

Speaking Up, Advocating for Yourself

Deep Dive Modules · Resilience & Self-Care

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Part 1 · Overview

Speaking Up, Advocating for Yourself

Heeding the Advice You Give Others Every Day

For SUD Clinicians & Staff — The Recovery Files

Silent

Absorbing, enduring, swallowing it

→

Heard

Clear, professional, sustainable

Reading Sections

Finding Your Professional Voice: Advocacy as Clinical Competency

Self-Assessment

Worksheets & Exercises

Export Your Progress Report

Download a formatted PDF of your assessment scores, reflections, exercise responses, and declaration — ready to keep for your records or share with a supervisor.

Part 2 · The Advocacy Paradox: Champions for Everyone But Yourself

The Advocacy Paradox: Champions for Everyone But Yourself

You spend your professional life advocating for other people. You advocate for your clients to insurance companies that want to cut treatment short. You advocate for adequate discharge planning when the system pushes for premature releases. You advocate for trauma-informed care when the culture defaults to confrontation. You advocate for clients who cannot yet advocate for themselves — who are too vulnerable, too early in recovery, too deep in shame to stand up and say "I need more than this."

And you are extraordinarily good at it. You write compelling clinical justifications. You make phone calls that other people would avoid. You push back against policies that harm clients. You fight for resources, extensions, appropriate levels of care. You sit in staffings and treatment team meetings and you say the thing that needs to be said on behalf of someone who is not in the room.

Then your supervisor adds a third group to your schedule. And you say nothing.

Your caseload exceeds the number recommended by every professional standard in the field. And you say nothing.

You eat lunch at your desk — again — because there is no time between sessions. And you say nothing.

This is the advocacy paradox. The very people who are professionally trained and personally motivated to advocate for others are often the least capable of advocating for themselves. Not because they lack the skills. They have the skills in abundance. But because every psychological, cultural, and organizational force in their environment conspires to keep them silent about their own needs.

Self-advocacy is not the opposite of client advocacy. It is its prerequisite. You cannot fight for others if you have been ground to dust by the system you are fighting within. You cannot model healthy boundaries for clients if you have none of your own. You cannot teach the people in your care to speak up for their needs if you will not speak up for yours.

The paradox has a solution, and the solution begins with a single, uncomfortable recognition: you deserve exactly the same quality of advocacy you provide to the people who sit across from you.

Reflection Questions

1. Describe a recent situation where you advocated effectively for a client. What did you say? How did you approach it? What gave you the confidence to push back?

Take your time with this reflection...

2. Now describe a recent situation where you should have advocated for yourself but did not. What kept you silent? What did that silence cost you?

Take your time with this reflection...

3. What messages — from your family of origin, your personal recovery, your training, or your workplace culture — have taught you that advocating for yourself is inappropriate, selfish, or weak?

Take your time with this reflection...

4. If a client described your current workload and working conditions, would you tell them it was sustainable? Would you tell them to accept it without complaint? Be honest.

Take your time with this reflection...

5. What would change in your professional life if you advocated for yourself with the same skill, conviction, and persistence you bring to advocating for your clients?

Take your time with this reflection...

Part 3 • The Weight of Silence: What Happens When You Don't Speak Up

The Weight of Silence: What Happens When You Don't Speak Up

Silence in the face of unsustainable conditions is not neutral. It is not a holding pattern. It is not keeping the peace. Silence is an active process that produces specific, measurable, and progressive consequences — for you, for the people you serve, and for the organization you serve within.

The first cost is internal. When you know something needs to be said and you do not say it, the unsaid thing does not disappear. It becomes a low-grade hum of resentment that colors everything: your interactions with colleagues, your emotional availability in sessions, your ability to enjoy time off. Resentment is the long-term emotional consequence of unspoken needs, and it is corrosive. It erodes your passion for the work.

The second cost is relational. When clinicians do not speak up, their frustration leaks sideways. It shows up as short-tempered exchanges with coworkers. It shows up as passive-aggressive behavior in team meetings. It shows up as gossip — endless hallway and parking lot conversations about problems that are never raised to the people who have the power to address them.

The third cost is clinical. When a clinician's workload exceeds their capacity, the quality of care declines. Not dramatically at first — not in a way that shows up on an audit. It declines in the small, invisible ways that only the clinician and the client would notice. Sessions become slightly less present. Treatment plans become slightly more formulaic. Clinical creativity diminishes. Risk assessment becomes hurried.

