Reading Your Patients

Sharpen how you read body, voice, omission, deflection, and the discernment between what patients want and what they need

10-Day Challenges

CONTENTS

- Part 1 · About this challenge
- Part 2 · Clinical Observation Self-Assessment
- Part 3 · Day 1 · The Art of Clinical Observation
- Part 4 · Day 2 · The Body Speaks First
- Part 5 · Day 3 · Hearing What Words Cannot Tell You
- Part 6 · Day 4 · The Language of Omission
- Part 7 · Day 5 · When Laughter Is Armor
- Part 8 · Day 6 · The Distraction Arsenal
- Part 9 · Day 7 · Needs vs. Wants
- Part 10 · Day 8 · The Mirror Turned Inward
- Part 11 · Day 9 · Reading the Whole Patient
- Part 12 · Day 10 · From Insight to Practice

© The Recovery Files

Part 1 · About this challenge

A ten-day clinical observation intensive — sharpening how you read body, voice, omission, deflection, and the discernment between what patients want and what they need.

Recovery Made Simple · Father Martin's Legacy

Clinical Observation Self-Assessment

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

The 10-Day Pathway

DAY 1 · FOUNDATION
The Art of Clinical Observation

Learning to read the patient, not just listen to them

DAY 2 · THE BODY
The Body Speaks First

Reading non-verbal communication

DAY 3 · THE VOICE
Hearing What Words Cannot Tell You

Tone, pace, and the paralinguistic channel

DAY 4 · THE UNSAID
The Language of Omission

What has not been said

DAY 5 · DEFLECTION
When Laughter Is Armor

Humor and sarcasm as deflection

DAY 6 · DISTRACTION
The Distraction Arsenal

Recognizing how patients redirect the session

DAY 7 · DISCERNMENT
Needs vs. Wants

The heart of clinical judgment

DAY 8 · BLIND SPOTS
The Mirror Turned Inward

Examining what you tend to miss, and why

DAY 9 · INTEGRATION
Reading the Whole Patient

© The Recovery Files

Putting every channel together

DAY 10 · PRACTICE

From Insight to Practice

Turning awareness into a clinical commitment

© The Recovery Files

Part 2 · Clinical Observation Self-Assessment

Clinical Observation Self-Assessment

Rate each statement 1 (Not at all like me) to 5 (Very much like me). Take it on Day 1, return on Day 10.

Observational Awareness

I consciously observe patients' non-verbal behavior before, during, and after sessions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice when a patient's words and body language are incongruent

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I pay attention to what patients do NOT say as much as what they do say

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am aware of changes in a patient's presentation from session to session

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I track patterns in when patients become more or less engaged during sessions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice shifts in a patient's energy, posture, or affect in real time

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I observe physical cues patients bring with them (appearance, hygiene, weight changes)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I register my own gut reactions and body sensations as clinical data during sessions

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

Non-Verbal Literacy

I can tell the difference between anxiety-based fidgeting and boredom-based restlessness

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I understand what sustained, averted, or darting eye contact may indicate

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

© The Recovery Files

I interpret arm and leg positioning (crossed, open, protective) clinically

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I observe facial micro-expressions that contradict the patient's spoken narrative

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice changes in breathing (shallow, held, sighing) as signs of emotional activation

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I am attuned to vocal tone shifts in pitch, pace, volume, and flatness

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I observe how patients position themselves in relation to me, the door, and the group

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice the timing of non-verbal shifts and what question or topic triggered them

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

Detecting Deflection & Avoidance

I recognize when humor is being used to avoid emotional depth

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I read sarcasm as a protective mechanism rather than taking it at face value

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice when patients redirect away from substance use toward safer topics

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I track when patients use excessive detail about irrelevant topics to consume time

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize "yes-butting" — surface agreement followed by dismissal — as deflection

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I distinguish genuine confusion from strategic misunderstanding used to avoid answering

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice intellectualization and "helping others" talk used to avoid vulnerability

© The Recovery Files

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize dramatic but non-therapeutic disclosures that hide what matters most

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

Needs vs. Wants Discernment

I differentiate between what a patient is asking for and what they clinically need

