

Reading Your Patients

Deep Dive Modules · Clinical Strength

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Part 1 · Overview

Reading Your Patients

A Clinical Observation Intensive for SUD Clinicians & Staff

Body Language · Omission · Deflection · Needs vs. Wants · Clinical Cues

The Clinical Lens

Father Martin taught that the best counselors see what the patient cannot yet see about themselves — and hold that awareness with compassion. This intensive sharpens the clinical skills that make that vision possible: reading the unspoken, decoding the deflection, and discerning what patients actually need beneath what they say they want.

Overall Progress

0

Sections Done

Reading Sections

Self-Assessment

Worksheets & Exercises

Clinical Pairing Note

This intensive pairs naturally with the Emotional Constipation intensive, the Building Recovery Support Network intensive, and the Group Leadership Style Assessment. It draws on research in non-verbal communication, motivational interviewing micro-skills, affect labeling (Lieberman), Polyvagal Theory applied to therapeutic attunement, and Father Martin's observational teaching methodology.

The Recovery Files · Embrace, Empower & Evolve · Recovery Made Simple

www.TheRecoveryFiles.com · Sheamus Moran - Founder of The Recovery Files

Part 2 · The Art of Clinical Observation

The Art of Clinical Observation

Every patient who walks into your office, group room, or treatment facility is communicating on multiple channels simultaneously. They are speaking words — and those words carry meaning. But beneath the words, around the words, and often in direct contradiction to the words, an entire symphony of communication is playing. Your ability to hear that symphony — to read the patient, not just listen to the patient — is what separates competent clinical work from exceptional clinical work.

Clinical observation is not intuition, though intuition plays a role. It is a disciplined, trainable skill set that involves watching with purpose, listening with depth, tracking patterns over time, and developing the professional courage to name what you see even when the patient would prefer you didn't notice.

Father Martin used to say that the best counselors are the ones who can see what the patient cannot yet see about themselves — and hold that awareness with compassion until the patient is ready to look. This is not about catching people in lies, playing detective, or demonstrating clinical superiority. It is about gathering the complete clinical picture so that your interventions are based on reality rather than the curated narrative the patient has learned to present.

The stakes of clinical observation are real. A patient who presents as engaged and compliant while internally spiraling toward relapse is a patient whose clinician missed the cues. A patient who uses charm, humor, and people-pleasing to avoid ever being challenged is a patient whose treatment stays at the surface. A patient whose body screams distress while their mouth says "everything's great" is a patient who has not been truly seen — and being truly seen may be the single most therapeutic experience recovery can offer.

This intensive is designed to sharpen your observational skills across every channel of patient communication: body language, vocal tone, behavioral patterns, what is said, what is not said, and the clinical significance of deflection, humor, sarcasm, and distraction. It will also train you to distinguish between what patients want and what patients need — a distinction that defines the quality of your clinical judgment. The goal is not to turn you into a human lie detector. The goal is to make you a clinician who sees the whole patient — not just the version they're comfortable showing you.

Reflection Questions

1. When you think about your current clinical observation skills, where do you feel most confident and where do you feel you have blind spots?

2. Describe a clinical situation where you sensed something was "off" with a patient but couldn't articulate what you were seeing. What happened?

3. How comfortable are you naming what you observe? Do you tend to notice incongruence silently, or do you bring it into the therapeutic conversation?

4. Think of a patient who "fooled" you — whose presentation didn't match their reality. What did you miss, and what would you watch for now?

5. How does the concept of "reading the whole patient, not just the version they show you" apply to your current caseload? Who might you be seeing incompletely?

Part 3 • The Body Speaks First: Non-Verbal Communication

The Body Speaks First: Non-Verbal Communication

Research in communication science consistently demonstrates that between 55% and 93% of emotional meaning is transmitted non-verbally. The exact percentage is debated; what is not debated is that the body communicates faster, more honestly, and more continuously than language. When a patient's words say one thing and their body says another, clinical wisdom says: believe the body.

Non-verbal communication in the clinical setting includes several distinct channels. Kinesics encompasses body movements, gestures, posture, and facial expressions. A patient who leans back, crosses their arms, and angles their body toward the door is communicating something very different from a patient who leans forward, maintains open posture, and orients directly toward you. Facial micro-expressions — flashes of emotion lasting less than half a second — are particularly valuable because they are involuntary.

Proxemics — the use of physical space — is often overlooked. Where does the patient sit when given a choice? Do they position themselves near the exit? Do they create physical barriers (bags, cushions, jackets) between themselves and you? In group settings, who do they sit near and who do they avoid?

