

Clinical Step Working Guide

Steps 8-9: Amends

For SUD and mental health counselors

Step Eight

"Made a list of all persons we had harmed, and became willing to make amends to them all."

The step of preparation—identifying harm and developing willingness.

Step Nine

"Made direct amends to such people wherever possible, except when to do so would injure them or others."

The step of action—making things right while protecting others.

Clinician Resources

Understanding Steps Eight and Nine deeply allows you to support patients through the vulnerable, transformative work of making amends—repairing relationships, clearing conscience, and experiencing the freedom the Big Book promises.

Recommended Reading

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

Clinical Training

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

Step Eight: Foundation

Understanding the amends list and becoming willing

The Two Parts of Step Eight: List and Willingness

OVERVIEW

Step Eight states: "Made a list of all persons we had harmed, and became willing to make amends to them all." Note the two distinct parts: making the list AND becoming willing. These are separate tasks. A patient can complete the list before achieving full willingness. The willingness work may take time—and that's appropriate.

KEY POINTS FOR CLINICIANS

- Step Eight has two components: list-making and willingness
- The list can be completed before full willingness develops
- Willingness is the internal work; the list is external
- "All persons" means comprehensive—no one excluded initially
- "Became willing" implies a process, not instant achievement
- Willingness is required before Step Nine action

CLINICAL INSIGHT

Many patients conflate the list with the amends themselves, feeling they must be ready to face everyone before writing names. Separate these: "First, we honestly list everyone harmed. The willingness to actually approach them is different work." This removes a barrier to beginning.

THE PATIENT EXPERIENCE

Patients often say: "I can't put them on the list because I'm not ready to talk to them." Clarify: "The list isn't a commitment to immediate action. It's honest acknowledgment of harm. Willingness is the next piece, and it develops over time."

CLINICAL REFLECTION

How do you help patients distinguish between making the list and becoming willing? What blocks willingness most commonly in your patients?

CLINICAL EXERCISE / ASSESSMENT TOOL

Separating list from willingness:

- "Let's make the list without worrying about what comes next"
- "Who have you harmed? Write them all—we'll work on willingness separately"
- "For each name, rate your willingness 0-100%. We'll work on the lower ones"
- "What makes you unwilling regarding [specific person]?"
- "Willingness can grow. Where might willingness develop over time?"

ACTION STEP FOR YOUR PRACTICE

Help a patient complete their Step Eight list without requiring immediate willingness. Then work on willingness as a separate, subsequent process.

Defining "Harm" Comprehensively

OVERVIEW

The Step Eight list includes "all persons we had harmed." But what constitutes harm? It extends far beyond obvious damage to include: broken promises, emotional unavailability, stolen time and attention, lies, manipulation, neglect, financial impact, worry caused, role-modeling dysfunction, and subtle damage that accumulated over time.

KEY POINTS FOR CLINICIANS

- Harm includes obvious damage AND subtle accumulation
- Emotional harm: unavailability, worry, fear, disappointment
- Financial harm: theft, unpaid debts, economic impact
- Relational harm: broken trust, violated boundaries
- Harm by omission: neglect, abandonment, absence
- Harm to institutions, employers, communities—not just individuals

CLINICAL INSIGHT

Patients often have narrow definitions of harm, listing only dramatic incidents. Help them expand: "What about the worry your mother carried? The childhood experiences your kids missed? The coworkers who covered for you?" Comprehensive listing enables comprehensive healing.

THE PATIENT EXPERIENCE

Patients may minimize: "I never hit anyone. I wasn't that bad." Expand their view: "Harm isn't just physical violence. It's every way your addiction affected others—the fear, the disappointment, the broken promises, the absence."

CLINICAL REFLECTION

How do you help patients expand their definition of harm? What categories of harm do your patients most often overlook?

CLINICAL EXERCISE / ASSESSMENT TOOL

Harm inventory expansion:

- "Beyond obvious harms, who worried about you?"
- "Who was disappointed by broken promises?"

- "Who was emotionally affected by your unavailability?"
 - "What financial impacts did others experience?"
 - "Who counted on you when you weren't reliable?"
 - "What institutions or employers were affected?"
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ACTION STEP FOR YOUR PRACTICE

Review a patient's Step Eight list for comprehensiveness. Help them identify categories of harm they may have overlooked.

Step Eight Builds on Step Four

OVERVIEW

Step Eight isn't created from scratch—it builds directly on Step Four's harms inventory. The names from the Fourth Step become the foundation of the Eighth Step list. However, Step Eight may include additional names that emerge with continued reflection, and it transforms the inventory into an action-oriented list.

KEY POINTS FOR CLINICIANS

- Step Four harms inventory becomes Step Eight foundation
- Additional names may emerge beyond Step Four list
- Step Eight transforms insight into action preparation
- The "my part" from Step Four clarifies what amends are owed
- Step Eight is more focused—specifically on persons harmed
- Time between Steps Four and Eight may surface new awareness

CLINICAL INSIGHT

If a patient's Step Eight list looks very different from their Step Four harms inventory, explore why. Did they hold back in Step Four? Has new awareness emerged? The alignment—or lack of it—is diagnostically useful.

THE PATIENT EXPERIENCE

Patients may feel like they're repeating work: "I already did this in Step Four." Clarify the difference: "Step Four was about understanding yourself. Step Eight is about preparing to repair relationships. The list serves a different purpose now."

CLINICAL REFLECTION

How do you help patients connect Step Eight to their Step Four work? What additional harms typically emerge between these steps?

CLINICAL EXERCISE / ASSESSMENT TOOL

Connecting Steps Four and Eight:

- "Let's review your Step Four harms—these form your Step Eight foundation"
 - "Who else has come to mind since completing Step Four?"
 - "Looking at your resentment inventory, where were you also at fault?"
 - "What harms did you minimize in Step Four that need fuller acknowledgment?"
 - "How has your understanding of harm evolved since Step Four?"
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ACTION STEP FOR YOUR PRACTICE

When a patient begins Step Eight, start by reviewing their Step Four inventory to ensure continuity and identify any gaps or new awareness.

Including Oneself on the List

OVERVIEW

A frequently overlooked aspect of Step Eight: the patient has harmed themselves. Self-harm through addiction includes physical damage, wasted years, lost opportunities, self-betrayal, and violated personal values. Including self on the amends list—and making amends to oneself—is legitimate and important recovery work.

KEY POINTS FOR CLINICIANS

- Patients have harmed themselves through addiction
- Self-harm includes: physical damage, lost time, violated values
- Self-amends is legitimate recovery work
- Self-forgiveness is often the hardest amend
- Amends to self may include: self-care, keeping promises to self, living in integrity
- Self-compassion supports ability to make amends to others

CLINICAL INSIGHT

Patients who cannot forgive themselves often struggle to make amends to others. Self-directed amends—treating oneself with the respect and care previously denied—can unlock willingness toward others. Don't overlook this dimension.

THE PATIENT EXPERIENCE

Some patients resist self-inclusion: "This is supposed to be about others." Others overemphasize self: "I'm the one who really suffered." Balance is key: the self belongs on the list alongside—not instead of—others.

CLINICAL REFLECTION

How do you address self-amends with patients? What does making amends to oneself look like in practice?

CLINICAL EXERCISE / ASSESSMENT TOOL

Self-amends exploration:

- "How have you harmed yourself through addiction?"
 - "What would making amends to yourself look like?"
 - "What promises to yourself have you broken?"
 - "How might you treat yourself differently going forward?"
 - "Can you forgive yourself for what addiction cost you?"
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ACTION STEP FOR YOUR PRACTICE

Ensure patients include themselves on the Step Eight list. Explore what self-amends might look like concretely.

Willingness Toward Those Who Also Harmed Us

OVERVIEW

The hardest willingness challenge: people who harmed the patient. "Why should I make amends to someone who hurt me worse?" Step Eight asks for willingness to make amends for our part, regardless of others' behavior. This doesn't minimize what was done to the patient—it focuses on cleaning their own side of the street.

KEY POINTS FOR CLINICIANS

- Many on the list also harmed the patient
- Amends are about cleaning our side, not theirs
- Others' wrongs don't cancel our responsibility
- Willingness doesn't require minimizing what they did
- "My part" focus keeps it actionable
- This is often the biggest willingness challenge

CLINICAL INSIGHT

Validate the patient's experience: "Yes, they hurt you. That was real and wrong. AND you also caused harm that's yours to address. Both are true. You can only clean up your part." This both/and framing helps patients move forward without feeling dismissed.

THE PATIENT EXPERIENCE

Patients often protest: "But they started it!" "They did worse to me!" "Why don't they have to make amends?" These are understandable reactions. Acknowledge them while redirecting: "You're responsible for your behavior, not theirs. What's your part?"

CLINICAL REFLECTION

How do you help patients develop willingness toward people who harmed them? How do you validate their wounds while maintaining Step Eight focus?

CLINICAL EXERCISE / ASSESSMENT TOOL

Willingness with mutual harm:

- "What did they do to you? [Validate] AND what was your part?"
 - "You can't control whether they make amends. What can you control?"
 - "Making amends doesn't mean what they did was okay"
 - "How would holding onto this affect your recovery?"
 - "What would freedom from this resentment be worth?"
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ACTION STEP FOR YOUR PRACTICE

Identify patients who struggle with willingness toward people who hurt them. Work on this specific block with both/and validation.

