Do I Really Know the Disease?

Close the gap between clinical training and lived reality — then build your own treatment plan as a clinician

10-Day Challenges

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Part 1 · About this challenge

A ten-day professional development journey for SUD clinicians — closing the gap between clinical training and the lived reality of addiction, then building your own treatment plan. One day at a time.

Helpers Helping Helpers · Father Martin's Legacy

Your Journey

Before You Begin

We ask our patients to examine themselves with courage and honesty. The least we can do is extend ourselves the same invitation. This pathway is your own treatment plan — move through one day at a time. Some days will be uncomfortable. That discomfort is the work.

Clinician Self-Assessment

Take it on Day 1 · Return to it on Day 10

The 10-Day Pathway

DAY 1 · THE DISCONNECT

The Disconnect We Don't Talk About

The gap between clinical training and lived reality

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DAY 7 · THE RELATIONSHIP

The Relationship Is the Intervention

Presence, trust, and the alliance itself

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DAY 8 · RECOVERY PROCESS

Recovery Is Measured in Years

Sobriety, recovery, and the long arc

DAY 9 · MY LENS

My Own Lens

Bias, blind spots, and the cost of carrying this work

DAY 10 · MY TREATMENT PLAN

My Own Treatment Plan

Turning insight into a development goal

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Part 2 · Clinician Self-Assessment

Clinician Self-Assessment

Rate each statement honestly: 1 (Strongly Disagree) to 5 (Strongly Agree). This is not a test — it is a mirror. Take it on Day 1 as your baseline, and again on Day 10 to see your movement.

Addiction Disease Literacy

I can explain the neurobiological basis of addiction to a patient in plain language

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand the difference between physical dependence and the disease of addiction

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I can describe the progression of addiction from early to late stage

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I know the criteria that differentiate substance use from substance use disorder

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand how co-occurring mental health disorders interact with addiction

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I can explain why willpower alone is insufficient for sustained recovery

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I am familiar with the current evidence on medication-assisted treatment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand how trauma, ACEs, and environmental factors contribute to addiction risk

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

Understanding the Patient's Reality

I have genuinely considered what it feels like to lose control over a substance day after day

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand why patients often tell clinicians what they want to hear rather than the truth

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

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I recognize that positive discharge feedback may reflect gratitude for basic human connection rather than clinical progress

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I know the difference between a patient who has internalized recovery skills and one who is complying to complete treatment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand the level of fear, confusion, and cognitive impairment present in early recovery

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I appreciate how long it takes for a brain affected by addiction to restore baseline functioning

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I have considered what it would be like to have my primary coping mechanism removed with nothing to replace it

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand how isolation in active addiction makes even small acts of compassion feel enormous

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

Clinical Humility & Self-Honesty

I regularly question whether I am truly connecting with patients or performing the role of clinician

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I can identify times when I may have mistaken patient compliance for genuine insight or growth

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I am aware of my own emotional reactions to patient relapse and how those reactions affect my clinical judgment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I recognize that my training may have given me frameworks but not necessarily lived understanding

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I actively seek out feedback from patients, peers, and supervisors about my blind spots

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

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Strongly Disagree · Strongly Agree

I am honest with myself about the limits of what I know about addiction and recovery

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I consider whether my treatment plans reflect what patients need or what the system requires

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I have examined my personal beliefs about addiction and whether they help or hinder my clinical work

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

Recovery Process Competency

I can describe the stages of change with real clinical examples, not just textbook definitions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand why recovery is measured in years and decades, not days and weeks

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I know the practical differences between sobriety (abstinence) and recovery (life transformation)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I am familiar with multiple pathways to recovery beyond the 12-step model

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand the typical timeline of post-acute withdrawal symptoms and cognitive recovery

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I can explain why relapse is common and what it actually reveals about a patient's recovery plan

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I appreciate the magnitude of what patients are asked to do — rebuild an entire life from scratch

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand why early recovery patients may appear engaged but lack the cognitive capacity to fully process what they learn

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

Therapeutic Relationship Depth

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I create space for patients to be honest without fear of judgment or consequence

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I can identify the difference between challenging a patient and shaming a patient

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I understand that the therapeutic relationship itself is often the most powerful intervention I offer

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I recognize when a patient is testing the safety of the relationship before sharing deeper truths

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I am conscious of the power dynamic between clinician and patient and how it shapes disclosure

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I can tolerate uncertainty and ambiguity in treatment without rushing to fix or solve

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I show up consistently so that patients can begin to trust that adults do what they say they will

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

I am aware that my presence and attunement may matter more than my techniques in early treatment

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Strongly Disagree · Strongly Agree

Scoring guide

Each group gets its own score, as a percent.