Paralinguistics — the vocal qualities beyond words — carry enormous clinical information. Pace of speech changes with emotional activation: anxious patients speak faster, depressed patients slower, patients approaching a painful topic often slow down or speed up suddenly.

The critical clinical skill is not just observing these non-verbal channels but tracking the timing of shifts. The question is not just "does this patient fidget?" but "when did the fidgeting start?" Non-verbal behavior gains meaning through context and timing.

One essential caveat: cultural competence is non-negotiable in non-verbal interpretation. Eye contact norms vary dramatically across cultures. Personal space preferences differ. A patient who avoids eye contact may be showing respect, not evasion. The clinician's task is observation first, interpretation second, and cultural humility always.

Reflection Questions

1. Which channel of non-verbal communication do you naturally pay the most attention to? Which do you tend to overlook?

2. Think of a recent session. Without reviewing notes, can you recall the patient's body language? What does your recall (or lack of it) tell you about your observation habits?

3. Describe a time when a patient's non-verbal communication gave you critical information that their words alone did not provide. How did you use it?

4. How aware are you of cultural differences in non-verbal expression among your patient population? Where might you need to expand your cultural competence?

5. How does your own non-verbal behavior affect your patients? What message does your body send during sessions?

Part 4 · The Language of Omission: What Hasn't Been Said

The Language of Omission: What Hasn't Been Said

What a patient does not say is often more clinically significant than what they do say. Omission is one of the most sophisticated and least-addressed forms of patient communication, and reading it requires the clinician to hold a mental map of what a complete, honest clinical picture would include — and then notice what's missing.

Topical avoidance is the most common: the patient who discusses every life area except their marriage, the patient who talks freely about their drug use but never mentions alcohol. The absent topic is the diagnostic finding.

Emotional omission is subtler. This is the patient who narrates objectively devastating experiences with no affect — describing the loss of their children with the emotional tone of someone reading a grocery list. This dissociation between content and emotion is itself a clinical finding.

Temporal omission is particularly relevant in SUD treatment. This is the patient who can describe their life story but skips entire years or eras — usually the periods of heaviest use. "After college I got married, and then I ended up here" erases a decade.

Relational omission occurs when patients describe their social world with strategic absences. They mention their sponsor but never their dealer. The missing characters in the patient's narrative are often the ones exerting the most influence on their current behavior.

Perhaps the most important form of omission is self-omission — when the patient talks about everything and everyone except themselves. This externalization pattern is clinically significant because recovery fundamentally requires the patient to shift from "things are happening to me" to "I am making choices and experiencing consequences."

Reading omission requires two practices. First, ask yourself after each interaction: "What didn't come up today?" Second, cultivate the clinical courage to gently name the absence.

Reflection Questions

1. Think of a patient on your current caseload. What topics have they never raised — and what might that avoidance tell you clinically?

2. How often do you track emotional omission — the patient who narrates pain without affect? How do you typically respond when you notice it?

3. Identify a patient who has significant "time gaps" in their history. What might those missing periods contain?

4. How comfortable are you naming omission to patients? What makes it difficult, and what would make it easier?

5. Reflect on your own clinical omissions: are there topics you tend to avoid raising with patients? What is that avoidance about?

Part 5 · Humor, Sarcasm & The Deflection Arsenal

Humor, Sarcasm & The Deflection Arsenal

Humor is one of the most powerful defense mechanisms in the clinical setting — powerful because it works on the clinician as well as the patient. When a patient makes the room laugh, something changes in the therapeutic dynamic. The tension drops. The clinician relaxes. The painful moment passes. And everyone moves on without ever addressing what was underneath the joke.

Not all humor in treatment is deflection. Genuine humor — the ability to laugh at the absurdity of addiction, to find lightness in recovery — is healthy and should be welcomed. The clinical question is not "is the patient being funny?" but "what is the humor doing?" Is it creating connection, or is it preventing connection?

Deflective humor has identifiable characteristics. It almost always comes at a specific moment — usually when the conversation approaches emotional depth. The timing reveals the function.

Sarcasm is humor's sharper sibling, and in the clinical setting it serves as armor with teeth. The sarcastic patient is communicating: "I am not safe enough to be earnest." Clinical sarcasm directed at the treatment process or recovery concepts is almost always a marker of unprocessed pain.

The clinician's response to deflective humor is critical. The worst response is to laugh along and move on. The best response generally involves pausing, not laughing, and gently naming what just happened: "That was funny. And I also noticed you were about to say something real before the joke came. Do you want to go back to it?"

