

P H C F

POSITIVE HEALTH
CLASSIFICATION
FRAMEWORK

FIRST
EDITION

PAUL D. KREMER

POSITIVE HEALTH CLASSIFICATION FRAMEWORK

A Complementary Framework for
Classifying Positive Mental Health,
Adaptive Capacity and Recovery

FIRST EDITION

A CLINICALLY ORIENTED FRAMEWORK
FOR COMPLEMENTING DIAGNOSIS AND FUNCTIONING

The Positive Health Classification Framework

**A Proposed Complementary
Classification of Mental
Health**

Version 0.1 – Positive Health Classification Framework

By

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The Positive Health Classification Framework begins from the position that psychiatric diagnosis tells an important yet incomplete part of the clinical story. It does not fully describe what remains intact, what has been learned through adversity, what capacities can still be mobilised or what resources continue to support recovery. PHCF was developed to make that other part of the clinical story visible.

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Artificial intelligence (ChatGPT (OpenAI)) was used during the development of this book as an assistive tool editing, language refinement, and the development of figures. The conceptual architecture, theoretical propositions, interpretation of evidence, development of the Positive Health Classification Framework, and decisions concerning the final content are those of the author.

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The Positive Health Classification Framework (PHCF) was conceived and developed by Paul D. Kremer.

The First Edition establishes the original PHCF architecture comprising Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology, together with the framework's classification logic, Clinical Presentation Module architecture, clinical application principles, ethical safeguards and proposed approach to future development. When referring specifically to the framework rather than the book, the following attribution is recommended:

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Chapter One - Introduction and Rationale for a Positive Health Classification Framework

The Problem of an Incomplete Description of Mental Health

Mental health classification has achieved something remarkable across countries, professions and health systems, clinicians can describe patterns of psychological disturbance using increasingly standardised terminology. The Diagnostic and Statistical Manual of Mental Disorders “DSM”, Fifth Edition, Text Revision, or DSM-5-TR (American Psychiatric Association, 2022), provides diagnostic criteria and associated clinical descriptions designed to support reliable identification of mental disorders. The World Health Organization's International Classification of Diseases, Eleventh Revision, or ICD-11, provides an international classification and reporting system for diseases and health-related conditions, accompanied by detailed clinical descriptions and diagnostic requirements for mental, behavioural and neurodevelopmental disorders (World Health Organization [WHO], 2024). These systems serve essential purposes. Diagnostic classification provides clinicians with a common language, supports communication across services and professions, enables research, informs treatment planning and contributes to health-system administration. Their value should not be understated. The problem considered in the present framework is not that psychiatric diagnosis is unnecessary or inherently deficit based. Rather, that classification has become considerably more sophisticated in describing what is disrupted than in describing what remains healthy, adaptive or potentially protective within the same person. The distinction is increasingly important.

The WHO estimates that more than one billion people globally were living with a mental disorder in 2021, with anxiety and depressive disorders accounting for more than two-thirds of identified mental disorders. Mental disorders also remain major contributors to disability worldwide (WHO, 2025a). At the same time, WHO defines mental health positively, describing it as a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn and work, and contribute to their communities. WHO further recognises that mental health occurs along a complex continuum and is influenced by individual, family, community and structural factors (WHO, 2025b). The definition contains an important conceptual tension. Mental health is formally understood as more than the absence of disorder, while much of the clinical classification continues to begin with the identification and characterisation of disorder/s. Importantly, the tension does not suggest that positive functioning is absent from contemporary health classification. The International Classification of Functioning, Disability and Health, or ICF, provides a sophisticated framework for describing body functions, activities, participation and environmental factors. The ICF also distinguishes capacity, referring broadly to what an individual is capable of doing under specified conditions, from performance, referring to what the individual actually does within their lived environment. WHO considers ICD and ICF complementary classifications capable of providing a more complete account of health than either system can provide alone (WHO, 2001, 2026). Similarly, recovery-oriented mental health practice has progressively shifted attention beyond symptom control. WHO guidance now explicitly supports person-centred, rights-based and recovery-oriented mental health services that facilitate participation and meaningful life within the community (WHO, 2021). Personal recovery research has identified connectedness, hope and optimism, identity, meaning and empowerment as recurrent processes associated with recovery from mental illness. The influential CHIME (*Connectedness, Hope/Optimism, Identity, Meaning of life, Empowerment*) framework emerged from a systematic review involving 97 included studies and has subsequently become an important organising framework within recovery-oriented mental health research and practice (Leamy et al., 2011; Penas et al., 2020).