The Willingness Process: From Resistance to Readiness

OVERVIEW

Willingness is rarely instant. Patients typically move through stages: resistance ("I'll never make amends to them"), partial willingness ("Maybe someday"), growing openness ("I'm starting to see why"), and genuine willingness ("I'm ready to do this"). Understanding this progression helps clinicians support patients wherever they are.

KEY POINTS FOR CLINICIANS

- Willingness develops in stages, not instantly
- Resistance → Partial willingness → Growing openness → Readiness
- Different names on the list may be at different stages
- "Willing to become willing" is a valid starting point
- Forcing premature willingness backfires
- Time, prayer, and processing support willingness development

CLINICAL INSIGHT

Meet patients where they are on the willingness spectrum. A patient willing to become willing has made progress. Don't demand readiness that hasn't developed. At the same time, gently challenge long-term stuckness—sometimes growth requires a push.

THE PATIENT EXPERIENCE

Patients often feel they should be further along: "I've been sober six months—why can't I forgive them yet?" Normalize the process: "Willingness develops at its own pace. Where are you today?"

That's where we work."

CLINICAL REFLECTION

How do you assess where patients are on the willingness spectrum? How do you support movement without forcing premature action?

CLINICAL EXERCISE / ASSESSMENT TOOL

Willingness spectrum assessment:

- "Rate your willingness for each person: 0-100%"
- "For anyone below 50%, what would help willingness grow?"
- "Are you willing to become willing?"
- "What shifts when you imagine actually making this amend?"
- "What support do you need to move toward readiness?"

ACTION STEP FOR YOUR PRACTICE

Create a willingness assessment with a patient: map where they are with each name on their list and identify what would support movement.

Step Nine: Foundation

Understanding direct amends and the process

The Meaning of "Direct Amends"

OVERVIEW

Step Nine specifies "direct amends"—face-to-face acknowledgment and repair wherever possible. Direct amends means going to the person, acknowledging the harm, expressing genuine remorse, and asking what can be done to make it right. It's not indirect (through others) or vague (general apologies). It's specific, personal, and direct.

KEY POINTS FOR CLINICIANS

- "Direct" means face-to-face when possible
- Includes: specific acknowledgment of harm, genuine remorse, offer to repair
- Not just "I'm sorry" but "I did this, I'm sorry, how can I make it right?"
- Phone or written amends when face-to-face isn't possible
- Indirect amends (through third parties) are last resort
- Amends differ from apologies—they include action

CLINICAL INSIGHT

Many patients want to make amends through letters or texts to avoid face-to-face vulnerability. While sometimes appropriate, direct in-person amends carries different weight. Help patients understand why directness matters while being realistic about what's possible.

THE PATIENT EXPERIENCE

Patients often prefer less direct approaches: "Can I just send a card?" "I'll apologize if I run into them." Explore the avoidance: "What would be different about going directly to them? What are you avoiding?"

CLINICAL REFLECTION

How do you guide patients toward direct amends while remaining flexible when direct isn't possible? What makes directness therapeutically valuable?

CLINICAL EXERCISE / ASSESSMENT TOOL

Direct amends preparation:

- "What specifically do you need to acknowledge?"
- "What would you say face-to-face?"
- "What are you afraid will happen if you approach directly?"
- "What repair can you offer?"
- "Practice: Say it to me as if I were that person"

ACTION STEP FOR YOUR PRACTICE

Help a patient prepare for a direct amend: script the acknowledgment, practice delivery, and plan for various responses.

Amends vs. Apologies: Understanding the Difference

OVERVIEW

Apologies and amends are not the same. An apology is "I'm sorry." An amend is "I'm sorry, here's what I did wrong, and here's what I'm willing to do to make it right." Amends include acknowledgment, remorse, AND repair or restitution. The word "amend" means to change or improve—it implies action beyond words.

KEY POINTS FOR CLINICIANS

- Apology = expression of regret
- Amend = acknowledgment + remorse + repair/action
- "Amend" means to change, improve, or repair
- Words alone may not constitute full amends
- Changed behavior often matters more than words
- Some amends are primarily verbal; others require action

CLINICAL INSIGHT

Patients who have apologized repeatedly during active addiction may believe amends have already been made. Help them see the difference: "You've said sorry many times. What's different now is backing words with changed behavior over time. That's the amend."

THE PATIENT EXPERIENCE

Patients sometimes think: "I already apologized for that years ago." Explore: "How was that apology received? Did anything change afterward? What would a true amend look like now, with the substance use addressed?"

CLINICAL REFLECTION

How do you help patients distinguish between apologies they've already made and genuine amends? What makes amends different from past apologies?

CLINICAL EXERCISE / ASSESSMENT TOOL

Apology vs. amends clarification:

- "Have you apologized to this person before? What happened?"
- "What would be different about an amend versus past apologies?"

- "Beyond words, what action could repair this harm?"
 - "What does this person actually need from you?"
 - "How will sustained changed behavior demonstrate your amend?"
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ACTION STEP FOR YOUR PRACTICE

Help patients identify where past apologies failed and what genuine amends would include beyond words.

The Timing of Amends

OVERVIEW

Step Nine doesn't say "immediately made amends." Timing matters. Premature amends—made before adequate sobriety, preparation, or willingness—can backfire. The Big Book advises waiting until patients are ready and the timing is appropriate. Rushed amends may serve the patient's need for relief more than the other person's healing.

KEY POINTS FOR CLINICIANS

- Timing of amends requires wisdom and guidance
- Premature amends can do more harm than good
- Adequate sobriety foundation before major amends
- Sponsor/clinical guidance on timing is important
- Some amends take years to become appropriate
- Patient's urgency may not match recipient's readiness

CLINICAL INSIGHT

Patients newly in recovery often feel urgent about amends—driven by guilt, desire for relief, or pressure. Help them slow down: "Let's make sure you're ready, the timing is right, and the amend will actually help—not just make you feel better."

THE PATIENT EXPERIENCE

Early recovery often brings urgency: "I need to apologize to everyone right now!" This urgency may be guilt-driven rather than other-focused. Explore: "Who is this amend for? What timing would serve them, not just you?"

CLINICAL REFLECTION

How do you counsel patients on amends timing? What signs indicate readiness versus premature urgency?

CLINICAL EXERCISE / ASSESSMENT TOOL

Timing assessment:

- "What's driving the urgency to make this amend now?"
 - "How solid is your recovery foundation?"
 - "Is the other person ready to receive this?"
 - "What would be lost by waiting? What might be gained?"
 - "Have you discussed timing with your sponsor?"
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ACTION STEP FOR YOUR PRACTICE

When patients express urgency about amends, explore whether the timing serves recovery or avoids discomfort. Guide appropriate pacing.

The Role of the Sponsor in Step Nine

OVERVIEW

The Big Book emphasizes not making amends without guidance: "Reminding ourselves that we have decided to go to any lengths... we ask that we be given strength and direction to do the right thing, no matter what the personal consequences may be." Sponsors help patients navigate complex amends decisions, timing, and approach.

KEY POINTS FOR CLINICIANS

- Sponsor guidance is emphasized for Step Nine
- Complex amends require experienced perspective
- Sponsors help with timing, approach, and "except when" decisions
- Patients may have blind spots about impact on others
- Accountability prevents avoidance and prevents harm
- Clinicians can support but typically don't replace sponsor role

CLINICAL INSIGHT

Your role as clinician complements but doesn't replace the sponsor role in Step Nine. Sponsors typically have lived experience with amends. You add clinical perspective on trauma, safety, relationships, and mental health considerations. Collaboration is ideal.

THE PATIENT EXPERIENCE

Some patients want to make amends decisions alone: "I know what I need to do." Others rely too heavily on being told what to do. The balance: "You make the final decision, with wise counsel. Neither isolated nor dependent."

CLINICAL REFLECTION

How do you collaborate with sponsors on Step Nine guidance? What unique clinical perspective do you add?

CLINICAL EXERCISE / ASSESSMENT TOOL

Support structure exploration:

- "What does your sponsor advise about this amend?"
 - "Where do you see things differently?"
 - "What clinical considerations might affect this amend?"
 - "How can therapy support your Step Nine work?"
 - "What wisdom are you drawing on for this decision?"
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ACTION STEP FOR YOUR PRACTICE

Establish clear role boundaries with patients doing Step Nine: support the process, add clinical perspective, but respect the sponsor relationship.

What to Say: The Anatomy of an Amend

OVERVIEW

Effective amends have common elements: taking full responsibility (no excuses, no "but"), specific acknowledgment of what was done, genuine expression of remorse, recognition of impact on the other person, and an offer to repair. The focus stays on the patient's behavior, not explanations or defenses.

KEY POINTS FOR CLINICIANS

- Take full responsibility—no "buts" or qualifications
- Be specific about what was done wrong
- Express genuine remorse (not guilt-driven or performative)
- Acknowledge impact on the other person
- Ask what would help or what repair is possible
- Keep it about your behavior, not their response

CLINICAL INSIGHT

Rehearse amends with patients. Listen for qualifications ("I'm sorry, BUT..."), explanations that minimize, or focus on getting forgiveness. Redirect to clean acknowledgment: "What happens if you remove the 'but'? What happens if you don't explain why?"