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I recognize when requests are clinically driven versus avoidance-driven

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice when patients advocate for comfort over growth and can address it

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I identify when stated treatment goals are genuine versus performative

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I tell the difference between a flight response and a legitimate readiness indicator

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I distinguish a patient who wants validation from one who needs honest confrontation

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I notice when patients request what worked for someone else rather than what they need

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I track whether a patient is absorbing recovery concepts or just performing activities

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

Responsive Clinical Intervention

When I observe incongruence, I address it in a therapeutic manner

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I use what I observe non-verbally to inform my interventions in real time

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

© The Recovery Files

I adjust my therapeutic approach based on the cues I am reading

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I name what I see when appropriate, without shaming the patient

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I create space for patients to explore their own deflection patterns

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I document observed behavioral cues in clinical notes, not just self-reported content

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I use strategic silence, pausing after a deflection rather than filling the space

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

I consult colleagues when I observe patterns beyond my experience or cultural competence

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Not at all · Very much

Scoring guide

Each group gets its own score, as a percent.

Score: 0–25% — Emerging Skill: Make it a deliberate, named focus in supervision and practice.

Score: 26–45% — Developing: You have a foundation here. Targeted practice will build it quickly.

Score: 46–65% — Competent: A solid working skill. Refine it with peer feedback and intentional attention.

Score: 66–80% — Proficient: A real clinical strength. Keep deepening it.

Score: above 80% — Expert Observer: A signature clinical strength. Lean on it, teach it, and protect it.

© The Recovery Files

Part 3 · Day 1 · The Art of Clinical Observation

DAY 1 OF 10 · FOUNDATION

Learning to read the patient, not just listen to them

Today's Reading

Every patient who walks into your office, group room, or facility is communicating on multiple channels at once. They are speaking words, and those words carry meaning. But beneath the words, around them, and often in direct contradiction to them, an entire symphony of communication is playing. Your ability to hear that symphony — to read the patient, not just listen to the patient — is what separates competent clinical work from exceptional clinical work.

Clinical observation is not mystical intuition, though intuition plays a role. It is a disciplined, trainable skill: watching with purpose, listening with depth, tracking patterns over time, and developing the professional courage to name what you see even when the patient would prefer you didn't notice. Father Martin taught that the best counselors are the ones who can see what the patient cannot yet see about themselves — and hold that awareness with compassion until the patient is ready to look.

This is not about catching people in lies or playing detective. Most patients in SUD treatment have spent years, sometimes decades, perfecting the art of appearing okay. They survived by controlling how they were perceived. Your job is not to punish that survival skill but to gently make it unnecessary. Over the next ten days you will sharpen your observation across every channel — body, voice, omission, deflection, distraction — and train the discernment that separates what a patient wants from what they need.

Reflect

1. Where do you feel most confident as a clinical observer, and where do you suspect your blind spots are?

2. Describe a time you sensed something was "off" with a patient but could not name what you were seeing. What happened?

© The Recovery Files

3. How comfortable are you naming incongruence aloud, or do you tend to notice it silently and move on?

Today's Work

In your own words, describe your current clinical observation skills:

Be honest about where you are right now, not where you want to be...

Describe a clinical moment when you sensed something was "off" but could not articulate what you were seeing:

What was happening? What did you notice, and what did you miss?

Think of a patient who once "fooled" you. What would you watch for now?

What were the cues you can see in hindsight?

Set Your Baseline

Before going further, take the Clinical Observation Self-Assessment. 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 session:

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 4 · Day 2 · The Body Speaks First

DAY 2 OF 10 · THE BODY

Reading non-verbal communication

Today's Reading

Communication research consistently shows that a large majority of emotional meaning travels non-verbally. The exact percentage is debated; what is not debated is that the body communicates faster, more honestly, and more continuously than language. When a patient's words say one thing and their body says another, clinical wisdom says: believe the body.

Non-verbal communication runs across several channels. Kinesics — posture, gesture, and facial expression — tells you whether a patient is open or armored. Facial micro-expressions, flashes of emotion lasting less than half a second, are especially valuable because they are involuntary. And proxemics, the use of physical space — where a patient sits when given the choice, what barriers they build, how close they let you come — is diagnostic data, particularly for patients with trauma histories.

