CLINICAL EFFECTIVENESS INSTITUTE

Position Paper

Making the Implicit Explicit

Teaching the Reasoning Embedded in Clinical Practice

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> **Position**
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> *Psychotherapy practice requires clinicians to assess, arrive at an understanding of what is occurring, intervene, and evaluate what follows. Each of these functions depends on judgment. Clinicians must decide what information matters, what the available evidence supports, what remains uncertain, what a clinical response is intended to accomplish, and whether what happens next supports or challenges the original understanding.*
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> *The Clinical Effectiveness Institute holds that the reasoning embedded within assessment, clinical understanding (including diagnosis and formulation where relevant), intervention, and reassessment should be made explicit enough to become an object of psychotherapy education. Clinicians should be taught the content and procedures associated with these functions, as well as how to examine the thinking by which clinical information becomes clinical action.*
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> *Making the implicit explicit means rendering that reasoning visible enough to teach, question, practice, supervise, and revise.*

Introduction

Psychotherapy is taught through several distinct professional pathways, each with its own educational standards, competencies, and requirements for supervised practice. Across these pathways, clinicians are taught forms of assessment, diagnosis or case conceptualization, intervention, and evaluation of clinical work, though the terminology, emphasis, depth, and organization of this preparation vary considerably.

These functions can appear deceptively straightforward when named in the abstract. Assessment can sound like gathering information. Diagnosis can sound like identifying a syndrome. Formulation can sound like organizing a case. Intervention can sound like selecting and delivering a technique. Evaluation can sound like determining whether treatment is working.

In practice, each of these functions involves more than procedure.

Assessment requires the clinician to decide what information is relevant, what is missing, what deserves further inquiry, and what conclusions would be premature. Diagnosis and formulation require judgments about what the available information means, how different observations relate to one another, what competing explanations remain plausible, and how certain any conclusion should be. Intervention requires the clinician to determine what problem is being addressed, what change is being sought, why a particular response follows from the current understanding of the case, and what would count as evidence that the response was useful. Reassessment requires the clinician to interpret what happened next and decide whether the original understanding should be strengthened, modified, or abandoned.

The reasoning involved in these functions is often less visible than the functions themselves.

A trainee may learn the criteria for a diagnosis, apart from being shown how an experienced clinician weighs ambiguous or contradictory evidence. A clinician may learn how to deliver an intervention, apart from learning how to justify why that intervention belongs in this case. A supervisor may tell a trainee to slow down, become more direct, attend to the alliance, or stop reinforcing avoidance, leaving unstated the observations and inferences that led to that recommendation.

Professional training already addresses clinical reasoning through language written into accreditation standards. CACREP's 2024 standards require critical thinking and reasoning strategies for clinical judgment and case conceptualization (Council for Accreditation of Counseling and Related Educational Programs, 2024). The Council on Social Work Education expects social workers to critically evaluate and apply knowledge during assessment (Council on Social Work Education, 2022). The American Psychological Association requires demonstrated competencies in assessment and intervention (American Psychological Association, 2015). Clinical reasoning is therefore recognized within professional training.

What remains less settled is how consistently the reasoning underlying assessment, clinical understanding, and intervention is made visible as a process trainees are expected to articulate, examine, practice, and revise. The pedagogical problem, more precisely, is that this reasoning can remain underarticulated even where standards already name its importance.

The Clinical Effectiveness Institute holds that this reasoning should be made explicit enough to examine.

This is fundamentally a position about clinical effectiveness. Effective psychotherapy depends on more than whether a clinician knows relevant concepts or can competently perform a technique. It also depends on whether the clinician has assessed the case soundly, drawn warranted conclusions, selected an intervention for a defensible reason, and revised the clinical understanding when the evidence changes. If the thinking by which these judgments are made remains largely invisible, an essential part of clinical competence remains difficult to teach and difficult to correct.