THE PATIENT EXPERIENCE

Patients often want to explain: "But I was addicted," "But they also..." Help them see: "Explanations often sound like excuses to the listener. Pure acknowledgment is more powerful."

CLINICAL REFLECTION

How do you help patients craft effective amends statements? What common mistakes do you hear in rehearsal?

CLINICAL EXERCISE / ASSESSMENT TOOL

Amends script development:

- "State what you did wrong without any qualifiers"
 - "Express remorse in your own words"
 - "Acknowledge specifically how it affected them"
 - "Ask what you could do to make it right"
 - "Now remove anything that sounds like an excuse"
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ACTION STEP FOR YOUR PRACTICE

Practice amends statements with patients, listening for qualifications, explanations, or focus on getting forgiveness. Help them achieve clean acknowledgment.

When Amends Are Not Accepted

OVERVIEW

Not everyone will accept amends. Some people are not ready, some are still too hurt, some have moved on and don't want contact. Patients must be prepared for rejection, anger, or indifference. The amend is the patient's responsibility; the response is not theirs to control. Making the amend, not getting a desired response, is the goal.

KEY POINTS FOR CLINICIANS

- Amends may be rejected—prepare patients for this
- Others are not obligated to accept or forgive
- The patient's job is making the amend, not controlling response
- Rejection doesn't mean the amend was wrong
- Some relationships won't be restored—grief may follow
- Making the amend is completing the work, regardless of outcome

CLINICAL INSIGHT

Patients often secretly hope amends will repair relationships or provide closure. Help them release attachment to outcome: "You're responsible for your side—the honest acknowledgment and offer of repair. Their response is their business. Can you make this amend without needing anything back?"

THE PATIENT EXPERIENCE

After rejection, patients may say: "What was the point?" "It didn't work." Help reframe: "The point was cleaning your side of the street. You did that. Their response isn't something you can control."

CLINICAL REFLECTION

How do you prepare patients for possible rejection? How do you help them process when amends aren't accepted?

CLINICAL EXERCISE / ASSESSMENT TOOL

Preparing for response:

- "What response do you hope for?"
- "What if they're angry? Cold? Dismissive?"
- "Can you make this amend without needing forgiveness?"
- "What would you need to process if they don't accept?"
- "How will you care for yourself regardless of outcome?"

ACTION STEP FOR YOUR PRACTICE

Before significant amends, explore patients' expectations and prepare them for the full range of possible responses, including rejection.

Types of Amends

Direct, living, financial, and other forms of amends

Direct Amends: Face-to-Face Acknowledgment

OVERVIEW

Direct amends are the gold standard: personal, face-to-face acknowledgment of harm with offer of repair. This requires the most vulnerability and typically creates the most powerful impact. When possible and safe, direct amends should be the default approach.

KEY POINTS FOR CLINICIANS

- Face-to-face is most vulnerable and most powerful
- Includes verbal acknowledgment and often physical presence
- Allows for dialogue, questions, emotional exchange
- Demonstrates seriousness and commitment
- Not always possible (distance, safety, death)
- Should be the default when circumstances allow

CLINICAL INSIGHT

Direct amends are harder, which is part of why they're valuable. The vulnerability of looking someone in the eye while acknowledging harm creates different internal and relational dynamics than written or phone amends.

THE PATIENT EXPERIENCE

Patients may avoid direct amends through excuses: "They're too far away," "They don't want to see me," "A letter would be better." Explore whether these are genuine barriers or avoidance.

CLINICAL REFLECTION

When do you encourage direct face-to-face amends? How do you help patients overcome avoidance of direct approaches?

CLINICAL EXERCISE / ASSESSMENT TOOL

Direct amends preparation:

- "What would it be like to say this looking them in the eye?"
 - "What are you avoiding by preferring a letter or call?"
 - "What could direct contact provide that other methods can't?"
 - "Let's practice: make this amend to me as if I were them"
 - "What support do you need to do this directly?"
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ACTION STEP FOR YOUR PRACTICE

Challenge patients who default away from direct amends. Explore whether barriers are real or avoidance.

Living Amends: Changed Behavior Over Time**OVERVIEW**

Living amends are changes in behavior demonstrated consistently over time. They say "I'm different now" through action rather than words. Living amends are especially important for ongoing relationships (spouse, children, parents) where trust was destroyed and must be rebuilt through reliable, sustained changed behavior.

KEY POINTS FOR CLINICIANS

- Living amends = sustained changed behavior
- Actions over time rebuild trust that words cannot
- Essential for ongoing relationships damaged by addiction
- Complements but doesn't replace verbal acknowledgment
- Requires consistency over months and years
- The best evidence that change is real

CLINICAL INSIGHT

Living amends are not an excuse to avoid verbal acknowledgment. They complement direct amends. A patient who says "I'll just show them through my actions" may be avoiding the vulnerability of acknowledgment. Both are usually needed.

THE PATIENT EXPERIENCE

Patients may prefer living amends: "Actions speak louder than words." This is true AND verbal acknowledgment matters. Help them see: "Your changed behavior shows you're different. The direct acknowledgment of past harm also matters. Both."

CLINICAL REFLECTION

How do you help patients understand the relationship between living amends and direct amends? What does a living amend look like specifically?

CLINICAL EXERCISE / ASSESSMENT TOOL

Living amends planning:

- "What changed behavior would demonstrate your amend to [person]?"
- "What do they need to see consistently over time?"
- "How long before consistent behavior builds trust?"
- "What would they say a 'living amend' looks like?"
- "How does living amends complement what you'll say directly?"

ACTION STEP FOR YOUR PRACTICE

Help patients identify specific living amends behaviors for key relationships, understanding these complement rather than replace direct acknowledgment.

Financial Amends: Repaying Debts and Damages**OVERVIEW**

Financial amends address concrete monetary harm: theft, unpaid debts, borrowed money never returned, financial damage caused by addiction. These amends are tangible and measurable. Payment plans, restitution, and genuine effort to repay—even when full repayment seems impossible—demonstrate accountability.

KEY POINTS FOR CLINICIANS

- Financial harms require financial repair when possible
- Includes: theft, unpaid debts, damage to property, borrowed money
- Full repayment may not be immediately possible
- Payment plans and genuine effort demonstrate sincerity
- Some financial amends may take years
- Intention to repay, with action, is the amend

CLINICAL INSIGHT

Financial amends can feel overwhelming when amounts are large. Help patients develop realistic plans: "You may not be able to repay this immediately. What can you commit to? A payment plan, even small, shows sincerity."

THE PATIENT EXPERIENCE

Patients may feel hopeless about large debts: "I'll never be able to repay that." Reframe: "It's not about being able to repay instantly. It's about genuine effort over time. What can you do?"

CLINICAL REFLECTION

How do you help patients approach financial amends when amounts feel overwhelming? What constitutes adequate financial amends?

CLINICAL EXERCISE / ASSESSMENT TOOL

Financial amends planning:

- "What financial harms do you owe amends for?"
- "What's realistic to repay and on what timeline?"
- "What payment plan could you commit to?"

- "How do you communicate your intention to make this right?"
 - "What if full repayment isn't possible?"
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ACTION STEP FOR YOUR PRACTICE

Help patients inventory financial harms and develop realistic repayment plans that demonstrate sincerity even when full repayment isn't immediately possible.

Amends to Institutions and Organizations

OVERVIEW

Amends aren't only to individuals. Patients may owe amends to employers (theft, fraud, poor performance), institutions (legal violations, unpaid debts), communities, or organizations. These amends may involve restitution, volunteer service, or direct acknowledgment to institutional representatives.

KEY POINTS FOR CLINICIANS

- Amends may be owed to employers, institutions, communities
- Workplace harms: theft, fraud, time theft, poor performance
- Legal/institutional harms may require restitution
- Community harms might be addressed through service
- Anonymous amends possible when direct isn't appropriate
- Some institutional amends involve financial restitution

CLINICAL INSIGHT

Institutional amends can be complex. Directly confessing to an employer about theft may have legal implications. Work with patients (and possibly legal counsel) to navigate these carefully. The spirit of amends can be honored in various ways.

THE PATIENT EXPERIENCE

Patients may minimize institutional harm: "They're a big company—they didn't really suffer." Challenge this: "The company is made of people. And this is about your integrity, not just their loss."

CLINICAL REFLECTION

How do you guide patients through amends to institutions? What considerations differ from interpersonal amends?

CLINICAL EXERCISE / ASSESSMENT TOOL

Institutional amends assessment:

- "What employers, institutions, or organizations did your addiction affect?"
 - "What form might amends take for each?"
 - "Are there legal considerations to navigate?"
 - "What would make this right, even symbolically?"
 - "How might anonymous or indirect amends work here?"
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ACTION STEP FOR YOUR PRACTICE

Help patients identify institutional harms and explore appropriate forms of amends, including legal considerations when relevant.

Symbolic Amends: When Direct Isn't Possible

OVERVIEW

When direct amends are impossible (person deceased, unlocatable, or where contact would cause harm), symbolic amends can honor the intention. This might include: donations in someone's name, service to causes they cared about, letters never sent, or changed behavior that honors what was owed.