The critical skill is not noticing that a patient fidgets, but tracking the timing of the shift — exactly which question made the leg start bouncing or the eye contact break. Non-verbal behavior gains its meaning through context and timing. One non-negotiable caveat: cultural competence. Eye contact norms, personal space, and gesture meanings vary dramatically across cultures, and neurodevelopmental differences change presentation. Observe first, interpret second, hold cultural humility always.

Reflect

1. Which non-verbal channel do you naturally attend to most, and which do you tend to overlook?

2. Recall a recent session. Can you picture the patient's body language? What does your recall reveal about your observation habits?

3. Where on your current caseload might you need to expand your cultural competence in reading non-verbal cues?

© The Recovery Files

Today's Work

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 5 · Day 3 · Hearing What Words Cannot Tell You

DAY 3 OF 10 · THE VOICE

Tone, pace, and the paralinguistic channel

Today's Reading

The same three words — "I'm doing great" — can carry opposite meanings depending on pace, volume, pitch, and vocal quality. Paralinguistics, the channel beyond the words themselves, carries enormous clinical information that the verbal content alone will never give you. Learning to hear the emotional soundtrack playing underneath the words is one of the most underused observational skills.

Pace shifts with emotional activation: anxious patients speed up, depressed patients slow down, and a patient approaching something painful often changes pace suddenly. Volume signals just as clearly — the drop to a near-whisper when shame is close, the rise as anger nears the surface, the artificially even and controlled tone of a patient managing their presentation.

As with body language, timing is everything. The question is not only how a patient sounds, but when the sound changed and what was being discussed at that exact moment. A measured, level voice that suddenly tightens and quickens the instant you mention their sponsor is telling you something the words may be working hard to conceal.

Reflect

1. When you replay a recent session in your mind, what do you remember about how the patient sounded, not just what they said?

2. Which vocal shift do you most reliably notice, and which do you tend to miss entirely?

3. Think of a patient whose tone contradicted their words. What was the voice telling you that the words were not?

Today's Work

© The Recovery Files

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 6 · Day 4 · The Language of Omission

DAY 4 OF 10 · THE UNSAID

What has not been said

Today's Reading

What a patient does not say is often more clinically significant than what they do say. Omission is one of the most sophisticated and least-addressed forms of patient communication, and reading it requires a different attention than reading the body. It means holding a mental map of what a complete, honest clinical picture would include, and then noticing what is missing.

Omission comes in categories. Topical avoidance is the most common — the patient who discusses every life area except the marriage, who talks freely about drugs but never alcohol. Emotional omission is subtler — devastating events narrated with no affect, the words describing pain while the emotion is entirely absent. Temporal omission skips entire eras, usually the years of heaviest use. And self-omission is the most important: the patient who talks about everyone except themselves.

Reading omission takes two practices. First, after each interaction, ask yourself: what didn't come up today? Second, cultivate the clinical courage to gently name the absence — "we talk about a lot of things, but you've never brought up your father, and I'm curious about that." These observations are not accusations. They are invitations.

Reflect

1. Think of a patient on your caseload. What topics have they never raised, and what might that avoidance tell you clinically?

2. How do you respond when you notice emotional omission — pain narrated without affect?

3. How comfortable are you naming an omission to a patient? What makes it difficult?

Today's Work

© The Recovery Files

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 7 · Day 5 · When Laughter Is Armor

DAY 5 OF 10 · DEFLECTION

Humor and sarcasm as deflection

Today's Reading

Humor is one of the most powerful defense mechanisms in the clinical setting — powerful because it works on the clinician as well as the patient. When a patient makes the room laugh, the tension drops, the clinician relaxes, the painful moment passes, and everyone moves on without ever addressing what was underneath. That is exactly why it gets used.

Not all humor is deflection. Genuine humor — laughing at the absurdity of addiction, finding lightness in recovery — is healthy and should be welcomed. The clinical question is never "is the patient being funny?" but "what is the humor doing?" Deflective humor has a tell: it almost always arrives at a specific moment, just as the conversation approaches emotional depth. Sarcasm is humor's sharper sibling — armor with teeth.

