

H.A.L.T. for Clinicians

Deep Dive Modules · Resilience & Self-Care

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Part 1 • Overview

H

A

L

T

H.A.L.T. for Clinicians

Practicing What We Preach

For SUD Clinicians & Staff — The Recovery Files

H

Hungry

Physical • Emotional • Spiritual

A

Angry

The Iceberg Beneath

L

Lonely

Isolation • Avoidance

T

Tired

Physical • Emotional • Mental

Reading Sections

Self-Assessment

Worksheets & Exercises

Part 2 · H.A.L.T. — The Acronym You Teach But Forget to Practice

H.A.L.T. — The Acronym You Teach But Forget to Practice

If you have spent any time in substance use disorder treatment — as a clinician, a technician, a case manager, a supervisor, or in any clinical role — you have taught H.A.L.T. You have written it on whiteboards. You have included it in psychoeducation groups. You have referenced it in individual sessions. You have explained to clients, with genuine conviction, that when they are Hungry, Angry, Lonely, or Tired, they are at their most vulnerable — that these four states impair judgment, erode emotional regulation, amplify cravings, and create the conditions where poor decisions feel like reasonable ones.

And you were right. The H.A.L.T. framework, despite its simplicity, captures something that decades of neuroscience research has confirmed: basic human needs, when unmet, degrade the brain's capacity for executive function, impulse control, empathic attunement, and rational decision-making. Hunger disrupts glucose regulation and cognitive performance. Anger narrows attentional focus and increases reactive behavior. Loneliness activates threat circuitry and impairs social cognition. Tiredness compromises every system in the brain that clinical work demands — memory, attention, emotional regulation, and judgment. These are not metaphors. They are neurobiological facts.

Now here is the question this intensive exists to ask: When was the last time you applied H.A.L.T. to yourself?

Not as a passing thought. Not as a self-deprecating joke in the break room — "Ha, I'm definitely H.A.L.T. today." As an actual practice. A genuine, honest self-assessment of whether the person delivering clinical care today is operating from a state of basic human need fulfillment — or from a state of depletion so chronic that it has become invisible.

Because here is what happens in treatment settings across the country, every single day: clinicians skip breakfast and work through lunch. They suppress anger about systemic injustice and call it professionalism. They isolate from personal relationships because they are too depleted to invest in them. They run on four or five hours of sleep and compensate with caffeine. They teach H.A.L.T. to their clients at 10:00 AM and violate every principle of it by 2:00 PM. They know the material. They believe the material. And they exempt themselves from it.

The exemption is not conscious. It is structural. It is built into a professional culture that treats clinician self-neglect as a feature rather than a bug — where skipping lunch is dedication, where suppressing anger is emotional maturity, where isolation is self-sufficiency, and where exhaustion is the price of meaningful work.

This is the irony that sits at the center of SUD treatment: we have built an entire clinical framework around the recognition that unmet basic needs create vulnerability, and then we have constructed a professional environment that systematically undermines the basic needs of the people who teach that framework.

The H.A.L.T. check is not just for clients. It is for you. Not as a nice self-care add-on. As a clinical imperative. Because a clinician who is hungry, angry, lonely, and tired is a clinician whose judgment is impaired, whose empathy is diminished, whose patience is thin, and whose capacity to hold space for another person's pain is compromised.

This intensive applies the H.A.L.T. framework to you — deeply, specifically, and without the luxury of exemption. Each letter will be examined not as a simple concept you already know, but as a layered, multidimensional reality that operates in your life in ways you may not have fully acknowledged.

Reflection Questions

1. When was the last time you were genuinely not hungry, not angry, not lonely, and not tired — all at the same time? Can you remember a recent day like that?

Take your time with this reflection...

2. How often do you teach H.A.L.T. to clients? How often do you practice a genuine H.A.L.T. check on yourself?

Take your time with this reflection...

3. Which letter of H.A.L.T. is most chronically activated in your life right now? Which one has been operating so long that you have stopped noticing it?