KEY POINTS FOR CLINICIANS

- Symbolic amends when direct isn't possible
- Honoring the intention when person is unavailable
- Options: donations, service, letters written but not sent
- Behavior change that honors what was owed
- Spiritual practices (prayer, meditation) for the person
- Not a substitute for direct amends when those are possible

CLINICAL INSIGHT

Symbolic amends should never be an easy out. They're reserved for genuine impossibility, not discomfort. When used appropriately, they provide meaningful closure when direct amends can't happen.

THE PATIENT EXPERIENCE

Patients may need help finding meaning in symbolic amends: "What's the point if they'll never know?" The point is completing the patient's work, honoring what was owed, and integrating the loss.

CLINICAL REFLECTION

When do you recommend symbolic amends? How do you ensure they're meaningful rather than an avoidance of harder work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Symbolic amends creation:

- "Since direct amends isn't possible, how might you honor what was owed?"
 - "What did this person value? How might you honor that?"
 - "Would a letter—even unsent—help you process?"
 - "What service or contribution might represent this amend?"
 - "How can you carry forward what you owe them?"
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ACTION STEP FOR YOUR PRACTICE

Help patients create meaningful symbolic amends for situations where direct amends are genuinely impossible.

The "Except When" Clause

When NOT to make amends—protecting others from harm

Understanding "Except When to Do So Would Injure"

OVERVIEW

Step Nine includes a crucial exception: "except when to do so would injure them or others." This isn't an escape clause for avoiding difficult amends—it's guidance for preventing amends from causing additional harm. The exception protects others, not the patient's comfort.

KEY POINTS FOR CLINICIANS

- The exception protects others, not the patient
- Not about avoiding uncomfortable amends
- Asks: Would this amend cause harm to someone?
- Harm to "them" (the person receiving amends) or "others"
- Requires careful, honest assessment
- Sponsor/clinical guidance important for these decisions

CLINICAL INSIGHT

Patients sometimes misuse this exception to avoid hard amends: "It might upset them." Upset is not the same as injury. Help patients distinguish between discomfort (which is often necessary) and genuine harm (which should be avoided).

THE PATIENT EXPERIENCE

Patients may rationalize avoidance: "They've moved on—bringing this up would hurt them." Explore honestly: "Would it really harm them? Or are you predicting discomfort that might actually be manageable?"

CLINICAL REFLECTION

How do you help patients honestly apply the "except when" exception? What distinguishes legitimate protection from avoidance?

CLINICAL EXERCISE / ASSESSMENT TOOL

"Except when" assessment:

- "Who might be harmed if you make this amend?"
- "Is this 'harm' or 'discomfort'?"
- "Whose interests are you protecting—theirs or yours?"
- "What would happen if you made this amend?"
- "What does your sponsor say about this?"

ACTION STEP FOR YOUR PRACTICE

When patients invoke the exception, carefully explore whether they're genuinely protecting others or avoiding discomfort.

Protecting the Innocent: Affairs and Secrets

OVERVIEW

Classic "except when" scenarios involve affairs or secrets that, if disclosed, would devastate innocent parties. Confessing an affair to "make amends" might relieve the patient's guilt while destroying a spouse or family. Here, the patient's desire for confession conflicts with others' wellbeing. Guidance is essential.

KEY POINTS FOR CLINICIANS

- Confessing affairs may harm innocent spouses
- Patient's guilt relief vs. others' devastation
- These amends require very careful consideration
- Living amends may be more appropriate than confession
- Each situation is unique—no universal rule
- Experienced guidance essential for these decisions

CLINICAL INSIGHT

The affair confession scenario highlights the difference between amends and confession. Is the patient seeking to make things right or seeking relief from guilt? If confession would primarily relieve the patient while devastating the spouse, the "except when" clause applies.

THE PATIENT EXPERIENCE

Patients carrying secret affairs often feel tortured: "I need to tell her—the lying is killing me." Explore: "Who would the telling serve? What harm might it cause? Is there another way to live amends without devastating disclosure?"

CLINICAL REFLECTION

How do you counsel patients about amends involving secret affairs? What factors inform these difficult decisions?

CLINICAL EXERCISE / ASSESSMENT TOOL

Secret/affair amends assessment:

- "Who would be affected by this disclosure?"
- "What harm might confession cause to innocent parties?"

- "Is this about making amends or relieving your guilt?"
 - "What would a living amend look like without confession?"
 - "Have you discussed this with your sponsor?"
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ACTION STEP FOR YOUR PRACTICE

When patients face amends involving secrets that could harm innocents, engage in thorough assessment before any action.

When Contact Would Harm the Other Person

OVERVIEW

Sometimes the person harmed would be further harmed by contact. This includes: stalking or harassment situations, abusive relationships where the patient was perpetrator, cases where the other person has explicitly requested no contact, or situations where the person has healed and moved on and contact would retraumatize.

KEY POINTS FOR CLINICIANS

- Some people would be harmed by any contact
- Prior abuse or harassment situations
- When no-contact has been explicitly requested
- When the person has healed and contact would reopen wounds
- Respecting others' boundaries is itself an amend
- Living amends or symbolic amends may be appropriate

CLINICAL INSIGHT

A patient who abused or stalked someone does not have the right to initiate contact for their own closure. Respecting the other person's boundaries—staying away—IS the amend. This can be hard for patients who want active closure.

THE PATIENT EXPERIENCE

Patients may feel incomplete: "I need to apologize to her." But if she's requested no contact, the amend is honoring that: "Your amend is respecting her boundary. Leaving her alone IS making amends."

CLINICAL REFLECTION

How do you help patients accept that non-contact can be the appropriate amend? What makes staying away a form of amends?

CLINICAL EXERCISE / ASSESSMENT TOOL

When non-contact is the amend:

- "Has this person asked for no contact?"
 - "Would contact serve them or you?"
 - "How might respecting their boundary BE the amend?"
 - "What living or symbolic amend could honor what you owe?"
 - "Can you find peace without their direct response?"
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ACTION STEP FOR YOUR PRACTICE

Help patients understand that in certain situations, staying away and respecting boundaries IS the amend. Support them in finding closure without contact.

Legal Consequences and Self-Incrimination

OVERVIEW

Some potential amends involve confessing to crimes. The "except when" clause can apply when amends would result in criminal prosecution, imprisonment, or legal consequences that would harm the patient's family. This requires careful navigation with legal counsel and program guidance.

KEY POINTS FOR CLINICIANS

- Some amends involve confessing to crimes
- Criminal prosecution affects patient AND their family
- Legal counsel may be appropriate
- Each situation requires individual assessment
- Some choose to make amends despite legal risk
- Others find alternative ways to address the harm

CLINICAL INSIGHT

This is delicate territory. Some patients feel called to confess regardless of consequences; others must consider families dependent on them. There's no universal answer. Help patients think through the full implications while respecting their ultimate decision.

THE PATIENT EXPERIENCE

Patients may be torn: "I stole from my employer. Confessing might mean charges. But how can I live with this?" Help them explore: "What are all the implications? Who would be affected? What does your conscience require?"

CLINICAL REFLECTION

How do you navigate amends with legal implications? What role do you play in these decisions?

CLINICAL EXERCISE / ASSESSMENT TOOL

Legal implications assessment:

- "What legal consequences could result?"
 - "Who else would be affected by those consequences?"
 - "Have you consulted legal counsel?"
 - "What does your conscience require?"
 - "Are there ways to make amends without criminal exposure?"
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ACTION STEP FOR YOUR PRACTICE

When amends involve potential legal consequences, encourage thorough consideration including legal consultation when appropriate.

Balancing Honesty and Harm: Making Difficult Decisions

OVERVIEW

The "except when" clause creates genuine ethical tension: recovery demands honesty AND we must not harm others. How do we balance these values? The Big Book advises "we cannot be helpful to all people" and emphasizes avoiding harm while maintaining integrity. Each case requires wisdom.

KEY POINTS FOR CLINICIANS

- Genuine tension between honesty and harm prevention
- Recovery values both—they can conflict
- Wisdom required for each unique situation
- Guidance from sponsor, spiritual advisor, or clinician essential
- Prayer/meditation often part of decision process
- Some decisions remain ambiguous—imperfect choices

CLINICAL INSIGHT

Not all "except when" decisions are clear. Some patients will face genuinely ambiguous situations where thoughtful people might disagree. Support the process of discernment without mandating specific outcomes. Sometimes the patient must make an imperfect choice.

THE PATIENT EXPERIENCE

Patients may want certainty: "Just tell me what to do." Sometimes there's no clear right answer: "I can help you think through this, but ultimately you'll need to make a decision you can live with."

CLINICAL REFLECTION

How do you support patients facing ambiguous "except when" decisions? What's your role when there's no clear right answer?

CLINICAL EXERCISE / ASSESSMENT TOOL

Decision-making support:

- "What values are in tension here?"
 - "What would honesty require? What would harm prevention require?"
 - "What can you live with?"
 - "What does your Higher Power/conscience guide you toward?"
 - "Can you make an imperfect choice and accept that?"
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ACTION STEP FOR YOUR PRACTICE

Support patients through ambiguous amends decisions by helping them weigh values and discern conscience, without mandating outcomes.