Higher scores indicate stronger knowledge and awareness in that domain. This is a map, not a verdict — your lowest-scoring domains are the most natural candidates for the development goal you build on Day 10.

Score: 85% and above — Deep Competency: Strong, well-integrated understanding here. Stay current and mentor others in this domain.

Score: 70–84% — Solid Foundation: A reliable base with room to deepen. Targeted growth will sharpen your edge.

Score: 50–69% — Developing: Real working knowledge, but gaps remain. A good candidate for a development goal.

Score: 30–49% — Growth Area: This domain needs deliberate attention. Prioritize it in your plan.

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Score: below 30% — Priority Focus: A significant gap between current knowledge and what patients need. Make this central.

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Part 3 · Day 1 · The Disconnect We Don't Talk About

DAY 1 OF 10 · THE DISCONNECT

The gap between clinical training and lived reality

Today's Reading

There is an uncomfortable truth in the substance use disorder treatment field that rarely gets discussed openly: many clinicians believe they understand their patients far more deeply than they actually do. This is not a character flaw. It is a structural problem — a gap between clinical training and the lived reality of addiction that no textbook can fully bridge.

Consider what happens when a patient completes treatment and rates their counselor highly. They say they felt heard. They express gratitude. The clinician reasonably concludes: "I made a difference. This patient got what they needed." But here is the question worth sitting with: did the patient get what they needed clinically, or was this the first time in months — maybe years — that another human being looked them in the eye, listened without judgment, and treated them with basic dignity? Those two things feel identical from the clinician's seat. They are profoundly different from the patient's.

The goal of these ten days is not to create doubt — it is to create depth. We ask our patients to write treatment plans, set goals, identify barriers, and do the hard work of self-examination. This pathway invites you to do the same — not as a patient, but as a clinician committed to understanding the disease at the level your patients need you to understand it. If we are going to ask them to be honest, courageous, and vulnerable, the least we can do is start with ourselves.

Reflect

1. When was the last time you assumed a patient was further along than they were? What did you base that on?

2. What part of addiction do you suspect you understand more from training than from genuine grasp of the human experience?

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3. If a patient rates you highly on discharge, what does that actually tell you — and what does it not tell you?

Today's Work

In one honest paragraph: how well do you believe you understand the lived reality of the patients you treat — and where does that belief come from?

Be candid. No one is grading this...

Name one moment when a patient's gratitude or high rating may have masked something you missed.

What did the feedback hide?

What do you most hope to understand more deeply by the end of these ten days?

Your honest intention for this work...

Set Your Baseline

Before going further, take the Clinician Self-Assessment. It maps your current knowledge and awareness across five domains. On Day 10 you will return to it and measure how far you have come.

Carry Forward

One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 4 · Day 2 · Did They Get Better, or Get Seen?

DAY 2 OF 10 · DISCERNMENT

Compliance vs. internalization, gratitude vs. growth

Today's Reading

Active addiction is isolating in ways that are difficult to comprehend if you have not experienced it. The shame, the secrecy, the progressive loss of relationships and trust, the cognitive distortion that becomes normal — it all creates a person who has been functionally disconnected from genuine human interaction for a very long time. When that person sits across from a clinician who is kind, attentive, and compassionate, the experience can feel transformative. And in a real sense, it is. But it may not be clinical progress. It may simply be the first warm handshake after years in the cold.

This is not to diminish the clinician's role. That moment of connection matters enormously. But if we mistake it for evidence that our interventions have landed, we risk believing patients are further along than they are. We risk confusing compliance with internalization, gratitude with growth, and a patient's relief at being treated humanely with actual therapeutic change.

