CLINICAL EFFECTIVENESS INSTITUTE

Position Paper

The Missing Formulation

Formulation, Clinical Reasoning, and the Accountability of the Therapeutic Work

Sarah Ozol Shore, MS

Clinical Trainer · Clinical Effectiveness Institute

sarahozolshore@gmail.com | sarahozolshore.com

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The Clinical Problem

A therapist may have a detailed understanding of a client's clinical history and current presentation, including the circumstances in which the client struggles and the goals that brought the client to therapy. The therapist may also understand the client's subjective experience with considerable precision and communicate that understanding effectively in the therapeutic relationship. The client may feel accurately understood. The therapist may be empathic, clinically experienced, and highly skilled in the relational work of therapy.

Despite those specific skills, the therapist may not be able to answer a basic clinical question: What is producing and maintaining the difficulty the client has brought to therapy, and why does it take the form it does? Formulation is the clinician's attempt to answer that question: to move from knowing the facts of the case to explaining how they fit together, what keeps the problem going, and what that means for the clinical work. That is a different clinical task from assessment, diagnosis, or history-taking.

Case formulation, or case conceptualization, is formally recognized as a core professional competence across psychology and counseling. The American Psychological Association's evidence-based practice policy places *systematic case formulation* inside clinical expertise itself, alongside assessment, diagnostic judgment, treatment planning, and progress monitoring (American Psychological Association, Presidential Task Force on Evidence-Based Practice in Psychology, 2006). Counselor education carries the same expectation in different language: current accreditation standards for counselor training require both critical thinking and reasoning strategies for clinical judgment and case conceptualization skills using a variety of models and approaches, and the standards that preceded them required it as well (Council for Accreditation of Counseling and Related Educational Programs, 2024).

The central problem is that formulation is recognized as a core clinical competence but is not built into ordinary clinical practice in a way that requires the clinician to develop, state, and revise an explanatory account of the client's difficulty. A clinician can assess, establish a therapeutic relationship, select interventions, and continue treatment while the explanatory account guiding the

work remains implicit or undeveloped. Therapy can therefore proceed without a clear statement of what the clinician believes is producing and maintaining the client's difficulty, why the chosen approach addresses it, or what course of response would call that understanding into question. A recent overview of the field describes the same problem from another direction: broad cross-theoretical agreement that formulation is a core clinical skill exists alongside a limited empirical literature, substantial variation in how formulation is constructed, and evidence that the skill is difficult to acquire and unevenly developed among clinicians (Eells, 2025).

The Clinical Task of Formulation

A formulation is a provisional explanatory account of what appears to produce and maintain the client's difficulty and what that understanding implies for the clinical work. Its provisional status means that the clinician holds the explanation open to revision in response to the client, clinical observation, and what occurs in therapy. Its explanatory function requires the clinician to connect relevant information into an account of how the difficulty operates and what sustains it.

Clinical Task	Function	Example
Biopsychosocial Assessment	Gathers and organizes relevant information across biological, psychological, and social domains.	Childhood instability; chronic anxiety; disrupted sleep; work conflict; financial stress; repeated responsibility-taking for others.
Diagnosis	Classifies the presentation according to a recognized diagnostic category based on symptoms and criteria.	The client meets criteria for generalized anxiety disorder.
Formulation	Integrates relevant information into a provisional explanation of what produces and maintains the difficulty and what that implies for the clinical work.	When the client anticipates that another person will not manage a situation adequately, she becomes urgent and assumes responsibility. Taking control reduces her anxiety in the short term, reinforcing the response, while repeated overfunctioning contributes to the exhaustion and resentment that brought her to therapy.

These are different clinical tasks. The biopsychosocial assessment establishes what is present in the client's history, circumstances, functioning, and current experience. Diagnosis places part of that presentation within a clinical category. Formulation connects selected information into an explanatory account of how the difficulty operates and what sustains it. The same assessment data and diagnosis can therefore support very different formulations in different clients. Treatment

planning serves a different function. A treatment plan specifies goals and interventions; formulation provides the explanatory account that makes those choices clinically intelligible.