The fourth cost is organizational. When clinicians do not speak up, leadership loses access to the most important data in the organization: the on-the-ground reality of what clinical work actually requires. Leaders who never hear honest feedback from their clinical staff are making decisions in an information vacuum. Staff turnover in SUD treatment is catastrophically high, and the primary driver is the feeling that the work is unsustainable and that no one in a position of authority cares enough to change it.

Breaking the silence is not about being difficult. It is about being responsible — to yourself, to your clients, to your colleagues, and to the organization that cannot function without you.

Reflection Questions

1. What have you been silent about at work that you know needs to be addressed? Name the specific issues — not in generalities, but in concrete terms.

Take your time with this reflection...

2. What form does your unspoken frustration take? Resentment? Passive-aggression? Gossip? Withdrawal? Cynicism? Be honest about the leak.

Take your time with this reflection...

3. How has your silence affected the quality of care you provide? Can you identify specific moments where being overloaded led to less-than-optimal clinical work?

Take your time with this reflection...

4. What do you think leadership does not know about the on-the-ground clinical reality in your workplace? What would they need to hear?

Take your time with this reflection...

5. What is the cost of continuing to stay silent? Project forward six months, one year, three years — what happens if nothing changes because nobody speaks up?

Take your time with this reflection...

Part 4 · Heeding Your Own Advice: The Full Plate Problem

Heeding Your Own Advice: The Full Plate Problem

There is a phrase you have almost certainly used with clients, probably many times: "Don't put too much on your plate." You have said it to the client in early recovery who is simultaneously starting a new job, repairing a marriage, fighting a custody battle, going back to school, and attending ninety meetings in ninety days. You have said it gently, clinically, wisely: "One thing at a time. You don't have to fix everything today. Taking on too much is a relapse risk." And you were right.

Now look at your own plate.

How many clients are on your caseload? How many groups do you run per week? How many treatment plans are due? How many family sessions are scheduled? How many times this week have you worked through lunch? How many evenings have you brought documentation home? If a client presented you with a schedule that looked like yours, you would intervene. You would gently but firmly point out that this level of demand is not sustainable. You would help them prioritize. You would encourage them to delegate, to ask for help, to let some things wait. You would remind them that doing everything poorly is not better than doing fewer things well.

But you do not apply this wisdom to yourself. And the reason is worth examining honestly: you have internalized the belief that the rules of human sustainability apply to everyone except you.

This belief has a name in psychology. It is called a double standard — specifically, a self-other double standard in which you apply reasonable, compassionate expectations to others while holding yourself to impossible, punishing ones. Double standards of this kind are a hallmark of perfectionism, and perfectionism is epidemic in helping professions. It sounds like: "I should be able to handle this." "Other people manage; what's wrong with me?" "If I can't keep up, maybe I'm not cut out for this work."

Every one of these statements is something you would challenge in a client. You would say: "Where does that 'should' come from?" You would say: "Acknowledging your limits is not the same as giving up."

The full plate is not a badge of honor. It is a diagnostic indicator. And the treatment plan starts with the same advice you give your clients every single day: take something off the plate. Ask for help. Set a limit. Say what you need. You are the clinician in this scenario, and you are also the client. Act accordingly.

Reflection Questions

1. Describe your plate right now — everything on it, professional and personal. Write it all down. Look at it. What would you say to a client who showed you this?

Take your time with this reflection...

2. What is the double standard operating in your professional life? Where do you hold yourself to expectations you would never impose on someone in your care?

Take your time with this reflection...

3. What "should" statements drive your inability to set limits? ("I should be able to handle this." "I should be more resilient." "I should not need help.") Where did those messages come from?

Take your time with this reflection...

4. What is on your plate right now that does not belong there — tasks that are not yours, responsibilities you absorbed because nobody else would, work that should have been delegated?

Take your time with this reflection...

5. If you took your own clinical advice and removed one thing from your plate this week, what would it be? What stops you?

Take your time with this reflection...

Part 5 · What Are You Afraid Of? The Fear Behind the Silence

What Are You Afraid Of? The Fear Behind the Silence

If self-advocacy is the solution, then fear is the lock on the door. Every clinician who stays silent about unsustainable conditions does so for reasons that feel completely rational in the moment. Understanding those reasons — naming the specific fears — is essential, because unnamed fears operate with unchallenged authority.

The fear of being seen as weak is perhaps the most common. In many treatment settings, the unwritten cultural code equates silence with strength and complaint with fragility. This fear is especially potent for clinicians in personal recovery, where the culture of stoicism — "suit up and show up" — can be weaponized against the very people it was meant to support.

