Advanced Skills Workshop: Non-Pathologizing Documentation

Clinical Notes, Treatment Plans, Case Presentations, and Assessment Boundaries

Workshop Synopsis

Every clinical file tells a story — and most therapists were trained to tell the wrong one. The standard documentation culture of psychotherapy is built on the medical model: deficit-forward, therapist-centred, and organized around symptom management, compliance, and pathological interpretation. This workshop challenges that culture at its root, demonstrating that rigorous, legally defensible clinical records and genuinely humane, non-pathologizing documentation are not in tension — they are the same thing done well.

Designed for practising psychotherapists, this is a hands-on skills workshop. It moves from regulatory foundations through philosophical reorientation, and then into intensive practical translation exercises. Participants will leave with revised templates, concrete language alternatives, a clear framework for understanding assessment scope, and the CORE model as a working tool for clinical notes, treatment plans, case presentations, and therapeutic letters.

The Central Tension — and the Myth That Creates It

Psychotherapists who encounter non-pathologizing philosophy often face an immediate anxiety: *Can I write a warm, client-centred note and still be credible if my file is ever reviewed?* This workshop begins by dismantling the myth that professional documentation must sound detached, heavily diagnostic, and full of technical shorthand to hold up to scrutiny. Drawing directly on CRPO Professional Practice Standard 5.1 (Clinical Records), participants are shown that what makes a note credible is clarity, completeness, clinical reasoning, and traceability — not the presence of deficit language or diagnostic shorthand. CRPO explicitly allows progress notes written in the language of therapy, and notes should be written in a professional, respectful tone, avoiding pejorative or pathologizing language that is not clinically justified.

The workshop then introduces a deeper reframe: documentation can itself be therapeutic. When the clinical record reflects the client's own language, their preferred identity, their strengths, and the contextual pressures shaping their experience, the note becomes more than evidence of care — it becomes part of care.

The Regulatory Baseline

Before any philosophy, participants are grounded in what the record must contain. Drawing on CRPO Standard 5.1 and the Clinical Records Checklist, the workshop establishes the non-negotiable clinical and practice essentials every file must demonstrate:

- Initial and ongoing **informed consent**, including consent to plan changes and modality shifts
- **Assessment and case formulation**, including methods used, professional impressions, and problem formulation
- **Risk assessment** — initial and ongoing — with sufficient rationale to justify conclusions and actions taken
- **Interventions used**, with client response and next steps
- **Significant incidents, mandatory reports**, and changes to treatment direction
- Accurate, complete, legible, and retrievable records stored securely for a minimum of 10 years

The emphasis here is that this baseline exists equally in non-pathologizing practice. A CORE-style note does not replace clinical accountability — it re-houses it in a more collaborative structure.

The CRPO Psychotherapy Interventions and Controlled-Act Guide is introduced as a companion resource, helping participants understand the five-element test for the controlled act of psychotherapy, the five prescribed therapy categories (cognitive-behavioural, experiential-humanistic, psychodynamic, somatic, and systemic-collaborative), and how to locate any intervention they use within a recognized theoretical framework — which must be documentable. This includes guidance on dual practice, when activities fall outside the controlled act, and when consultation or documentation of competence is required.

The Four Anchors of Non-Pathologizing Records

The philosophical architecture of the workshop rests on four lenses that participants carry into all documentation practice:

1. **Intrinsic worth** — the client is never reducible to a label, symptom cluster, or file summary
2. **Protest language** — what appears in the record as a symptom may also be a protest against harm, pressure, fear, or oppression
3. **Safety logic** — behaviours documented as maladaptive are often attempts to restore control and create safety
4. **Differentiation** — the file should track who the client wants to become and how they want to be known

These anchors produce concrete language shifts. Instead of *"dysregulated, irritable, hopeless" — "navigating intense emotional experiences and working toward greater steadiness and understanding."* Instead of *"substance abuse, self-harm" — "using familiar strategies to manage overwhelming pain while exploring safer ways to cope."* Instead of *"poor hygiene, socially withdrawn" — "experiencing strain in daily routines and gradually re-engaging with care, structure, and connection."* The workshop is explicit that these are not euphemisms or softening — they are more precise, contextual, and ethically responsible translations that still meet the CRPO requirement for accurate professional observations.

The CORE Model — From SOAP Habit to New Discipline

The structural centrepiece of the workshop is the **CORE model** for clinical case notes:

- **C — Collaborative Narrative**: the client's language, priorities, and session meaning
- **O — Observed Strengths and Resources**: what supported the client this week
- **R — Resilience in Context**: life pressures, systemic factors, grief, caregiving, oppression
- **E — Evolution and Next Steps**: what is shifting, what was learned, what comes next

Participants examine side-by-side comparisons of SOAP-style notes and CORE rewrites of the same session. In SOAP-style notes as typically practised, therapist observations dominate, symptoms become the main identity marker, missed goals are documented as client failures, and plan language reflects therapist control. In CORE, client voice is visible, strengths and adaptive efforts are documented, barriers are explored rather than moralized, and next steps are co-created and revisable. Complete CORE examples — including an individual therapy note, a supervision note, and a therapeutic letter — are provided as models, all based on the same fictional client file.