The patient who tells you everything you want to hear may be the one who needs the most help — and is getting the least. Discernment here is not cynicism. It is the discipline of separating the relationship's real value from a false read on clinical progress, so you can keep meeting the patient where they actually are rather than where the feedback suggests they might be.

Reflect

1. Recall a recent "success." Honestly — was it internalized change, or relief at being treated with dignity? How can you tell the difference?

2. How do you personally distinguish a patient complying to complete treatment from one who has genuinely absorbed a recovery skill?

3. What feedback do you tend to take at face value because it feels good to receive?

Today's Work

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Describe a recent patient you considered a clear success. What specifically led you to that conclusion?

The case, and your evidence for "success"...

Now re-examine it: what signs pointed to internalized change, and what signs could equally be explained by relief at being treated humanely?

Hold both columns honestly...

My working test for the difference

What concrete, observable markers would tell you a skill has been internalized rather than performed? Write a test you could actually apply.

A patient has internalized a skill when I observe...

What feedback do I most want to be true — and therefore should scrutinize most?

The feedback I am most vulnerable to over-trusting...

Carry Forward

One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 5 · Day 3 · The Weight of Time

DAY 3 OF 10 · TIME

Why recovery outlasts the treatment window

Today's Reading

One of the most significant disconnects between clinicians and patients is the understanding of time. A 28-day program feels like a meaningful intervention from the clinician's perspective. From the patient's perspective, it is a single breath after years of drowning.

Consider what we ask a patient to do in treatment: change the way they think, feel, cope, relate, and live — in less than a month. Now consider that the patient's brain has been neurologically rewired by years of substance use. Post-acute withdrawal symptoms — cognitive fog, emotional dysregulation, sleep disruption, anxiety — can persist for 12 to 24 months. The patient sitting in your group is quite literally operating with a brain that has not yet recovered the capacity to fully process the information you are delivering.

This does not mean treatment is futile. It means we need to be honest about what treatment can accomplish in its initial phase and humble about what the patient is up against. Recovery is not a project with a completion date. It is the reconstruction of an identity, a coping system, a social network, a daily rhythm, a self-concept, and a relationship with reality itself. The clinicians who maintain their effectiveness over decades learn to hold two truths at once: what I offer matters, and it is not enough — not because I am inadequate, but because the disease is enormous.

Reflect

1. When a patient relapses shortly after discharge, what is your first internal explanation? How often is the real answer simply "the disease takes longer than the window allows"?

2. How does knowing PAWS can last 12 to 24 months change what you can reasonably expect a patient to retain in week three?

3. Where in your current practice do your timelines reflect the system's schedule rather than the patient's actual neurological recovery?

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Today's Work

Hold the two timelines side by side — the one the system runs on, and the one the patient's brain runs on.

WHAT THE SYSTEM ASKS FOR

The timeline, milestones, and expectations baked into your program...

WHAT THE BRAIN ACTUALLY NEEDS

What the patient's neurological recovery actually requires...

A time I personalized a patient's relapse — and what the timeline lens tells me now:

What I told myself then, versus what may have actually been true...

One expectation I will recalibrate this week to fit the real recovery timeline:

Specific and concrete...

Carry Forward

One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 6 · Day 4 · Do I Know the Disease?

DAY 4 OF 10 · DISEASE LITERACY

The rigor we expect of every other specialty

Today's Reading

Clinical humility means being willing to ask: what do I actually know about this disease that I have not experienced? Have I spent time understanding what withdrawal feels like, what craving does to decision-making, what it is like to wake up every morning knowing you have destroyed the trust of everyone who loved you? Or have I studied the DSM criteria, memorized the neuroscience talking points, and learned the therapeutic techniques without truly grasping the human devastation underneath?

This is not about guilt. It is about rigor — the same rigor we expect from a cardiologist who studies not just the anatomy of the heart but what it feels like to live with heart failure. The same rigor we expect from an oncologist who understands not just tumor biology but the existential weight of a cancer diagnosis. Our patients deserve clinicians who have done the deep work of understanding not just the pathology of addiction, but the experience of it.