Positive psychiatry has extended the argument further, Jeste et al. (2015) proposed psychiatry should attend systematically to positive psychosocial characteristics and positive mental health outcomes among people with mental and physical illnesses. Relevant constructs include wellbeing, resilience, optimism, personal mastery, coping self-efficacy, social engagement, social support and other environmental influences. Subsequent work has demonstrated numerous instruments are available for assessing positive psychosocial factors, although measurement remains fragmented and frequently dependent on self-report measures (Eglit et al., 2018). There is no defensible basis for claiming that current mental health care simply ignores wellbeing, recovery, functioning, resilience or strengths. These areas have been substantiated in the research literature and, in several cases, established measurement frameworks. The more precise problem is one of integration and classification. Mental health services possess diagnostic classifications for psychopathology, frameworks for functioning, measures of quality of life, models of personal recovery, resilience scales, strengths assessments and approaches to protective-factor formulation. These constructs often coexist within practice however do not presently form a common positive-health classification capable of accompanying a person's psychiatric classification across diagnostic systems, clinical settings and time. The Positive Health Classification Framework, or PHCF, is proposed as a response to that narrower problem.

Mental Illness and Positive Mental Health Are Not Simple Opposites

A central theoretical premise of PHCF is that mental illness and positive mental health should not be conceptualised as opposite ends of a single continuum. Keyes (2002) provided an influential empirical challenge to the assumption that the absence of mental illness equates to mental health. Positive mental health was conceptualised through positive emotional experience concurrently with psychological and social functioning. The resulting Mental Health Continuum distinguished flourishing, moderate mental health and languishing. Importantly, the model did not redefine low psychopathology as flourishing. Keyes (2002) subsequently tested what became known as the Complete-State Model of Health, see Figure 1.1.

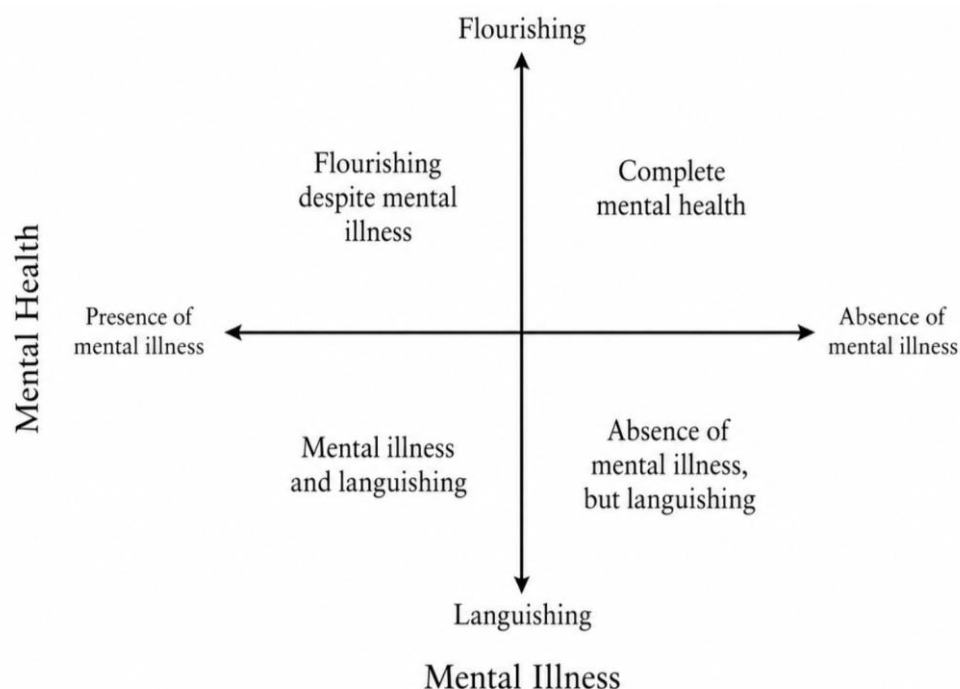


Figure 1.1. *Complete-State Model of Health (Adapted from Keyes, 2002).*

Confirmatory factor analyses have supported mental illness and positive mental health as separate but correlated dimensions (Keyes, 2005; Franken et al., 2018). The findings allowed combinations that would be difficult to represent within a simple illness-to-health continuum. An individual could experience mental illness while also retaining comparatively high positive mental health. Another individual could be free from a diagnosed disorder while experiencing low positive mental health, see Figure 1.2.