Take your time with this reflection...

4. What messages — from your training, your workplace culture, or your personal values — have taught you that H.A.L.T. applies to clients but not to clinicians?

Take your time with this reflection...

5. If you applied the same urgency to your own H.A.L.T. state that you apply when a client is in a vulnerable state, what would you do differently today?

Take your time with this reflection...

Part 3 • H — Hungry: Physical, Emotional & Spiritual Starvation

H — Hungry: Physical, Emotional & Spiritual Starvation

Hunger, as it applies to clinicians, operates on three levels — and the clinical field's failure to address all three is one of the primary drivers of burnout, compassion fatigue, and professional attrition.

Physical hunger is the most obvious and the most commonly ignored. In many treatment settings, the workday is structured in a way that makes regular, nutritious eating nearly impossible. Back-to-back sessions. Groups that run through lunch. Documentation that fills whatever gaps remain. The result is a workforce that runs on caffeine and adrenaline through the morning, grabs whatever is available at 2:00 PM, and arrives at their evening session with blood sugar levels that would concern an endocrinologist.

This is not a minor inconvenience. The brain consumes approximately 20 percent of the body's glucose supply. When glucose drops — because you skipped breakfast, ate a handful of crackers at your desk, and called that lunch — cognitive performance deteriorates measurably. Working memory shrinks. Decision-making becomes more impulsive. Emotional regulation weakens. Empathic capacity diminishes.

Emotional hunger is the deeper layer. It is the need to be seen, heard, valued, appreciated, and recognized — not as a clinical instrument, but as a human being. Clinical work in SUD treatment is relationally one-directional by design. You give empathy; you do not receive it from your clients. You hold space for pain; no one holds space for yours during the workday. Over time, this relational one-directionality creates an emotional deficit that is as real and as debilitating as a caloric deficit.

Spiritual hunger is the deepest layer. It is the craving for meaning, purpose, connection to something larger, and a sense that the work you are doing matters in a way that transcends productivity metrics and billable hours. When spiritual hunger goes unaddressed, the work begins to feel mechanical. The spark is gone. The clients blur together.

H.A.L.T. begins with H. And H begins with the question: What are you hungry for?

Reflection Questions

1. Describe your typical eating patterns on a workday. Are you genuinely nourishing your body, or are you subsisting on whatever you can grab between sessions?

Take your time with this reflection...

2. Where is your emotional hunger right now? What do you need emotionally that you are not getting — recognition, reciprocity, being seen, being cared for?

Take your time with this reflection...

3. When was the last time you felt genuinely connected to the meaning and purpose of your work — not as an idea, but as a lived experience?

Take your time with this reflection...

4. Which of the three hungers — physical, emotional, spiritual — is most acute for you right now? How long has it been unaddressed?

Take your time with this reflection...

5. If you wrote yourself a "nourishment prescription" — covering all three levels of hunger — what would it include?

Take your time with this reflection...

Part 4 • A — Angry: The Iceberg Beneath the Surface

A — Angry: The Iceberg Beneath the Surface

In substance use disorder treatment, we teach clients about the anger iceberg — the concept that anger is a surface emotion, the visible ten percent above the waterline, while beneath it lies a vast underwater structure of primary emotions: hurt, fear, grief, helplessness, shame, frustration, betrayal, and loss. We teach clients that managing anger requires going below the waterline — identifying what anger is actually protecting them from feeling.

Clinicians know this concept. They teach it. And yet, many of them have never applied it to the anger they carry every single day in this work.

Because clinicians are angry. Not all the time. Not every one of them. But the anger is there — and it is pervasive, and it is justified, and it is almost never addressed directly. It leaks instead. It shows up as cynicism in the break room. As gallows humor that crosses a line. As impatience with a client who "should know better by now." As emotional withdrawal from people at home.

