Advanced Skills Workshop: Consent as Collaboration

Transforming Informed Consent from a Legal Requirement into a Non-Pathologizing Relational Practice

Workshop Synopsis

Every psychotherapist is familiar with informed consent as a procedural obligation — a form to be signed, a disclosure to be read, a box to be checked before the work begins. This workshop argues that this understanding of consent is not only ethically inadequate under the new CHCPBC Ethics and Practice Standards, but that it is fundamentally incompatible with a non-pathologizing philosophy of care. Informed consent, properly understood, is not a single event that happens before therapy starts. It is an ongoing relational act — a continuous invitation to the client to understand, question, agree, and refuse — that must be renewed every time the therapist introduces a new intervention, shifts modalities, or changes direction mid-session. Reframing consent through the protest language framework reveals something more: a client who does not freely and fully consent is already saying *no*. Learning to hear that *no* is not a compliance skill — it is the foundation of non-pathologizing clinical practice.

The Problem the Workshop Addresses

The CHCPBC Practice Standard on Consent is one of the most substantive in the new Ethics and Practice Standards document, spanning nineteen specific requirements. Yet most psychotherapists were trained under a model in which consent was understood as an intake procedure — a threshold to cross before therapy could begin — rather than as an active, relational, and continuous process. The result is that consent is chronically underused as a clinical tool, and frequently violated in ways therapists do not recognize.

The most significant shift now enshrined in the CHCPBC standard is that a therapist must obtain new consent before *modifying a treatment plan or other aspects of the patient's health services*. This requirement — which mirrors the CRPO's 2023 update requiring therapists to stop mid-session if necessary to obtain informed consent when changing modalities or introducing new interventions — makes explicit something the non-pathologizing framework has always held: the classic practice of *doing what feels right in the moment* is no longer professionally acceptable. What that practice reveals, when examined, is a therapist's reliance on moralization — the assumption that because something feels therapeutically right to the therapist, the client's consent is implied or unnecessary.

The workshop addresses three specific failure modes in how consent is currently practiced:

- **Consent as transaction**: Treating the intake form as the whole of the consent obligation, never returning to it as the work evolves

- **Consent as compliance**: Presenting consent in language the client cannot access or understand, then recording their signature as evidence of understanding
- **Consent as paternalism**: The therapist deciding that the client needs a particular intervention and presenting it in a way that does not leave genuine room for refusal — a subtle but powerful form of the medical model's expert-over-client dynamic

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The CHCPBC Consent Standard: What Is Now Required

The CHCPBC standard requires, at minimum, that therapists:

1. Explain the **nature, purpose, intended benefits, limitations, risks, and alternatives** to any proposed health service in language that is accessible and culturally relevant, adapted for age, culture, language, cognitive ability, and health literacy
2. Expressly **confirm with the client** that they have understood the information provided — not assume understanding from silence or compliance
3. Advise the client of their **right to refuse** or withdraw consent at any time, and explain the consequences of refusal if relevant
4. Obtain **new consent** before modifying a treatment plan, introducing a new modality, introducing physical contact, or assigning care to a supervisee
5. Ensure that consent is given **voluntarily** and not under duress or coercion — a requirement that carries significant clinical weight in a context where the power imbalance between therapist and client is structural and persistent
6. Refrain from making **stereotypical or other assumptions** when providing information for the purposes of obtaining consent
7. Recognize the **client's right to refuse** and respect that decision, honouring the Discontinuing Health Services standard when applicable

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Consent as the First Site of Protest Language

The protest language framework offers a clinically rich and practically useful lens for teaching consent. When a client signs a consent form they do not understand, that is not agreement — it is compliance. When a client nods along as a therapist introduces a new technique without genuine explanation, that is not consent — it is performance. Both dynamics are forms of silenced protest. The client is not saying *yes*; they have simply been placed in a situation where they cannot easily say *no*.