Clinical Practice Already Contains the Reasoning

Psychotherapy already requires assessment, clinical understanding, intervention, and ongoing evaluation. Reasoning is contained within each of them. The problem becomes clearer when each function is unpacked.

Assessment

Assessment is more than acquiring information. Two clinicians can hear the same history and leave with different understandings because they have attended to different facts, assigned different

significance to those facts, asked different follow-up questions, and made different assumptions about what requires explanation. Clinical assessment therefore includes judgments such as:

- What is actually known?
- What was directly observed?
- What comes from the client's report?
- What is inference?
- Which details appear central?
- Which may be incidental?
- What information is still missing?
- What should be investigated further?
- What explanations should remain open?

The quality of an assessment depends more on how information has been selected, differentiated, and interpreted than on how much has been collected.

Clinical Understanding

Clinical understanding, encompassing diagnosis and formulation where each applies, requires a further level of reasoning. A diagnosis asks whether the available information sufficiently supports a particular classification. A formulation asks how the clinically important features of the case fit together and what might explain why this person is experiencing this difficulty in this form.

Diagnosis requires more than naming a condition and formulation requires more than summarizing a case history. The clinician must decide which observations support a conclusion and which fall short, what competing explanations remain possible, how much confidence the evidence warrants, and what remains unknown.

Formulation adds another task: constructing an explanatory account rather than merely a descriptive one. The clinician must determine what requires explanation, identify recurring patterns, distinguish observation from interpretation, propose relationships among the available facts, consider possible mechanisms, and develop an account that can guide clinical work while remaining open to revision.

Intervention

Intervention is similarly more than knowing or performing a technique. The clinician must determine what the intervention is intended to accomplish, why that goal follows from the current understanding of the problem, and why this intervention is a reasonable means of pursuing it.

A technically competent intervention can still be poorly chosen. A therapist may perform exposure competently while targeting the wrong maintaining process. A therapist may offer an accurate interpretation that misses the central problem. A therapist may provide excellent emotional support while leaving unclear what therapeutic function the support is serving.

The relevant question goes beyond: Can the therapist perform this intervention? It is also: Why this intervention? Why now? For what purpose? Based on what understanding of the problem?

Reassessment

Clinical reasoning continues after the therapist acts. The client's response becomes new information. The clinician must determine what that response means and whether it supports the understanding that guided the intervention.

When improvement stalls, several possibilities remain open. The intervention may have been poorly executed. The intervention may have been competently executed but poorly selected. The formulation may have been incomplete. The original assessment may have missed something important. The goal may have been wrong. External conditions may have changed. The therapist may have expected change too quickly.

Reassessment requires distinguishing among these possibilities rather than treating outcome as a simple verdict on whether a technique "worked." Seen this way, clinical reasoning sits inside assessment and intervention themselves, rather than functioning as an additional step between them. It is the thinking through which assessment, clinical understanding, intervention, and reassessment become clinically meaningful rather than merely procedural.

The Problem With Teaching Conclusions

Clinical instruction can be delivered as a conclusion rather than as an explanation of the reasoning that produced it. Supervisors tell trainees to slow down, stay with the affect, avoid reinforcing avoidance, offer more structure, become more direct, give the work more time, attend to the alliance, or move away from the content. These recommendations may be useful or they may be wrong. The recommendation itself gives the learner little basis for knowing the difference.

Consider the apparently simple instruction to slow down. On its own, the phrase is underspecified. It may refer to the pace of questioning, the amount of material being introduced, the emotional intensity of the work, the degree of interpretation, the frequency of therapist intervention, or the broader progression of treatment. More importantly, the recommendation rests on prior judgments that may go unarticulated.

The supervisor has noticed something. Certain aspects of the client's speech, affect, behavior, or participation have been treated as significant. Those observations have been interpreted in a particular way. Some explanations have been favored over others. The supervisor has formed some understanding of what is happening and some prediction about what may happen if the therapist continues in the same direction.