A useful formulation identifies the process that appears to produce and maintain the client's difficulty, the conditions under which that process operates, and the observations that would support or challenge the account. Different theoretical models may explain that process differently. A trans-theoretical definition is necessary because the field has not established a single agreed-upon model of formulation. In a recent Delphi study, practicing clinical psychologists reached agreement on some components of formulation but continued to disagree about others (Thrower et al., 2024). The Clinical Effectiveness Institute therefore defines formulation by its clinical function: an individualized, provisional explanation of the client's difficulty that guides the clinical work and can be revised in response to what happens in therapy.

> *The Clinical Effectiveness Institute takes the position that clinicians have a professional responsibility to maintain an explicit, provisional, revisable explanatory account of the problems they are treating, and that this responsibility does not depend on the field first resolving its disagreements about method.*

Experiential Understanding and Psychological Explanation

A therapist can understand a client's experience extremely well without yet having an explanatory account capable of organizing the clinical work. Experiential understanding concerns how the client experiences a particular event: what it meant, how it felt, and why the response made sense from the client's point of view. Formulation requires a different kind of understanding: an account of the psychological process operating across events.

A therapist may understand why a client felt devastated by a friend's canceled plans, a colleague's brief email, and a partner's request for an evening alone. That is an understanding of the client's experience in each episode. Understanding the underlying psychology requires identifying what is common across those episodes and how that recurring process contributes to the client's difficulty.

Formulating Current Psychology Before Developmental Origin

A clinician can begin formulating a client's difficulty before knowing how the underlying psychological organization developed. The first task is to identify how the difficulty operates in the present: the conditions under which it emerges, the responses that recur, and the consequences that appear to keep the sequence in place.

Consider a composite client who repeatedly anticipates that other people will not manage a situation adequately. She quickly experiences urgency, assumes responsibility, and takes control. Taking over reduces her immediate uncertainty, but the pattern repeatedly leaves her exhausted and resentful. The same sequence appears at work, with her adult children, and in close friendships.

At this point, the clinician can identify a recurring psychological organization and connect it to the problem the client has brought to therapy:

> *The client's expectation that another person will not manage adequately appears to activate urgency and responsibility-taking.*

The developmental origin of the pattern is a separate clinical question. Later information about the client's history may explain how this psychological organization developed and may deepen or alter the formulation. The clinician does not need that explanation in order to begin understanding how the difficulty operates and is maintained in the present.

From Description Toward Explanation

Clinical work moves through distinct levels of understanding and action. Assessment establishes the relevant facts of the case. Recognition of recurring psychological organization identifies how the client's difficulty repeatedly takes shape. Formulation explains how that organization contributes to producing or maintaining the difficulty. Treatment planning then translates that explanation into the specific focus, priorities, and interventions of the clinical work. A formulation is clinically useful to the extent that it is specific enough to generate expectations and to be revised in response to what happens.

In contemporary practice, treatment planning can occur without that explanatory step. Goals and interventions can be selected from the diagnosis, presenting complaint, standardized templates, or familiar modality conventions. A treatment plan derived from an explicit formulation would look substantially different: its goals, sequencing, and interventions would be traceable to the clinician's explanation of what is maintaining the client's difficulty.

Research on case formulation in cognitive therapy, for example, supports the distinction between describing a case and explaining it. When practitioners were asked to formulate the same case, they showed considerably greater agreement about descriptive information than about the inferences required to explain the client's difficulties, and only 44 percent of the formulations met the study's threshold for adequate quality (Kuyken et al., 2005). The findings show that gathering and organizing clinical information does not, by itself, produce an adequate explanatory formulation. Two decades later, the field still recognizes formulation as essential while continuing to struggle with its reliable use in practice (Eells, 2025).