The Patient Experience

What patients actually experience during Steps Eight and Nine

Fear and Avoidance in Steps Eight and Nine

OVERVIEW

Steps Eight and Nine trigger intense fear: fear of rejection, anger, humiliation, legal consequences, and the vulnerability of facing those we've harmed. Avoidance is natural. Patients may stall at Step Eight, finding reasons to delay Step Nine indefinitely. Understanding these fears helps clinicians support movement.

KEY POINTS FOR CLINICIANS

- Fear is the most common barrier to amends
- Fears include: rejection, anger, humiliation, consequences
- Avoidance shows up as "reasons" to delay
- Procrastination often masks fear
- Fear is normal—it doesn't prevent action
- Support helps patients move through fear, not around it

CLINICAL INSIGHT

Listen for rationalizations that mask fear: "The timing isn't right," "They probably don't want to hear from me," "I need to be more stable first." These may be legitimate—or they may be fear-based avoidance. Explore gently.

THE PATIENT EXPERIENCE

Patients may not identify their avoidance as fear: "I'm just being thoughtful about timing." Help them name it: "What if underneath all these good reasons, there's also fear? What are you afraid might happen?"

CLINICAL REFLECTION

How do you distinguish legitimate caution from fear-based avoidance? What helps patients move through fear toward action?

CLINICAL EXERCISE / ASSESSMENT TOOL

Fear exploration:

- "What are you afraid will happen when you make this amend?"
- "What's the worst-case scenario?"
- "What would you do if that happened?"
- "Is this reason to delay legitimate or fear-based?"
- "What support would help you move forward despite fear?"

ACTION STEP FOR YOUR PRACTICE

When patients seem stuck on Steps Eight or Nine, explore fear directly. Name it, validate it, and help them move through rather than around it.

The Weight of Guilt and the Relief of Action

OVERVIEW

Many patients carry crushing guilt about harm they've caused. This guilt can become paralyzing or can drive relapse. Steps Eight and Nine offer a structured path through guilt into action. Making amends doesn't erase the past, but it transforms guilt into accountability and repair.

KEY POINTS FOR CLINICIANS

- Guilt about harm can be crushing and paralyzing
- Unaddressed guilt may drive relapse
- Steps 8 and 9 transform guilt into action
- Action is liberating where rumination is not
- Amends don't erase but do address the past
- Relief follows genuine accountability and repair

CLINICAL INSIGHT

Patients stuck in guilt need action, not just processing. Therapy can help with guilt, but at some point, doing something about the harm provides relief that talking about it cannot. Steps Eight and Nine provide that path.

THE PATIENT EXPERIENCE

Patients weighed by guilt may say: "I can't stop thinking about what I did to them." The antidote: "Thinking about it doesn't change it. Making amends does. Not to erase the past, but to do what's possible now."

CLINICAL REFLECTION

How do you help patients move from guilt rumination to amends action? What makes action different from endless processing?

CLINICAL EXERCISE / ASSESSMENT TOOL

Guilt to action:

- "How long have you been carrying this guilt?"
- "Has thinking about it changed anything?"
- "What would actually doing something look like?"

- "What could you do, not to erase the past, but to address it?"
 - "What relief might come from action?"
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ACTION STEP FOR YOUR PRACTICE

For patients stuck in guilt rumination, guide them toward Step Eight and Nine action as the path through guilt, not just talking about it.

The Experience of Making the Amend

OVERVIEW

The actual moment of making an amend—facing the person, saying the words—is often intense. Patients may experience anxiety before, relief during, and a range of emotions after. The experience varies widely: some amends go better than expected; some are harder. Each is its own journey.

KEY POINTS FOR CLINICIANS

- The moment of amends is often emotionally intense
- Pre-amends anxiety is common and normal
- The actual experience varies widely
- Some go better than expected; some are harder
- Relief often follows the vulnerability
- Each amend is its own experience

CLINICAL INSIGHT

Support patients before, during (if appropriate), and after significant amends. Pre-amends sessions for preparation, perhaps availability during (phone), and processing sessions after all help patients integrate these significant experiences.

THE PATIENT EXPERIENCE

After amends, patients often say: "It was different than I expected." Whether better or worse, the reality rarely matches the imagination. Help patients see: "You faced it. That's what matters. Now let's process what happened."

CLINICAL REFLECTION

How do you support patients through the amends experience—before, during, and after? What preparation helps most?

CLINICAL EXERCISE / ASSESSMENT TOOL

Processing the amends experience:

- "What was that like for you?"
 - "What surprised you?"
 - "How did they respond?"
 - "What are you feeling now?"
 - "What did you learn from this experience?"
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ACTION STEP FOR YOUR PRACTICE

Schedule processing sessions after significant amends to help patients integrate the experience, whether it went well or poorly.

When Amends Open Old Wounds

OVERVIEW

Making amends sometimes opens wounds the patient had suppressed. Facing the reality of harm caused, seeing someone's pain, or having consequences become real can surface grief, shame, or trauma. Clinicians should be prepared for emotional intensification during amends work.

KEY POINTS FOR CLINICIANS

- Amends can surface suppressed emotions
- Seeing the real impact of harm is confronting
- Grief, shame, and trauma may intensify
- This is part of the healing process
- Clinical support may be especially important here
- The wounds need opening to heal

CLINICAL INSIGHT

Watch for increased symptoms during Step Nine work. Patients may need extra support—more frequent sessions, crisis availability, or coping skills work. The intensity usually indicates engagement, not deterioration, but monitor carefully.

THE PATIENT EXPERIENCE

Patients may be surprised by their own reactions: "I thought I was ready for this, but seeing her face when I admitted what I did..." The emotional reality can exceed intellectual preparation.

CLINICAL REFLECTION

How do you prepare patients for emotional intensity during amends? What support structures help?

CLINICAL EXERCISE / ASSESSMENT TOOL

Emotional intensity preparation:

- "What emotions might come up during this amend?"
 - "How will you care for yourself before and after?"
 - "What support do you have available?"
 - "What coping tools might you need?"
 - "How will you know if you need additional help?"
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ACTION STEP FOR YOUR PRACTICE

Before significant amends, establish support structures: extra sessions, crisis availability, coping plans, and permission to reach out.

The Spiritual Experience of Amends

OVERVIEW

The Big Book describes Step Nine as often producing profound spiritual experiences: a sense of freedom, peace, connection to Higher Power, and what it calls "a new freedom and a new happiness." These spiritual fruits of amends work—while not guaranteed—are real and transformative for many patients.

KEY POINTS FOR CLINICIANS

- Amends often produce spiritual experiences
- The Big Book describes "new freedom and new happiness"
- Freedom from guilt and shame is spiritual in nature
- Connection to Higher Power often deepens
- Integrity restoration has spiritual dimensions
- These experiences motivate continued recovery

CLINICAL INSIGHT

Support patients' spiritual experiences without requiring or promising them. Some will have profound spiritual moments; others will have more subtle experiences. Both are valid. The spiritual dimension is real for many, even if not all.

THE PATIENT EXPERIENCE

After meaningful amends, patients often describe spiritual shift: "Something lifted." "I feel different inside." "I felt God's presence." "I finally feel free." These experiences are significant recovery markers.

CLINICAL REFLECTION

How do you support the spiritual dimensions of amends work? How do you honor spiritual experiences without requiring them?

CLINICAL EXERCISE / ASSESSMENT TOOL

Spiritual experience exploration:

- "What happened inside you during/after this amend?"
 - "Do you notice any spiritual shift?"
 - "What does this freedom feel like?"
 - "How does this affect your relationship with your Higher Power?"
 - "What has changed in how you see yourself?"
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ACTION STEP FOR YOUR PRACTICE

Create space for patients to discuss spiritual dimensions of amends work without mandating or minimizing spiritual experiences.

Integrating Steps Eight and Nine into Daily Life

OVERVIEW

Steps Eight and Nine aren't completed and filed away—they become part of ongoing life. New harms require prompt attention. Living amends continue. The willingness to make amends becomes a life orientation. Integration means these steps become how patients live, not just something they did.

KEY POINTS FOR CLINICIANS

- Steps 8 and 9 become ongoing life practice
- New harms require prompt amends (Step 10)
- Living amends continue indefinitely
- The willingness orientation becomes permanent
- Integration changes how patients relate to others
- The work never really "ends"

CLINICAL INSIGHT

Help patients see Steps Eight and Nine as training for a new way of living, not just items to complete. The goal is people who naturally address harm, maintain integrity, and clean up their side of the street continuously.

THE PATIENT EXPERIENCE

Some patients want closure: "When will I be done with amends?" Reframe: "The formal Step Nine process may complete, but the willingness to make amends becomes how you live. It never really ends—it becomes who you are."

CLINICAL REFLECTION

How do you help patients integrate amends orientation into ongoing life? What distinguishes "completed" Step Nine from ongoing amends living?

CLINICAL EXERCISE / ASSESSMENT TOOL

Integration planning:

- "How will making amends become part of how you live?"
 - "What will you do when you cause new harm?"
 - "What living amends are ongoing?"
 - "How has this process changed you?"
 - "What kind of person are you becoming through this work?"
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ACTION STEP FOR YOUR PRACTICE

Help patients understand Steps Eight and Nine as training for life, not just tasks to complete.
Discuss ongoing integration.

