

Clinical practice and supervision

Ten original resources for More Than Therapy. Choose a page that fits the client's priorities and review the clinical notes before use. The materials support professional care and are not validated assessments.

CLN01 Build a Shared Session Agenda

Worksheet | 5 to 10 minutes

CLN02 Track a Meaningful Treatment Goal

Worksheet | 10 to 15 minutes

CLN03 Separate Facts From Clinical Hypotheses

Worksheet | 10 to 15 minutes

CLN04 Plan Practice Between Sessions

Worksheet | 10 to 15 minutes

CLN05 Notice Activation Before You Respond

Worksheet | 10 to 15 minutes

CLN06 Ask About Context and Meaning

Worksheet | 10 to 15 minutes

CLN07 Write a Clinically Useful Note

Handout | 10 to 15 minutes

CLN08 Respond When Therapy Misses the Mark

Clinician script | 10 to 15 minutes

CLN09 Structure a Collaborative Therapy Session

Session guide | 50 minutes

CLN10 Reflect Before the Next Session

Journal prompts | 10 to 15 minutes

Fillable responses work in compatible PDF readers. Save each completed worksheet separately in an approved record system.

Clinical notes

Clinical practice and supervision

CLN01 Build a Shared Session Agenda

Do not use agenda setting to bypass assessment, client questions, or rupture repair. Document a changed focus when relevant. Adapt pace and format to language, literacy, neurodivergence, and the client's preferred participation style.

CLN02 Track a Meaningful Treatment Goal

Keep goals individualized and attainable within the client's circumstances. Do not use an informal number to determine risk, diagnosis, or medical necessity. Record client disagreement or uncertainty instead of implying shared endorsement.

CLN03 Separate Facts From Clinical Hypotheses

This reflection tool does not establish a diagnosis or replace a comprehensive assessment. Avoid speculative trauma explanations and unsupported causal claims. Use supervision or consultation when uncertainty materially affects care.

CLN04 Plan Practice Between Sessions

Do not assign disclosure, exposure, or confrontation without assessment and appropriate treatment planning. Avoid recording unnecessary identifying details in take-home materials. Provide accessible alternatives and confirm how urgent concerns should be handled.

CLN05 Notice Activation Before You Respond

This is an original reflection aid, not a validated activation inventory. Do not use it to assess fitness to practice or require personal trauma disclosure. Address impairment or urgent clinical concerns through appropriate professional processes.

CLN06 Ask About Context and Meaning

Ask permission before sensitive identity questions and explain their relevance. Avoid stereotypes or assuming within-group similarity. Use qualified language access where needed and include client corrections in the ongoing formulation.

CLN07 Write a Clinically Useful Note

Verify organizational, licensing, payer, and jurisdictional requirements separately. Never add services, observations, time, consent, or assessments that did not occur. Use approved systems and review any generated text before it enters a record.

CLN08 Respond When Therapy Misses the Mark

Do not make the client responsible for managing your feelings or professional development. Consider power, culture, access, and prior harm in treatment. Document relevant feedback and agreed changes accurately.

CLN09 Structure a Collaborative Therapy Session

Do not squeeze an incomplete safety assessment into the remaining minutes. Adjust treatment, consultation, referral, or level of support according to clinical findings. This timing does not establish a billing code or medical necessity.

CLN10 Reflect Before the Next Session

Protect confidentiality and follow your setting's rules for reflective notes. Avoid using reflection as a reason to delay required reporting, risk response, or consultation. No score or competency conclusion should be derived from this page.

Build a Shared Session Agenda

Clinical practice and supervision | Clinicians | 5 to 10 minutes

Agree on a session priority while leaving room for emerging clinical needs.

Use this page with the client at the beginning of a session. An agenda can organize attention, but it remains flexible. Safety, urgent needs, or new information may change what the meeting requires.

Invite the client first

Ask what would make today's meeting useful. Include practical concerns, relationships, symptom changes, and questions about therapy. Offer your clinical priority transparently instead of treating the planned worksheet as the session's purpose.

Choose a workable focus

Name one primary goal and, if useful, a second topic. Discuss what can fit in the available time. A broad concern such as "my relationship" may become "practice asking for a pause during difficult conversations."

Agree on how to review

Ask what the client hopes to understand or do differently by the end. Reserve time for feedback and a next step. Revisit the agenda if the chosen activity feels irrelevant, too intense, or inaccessible.

The client's priorities in their own words

Clinical needs or follow-up that require attention

The agreed focus and intended session outcome

Topics deferred and how we will revisit them

Track a Meaningful Treatment Goal

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Translate a client-defined goal into observable indicators and a review plan.

A useful goal connects to a change the client values in daily life. This page supports collaborative planning and review. Its ratings or observations are informal indicators, not validated measures, diagnostic thresholds, or proof of treatment effectiveness.

Start with the life change

Ask what would become possible if therapy helped. Example: "I want to speak during meetings instead of avoiding them." Describe the current pattern using the client's report and relevant observations without inventing a baseline.