The fear of consequences is concrete and not irrational. Will I be passed over for promotion? Will my schedule get worse? Will I be labeled a troublemaker? Will my contract not be renewed? In an industry where job security is often tenuous and replacement staff are always available, the risk calculation is real.

The fear of being a burden operates on a deeply personal level. For helpers — people who have organized their identity around making things easier for others — the idea of creating a problem, adding to someone else's stress, or being the person who complicates things feels almost physically repulsive. The fear of being a burden is the helper identity's immune response to self-advocacy.

The fear of conflict keeps many clinicians silent because they associate advocacy with aggression. They picture a confrontation: raised voices, defensive postures, damaged relationships. They do not have a mental model for calm, professional, solution-oriented advocacy.

The fear of invalidation is the most insidious. This is the fear that you will speak up and be told that your experience is wrong — that the workload is not actually unreasonable, that everyone else manages just fine, that you are being too sensitive.

Here is what you know clinically about fear: it thrives in the dark. It grows stronger when it is avoided. And the only reliable method for reducing its power is exposure — bringing it into the light, naming it specifically, and then testing it against reality. You do this with clients every day.

Your silence is avoidance. Your advocacy is approach. And just as you would tell a client: the fear is real, and the avoidance is making it worse.

Reflection Questions

1. Name your fears about speaking up. Write them down. All of them. The rational ones and the irrational ones. The small ones and the ones that feel enormous. Get them out of the shadows.

Take your time with this reflection...

2. Which fear has the most power over your behavior? The fear of being seen as weak? The fear of consequences? The fear of being a burden? The fear of conflict? The fear of invalidation?

Take your time with this reflection...

3. Has any of these fears ever been confirmed by actual experience? When you did speak up, what actually happened? How does the reality compare to the catastrophe your mind predicted?

Take your time with this reflection...

4. What would you say to a client who told you they were afraid to advocate for themselves because of the fears you just listed? What clinical wisdom would you offer them?

Take your time with this reflection...

5. What is the smallest possible step of self-advocacy you could take this week that would begin to test one of these fears against reality?

Take your time with this reflection...

Part 6 • Finding Your Professional Voice: Advocacy as Clinical Competency

Finding Your Professional Voice: Advocacy as Clinical Competency

Self-advocacy is not an innate personality trait. You are not born an advocate or a doormat. Self-advocacy is a skill — a learnable, practicable, refinable clinical competency that is no different in kind from motivational interviewing, treatment planning, or group facilitation. It can be studied. It can be practiced. It can be improved. And like any clinical skill, it gets stronger with deliberate use and atrophies with disuse.

This reframe matters because it removes the shame. If self-advocacy is a personality trait, then your inability to speak up reflects a flaw in who you are. But if self-advocacy is a skill, then your difficulty with it simply means you need training and practice. The inability to advocate for yourself is not a character defect. It is a skill gap. And skill gaps are closable.

Effective professional self-advocacy has several core components.

The first is clarity about what you need. "I'm overwhelmed" is not an advocacy statement. It is an emotional disclosure. "I need my caseload reduced from 32 to 24 to maintain clinical quality and prevent documentation delays" is an advocacy statement.

The second is data. Leaders respond to data far more reliably than they respond to emotion. "I'm exhausted" invites the response "We all are." But "I am currently carrying 34 active clients, running 8 groups per week, and averaging 2.5 hours of overtime per day — which exceeds the NAADAC-recommended caseload by 40 percent" invites a different conversation.

The third is timing and approach. Advocacy is most effective when it is proactive rather than reactive. Requesting a scheduled meeting to discuss workload sustainability — in advance, when you are calm, when you have prepared your points — is advocacy under optimal conditions.

The fourth is solution-orientation. Leaders are more receptive to advocacy that comes with proposed solutions than to advocacy that simply presents problems.

The fifth is persistence. Self-advocacy is rarely a single conversation. It is an ongoing practice — a repeated, professional, documented assertion of your needs and limits.

The sixth is the internal permission that precedes all the rest. Before you can advocate effectively to anyone else, you must first give yourself permission to advocate at all.

You already have every skill you need to advocate for yourself. You use them every day, for other people. The only thing missing is the decision to turn those skills inward.

Reflection Questions

1. Of the six components described — clarity, data, timing, solution-orientation, persistence, and internal permission — which is your strongest? Which needs the most development?

Take your time with this reflection...