A dedicated section addresses risk documentation, which is sometimes weakened in the name of non-pathologizing practice. The workshop is unambiguous: non-pathologizing work never means obscuring or softening risk. Risk notes must document ideation, intent, means, supports, consultation, and safety planning clearly. The change is the elimination of motive-reading — attributing motivations such as *manipulation, drama, or attention-seeking* — and the addition of explicit clinical reasoning explaining why risk was assessed at the level it was and what followed.

Treatment Plans and Case Presentations

The workshop extends the translation methodology to the wider architecture of the clinical file. Non-pathologizing treatment plans ask four questions that standard plans omit: *Why is this information being gathered? How does the client understand the problem? What meanings are attached to it? What changes feel possible and chosen?* Participants are guided to justify every

intake question on clinical grounds, to track the client's relationship to the problem rather than just symptoms, to make goals client-led and flexible (so that unmet goals are explored for fit, fear, and readiness rather than documented as failure), and to make consent visible whenever a specific modality or intervention is incorporated into the plan.

The case presentation module addresses the specific pathologizing dynamics of consultation and supervision culture: diagnosis-first openings that turn the client into a category before their own world is introduced, theoretical language that presents as neutral truth, and the consistent omission of identity, strengths, and context from peer presentations. Participants receive a practical four-part presentation structure grounded in non-pathologizing principles: start with the client's own concern in their own words; place the struggle in relational, systemic, and cultural context; name preferred identity; close with clinical reasoning including interventions, risk, and next steps.

Assessment Boundaries — Scope, Tools, and the Five Questions

The final content module addresses one of the most common areas of documentation confusion for psychotherapists: the boundary between clinical screening, outcome monitoring, and formal psychological assessment. Participants learn that Level A screening tools (PHQ-9, GAD-7, PCL-5) and outcome monitoring instruments (ORS, SRS, DASS-21) are generally within psychotherapy scope when used for treatment planning and progress tracking. Formal psychological assessment for diagnosis, Level C standardized instruments (WAIS, MMPI-3, PAI, ADOS-2), and written diagnostic assessment reports are typically reserved to psychologists. The CRPO controlled-act guide clarifies the five-element test that determines whether any given clinical activity constitutes the controlled act of psychotherapy, and establishes that intervention choice must be grounded in recognized psychotherapeutic theory, within the therapist's competence, and documentable.

Five practical questions are offered as a standing checklist before using any assessment tool: *What province and regulator define my scope? Am I screening, monitoring, or formally assessing? What qualification level does the publisher require? Do I have adequate training and supervision? If uncertain, have I consulted my college or supervisor?*

Workshop Exercises

The workshop includes three sequential practical exercises:

- **Exercise 1 — Find the Hidden Judgment**: Participants bring their own recent clinical note or supervision summary and underline words that imply blame, deficit, fixed pathology, or therapist certainty. Discussion focuses on which terms sound objective but

carry judgment, which phrases erase context or client meaning, and how each could be translated without losing clinical clarity
- **Exercise 2 — Write the Session Note Twice**: Using a provided clinical scenario (client who missed homework, drank after a conflict, and reported fleeting suicidal ideation without plan or intent), participants write first in their usual style, then in CORE format — keeping risk, interventions, and rationale visible while removing hidden blame and diagnostic overreach
- **Exercise 3 — Write a Therapeutic Letter**: Participants rewrite a clinical case note summary as an 8–10 sentence letter addressed directly to the client, incorporating one direct quote, one named strength, one contextual factor, and one client-led next step

---

Learning Outcomes

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

- Write records that meet CRPO Standard 5.1 requirements while using non-pathologizing, collaborative, context-honouring language
- Replace deficit-heavy, moralizing, and therapist-centred documentation habits with the CORE framework across session notes, treatment plans, and case presentations
- Document risk with clinical precision and without motive-reading or contempt
- Identify the boundary between psychotherapy scope and formal psychological assessment, and apply the five-question checklist to any tool
- Write therapeutic letters that function simultaneously as clinical records and collaborative therapeutic interventions
- Implement concrete, sustainable changes to their practice documentation — revising one note template, one treatment-plan template, and one presentation format

---

CHCPBC and CRPO Standards Addressed

This workshop directly addresses the CHCPBC **Records** Practice Standard (accurate, complete, legible, retrievable documentation; secure storage and retention; records legible to another competent practitioner), the **Consent** Standard (documentation of ongoing and modified consent), the **Evidence-Informed Practice** Standard (documenting intervention rationale and outcome), and the **Risk Management and Safety** Standard (explicit, reasoned risk documentation). It is grounded in CRPO Professional Practice Standard 5.1 (Clinical Records) and the CRPO Controlled-Act Guide.