Knowing the disease means being able to explain — in plain language a frightened patient can absorb — the neurobiology, the progression, the difference between dependence and the disorder itself, how co-occurring conditions interact, and why willpower alone is insufficient. Today is an honest inventory of where that knowledge is solid and where it is thinner than you would like to admit.

Reflect

1. Which part of the disease could you explain confidently to a patient in plain language right now — and which part would you have to reach for?

2. Where did the bulk of your addiction knowledge come from: training, lived proximity, or patient narratives? What is the gap that creates?

3. What is one specific concept about the neurobiology or progression of addiction you have been meaning to deepen but have not?

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Today's Work

Tap each area you could explain confidently, in plain language, to a frightened patient right now.

Neurobiology of addiction

Progression across stages

Dependence vs. the disorder

Co-occurring / dual diagnosis

Tolerance, withdrawal, craving

Medication-assisted treatment

ACEs and trauma's role

Genetic & environmental risk

Medical complications

Use vs. misuse vs. addiction

The area I could explain most confidently — and how I know I actually grasp it:

What makes this one solid?

The area where my knowledge is thinner than I usually admit:

Be honest here...

One specific concept I commit to deepening — and the single resource or step I will use:

The concept, and how I will close the gap...

Carry Forward

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One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 7 · Day 5 · What It Actually Feels Like

DAY 5 OF 10 · PATIENT REALITY

Stepping inside the experience we treat

Today's Reading

It is one thing to know the clinical features of addiction. It is another to have genuinely considered what it feels like to lose control over a substance, day after day, and to wake up inside that loss. The patient in front of you has been living it. The distance between studying that reality and imagining your way into it is the distance this day asks you to close.

Consider what it would be like to have your primary coping mechanism — the one thing that reliably made the unbearable bearable — removed, with nothing yet in place to replace it. Consider the level of fear, confusion, and cognitive impairment present in early recovery. Consider how isolation in active addiction makes even small acts of compassion feel enormous, which is exactly why your kindness can be mistaken, by both of you, for clinical progress.

Understanding why patients often tell clinicians what they want to hear starts here. Their survival for years has depended on reading people — figuring out what someone wants and delivering it. That is not manipulation; it is a finely tuned survival skill aimed at a person who holds power over their discharge. When you can feel your way into that reality, your expectations recalibrate, and your patients stop having to perform for you.

Reflect

1. Sit with this honestly: what would it be like to lose your primary coping mechanism with nothing yet to replace it? What would you reach for?

2. How might a patient's years of reading people for survival show up in the room with you — and how would you know?

3. What small act of yours might a patient experience as enormous because of how isolated they have been? What does that change?

Today's Work

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Imagining Your Way In

If your single most reliable coping mechanism were removed today, with nothing yet to replace it — what would the first 72 hours feel like?

Step inside it...

What would you do to make a person in power believe you were "doing well" — even if you were not?

This is the survival skill your patients bring...

What small kindness would feel enormous to you in that state — and why?

Connect this to how your patients read you...

What This Changes

Having sat inside it: what is one expectation or interpretation about your patients you will hold differently tomorrow?

I will assume less / more about... and instead I will...

Carry Forward

One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 8 · Day 6 · Am I Connecting or Performing?

DAY 6 OF 10 · SELF-HONESTY

The built-in trap of the helping relationship

Today's Reading

There is a moment in every clinician's career — sometimes many — where you have to ask an uncomfortable question: am I actually helping this person understand their disease and build a recovery, or am I performing the role of helper in a way that feels productive to me but does not challenge the patient in the ways they need?

The clinical relationship in SUD treatment has a built-in trap. Patients in early recovery are often desperate to be liked, accepted, and seen as doing well, and they are experts at feedback. And clinicians are not immune. We went into helping professions because connection and impact matter to us. When a patient tells us we changed their life, it feeds something real. The danger is when that positive feedback becomes the metric by which we measure our own effectiveness.

This is the day to examine your own reactions honestly — your countertransference, your response to patient relapse, the difference between when you challenge a patient and when you appease them to preserve the warmth in the room. None of this means your care is not real. It means your care deserves the same scrutiny you would bring to any other clinical instrument. The most caring thing you can do is refuse to let being liked stand in for doing the work.