2. Write a specific advocacy statement for a current workplace concern. Not an emotional disclosure — a clear, data-informed, solution-oriented request.

Take your time with this reflection...

3. What is the conversation you most need to have with leadership right now? Who needs to hear it? What specific outcome are you requesting?

Take your time with this reflection...

4. How would you rate your current internal permission to advocate for yourself — on a scale of 1 to 10? What would move it one point higher?

Take your time with this reflection...

5. If you treated self-advocacy as a clinical competency — something to be developed through study and deliberate practice — what would your training plan look like?

Take your time with this reflection...

Part 7 · Self-Advocacy Readiness Assessment

Self-Advocacy Readiness Assessment

Rate each statement: 1 (Not at all like me) to 5 (Very much like me)

I can recognize when I am taking on more than is reasonable — and I name it to myself honestly rather than normalizing it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of the gap between what I advocate for my clients and what I tolerate for myself

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when my workload has crossed from challenging into unsustainable, and I trust that perception rather than second-guessing it

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can distinguish between healthy dedication to my work and self-abandonment disguised as commitment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am honest with myself about the physical, emotional, and relational cost of carrying an unsustainable workload

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I pay attention to my own stress signals — resentment, exhaustion, cynicism, withdrawal — and treat them as data rather than character flaws

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize that accepting every task, every responsibility, and every request without pushback is not a virtue — it is a pattern

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I regularly check in with myself about whether my current workload and expectations are sustainable for the long term

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am comfortable expressing my needs, concerns, or limits to colleagues and supervisors in a direct, professional manner

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can articulate what I need without over-explaining, apologizing, or minimizing the request

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I disagree with a decision that affects my work, I speak up rather than complying in silence and building resentment

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am able to say "no" to additional responsibilities when my plate is already full — and I do it without excessive guilt

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I communicate my workload concerns with specific facts and examples rather than vague complaints or emotional outbursts

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can initiate a difficult conversation with a supervisor without catastrophizing the outcome before it even happens

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I express my ideas and suggestions in team meetings rather than staying silent and wishing someone else would raise the point

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I trust that my perspective has value and that sharing it contributes to better outcomes for clients, staff, and the organization

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I maintain a realistic caseload rather than consistently operating beyond what is clinically safe or personally sustainable

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I protect time in my schedule for documentation, supervision, and basic needs like eating and using the restroom

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I decline additional tasks or responsibilities when accepting them would compromise the quality of care I provide to existing clients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I have communicated my capacity limits to my supervisor or leadership in concrete terms

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I do not routinely work through lunch, stay late, or bring work home as a default operating mode

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I advocate for adequate staffing, resources, or systemic changes when I see that staff are being asked to do too much with too little

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I resist the cultural pressure in my workplace to treat overwork as proof of commitment or competence

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I believe that setting workload limits is a professional responsibility, not a personal weakness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I understand the decision-making structure in my organization and I know who has the authority to address my specific concerns

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I approach leadership conversations as collaborative problem-solving rather than confrontation or complaint

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I raise a concern, I come prepared with specific examples, data, and — when possible — proposed solutions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I follow up when concerns I have raised are acknowledged but not addressed, rather than assuming silence means the issue is resolved

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can distinguish between concerns that should be addressed with my direct supervisor and those that require escalation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I document my workload, concerns, and the conversations I have had about them in case I need to reference them later

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I build professional relationships with leadership and decision-makers so that when I need to advocate, I am not starting from zero

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I remain professional and solution-oriented even when I feel frustrated, unheard, or dismissed by the chain of command

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I believe that my needs as a clinician matter as much as the needs of my clients, my colleagues, and my organization

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I do not derive my entire sense of self-worth from being the person who always says yes, always steps up, and never complains

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize that advocating for myself is not selfish — it is a necessary condition for providing sustainable, quality care

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can ask for what I need without feeling like I am being difficult, ungrateful, or not a team player

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I do not believe that suffering in silence is a sign of strength or that speaking up is a sign of weakness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I value my own time, energy, and expertise enough to protect them from being taken for granted

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I believe that the organization benefits when staff feel empowered to speak up about what is working and what is not

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I see self-advocacy as a clinical competency — not just a personal preference, but a professional skill that protects both staff and clients

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which domain scored highest? Where is your self-advocacy voice already functioning? What specific practices or experiences built that strength?

Your reflection...

2. Which domain scored lowest? What is the cost — to you, to your clients, and to your relationships — of this area remaining undeveloped?

Your reflection...

3. Which specific items did you rate as 1 or 2? These represent the exact points where your voice is most suppressed. What pattern connects them?