Your response is what matters most. The worst move is to laugh along and move on. The more therapeutic move is to pause, not laugh, and gently name what happened: "That was funny — and you were about to say something real before the joke came. Do you want to go back to it?" And the hardest skill of all is noticing when you, the clinician, collude with the deflection because it is more comfortable for you, too.

Reflect

1. Think of the funniest patient you have worked with. How much of their humor was genuine, and how much was armor? Did you address it?

2. How do you usually respond to sarcasm aimed at the process, at recovery concepts, or at you?

3. Be honest: when have you colluded with a patient's deflection because it was easier?

Today's Work

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 8 · Day 6 · The Distraction Arsenal

DAY 6 OF 10 · DISTRACTION

Recognizing how patients redirect the session

Today's Reading

Beyond humor and sarcasm, patients deploy an entire arsenal of distraction strategies — not out of malice, but because these moves have always worked. They redirect the session to avoid pain, to keep control, to consume time so the hard work is never reached, or to test whether the clinician will let them lead.

The patterns are recognizable. The Storyteller monopolizes time with elaborate narratives that feel like disclosure but never arrive at emotional honesty. The Helper offers everyone else advice while never sitting in their own vulnerability. The Intellectual discusses addiction in abstract terms that reveal nothing personal. The Crisis Generator manufactures external drama that swallows clinical attention. The Performer offers dramatic but non-therapeutic disclosures that hide what matters most. And the Challenger debates treatment philosophy to avoid personal application.

Recognizing the strategy is step one. Responding therapeutically is step two. Naming the pattern without shaming the patient invites them to see their own distraction. The redirection is not "stop avoiding." It is closer to, "I notice we keep moving toward other people's stories — I wonder what happens if we stay with yours for a moment."

Reflect

1. Which distraction strategy do you encounter most on your current caseload? Name a specific patient and a specific example.

2. What is that patient avoiding? What would they have to face if the distraction were removed?

3. Which strategy is hardest for you to redirect, and why?

Today's Work

© The Recovery Files

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 9 · Day 7 · Needs vs. Wants

DAY 7 OF 10 · DISCERNMENT

The heart of clinical judgment

Today's Reading

Every patient in treatment has wants. They want to feel better, to go home, to have the consequences stop, to be understood as a special case. These wants are understandable, often legitimate, and sometimes clinically important. But they are not the same thing as needs — and the ability to discern the difference is the core of clinical judgment in SUD treatment.

A patient wants to leave early because they feel better; what they need is to stay long enough for the neurological and behavioral changes to stabilize. A patient wants individual therapy instead of group because group is triggering; what they need is to tolerate being seen by peers, because isolation is the soil relapse grows in.

Two indicators help. First, the emotional energy behind the request: a genuine need usually carries groundedness and even vulnerability, while a want dressed as a need carries urgency and external justification. Second, the relationship between the request and the patient's established pattern. Your job is to hear both the request and what is underneath it, and to bring the patient into the discernment itself: "Help me understand what that would do for you. What are you afraid will happen if you don't get it?"

Reflect

1. Describe a recent moment where a patient's want and their clinical need were in conflict. How did you handle it?

2. How do you decide when to honor a stated preference versus override it with clinical judgment without becoming paternalistic?

3. When have you granted a request because it was easier than the therapeutic conversation about what the patient actually needed?

Today's Work

© The Recovery Files

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 10 · Day 8 · The Mirror Turned Inward

DAY 8 OF 10 · BLIND SPOTS

Examining what you tend to miss, and why

Today's Reading

Every clinician has blind spots — populations, presentations, or patterns we consistently misread, overlook, or respond to less effectively. This day is not about shame. It is about professional integrity: knowing your limitations so they do not become your patients' liabilities.

Blind spots cluster in three areas. Awareness blind spots are the channels you reliably miss, or the population whose non-verbal communication you find harder to read. Emotional blind spots are the patient emotions hardest for you to sit with — anger, grief, shame, helplessness — and what your discomfort does to your observational capacity. Interpretive bias is the third: over-reading some cues and under-reading others, plus the premature hypotheses you tend to reach for before the evidence is in.

