

Clinical Step Working Guide

Step 3: Decision

For SUD and mental health counselors

"Made a decision to turn our will and our lives over to the care of God as we understood Him."

THE DECISION

Direction, not perfection

THE SURRENDER

Will, lives, ego, judgment

THE SOLUTION

Guidance, direction, service

Clinician Resources

Step Three is where patients move from understanding the problem to committing to the solution. Your role is to facilitate genuine decision-making, help dismantle ego barriers, and support patients in following guidance from sponsors, the fellowship, and the program.

Recommended Reading

Alcoholics Anonymous "Big Book" - Chapter 5: "How It Works"

Clinical Training

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

THE DECISION: Turning Point

What "making a decision" really means—direction, not perfection

Made a DECISION: Direction, Not Perfection

OVERVIEW

Step Three begins with "Made a decision"—not "perfectly surrendered," not "fully turned over," but simply "made a decision." A decision is a turning point, a change in direction. It's the moment the patient stops fighting recovery and starts cooperating with it. The decision doesn't have to be complete; it just has to be sincere.

KEY POINTS FOR CLINICIANS

- A decision is a starting point, not an ending point
- Direction matters more than distance
- The decision will be tested and renewed daily
- Imperfect willingness is still willingness
- Making the decision opens the door to Steps Four through Twelve

CLINICAL INSIGHT

Patients often resist Step Three because they think it requires perfect surrender. Clarify: "You're making a decision to go in a new direction. You don't have to do it perfectly—you just have to point yourself that way and take the next step." This removes the perfectionism barrier.

THE PATIENT EXPERIENCE

The power of decision: "I thought I had to completely surrender before I could do Step Three. My sponsor said, 'Just decide to try it. Decide to go this direction instead of your old direction. That's all—just a decision.' That I could do."

CLINICAL REFLECTION

How do you help patients understand that Step Three requires decision, not perfection? Do you address perfectionism barriers?

CLINICAL EXERCISE / ASSESSMENT TOOL

Decision clarification:

- "What does 'making a decision' mean to you—is it a one-time event or an ongoing commitment?"
- "What would it look like to decide to go in a different direction, even imperfectly?"
- "What decisions have you made before that you had to renew daily?"
- "Can you decide to TRY this approach, even without certainty it will work?"

SUGGESTION FOR YOUR PRACTICE

Frame Step Three as a "directional decision" rather than a "total transformation." Use the analogy of deciding to go north—you start walking north; you don't teleport to the North Pole. The decision sets the direction; the journey unfolds over time.

ACTION STEP FOR YOUR PRACTICE

Develop language around "directional decision" versus "perfect surrender." Help patients see Step Three as achievable willingness, not impossible perfection.

The Decision That Opens the Door

OVERVIEW

Step Three is sometimes called the "gateway step." Steps One and Two created awareness and hope; Step Three is the decision to act on them. Without this decision, the remaining steps remain theoretical. Making this decision opens the door to the transformative work of Steps Four through Nine.

KEY POINTS FOR CLINICIANS

- Steps One and Two are preparation; Step Three is commitment
- Without the decision, subsequent steps don't happen
- The decision converts insight into action
- This is where recovery moves from thinking to doing
- Step Three bridges "I need help" to "I'm accepting help"

CLINICAL INSIGHT

Some patients get stuck between Step Two and Step Three—they believe recovery is possible but won't commit to pursuing it. This is often fear masquerading as analysis. Help them see that the decision itself begins the transformation.

THE PATIENT EXPERIENCE

Opening the door: "I spent months believing recovery was possible without actually deciding to do it. I understood the problem, I believed in the solution, but I wouldn't commit. Making the Step Three decision was like finally walking through a door I'd been standing in front of."

CLINICAL REFLECTION

How do you identify patients stuck between Steps Two and Three? What helps move them from belief to decision?

CLINICAL EXERCISE / ASSESSMENT TOOL

Decision readiness assessment:

- "You believe recovery is possible. What's stopping you from committing to it?"
- "What would making this decision require of you?"
- "What are you afraid of losing if you make this decision?"
- "What's the cost of not deciding?"

SUGGESTION FOR YOUR PRACTICE

When patients seem stuck after Step Two, explore what's blocking the decision. Often it's fear of what Step Three requires (ego deflation, following direction). Address the fear directly: "What are you afraid will happen if you make this decision?"

ACTION STEP FOR YOUR PRACTICE

Develop assessment for decision-readiness. Identify patients stuck in pre-decision limbo and address specific barriers to commitment.

The Decision Requires Action

OVERVIEW

"Made a decision" implies subsequent action. A decision without follow-through is just a thought. Step Three decision-making means committing to follow direction, work the steps, and do things differently. The decision is proven by behavior, not just intention.

KEY POINTS FOR CLINICIANS

- Decision without action is just intention
- The decision is proven by what follows
- "Easy does it, but do it"—action is required
- Behavior reveals whether the decision is real
- The steps that follow ARE the action

CLINICAL INSIGHT

Watch for patients who claim to have "done" Step Three without any behavioral change. The decision should produce observable action: attending meetings, calling sponsors, starting step work, following suggestions. If nothing changes, the decision may be superficial.

THE PATIENT EXPERIENCE

Learning that decision requires action: "I told my sponsor I'd made the decision. She asked, 'Great—what are you doing differently?' I couldn't answer. I'd made the decision in my head but not in my life. Real decision shows in action."

CLINICAL REFLECTION

How do you assess whether a patient's Step Three decision is genuine versus superficial? What behavioral evidence do you look for?

CLINICAL EXERCISE / ASSESSMENT TOOL

Action evidence assessment:

- "What specific actions have you taken since making this decision?"
 - "How is your behavior different now than before the decision?"
 - "What are you doing that you weren't doing before?"
 - "If someone watched your life, would they know you'd made this decision?"
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SUGGESTION FOR YOUR PRACTICE

Require behavioral evidence of Step Three. Ask: "What are you doing differently since making this decision?" If the answer is "nothing," the decision may need revisiting. Connect the decision to specific actions.

ACTION STEP FOR YOUR PRACTICE

Develop behavioral markers for genuine Step Three decision. Assess and reinforce the action component of decision-making.

The Decision Must Be Renewed

OVERVIEW

The Step Three decision is not once-and-done—it must be renewed continuously. Each day, patients face the choice: will I follow my self-will or seek guidance? The initial decision sets direction; daily renewal keeps them on course. Many use the Third Step Prayer each morning as this renewal practice.

KEY POINTS FOR CLINICIANS

- The decision is made once formally, renewed daily
- Each day brings opportunities to choose self-will or surrender
- The Third Step Prayer is often a daily practice
- Renewal prevents drift back to old patterns
- "Just for today" applies to Step Three

CLINICAL INSIGHT

Help patients understand that struggling with self-will after Step Three is normal—the decision needs renewal. It's not a failure to struggle; it's an opportunity to re-decide. Morning practices like the Third Step Prayer support daily renewal.

THE PATIENT EXPERIENCE

Daily renewal: "I thought once I did Step Three, I'd be permanently surrendered. Instead, I wake up every morning with my self-will fully restored. The Third Step Prayer each morning reminds me: today, again, I choose to seek guidance instead of running the show."

CLINICAL REFLECTION

How do you teach patients to renew their Step Three decision daily? Do you introduce specific practices?

CLINICAL EXERCISE / ASSESSMENT TOOL

Daily renewal planning:

- "What practice could you use to renew your Step Three decision each morning?"
 - "What happens when you face situations where you want to take back control?"
 - "How will you recognize when self-will is reasserting itself?"
 - "What's your plan for re-deciding in the moment?"
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SUGGESTION FOR YOUR PRACTICE

Introduce daily renewal practices early. The Third Step Prayer, morning meditation, or daily intention-setting can make Step Three a living practice rather than a historical event.

ACTION STEP FOR YOUR PRACTICE

Develop daily renewal practices for patients. Introduce the Third Step Prayer or alternative practices for daily recommitment.

The Third Step Prayer: Words of Commitment

OVERVIEW

The Third Step Prayer from the Big Book gives words to the decision: "God, I offer myself to Thee—to build with me and to do with me as Thou wilt. Relieve me of the bondage of self, that I may better do Thy will. Take away my difficulties, that victory over them may bear witness to those I would help of Thy Power, Thy Love, and Thy Way of life. May I do Thy will always!" These words encapsulate the surrender.

KEY POINTS FOR CLINICIANS

- The prayer offers structure for the decision
- "Build with me and do with me as Thou wilt"—availability
- "Relieve me of the bondage of self"—ego deflation
- "That I may better do Thy will"—purpose beyond self
- The prayer can be adapted for various spiritual frameworks

CLINICAL INSIGHT

The Third Step Prayer may need adaptation for patients with non-theistic or non-traditional spiritual frameworks. The core elements—offering self, asking for ego relief, seeking to be useful—can be expressed in various ways. Help patients find language that works for them.

THE PATIENT EXPERIENCE

Finding meaning in the prayer: "The God language didn't work for me at first. My sponsor helped me translate: 'I offer myself to recovery—to be changed by it. Relieve me from my self-obsession

so I can be useful to others.' Same meaning, words I could say sincerely."