Your reflection...

4. Were there items where you wanted to rate yourself higher than reality warrants — where you rated the aspiration rather than the current truth?

Your reflection...

5. Based on this assessment, what is the single most important advocacy skill you need to develop? What would developing it change about your professional life?

Your reflection...

Scoring guide

Workload — Applied to Yourself

Saying No — Applied to Yourself

Rest & Recovery — Applied to Yourself

Asking for Help — Clinical Advice

Asking for Help — Applied to Yourself

Clinical Wisdom on Fear of Weakness

Direct Supervisor — What to Raise

Exercise 9: 7-Day Voice Practice Log — Reflection

Week Reflection — Trends

Most Courageous Moment

Moment of Silence

What I Learned

Next Step

Reset all progress? This cannot be undone.

Higher scores indicate areas where you are already practicing self-advocacy. Lower scores reveal where your voice is most constrained — where the gap between what you would advocate for a client and what you tolerate for yourself is widest.

Part 8 · Exercise 1: The Double Standard Inventory

The Double Standard Inventory

What You Advocate for Clients vs. What You Accept for Yourself

The Mirror Test

For each scenario, you will first write the clinical advice you would give a client. Then you will apply that exact advice to your own situation. The gap between the two reveals the double standard — and the double standard is where your self-advocacy work begins.

A client in early recovery tells you they are working two jobs, going to school, attending daily meetings, rebuilding a relationship, and fighting a legal case — all simultaneously. What do you tell them?

Now Apply It to Yourself

Now look at your own professional workload — caseload, groups, documentation, meetings, supervisions, on-call hours. How does your advice to that client apply to you?

Apply that advice to your own situation...

A client tells you: "I can't say no to anyone. Every time someone asks me for something, I just say yes even when I'm drowning." What clinical guidance do you provide?

Now Apply It to Yourself

When was the last time your supervisor or a colleague asked you to take on something additional and you agreed even though you were already overloaded? Apply your clinical guidance to that moment.

Apply that advice to your own situation...

A client says: "I don't have time to take care of myself. There's too much to do. I'll rest when things calm down." What is your response?

Now Apply It to Yourself

When was the last time you said essentially the same thing — to yourself, to your partner, to a friend? How long have you been waiting for "things to calm down"?

Apply that advice to your own situation...

A client admits: "I should be able to handle this on my own. Asking for help makes me feel like a failure." What do you tell them?

Now Apply It to Yourself

Apply that response to your own professional life. When was the last time you asked for help — genuinely, not as a last resort when everything was already on fire?

Apply that advice to your own situation...

1. Where is the gap widest between what you advocate for clients and what you accept for yourself?

Examine the gap...

2. What beliefs or messages drive this double standard? Where did you learn that the rules apply differently to you?

Examine the gap...

3. If you applied your own clinical wisdom to your professional life with the same conviction you apply it to your clients, what is the first thing that would change?

Examine the gap...

4. Write one sentence of clinical advice — from you the clinician, to you the person — that you commit to following this week.

Examine the gap...

Part 9 · Exercise 2: The Unsaid Inventory

The Unsaid Inventory

Everything You Have Been Holding Back

What Lives in the Silence

Every unsaid thing has weight. This exercise brings every unsaid thing out of the shadows and onto the page — not because you must say all of them aloud tomorrow, but because naming them removes their power to operate invisibly.

What have you been wanting to say to your supervisor about your workload, expectations, or working conditions that you have not yet said?

Say what needs to be said...

What concern about clinical quality, safety, or sustainability have you raised internally but not communicated upward?

Say what needs to be said...

What do you need from your supervisor that you have not asked for? A schedule change? A caseload adjustment? More support? Clearer expectations? Name it.

Say what needs to be said...

Is there a team dynamic — an unfair distribution of work, a pattern of certain people doing less while you do more — that needs to be addressed?

Say what needs to be said...

What frustration have you been expressing through passive behavior, gossip, or silence that would be better expressed directly?

Say what needs to be said...

What would you say to your team if you knew it would be received without defensiveness?

Say what needs to be said...

What systemic problem in your organization have you accepted as unchangeable that actually might change if enough people spoke up?

Say what needs to be said...

What policy, procedure, or cultural expectation is actively harming staff wellbeing or client care?

Say what needs to be said...

If you had five uninterrupted minutes with the highest-ranking person in your organization, what would you say?

Say what needs to be said...

What truth about your current professional situation have you been avoiding?