A related study asked expert, experienced, and novice cognitive-behavioral and psychodynamic therapists to produce case formulations in response to standardized clinical vignettes (Eells et al., 2005). Expert therapists produced formulations that were significantly more comprehensive, elaborated, complex, and systematic than those of experienced and novice therapists, with medium-to-large effect sizes, and linked their treatment plans more closely to the formulations they had constructed. The finding is important because it connects the quality of the explanatory formulation to the organization of the treatment plan.

Consider the earlier example of the client who becomes urgent and assumes responsibility when she expects another person to handle a situation poorly. If that expectation is part of what triggers the pattern, the clinician should see greater urgency and responsibility-taking when the client anticipates that another person will not manage adequately than when she expects the other person to manage competently. If the client becomes equally urgent and takes over in both situations, the proposed trigger has not held up. The clinician can no longer explain the pattern by saying that it is activated by the client's expectation of others' inadequacy. That element of the formulation must be revised. This is the practical meaning of testability in formulation: the clinician states the proposed relationship between a psychological process and the client's difficulty clearly enough that ordinary clinical observations can show where the explanation is wrong.

Clinical Work Without Formulation

A therapist may validate, teach coping strategies, provide psychoeducation, process trauma, teach mindfulness, or offer an interpretation, and any of these interventions may genuinely help. The rationale for selecting a particular intervention may come from the presenting symptom, the clinician's preferred modality, the client's request, prior success with similar cases, or evidence supporting the intervention for the diagnosis. Each can inform sound clinical judgment. The separate clinical task is explaining what appears to be producing and maintaining the client's difficulty and why the selected intervention addresses that process.

A modality provides a general account of how problems develop or how change occurs; formulation determines whether that account explains the psychological process operating. Formulation therefore comes before allegiance. Relational, behavioral, interpretive, and somatic approaches each propose mechanisms through which change may occur. Formulation provides the basis for deciding which of those mechanisms is relevant, what it is intended to address, and why it belongs at that point in the clinical work.

The same distinction applies to eclectic or integrative practice. A clinician may have a broad repertoire and respond sensibly to what appears in the therapy room: grounding in response to distress, exposure in response to avoidance, interpretation in response to a recurring relational sequence. Formulation integrates those choices within an explanation of what is producing and maintaining the difficulty. It gives the clinician a reason for selecting one response rather than another, for establishing priorities among them, and for knowing what the clinical work is intended to change.

Clinical Change as Evidence

Formulation allows the course of therapy to test the clinician's reasoning. When the client changes as the clinician expected, the observed change provides some support for the clinician's explanation

of the difficulty and clinical approach selected on the basis of that explanation. When the expected change does not occur, the lack of change should prompt reconsideration of the clinician's explanation, the judgment that the chosen intervention addresses the relevant process, or the way the intervention is being used.

Some research associates stronger formulation competence with better clinical process and outcomes, including greater symptom reduction and lower rates of premature dropout, although the evidence remains limited (Eells, 2025). Whether formulation improves outcomes is a separate empirical question from whether it makes clinical reasoning more accountable. Formulation makes the clinician's understanding and treatment rationale explicit enough to be examined when therapy does not proceed as expected.

An explicit formulation creates a traceable sequence. The clinician proposes what is producing or maintaining the client's difficulty, selects a way of working because it follows from that explanation, and observes whether the expected change occurs. The course of therapy can then support or challenge the clinician's original explanation. Persons's case formulation approach makes this process explicit:

> *The clinician monitors and revises the formulation throughout treatment, and a lack of expected change becomes a reason to reconsider the formulation, including whether a different explanation would suggest a more effective way of working (Persons, 2008).*

When a client does not improve, the clinician may conclude that the client needs more time, more safety, more trust, or greater readiness before change can occur. Any of those conclusions may be correct when the clinician can specify what evidence supports the conclusion, what change should follow if it is correct, and what observations would require reconsideration. A problem arises when continued lack of improvement is used to support the same conclusion indefinitely. If another three months without change simply leads to the judgment that the client needs three more months, the fact that change has not occurred does not register as a reason to reconsider the clinician's understanding or approach. A clinically useful formulation makes it possible for a lack of expected change to challenge the clinician's explanation. When the change predicted by the formulation does not occur, the clinician has reason to reconsider what is maintaining the client's difficulty and whether the chosen way of working addresses it.