Beyond humor and sarcasm, patients deploy an entire arsenal of deflection strategies: storytelling that never arrives at emotional honesty, intellectualization, and the particularly insidious deflection of helping others — the patient who spends every group session offering advice to others while never sitting in their own vulnerability.

Recognizing when you, as the clinician, are colluding with the deflection because it's more comfortable for you too — that is step three.

Reflection Questions

1. Think of the funniest patient you've worked with. Looking back, how much of their humor was genuine and how much was deflection? Did you address it?

2. How do you typically respond when a patient uses sarcasm to deflect from a clinical conversation?

3. Identify a patient who uses storytelling, intellectualization, or "helping others" as deflection. What is underneath their chosen strategy?

4. How comfortable are you not laughing when a patient makes a deflative joke? What would it take to sit in that silence?

5. Be honest: are there times when you have colluded with a patient's deflection because it was more comfortable for you?

Part 6 • Needs vs. Wants: The Heart of Clinical Discernment

Needs vs. Wants: The Heart of Clinical Discernment

Every patient in treatment has wants. They want to feel better. They want the consequences to stop. They want to go home. But they are not the same thing as needs — and the ability to discern the difference is the core of clinical judgment in SUD treatment.

A patient wants to leave treatment early because they feel better. What they need is to stay long enough for the neurological and behavioral changes to stabilize. A patient wants their family brought into therapy immediately so they can demonstrate how much they've changed. What they need is to do enough individual work first so that the family session doesn't become a performance.

This is not to say that patient wants are always wrong or that clinicians always know best. Sometimes what the patient wants and what they need are the same thing. The discernment lies in knowing the difference — and it requires reading the patient's full communication, not just their verbal requests.

One key indicator is the emotional energy behind the request. When a patient advocates for something they need, there is usually a quality of groundedness and self-awareness. When a patient advocates for something they want but frames it as a need, there is often urgency, escalation, and an unwillingness to explore the request therapeutically.

Another indicator is the relationship between the request and the patient's established clinical patterns. The patient whose primary defense mechanism is avoidance now wants to skip the family therapy module. The request may sound reasonable in isolation, but when viewed through the lens of the patient's clinical history, it reveals a familiar pattern.

Your job is to hear both the request and what's underneath it. To explore rather than simply grant or deny. To bring the patient into the discernment process itself.

Reflection Questions

1. Describe a recent situation where a patient's want and their clinical need were in conflict. How did you handle it?

2. How do you determine when to honor a patient's stated preference versus overriding it in favor of clinical judgment?

3. Think of a patient who presents their wants in clinical language. How do you see past the presentation to the underlying need?

4. How do you handle the power dynamic inherent in deciding what a patient "needs" versus what they "want"?

5. Reflect honestly: are there times when you've granted a patient's request because it was easier than having the therapeutic conversation?

Part 7 · Clinical Observation Skills Assessment

Clinical Observation Skills Assessment

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

I consciously observe patients' non-verbal behavior before, during, and after sessions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when a patient's words and body language are incongruent

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I pay attention to what patients do NOT say as much as what they do say

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am aware of changes in a patient's presentation from session to session

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I track patterns in when patients become more or less engaged during sessions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice shifts in a patient's energy, posture, or affect in real time

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I observe the physical environment cues patients bring with them (appearance changes, hygiene shifts, new tattoos, weight fluctuation)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I register my own gut reactions and body sensations as clinical data during sessions

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can accurately read the difference between anxiety-based fidgeting and boredom-based restlessness

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice eye contact patterns and understand what sustained, averted, or darting eye contact may indicate

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I pay attention to arm and leg positioning (crossed, open, protective, aggressive) and interpret it clinically

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I observe facial micro-expressions — brief flashes of emotion that contradict the patient's spoken narrative

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice changes in breathing patterns (shallow, held, sighing) as indicators of emotional activation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I am attuned to vocal tone changes — when pitch rises, pace quickens, volume drops, or speech becomes monotone

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I observe proxemics — how patients position themselves in relation to me, the door, and other group members

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice the timing of non-verbal shifts — exactly what topic or question triggered the physical change

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when humor is being used to avoid emotional depth or deflect from a painful topic

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can identify sarcasm as a protective mechanism rather than taking it at face value

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when patients redirect conversations away from substance use toward safer topics

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I track when patients offer excessive detail about irrelevant topics to consume session time

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize "yes-butting" — surface agreement followed by immediate dismissal — as a deflection pattern

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can distinguish between genuine confusion about a question and strategic misunderstanding used to avoid answering