Reflect

1. When do you notice yourself softening a necessary challenge to stay liked? What is the cost to the patient?

2. What is your honest emotional reaction when a patient relapses — and how does that reaction shape your clinical judgment afterward?

3. Where might a personal belief about addiction be quietly biasing how you read a particular patient's readiness?

Today's Work

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Tap the patterns you have honestly noticed in yourself. This stays private — candor is the whole point.

I soften challenges to stay liked

I take high ratings as proof of effectiveness

I personalize patient relapse

I over-rescue patients who are not ready

I detach when a patient frustrates me

I avoid confronting comfortable patients

I read certain patients through a personal bias

I mistake my own relief for the patient's progress

The pattern I most need to watch — and a specific recent example of it:

Name it concretely...

What that pattern costs the patient when it goes unchecked:

Follow the consequence honestly...

My honest emotional reaction to patient relapse — and how it bends my judgment afterward:

What comes up, and what it does to my clinical read...

One personal belief about addiction that may be biasing how I read a current patient:

The belief, and where it came from...

Carry Forward

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One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 9 · Day 7 · The Relationship Is the Intervention

DAY 7 OF 10 · THE RELATIONSHIP

Presence, trust, and the alliance itself

Today's Reading

The therapeutic relationship itself is often the most powerful intervention you offer — more than any single technique. This is especially true in early treatment, when a patient's cognitive capacity to process content is still impaired but their capacity to register safety, attunement, and consistency is fully intact.

Building trust with a patient who trusts no one is slow, deliberate work. They are conscious of the power dynamic between you. They are reading whether it is safe to be honest before they risk it. They may test the relationship — small provocations, missed details, half-truths — to find out whether you will stay. The clinician who shows up consistently, who does what they say they will do, begins to teach something the patient may not have learned in years: that an adult can be relied upon.

There is a fine line between challenging a patient and shaming one, and it lives entirely inside the relationship. The same words land as an invitation when trust is present and as an attack when it is not. Today you will take an honest inventory of the relational instrument you bring — your consistency, your tolerance for ambiguity, your ability to hold space without rushing to fix, and your awareness of how your presence shapes what a patient is willing to disclose.

Reflect

1. Where on the line between challenging and shaming do you tend to land under pressure — and what tips you one way or the other?

2. How do you respond when a patient tests the safety of the relationship before sharing something deeper? What do they learn from your response?

3. Can you tolerate uncertainty in treatment without rushing to fix or solve? Where does that get hard for you?

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Today's Work

The Relational Instrument I Bring

Consistency — do I reliably do what I say I will, so patients learn an adult can be trusted? Where do I slip?

Honest self-assessment...

Challenge vs. shame — under pressure, which way do I tend to land, and what tips me?

Where is your line, and what moves it...

Holding space vs. fixing — how well do I tolerate uncertainty without rushing to solve?

When does the urge to fix take over?

When the Relationship Was Tested

A time a patient tested the safety of the relationship before opening up — what did they do, and how did I respond?

The test, and what they learned from my response...

One concrete way I will strengthen the relational instrument itself this month:

Specific and actionable...

Carry Forward

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One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 10 · Day 8 · Recovery Is Measured in Years

DAY 8 OF 10 · RECOVERY PROCESS

Sobriety, recovery, and the long arc

Today's Reading

There is a practical difference between sobriety and recovery that is easy to blur in a treatment setting. Sobriety is abstinence — the removal of the substance. Recovery is the transformation of a life: the rebuilding of identity, relationships, coping, purpose, and a relationship with reality. The first can begin in days. The second is measured in years and decades. Treating them as the same thing sets both clinician and patient up for disappointment.

The stages of change are real, but they rarely move in the clean, linear way a textbook diagram suggests. Recovery involves the role of surrender as much as willpower — the paradox that trying harder is often not the answer, and that mutual-aid and 12-step frameworks work in part because they relieve the person of the impossible job of controlling the disease through sheer effort. Relapse, when it happens, is rarely a moral failure or a sign of clinical incompetence. It is most often information: it reveals where the recovery plan was thin.

Appreciate the magnitude of what patients are asked to do — rebuild an entire life from scratch — and your competency in the recovery process deepens. You stop measuring success by the treatment episode and start measuring it by the trajectory. Today you will assess how well you actually understand the long arc your patients are walking, beyond the textbook version.