There is helplessness — the agonizing awareness that despite your training, your skill, your commitment, and your care, you cannot save everyone. Some clients will relapse. Some will die. And that helplessness produces a grief that many clinicians convert to anger because grief feels unbearable and anger feels manageable.

There is moral injury — the damage that occurs when you are forced to participate in or witness actions that violate your moral code. Discharging a client who is not ready because insurance ran out. Implementing policies you know are clinically harmful. Working in a system that prioritizes revenue over recovery.

There is unacknowledged hurt. The client who cursed at you and nobody asked if you were okay. The colleague who took credit for your work. The supervisor who dismissed your concern.

The anger iceberg applies to you. The ten percent above the waterline is what everyone sees: the irritability, the frustration, the occasional sharp tone. The ninety percent below is what needs your attention. And addressing it requires the same courage you ask of your clients every day: the willingness to go below the surface and feel what is actually there.

Reflection Questions

1. What are you angry about right now in your professional life? List everything — from the trivial irritations to the deep, systemic grievances. Get it all out.

Take your time with this reflection...

2. Now go below the waterline. Pick the anger that has the most energy and ask: what is underneath it? Is it helplessness? Grief? Moral injury? Hurt? Fear?

Take your time with this reflection...

3. How does your anger leak? Does it come out as cynicism, impatience, withdrawal, sarcasm, overwork, or something else?

Take your time with this reflection...

4. Have you experienced moral injury in your clinical career — being asked to do things or participate in systems that violated your professional or personal values?

Take your time with this reflection...

5. What would happen if you allowed yourself to feel what is beneath the anger — the grief, the helplessness, the hurt — without converting it?

Take your time with this reflection...

Part 5 · L — Lonely: The Isolation Nobody Sees

L — Lonely: The Isolation Nobody Sees

Loneliness in clinicians is one of the most underrecognized hazards in the behavioral health field, and it is underrecognized precisely because it is paradoxical. How can someone who spends their entire day in relational contact with other people — sessions, groups, family conferences, team meetings, supervision — be lonely?

And yet. The relational contact of clinical work is structurally one-directional. You listen; you are not listened to. You ask the deep questions; nobody asks them of you. You witness vulnerability; your own vulnerability stays hidden behind the clinical frame. You can be surrounded by people all day and still be profoundly lonely — because the connections you have are connections in which you are always the giver, never the receiver.

The first layer is professional isolation. Despite working on teams, many clinicians operate as functional soloists. They run their sessions alone. They process their clinical material alone. They carry the weight of difficult cases alone. Supervision, when it exists, is often focused on administrative compliance rather than emotional support.

The second layer is personal isolation — the withdrawal from non-clinical relationships that happens gradually and is driven by exhaustion, emotional depletion, and a shrinking capacity for connection. After spending all day in deep relational contact, the last thing many clinicians want is more relating.

The third layer is the loneliness of the helper identity itself. Many people in this field carry a belief — often unconscious — that their role is to support others, not to be supported. You cannot be nourished by a connection in which you are always the nourisher.

The clinical research on loneliness is unambiguous: chronic loneliness is associated with increased inflammation, impaired immune function, elevated cortisol, disrupted sleep, cognitive decline, and increased mortality. Loneliness is not a soft concern. It is a clinical risk factor — for you and, by extension, for the people you serve.

Reflection Questions

1. Are you lonely? Not in the abstract — right now, in your actual life. Be honest. When was the last time you felt genuinely seen and known by another person?

Take your time with this reflection...

2. How has your clinical work affected your personal relationships? What has been gained and what has been lost?

Take your time with this reflection...

3. Do you have even one person in your life who you trust enough to tell the complete truth about how you are doing — not the professional version, but the real version?

Take your time with this reflection...

4. If you are in personal recovery: Is your recovery community a genuine source of connection, or have you assumed the helper role there too?

Take your time with this reflection...

5. What would it take for you to ask for support — genuinely, honestly, without deflecting or minimizing?

Take your time with this reflection...