CLINICAL REFLECTION

How comfortable are you working with the Third Step Prayer? Can you help patients adapt it for their spiritual framework?

CLINICAL EXERCISE / ASSESSMENT TOOL

Prayer exploration:

- Read the Third Step Prayer together
- "What does each line mean to you?"
- "What parts resonate? What parts feel foreign?"
- "How could you express the same commitment in your own words?"
- "What would your version of this prayer sound like?"

SUGGESTION FOR YOUR PRACTICE

Offer the traditional Third Step Prayer AND help patients create versions that match their spiritual framework. The mechanism is the commitment expressed, not the specific words used.

ACTION STEP FOR YOUR PRACTICE

Develop comfort with the Third Step Prayer and help patients either embrace it or create authentic alternatives that express the same commitment.

WILL & LIVES: What We Turn Over

Understanding what we surrender and what we receive

Understanding "Will": What I Want and How I Get It

OVERVIEW

"Our will" refers to what we want and how we pursue it. Self-will says: "I know what's best for me, and I'll get it my way." Turning over our will means releasing our demands about how life should go, what we should have, and how others should behave. It's surrendering the agenda.

KEY POINTS FOR CLINICIANS

- Will = desires + the drive to fulfill them our way
- Self-will has been running the show—usually into the ground
- Turning over will means releasing demands and expectations
- It doesn't mean having no desires—it means holding them loosely
- The shift is from "my will be done" to "thy will be done"

CLINICAL INSIGHT

Patients often think "turning over will" means becoming passive or desire-less. Clarify: it's about releasing the demand that life conform to their expectations. They can still have preferences; they just stop insisting the universe comply.

THE PATIENT EXPERIENCE

Understanding will: "I thought giving up my will meant becoming a robot. My sponsor explained: your will is your demand that things go YOUR way. Turning it over means being okay when they don't. You can still have goals—you just stop throwing tantrums when reality differs from your plans."

CLINICAL REFLECTION

How do you explain "will" to patients? Can you distinguish healthy desire from self-will run riot?

CLINICAL EXERCISE / ASSESSMENT TOOL

Will examination:

- "What do you demand from life? From others? From yourself?"
- "What happens when these demands aren't met?"
- "Where has insisting on your way caused problems?"
- "What would it look like to hold your desires more loosely?"

SUGGESTION FOR YOUR PRACTICE

Distinguish between healthy desires and self-will run riot. Self-will is characterized by demand, control, and resentment when thwarted. Help patients identify where their will has become rigid demand rather than flexible preference.

ACTION STEP FOR YOUR PRACTICE

Develop clear explanations of "will" in recovery terms. Help patients examine their demands and their response when demands aren't met.

Understanding "Lives": How We Actually Live

OVERVIEW

"Our lives" refers to the day-to-day reality of how we live—our choices, actions, relationships, and priorities. Turning over our lives means letting guidance shape how we actually live, not just how we think. It's practical, not just philosophical.

KEY POINTS FOR CLINICIANS

- Lives = daily choices, actions, priorities, relationships
- Turning over our lives means living differently, not just thinking differently
- This is practical surrender visible in behavior
- Our lives include time, money, relationships, work—everything
- The change shows in calendar and checkbook, not just intentions

CLINICAL INSIGHT

Some patients surrender philosophically while their lives remain unchanged. Challenge this: "If someone watched your life but couldn't read your mind, would they know you'd turned it over? What would be different?" Lives are lived visibly.

THE PATIENT EXPERIENCE

Turning over my life: "Turning over my will was the thinking part. Turning over my life was the living part. It meant actually going to meetings, actually calling my sponsor, actually making amends—not just agreeing these were good ideas."

CLINICAL REFLECTION

How do you assess whether patients have turned over their lives in practice, not just in theory?

CLINICAL EXERCISE / ASSESSMENT TOOL

Life examination:

- "How has your daily life changed since making this decision?"
- "What does your schedule show about your priorities?"
- "Where do you spend your time, money, energy now versus before?"
- "What would an observer notice is different about how you live?"

SUGGESTION FOR YOUR PRACTICE

Assess behavioral changes, not just attitudinal ones. How is the patient living differently? What changed in their schedule, their relationships, their priorities? If nothing tangible changed, the surrender may be abstract only.

ACTION STEP FOR YOUR PRACTICE

Develop concrete behavioral assessments for "lives turned over." Look at time, money, relationships, and daily choices as evidence.

To the "Care" of God: What We Receive

OVERVIEW

Step Three specifies turning will and lives over to the "care" of God—not to God's control, not to God's punishment, but to God's care. This implies being cared for, protected, guided. What patients give up (self-will) is exchanged for something better (being cared for).

KEY POINTS FOR CLINICIANS

- "Care" implies nurturing, protection, guidance
- This is not losing something—it's gaining something better
- Surrendering control doesn't mean being abandoned
- The exchange: self-will for being cared for
- This addresses the fear that surrender means vulnerability

CLINICAL INSIGHT

Many patients resist surrender because they associate it with being vulnerable, unprotected, or abandoned. The word "care" is important—they're not being left to fend for themselves; they're being cared for. Address this fear directly.

THE PATIENT EXPERIENCE

Receiving care: "I was terrified to give up control because I thought it meant no one would protect me. Then someone pointed out the word 'care'—I wasn't being abandoned, I was being cared for. That changed everything."

CLINICAL REFLECTION

How do you present the "care" aspect of Step Three? Do you address fears of abandonment in surrender?

CLINICAL EXERCISE / ASSESSMENT TOOL

Care exploration:

- "What comes to mind when you hear 'being cared for'?"
 - "What fears come up when you think about giving up control?"
 - "What would it feel like to be guided instead of having to figure everything out yourself?"
 - "Where have you experienced being cared for well in your life?"
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SUGGESTION FOR YOUR PRACTICE

Emphasize "care" in discussing Step Three. Patients are exchanging the exhausting burden of running the show for the relief of being guided and cared for. This is not loss—it's gain.

ACTION STEP FOR YOUR PRACTICE

Develop language emphasizing "care" in Step Three. Address fears of vulnerability and help patients see surrender as receiving, not just giving up.

As We Understood Him: Personal Conception

OVERVIEW

"God as we understood Him" is crucial—patients don't have to accept someone else's conception of God. Their understanding can be the group, the program, nature, love, the universe, or a traditional deity. What matters is that they find something greater than self-will to guide them.

KEY POINTS FOR CLINICIANS

- "As we understood" allows personal spiritual framework
- The understanding can evolve over time
- What matters is finding guidance beyond self-will
- Rigid theological positions (for or against) can block the step
- The program suggests openness to spiritual growth

CLINICAL INSIGHT

Help patients find a working Higher Power concept rather than getting stuck on theological debates. The question is practical: "What can you turn to for guidance that's wiser than your self-will?" This can be addressed without resolving metaphysical questions.

THE PATIENT EXPERIENCE

Finding my understanding: "I couldn't accept the God of my childhood. My sponsor said, 'Find your own understanding. What's greater than your self-will that you could trust for guidance? Start there.' That opened a door the old God concept had closed."

CLINICAL REFLECTION

How do you help patients find their own "understanding"? Can you facilitate this without imposing or avoiding spiritual content?

CLINICAL EXERCISE / ASSESSMENT TOOL

Personal conception exploration:

- "What does 'God as you understand Him' mean to you?"
- "What could serve as a source of guidance beyond your own thinking?"
- "What understanding do you currently have—even if partial or uncertain?"
- "How might your understanding evolve over time?"

SUGGESTION FOR YOUR PRACTICE

Don't get caught in theological debates. Focus on function: "What can serve as a source of guidance beyond your self-will?" The answer can be very personal and doesn't require resolving abstract spiritual questions.

ACTION STEP FOR YOUR PRACTICE

Develop comfort helping patients articulate their own Higher Power understanding. Focus on functional guidance rather than theological precision.

What We Keep: Responsibility Remains

OVERVIEW

Turning over will and lives doesn't mean turning off responsibility. Patients remain responsible for their actions, their recovery work, their choices. They turn over the results, the outcomes, the demand that things go their way—not the effort, the work, or the participation.

KEY POINTS FOR CLINICIANS

- Surrender is not passivity or irresponsibility
- We turn over outcomes, not efforts
- We remain responsible for showing up, doing the work
- "Let go and let God" doesn't mean "do nothing"
- The serenity prayer distinguishes what we can and can't control

CLINICAL INSIGHT

Some patients misuse Step Three as excuse for passivity: "I turned it over, so I don't have to do anything." Correct this misunderstanding. They turn over results; they keep responsibility for effort. Recovery requires action.

THE PATIENT EXPERIENCE

Understanding responsibility: "I thought turning it over meant I could stop trying. My sponsor laughed. 'You turn over the results—you keep the effort. God's not going to attend meetings for you or make amends for you.' I had to stop using surrender as an excuse."

CLINICAL REFLECTION

How do you address misuse of surrender as passivity? Do you clarify what is and isn't turned over?