The strongest clinicians are not the ones without blind spots. They are the ones who know theirs and build structures around them — supervision, peer feedback, consultation, and the humility to say, "this is at the edge of my competence."

Reflect

1. Which non-verbal channel or patient population do you most often misread, and why might that be?

2. Which patient emotions are hardest for you to sit with, and how does that discomfort affect what you observe?

3. What is a premature hypothesis you tend to reach for before gathering enough observational evidence?

Today's Work

© The Recovery Files

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 11 · Day 9 · Reading the Whole Patient

DAY 9 OF 10 · INTEGRATION

Putting every channel together

Today's Reading

In every clinical session there are two conversations happening at once: the one being spoken, and the one being communicated through everything else — body, tone, omission, deflection, and affect. The integrated clinician tracks both and notices where the distance between them is greatest, because that gap is usually where the most important clinical material lives.

Integration means putting the channels together rather than reading them in isolation. Crossed arms alone mean little. But crossed arms that appeared exactly when you asked about the marriage, paired with a sudden drop in volume and an abrupt topic change, tell a coherent story. The skill is to hold the whole picture at once and let that composite inform your intervention in real time.

Two practices build this capacity. A structured session observation log, completed within an hour while the observations are still fresh, sharpens your attention in future sessions. And an "unspoken session" review reconstructs the subtext — the conversation that ran beneath the words. Over time, these practices move observation from something you do afterward into something you do continuously, in the room, as the session unfolds.

Reflect

1. Think of a recent session. Where was the gap between the spoken and the unspoken conversation greatest?

2. When you integrate channels, which one tends to anchor your read, and does that ever lead you to discount the others?

3. What would change in your documentation if you recorded observational data, not just self-reported content?

Today's Work

© The Recovery Files

Apply today's concept to a current patient (no identifying details):

What channel are you observing, what did you notice, what might it mean...

One specific thing you will do differently in your next session based on today:

Concrete, actionable, specific...

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files

Part 12 · Day 10 · From Insight to Practice

DAY 10 OF 10 · PRACTICE

Turning awareness into a clinical commitment

Today's Reading

Everything in this pathway has been about expanding awareness. Awareness alone changes nothing. Skills sharpen with intentional practice, not good intentions — and this final day converts insight into concrete, time-bounded professional commitments.

The most reliable way to develop is depth over breadth: choose one observation skill and practice it in every session for thirty days, rather than spreading your attention thin across all of them at once. Track it — through session logs, supervision notes, or peer feedback. Decide in advance what success will look like, so you can recognize the growth when it comes. And upgrade your documentation to include what you observe, not just what the patient reports, because what gets written down gets attended to.

Father Martin taught that the best counselors see what the patient cannot yet see, and hold it with compassion until the patient is ready to look. That vision is not a gift some clinicians are born with — it is a practice, built one session at a time. Today you name your strengths and blind spots honestly, commit to a single focused skill, and write a clinical observation commitment in your own words.

Reflect

1. Across these ten days, what is the single most important shift in how you observe?

2. What is the one observation skill you will practice in every session for the next thirty days?

3. Who will hold you accountable to this commitment, and what will you do when you notice yourself sliding back?

Today's Work

© The Recovery Files

My two greatest strengths as a clinical observer:

Based on the readings, assessment, and exercises...

My two most significant blind spots or underdeveloped skills:

Be honest...

The ONE observation skill I will practice in every session for the next 30 days:

Choose one to build depth, not breadth...

How I will track my practice:

Session logs, supervision notes, peer feedback...

What success will look like in 30 days — how will I know this skill has improved?

Define it concretely...

My Clinical Observation Commitment

In Your Own Words

Write what you are committing to seeing, what you are committing to naming, and why. Specific, personal, and grounded in these ten days.

I commit to seeing... to naming... because...

© The Recovery Files

Revisit Your Baseline

You completed your baseline on Day 1. Return to it now and notice what has shifted.

Carry Forward

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

A single observation skill, intention, or question to hold onto...

© The Recovery Files