That sequence is the educational material. What did the supervisor actually observe? Which observations were treated as significant? What was inferred from them? What other explanations

were possible? Why was the problem understood as pacing rather than misunderstanding, disagreement, insufficient structure, anxiety, rupture, or something else?

What is slowing down intended to change? What would the supervisor expect to observe if the judgment were sound? What response would require reconsideration? When those questions remain unasked, the trainee is at risk of learning a rule rather than learning how to assess a case.

The lesson becomes that a certain presentation means resistance, that another requires confrontation, or that a particular kind of client should be given more structure. Such conclusions can easily become detached from the evidence that originally justified them and then be applied to superficially similar situations in which the same reasoning has stopped applying.

Making the reasoning explicit changes what is being taught. The trainee moves beyond simply learning what a supervisor would do. The trainee is learning how the supervisor moved from observation to conclusion, how alternative explanations were handled, and how the proposed action was connected to the understanding of the problem.

A recommendation is the endpoint of a reasoning process. It should be recognized as distinct from the reasoning itself.

The Difference Between a Label and an Assessment

Psychotherapy relies heavily on language, and clinical language can conceal reasoning as easily as it can clarify it. Terms such as resistant, avoidant, dysregulated, defended, dependent, activated, unmotivated, insightful, engaged, or ready can compress multiple observations and interpretations into a single word.

Such terms can be clinically useful but the problem arises when the label substitutes for the assessment that should support it. A therapist may say, “The client became resistant.” What does that mean? Did the client become silent? Disagree? Change the subject? Laugh? Appear confused? Miss an appointment? Reject an interpretation? Say directly that the therapy felt unhelpful? Each of these is different and the process of arriving at an explanation depends on gathering further information.

The term resistance may be clinically useful within a particular theoretical framework, but its usefulness depends on whether the clinician can distinguish the observable event from the interpretation placed upon it. This distinction is basic to clinical reasoning.

An observation remains distinct from an explanation because plausibility alone does not establish an explanation as fact. Making clinical reasoning explicit therefore requires precision about the status of a claim: what happened, what the clinician thinks it means, what evidence supports that interpretation, what alternatives remain plausible, how certain the conclusion is, and what follows clinically if the conclusion is correct. These questions belong within assessment and formulation. They are part of what those functions require when performed carefully.

Formulation as an Example of Reasoning Made Visible

Case formulation provides one of the clearest examples of what happens when ordinarily compressed clinical thinking is made explicit.

Clinicians routinely form impressions about why a person is struggling. Those impressions may remain distributed across diagnosis, history, theoretical language, treatment planning, and intuitive expectation. A therapist may know many facts about a client and still lack a clear explanatory account of how those facts relate.

Formulation requires the clinician to expose that reasoning.

- What exactly requires explanation?
- Which facts are most important?
- What pattern connects them?
- What is observation and what is inference?
- What explanation best accounts for the pattern?
- What competing explanations remain?
- Why this pattern for this person?
- What follows clinically if the formulation is correct?
- What new information would require revision?

The value of formulation therefore extends beyond the written formulation itself. Formulation makes the clinician's understanding visible enough to examine.

Research by Eells and colleagues on psychotherapy case formulation illustrates why this matters. Expert clinicians produced formulations that were more comprehensive, elaborated, complex, and systematic than those produced by experienced and novice clinicians, with treatment plans more closely connected to their formulations (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). A subsequent analysis of the same clinical material found that these differences extended specifically to inferential and diagnostic reasoning, evidence that clinicians differ in how they reason through case material, beyond what they know (Eells, Lombart, Salsman, Kendjelic, Schneiderman, & Lucas, 2011).

The finding is important because it suggests that differences in clinical performance can appear in how information is selected, organized, and linked to treatment rather than merely in how much information a clinician possesses. Formulation is therefore one place where the reasoning within clinical practice can be brought into view.