Formulation as a Provisional Clinical Responsibility

Formulation carries real risks when the clinician treats an explanatory account as established fact rather than as a working hypothesis. A formulation may reflect the clinician's theoretical commitments more strongly than the client's actual psychological organization. It may pathologize ordinary variation, override the client's account of experience, interpret a realistic response to social circumstances as an intrapsychic problem, or become a coherent explanation that the clinician continues to favor despite contradictory evidence.

The appropriate safeguard is disciplined provisionality. The clinician develops an explanatory account, makes the reasoning transparent enough to be discussed with the client, remains attentive to disagreement and new information, and revises the formulation when the clinical evidence warrants revision. Professional humility requires the clinician to remain open to being wrong while still taking responsibility for developing an explanation of what appears to be producing and maintaining the client's difficulty.

Therapeutic change can occur without an explicit formulation; the professional function of formulation is not to make change possible, but to make the clinician's understanding and rationale for the clinical work explicit, examinable, and revisable. Formulation develops alongside the clinical work. Persons's case formulation approach treats the formulation as a working hypothesis that is continually tested against what occurs in treatment (Persons, 2008). Early interventions, the client's responses to them, and new information that emerges in therapy can all refine or alter the clinician's formulation.

A Minimum Standard for Clinical Formulation

A clinician working with a client should be able to state, provisionally, what appears to be producing or maintaining the client's difficulty, what observations support that explanation, and what the explanation implies for the clinical work. The clinician should also be able to state what changes would be expected if the formulation is accurate and what observations would require the formulation to be reconsidered. This standard does not require a complete account of the client. It requires an explicit, revisable account sufficient to guide clinical reasoning.

The formulation may remain incomplete, change substantially over time, or differ from the formulation another clinician would construct from a different theoretical tradition or even within the same one. The clinician's choices about focus, sequencing, and intervention should nevertheless be traceable to the clinician's current understanding of the problem. That connection makes it possible to evaluate not only whether the client changed, but whether the reasoning that guided the clinical work continues to make sense in light of what has happened. The clinician owes the client disciplined clinical thought. Formulation makes the clinician's reasoning accountable to what happens in therapy.

The clinician's responsibility for formulation is ongoing. The clinician develops a provisional explanation, uses that explanation to guide the work, compares the expected course with what actually occurs, and revises the formulation when the clinical evidence requires revision. Each additional session can sharpen, test, or change the clinician's understanding of what is happening and what the clinical work needs to address. That is what gives a client reason to believe that telling the therapist more is actually leading somewhere.

About the Clinical Effectiveness Institute

The Clinical Effectiveness Institute trains mental health clinicians and psychotherapists to practice with greater clinical accountability, on the conviction that effective work requires more than technique, empathy, or theoretical allegiance. Ethical practice requires clinical effectiveness.

This paper describes a specific and common gap in that accountability: the frequent absence of an explicit, individualized formulation connecting what a clinician believes is happening for a client to what the clinician does about it. Closing that gap requires clinicians to practice formulation directly, on real and representative cases, until the reasoning described here becomes an active habit of clinical thought rather than a competency named once in graduate training and rarely revisited.

The Institute develops formulation training through a sequence of offerings built for that purpose. A monthly online seminar, Why Good Interventions Fail, introduces the reasoning problem described in this paper to a general clinical audience. Live training builds on that foundation with structured practice in formulation itself, walking clinicians through the cognitive operations of connecting assessment to explanation across contrasting and longitudinal cases. The mission of the institute is to make the professional responsibility described here something a clinician can actually carry out, session by session, with the client in front of him or her.

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