realistic progress markers

ACTION STEP FOR YOUR PRACTICE

Explicitly discuss expectations with patients approaching Steps Six and Seven. Set realistic expectations about pace and pattern of change.

Pathologizing Normal Character Flaws**OVERVIEW**

While character defects need attention, clinicians sometimes over-pathologize normal human imperfection. Not every flaw is a "defect." Not every imperfection requires treatment. The goal is functional humanity, not sainthood. Help patients prioritize defects that cause significant problems.

KEY POINTS FOR CLINICIANS

- Not every imperfection is a character defect requiring work
- Normal human flaws don't all need clinical attention
- Focus on defects causing significant dysfunction
- Recovery goal is functional humanity, not perfection
- Over-analysis of every flaw can paralyze patients
- Some things are just human—not everything needs fixing

CLINICAL INSIGHT

Help patients prioritize. Ask: "Which of these patterns is causing the most harm to your recovery, relationships, or wellbeing?" Start there. Not every tendency needs to be a clinical focus. Some imperfections are just... being human.

THE PATIENT EXPERIENCE

Perfectionistic patients may try to eliminate every flaw: "I need to work on my impatience, my procrastination, my occasional white lies, my mild envy..." Help them focus: "Let's work on the ones actually causing problems. The rest is just being human."

CLINICAL REFLECTION

How do you help patients prioritize character work? How do you distinguish between significant defects and normal human imperfection?

CLINICAL EXERCISE / ASSESSMENT TOOL

Prioritization:

- "Which of your patterns causes the most damage?"
 - "If you could only change one thing, what would matter most?"
 - "What's causing problems vs. what's just being imperfect?"
 - "Not everything needs to be fixed. What actually needs attention?"
 - Help focus on high-impact issues
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ACTION STEP FOR YOUR PRACTICE

With a patient doing Step Six work, help them prioritize. Identify the 2-3 defects causing most dysfunction rather than trying to address everything.

Doing the Patient's Work for Them

OVERVIEW

Clinicians sometimes overfunction—identifying defects for patients, pushing them toward willingness, even praying/setting intentions on their behalf. But Steps Six and Seven require the patient's active engagement. The clinician's role is to support, not substitute for, the patient's own work.

KEY POINTS FOR CLINICIANS

- The patient must identify their own defects (with help)
- Willingness cannot be imposed from outside
- The asking in Step Seven is the patient's, not the clinician's
- Overfunctioning creates dependency, not recovery
- Support the process; don't do it for them
- Struggle is part of the growth—don't steal it

CLINICAL INSIGHT

Your job is to ask good questions, provide tools, offer feedback, and maintain the frame. It's not to make decisions for patients, generate their willingness, or move them through steps they're not ready for. That's their work.

THE PATIENT EXPERIENCE

Patients may want the clinician to tell them what to do: "Just tell me what my defects are and I'll work on them." Resist this: "I can offer observations. But this is your inventory, your willingness,

your asking. I'm here to support, not replace."

CLINICAL REFLECTION

Where do you tend to overfunction with patients? How do you maintain supportive presence without doing their work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Appropriate support:

- Ask instead of tell: "What are you noticing?" vs. "Here's what I see"
- Reflect instead of direct: "What do you think you need to work on?"
- Support instead of do: "How can I help you engage with this?"
- Check your impulse to rescue or push
- Trust the patient's capacity to do their own work

ACTION STEP FOR YOUR PRACTICE

Notice when you're tempted to overfunction with a patient doing step work. Practice holding back, asking questions, and letting them struggle productively.

Your clinical notes

Changes to my practice

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