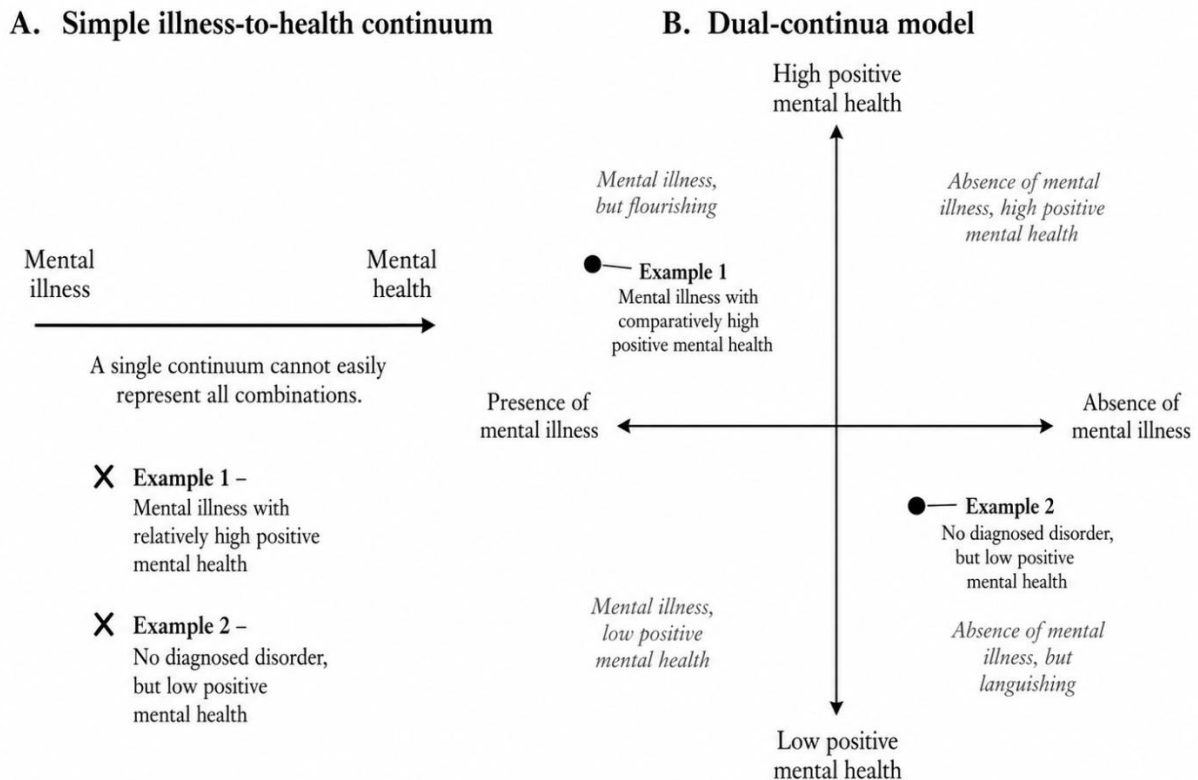


Figure 1.2. Dual-continua model of mental health. The figure illustrates how mental illness and positive mental health can coexist as related but distinct dimensions. An individual may experience mental illness while retaining comparatively high positive mental health, while another may have no diagnosed disorder yet experience low positive mental health. (Adapted from Keyes, 2002 and supported by Franken et al. 2018).

Later research provided additional support for the two-continua approach across populations and clinical settings, although the strength and independence of the continua vary between constructs, populations and measurement methods (Franken et al., 2018; Mason-Stephens et al., 2025; Westerhof & Keyes, 2010). The distinction has major implications for treatment outcomes. If positive mental health and psychopathology are related but not interchangeable, symptom reduction cannot automatically be interpreted as restoration of positive health. Conversely, persistence of symptoms does not necessarily demonstrate absence of positive capacities. Consider a person experiencing post-traumatic stress symptoms who remains capable of maintaining important relationships, seeking assistance, exercising judgement, caring for others and using sophisticated strategies for managing threat. The person's diagnosis may accurately identify clinically significant suffering, see Figure 1.3.