Part 6 · T — Tired: The Three Exhaustions

T — Tired: The Three Exhaustions

Tired, for a substance use disorder clinician, is never just tired. It is a compound word that contains at least three distinct forms of exhaustion — each with its own causes, its own consequences, and its own treatment — and the failure to distinguish among them is why "get more sleep" is such a profoundly inadequate response to clinician fatigue.

Physical exhaustion is the most recognized and the most straightforward. It is the tiredness of a body that has not received adequate rest, nutrition, movement, or medical care. Physical exhaustion responds to physical interventions: sleep, nutrition, movement, and time away from the demands of the body.

Emotional exhaustion is the deeper fatigue — the tiredness that sleep does not fix. It is the depletion that comes from the cumulative weight of empathic engagement: eight hours of listening to pain, holding space for suffering, witnessing relapse and loss and family rupture. Emotional exhaustion manifests as numbness, reduced empathy, irritability, emotional flatness, and the creeping sense that you have nothing left to give.

Mental exhaustion is the third form and the one least discussed. It is the fatigue of cognitive overload — the tiredness that comes from making hundreds of clinical decisions per day, each one carrying the weight of potential consequences for another person's life. By 3:00 PM, the prefrontal cortex is running on fumes.

The compound nature of clinician tiredness means that addressing it requires more than a single strategy. Physical exhaustion needs sleep and rest. Emotional exhaustion needs connection, processing, and empathic refueling. Mental exhaustion needs cognitive rest.

What clinician tiredness does not need is to be normalized, celebrated, or worn as a badge of professional commitment. The clinician who sets limits, protects their rest, and shows up rested is sometimes viewed with suspicion — as if sustainability were a form of laziness. This inversion is not just wrong. It is dangerous.

Reflection Questions

1. Of the three exhaustions — physical, emotional, and mental — which is most dominant in your life right now? How do you know?

Take your time with this reflection...

2. Describe what you feel like at the end of a typical workday. Is it primarily physical fatigue, emotional depletion, cognitive drain, or some combination?

Take your time with this reflection...

3. What do you do to address your tiredness? Is it actually addressing the right type of exhaustion?

Take your time with this reflection...

4. How has your organization's culture shaped your relationship with exhaustion? Is tiredness worn as a badge of honor? Is rest viewed with suspicion?

Take your time with this reflection...

5. If you took the T in H.A.L.T. as seriously as you take it when a client is running on empty, what would you change about how you are living right now?

Take your time with this reflection...

Part 7 · H.A.L.T. Self-Assessment

H.A.L.T. Self-Assessment

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

I eat regular, nourishing meals during my workday rather than skipping meals or grazing on whatever is available

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I am aware of emotional hunger — the craving for validation, recognition, or a sense of mattering — and I address it rather than suppress it

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I attend to my spiritual hunger through practices that connect me to meaning, purpose, or something larger than my daily tasks

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I notice when I am operating on empty — physically, emotionally, or spiritually — and I respond to the signal rather than push through

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not use caffeine, sugar, or other quick fixes as substitutes for genuine nourishment

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I recognize that hunger in all its forms impairs my clinical judgment and emotional regulation

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I have regular practices that feed my emotional and spiritual life, not just my body

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I take breaks during the workday that are genuinely restorative, not just pauses between crises

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I can distinguish between physical hunger, emotional hunger, and spiritual hunger — and I know what each one needs

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I treat my own nourishment as a professional requirement, not a luxury I will attend to when I have time

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I am aware of anger when it arises in my professional life and I treat it as information rather than something to suppress

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I recognize the emotions beneath my anger — the hurt, fear, frustration, helplessness, or grief that anger is protecting

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I have healthy outlets for the frustration and resentment that accumulate in clinical work

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not take my work-related anger out on clients, colleagues, family, or myself

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I address anger-producing situations directly rather than letting resentment build through silence

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I recognize when institutional injustice, systemic failure, or moral injury is the real source of my anger