The same principle applies elsewhere. A diagnostic conclusion can be examined, as can the alliance, a treatment decision, a judgement that the client is either avoiding, overwhelmed, disengaged, or improving. Clinicians need to be able to examine the path from observation to conclusion in order to demonstrate the effectiveness of their practice, regardless of client outcomes.

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Tacit Judgment Is Not Self-Validating

Clinical judgments often become more automatic with repetition. However this does not reveal whether those judgments become more accurate over time. A clinician may recognize a pattern quickly because years of experience have refined genuine expertise, but the same speed may also reflect a familiar theoretical explanation that has become habitual. Repetition can strengthen sound judgment, and it can just as easily strengthen assumption.

The literature on tacit knowledge and expertise helps clarify this distinction. Polanyi described tacit knowing as the fact that people often know more than they can fully state. Schön described reflection-in-action as a form of professional thinking embedded within activity itself, while Dreyfus and Dreyfus described the movement from rule-governed performance toward increasingly intuitive and context-sensitive judgment. These accounts help explain how clinical judgment can become faster and less consciously articulated with experience, but they do not establish that intuition is necessarily accurate.

Kahneman and Klein's work on intuitive expertise is especially relevant here. They argue that trustworthy intuitive judgment develops when the environment contains learnable regularities and practitioners receive sufficiently reliable feedback about the accuracy of their judgments. Psychotherapy may not always provide those conditions clearly. Feedback can be delayed, ambiguous, or difficult to interpret: a therapist can hold an inaccurate formulation for months, a client may improve for reasons unrelated to the therapist's favored explanation, and a treatment may fail without revealing whether the difficulty arose from assessment, diagnosis, formulation, intervention, implementation, external conditions, or some combination of these factors. Although Kahneman and Klein did not study psychotherapy directly, their account raises an important question about how confidently clinical intuition should be treated when the quality of feedback is uncertain.

For training purposes, the implication is that expert judgment should remain open to examination. A clinician's inability to reconstruct the basis of a conclusion may reflect expertise, habit, theoretical conditioning, unexamined assumption, or several of these at once. Making the reasoning explicit creates an opportunity to examine the basis of the judgment and determine which of these possibilities is operating.

What It Means to Make the Implicit Explicit

Making reasoning explicit is primarily a training and supervision activity. Therapists conduct psychotherapy while reserving that narration for training and supervision. The purpose is to create settings in which clinical material can be slowed down enough for the structure of the clinician's thinking to become visible.

A therapist may report, for example, that a client "became defensive." The material can be reopened. What happened immediately before that judgment? What did the client actually say or do? What changed? What did the therapist infer from that change? What other explanations were possible? What larger understanding of the case made defensiveness seem likely? What did the therapist do next because of that interpretation? What happened afterward? Did the client's response support the original conclusion?

This process exposes several distinct operations that otherwise collapse into a single clinical impression. Observation can be separated from inference. Inference can be separated from theoretical explanation. A plausible explanation can be separated from a settled conclusion. An intervention can be linked explicitly to the understanding that justified it. The client's subsequent response can be treated as evidence capable of changing the clinician's mind.

This is what the Clinical Effectiveness Institute means by making the implicit explicit: psychotherapy itself stays unproceduralized, while its reasoning becomes examinable.

Clinical Effectiveness and Accountability

The argument for making reasoning explicit is ultimately an argument about clinical effectiveness. Outcome guarantees lie beyond what any therapist can provide. Psychotherapy unfolds within biological, relational, developmental, economic, social, and cultural conditions extending far beyond the therapist's control.

The clinician is nevertheless responsible for the quality of the clinical contribution. That responsibility extends beyond whether a technique was performed correctly. A technically competent intervention can rest on a poor assessment. A diagnosis can be accurate while the clinically important problem remains poorly understood. A coherent formulation can still be incomplete. A treatment can follow a model faithfully while failing to address what is maintaining the client's difficulty. A strong therapeutic relationship can coexist with unclear clinical purpose. An intervention can initially make sense and later cease to fit as new information emerges.