Choose a fair indicator

Select a behavior, frequency, duration, or client-defined marker. Include context: attending one meeting may depend on whether meetings were offered. Use an appropriate validated measure separately when clinically indicated and permitted.

Review the meaning of change

Set a date to revisit the goal. Ask whether the indicator still reflects what matters and whether progress came with unwanted costs. Modify the goal, intervention, or supports when evidence suggests a poor fit.

The valued life change in the client's words

Current pattern and the source of that information

Observable indicator and relevant context

Review date and criteria for revising the plan

Separate Facts From Clinical Hypotheses

Clinical practice and supervision | Clinicians | 10 to 15 minutes

Organize available information while making uncertainty and alternative explanations visible.

A formulation is a working explanation that guides inquiry and care. Use this page to distinguish what the client reports, what you directly observed, and what you are considering. Revise the explanation as new information becomes available.

Name the information source

Write "client reports," "partner reports with consent," or "observed in session" where appropriate. Describe behavior before assigning meaning. Silence, for example, could reflect uncertainty, processing time, fear, fatigue, or several other experiences.

Consider context and alternatives

Include strengths, supports, cultural meaning, health, environment, and current demands. Identify what supports each hypothesis and what would challenge it. Do not present a compelling story as established history.

Use the formulation collaboratively

Ask whether the explanation fits the client's experience and what it misses. Choose a question, assessment, consultation, or intervention that could clarify the picture. Note the limits of the information available today.

Reported information and its source

Direct observations without interpretation

Working hypotheses and plausible alternatives

Missing information and the next step to clarify it

Plan Practice Between Sessions

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Create a small, client-chosen practice task with a realistic review plan.

Between-session practice should serve an agreed treatment goal and fit the client's actual life. Use this page to define the activity together. Declining or changing a task is information about fit, not automatic evidence of resistance.

Connect the practice to purpose

Explain how the activity relates to the client's goal and ask whether the connection makes sense. Choose a brief action, such as trying one request, noting one trigger, or practicing one settling option.

Check feasibility before agreement

Ask about time, privacy, energy, language, resources, and emotional impact. Have the client explain or demonstrate the first step. If the plan feels too large, reduce it or choose an alternative rather than securing reluctant agreement.

Plan a useful review

Decide what to notice, how much to record, and when to revisit it. Include what to do if the exercise increases distress or feels unsafe: stop and use the agreed support plan. Review barriers without blame at the next meeting.

Agreed goal and the practice chosen by the client

When, where, and the first step

Likely barrier and a smaller alternative

What to notice and when we will review

Notice Activation Before You Respond

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Reflect on a clinician reaction and identify a deliberate response or consultation need.

Use this page after a challenging clinical or supervisory moment. Personal activation is a cue for reflection, not a diagnosis or proof of wrongdoing. Keep identifying client information out of materials used outside approved clinical systems.

Describe the moment

Record the event, your body or emotional response, and the action you felt pulled to take. Separate your experience from assumptions about the other person. Example: noticing urgency does not establish that the client was manipulating the session.

Ask what may be influencing you

Consider personal resonance, workload, organizational pressure, cultural assumptions, power, or an unmet professional need. You do not need to disclose personal trauma to examine how your response might affect care.

Choose the professional next step

Identify a pause, repair, boundary, consultation, workload discussion, or further assessment. Ask what the client or supervisee needs from you now. Bring uncertainty to an appropriate supervisor rather than relying only on private reflection.

The event and my immediate internal response

The action I felt pulled toward and its possible impact

Context or assumptions I need to examine

My deliberate response and consultation plan

Ask About Context and Meaning

Clinical practice and supervision | Clinicians | 10 to 15 minutes

Explore the client's interpretation of a concern and relevant social context.

Invite the client to define what matters in their experience. Identity, relationships, community, faith, disability, work, and systems can shape a problem and possible support. Ask with curiosity without requiring the client to educate you about an entire group.

Begin with the client's explanation

Ask: "What do you call this concern? What do you think contributes to it? What do people important to you understand differently?" Leave room for uncertainty and for more than one explanation.

Explore resources and barriers

Ask about belonging, responsibilities, discrimination, financial pressure, access, and support when relevant. Notice both individual coping and changes needed in the environment. Do not turn structural harm into a personal thinking error.

Check your own interpretation

Offer a tentative summary and invite correction: "What have I missed or assumed?" Discuss whether the proposed intervention fits the client's values and circumstances. Identify knowledge you need to seek independently or through consultation.

The client's language and explanation of the concern

Relevant relationships, identities, resources, and pressures

My assumptions or gaps in understanding

How the treatment plan will respond to this context

Write a Clinically Useful Note

Clinical practice and supervision | Clinicians | 10 to 15 minutes

Support accurate notes that connect the session to care without inventing observations.

A useful clinical note explains what occurred, why the work was relevant, and what happens next. Follow the actual documentation requirements of your setting and payer where applicable. This handout is a writing aid, not a legal or billing standard.

Distinguish information types

Attribute client and collateral reports. Describe relevant observations precisely. Mark clinical interpretations as interpretations, and state important uncertainty. Do not convert an unasked question into a denial or a copied template phrase into an observed fact.