Reflect

1. How do you explain the difference between sobriety and recovery to a patient — and does your practice reflect that difference?

2. When a patient relapses, can you read it as information about a thin recovery plan rather than a verdict on them or on you? What gets in the way?

3. Beyond the 12-step model, how familiar are you with the multiple pathways to recovery your patients might need?

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Today's Work

SOBRIETY (ABSTINENCE)

What sobriety asks of a patient, in your words...

RECOVERY (TRANSFORMATION)

What recovery asks beyond abstinence...

Pathways to recovery I can speak to with real fluency (tap all that apply):

12-step / mutual aid

SMART Recovery

Medication-assisted treatment

Faith-based recovery

Refuge / mindfulness-based

Recovery community organizations

Harm reduction approaches

Culturally specific pathways

When a patient relapses, can I read it as information about a thin plan rather than a verdict? What gets in the way?

Honest answer...

One pathway I am least familiar with that my patient population may actually need — and how I will learn it:

The gap, and the step...

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Carry Forward

One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 11 · Day 9 · My Own Lens

DAY 9 OF 10 · MY LENS

Bias, blind spots, and the cost of carrying this work

Today's Reading

Every clinician views patients through a lens shaped by their own history, training, beliefs, and current state. That lens is not a flaw to eliminate — it cannot be eliminated — but it can be known. The clinician who has examined their lens makes more accurate clinical judgments than the one who believes they have none.

Your personal beliefs about addiction, formed long before you entered the field, may help or hinder your work. Your own history — including any proximity to addiction in your family or life — shapes what you notice and what you miss. And your current state matters: burnout, compassion fatigue, and the slow accumulation of vicarious pain quietly distort judgment, shorten patience, and pull you toward either over-rescuing or detachment. The "Helpers Helping Helpers" principle is simple: the same honest self-examination we ask of patients, we owe to ourselves, because an unexamined clinician is a less effective one.

This is not about achieving perfect objectivity. It is about knowing your lens well enough to correct for it. Today you will name the assumptions you carry, the blind spots you suspect, and the state you are actually in — because you cannot adjust for a distortion you refuse to look at.

Reflect

1. What belief about addiction did you hold before you ever trained — and how might it still be operating in your clinical judgment?

2. Where are you on the burnout-to-compassion-satisfaction spectrum right now, honestly, and how is that showing up with patients?

3. What is one blind spot you suspect you have but have been reluctant to examine? Name it here.

Today's Work

Where am I, honestly, right now? (tap all that fit)

Energized & engaged

Steady but tired

Running on fumes

Cynical / detached

Over-invested / rescuing

Numb to patient pain

Easily irritated

Compassion satisfaction intact

A belief about addiction I held before I ever trained — and how it may still be operating in my judgment:

The belief, and its quiet influence...

How my own history (including any proximity to addiction) shapes what I notice and what I miss:

Held with honesty, not judgment...

My current state, named plainly — and how it is showing up with patients right now:

Burnout, fatigue, over-rescue, detachment...

One blind spot I suspect I have but have avoided examining:

Name it here, finally...

Helpers Helping Helpers

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An unexamined clinician is a less effective one. The same honest self-examination we ask of patients, we owe to ourselves — not to achieve perfect objectivity, but to know the lens well enough to correct for it.

Carry Forward

One thing from today I am carrying into my next clinical encounter:

A single insight, intention, or adjustment to bring into the room...

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Part 12 · Day 10 · My Own Treatment Plan

DAY 10 OF 10 · MY TREATMENT PLAN

Turning insight into a development goal

Today's Reading

We ask patients to write treatment plans — to set goals, name objectives, identify the specific steps and interventions, and commit to a timeframe. This final day asks you to do the same, applying the rigor of a treatment plan to your own development as a clinician.

This is not paperwork. It is the natural conclusion of nine days of honest self-examination. Somewhere across this pathway, a gap revealed itself — a part of the disease you understand more from training than from grasp, a relational instrument that needs sharpening, a bias you had not looked at squarely, a part of the patient experience you had never fully imagined. That gap is your goal. The same way you would help a patient move from a vague intention to a concrete, measurable plan, move yourself there now.