The workshop draws on the protest language methodology to reframe the consent process as *listening for the client's no before the work begins* — and throughout the work at every stage. Consent is reconceived not as the absence of refusal, but as the active, vocal presence of agreement, arrived at after genuine understanding. This reframing has three practical clinical implications:

1. Consent as Externalization
The non-pathologizing approach uses externalization as a foundational technique — separating the problem from the person. The same principle applies to consent: the *intervention* or *modality* is externalized as something the client is being invited to engage with, not something that is happening *to* them by virtue of being in the therapist's care. The therapist presents the intervention as a distinct, named thing, explains its purpose and its limitations, describes what it will ask of the client, and explicitly creates space for the client to decline.

2. Consent as Ongoing Relational Check
The triage model positions safety as the first and always-present layer of clinical work. Consent is the mechanism through which safety is co-created and maintained. Each time a therapist moves from one clinical territory to another — from grief to identity, from identity to trauma, from psychoeducation to somatic work — the client must be invited to move with them. The invitation itself is a consent question: *I'm thinking we might try something here. Would you like to hear more about it before we decide?*.

3. Consent as Anti-Pathologizing Practice
When a client declines an intervention, asks a therapist to slow down, or expresses discomfort with a direction in therapy, the medical model tends to interpret that response as resistance, avoidance, or defensiveness. The non-pathologizing framework identifies it as protest language — the client's clearest and most direct communication about their own needs. A therapist who treats a refusal as clinically meaningful rather than clinically obstructive is practicing consent as it is ethically intended: as a genuine commitment to the client's autonomy and agency.

The Triage Model and Sequenced Consent

A particularly important application of the CHCPBC Consent Standard is its connection to clinical sequencing. The non-pathologizing triage model — Safety, Grief, Identity, Trauma — is not only a therapeutic framework; it is a consent framework. Each stage of the triage sequence represents a different level of clinical depth and relational risk, and movement between stages requires active, explicit, renewed consent.

- **Stage 1 — Safety**: Before any clinical work begins, the therapist is required to explain what the work will involve and what it will ask of the client. At this stage, consent is foundational: the client needs to understand what safety means in this clinical context and how they will be supported in creating it.
- **Stage 2 — Grief**: Movement into grief work — which may involve exploring loss, rupture, and the end of systems of belonging — represents a significant clinical shift. The CHCPBC standard requires new consent before any modification of the treatment approach. The therapist must name the shift, explain why it is being proposed, and genuinely invite the client's participation.
- **Stage 3 — Identity**: Identity work in the non-pathologizing frame involves inviting the client to examine and reauthor self-descriptions that may have been inherited from pathologizing systems — family, institutional, diagnostic. This work is intimate and

carries real risk of destabilization. Consent here includes explaining what the work will ask of the client and that there is no predetermined outcome the therapist is steering toward.
- **Stage 4 — Trauma**: Trauma work, which comes last in the sequence precisely because it requires all prior groundwork in place, carries the highest clinical risk. The CHCPBC standard is explicit that assessment tools and procedures that risk causing harm or re-traumatization must be adapted in consultation with the client. This is a consent requirement: the client must understand what trauma work will involve, what it might surface, and what supports will be in place.

Consent and Self-Pathology

One of the most clinically nuanced consent issues in psychotherapy involves what happens when the client's own self-description is pathologizing. When a client says *I'm broken*, *I've tried everything*, *I can't be helped*, or *I don't trust my own judgment*, they are simultaneously describing themselves and implicitly consenting to a therapeutic process organized around those descriptions. The workshop addresses this directly: the therapist's non-pathologizing obligation to interrupt self-pathology in the moment is also a consent obligation. Before engaging with a client's self-description as the organizing frame for the work, the therapist needs to create enough space for the client to examine that description — to check whether it is truly their own, or whether it has been inherited from systems that pathologized them.

This is also where the CHCPBC requirement to refrain from making *stereotypical or other assumptions when providing information for the purposes of obtaining consent* becomes clinically significant. A therapist who hears a client's self-pathologizing language and simply confirms it by building a treatment plan around it has not obtained meaningful consent — they have reinforced an externally imposed identity without the client's genuine participation.