CLINICAL EXERCISE / ASSESSMENT TOOL

Responsibility clarification:

- "What are you turning over? What are you keeping?"
 - "What is your responsibility in recovery versus what's not your responsibility?"
 - "How do you distinguish effort (yours) from outcome (turned over)?"
 - "Where might you be using 'surrender' as an excuse for not trying?"
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SUGGESTION FOR YOUR PRACTICE

Distinguish what patients turn over from what they keep. They turn over: outcomes, other people, the future. They keep: effort, choices, recovery actions. The Serenity Prayer provides this framework.

ACTION STEP FOR YOUR PRACTICE

Develop clear teaching on what is and isn't turned over. Address passive misuse of Step Three by clarifying continued responsibility.

DISMANTLING EGO: Self-Will Run Riot

Addressing the self-centeredness at the core of addiction

Self-Centeredness: The Root of the Problem

OVERVIEW

The Big Book identifies self-centeredness as the root of the alcoholic's troubles. It's not the drinking alone—it's the self-obsession that drives it. Step Three addresses this by turning away from self-will toward guidance. Ego deflation is essential for recovery.

KEY POINTS FOR CLINICIANS

- Self-centeredness is identified as THE problem
- Addiction is symptom of self-centered fear
- Self-obsession creates isolation and resentment
- Step Three begins the ego deflation process
- The remaining steps continue dismantling self-centeredness

CLINICAL INSIGHT

Help patients see self-centeredness not as moral failing but as disease characteristic. This isn't about being "bad"—it's about having a disease that manifests as self-obsession. Understanding this reduces shame while maintaining accountability.

THE PATIENT EXPERIENCE

Seeing my self-centeredness: "When my sponsor said I was self-centered, I was offended. But she explained: 'Your world revolves around you—your fears, your desires, your resentments. Even your problems are self-centered. That's the disease.' She was right."

CLINICAL REFLECTION

How do you address self-centeredness without inducing shame? Do you help patients see it as disease characteristic?

CLINICAL EXERCISE / ASSESSMENT TOOL

Self-centeredness assessment:

- "How much of your mental energy focuses on yourself—your problems, your needs, your feelings?"
 - "When you're in a room, what are you usually thinking about?"
 - "How does your self-focus affect your relationships?"
 - "What would it feel like to be less the center of your own universe?"
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SUGGESTION FOR YOUR PRACTICE

Frame self-centeredness clinically rather than morally. It's a symptom of the disease—the world shrinks to self-survival mode. Step Three begins expanding that world beyond the narrow confines of self-will.

ACTION STEP FOR YOUR PRACTICE

Develop non-shaming language for addressing self-centeredness. Help patients recognize it as disease symptom requiring treatment, not moral failure requiring punishment.

The Bondage of Self: What We're Escaping

OVERVIEW

The Third Step Prayer asks for relief from "the bondage of self." Self-obsession is a prison—patients are trapped in their own fears, desires, and resentments. Step Three offers freedom from this bondage. The irony: focusing on self created imprisonment; turning away from self creates liberation.

KEY POINTS FOR CLINICIANS

- Self-obsession is bondage, not freedom
- The self-focused life is exhausting and unfulfilling
- Freedom comes through letting go of self-will
- This is the paradox: losing self-focus, we find ourselves
- Service to others is the key that unlocks the bondage

CLINICAL INSIGHT

Patients often think self-focus is self-protective. Help them see it as self-imprisonment. The most miserable people are the most self-obsessed. Relief comes not from getting more for self but from being freed from self-obsession.

THE PATIENT EXPERIENCE

Finding freedom: "I thought protecting myself meant focusing on myself. But the more I focused on me, the more miserable I became. When I started focusing on others—in service, in meetings—something shifted. Getting out of myself was the freedom I'd been looking for."

CLINICAL REFLECTION

How do you help patients experience freedom from self-obsession? Do you use service as a tool for ego deflation?

CLINICAL EXERCISE / ASSESSMENT TOOL

Bondage recognition:

- "How does your self-focus feel? Does it feel like freedom or imprisonment?"
- "What does 'bondage of self' mean to you?"
- "When have you experienced relief from self-obsession?"
- "What happens when you focus on helping others instead of fixing yourself?"

SUGGESTION FOR YOUR PRACTICE

Introduce service early as a tool for relieving self-obsession. Even small acts of service—greeting at meetings, helping newcomers—can begin to break the bondage of self.

ACTION STEP FOR YOUR PRACTICE

Help patients recognize self-obsession as bondage. Introduce service and other-focused activities as tools for relief.

Pride and Fear: The Ego's Defenses

OVERVIEW

Ego expresses itself through pride (I'm better than) and fear (I'll be exposed as less than). Both keep patients isolated and resistant. Pride prevents asking for help; fear prevents honest vulnerability. Step Three requires lowering both defenses.

KEY POINTS FOR CLINICIANS

- Pride and fear are two sides of ego
- Pride says: "I don't need help; I can handle this"
- Fear says: "If people knew the real me, they'd reject me"
- Both prevent the connection recovery requires
- Step Three challenges both: accepting help, being honest

CLINICAL INSIGHT

Assess for both pride and fear barriers. Some patients are obviously prideful; others' pride is hidden behind fear. Either way, ego defenses block the vulnerability Step Three requires.

THE PATIENT EXPERIENCE

Seeing my pride and fear: "I looked humble because I was afraid, but underneath I was full of pride—too proud to really ask for help, too proud to admit I couldn't figure this out. My fear and my pride were the same thing wearing different masks."

CLINICAL REFLECTION

How do you assess pride and fear barriers in patients? Do you recognize how they present differently but serve the same ego protection?

CLINICAL EXERCISE / ASSESSMENT TOOL

Pride and fear exploration:

- "Where does pride show up for you? 'I don't need help' thinking?"
- "Where does fear show up? Fear of being seen, known, exposed?"

- "How do pride and fear keep you isolated?"
 - "What would be possible if you could lower these defenses?"
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SUGGESTION FOR YOUR PRACTICE

Explore both pride and fear with patients. Often they present one while hiding the other. Both block Step Three surrender. Addressing them requires creating safety for vulnerable honesty.

ACTION STEP FOR YOUR PRACTICE

Assess both pride and fear in your patients. Recognize them as ego defenses that block Step Three vulnerability.

The Ego's Resistance to Step Three

OVERVIEW

The ego does not surrender gracefully. When patients approach Step Three, expect resistance: intellectualization, doubt, argument, finding fault with the program, sponsors, or meetings. This resistance is the ego fighting for survival. Recognizing it as resistance rather than valid objection is important.

KEY POINTS FOR CLINICIANS

- Ego resists its own diminishment
- Resistance shows as doubt, argument, criticism
- The timing is notable: resistance intensifies near Step Three
- This is often the disease speaking, not the person
- Working through resistance (not around it) is important

CLINICAL INSIGHT

When patients who were engaged suddenly become critical of the program, sponsors, or meetings right before Step Three—that's ego resistance. Don't be fooled. Name it: "Your ego is fighting for survival. This resistance is expected."

THE PATIENT EXPERIENCE

Recognizing my resistance: "Right before I was supposed to do Step Three, I suddenly had all these objections—the program was outdated, my sponsor was annoying, meetings were boring. My sponsor said, 'That's your disease trying to keep you from surrendering.' She was right."

CLINICAL REFLECTION

How do you recognize ego resistance versus valid concerns? Do you anticipate intensified resistance near Step Three?

CLINICAL EXERCISE / ASSESSMENT TOOL

Resistance recognition:

- "Have your objections to the program increased recently? What's the timing?"
 - "What if your doubts are your ego trying to prevent surrender?"
 - "What would your disease want you to believe about Step Three?"
 - "Can you distinguish valid concerns from resistance to change?"
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SUGGESTION FOR YOUR PRACTICE

Anticipate and name ego resistance. When patients bring sudden objections, explore whether the timing correlates with Step Three. Help them recognize resistance as disease symptom.

ACTION STEP FOR YOUR PRACTICE

Anticipate and name ego resistance with patients. Help them see sudden objections near Step Three as potential disease symptoms.

Ego Deflation: Necessary, Not Punitive

OVERVIEW

Ego deflation is not humiliation—it's relief. The inflated ego is exhausting to maintain. Deflation brings relief from the constant performance, defense, and self-protection. Patients often fear ego deflation but experience it as liberation.

KEY POINTS FOR CLINICIANS

- Ego deflation is therapeutic, not punitive
- The inflated ego is exhausting to maintain
- Deflation brings relief, not defeat
- Right-sized ego is the goal, not no ego
- This is liberation from the prison of self-inflation

CLINICAL INSIGHT

Reframe ego deflation positively. Patients fear humiliation; help them understand that deflation brings relief. The ego's burden was heavy; putting it down is freedom.

THE PATIENT EXPERIENCE

Experiencing deflation as relief: "I thought ego deflation would be humiliating. Instead, it was such a relief. I didn't have to pretend anymore. I didn't have to know everything, control everything, be right about everything. I could just be human."

CLINICAL REFLECTION

How do you frame ego deflation—as punishment or relief? Can you help patients anticipate liberation rather than fear humiliation?