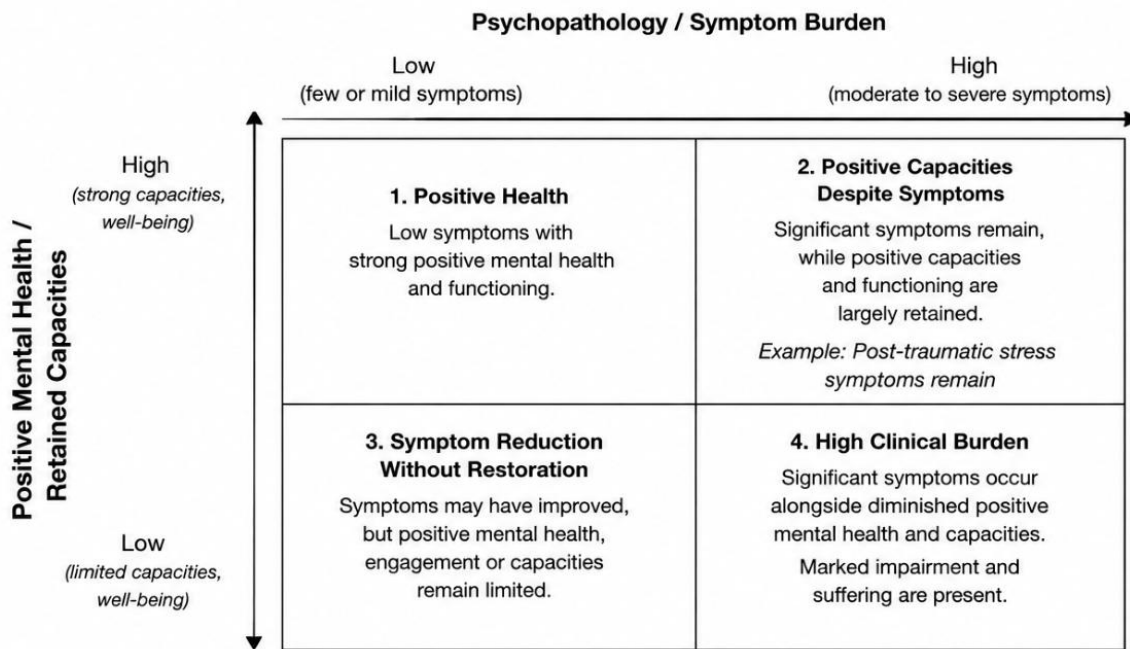


Figure 1.3. Psychopathology and positive mental health as related but distinct dimensions. The figure illustrates that symptom burden and positive mental health are not interchangeable. Reduced psychopathology does not necessarily indicate restoration of positive mental health, functioning or retained capacities. Conversely, clinically significant symptoms may coexist with strong relationships, judgement, help-seeking, caregiving and adaptive coping. The model highlights the need to assess both psychopathology and positive mental health when describing an individual's overall mental health status.

The same diagnosis may communicate relatively little about the adaptive capacities that have allowed the person to continue participating in life. The alternative error is equally important. A person may no longer meet criteria for a depressive episode (or other disorder) while experiencing disconnection, limited agency, absence of meaning or little confidence in managing future deterioration. Diagnostic remission in such a case would represent an important clinical improvement, however it would not provide a complete description of the person's positive mental health. The conceptual position proposed by PHCF is additive. Psychopathology and positive health can coexist and improvement in psychopathology and improvement in positive health can occur at different rates. Positive capacities may persist during periods of substantial psychopathology with the absence of diagnosable psychopathology does not establish the presence of positive health. Table 1 summarises the distinction.

Table 1.1.*Summary of the Classification Distinction*

Clinical State	Psychopathology	Positive Health	Possible Interpretation
High psychopathology with limited positive health	High	Low	Significant symptoms accompanied by limited current positive-health resources
High psychopathology with substantial positive health	High	High	Significant symptoms coexist with meaningful capacities, connection, adaptation or recovery resources
Low psychopathology with limited positive health	Low	Low	Few symptoms, but limited wellbeing, agency, connection or adaptive resources
Low psychopathology with substantial positive health	Low	High	Few symptoms accompanied by substantial positive-health capacities and resources

The model does not require these combinations to be treated as fixed categories; their value is conceptual. They demonstrate why a single bipolar continuum from illness to health could obscure clinically meaningful variation in presentation.