Say what needs to be said...

What have you been telling yourself to justify staying silent? Are those statements true?

Say what needs to be said...

What do you need to hear from yourself right now? Write it as if you were the wisest, most compassionate version of yourself speaking to the version that is struggling.

Say what needs to be said...

1. Of everything you just wrote, which unsaid item carries the most weight?

Prioritize your voice...

2. Which item is most actionable — where speaking up could realistically produce change?

Prioritize your voice...

3. Which item will you address first? Not eventually — this month.

Prioritize your voice...

4. What is the cost of leaving all of these things unsaid for another year?

Prioritize your voice...

Part 10 • Exercise 3: The Full Plate Audit

The Full Plate Audit

Documenting What Is Actually on Your Plate

The Data for Your Advocacy

When you advocate for a client, you bring data. This exercise helps you compile the data for your own advocacy: a detailed, factual inventory of everything on your professional plate, so that when you speak up, you speak with specifics rather than generalities.

How many active clients are on your caseload? How does this compare to recommended guidelines?

Document your plate...

How many groups do you facilitate per week? List each one with its duration.

Document your plate...

How many individual sessions, family sessions, and assessments do you conduct per week on average?

Document your plate...

How many hours per week do you spend on documentation? Is this time protected in your schedule?

Document your plate...

List every non-clinical task on your plate: meetings, committee work, training, coverage, supervision, on-call duties.

Document your plate...

How many hours per week do you actually work versus your scheduled hours?

Document your plate...

What tasks do you perform that nobody sees, counts, or compensates — mentoring new staff, emotional support for colleagues, crisis de-escalation?

Document your plate...

What responsibilities have you absorbed because "someone had to do it"?

Document your plate...

How much emotional labor do you carry that is never counted in productivity metrics?

Document your plate...

1. Looking at everything documented above, is your plate sustainable? Not whether you are currently surviving it, but whether you could do this for five more years without significant harm.

Your verdict...

2. What needs to come off your plate? Identify 2-3 specific items that either do not belong there or exceed your capacity.

Your verdict...

3. What would you need to say, to whom, to begin the process of making your workload sustainable? Draft the opening sentence.

Your verdict...

4. What is the clinical cost of your full plate? How would the care you provide improve if your workload were manageable?

Your verdict...

Part 11 • Exercise 4: The People-Pleasing Autopsy

The People-Pleasing Autopsy

Why You Say Yes When You Mean No

Compliance Is Not the Same as Commitment

People-pleasing is not generosity. It is a survival strategy. In your professional life, chronic people-pleasing produces a predictable outcome: you become the person everyone relies on, nobody checks on, and eventually loses.

1. Describe the last three times you said "yes" to a professional request when your honest answer was "no" or "I can't right now." What happened in each case?

Examine the pattern...

2. What was the internal experience during each of those moments? What emotion drove the compliance?

Examine the pattern...

3. What are the consequences of your pattern of saying yes — for you, for the quality of your work, and for the people who never learn to share the load because you always carry it?

Examine the pattern...

1. Where did your people-pleasing originate? Was it a family role? A survival strategy? Trace it back.

Trace the origin...

2. What do you believe will happen if you say no? Write it out in full — the worst-case scenario your fear constructs.

Trace the origin...

3. What has actually happened in the past when you did set a limit or say no? How does the reality compare to the catastrophe?

Trace the origin...

Write three specific scripts for saying no in professional situations — tailored to the actual situations you face.

1. Script 1: When a supervisor asks you to add a client to your already-full caseload. Write the actual words you would say.

Write the actual words...

2. Script 2: When a colleague asks you to cover their group or shift and you do not have the capacity. Write the actual words.

Write the actual words...

3. Script 3: When an institutional expectation is placed on you that you believe is unreasonable. Write a calm, professional response.

Write the actual words...

Part 12 · Exercise 5: The Fear Inventory — What Keeps You Silent

The Fear Inventory

What Keeps You Silent

Fears Unnamed, Fears Unchallenged

You know clinically that unnamed fears grow stronger and that the antidote to avoidance is approach. This exercise applies that clinical principle to your own advocacy fears.

How does the fear of appearing weak, fragile, or "not tough enough" prevent you from speaking up? Where did this message come from?

Name and examine this fear...

What would you say to a client who was held back by this exact fear? Write the clinical response, then sit with how it applies to you.

Your clinical wisdom...

What specific professional consequences are you afraid of? How realistic are these fears based on actual evidence?

Name and examine this fear...