CLINICAL EXERCISE / ASSESSMENT TOOL

Reframing deflation:

- "What's exhausting about maintaining your current self-image?"
 - "What would it be like to not have to be right, in control, or together?"
 - "Where might ego deflation bring relief rather than shame?"
 - "What burden could you put down?"
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SUGGESTION FOR YOUR PRACTICE

Use language of relief, not punishment. "What would it be like to put down the burden of being right all the time?" "What if you didn't have to control everything?" Help patients anticipate relief rather than fear humiliation.

ACTION STEP FOR YOUR PRACTICE

Develop language framing ego deflation as relief and liberation. Help patients see the upside of releasing ego burdens.

JUDGMENT & OPINION: Releasing the Need to Be Right

Letting go of the thinking that keeps us sick

Our Best Thinking Got Us Here

OVERVIEW

One of the most quoted lines in the rooms is "My best thinking got me here." Patients arrive with confidence in their own judgment, even after that judgment has repeatedly led them back to using. Step Three asks them to treat their own thinking as one voice among several rather than the final authority. This is not an insult to their intelligence; it is an honest look at the track record.

KEY POINTS FOR CLINICIANS

- Patients' judgment has been shaped by the disease
- The track record of "my way" is evidence, not opinion
- Intelligence and insight do not protect against addiction
- Questioning one's own thinking is a recovery skill
- Seeking outside input is a sign of wisdom, not weakness

CLINICAL INSIGHT

Highly capable patients often resist this most. Their thinking has worked in school, at work, and in crises. Help them see that addiction affects judgment specifically in the areas related to using, risk, and self-assessment. Their thinking isn't broken everywhere; it's unreliable exactly where it matters most for recovery.

THE PATIENT EXPERIENCE

Questioning my own thinking: "I was the smartest person in most rooms I walked into. My sponsor asked me to list every plan I'd made to control my drinking and how each one turned out. The list was long and every ending was the same. That was the first time I considered that my thinking might be part of the problem."

CLINICAL REFLECTION

How do you help patients question their own thinking without attacking their self-worth? Do you use their history as evidence?

CLINICAL EXERCISE / ASSESSMENT TOOL

Track record review:

- "List three plans you made to control or cut down your use. What happened with each?"
- "What did your thinking tell you right before each relapse?"
- "In what areas of your life is your judgment reliable? In what areas has it failed you?"
- "Who could you check your thinking with before acting on it?"

SUGGESTION FOR YOUR PRACTICE

Use the patient's own history as the evidence. Avoid telling them their judgment is poor; ask them to review the outcomes of their own decisions about using. Let the record speak.

ACTION STEP FOR YOUR PRACTICE

Develop a track-record review you can use with patients who over-trust their own judgment. Let the outcomes, not your opinion, make the case.

The Need to Be Right

OVERVIEW

Many patients would rather be right than be well. The need to win arguments, prove points, and have the last word drives conflict, resentment, and isolation. Step Three invites patients to release the need to be right as part of releasing self-will. Being teachable requires being willing to be wrong.

KEY POINTS FOR CLINICIANS

- The need to be right is self-will in conversation
- Winning arguments often costs relationships
- Being right does not produce serenity
- Teachability requires willingness to be wrong
- "Would you rather be right or be happy?"

CLINICAL INSIGHT

The need to be right often protects a fragile sense of worth. If being wrong feels like being worthless, patients will defend their positions fiercely. Address the underlying shame: being wrong about something is an event, not an identity.

THE PATIENT EXPERIENCE

Letting go of being right: "I could argue anyone into the ground. I won almost every fight with my wife and was losing my marriage. My sponsor asked, 'How's all that winning working out for you?' I didn't have an answer."

CLINICAL REFLECTION

How do you respond when patients need to be right with you? Do you model the willingness to be wrong?

CLINICAL EXERCISE / ASSESSMENT TOOL

Right vs. well exploration:

- "Think of your last serious argument. What did being right cost you?"
 - "What would it mean about you if you were wrong?"
 - "Where in your life are you more committed to being right than to being at peace?"
 - "What would it look like to say, 'You may be right,' and mean it?"
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SUGGESTION FOR YOUR PRACTICE

Notice when patients argue with you in session. Instead of defending your point, get curious about what being right protects for them. Model being wrong gracefully yourself.

ACTION STEP FOR YOUR PRACTICE

Practice the phrase "You may be right" with patients as a tool for releasing the need to win. Explore what being wrong means to them.

Contempt Prior to Investigation

OVERVIEW

Patients often dismiss the program before trying it: meetings are a cult, sponsors are controlling, prayer is for weak people, the steps are outdated. This contempt prior to investigation protects the disease by keeping the solution at a distance. Step Three asks for open-minded willingness to try before judging.

KEY POINTS FOR CLINICIANS

- Dismissing the solution protects the problem
- Contempt is often fear dressed as certainty
- Judging the program from the outside isn't real investigation
- Open-mindedness is one of the essentials of recovery
- Patients can test the program the way they'd test anything else

CLINICAL INSIGHT

Treat contempt as data about fear, not as a debate to win. Patients who are most certain the program won't work are often most afraid that it will, and that it will ask something of them. Invite experiment rather than belief.

THE PATIENT EXPERIENCE

Investigating before judging: "I'd decided AA was a bunch of sad people talking about God. I'd never been to a meeting. My counselor said, 'Go to six different meetings and then tell me what you think.' By the fourth one I'd stopped looking for reasons to leave."

CLINICAL REFLECTION

How do you work with patients who dismiss the program before trying it? Do you argue, or invite investigation?

CLINICAL EXERCISE / ASSESSMENT TOOL

Investigation contract:

- "What have you already decided about meetings, sponsors, or the steps?"
- "How much direct experience is that judgment based on?"
- "What would a fair test look like?"
- "What are you afraid you'd find if it actually worked?"

SUGGESTION FOR YOUR PRACTICE

Propose a time-limited experiment: a set number of meetings, a trial of daily practice, a few weeks of following suggestions. Then review the results together. Experiment bypasses the need to win the argument.

ACTION STEP FOR YOUR PRACTICE

Develop a time-limited "fair test" you can offer patients who dismiss the program. Agree on what you'll review together at the end.

Taking Others' Inventory**OVERVIEW**

Early in recovery, patients often become expert critics of everyone else: the speaker who talks too long, the sponsor who isn't spiritual enough, the member who relapsed. Judging others keeps the focus off self and feeds a sense of superiority. Step Three turns attention back to "keeping our own side of the street clean."

KEY POINTS FOR CLINICIANS

- Judging others is a way of avoiding self-examination
- Criticism of others often reflects what we can't face in ourselves
- "Taking someone else's inventory" is a recognized recovery trap
- Superiority isolates as surely as shame does
- The question shifts from "What's wrong with them?" to "What's my part?"

CLINICAL INSIGHT

Watch for patients who spend sessions describing other people's failings. This can feel like insight but often functions as deflection. Gently redirect: "That sounds frustrating. What's going on with you?"

THE PATIENT EXPERIENCE

Turning the focus around: "I could tell you everything wrong with every person in my home group. My sponsor finally said, 'You know a lot about their recovery. How's yours?' It stung, because I'd

been using their problems to avoid mine."

CLINICAL REFLECTION

How do you redirect patients who focus on others' failings? Can you do it without making them feel judged in turn?

CLINICAL EXERCISE / ASSESSMENT TOOL

Inventory redirect:

- "Whose behavior bothers you most right now?"
- "What about that person do you recognize in yourself?"
- "What would you be thinking about if you weren't thinking about them?"
- "What's your part in this situation?"

SUGGESTION FOR YOUR PRACTICE

Track how much session time patients spend on other people versus themselves. Reflect the pattern without shaming. Help them notice what judging others protects them from feeling.

ACTION STEP FOR YOUR PRACTICE

Develop gentle redirect language for patients who take others' inventory. Practice returning the focus to the patient's own recovery.

Holding Opinions Loosely

OVERVIEW

Step Three does not ask patients to have no opinions. It asks them to hold opinions loosely enough to be changed by new information, by guidance, and by experience. Rigid opinions keep patients stuck; flexible ones allow growth. Open-mindedness is a daily practice, not a personality trait.

KEY POINTS FOR CLINICIANS

- Having opinions is healthy; being ruled by them is not
- Rigid thinking is a common feature of active addiction
- Flexibility allows learning and change
- Open-mindedness can be practiced like any skill
- "Maybe" is a powerful recovery word

CLINICAL INSIGHT

Cognitive rigidity is well documented in substance use disorders and often eases with sustained abstinence. Normalize this: patients aren't stubborn by nature; their thinking may loosen as the brain heals. Meanwhile, open-mindedness can be practiced deliberately.

THE PATIENT EXPERIENCE

Learning to hold opinions loosely: "I used to have an opinion about everything and I'd fight for all of them. Now I try to add 'at least that's how I see it today.' It sounds small, but it keeps me teachable."

CLINICAL REFLECTION

How do you encourage flexibility in patients' thinking? Do you notice and reinforce moments of open-mindedness?

CLINICAL EXERCISE / ASSESSMENT TOOL

Flexibility practice:

- "Name an opinion you've changed since getting into recovery."
 - "What's an opinion you hold strongly right now? What would it take to change it?"
 - "Notice your 'always' and 'never' statements this week. Write them down."
 - "Try adding 'maybe' or 'for today' to one strong opinion. What shifts?"
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SUGGESTION FOR YOUR PRACTICE

Teach the difference between "I think" and "I know." Encourage patients to notice absolute language (always, never, everyone, nothing) and soften it. Celebrate moments when patients change their mind.