Clinical accountability therefore requires more than technical fidelity. It requires willingness to examine whether the reasoning supporting the work remains sound. A clinician who can articulate why a particular understanding or intervention was chosen can compare that rationale with what follows. An assumption can be recognized. A prediction can fail. A formulation can be revised. A diagnosis can be reconsidered. An intervention can be abandoned when the evidence stops supporting it.

Explicit reasoning improves the odds of accuracy, short of guaranteeing it. It creates the conditions under which inaccuracy can be more readily detected. That is the connection between pedagogy and effectiveness.

This concern carries practical weight beyond theory. Vaz, McLeod, and Nissen-Lie (2025) report mixed and often disappointing evidence that traditional supervision reliably improves therapist skill or client outcomes, and argue for more active, deliberate forms of practice in its place, while cautioning that deliberate practice itself still requires stronger evidence. Their review strengthens the case for supplementing discussion-based supervision with more active, structured forms of practice in which clinical performance, and potentially the reasoning supporting it, can be examined directly.

Making Reasoning Explicit Without Making Psychotherapy Mechanical

A reasonable concern is that greater explicitness could overproceduralize psychotherapy. Clinical practice exceeds what a checklist can capture. Therapists reasonably continue working fluidly, rather than pausing during every exchange to consciously label each observation, inference, hypothesis, and decision.

The actual proposal here is to distinguish the conditions of practice and the conditions of learning. Complex skills are often slowed down in training. Components are isolated and errors examined. Decisions can be reconstructed and then the pieces are reintegrated into more fluid performance. Clinical material can be slowed down in supervision, training, consultation, transcript review, and deliberate practice without requiring therapists to conduct sessions as though following an algorithm.

Explicitness also carries risks. A clinician may produce a persuasive explanation after the fact that diverges from what actually guided the original decision. A supervisor may mistake a favored theoretical framework for direct clinical reality. A trainee may become overly concerned with producing a correct explanation rather than tolerating uncertainty.

The purpose of explicit reasoning is to make these problems visible, rather than eliminate them through procedure. A strong pedagogy of clinical reasoning therefore requires attention to conclusions as much as to uncertainty, alternatives, assumptions, and the possibility of error. The aim is accountable judgment, not certainty.

CEI Proposal: Make the Reasoning Traceable

The Clinical Effectiveness Institute proposes a simple pedagogical shift: when clinicians are learning assessment, clinical understanding, intervention, and reassessment, they should be required to make the reasoning supporting their conclusions visible enough to examine.

The aim is to change what counts as sufficient learning in training and supervision, rather than to add another clinical function or require therapists to follow a reasoning algorithm in the therapy room. Producing a diagnosis, a formulation, or an intervention completes only part of the educational task. The trainee should also be able to identify the information on which the conclusion rests, distinguish observation from inference, state what remains uncertain, consider

plausible alternatives, explain why a proposed intervention follows from the current understanding of the problem, and identify what subsequent evidence would support or require revision of that understanding.

The same expectation applies to supervision. When a supervisor recommends slowing down, confronting a pattern, attending to the alliance, offering more structure, or changing course, the recommendation should wherever possible be accompanied by the reasoning that produced it. What was observed? What was inferred? Why was that interpretation favored? What clinical purpose would the proposed response serve? What would make the supervisor reconsider? Supervisors can then require supervisees to work in the same way, shifting supervision from the transfer of conclusions toward the development of independently examinable judgment.

