

VIEW POINT

Formulation is becoming the “lost skill” in psychiatry: implications for clinical practice, training, and professional identity

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Abstract

Case formulation has historically been central to psychiatric practice, providing a structured method to integrate biological, psychological, and social factors into a coherent understanding of mental illness. However, contemporary psychiatry increasingly prioritizes diagnostic classification and protocol-driven care over individualized formulation. This shift, driven by time constraints, service structures, and standardization, risks reducing clinical encounters to algorithmic decision-making. The erosion of formulation undermines diagnostic depth, contributes to apparent treatment resistance, and weakens therapeutic engagement. This article argues that formulation is not an optional academic exercise but a core psychiatric competency. By revisiting its conceptual foundations, including the “5 Ps” framework, major formulation models, and its iterative clinical process, it examines the consequences of its decline and proposes strategies for reintegration into routine psychiatric practice.

Keywords: case formulation, biopsychosocial model, diagnostic reasoning, therapeutic alliance, reflective practice

Introduction

Psychiatry occupies a distinctive position within medicine by requiring not only diagnosis and treatment but also interpretation of subjective experience (1). Unlike many medical specialties where diagnosis leads relatively directly to treatment decisions, psychiatric care requires an appreciation of how symptoms emerge from complex interactions between biological vulnerability, psychological processes, and social context (1, 2).

Case formulation has traditionally served as the clinical method through which this complexity is synthesized into a meaningful understanding (3). It moves beyond descriptive diagnosis to explanatory reasoning, enabling clinicians to link symptoms with underlying mechanisms and contextual factors. In doing so, formulation supports individualized, patient-centered care rather than generic protocol-driven management.

However, in contemporary psychiatric practice, formulation is increasingly overshadowed by operational

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diagnostic systems and standardized treatment pathways (4). While these developments have improved reliability and scalability of care, they have also inadvertently narrowed the scope of clinical reasoning. As a result, formulation is often reduced to a brief academic exercise rather than a central component of clinical practice.

This paper argues that formulation is becoming a “lost skill” in psychiatry. Its decline reflects broader systemic and epistemological shifts within the discipline and has significant implications for patient care, training, and professional identity.

What is case formulation? Beyond definition to clinical function

Case formulation is best understood not as a static summary but as a hypothesis-driven, collaborative process that organizes clinical information into an explanatory framework (3). Unlike diagnosis, which categorizes, formulation explains.

At its core, formulation integrates multiple domains through a structure often conceptualized as the “5 Ps” presenting, predisposing, precipitating, perpetuating, and protective (or positive) factors. These are not merely checklist components but elements of a clinical narrative that situates symptoms within a temporal and contextual framework.

- The *presenting problem* anchors the formulation in the patient’s current distress and functional impairment.
- *Predisposing factors* reflect long-standing vulnerabilities, including genetic loading, developmental experiences, and personality traits.
- *Precipitating factors* identify the proximal triggers that bring latent vulnerabilities into clinical expression.
- *Perpetuating factors* explain why symptoms persist, often revealing maladaptive coping, interpersonal patterns, or environmental reinforcers.
- *Protective factors* highlight resilience and resources that can be mobilized in treatment.

Together, these elements transform diagnosis from a static label into a dynamic, individualized account of illness.

Crucially, formulation is not tied to a single theoretical model. The biopsychosocial framework provides its overarching structure (1), while specific models such as cognitive-behavioral or psychodynamic formulations offer different lenses through which mechanisms can be understood and targeted (3). What unites these approaches is not theoretical allegiance but a shared commitment to explanatory depth.

Formulation is also inherently iterative. It evolves over time as new information emerges, as the therapeutic relationship develops, and as interventions alter the clinical

picture. In this sense, formulation is not a one-time exercise but an ongoing process of clinical reasoning.

The shift from formulation to classification

The rise of operational diagnostic systems has brought important advances in psychiatry, particularly in improving inter-rater reliability and facilitating research (4). However, this progress has also contributed to an unintended consequence: the gradual displacement of formulation-based thinking by classification-based practice.

In many clinical settings, diagnosis is treated as the endpoint of assessment rather than the starting point for deeper understanding. Once a diagnostic label is assigned, treatment often follows standardized protocols with limited consideration of individual variability. This approach, while efficient, risks oversimplifying complex human experiences.

Several systemic factors reinforce this shift. Time constraints in busy clinical settings limit opportunities for in-depth exploration. Standardized guidelines and care pathways emphasize uniformity over individualization. Electronic health records prioritize structured data entry, often at the expense of narrative documentation. Training environments may further reinforce this pattern by focusing heavily on diagnostic accuracy and pharmacological knowledge, with comparatively less emphasis on formulation skills (5).

Over time, these influences shape a clinical culture in which formulation is perceived as optional rather than essential.