ACTION STEP FOR YOUR PRACTICE

Help patients notice absolute language and practice softening it. Reinforce open-mindedness whenever you see it.

GUIDANCE & DIRECTION: Following Others' Lead

Trusting sponsors, fellowship, and the program

Taking Suggestions: The Practice of Teachability

OVERVIEW

The program runs on suggestions: go to meetings, get a sponsor, call before you use, read the literature. Taking suggestions is Step Three in action. It means acting on guidance even when patients don't fully understand or agree with it. Teachability, the willingness to be taught, is the soil Step Three grows in.

KEY POINTS FOR CLINICIANS

- Suggestions are how guidance becomes action
- Patients don't have to understand a suggestion to try it
- Teachability is a choice, not a temperament
- "Suggested" doesn't mean "optional" for people who want results
- Following suggestions builds trust through experience

CLINICAL INSIGHT

Patients often want explanations before they'll act. Sometimes understanding comes only after action. Help patients see that some suggestions make sense in hindsight, and that their own way of deciding has not served them well around using.

THE PATIENT EXPERIENCE

Learning to take suggestions: "My sponsor told me to call her every day. I thought it was pointless; I had nothing to say. I did it anyway. Three weeks in, I called her instead of drinking. That's when I understood why she'd asked."

CLINICAL REFLECTION

How do you assess a patient's teachability? Which suggestions do your patients most often resist, and what does that tell you?

CLINICAL EXERCISE / ASSESSMENT TOOL

Suggestion inventory:

- "What suggestions have you been given in recovery so far?"
- "Which have you followed? Which have you skipped?"
- "What's your reason for skipping the ones you've skipped?"
- "Which one suggestion could you try this week, even without fully agreeing?"

SUGGESTION FOR YOUR PRACTICE

Track which suggestions patients follow and which they skip. The skipped ones often point to the deepest resistance. Ask about them with curiosity, not judgment.

ACTION STEP FOR YOUR PRACTICE

Build a simple suggestion inventory into your Step Three work. Use skipped suggestions as a window into resistance.

Sponsorship as Guidance

OVERVIEW

For many patients, a sponsor is the most concrete form of Step Three guidance. A sponsor offers experience, direction, and accountability from someone who has walked the path. Letting a sponsor guide them is practice in turning over self-will to something outside themselves, in a relationship that is human and immediate.

KEY POINTS FOR CLINICIANS

- A sponsor gives guidance a human face
- Sponsors share experience, not professional advice
- Asking for and accepting direction is practice in surrender
- The relationship builds trust over time
- Sponsorship complements clinical care; it doesn't replace it

CLINICAL INSIGHT

Patients may avoid getting a sponsor because it means letting someone see them clearly and tell them things they don't want to hear. Explore the fear behind the delay. Also help patients understand what a sponsor is and isn't: a guide through the steps, not a therapist, doctor, or lawyer.

THE PATIENT EXPERIENCE

Letting someone guide me: "I put off getting a sponsor for months. I said I was looking for the right person, but really I didn't want anyone telling me what to do. When I finally asked, the hardest part was the asking. After that, it was a relief to stop figuring everything out alone."

CLINICAL REFLECTION

How do you support patients in finding and using a sponsor? Are you clear with patients about the difference between your role and a sponsor's?

CLINICAL EXERCISE / ASSESSMENT TOOL

Sponsorship readiness:

- "What has kept you from asking someone to sponsor you?"
- "What qualities would you look for in a sponsor?"
- "What are you afraid a sponsor might ask of you?"
- "How would you ask? Let's practice it now."

SUGGESTION FOR YOUR PRACTICE

Support sponsorship actively: discuss how to choose a sponsor, rehearse asking, and process the relationship in session. Clarify roles so patients bring clinical issues to you and step work to their sponsor.

ACTION STEP FOR YOUR PRACTICE

Develop a short sponsorship guide for patients: how to choose, how to ask, and what the role does and doesn't include.

The Group Conscience: Wisdom Beyond One Person

OVERVIEW

For patients who cannot yet relate to a traditional God concept, the group itself can be a source of guidance greater than self-will. The collective experience of a meeting, many people's hard-won wisdom, often sees what one person cannot. Learning to trust the group is a practical form of Step Three.

KEY POINTS FOR CLINICIANS

- The group holds more experience than any one member
- Shared wisdom often catches what individual thinking misses
- "Group of drunks" (G.O.D.) can be a working Higher Power
- Trusting the group is practice in trusting beyond self
- Listening for identification builds trust in the group

CLINICAL INSIGHT

Using the group as a Higher Power is a legitimate and often effective starting point, especially for agnostic or atheist patients. It is concrete, observable, and immediately available. Over time, patients' understanding may widen or may stay with the group; either can support recovery.

THE PATIENT EXPERIENCE

Trusting the group: "I didn't believe in God, but I couldn't argue with the room. Forty people who used to drink like me were sober and seemed happy. If they said something worked, I figured it was worth more than my opinion."

CLINICAL REFLECTION

How comfortable are you offering the group as a Higher Power? How do you help patients learn to trust collective wisdom?

CLINICAL EXERCISE / ASSESSMENT TOOL

Group guidance exploration:

- "What have you heard in meetings that turned out to be true for you?"
 - "Is there a decision you're facing that you could bring to your group?"
 - "What does the group know that you don't?"
 - "What would it mean to trust the group's experience over your own thinking?"
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SUGGESTION FOR YOUR PRACTICE

Offer the group as a practical Higher Power concept for patients stuck on theology. Encourage patients to bring decisions to their group, not just their sponsor, and to listen for shared experience.

ACTION STEP FOR YOUR PRACTICE

Develop language for presenting the group as a working source of guidance. Encourage patients to test it with a real decision.

Discernment: Pause, Ask, Then Act

OVERVIEW

Following guidance doesn't mean doing whatever anyone says. Step Three builds a habit of discernment: pausing before acting, asking for guidance, and checking impulses against wiser sources. The Big Book suggests that when agitated or doubtful, we pause and ask for the right thought or action. This habit replaces impulsive self-will with considered response.

KEY POINTS FOR CLINICIANS

- Discernment is the skill of seeking guidance before acting
- The pause interrupts impulsive self-will
- Guidance can come through prayer, sponsors, the group, or reflection
- Impulsive decisions are a hallmark of active addiction
- Discernment improves with practice

CLINICAL INSIGHT

The pause aligns closely with evidence-based skills like urge surfing and stop-think-act techniques. Present Step Three discernment and these clinical tools as complementary. Both build space between impulse and action.

THE PATIENT EXPERIENCE

Learning to pause: "I used to act on every thought I had: quit the job, send the angry text, drive to the liquor store. Now I try to pause and ask, 'What would my sponsor say? What's the next right thing?' Most of the time the urgency passes."

CLINICAL REFLECTION

How do you teach patients to pause before acting? Do you connect Step Three discernment with the clinical skills you already use?

CLINICAL EXERCISE / ASSESSMENT TOOL

Pause planning:

- "Describe a recent decision you made impulsively. What happened?"
 - "What are your signs that you're about to act on impulse?"
 - "Who or what could you check with before acting?"
 - "What's a simple pause practice you could use in the moment?"
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SUGGESTION FOR YOUR PRACTICE

Teach a specific pause practice and rehearse it in session. Help patients identify their own warning signs of impulsivity and a short list of people or practices to check with before big decisions.

ACTION STEP FOR YOUR PRACTICE

Develop a simple pause-ask-act protocol for patients. Practice it in session with a real situation they're facing.

Following Direction Without Giving Up Judgment

OVERVIEW

Step Three asks patients to follow guidance, but it does not ask them to give up all judgment or tolerate harm. Patients with trauma histories, or those who have been controlled or exploited, need to know that healthy guidance respects their safety and dignity. Discerning trustworthy guidance from controlling or harmful direction is itself part of recovery.

KEY POINTS FOR CLINICIANS

- Surrender to guidance is not surrender to abuse
- Healthy guidance respects safety, boundaries, and dignity
- Sponsors and groups are human and can be wrong
- Patients keep responsibility for their safety
- Discernment protects both recovery and wellbeing

CLINICAL INSIGHT

Most sponsors and groups offer sound guidance, but not all. Some patients, especially trauma survivors, may hear "follow direction" as "do whatever you're told." Clarify the difference. Help patients recognize red flags: pressure to stop prescribed medication, financial or sexual exploitation, isolation from other supports.

THE PATIENT EXPERIENCE

Learning the difference: "After everything I'd been through, 'turn it over' sounded like 'let someone control you again.' My counselor helped me see the difference. I could follow my sponsor's guidance on the steps and still say no to things that weren't safe. That made it possible for me to trust at all."

CLINICAL REFLECTION

How do you help patients follow guidance while protecting their safety? Do you discuss red flags in sponsor relationships?