Clinical material should be used in forms that permit this reasoning to be seen. Transcripts, recorded segments, structured vignettes, competing formulations, think-aloud exercises, intervention-to-rationale exercises, and retrospective analysis of clinical errors all allow the clinician's thinking to be slowed down and inspected. The particular method matters less than the educational requirement underlying it: *the path from evidence to conclusion to action should remain visible even when the conclusion sounds clinically plausible.*

This approach also changes how clinical error is understood. When treatment diverges from what was expected, the question can extend beyond what the therapist should have done differently. Training can ask where the reasoning failed. Was relevant information missed during assessment? Was an inference treated as fact? Was the formulation insufficiently explanatory? Did the intervention fail to follow from the formulation? Was the intervention appropriate but poorly executed? Did new information emerge that should have prompted revision? Locating the error creates a more precise learning target than replacing one intervention with another.

Making reasoning traceable therefore provides a practical bridge between psychotherapy education and clinical effectiveness. It allows clinical judgments to be examined before they harden into habits, allows supervisors to challenge the basis of a conclusion rather than merely disagree with it, and allows clinicians to use what happens in therapy as evidence about the quality of the understanding guiding their work.

As a standard, consequential clinical judgments should be capable of examination, what supported them, what they were intended to accomplish, what happened as a result, and whether the evidence now requires revision, rather than requiring that clinicians always be correct. Stated against the four functions this paper has described, the standard becomes:

- Assessment: What do we know?
- Clinical understanding: What does the evidence warrant us concluding?
- Intervention: Given that understanding, what are we trying to change, and why this action?
- Reassessment: What happened, and what does it require us to revise?

A Pedagogy for Making Reasoning Visible

If traceability is the educational standard, training needs methods that allow the reasoning to be observed and practiced. Several methods are particularly well suited to this purpose.

Think-Aloud Assessment

A trainee can review clinical material while narrating what is being noticed, what seems important, what remains unclear, and what additional information would be sought. The purpose extends beyond hearing the trainee's conclusion. It is to expose how the trainee is assessing.

- Where does observation become inference?
- What information receives disproportionate weight?
- What possibilities disappear too quickly?
- What assumptions enter before sufficient evidence exists?

Paused Session Review

Recorded material can be stopped before a consequential therapist response. The trainee can be asked:

- What do you think is happening?
- What supports that conclusion?
- What remains uncertain?
- What are you trying to accomplish next?
- Why would this intervention serve that purpose?
- What else could you do?

The recording can then continue. The client's actual response provides new evidence that can be used to revisit the original judgment.

Transcript Microanalysis

A brief segment of session material can be examined line by line. This allows clinicians to distinguish what actually occurred from global summaries such as “the client shut down” or “the session became dysregulated.” The exercise strengthens assessment by forcing attention back to observable material.

Competing Formulations

Trainees can generate more than one plausible explanation of the same case. They can then identify:

- What each explanation accounts for.
- What each leaves unexplained.
- What evidence supports each one.
- What additional information would help discriminate among them.
- What different interventions would follow from each understanding.

The goal is *disciplined provisionality.*

Intervention-to-Rationale Exercises

- Rather than asking only what a trainee would do, the trainer asks why.
- What problem is this intervention addressing?
- What is it intended to change?
- How does that goal follow from the assessment or formulation?
- Why this intervention rather than another?
- What response would suggest that the intervention matched the problem?
- What response would require reconsideration?

The intervention is thereby connected explicitly to clinical understanding.

Error Analysis

Clinical moments that diverge from what was expected provide especially valuable material. The relevant question goes beyond "What should the therapist have done instead?" The reasoning can be examined more precisely:

- Was important information missed during assessment?
- Was the information accurately gathered but poorly interpreted?
- Was the diagnosis or formulation incomplete?
- Was the intervention mismatched to the formulation?
- Was the intervention appropriate but poorly executed?
- Did the client provide contradictory information that arrived too late to be incorporated?

Different errors arise at different points in clinical practice. Making the reasoning explicit allows the error to be located.