Special Situations

Deceased persons, legal issues, danger, and complex cases

Amends to Deceased Persons

OVERVIEW

When someone we harmed has died, direct amends are impossible. Yet the need to make things right persists. Patients can make meaningful amends to deceased persons through: letters written to them, symbolic acts honoring them, service to causes they valued, or changed behavior that honors what was owed.

KEY POINTS FOR CLINICIANS

- Death doesn't eliminate the need for amends
- Direct amends impossible; symbolic meaningful
- Letters to the deceased can provide closure
- Service or contributions in their name
- Living amends to surviving family
- Spiritual practices for the deceased

CLINICAL INSIGHT

Amends to the deceased often carry extra grief. The patient can't make it right. Help them find meaningful symbolic action while grieving the impossibility of direct repair. This is both amends work and grief work.

THE PATIENT EXPERIENCE

Patients often carry particular pain about deceased persons: "I'll never be able to tell them I'm sorry." Help them find meaning: "You can't tell them directly. AND you can honor what you owed them. What would be meaningful?"

CLINICAL REFLECTION

How do you help patients make meaningful amends to deceased persons? How do you address the grief mixed with the amends work?

CLINICAL EXERCISE / ASSESSMENT TOOL

Amends to the deceased:

- "What would you say to them if you could?"
- "Write a letter to them—we'll figure out what to do with it"
- "What would honor them? What did they value?"
- "How might you make amends to their surviving family?"
- "What living amend continues what you owed them?"

ACTION STEP FOR YOUR PRACTICE

Help patients create meaningful rituals or actions for amends to deceased persons, honoring both the amends need and the grief.

Amends When the Other Person is Dangerous

OVERVIEW

Some people on the amends list pose genuine danger: violent individuals, unstable persons, or situations where contact could result in physical harm. Safety must come first. The "except when" clause clearly applies when making amends would put the patient (or others) in danger.

KEY POINTS FOR CLINICIANS

- Safety takes precedence over amends completion
- Some people are genuinely dangerous
- The "except when" clause clearly applies
- Alternative amends may be appropriate
- No amend is worth physical safety
- Living amends or symbolic may substitute

CLINICAL INSIGHT

Validate that safety is legitimate, not avoidance. Help patients distinguish between discomfort (which they should face) and danger (which they should avoid). When genuinely dangerous people are on the list, help find alternative ways to complete the work.

THE PATIENT EXPERIENCE

Patients may feel incomplete: "I can't face him—he's dangerous. But how do I make amends?" Affirm: "Your safety matters. Staying away from a dangerous person is appropriate. Let's find another way to address what you owe."

CLINICAL REFLECTION

How do you help patients assess genuine danger versus feared danger? What alternatives work when direct amends are unsafe?

CLINICAL EXERCISE / ASSESSMENT TOOL

Danger assessment:

- "What specifically makes this person dangerous?"
- "Is this genuine danger or feared confrontation?"
- "What would keep you safe?"

- "How might you address what you owe without contact?"
 - "What living or symbolic amend could work?"
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ACTION STEP FOR YOUR PRACTICE

Help patients honestly assess danger and find alternative amends approaches when safety is legitimately at risk.

Amends Involving Children

OVERVIEW

Amends to children—especially one's own children—carry unique considerations. Children may not understand full amends. Age-appropriate honesty is required. Living amends (consistent presence, reliable behavior) often matter more than words. The ongoing relationship is the amends.

KEY POINTS FOR CLINICIANS

- Children require age-appropriate amends
- Full disclosure may not be appropriate for young children
- Living amends often most important
- Consistency and presence ARE the amend
- Amends evolve as children age
- Some amends may wait until adulthood

CLINICAL INSIGHT

Help patients think developmentally: What can this child understand? What do they need? Often what children need is reliable presence, not detailed confession. The living amend—showing up consistently—is the amend.

THE PATIENT EXPERIENCE

Patients may carry intense guilt about parenting: "How do I tell my 8-year-old I was using when he was little?" Consider: "What does an 8-year-old need? Maybe not detailed confession, but consistent, reliable presence now."

CLINICAL REFLECTION

How do you guide amends to children at different developmental stages? What do children actually need from amends?

CLINICAL EXERCISE / ASSESSMENT TOOL

Child amends planning:

- "What does your child understand developmentally?"
 - "What do they actually need from you now?"
 - "What would a living amend to your child look like?"
 - "What age-appropriate honesty is possible?"
 - "How might amends evolve as they grow?"
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ACTION STEP FOR YOUR PRACTICE

Help patients develop age-appropriate amends approaches for children, emphasizing living amends and consistency over detailed confession.

Amends to People Who Don't Know About the Harm

OVERVIEW

Sometimes patients harmed people who remain unaware: affairs the spouse doesn't know about, theft the employer didn't notice, lies that were never discovered. Making amends here raises the "except when" question: Would disclosure harm them more than silence?

KEY POINTS FOR CLINICIANS

- Some harms were never discovered
- Disclosure may cause more harm than benefit
- Each situation requires careful assessment
- Living amends may be more appropriate than confession
- Patient's desire for confession vs. others' wellbeing
- Guidance essential for these decisions

CLINICAL INSIGHT

When someone doesn't know about harm, the amends question becomes complex. Is disclosure for their benefit or the patient's relief? Would knowing help them or devastate them? These require careful individual assessment.

THE PATIENT EXPERIENCE

Patients may feel tortured by hidden wrongs: "She doesn't know I cheated. Don't I have to tell her?" Explore: "What would telling her accomplish? For her? For you? Is there another way to address this?"

CLINICAL REFLECTION

How do you counsel patients about amends for hidden harms? What factors inform disclosure decisions?

CLINICAL EXERCISE / ASSESSMENT TOOL

Hidden harm assessment:

- "Who would be affected if you disclosed this?"
 - "Would disclosure help them or primarily relieve your guilt?"
 - "What living amend could address this without disclosure?"
 - "What does your conscience require?"
 - "What would your sponsor/spiritual advisor say?"
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ACTION STEP FOR YOUR PRACTICE

When patients face amends for hidden harms, facilitate careful assessment of disclosure impacts rather than reflexive confession.

Amends to Former Partners and Ex-Spouses

OVERVIEW

Amends to former romantic partners are complex. There may be ongoing co-parenting, legal entanglements, or new relationships involved. The other person may have moved on. New partners on either side may complicate direct contact. These amends require sensitivity to multiple relationships.

KEY POINTS FOR CLINICIANS

- Former partners involve complex relationship dynamics
- Consider new partners on both sides
- Co-parenting relationships may be affected
- Legal situations may constrain options
- The person may have moved on and not want contact
- Approach requires sensitivity and guidance

CLINICAL INSIGHT

Former partner amends must consider the whole system: new partners, children, custody arrangements, legal orders. What looks like appropriate amends from the patient's perspective may feel intrusive or threatening from the ex's perspective.

THE PATIENT EXPERIENCE

Patients may underestimate complexity: "I just want to apologize to her." But "her" may now be married, protective of her new family, or bound by custody agreements. Help them see the full picture.

CLINICAL REFLECTION

How do you help patients navigate amends to former partners with appropriate sensitivity? What factors complicate these amends?

CLINICAL EXERCISE / ASSESSMENT TOOL

Former partner amends planning:

- "What's the current relationship status on both sides?"
 - "Are there children or custody considerations?"
 - "What might your ex need from you—or need you to avoid?"
 - "How might direct contact be received?"
 - "What form of amends would respect everyone involved?"
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ACTION STEP FOR YOUR PRACTICE

Before amends to former partners, assess the full relational system and potential impacts on multiple parties.

Legal Amends: Court Fines, Probation, Restitution

OVERVIEW

Some amends are legally mandated: court-ordered restitution, probation requirements, or legal fines. These overlap with but differ from program-based amends. Patients should complete legal obligations while also addressing the spiritual dimension of making things right beyond what's required.

KEY POINTS FOR CLINICIANS

- Legal requirements may overlap with amends
- Court-ordered restitution is minimum, not maximum
- Legal compliance doesn't complete spiritual amends
- Both legal and program amends may be needed
- Some legal amends precede or follow program amends
- Full accountability goes beyond what's legally required

CLINICAL INSIGHT

Legal and program amends serve different purposes. Patients sometimes think: "I paid my fine—I made amends." Help them see: legal consequences are separate from the relational and spiritual work of genuine amends.

THE PATIENT EXPERIENCE

Patients may conflate legal and program amends: "I did my community service. Isn't that enough?" Clarify: "Legal requirements are about societal accountability. Amends are about relationship repair and spiritual integrity. They overlap but aren't identical."

CLINICAL REFLECTION

How do you help patients understand the relationship between legal obligations and program amends? What makes them different?

CLINICAL EXERCISE / ASSESSMENT TOOL

Legal vs. spiritual amends:

- "What does the law require?"
- "What does your conscience require beyond that?"
- "Who was harmed that legal consequences don't address?"
- "What would make this right spiritually, not just legally?"
- "How do legal and program amends work together?"

ACTION STEP FOR YOUR PRACTICE

Help patients distinguish between legal compliance and spiritual amends, encouraging both while understanding their different purposes.