Consent, Power Imbalance, and Cultural Safety

The CHCPBC standard defines a *power imbalance* as the dynamic that exists by virtue of the authority and influence that a healthcare professional holds in relation to a patient due to their role and subject matter knowledge, placing the patient in a vulnerable position. The standard requires that therapists account for *power dynamics, accessibility, and equity needs* when adapting their communication style to obtain consent.

The protest language framework identifies power imbalance as one of the primary structural conditions under which client protest is silenced. When a client does not understand what they are consenting to, when they come from a cultural context in which refusing a professional's recommendation is experienced as disrespectful, when they are in acute distress and cannot

easily distinguish their own preferences from the therapist's suggestion — in all of these situations, the consent obtained may be procedurally valid but relational impoverished.

The workshop addresses consent through an intersectional lens, drawing on the CHCPBC's requirement to adapt consent information for *age, culture, language, cognitive ability, and health literacy*. For Indigenous clients in particular, the standard requires recognition of *the historical and ongoing impacts of colonisation, systemic racism, and trauma in healthcare* and the need to *seek permission before engaging in assessments or treatments*. The consent process itself must be culturally safe — meaning that the therapist's invitation to consent does not reproduce the structures of authority and exclusion that have historically made it dangerous for Indigenous patients to refuse care.

Translating Consent Language: From Procedure to Collaboration

A central practice component of the workshop applies the 9-step Translation Protocol to the consent process itself:

Original consent language (procedural): *By signing this form, you confirm that you understand and agree to the terms of psychotherapy, including confidentiality, fees, and the nature of the therapeutic relationship.*

Translated consent language (collaborative): *Before we begin working together, I want to make sure you have a clear picture of what this work involves — what I can offer, what it will ask of you, what you can expect, and what you might choose not to do. There are no obligations once you walk in here. Your job is to tell me what works for you and what doesn't, and my job is to listen for that, including when you're saying it without words.*

The workshop uses this translation process to generate a set of consent language templates that participants can take directly into their practice — for initial consent, for mid-session consent when shifting modalities, for consent to documentation practices including CORE notes, and for consent to the use of specific interventions.

Consent and Documentation: The CORE Connection

The CHCPBC standard requires that consent be documented in the patient record. The workshop connects this requirement directly to the CORE documentation framework: a CORE note that records the client's relationship to the session's work — including what they agreed to, what they declined, how they responded, and what they want to do differently next time — is simultaneously a clinical note and a consent record. The note demonstrates that the therapist sought the client's understanding and response, not just their compliance.

My textbook's (Protest Language) argument that open notes are themselves a consent intervention is directly relevant here: when clients have access to what the therapist has written about them, and are invited to correct or amend that record, the consent process extends beyond the session and into the ongoing therapeutic relationship. This represents the most complete expression of consent as collaboration — not a threshold crossed once, but a living document of the client's active participation in their own care.

Learning Outcomes

By the end of this workshop, participants will be able to:

- Articulate the difference between procedural and relational consent, and identify where in their current practice consent functions as a transaction rather than a collaboration
- Apply the CHCPBC Consent Standard's nineteen requirements across the full arc of clinical work — from intake through mid-session modality shifts to treatment plan modifications — with specific reference to the requirement for new consent whenever the clinical approach changes
- Use the protest language framework to listen for the client's *no* within the consent process itself — recognizing that compliance, silence, and performance are not the same as genuine agreement
- Apply the triage model as a consent sequencing tool, obtaining renewed consent at each transition between Safety, Grief, Identity, and Trauma work
- Translate standard consent forms and scripts into non-pathologizing collaborative language that is accessible, culturally relevant, and genuinely open to refusal
- Interrupt self-pathologizing client language that may function as implicit consent to a pathologizing therapeutic frame, creating space for the client to examine and reauthor that frame
- Address power imbalance, cultural context, and intersectional identity in the consent process, including the specific requirements for Indigenous cultural safety in consent practice
- Document consent collaboratively using the CORE framework, treating the note as both a clinical record and a living consent document
- Recognize the ethical alignment between consent as collaboration and the core ethical principles of autonomy, non-maleficence, beneficence, and justice