Supervision and the Development of Independent Judgment

Supervision is one of the primary places where clinicians learn how to assess, understand, and intervene. It is therefore also one of the places where reasoning can remain compressed. A supervisee presents a case. The supervisor produces an answer. The trainee leaves with the answer. This can solve an immediate clinical problem while doing relatively little to strengthen the supervisee's ability to solve the next one independently.

A supervisor can instead expose the basis of the recommendation. Rather than saying only, "I think you need to confront this," the supervisor can identify what pattern was noticed, what evidence supports that interpretation, what alternative explanations were considered, what the confrontation is intended to accomplish, what risks it carries, and what response would cause the supervisor to reconsider. The supervisee is then learning more than what to do. The supervisee is learning how a clinical conclusion was constructed.

Friedlander's work on responsive supervision emphasizes both explicit instruction and implicit modeling. CEI's position adds a related pedagogical emphasis: *the supervisor can make the process of assessment and clinical decision-making itself more visible.*

The ultimate goal of supervision should extend beyond the accumulation of supervisor-derived answers. It should be increasing independence of clinical judgment. A clinician should gradually become more able to ask:

- What do I actually know?
- What am I inferring?
- What explanation best fits the evidence?
- What remains uncertain?
- What am I trying to accomplish?
- Why does this intervention follow?
- What happened afterward?
- What do I now need to revise?

That is more disciplined performance of a function clinicians already carry out, rather than a new one.

Implications for Psychotherapy Education

Making reasoning traceable changes the unit of clinical education. Competence is demonstrated by more than arriving at a plausible formulation, selecting an accepted intervention, or producing a defensible recommendation. The clinician must also be able to expose enough of the path from evidence to conclusion to action that the judgment can be examined. In other words, to borrow a phrase from math class, “Show your work.”

This expectation applies across theoretical orientations and professional pathways because it leaves open what clinicians must conclude. It asks them to make clear how they arrived there, what evidence supports the conclusion, what remains uncertain, what clinical action follows, and what would warrant revision.

CEI Position

The Clinical Effectiveness Institute holds that the reasoning embedded within assessment, clinical understanding (including diagnosis and formulation where relevant), intervention, and reassessment should be made explicit enough to teach, examine, supervise, and improve.

Psychotherapy education should extend beyond teaching what information to gather, what diagnoses mean, how cases can be conceptualized, or how interventions are performed. Clinicians should also learn how to evaluate evidence, distinguish observation from inference, weigh

competing explanations, justify clinical conclusions, connect interventions to an understanding of the problem, and revise those conclusions when the clinical evidence changes.

Making the implicit explicit means making visible the thinking already required to perform the existing work well, rather than creating an additional clinical domain called reasoning. This position follows directly from the Institute's commitment to clinical effectiveness.

Ethical practice requires sustained responsibility for whether psychotherapy is contributing meaningfully to the client's movement. That responsibility requires more than theoretical allegiance, technical competence, relational quality, or good intention alone. It requires clinicians who can examine how they arrived at an understanding, why they chose a course of action, what happened as a result, and whether the evidence now requires them to think differently.

The reasoning inside clinical practice should therefore become part of what psychotherapy education teaches explicitly.

Continue the Work with the Clinical Effectiveness Institute

The Clinical Effectiveness Institute develops training for psychotherapists who want to strengthen the quality of the clinical decisions underlying their work. CEI focuses on making the reasoning embedded within assessment, formulation, intervention, and evaluation more visible, examinable, and teachable.

Clinical Formulation: The Missing Link Between Understanding and Intervention is a three-hour live training focused on one of the clearest applications of this approach: learning to move from clinical information to an explanatory formulation that can guide therapeutic work. Rather than treating formulation as a summary of history, diagnosis, or presenting concerns, the training teaches clinicians to identify what requires explanation, distinguish observation from inference, recognize meaningful patterns, and develop a provisional account of why this difficulty takes this form for this person.

Learn more about the Clinical Effectiveness Institute and upcoming trainings at **clinicaleffectivenessinstitute.com**.

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