Clinical Case Conceptualization & Treatment Planning Guide

STORM HAVEN, COUNSELING & WELLNESS | clinical learning and supervision resource

A working guide for associate and licensed therapists. Use it to connect what the client tells you, what your assessment suggests, what you do in session, and how you recognize change. It supports clinical judgment; it does not replace supervision, professional standards, current law, payer contracts, or individualized care.

01 Start with the person, then build the formulation

Presenting story. What brought the client now, in their own words? What matters to them, and what would be different if therapy helped? Attend to identity, culture, accessibility, strengths, relationships, values, and environmental stressors alongside symptoms.

Clinical assessment. Explore symptom course, severity, frequency, duration, functional impact, relevant history, previous care, medications, substance use, health considerations, protective factors, and risk. Complete informed consent and indicated safety assessment directly; do not rely on the narrative to cover every required domain.

Working hypothesis. Describe the mechanisms maintaining distress, not just the events triggering it. Consider patterns of avoidance, beliefs, attachment strategies, emotional regulation, learning history, trauma responses, systemic context, and available supports. Reassess the hypothesis as information changes.

A concise formulation prompt

When [context or trigger] occurs, the client tends to experience [thoughts, emotions, body cues] and respond with [protective strategy or behavior]. This may provide [short-term function] while contributing to [longer-term difficulty]. Strengths and supports include [resources]; treatment will focus on [collaborative direction].

02 Connect formulation to diagnosis and need

Document diagnoses only when supported by appropriate assessment and diagnostic criteria. When the picture is uncertain, describe that uncertainty accurately and reassess. For insurance-funded care, establish the connection among the covered condition, symptoms or impairment, medically necessary services, and treatment rationale under the applicable plan. For private-pay care, maintain clinically appropriate assessment, informed consent, records, and clear service goals without inventing a disorder.

03 Create goals that mean something

Start with the client’s own description of desired change. Translate it into a collaborative goal, then specify observable or reportable indicators and a review interval. SMART principles can help, but avoid arbitrary counts unless they are meaningful and feasible to track.

Goal-writing bridge

Client language: “I say yes and then resent everyone.”
Goal: Increase flexibility in expressing needs while reducing anxiety-related avoidance.
Objective: Recognize early anxiety cues and practice pausing before responding to interpersonal requests, with progress evaluated through client report, discussion of specific interactions, and functioning at work and home.
Review: Revisit baseline examples and agreed indicators at a clinically appropriate interval.

From formulation to the session

A clinical thread, not a rigid script

04 Keep the treatment plan alive during sessions

A weekly check-in may uncover meaningful material. Listen for themes and changes, then collaboratively decide whether to deepen the current experience, return to an established treatment target, address an urgent need, or revise the focus. Different modalities will move differently: CBT may use a behavioral experiment; ACT may examine avoidance and values; DBT may prioritize a chain analysis; IFS may explore protective parts; psychodynamic work may attend to relational repetition; EMDR follows its phased protocol and clinical readiness.

A natural transition

“You’ve described three different situations, and I’m noticing a familiar pressure to keep everyone comfortable. We’ve been exploring how that affects your anxiety. Would you like to spend some time with that pattern today, or does something else feel more important?”

05 A worked example: Morgan (fictional)

Presentation: Morgan reports persistent worry, difficulty sleeping, and interpersonal overcommitment that interfere with work and relationships. The assessment explores symptom criteria and differential considerations; any diagnosis must be clinically supported rather than inferred from this brief illustration.

Formulation: Anticipated rejection triggers chest tightness and the thought “They’ll think I’m difficult.” Morgan agrees quickly to avoid discomfort, experiences temporary relief, then resentment and exhaustion. Their protective response may have developed in an environment where disagreement carried relational costs.

Collaborative focus: Notice early anxiety cues, build willingness to tolerate interpersonal discomfort, and communicate needs more flexibly. The therapist integrates ACT-informed work, attachment exploration, and behavioral rehearsal as appropriate.

In session: Morgan recounts a coworker’s request. The therapist notices a repeating pattern, asks permission to explore it, attends to body cues, examines the prediction of rejection, and invites Morgan to practice: “Let me check my workload before I commit.” The therapist asks what shifted and what remained uncomfortable.

Between sessions: Morgan experiments with pausing before responding, if appropriate and collaboratively chosen. The next session explores what happened without framing an unsuccessful attempt as failure.

06 Document the reasoning, not just the conversation

A useful progress note links the clinical focus, intervention, client response, observed or reported change, and rationale for next steps. Follow Storm Haven’s current approved note format and any applicable payer-specific requirements; this guide does not establish a new required template.