CLINICAL EXERCISE / ASSESSMENT TOOL

Healthy guidance check:

- "What does healthy guidance feel like? What does control feel like?"
- "Has anyone in recovery asked you to do something that felt unsafe?"
- "What would you do if your sponsor's suggestion conflicted with your medical care?"
- "Who could you talk to if a relationship in recovery didn't feel right?"

SUGGESTION FOR YOUR PRACTICE

Name the difference between guidance and control explicitly, especially with trauma survivors. Discuss red flags in sponsor relationships and make sure patients know they can bring concerns to you.

ACTION STEP FOR YOUR PRACTICE

Develop clear language distinguishing healthy guidance from control. Include sponsor red flags in your patient education.

LIVING IN THE SOLUTION: Daily Practice

Practical application of Step Three in daily life

Morning: Setting the Direction

OVERVIEW

The Step Three decision is renewed most reliably at the start of the day. A brief morning practice, such as prayer, meditation, reading, or simply stating an intention, sets the direction before self-will takes over. Patients who begin the day with a deliberate turn toward guidance often find the rest of the day goes differently.

KEY POINTS FOR CLINICIANS

- How the day starts shapes how it goes
- A morning practice renews the Step Three decision
- The practice can be brief and simple
- Consistency matters more than length
- The practice can match the patient's spiritual framework

CLINICAL INSIGHT

Morning routines provide structure, which many patients lacked in active addiction. A brief, consistent practice also builds a sense of competence and early success. Help patients choose something small enough that they will actually do it.

THE PATIENT EXPERIENCE

Starting the day differently: "I used to wake up and immediately start worrying. Now I sit on the edge of the bed for two minutes and say the Third Step Prayer before I look at my phone. It doesn't fix everything, but it reminds me I'm not running the show."

CLINICAL REFLECTION

Do you help patients build a concrete morning practice? How do you support consistency?

CLINICAL EXERCISE / ASSESSMENT TOOL

Morning practice design:

- "What's the first thing you do when you wake up?"
- "What could you add, even for two minutes, to set your direction for the day?"
- "What words or practice fit your understanding of a Higher Power?"
- "What will you do on mornings when you don't feel like it?"

SUGGESTION FOR YOUR PRACTICE

Help patients design a morning practice of two to five minutes. Anchor it to something they already do, like making coffee. Review it in session and adjust as needed.

ACTION STEP FOR YOUR PRACTICE

Help each patient design a brief, specific morning practice. Anchor it to an existing habit and review it regularly.

The Pause: Re-Deciding in the Moment

OVERVIEW

The morning decision will be tested during the day: a frustrating coworker, a disappointing call, a craving. Living Step Three means re-making the decision in those moments. A brief pause, a breath, a short prayer or phrase, lets patients choose again instead of reacting on autopilot.

KEY POINTS FOR CLINICIANS

- Self-will reasserts itself throughout the day
- Each difficult moment is a chance to re-decide
- A short phrase or breath can anchor the pause
- Re-deciding is not failure; it's the practice
- Many small re-decisions add up to change

CLINICAL INSIGHT

Patients often feel they've failed Step Three when they catch themselves in old patterns. Reframe: noticing self-will and choosing again is exactly what Step Three looks like in practice. The skill is returning, not never leaving.

THE PATIENT EXPERIENCE

Choosing again: "I used to think if I got angry, I'd blown my Third Step. Now I notice it, take a breath, and say 'Thy will, not mine' in my head. Some days I say it fifty times. That's the program for me now."

CLINICAL REFLECTION

How do you help patients re-decide in difficult moments? Do you reframe struggle as practice rather than failure?

CLINICAL EXERCISE / ASSESSMENT TOOL

In-the-moment practice:

- "When during the day does self-will most often take over?"
- "What could you say or do in that moment to pause?"
- "What happens in your body right before you react?"
- "Let's rehearse: recall a recent moment and practice the pause now."

SUGGESTION FOR YOUR PRACTICE

Help patients choose a short anchor phrase or action. Practice it in session by recalling a recent frustrating moment and rehearsing the pause.

ACTION STEP FOR YOUR PRACTICE

Help patients develop a personal pause practice and rehearse it in session using real situations from their week.

Acceptance in Daily Life

OVERVIEW

Step Three is lived largely through acceptance: of people, places, and situations patients cannot change. Much of the suffering in early recovery comes from fighting reality, from insisting things be different than they are. Acceptance doesn't mean approval; it means stopping the war with what is so that patients can respond wisely.

KEY POINTS FOR CLINICIANS

- Acceptance is the daily face of Step Three
- Fighting reality creates suffering
- Acceptance is not approval, resignation, or passivity
- Acceptance makes wise action possible
- The Serenity Prayer frames acceptance and courage together

CLINICAL INSIGHT

Acceptance is central to evidence-based approaches such as ACT and DBT's radical acceptance. Patients often confuse acceptance with giving up. Clarify that acceptance is the starting point for effective action, not the end of it.

THE PATIENT EXPERIENCE

Learning acceptance: "My life was full of things I wanted to be different: my ex, my job, my health. I spent all my energy being angry about them. When I started accepting what I couldn't change, I finally had energy for what I could."

CLINICAL REFLECTION

How do you teach acceptance without implying passivity? Do you connect Step Three acceptance with clinical acceptance-based approaches?

CLINICAL EXERCISE / ASSESSMENT TOOL

Acceptance sorting:

- "What situation are you most fighting right now?"
 - "What part of it can you change? What part can't you?"
 - "What has fighting the unchangeable part cost you?"
 - "What would accepting it make possible?"
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SUGGESTION FOR YOUR PRACTICE

Use the Serenity Prayer as a practical sorting tool: what can the patient change, and what can't they? Help them direct effort to the first and acceptance to the second.

ACTION STEP FOR YOUR PRACTICE

Use the Serenity Prayer as a sorting tool with patients. Help them separate what to accept from what to act on.

One Day at a Time: Shrinking the Decision

OVERVIEW

Turning will and life over "forever" can feel impossible. Turning them over for today is manageable. Living Step Three one day at a time shrinks the decision to a size patients can actually make. It also keeps them focused on the present, where recovery happens, rather than on fears about the future.

KEY POINTS FOR CLINICIANS

- "Forever" overwhelms; "today" is possible
- One day at a time applies to surrender, not only abstinence
- The present is where action happens
- Future-tripping fuels anxiety and self-will
- Days of practice become a way of life

CLINICAL INSIGHT

Anxious patients often get stuck imagining a lifetime of surrender and decide they can't do it. Bring them back to the present: "Can you make this decision for today?" This reduces overwhelm and builds momentum through repeated small successes.

THE PATIENT EXPERIENCE

Shrinking it down: "The idea of turning my whole life over for the rest of my life made me panic. My sponsor said, 'Just do it till bedtime.' I could do that. I've been doing it till bedtime for a few years now."

CLINICAL REFLECTION

How do you help patients who are overwhelmed by the permanence of Step Three? Do you use "one day at a time" for surrender as well as abstinence?

CLINICAL EXERCISE / ASSESSMENT TOOL

Today-sized surrender:

- "What feels overwhelming about Step Three when you think about forever?"
- "What would turning it over look like just for today?"
- "What future fear is taking your attention away from today?"
- "What's one thing you can turn over between now and bedtime?"

SUGGESTION FOR YOUR PRACTICE

When patients are overwhelmed by the scope of Step Three, shrink the timeframe. Ask what turning it over would look like for the next 24 hours, or even the next hour.

ACTION STEP FOR YOUR PRACTICE

Use "just for today" framing with patients overwhelmed by Step Three. Help them define one day's surrender in concrete terms.

Evening Review: Where Did Self-Will Show Up?**OVERVIEW**

A brief evening review closes the daily cycle that the morning practice begins. Patients look back at the day: where did self-will take over, where did they follow guidance, what went well? This prepares the ground for Step Ten and keeps Step Three a living practice rather than a one-time event.

KEY POINTS FOR CLINICIANS

- The evening review completes the daily cycle
- Looking back builds self-awareness
- The review includes successes, not only mistakes
- It prepares patients for Step Ten's daily inventory
- The goal is learning, not self-punishment

CLINICAL INSIGHT

Some patients use evening reviews to criticize themselves harshly. Teach a balanced review: what went well, where self-will showed up, what to try differently tomorrow. Self-compassion supports learning; shame shuts it down.

THE PATIENT EXPERIENCE

Looking back at the day: "At first my evening review was just a list of everything I'd done wrong. My sponsor made me start with three things that went right. It changed the whole feel of it. Now I actually learn something instead of just feeling bad."

CLINICAL REFLECTION

How do you help patients review their day without sliding into shame? Do you connect this practice to Step Ten?

CLINICAL EXERCISE / ASSESSMENT TOOL

Balanced evening review:

- "What went well today?"
- "Where did self-will take over? What happened?"
- "Where did you pause and seek guidance?"
- "What would you like to do differently tomorrow?"

SUGGESTION FOR YOUR PRACTICE

Provide a simple review structure with balanced questions. Ask patients to bring their reviews to session occasionally so you can see patterns and reinforce growth.

ACTION STEP FOR YOUR PRACTICE

Teach a short, balanced evening review. Invite patients to bring it to session periodically so you can track patterns together.