From Symptom Reduction to a More Complete Account of Recovery

The distinction between clinical recovery and personal recovery strengthens the argument proposed by the PHCF. Clinical recovery commonly emphasises changes in symptoms, diagnostic status and functioning. Personal recovery literature has developed partly because these outcomes do not fully describe how people understand recovery themselves (Leamy et al., 2011). Leamy et al. (2011) identified connectedness, hope, identity, meaning and empowerment as recurrent recovery processes. A later scoping review of systematic reviews and meta-analyses found continued support for CHIME while also showing that personal recovery remains conceptually and methodologically diverse (van Weeghel et al., 2019). The recovery literature creates an important challenge for classification. A person may continue to experience symptoms while developing a meaningful identity, greater agency, stronger relationships and an increased capacity to manage their condition. The clinical importance of such changes is not diminished because they fall outside conventional diagnostic criteria. Positive psychiatry presents a similar challenge. Jeste et al. (2015) argued that assessment of positive psychosocial characteristics should occur among people experiencing mental illness instead of only among nonclinical populations. Eglit et al. (2018) subsequently concluded that positive psychosocial factors vary substantially among people with serious mental illnesses and called for stronger psychometric assessment of their longitudinal course and clinical significance. The literature points toward a gap between recognising positive characteristics and classifying them systematically. A clinician may document that a person is resilient, insightful, connected to family, highly persistent or able to use effective coping strategies. Another clinician may record similar information under protective factors.

A third may incorporate it within formulation. A fourth may capture some aspects through a recovery measure or quality-of-life instrument. Each practice may be clinically sound. The problem is that the information lacks a common classification architecture. As a result, positive capacities can remain secondary to the diagnostic record, inconsistently defined and difficult to compare longitudinally. Their potential contribution to treatment selection, treatment engagement, relapse prevention, clinical handover and evaluation of recovery may remain underdeveloped.

Distinguishing Positive Health From Functioning and Quality of Life

A defensible positive-health framework must not simply rename established constructs. Functioning is particularly important because it already has a mature international classification framework through ICF. WHO defines functioning broadly through body functions, activities and participation, situated within environmental and personal contexts. The framework also recognises that actual performance is affected by the environment in which a person lives (WHO, 2001). Quality of life represents another related yet distinct construct concerning how individuals experience and evaluate important aspects of their lives. The distinction is important within psychiatric classification itself. In 2026, the American Psychiatric Association's Future DSM Strategic Committee published a series of papers outlining possible directions for the next iteration of DSM (Drexler et al., 2026; Oquendo et al., 2026; Öngür et al., 2026; Wainberg et al., 2026), see Figure 1.4.