Illustrative clinical note language

Focus: Anxiety-driven interpersonal avoidance affecting occupational functioning.
Intervention: Explored trigger-response sequence using ACT-informed cognitive defusion, somatic awareness, and behavioral rehearsal.
Response: Client identified early chest tension and practiced a non-apologetic delay response; reported anxiety remained present but felt more tolerable.
Plan: Review real-world application, symptom and functional changes, and barriers at next visit. Continue assessing clinical need and safety as indicated.

Measuring movement without reducing people to numbers

Baseline → observation → collaborative review → adjustment

07 Choose measures that answer the clinical question

Symptom measures: PHQ-9, GAD-7, and condition-specific instruments can track relevant symptom severity when appropriate. Scores supplement rather than replace diagnostic assessment and clinical interpretation.

FIDO interview: Ask about frequency, intensity, duration, and onset of experiences. FIDO is a descriptive interview framework, not a standardized validated outcome instrument.

Functioning and behavior: Track changes in work, school, relationships, self-care, avoidance, recovery time, communication, and participation in valued activities. Record concrete baseline examples to make comparisons possible.

Client-defined outcomes: Collaborative goal reviews and appropriately implemented Goal Attainment Scaling can capture individualized change. The Outcome Rating Scale (ORS) addresses self-reported well-being/functioning; the Session Rating Scale (SRS) addresses the session and alliance. Follow each instrument’s instructions and permissions.

08 Review progress with the client

Return to the client’s original words: “When we began, you said you wanted to stop agreeing automatically. What have you noticed lately?” Compare the answer with the baseline, functional observations, and any standardized measures. Ask what has improved, what remains difficult, and whether the work still fits. A stable symptom score may coexist with meaningful gains in functioning; worsening scores or emerging risk may require reassessment.

Three questions for clinical review

What has changed? Look at symptoms, functioning, patterns, capacity, and client experience.
What is maintaining difficulty? Revisit barriers, formulation, treatment fit, alliance, and environmental context.
What follows? Continue, adapt interventions, revise goals, consult, refer, or begin planning termination as clinically appropriate.

09 When the work feels stuck

Repetition can reflect deepening insight, necessary stabilization, grief, trauma processing, or a treatment plateau. Distinguish among them rather than assuming all recurring themes signal failure. Review safety and functioning, discuss the client’s experience of therapy, revisit the case formulation, and consider whether the intervention matches the problem and the client’s preferences.

If progress remains limited, seek consultation or supervision, reassess differential diagnoses and barriers, consider alternative evidence-informed approaches, and evaluate whether referral or a different level of care is appropriate. Avoid changing course merely to create the appearance of movement.

Revising, concluding, and consulting

Keeping care collaborative and clinically accountable

10 Revise treatment when the picture changes

Update the formulation and goals when new information emerges, meaningful objectives are achieved, circumstances change, or the current approach no longer fits. Document why the plan changed, how the client participated, what interventions will follow, and how outcomes will be evaluated. For insurance-funded care, reassess applicable medical necessity and coverage criteria rather than assuming new goals automatically justify ongoing treatment.

11 Prepare for termination intentionally

Review the client's initial concerns, baseline, progress, remaining vulnerabilities, and supports. Discuss feelings about ending, ways to maintain gains, early signs that additional support may be useful, and referral or follow-up arrangements when indicated. Not every ending follows goal completion; when care ends unexpectedly, follow applicable continuity-of-care, documentation, and ethical obligations.

12 Bring the case to supervision or consultation

A useful case presentation includes the client's presenting concern and context, relevant assessment and safety considerations, working diagnosis and formulation, collaborative goals, interventions tried, client response, progress indicators, and the specific clinical question. Protect confidentiality and share only what is appropriate for the consultation setting.

Supervision reflection

"Here is what I think is happening; here is what I have tried; here is what the client reports and what I observe; here is where I am uncertain; and here is the decision I would like help thinking through."

Clinical reasoning quick check

Before the session: What is our current formulation and treatment focus?
During: What is emerging, and what intervention serves this client now?
After: What did the client experience, what changed, and what will we revisit?
Periodically: Are goals, diagnosis, frequency, interventions, and level of care still appropriate?

Scope and use

Educational resource for Storm Haven, Counseling & Wellness. Adapt to the individual client, clinical orientation, current organizational procedures, and applicable California or other jurisdictional requirements. This guide is not a substitute for a full diagnostic assessment, risk protocol, payer contract, clinical supervision, or legal guidance. Fictional case details are illustrative and do not establish a diagnosis or medical necessity.