Clinical Applications

Translating Step Three into clinical practice

Assessing Step Three Readiness

OVERVIEW

Patients arrive at Step Three with very different levels of readiness. Some are eager; others are still resolving Steps One and Two. Assessing readiness helps clinicians meet patients where they are, avoid pushing too early, and identify specific barriers that need attention before the decision can be genuine.

KEY POINTS FOR CLINICIANS

- Readiness varies widely between patients
- Step Three rests on a foundation of Steps One and Two
- Pushing too early produces surface compliance
- Specific barriers can be identified and addressed
- Readiness can be reassessed over time

CLINICAL INSIGHT

Look for signs that Steps One and Two are in place: acceptance of powerlessness, some hope that recovery is possible. Without these, Step Three often becomes words without meaning. Readiness assessment also tells you which barriers, such as fear, theology, or trauma, need attention first.

THE PATIENT EXPERIENCE

Being met where I was: "My counselor didn't push me into Step Three. She asked questions about what I believed and what scared me. When I was ready, it was my decision, not hers. I think that's why it stuck."

CLINICAL REFLECTION

How do you assess Step Three readiness? Do you look for evidence that Steps One and Two are in place?

CLINICAL EXERCISE / ASSESSMENT TOOL

Readiness assessment:

- "How do you understand your powerlessness over substances today?"
- "Do you believe recovery is possible for you? What's that belief based on?"
- "What does 'making a decision' in Step Three mean to you?"
- "What is your biggest hesitation about taking this step?"

SUGGESTION FOR YOUR PRACTICE

Use a few structured questions to assess readiness rather than relying on the patient's statement that they're ready. Return to earlier steps when needed; that is good care, not a step backward.

ACTION STEP FOR YOUR PRACTICE

Develop a short Step Three readiness assessment. Use it to identify patients who need more work on Steps One and Two, and to name specific barriers.

Motivational Interviewing and the Decision

OVERVIEW

Step Three is a decision, and decisions are the heart of motivational interviewing. MI's focus on ambivalence, change talk, and patient autonomy fits naturally with helping patients reach a genuine Step Three decision. The decision must be the patient's own; MI helps them find it rather than having it imposed.

KEY POINTS FOR CLINICIANS

- Ambivalence about Step Three is normal
- MI helps patients resolve ambivalence in their own words
- Change talk signals movement toward the decision
- Autonomy supports genuine, lasting commitment
- Pushing increases resistance; evoking reduces it

CLINICAL INSIGHT

Clinicians sometimes argue for Step Three, listing its benefits. This often triggers the patient to argue against it. Instead, explore both sides of their ambivalence and reflect their own reasons for change. A decision the patient talks themselves into is far stronger than one you talk them into.

THE PATIENT EXPERIENCE

Finding my own reasons: "My counselor never told me I had to do Step Three. She asked what I thought I'd gain and what I was afraid of losing. Somewhere in that conversation I heard myself say I was tired of running everything. That was my decision, in my words."

CLINICAL REFLECTION

Do you argue for Step Three or evoke the patient's own reasons? How do you work with ambivalence about the decision?

CLINICAL EXERCISE / ASSESSMENT TOOL

MI-consistent Step Three questions:

- "On a scale of 0 to 10, how ready are you to make this decision? Why not lower?"
- "What would be better if you stopped running the show alone?"
- "What worries you about turning your will over?"
- "If you decided to try this, what might the first step look like?"

SUGGESTION FOR YOUR PRACTICE

Use open questions, reflections, and decisional balance to explore Step Three ambivalence. Listen for change talk and reflect it back. Respect the patient's pace and autonomy.

ACTION STEP FOR YOUR PRACTICE

Practice MI-consistent approaches to Step Three ambivalence. Notice when you're arguing for the decision and shift to evoking the patient's reasons.

Step Three with Trauma Survivors

OVERVIEW

For trauma survivors, the language of surrender, turning over, and following direction can be activating. Patients who survived by staying in control may experience Step Three as a threat to safety. Clinicians can help these patients find a version of the step that supports healing rather than reenacting harm.

KEY POINTS FOR CLINICIANS

- Control often served as a survival strategy
- Surrender language can trigger trauma responses
- Safety must come before surrender
- The step can be reframed in trauma-informed ways
- Pacing and choice are essential

CLINICAL INSIGHT

Recognize that a trauma survivor's resistance to Step Three may be protective, not pathological. Reframes can help: turning over the "burden" rather than the "self," choosing a source of guidance that feels safe, keeping the right to say no. Trauma-informed care and Step Three can work together when pacing and choice are respected.

THE PATIENT EXPERIENCE

Finding a safe way in: "When someone said 'surrender,' my whole body went into fight mode. Surrendering had been dangerous for me. My therapist helped me see that I was choosing what to put down, and I could pick it back up if I needed to. That choice made it safe enough to try."

CLINICAL REFLECTION

How do you adapt Step Three for trauma survivors? Do you recognize control as a survival strategy rather than simple resistance?

CLINICAL EXERCISE / ASSESSMENT TOOL

Trauma-informed Step Three exploration:

- "What comes up in your body when you hear the word 'surrender'?"
 - "When has letting go of control been unsafe for you?"
 - "What would need to be true for this step to feel safe?"
 - "What words could you use that fit your experience?"
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SUGGESTION FOR YOUR PRACTICE

Screen for trauma before introducing Step Three language. Collaborate with the patient on wording that feels safe. Coordinate with trauma treatment so step work and trauma processing support each other.

ACTION STEP FOR YOUR PRACTICE

Develop trauma-informed language for Step Three. Coordinate step work with trauma treatment and let the patient lead the pacing.

Integrating Step Three with ACT and CBT

OVERVIEW

Step Three shares core ideas with evidence-based therapies. ACT emphasizes acceptance, values, and stepping back from unhelpful thoughts. CBT examines distorted thinking and its consequences. Integrating these approaches with Step Three gives patients both spiritual and clinical language for the same change.

KEY POINTS FOR CLINICIANS

- Acceptance in ACT parallels turning over outcomes
- Values-based action parallels following guidance
- Cognitive defusion parallels questioning "my best thinking"
- CBT thought records support examining self-will
- Integration strengthens both approaches

CLINICAL INSIGHT

Some patients connect better with clinical language; others with step language. Offering both lets patients choose what resonates without treating the approaches as rivals. Point out the overlaps explicitly so patients see one path, not two competing systems.

THE PATIENT EXPERIENCE

Two languages, one idea: "In group therapy we talked about 'defusing' from thoughts. In meetings they said 'don't believe everything you think.' One day I realized they were the same thing. It made both make more sense."

CLINICAL REFLECTION

How do you integrate Step Three with the evidence-based therapies you use? Do you help patients see the overlaps?

CLINICAL EXERCISE / ASSESSMENT TOOL

Mapping the overlap:

- Acceptance (ACT) ↔ turning over outcomes (Step Three)
- Values-based action ↔ following guidance and doing the next right thing
- Cognitive defusion ↔ "my best thinking got me here"
- Thought records (CBT) ↔ examining self-will and its consequences
- "Which language works best for you? Where do you see them meet?"

SUGGESTION FOR YOUR PRACTICE

Map your clinical tools onto Step Three concepts. When teaching acceptance, defusion, or thought challenging, name the connection to Step Three. Invite patients to use whichever language helps them.

ACTION STEP FOR YOUR PRACTICE

Create a simple map connecting your clinical tools to Step Three concepts. Use it to help patients see one integrated path.

Step Three in Group Treatment**OVERVIEW**

Group treatment offers a powerful setting for Step Three work. Patients hear how others are wrestling with surrender, see the decision modeled, and practice letting go of the need to be right in real time. Clinicians can structure group sessions to support the decision and address common barriers together.

KEY POINTS FOR CLINICIANS

- Peers model the decision for each other
- Hearing others' struggles normalizes ambivalence
- Group interaction reveals self-will in action
- Peer feedback can land where clinician feedback doesn't
- Group builds the habit of seeking outside input

CLINICAL INSIGHT

Group dynamics often reveal Step Three themes directly: patients who must be right, who dominate, who withdraw, who reject feedback. Use these moments as live material. Gently naming the pattern in the room is often more powerful than discussing it in theory.

THE PATIENT EXPERIENCE

Learning from the group: "I didn't really get Step Three until I heard another guy in group describe exactly how I fight everyone who tries to help me. Hearing it from him, I couldn't deny it. When he said what changed for him, I wanted that."

CLINICAL REFLECTION

How do you use group treatment for Step Three work? Do you use group process as live material?

CLINICAL EXERCISE / ASSESSMENT TOOL

Group discussion prompts:

- "What does 'turning it over' mean to each of you right now?"
 - "Where in this room do you notice yourself needing to be right?"
 - "Who here has made the Step Three decision? What changed?"
 - "What's one piece of guidance you've received but haven't followed?"
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SUGGESTION FOR YOUR PRACTICE

Structure groups around Step Three themes such as willingness, guidance, and letting go of being right. Invite members further along to share their experience. Use group process to make self-will visible and workable.

ACTION STEP FOR YOUR PRACTICE

Develop a Step Three group session plan. Include peer sharing and use group interactions to illustrate self-will and surrender.