What would you say to a client who was held back by this exact fear? Write the clinical response, then sit with how it applies to you.

Your clinical wisdom...

How does the fear of adding to someone else's stress prevent you from communicating your own needs? What does it cost you?

Name and examine this fear...

What would you say to a client who was held back by this exact fear? Write the clinical response, then sit with how it applies to you.

Your clinical wisdom...

Do you associate advocacy with confrontation? What model of advocacy exists in your mind? Where did that model come from?

Name and examine this fear...

What would you say to a client who was held back by this exact fear? Write the clinical response, then sit with how it applies to you.

Your clinical wisdom...

What would it feel like if you spoke up and were told that your experience is wrong? How does this fear affect your willingness to trust your own perception?

Name and examine this fear...

What would you say to a client who was held back by this exact fear? Write the clinical response, then sit with how it applies to you.

Your clinical wisdom...

1. Which fear has the most power over your behavior right now? What would change if that fear lost even 20 percent of its grip?

Move from fear to action...

2. What is the smallest advocacy step you could take this week that would test one of these fears against reality?

Move from fear to action...

Part 13 · Exercise 6: Script Lab — Writing the Actual Words

Script Lab

Writing the Actual Words for the Conversations You Need to Have

Rehearsal Is Not Rehearsed

You prepare for clinical sessions. You prepare for assessments. This exercise asks you to prepare for the advocacy conversations you need to have — not by winging it, but by writing the actual words in advance.

The Scenario

You need to communicate to your supervisor that your current workload is not sustainable.

Opening: Write your opening 2-3 sentences. Lead with the concern, not the emotion. Example: "I want to discuss my current caseload and its impact on clinical quality."

Write the actual words...

Data: Present the specific facts — numbers, hours, comparison to guidelines.

Write the actual words...

Impact: Describe the clinical and personal impact as information, not complaint.

Write the actual words...

Request: State your specific ask — not "I need help" but a concrete request.

Write the actual words...

Collaboration: Close with solution-orientation. "I have two proposals. Can we discuss them?"

Write the actual words...

The Scenario

You need to establish or reinforce a professional boundary — about time, availability, scope of role, or expectations.

What is the specific boundary you need to set? Write it in one clear sentence.

Write the actual words...

How will you communicate this boundary without over-apologizing or over-explaining?

Write the actual words...

How will you respond if the boundary is challenged?

Write the actual words...

The Scenario

You see a systemic problem that needs to change — a policy, a practice, a cultural pattern.

Define the problem in concrete terms — with data and specifics.

Write the actual words...

Describe the impact on clinical care and staff retention with specific examples.

Write the actual words...

Propose at least one concrete solution. Write it as a recommendation, not a demand.

Write the actual words...

Part 14 • Exercise 7: Chain of Command Mapping

Chain of Command Mapping

Knowing Who to Talk To, About What, and How

Strategy, Not Spray

Effective advocacy is targeted. It goes to the person who has the authority and ability to address the concern. Complaining to a colleague who cannot change the policy is venting, not advocacy.

Who is your direct supervisor? What is their decision-making authority — what can they change, approve, or escalate?

Map your organization...

What is the most effective way to communicate with this person? What approach gets the best response?

Map your organization...

What concern or request are you currently holding that should go to this person? Why have you not brought it to them yet?

Map your organization...

Who oversees clinical operations? What is their scope of authority?

Map your organization...

What concerns fall outside your direct supervisor's ability to address and need to reach this level?

Map your organization...

What is the appropriate process for escalating concerns to this level professionally?

Map your organization...

Who are the executive leaders? What systemic decisions do they control?

Map your organization...

What systemic issues exist that only executive leadership can address?

Map your organization...

What channels exist for communicating with executive leadership? Which have you used? Which have you avoided?

Map your organization...

1. Based on your mapping, which level of leadership needs to hear your most pressing concern?

Who specifically will you talk to?

Build your strategy...

2. What is your preparation plan? What data will you bring? What solution will you propose? When will you schedule the conversation?

Build your strategy...

3. What is your follow-up plan if the first conversation does not produce change?

Build your strategy...

4. What allies do you have — colleagues who share your concerns and would support or co-advocate for the same changes?

Build your strategy...

Part 15 · Exercise 8: The Boundary Request Builder

The Boundary Request Builder

Turning Needs Into Actionable Requests

From Suffering to Specification

A need that stays vague stays unmet. This exercise transforms your general sense of being overwhelmed into three specific, actionable boundary requests — each with a clear what, who, when, and why.