Think like a treatment plan: a goal is the broad area of growth, objectives are the measurable steps, and interventions are the specific actions you will take. Be honest about where you are starting. And then ask yourself the same question your patients face — what would it look like if you were "appeasing" yourself the way patients sometimes appease clinicians, checking a box rather than doing the real work? Then return to your baseline assessment and notice how these ten days have moved it.

Reflect

1. Across these ten days, what single gap surfaced most insistently as the thing you most need to work on?

2. Why does closing that gap matter — to you, and to the patients who will sit across from you?

3. What would genuine growth in this area look like, as opposed to simply checking a box?

Today's Work

Think Like a Treatment Plan

A goal is the broad area of growth. Objectives are the measurable steps. Interventions are the specific actions you will take. Set a realistic timeframe and be honest about where you are starting from — exactly as you would ask of a patient.

Step 1: Define Your Goal

Goal domain

☐ Understanding the Disease of Addiction ☐ Understanding the Patient Experience ☐ Clinical Skills Development ☐ Clinician Self-Awareness & Bias ☐ Understanding the Recovery Process ☐ Cultural & Population Competency ☐ Therapeutic Relationship Quality ☐ Evidence-Based Practice Mastery

Goal statement

Example: "I will develop a deeper understanding of what early recovery actually feels like, so I can recalibrate my expectations in a patient's first 90 days."

Step 2: Why This Matters

What surfaced across these ten days that prompted this goal? Be honest — this is for you, not for a file.

This matters because...

Step 3: Objectives & Interventions

Objective #1

Type

☐ Knowledge — I will learn ☐ understand... ☐ Skill — I will be able to demonstrate... ☐ Experience — I will directly engage with... ☐ Reflection — I will examine my own... ☐ Application — I will implement in my practice...

Description — what specifically will you learn, do, or demonstrate?

Be concrete and measurable...

Intervention

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☐ How? ☐ Read a book or article on this topic ☐ Attend a training, workshop, or webinar ☐ Shadow or co-facilitate with an experienced clinician ☐ Attend an open 12-step or mutual aid meeting as an observer ☐ Listen to patient narratives or recovery stories ☐ Complete a self-assessment or reflection journal ☐ Discuss with a clinical supervisor ☐ Participate in peer consultation or case review ☐ Interview a person in long-term recovery ☐ Review current research literature ☐ Practice a new clinical technique with feedback ☐ Write a personal reflection paper ☐ Other (see notes)

Timeframe

☐ By when? ☐ 1 week ☐ 2 weeks ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months ☐ 1 year ☐ Ongoing

Objective #2

Type

☐ Knowledge — I will learn ☐ understand... ☐ Skill — I will be able to demonstrate... ☐ Experience — I will directly engage with... ☐ Reflection — I will examine my own... ☐ Application — I will implement in my practice...

Description — what specifically will you learn, do, or demonstrate?

Be concrete and measurable...

Intervention

☐ How? ☐ Read a book or article on this topic ☐ Attend a training, workshop, or webinar ☐ Shadow or co-facilitate with an experienced clinician ☐ Attend an open 12-step or mutual aid meeting as an observer ☐ Listen to patient narratives or recovery stories ☐ Complete a self-assessment or reflection journal ☐ Discuss with a clinical supervisor ☐ Participate in peer consultation or case review ☐ Interview a person in long-term recovery ☐ Review current research literature ☐ Practice a new clinical technique with feedback ☐ Write a personal reflection paper ☐ Other (see notes)

Timeframe

☐ By when? ☐ 1 week ☐ 2 weeks ☐ 30 days ☐ 60 days ☐ 90 days ☐ 6 months ☐ 1 year ☐ Ongoing

Step 4: Challenge to Self

What would it look like if you were "appeasing" yourself the way patients sometimes appease clinicians? What would genuine growth look like versus checking a box?

Be honest with yourself here...

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Revisit Your Baseline

You completed your baseline on Day 1. Return to it now and notice what has shifted. This is not a verdict — it is a map of how far you have traveled, and where the work continues.

Carry Forward

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