Barriers & Pitfalls

Common obstacles and how to address them

Surrender Sounds Like Defeat

OVERVIEW

Many patients hear "surrender" as losing, quitting, or being weak. In a culture that values self-reliance and toughness, the idea of turning over will and life can feel humiliating. Reframing surrender as joining the winning side, as an act of courage and intelligence, helps patients move past this barrier.

KEY POINTS FOR CLINICIANS

- Cultural messages equate surrender with weakness
- Self-reliance has been tried and has failed
- Surrender can be framed as a strategic choice
- It takes courage to admit the old way isn't working
- "Surrender to win" is a common recovery paradox

CLINICAL INSIGHT

Patients from professions or cultures that prize toughness (military, first responders, competitive careers) may find surrender language especially hard. Use frames that fit their world: switching to a better strategy, calling for backup, following a proven plan.

THE PATIENT EXPERIENCE

Rethinking surrender: "Where I come from, you never give up. Surrender was the worst word you could say to me. Then someone put it this way: 'You're not giving up the fight. You're switching to the side that wins.' That I could live with."

CLINICAL REFLECTION

How do you work with patients who equate surrender with defeat? Do you adapt your framing to their culture and values?

CLINICAL EXERCISE / ASSESSMENT TOOL

Surrender reframing:

- "What does the word 'surrender' mean to you? Where did you learn that?"
- "How has fighting this on your own gone so far?"
- "What would a strong, smart person do in your situation?"
- "Is there a frame from your own world, such as calling for backup or changing strategy, that fits?"

SUGGESTION FOR YOUR PRACTICE

Explore what surrender means to the patient and where that meaning came from. Offer reframes that respect their values while opening the door to the step.

ACTION STEP FOR YOUR PRACTICE

Develop several surrender reframes suited to different patient backgrounds. Explore the patient's meaning of surrender before offering one.

Religious Wounds and the "God" Word

OVERVIEW

Step Three's reference to God can stop patients who were harmed by religion, who were taught a punishing God, or who have no belief at all. For these patients, the word itself may trigger shame, anger, or dismissal. Clinicians can help them separate the step's purpose, finding guidance beyond self-will, from religious experiences that wounded them.

KEY POINTS FOR CLINICIANS

- Religious harm is real and deserves respect
- A punishing God concept can make Step Three feel dangerous
- "As we understood Him" leaves room for a new understanding
- Non-theistic approaches are legitimate within the program
- The step's function can be separated from past religious experience

CLINICAL INSIGHT

Don't minimize religious wounds or rush past them. Patients may need space to grieve or be angry before they can consider a Higher Power at all. Some will find a new spiritual understanding; others will work Step Three through the group, values, or principles. Both paths are valid.

THE PATIENT EXPERIENCE

Separating the step from the wound: "The God I grew up with was always angry at me. When I read Step Three, all I could feel was that old fear. My counselor asked, 'What if your Higher Power is nothing like that?' It took months, but I found something I could trust that didn't feel like punishment."

CLINICAL REFLECTION

How do you work with patients carrying religious wounds? Do you assess spiritual history before introducing Step Three?

CLINICAL EXERCISE / ASSESSMENT TOOL

Spiritual history exploration:

- "What were you taught about God growing up?"
- "How does that teaching affect how you hear Step Three?"
- "If you could design a Higher Power that would actually help you, what would it be like?"

- "What could serve as guidance for you that doesn't carry those old wounds?"
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SUGGESTION FOR YOUR PRACTICE

Ask about the patient's spiritual and religious history before introducing Step Three. Validate harm where it exists. Offer non-theistic options and the "as we understood Him" principle without pressuring any particular belief.

ACTION STEP FOR YOUR PRACTICE

Include spiritual and religious history in your assessment. Develop respectful language for patients with religious wounds and for those without belief.

Half Measures: The Partial Decision

OVERVIEW

Some patients make a partial Step Three decision. They turn over some areas of life while keeping firm control of others, such as relationships, money, or certain behaviors. These reserved areas often become the places where relapse risk hides. The program warns that half measures avail us nothing.

KEY POINTS FOR CLINICIANS

- Partial decisions leave self-will in charge of key areas
- Reserved areas often hold the biggest risks
- Patients may not recognize what they're holding back
- Honesty about reservations is the first step
- Willingness can grow to include more areas over time

CLINICAL INSIGHT

Ask directly what patients are not willing to turn over. The answer is often revealing: a relationship, a secret, a behavior they believe they can still manage. These reservations deserve careful, non-judgmental exploration, as they are often where relapse begins.

THE PATIENT EXPERIENCE

Seeing what I held back: "I'd turned over my drinking but kept total control of my relationships. My sponsor asked what I wasn't willing to let go of. I said 'nothing,' then realized I'd been fighting with everyone I loved for months. That was where my self-will was still running wild."

CLINICAL REFLECTION

How do you identify reservations in a patient's Step Three decision? Do you ask directly what they're holding back?

CLINICAL EXERCISE / ASSESSMENT TOOL

Reservation review:

- "In which areas of your life have you made the Step Three decision?"
 - "In which areas are you still running the show?"
 - "What would it cost you to turn those areas over?"
 - "Which reservation feels most connected to your risk of relapse?"
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SUGGESTION FOR YOUR PRACTICE

Use a life-areas review to identify where self-will still rules. Approach reservations with curiosity. Patients don't need to turn everything over at once, but they do need to be honest about what they're keeping.

ACTION STEP FOR YOUR PRACTICE

Develop a life-areas review for Step Three. Use it to identify reservations and explore them with curiosity rather than judgment.

The Clinician's Own Self-Will

OVERVIEW

Clinicians can fall into their own Step Three trap: needing patients to take the step, on the clinician's timeline, in the clinician's way. When clinicians push, argue, or take a patient's resistance personally, they are often acting out of their own self-will. This undermines the patient's genuine decision and models the very control Step Three asks patients to release.

KEY POINTS FOR CLINICIANS

- Clinicians can hold rigid agendas for patients' recovery
- Pushing the decision creates resistance and compliance
- A patient's pace is not a clinician's failure
- Clinicians can practice turning over outcomes too
- Modeling non-attachment supports the patient's decision

CLINICAL INSIGHT

Notice your own reactions when patients resist Step Three: frustration, urgency, the urge to argue or convince. These are signals of your own attachment to outcomes. Supervision and self-reflection help clinicians stay present without needing patients to change on their schedule.

THE PATIENT EXPERIENCE

Feeling pushed: "My first counselor really wanted me to do Step Three. Every session she pushed it. The more she pushed, the more I dug in. My next counselor just stayed curious. Without anyone to fight, I eventually got there on my own."

CLINICAL REFLECTION

Where might your own self-will show up in your work with patients? How do you notice and manage attachment to outcomes?

CLINICAL EXERCISE / ASSESSMENT TOOL

Clinician self-check:

- "Which patients' resistance frustrates me most? Why?"
- "Where am I attached to a patient taking Step Three on my timeline?"
- "What would it look like to turn over the outcome while still doing my part?"
- "What support do I need to stay steady when patients resist?"

SUGGESTION FOR YOUR PRACTICE

Bring your reactions to supervision. Practice your own version of turning over outcomes: do your best work, then let the patient own their decision. Your steadiness is part of the treatment.

ACTION STEP FOR YOUR PRACTICE

Reflect on your own attachment to patient outcomes. Bring Step Three countertransference to supervision.

Mandated Patients and the Coerced Decision

OVERVIEW

Patients mandated to treatment by courts, employers, licensing boards, or family ultimatums often see Step Three as one more demand from people controlling their lives. A decision made under pressure can feel meaningless. Yet research suggests mandated patients can do as well as voluntary ones when they find their own reasons for change.

KEY POINTS FOR CLINICIANS

- External pressure can bring patients in but can't make the decision
- Mandated patients often feel controlled and resentful
- Compliance is not the same as genuine decision
- Patients can find personal reasons within an external mandate
- Outcomes for mandated patients can match voluntary patients

CLINICAL INSIGHT

Acknowledge the mandate openly rather than pretending it isn't there. Then explore what the patient wants for themselves apart from the mandate. A genuine Step Three decision can grow from personal motivation even when the patient arrived under pressure.

THE PATIENT EXPERIENCE

From mandate to decision: "The judge sent me. I was going to do whatever it took to check the box. Then one day in group I realized I didn't want to go back to how things were, judge or no judge. That's when Step Three became mine instead of the court's."

CLINICAL REFLECTION

How do you approach Step Three with mandated patients? How do you help them move from compliance to a genuine decision?

CLINICAL EXERCISE / ASSESSMENT TOOL

Mandate exploration:

- "What does the mandate require of you? What doesn't it require?"
- "If the mandate disappeared tomorrow, what would you want for yourself?"
- "What would a decision that's yours, not theirs, look like?"
- "What's one reason for recovery that has nothing to do with the court or anyone else?"

SUGGESTION FOR YOUR PRACTICE

Separate what the mandate requires from what Step Three asks. Use MI to explore the patient's own goals. Be honest about your reporting obligations so trust isn't undermined.

ACTION STEP FOR YOUR PRACTICE

Develop an approach that acknowledges mandates honestly while helping patients find their own reasons for a Step Three decision.

Your clinical notes

Changes to my practice

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