Clinical Applications

Translating Step Eight & Nine understanding into clinical practice

Supporting Steps Eight and Nine in Clinical Practice

OVERVIEW

Clinicians support Steps Eight and Nine through: helping process emotions, providing reality testing, offering clinical perspective on "except when" decisions, processing amends experiences, and providing crisis support when needed. The sponsor leads the step work; the clinician provides complementary support.

KEY POINTS FOR CLINICIANS

- Clinical role complements, doesn't replace, sponsor role
- Emotional processing support essential
- Reality testing for "except when" decisions
- Crisis support during intensive amends work
- Processing difficult amends experiences
- Clinical perspective adds to program perspective

CLINICAL INSIGHT

Know your lane. Sponsors typically guide the specific step work—who, when, how. Clinicians add emotional processing, trauma-informed perspective, mental health considerations, and professional support. Collaboration serves patients best.

THE PATIENT EXPERIENCE

Patients benefit from both: "My sponsor helps me work through the list. My therapist helps me process the feelings and prepare mentally." Both perspectives are valuable.

CLINICAL REFLECTION

What unique value do you add to patients' Steps Eight and Nine work? How do you collaborate with sponsors effectively?

CLINICAL EXERCISE / ASSESSMENT TOOL

Role clarification:

- "What are you working on with your sponsor for Steps 8 and 9?"
- "How can therapy support that work?"
- "What emotional processing do you need?"
- "What clinical considerations affect your amends?"
- "How can we coordinate without duplicating?"

ACTION STEP FOR YOUR PRACTICE

Clarify your role with patients doing Steps Eight and Nine: complementary support, emotional processing, and clinical perspective alongside sponsor guidance.

Using Amends Work in Treatment Planning

OVERVIEW

Amends work reveals clinical targets: relationship patterns, guilt/shame issues, fear of confrontation, avoidance tendencies, and interpersonal skills deficits. The specific amends a patient struggles with often point to underlying clinical issues worth addressing.

KEY POINTS FOR CLINICIANS

- Amends struggles reveal clinical targets
- Patterns in avoidance are diagnostically useful
- Relationship skills may need development
- Guilt/shame processing may be needed
- Fear/anxiety may require intervention
- Amends work informs treatment focus

CLINICAL INSIGHT

A patient who avoids all amends involving confrontation may need assertiveness work. One who can't approach family members may need family systems work. One paralyzed by shame may need shame resilience development. The amends work reveals the clinical work.

THE PATIENT EXPERIENCE

Patients may not see the connection: "I just can't do that amend." Help them see: "What this tells us is there's something here—about confrontation, about this relationship, about your fears—that needs attention."

CLINICAL REFLECTION

How do amends patterns inform your treatment planning? What clinical issues show up in amends avoidance?

CLINICAL EXERCISE / ASSESSMENT TOOL

Amends-informed treatment planning:

- "What amends are hardest? What does that tell us?"
- "What pattern do you see in which amends you avoid?"
- "What skills might help with the amends you're avoiding?"

- "What emotional work does this point to?"
 - Map clinical interventions to amends challenges
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ACTION STEP FOR YOUR PRACTICE

Review a patient's amends progress for clinical patterns. What does their avoidance reveal? What skills or processing would help?

Trauma-Informed Approach to Amends

OVERVIEW

Trauma history complicates amends work. Trauma survivors may need to make amends to abusers, face people connected to traumatic events, or confront harm caused while traumatized. Trauma-informed amends work paces carefully, respects limits, and doesn't require re-traumatization.

KEY POINTS FOR CLINICIANS

- Trauma history complicates many amends
- Survivors may need to make amends to abusers
- Amends may trigger trauma responses
- Pacing and safety are essential
- Not all amends are appropriate for trauma survivors
- Clinical support often essential here

CLINICAL INSIGHT

The intersection of trauma and amends requires careful navigation. A survivor who harmed their abuser may technically owe amends—but making those amends could be retraumatizing. Work case-by-case with trauma-informed judgment.

THE PATIENT EXPERIENCE

Trauma survivors face unique amends challenges: "He abused me, but I also stole from him. Do I have to face him?" These require individualized guidance that honors both the trauma history and the amends principle.

CLINICAL REFLECTION

How do you modify amends guidance for trauma survivors? What amends might be inappropriate or need modification?

CLINICAL EXERCISE / ASSESSMENT TOOL

Trauma-informed amends assessment:

- "How does your trauma history affect this amend?"
 - "What would keep you safe while making amends?"
 - "Are there amends that would be retraumatizing?"
 - "What support do you need for trauma-related amends?"
 - "Can we modify this amend to respect your trauma history?"
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ACTION STEP FOR YOUR PRACTICE

For trauma survivors, assess how trauma history affects each amend and develop modified approaches that honor both recovery and safety.

Group Therapy During Steps Eight and Nine

OVERVIEW

Group therapy provides unique support for amends work: mutual identification, accountability, shared experience, practice opportunities, and encouragement. Patients can role-play amends, receive feedback, and witness others' amends journeys—learning from both successes and struggles.

KEY POINTS FOR CLINICIANS

- Groups provide mutual support for amends work
- Role-play allows practice before actual amends
- Feedback helps refine amends approach
- Witnessing others' journeys normalizes experience
- Accountability prevents indefinite avoidance
- Celebration of completed amends reinforces progress

CLINICAL INSIGHT

Group settings allow patients to practice amends in a safe environment, receive feedback about how their approach lands, and gain courage from others who've completed difficult amends. Use groups strategically.

THE PATIENT EXPERIENCE

Patients often benefit enormously: "Hearing how she approached her mother helped me think about mine." "When I practiced in group, they pointed out I was still making excuses." The group adds perspective.

CLINICAL REFLECTION

How do you use group therapy to support Steps Eight and Nine? What group interventions are most helpful?

CLINICAL EXERCISE / ASSESSMENT TOOL

Group amends support:

- Role-play: Practice amends with group members playing recipients
 - Feedback: "How did that land? What did you hear?"
 - Witness: Share amends experiences for mutual learning
 - Accountability: "What amend will you complete this week?"
 - Celebration: Acknowledge completed amends
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ACTION STEP FOR YOUR PRACTICE

Consider how your group programming supports amends work. Add structured role-play, feedback, and accountability components.

When Amends Work Reveals Need for Family Therapy**OVERVIEW**

Steps Eight and Nine often reveal damaged family systems that need clinical attention. The amends process may surface family patterns, expose ongoing dysfunction, or create readiness for family therapy. Clinicians should watch for when individual amends work points toward family system intervention.

KEY POINTS FOR CLINICIANS

- Amends often reveal family system dysfunction
- Individual work may surface need for family therapy
- Amends can create readiness for family engagement
- Family therapy may support amends process
- Some amends need family therapy context
- Watch for when individual work indicates family need

CLINICAL INSIGHT

When a patient's amends list is dominated by family members, and making individual amends keeps revealing systemic issues, family therapy may be indicated. The individual amends work can prepare for and complement family intervention.

THE PATIENT EXPERIENCE

Patients may realize: "I keep making amends to family members but the same patterns keep happening." This awareness can motivate family therapy engagement.

CLINICAL REFLECTION

How do you recognize when amends work indicates need for family therapy? How do you integrate these approaches?

CLINICAL EXERCISE / ASSESSMENT TOOL

Family therapy indicators:

- "What patterns do you see in your family amends?"
 - "Does making amends change the family dynamics?"
 - "Would your family benefit from therapy together?"
 - "What systemic issues underlie the individual harms?"
 - "How might family therapy support your amends work?"
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ACTION STEP FOR YOUR PRACTICE

Watch for when individual amends work reveals systemic family dysfunction. Consider family therapy referral or integration.

Clinical Pitfalls

Common mistakes clinicians make with Steps Eight and Nine

Pushing Premature Amends

OVERVIEW

Some clinicians (or treatment programs) pressure patients toward rapid amends completion. Premature amends—made before adequate sobriety, preparation, or readiness—often backfire. They may satisfy program requirements while failing to produce genuine healing or, worse, causing additional harm.

KEY POINTS FOR CLINICIANS

- Treatment pressure can push premature amends
- Adequate sobriety foundation matters
- Rushed amends often lack depth
- Premature amends may cause harm
- Timing should serve healing, not program completion
- Better to wait and do well than rush and fail

CLINICAL INSIGHT

Treatment timelines and patient eagerness can both push premature amends. Take a longer view: An amend made with 90 days sobriety may mean less than one made with a year. Help patients (and programs) understand that quality matters more than speed.

THE PATIENT EXPERIENCE

Patients may feel pressure: "I have to do Step Nine before I discharge." Challenge this: "Do you have to complete it, or begin it? What amends are appropriate now? Which should wait?"

CLINICAL REFLECTION

What pressures in your setting push premature amends? How do you advocate for appropriate timing?

CLINICAL EXERCISE / ASSESSMENT TOOL

Timing assessment:

- "What's driving the urgency on this amend?"
- "Is your recovery foundation solid enough?"
- "What would be lost by waiting? Gained?"
- "Are you making this amend for the right reasons?"
- "What does wise counsel say about timing?"