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when patients use intellectualization, abstract philosophizing, or "helping others" talk to avoid their own vulnerability

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize the pattern of offering dramatic but non-therapeutic disclosures to maintain an illusion of openness while hiding what matters most

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can differentiate between what a patient is asking for and what they clinically need

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when requests for schedule changes, roommate switches, or medication adjustments are clinically driven versus avoidance-driven

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when patients advocate for comfort over growth and can address this therapeutically

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I identify when a patient's stated treatment goals are genuine versus performative (for court, family, employer)

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I recognize when "I need to leave treatment" is a flight response versus a legitimate readiness indicator

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I can distinguish between a patient who wants validation and a patient who needs honest confrontation

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I notice when patients request what worked for someone else rather than what their own clinical picture requires

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I track the difference between a patient engaging in treatment activities and a patient actually absorbing and internalizing recovery concepts

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

When I observe incongruence between words and behavior, I address it in a therapeutic manner

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I use what I observe non-verbally to inform my clinical interventions in real time

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I adjust my therapeutic approach based on the cues I am reading — I am not locked into a single style

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I name what I see when appropriate: "I notice you crossed your arms when we started talking about your family"

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I create space for patients to explore their own deflection patterns without shaming them

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I document observed behavioral cues in clinical notes, not just self-reported content

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I use strategic silence — pausing after a deflection rather than immediately filling the space

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

I consult with colleagues when I observe patterns that exceed my clinical experience or cultural competence

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Not at all · Very much

1. Which domain scored highest? What has your career experience taught you about that area of observation?

Your clinical reflection...

2. Which domain scored lowest? What would it take to strengthen that skill set?

Your clinical reflection...

3. Is there a gap between your observation skills and your intervention skills — do you notice more than you act on?

Your clinical reflection...

4. Which specific items did you rate as 1 or 2? These represent your highest-priority development areas.

Your clinical reflection...

5. Based on this assessment, what is the single most important observation skill you want to develop in the next 90 days?

Your clinical reflection...

Scoring guide

Reset all progress? This cannot be undone.

Your Clinical Observation Profile

Higher scores across all five domains indicate stronger clinical observation skills. The gap between your Observational Awareness and Responsive Intervention scores reveals whether you are noticing cues but not acting on them — or whether your observation skills and intervention skills are developing in parallel.

Part 8 · Worksheet 1: Non-Verbal Cue Inventory

Non-Verbal Cue Inventory

Cataloging What the Body Communicates

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

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Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 9 · Worksheet 2: Tone & Inflection Analysis

Tone & Inflection Analysis

Hearing What Words Alone Cannot Tell You

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

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How did you respond, and what would you do differently?

Be specific...

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Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 10 · Worksheet 3: The Omission Detector

The Omission Detector

Finding What's Missing from the Clinical Picture

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

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What was the clinical significance — what did it tell you?

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What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 11 · Worksheet 4: Humor & Sarcasm Decoder

Humor & Sarcasm Decoder

When Laughter Is Armor

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

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Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 12 · Worksheet 5: Needs vs. Wants Clinical Mapping

Needs vs. Wants Clinical Mapping

Discerning What Patients Ask For vs. What They Need

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

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How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

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What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 13 · Worksheet 6: Distraction Pattern Recognition

Distraction Pattern Recognition

When Patients Redirect the Session

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

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How did you respond, and what would you do differently?

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Patient or situation context (use initials):

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What did you observe or experience related to this worksheet's theme?

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How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 14 · Worksheet 7: Clinical Blind Spot Audit

Clinical Blind Spot Audit

Examining What You Tend to Miss — and Why

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

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Patient or situation context (use initials):

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What was the clinical significance — what did it tell you?

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How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 15 · Worksheet 8: Session Observation Log

Session Observation Log

Structured Clinical Observation Practice

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 16 · Worksheet 9: The Unspoken Session Review

The Unspoken Session Review

Reconstructing What Was Really Communicated

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...

Part 17 · Worksheet 10: Clinical Observation Action Plan

Clinical Observation Action Plan

Turning Awareness Into Practice

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

Patient or situation context (use initials):

Be specific...

What did you observe or experience related to this worksheet's theme?

Be specific...

What was the clinical significance — what did it tell you?

Be specific...

How did you respond, and what would you do differently?

Be specific...

1. What is the most important insight you gained from this worksheet?

Clinical reflection...

2. How will you apply this learning in your next clinical session?

Clinical reflection...

3. What support or resources do you need to develop this skill further?

Clinical reflection...