What is the specific boundary or change you need? Write it in one sentence.

Build your request...

Why does this matter — for you and for clinical quality? Connect your personal need to professional impact.

Build your request...

Who needs to hear this request? Name the specific person.

Build your request...

When will you make this request? Set a date within the next 14 days.

Build your request...

What is your proposed solution? How could this be addressed for you and the organization?

Build your request...

What will you do if the request is denied or deferred? What is your follow-up plan?

Build your request...

What is the specific boundary or change you need? Write it in one sentence.

Build your request...

Why does this matter — for you and for clinical quality? Connect your personal need to professional impact.

Build your request...

Who needs to hear this request? Name the specific person.

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When will you make this request? Set a date within the next 14 days.

Build your request...

What is your proposed solution? How could this be addressed for you and the organization?

Build your request...

What will you do if the request is denied or deferred? What is your follow-up plan?

Build your request...

Part 16 · Exercise 9: 7-Day Voice Practice Log

7-Day Voice Practice Log

Seven Days of Using Your Voice

Practice, Not Perfection

Self-advocacy is a muscle. This week, you are training it. Some days you will speak up clearly. Some days you will stay silent and learn from it. Both kinds of days produce valuable data.

Did I speak up about something today? (1=stayed silent, 10=fully advocated)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much am I holding back today? (1=very little, 10=swallowing everything)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

I felt my needs mattered today (1=not at all, 10=fully)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What did I speak up about today — or what did I stay silent about?

What did I speak up about today — or what did I stay silent about?...

What happened when I used my voice (or what was the cost of staying quiet)?

What happened when I used my voice (or what was the cost of staying quiet)?...

What advocacy step will I take tomorrow?

What advocacy step will I take tomorrow?...

Did I speak up about something today? (1=stayed silent, 10=fully advocated)

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What advocacy step will I take tomorrow?

What advocacy step will I take tomorrow?...

1. Looking at your scores across seven days, what trends do you see? Is your voice getting stronger?

Reflect on your week...

2. What was your most courageous moment of self-advocacy this week?

Reflect on your week...

3. What was the moment where you most wanted to speak up but did not?

Reflect on your week...

4. What did you learn about yourself as an advocate this week?

Reflect on your week...

5. What specific advocacy step will you take next week?

Reflect on your week...

Part 17 · Exercise 10: The Advocacy Declaration

The Advocacy Declaration

Your Commitment to Your Own Voice

A Declaration, Not a Wish

You write treatment plans with specific goals, measurable objectives, and target dates. This declaration is your self-advocacy treatment plan — built with the same clinical rigor you apply to the people in your care. The difference is that this time, the client is you.

What self-awareness practices will you build into your professional life to catch overload before it becomes a crisis?

Build your declaration...

What are your personal early warning signs that your plate is too full?

Build your declaration...

How will you regularly check in with yourself about whether your workload and conditions are sustainable?

Build your declaration...

What specific conversations will you have in the next 30 days? With whom? About what?

Build your declaration...

How will you prepare — what data will you gather, what scripts will you rehearse, what solutions will you propose?

Build your declaration...

What will you do when fear tells you to stay silent?

Build your declaration...

What boundaries are you committing to establishing or reinforcing? Be specific.

Build your declaration...

How will you handle pushback? Write the sentence you will use when someone challenges your boundary.

Build your declaration...

What is the standard you will no longer accept? Name the line.

Build your declaration...

How will you close the gap between the advice you give clients and the standards you hold for yourself?

Build your declaration...

How could your self-advocacy benefit not just you but your colleagues?

Build your declaration...

If you are in personal recovery, how does advocating for yourself align with your recovery principles?

Build your declaration...

Write your Advocacy Declaration — a statement of what you have learned, what you are committing to change, and why it matters. Include the conversations you will have, the boundaries you will set, the double standards you will no longer accept, and the voice you are reclaiming.

My Advocacy Declaration...

1. How does it feel to see your commitment to self-advocacy in writing?

Final reflections...

2. Who will you share this declaration with? A colleague? A supervisor? A partner?

Final reflections...

3. When will you revisit this declaration? Set a date within 30 days.

Final reflections...

4. What is the single most important thing this intensive has taught you about your own voice?

Final reflections...

"You teach your clients to speak up for their needs. Now it is your turn."

The advice you give every day to the people in your care — advocate for yourself, set limits, ask for what you need — is not advice that exempts its author. You deserve the same quality of advocacy you provide.

Speaking Up, Advocating for Yourself — The Recovery Files