ACTION STEP FOR YOUR PRACTICE

Resist pressure (external or patient-driven) for premature amends. Advocate for appropriate timing even when it conflicts with treatment milestones.

Confusing Forgiveness and Amends

OVERVIEW

Patients sometimes confuse making amends with getting forgiveness. They may approach amends hoping to be forgiven, restored, or reconciled. But amends are about the patient's side—taking responsibility, acknowledging harm, offering repair. Forgiveness is the other person's business, not the amends goal.

KEY POINTS FOR CLINICIANS

- Amends ≠ getting forgiveness
- Forgiveness is the other person's choice
- Making amends is about taking responsibility
- Patients can't control forgiveness
- Expecting forgiveness leads to disappointment
- The amend is complete when the patient does their part

CLINICAL INSIGHT

When patients approach amends hoping for forgiveness, they're still focused on what they'll get. Reorient: "You're making amends to take responsibility and offer repair. Whether they forgive is their business. Can you make this amend without needing anything back?"

THE PATIENT EXPERIENCE

Patients often hope amends will fix relationships: "If I apologize, maybe she'll forgive me." Help them release this: "Maybe she will; maybe she won't. You're responsible for your part, not her response."

CLINICAL REFLECTION

How do you help patients release attachment to forgiveness outcomes? What reframe helps?

CLINICAL EXERCISE / ASSESSMENT TOOL

Releasing forgiveness expectation:

- "What are you hoping will happen when you make this amend?"
- "What if they don't forgive you?"
- "Can you make this amend for its own sake, not for their response?"

- "What's your responsibility? What's theirs?"
 - "How do you find peace regardless of their response?"
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ACTION STEP FOR YOUR PRACTICE

Before amends, explore patients' forgiveness expectations. Help them release attachment to response while still making genuine amends.

Allowing the "Except When" Clause to Become an Escape

OVERVIEW

The "except when to do so would injure" clause is often misused to avoid difficult amends. Patients may convince themselves (or be allowed to believe) that almost any amend would cause "harm." The exception should be narrow, protecting genuine interests, not avoiding discomfort.

KEY POINTS FOR CLINICIANS

- The exception is narrow, not broad
- Discomfort ≠ injury
- Genuine protection vs. avoidance rationalization
- Challenge claimed exceptions carefully
- Most amends will cause some discomfort
- The clause protects others, not the patient's comfort

CLINICAL INSIGHT

When patients frequently invoke the "except when" clause, examine whether these are genuine protection decisions or avoidance in disguise. Discomfort isn't injury. Awkwardness isn't harm. True protection is narrower than patients often claim.

THE PATIENT EXPERIENCE

Patients may rationalize: "It would upset her if I brought that up." Challenge gently: "'Upset' and 'injure' are different. Would you be protecting her or avoiding your own discomfort?"

CLINICAL REFLECTION

How do you distinguish legitimate "except when" applications from avoidance? What questions help clarify?

CLINICAL EXERCISE / ASSESSMENT TOOL

Exception examination:

- "Who specifically would be harmed? How?"
- "Is this 'harm' or 'discomfort'?"
- "Would any competent observer agree this is harmful?"

- "What do your sponsor and others say?"
 - "Are you protecting them or avoiding for yourself?"
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ACTION STEP FOR YOUR PRACTICE

When patients invoke the "except when" clause, examine carefully whether it's genuine protection or avoidance rationalization.

Not Providing Adequate Support During Amends

OVERVIEW

Steps Eight and Nine are emotionally demanding. Clinicians who don't provide adequate support—increased availability, processing sessions, crisis access—may leave patients struggling alone during vulnerable work. Intensive clinical support should accompany intensive amends work.

KEY POINTS FOR CLINICIANS

- Amends work is emotionally demanding
- Increased clinical support often needed
- Processing sessions after significant amends
- Crisis availability during intensive work
- Under-support leaves patients vulnerable
- Match support level to step work intensity

CLINICAL INSIGHT

Don't assume patients can do intensive amends work with standard session frequency. When patients enter active Step Nine work, consider increasing availability: extra sessions, phone check-ins, crisis access. The intensity deserves matching support.

THE PATIENT EXPERIENCE

Patients in intensive amends work may struggle: "I made that amend and then had no one to talk to for a week." Proactive support planning prevents this.

CLINICAL REFLECTION

How do you increase support during intensive Steps Eight and Nine work? What resources do you make available?

CLINICAL EXERCISE / ASSESSMENT TOOL

Support planning:

- "What amends are coming up?"

- "What support will you need before, during, and after?"
 - "Let's schedule extra sessions during this period"
 - "Here's how to reach me if you need support between sessions"
 - "What other support—sponsor, meetings, friends—is available?"
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ACTION STEP FOR YOUR PRACTICE

When patients enter intensive amends work, proactively increase support availability and create clear plans for processing and crisis access.

Overlooking Amends to Self

OVERVIEW

Clinicians may overlook patients' need to make amends to themselves. Self-forgiveness is often the hardest amend. Patients who've harmed themselves through addiction deserve acknowledgment of that harm and commitment to different treatment going forward. Don't skip this dimension.

KEY POINTS FOR CLINICIANS

- Self-amends are legitimate and important
- Often overlooked in step work
- Self-forgiveness may be hardest amend
- Includes changed self-treatment, not just words
- Self-compassion supports other amends
- Don't let this dimension be skipped

CLINICAL INSIGHT

Patients who cannot forgive themselves often struggle to make amends to others or to receive forgiveness. Self-amends—genuinely acknowledging self-harm and committing to different self-treatment—can unlock the entire amends process.

THE PATIENT EXPERIENCE

Patients may resist: "This is supposed to be about others, not me." Or they may be unable: "I don't know how to forgive myself." Help them see self-amends as essential, not indulgent.

CLINICAL REFLECTION

How do you incorporate self-amends into Steps Eight and Nine work? Why is this dimension often skipped?

CLINICAL EXERCISE / ASSESSMENT TOOL

Self-amends work:

- "You've listed everyone you harmed. Are you on the list?"
 - "How did you harm yourself through addiction?"
 - "What would making amends to yourself look like?"
 - "What commitment would you make to treat yourself differently?"
 - "Can you forgive yourself? What would that require?"
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ACTION STEP FOR YOUR PRACTICE

Ensure patients include themselves on the Step Eight list and address self-amends, not as indulgence but as essential recovery work.

Ignoring Cultural Factors in Amends

OVERVIEW

Amends expectations—direct confrontation, verbal acknowledgment, individual focus—reflect certain cultural values. Patients from cultures with different norms around apology, family systems, honor, or indirect communication may need adapted approaches. Cultural competence matters in amends work.

KEY POINTS FOR CLINICIANS

- Amends norms reflect cultural values
- Direct confrontation isn't universal
- Some cultures use indirect approaches
- Family/community may be involved differently
- Honor and face considerations vary
- Culturally adapted approaches may be needed

CLINICAL INSIGHT

The standard American AA approach to amends assumes certain cultural values about directness, individual responsibility, and verbal acknowledgment. Patients from other cultural backgrounds may need adapted approaches that honor both the amends principle and their cultural context.

THE PATIENT EXPERIENCE

Patients may feel caught: "In my culture, you don't directly confront elders like that." Help find culturally appropriate paths: "How would amends be made in your culture? What would honor both your recovery and your cultural values?"

CLINICAL REFLECTION

How do you adapt amends approaches for cultural differences? What cultural factors most often affect amends?

CLINICAL EXERCISE / ASSESSMENT TOOL

Cultural adaptation:

- "How does your culture approach apology and making things right?"
 - "What would be culturally appropriate for this amend?"
 - "Who might need to be involved in your culture?"
 - "How do we honor both recovery principles and cultural values?"
 - "What would making amends look like in your context?"
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ACTION STEP FOR YOUR PRACTICE

Assess cultural factors affecting patients' amends approaches. Adapt guidance to honor both recovery principles and cultural context.

Not Following Up After Amends

OVERVIEW

The work doesn't end when the amend is made. Processing the experience—whatever it was—matters for integration. Patients who make amends without follow-up processing may struggle with unexpected feelings or miss important learning. Always follow up after significant amends.

KEY POINTS FOR CLINICIANS

- Amends require follow-up processing
- Unexpected feelings often emerge
- Both "good" and "bad" outcomes need processing
- Learning comes through reflection
- Follow-up prevents emotional isolation
- Integration happens after, not during, the amend

CLINICAL INSIGHT

Schedule follow-up explicitly: "After you make this amend, let's meet to process." Don't assume patients will raise it themselves. Proactive follow-up ensures the experience is integrated, not just completed.

THE PATIENT EXPERIENCE

After significant amends, patients often need space to process: "I did it. Now I don't know what I feel." That processing needs a place to happen.

CLINICAL REFLECTION

How do you ensure follow-up after significant amends? What processing questions are most useful?

CLINICAL EXERCISE / ASSESSMENT TOOL

Post-amends processing:

- "What was that experience like?"
- "What surprised you?"
- "How did they respond? How did you respond to their response?"
- "What are you feeling now?"
- "What did you learn? What would you do differently?"

ACTION STEP FOR YOUR PRACTICE

Build explicit follow-up into amends planning. Schedule processing sessions after significant amends to ensure integration.

Your clinical notes

Changes to my practice

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