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I can express disagreement or frustration professionally without either exploding or shutting down

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not use cynicism, sarcasm, or dark humor as my primary way of processing workplace anger

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I am honest with myself about what I am actually angry about — not the surface trigger, but the deeper wound

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I understand that unprocessed anger compromises my empathy, my clinical presence, and my relationships

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I have meaningful professional relationships where I can be honest about how I am actually doing

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I actively maintain personal relationships outside of the treatment field that remind me who I am beyond my clinical role

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not isolate when I am struggling — I reach out, even when the impulse is to withdraw

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I participate in peer support, consultation, or supervision that addresses my emotional experience, not just case management

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I recognize the difference between healthy solitude and avoidant isolation — and I am honest about which one I am practicing

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not use the demands of work as an excuse to avoid personal relationships and social connection

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I have at least one person in my life who I trust enough to tell the unfiltered truth about how I am doing

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I am aware that professional caregiving can create an illusion of connection that masks genuine loneliness

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I notice when I am withdrawing from colleagues, friends, or family — and I treat it as a warning sign

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I believe I deserve connection and support, not just in my role as a helper, but as a human being

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I get adequate sleep on most nights — enough to feel genuinely rested, not just enough to function

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I recognize the difference between physical tiredness, emotional exhaustion, and mental fatigue — and I know what each one requires

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not wear exhaustion as a badge of honor or proof of my commitment to the work

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I take my days off and actually rest during them rather than using them to catch up on work or obligations

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I am aware that operating from exhaustion impairs my clinical judgment, my empathy, and my emotional regulation

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I have strategies for managing the cumulative fatigue that builds across a clinical week, not just a single day

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I set limits on my work hours rather than consistently operating beyond what is sustainable

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I do not rely on stimulants, substances, or compulsive behaviors to manage my exhaustion

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I can say "I am too tired to do this well" without feeling like a failure

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

I treat rest as a professional responsibility — not something I earn through suffering, but something my clients need me to have

Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very much

1. Which letter scored highest? What practices have you built that support this area?

Your reflection...

2. Which letter scored lowest? How long has this area been neglected? What is the cost?

Your reflection...

3. Which specific items did you rate as 1 or 2? These are your most critical vulnerabilities.

Your reflection...

4. If you had taken this assessment five years ago, would the results have been different?

Your reflection...

5. Based on this assessment, what is the single most urgent H.A.L.T. need you must address?

Your reflection...

Scoring guide

Higher scores indicate areas where you are attending to your own H.A.L.T. needs. Lower scores reveal which of the four states is most chronically activated in your life — the letter with the lowest score is where your H.A.L.T. practice needs the most immediate attention.

Part 8 · Exercise 1: The Three Hungers Inventory

H

The Three Hungers Inventory

Physical, Emotional & Spiritual

Describe your eating pattern on a typical workday. From waking to bedtime — when, what, and how do you eat?

How often do you skip meals? How often do you eat while working? How often do you eat something genuinely nourishing?

What does your body feel like by mid-afternoon on a typical day?

What are you emotionally hungry for right now? Recognition? Reciprocity? Validation that you are doing enough?

Where in your life do you receive genuine emotional nourishment — authentic two-way connection?

What do you do when you are emotionally hungry? Do you name it and seek nourishment, or suppress it and power through?

When was the last time you felt a deep sense of meaning and purpose in your work?

What spiritual or meaning-making practice is part of your life? Is it active or dormant?

What would it feel like to be spiritually fed — connected to purpose, grounded in meaning?

Which hunger is most acute for you right now? Physical, emotional, or spiritual?

What would change in your clinical work if all three hungers were adequately fed?

What is one action you can take today to address your most acute hunger?

Part 9 • Exercise 2: The Nourishment Plan

The Nourishment Plan

Feeding All Three Hungers

What specific changes will you make to your workday eating? Be concrete: what will you eat, when, and how will you protect the time?