Connect intervention and response

Identify what you actually did and its connection to the treatment goal. Describe the client's response using meaningful behavior or their account. "Practiced one request and revised it after feedback" is more informative than a list of modalities without a documented activity.

Document decisions and follow-up

Record significant changes, indicated assessment, consultation, referrals, and the agreed plan. If risk was assessed, document the relevant findings and actions through your clinical process; a single generic phrase is not a substitute.

Use only necessary detail

Include information needed for continuity and accountability. Avoid unnecessary intimate narrative, speculation, stigmatizing labels, or claims of progress unsupported by the session. Review the note for internal consistency before signing.

One documentation habit I will change

Respond When Therapy Misses the Mark

Clinical practice and supervision | Clinicians | 10 to 15 minutes

Invite feedback and respond to a therapy rupture with accountability and choice.

Use when a client says the work felt unhelpful, invalidating, or misattuned, or when you notice a possible change in engagement. Ask about the client's experience without requiring them to reassure you or accept your explanation.

Open the conversation

Clinician: "I noticed I moved quickly into problem solving. I wonder how that landed for you." If the client says, "You did not listen," respond: "Thank you for telling me. What did I miss or move past?" Allow time for the answer.

Acknowledge your part

Clinician: "I interrupted before I understood what you needed. I can see how that made this feel less useful." Be specific about your action. Avoid adding a defensive explanation or asking the client to confirm that you meant well.

Negotiate the next step

Clinician: "Would it help to return to that moment, change the focus, or discuss a different approach?" If the client does not know: "We can slow down. You do not have to solve this for me." If they request a change of clinician, discuss options respectfully.

Check whether the repair fits

Clinician: "What should I do differently next time, and how can we notice if this happens again?" Ask again later rather than treating one conversation as proof that the rupture is resolved. Seek supervision when the pattern continues.

My specific contribution and the change to follow up

Structure a Collaborative Therapy Session

Clinical practice and supervision | Clinicians | 50 minutes

Organize a flexible session around the client's priorities, practice, and feedback.

Use this structure within an individualized treatment plan and your scope of competence. The sequence is a guide, not a protocol for every presentation. Urgent concerns, risk assessment, or a rupture may appropriately change the entire session.

Minutes 0 to 8

Check changes since the last meeting, current needs, and safety as clinically indicated. Use direct follow-up rather than assuming absence of risk from a general mood check.

Minutes 8 to 15

Use CLN01 to agree on a focus. Review the relevant goal with CLN02 and ask whether it still reflects the client's priorities. Discuss a needed change openly.

Minutes 15 to 25

Explore one recent example. Separate reported information, observation, and interpretation using CLN03. Ask about context and alternative explanations before selecting an intervention.

Minutes 25 to 40

Introduce and rehearse one suitable intervention with consent. Explain its purpose, invite modification, and observe the client's response. Stop or change course if it is unhelpful or overwhelming.

Minutes 40 to 46

Use CLN04 to choose optional practice or another next step. Check feasibility, privacy, access, and support needs. Ask the client to describe the plan in their own words.

Minutes 46 to 50

Invite feedback about what helped and what missed the mark. Clarify unresolved needs, follow-up, and relevant support pathways. Document the actual work and decisions.

Session outcome, client feedback, and agreed next step

Reflect Before the Next Session

Clinical practice and supervision | Clinicians | 10 to 15 minutes

Review a clinical encounter and identify one learning or consultation priority.

Choose one encounter and reflect without including unnecessary identifying information. The purpose is to improve your next clinical decision. This page supports supervision and learning; it is not a substitute for the clinical record, consultation, or required action.

Look at both the work and the context

Notice the client's goals, your intervention, their response, and the conditions around the session. Consider time pressure, access, organizational expectations, and your own assumptions. Avoid judging the entire encounter by whether the client agreed with you.

Make uncertainty useful

Identify one point you do not yet understand. Ask what information or perspective could change your interpretation. A question taken to consultation is often more useful than a confident explanation built from limited evidence.

Turn reflection into action

Choose a specific adjustment: ask a missed question, revisit consent, repair a moment, seek training, or consult about a decision. Set a time to follow through. Address urgent safety or ethical concerns promptly through the appropriate process.

Where did the client's priorities guide my choices?

What response or feedback challenges my assumptions?

What uncertainty belongs in consultation or supervision?

What will I do differently and when will I follow through?

Clinical foundations

These sources inform the general clinical concepts. The original resources in this collection are not validated instruments or publisher-endorsed protocols. Links checked October 26, 2026.

S01 Psychotherapies

National Institute of Mental Health | n.d.

General psychotherapy principles, collaborative goals, skills practice, and choosing care.

<https://www.nimh.nih.gov/health/topics/psychotherapies>

S05 TIP 57 Trauma Informed Care in Behavioral Health Services

Substance Abuse and Mental Health Services Administration | 2014

Trauma informed principles, cultural context, choice, collaboration, and prevention of retraumatization.

<https://library.samhsa.gov/product/tip-57-trauma-informed-care-behavioral-health-services/sma14-4816>