Why formulation matters

Enhancing diagnostic depth

Diagnosis alone provides a descriptive framework but does not capture the full complexity of psychiatric presentations (2). Patients who meet criteria for the same disorder may differ substantially in etiology, course, and treatment response. Formulation allows clinicians to move beyond categorical labels and develop a nuanced understanding tailored to the individual.

Understanding “treatment resistance”

The concept of treatment resistance is often applied when patients do not respond to standard pharmacological interventions. However, in many cases, this apparent resistance reflects incomplete understanding rather than true

biological refractoriness (6). Without formulation, clinicians may escalate medication regimens without addressing underlying psychological conflicts, trauma, or social stressors that sustain symptoms.

Strengthening the therapeutic alliance

Formulation is inherently collaborative. When clinicians share their understanding with patients in a transparent and empathetic manner, it fosters trust and engagement. This shared understanding enhances adherence and contributes to better outcomes (7).

Guiding integrated treatment

Formulation provides a coherent framework for integrating different treatment modalities. Rather than applying pharmacological and psychological interventions in parallel without clear rationale, formulation ensures that each component of treatment is logically aligned with the patient's needs (8).

Formulation and psychotherapy: an inseparable relationship

Formulation and psychotherapy are not separate domains but complementary aspects of clinical practice (3). Psychotherapeutic approaches can be understood as structured methods for addressing the mechanisms identified through formulation. For instance, cognitive-behavioral therapy targets maladaptive cognitions and behaviors, while psychodynamic therapy explores unconscious processes and relational patterns.

Without formulation, psychotherapy risks becoming a set of techniques applied in a generic manner. Conversely, formulation without therapeutic application remains abstract and clinically inert. The integration of formulation and psychotherapy is therefore essential for meaningful clinical practice.

Systemic drivers of decline

The erosion of formulation cannot be understood without examining the systems within which psychiatry operates.

Time-constrained care

High patient volumes and brief consultations prioritize rapid assessment and medication management, leaving limited time for in-depth exploration.

Standardization and protocolization

Clinical guidelines and care pathways emphasize uniformity and efficiency, often at the expense of individualized understanding.

Documentation practices

Electronic health records favor structured data entry over narrative formulation, subtly discouraging reflective thinking.

Training and hidden curriculum

Although formulation is formally included in training curricula, its practical importance is often undermined by assessment systems that prioritize diagnostic accuracy and pharmacology. Trainees quickly learn what is valued in practice (9).

Implications for professional identity

The diminishing emphasis on formulation reflects a broader shift within psychiatry toward a predominantly biomedical model (10). While biological advances have significantly improved treatment options, an exclusive focus on neurobiology risks narrowing the scope of psychiatric practice.

Psychiatry's unique contribution lies in its ability to integrate multiple levels of understanding, biological, psychological, and social, into a coherent whole (1). When formulation is neglected, this integrative capacity is weakened, and psychiatry risks being reduced to a discipline centered primarily on diagnosis and medication management.

Maintaining formulation as a core skill is therefore essential not only for clinical effectiveness but also for preserving the identity and distinctiveness of the profession.

Implications for training

The decline of formulation is closely linked to how psychiatry is taught and assessed. If training programs prioritize diagnostic classification and pharmacological knowledge while treating formulation as secondary, trainees are likely to internalize these priorities.

Effective training should emphasize formulation as a core competency. This includes structured teaching of formulation models, supervised clinical practice, and

opportunities for reflective discussion. Longitudinal case work is particularly valuable, as it allows trainees to observe how formulations evolve over time.

Assessment methods should also reflect the importance of formulation. Evaluating trainees' ability to synthesize information and develop coherent explanatory models would reinforce its centrality to clinical practice.

Reintegrating formulation into psychiatric practice

Reintegration requires both conceptual and practical shifts.

Formulation must be reframed as a core clinical skill, not an optional academic exercise. Even in brief consultations, clinicians can adopt a formulation-informed approach by focusing on context, meaning, and maintaining factors.

Narrative documentation should be reintroduced alongside structured data, ensuring that clinical reasoning is preserved. Training programs must prioritize formulation through supervision, longitudinal case work, and assessment of integrative thinking (11).

Importantly, formulation should complement evidence-based guidelines, ensuring that standardized treatments are applied in individualized ways.

Conclusion

Case formulation is becoming a "lost skill" in psychiatry, not because it lacks relevance, but because contemporary systems prioritize efficiency and standardization over explanatory depth. It decline risks reducing psychiatry to diagnostic labeling and pharmacological management.

Reclaiming formulation is essential for restoring clinical reasoning, improving treatment outcomes, strengthening therapeutic relationships, and preserving psychiatry's integrative identity. In an era increasingly defined by protocols, formulation remains the discipline's most important tool for understanding the individual behind the diagnosis.

Ethical statement

Not applicable. This article is a viewpoint based on secondary data and published literature.

Author contributions

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