What is your hydration plan? Your movement plan? What physical practice will become non-negotiable?

Who in your life provides genuine emotional nourishment? How will you invest in those relationships this month?

What will you do to create reciprocal relational experiences — spaces where you receive, not just give?

What meaning-making practice will you commit to? Meditation, prayer, nature, creative expression, recovery work, journaling?

How will you reconnect to the purpose that brought you to this field? What specific action will you take this week?

Part 10 • Exercise 3: Your Anger Iceberg

A

Your Anger Iceberg

What Is Above and Below the Waterline

List everything you are angry or frustrated about in your professional life right now. Dump it all out — big and small.

How does your anger show up at work? Irritability, impatience, cynicism, withdrawal, sarcasm?

How does your anger show up at home? What do the people in your personal life see?

For each item above, go beneath the anger. What is the primary emotion underneath? Hurt? Fear? Helplessness? Grief? Shame? Moral injury?

Which beneath-the-surface emotion is largest? Which has been there the longest? Which one do you most avoid feeling?

What would it mean to feel the beneath-the-surface emotion directly — without converting it to anger?

Have you been asked to participate in or witness practices that violated your clinical values? Premature discharges? Policies that prioritized revenue over care?

What has moral injury done to your relationship with the work and your sense of professional integrity?

Is there grief underneath the moral injury — a mourning for the way the field should be versus the way it is?

Part 11 • Exercise 4: Anger Processing Protocol

Anger Processing Protocol

Healthy Outlets for Legitimate Anger

What physical outlet for anger works for you? Running, hitting a bag, intense cleaning, walking, weightlifting?

What verbal outlet for anger do you have? A trusted colleague? A therapist? A sponsor? A journal?

What reflective practice will you use to go below the waterline? Journaling, therapy, prayer, meditation?

When anger arises at work in real time, what is your in-the-moment strategy? Not suppression — actual regulation.

What situations at work reliably produce anger in you? For each, write a proactive response plan.

Part 12 · Exercise 5: The Loneliness Inventory

L

The Loneliness Inventory

Isolation, Avoidance & Disconnection

How connected do you feel to your colleagues — not professionally, but personally? Do you have real relationships at work, or just functional ones?

Who at work knows how you are actually doing? Not the professional performance — the human reality.

Do you have genuine peer support — a colleague who asks the vulnerable question, not just the case management question?

How have your personal relationships been affected by your clinical career? What friendships have atrophied?

When was the last time you invested in a personal relationship out of genuine desire for connection?

Are you withdrawing from people? Canceling plans? Choosing the couch and the screen over human contact? Be honest.

Do you deflect when people try to care for you? Do you redirect "How are you?" back to the other person?

If you are in personal recovery: have you become the helper in your recovery community rather than the participant?

What would it take for you to say to someone: "I am not okay. I need support." What stands between you and those words?

Part 13 • Exercise 6: The Connection Rebuilding Plan

The Connection Rebuilding Plan

From Isolation to Intentional Connection

Name 1-3 people you will invest in this month. Not because you should, but because the relationship genuinely matters to you.

What professional connection would nourish you — a peer consultation group, a colleague you trust, a mentor?

What social activity will you engage in that has nothing to do with clinical work or recovery?

If you are in personal recovery: What one thing will you do to re-engage with your own program — not as a helper, but as a participant?

What is the one phone call you will make this week that you have been putting off?

Part 14 • Exercise 7: The Three Exhaustions Audit

T

The Three Exhaustions Audit

Physical, Emotional & Mental

How many hours of sleep are you averaging? Is it enough? How do you know?

What does your body feel like at the end of a typical workday? Describe it from head to toe.

What physical habits are maintaining your exhaustion — poor sleep hygiene, caffeine dependence, lack of movement?

How is your empathy tank? Can you still feel genuinely present with clients, or are you going through the motions?

What does emotional exhaustion feel like in your body and your behavior? Numbness? Irritability? Flatness?

What would emotional refueling look like for you? Not physical rest — emotional replenishment. Who or what fills that tank?

How is your decision-making capacity by the end of the day? Can you still think clearly by your last session?

How much cognitive demand do you carry — clinical decisions, documentation, scheduling logistics, treatment planning?

What does cognitive rest look like for you? Not distraction — actual mental downtime where the decision-making apparatus is offline.

Part 15 · Exercise 8: The Rest Protocol

The Rest Protocol

Targeted Rest for Each Exhaustion

What specific changes will you make to your sleep, nutrition, and movement? Be concrete with times, amounts, and non-negotiables.

What is your minimum viable sleep — the number of hours below which you cannot function safely as a clinician?

What will you do to refuel emotionally? Therapy, peer support, creative expression, time in nature, honest conversation?

How will you create space for your own emotional processing during the workweek — not just on weekends or vacations?

What activities genuinely rest your mind — not just distract it? What is the difference between zoning out on screens and actual cognitive recovery?

How will you protect your cognitive capacity across the workday? Scheduled breaks? Limits on back-to-back sessions?

Part 16 • Exercise 9: 7-Day H.A.L.T. Check-In

7-Day H.A.L.T. Check-In

Seven Days of Practicing What You Preach

The Practice You Prescribe to Others

You ask your clients to do H.A.L.T. checks. This week, you do one. Every day. Rate each letter, take one action, and notice the connection between your H.A.L.T. state and your clinical presence.

Hungry? (1=well fed, 10=starving — all three levels)

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Angry? (1=at peace, 10=full iceberg)

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Lonely? (1=connected, 10=deeply isolated)

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Tired? (1=rested, 10=depleted on all levels)

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What did I do today to address my H.A.L.T. state?

What did I do today to address my H.A.L.T. state?...

What did I notice about how my H.A.L.T. state affected my clinical work?

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1. Which letter was consistently highest across seven days? What does that tell you about your most chronic vulnerability?

Reflect on your seven days...

2. Did you notice a connection between your H.A.L.T. scores and the quality of your clinical work?

Reflect on your seven days...

3. Which day was best — lowest H.A.L.T. scores overall? What was different about that day?

Reflect on your seven days...

4. What did you learn from seven days of treating yourself like a client who needs H.A.L.T. monitoring?

Reflect on your seven days...

5. Will you continue this practice? What would an ongoing H.A.L.T. check-in look like for you?

Reflect on your seven days...

Part 17 • Exercise 10: The H.A.L.T. Declaration

The H.A.L.T. Declaration

Your Commitment to Practicing What You Preach

Four Letters, Four Commitments

This declaration applies the H.A.L.T. framework to your own life with the same clinical seriousness you bring when you teach it to others. Each letter gets a specific, actionable commitment.

My commitment to physical nourishment:

My commitment to emotional nourishment:

My commitment to spiritual nourishment:

My commitment to anger awareness and processing:

My plan for addressing moral injury and systemic frustration:

How I will prevent anger from leaking into my relationships and clinical work:

My commitment to professional connection and peer support:

My commitment to personal relationships outside the work:

How I will ask for help when I need it, without deflecting or minimizing:

My commitment to physical rest:

My commitment to emotional recovery:

My commitment to mental downtime and cognitive rest:

Write your complete H.A.L.T. Declaration — what you will do differently, what you will no longer tolerate, and why it matters for you, for the people you love, and for the people you serve.

How does it feel to apply H.A.L.T. to yourself with the same seriousness you apply it to your clients?

Who will hold you accountable to this declaration? When will you revisit it?

What is the single most important thing this intensive has taught you about the person behind the clinical chair?

"H.A.L.T. is not just something you teach. It is something you live."

Your clients deserve a clinician who practices what they preach. Your family deserves a person who shows up whole. And you deserve the same quality of care you give away every single day.

H.A.L.T. for Clinicians — The Recovery Files