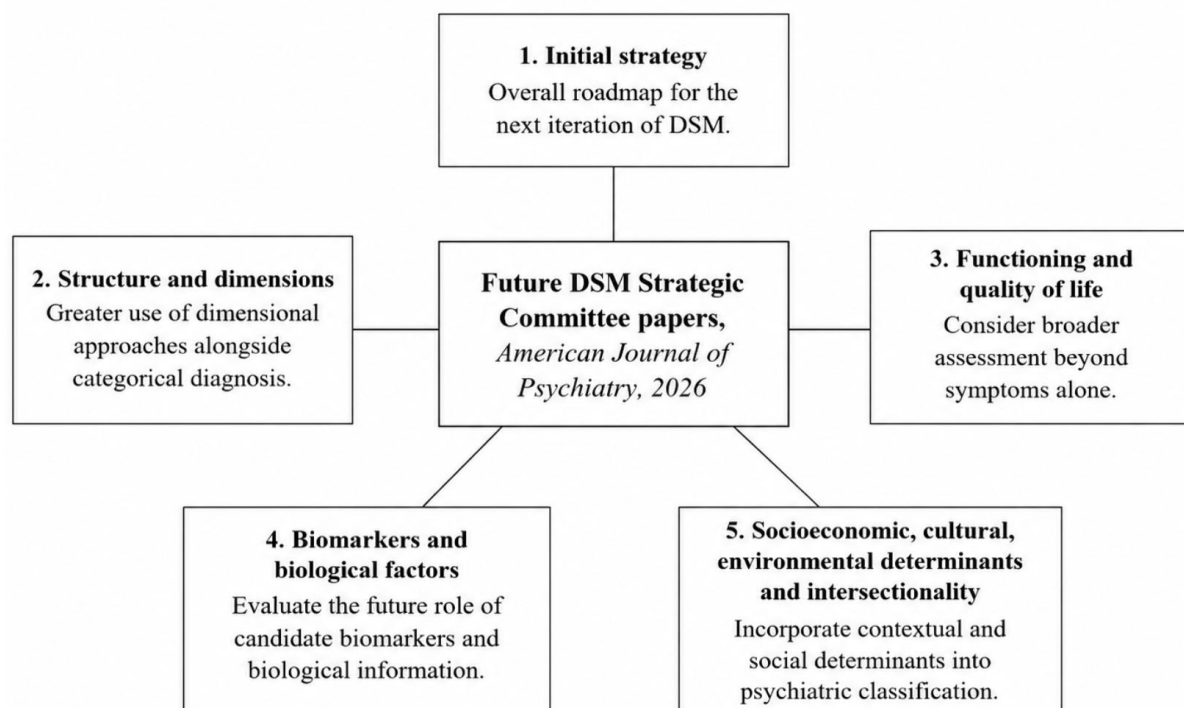


Figure 1.4. Proposed directions for the future DSM. The figure summarises the five areas highlighted in the 2026 Future DSM Strategic Committee paper series. These include an overarching strategy for future DSM development, greater use of dimensional approaches, consideration of functioning and quality of life, evaluation of biomarkers and biological factors, and increased attention to socioeconomic, cultural and environmental determinants and intersectionality. The figure is based on Oquendo et al. (2026), Öngür et al. (2026), Drexler et al. (2026), Cuthbert et al. (2026), and Wainberg et al. (2026).

The proposed direction includes greater dimensionality, different levels of diagnostic specificity, transdiagnostic characteristics and stronger consideration of contextual factors. One dedicated subcommittee concluded that functioning and quality of life are important elements of a complete mental health assessment and should be considered across diagnoses and longitudinally (Drexler et al., 2026; Oquendo et al., 2026; Öngür et al., 2026). The development is important for PHCF because it narrows and does not attempt to capture every positive aspect of a person's life. It does not reproduce ICF. It should not become another quality-of-life instrument. It should not simply add wellbeing scores to a psychiatric diagnosis. Its proposed contribution lies more specifically in the classification of positive-health capacities, demonstrated adaptation and protective resources that exist alongside psychopathology and may contribute to recovery, maintenance of health or adaptation to ongoing illness. Table 2 shows the conceptual boundaries.

Table 1.2.

The Relationship between PHCF and Other Frameworks

Framework or Construct	Primary Question	Proposed Relationship With PHCF
DSM and ICD	What mental disorder or clinical condition is present?	Source clinical classification remains unchanged
HiTOP and dimensional psychopathology approaches	How can psychopathology be organised dimensionally and hierarchically?	PHCF remains complementary to dimensional psychopathology
ICF	What can the person do, what do they do and how does context influence functioning?	Functioning remains separately describable
Quality of life	How does the person experience and evaluate their life?	Related outcome, but not equivalent to positive-health capacity
Personal recovery	How does the person experience living, adapting and developing a meaningful life with or beyond mental illness?	Major conceptual foundation for PHCF
Positive psychiatry	Which positive psychosocial characteristics and outcomes contribute to health?	Major construct and measurement foundation
PHCF	What positive capacities, demonstrated adaptations and protective resources are present, and how are they changing?	Proposed complementary classification

The boundary is critical. If PHCF merely reproduces wellbeing, functioning, resilience or recovery measures, then a new classification framework is unnecessary. Its scientific justification depends upon demonstrating that the proposed architecture captures clinically meaningful information that is not adequately represented by existing diagnostic, functioning or quality-of-life approaches.

The Emerging Direction of Psychiatric Classification

The proposed framework also emerges at a period of significant reconsideration of psychiatric classification. In 2024, the American Psychiatric Association established the Future DSM Strategic Committee to consider how the DSM should evolve as scientific knowledge advances. The committee's 2026 roadmap does not announce a DSM-6 or establish a final future architecture. It does, however, identify major directions under consideration, including dimensional assessment, diagnoses at different levels of specificity, transdiagnostic characteristics, greater incorporation of developmental and contextual information, functioning and quality of life, and mechanisms for more frequent revision as evidence changes (Oquendo et al., 2026). The Structure and Dimensions Subcommittee has proposed a flexible diagnostic construction model incorporating contextual factors, biological information, diagnostic classifications and transdiagnostic features. The stated intention is not simply to expand the number of diagnostic categories, but to consider whether psychiatric classification can represent clinical phenomena at different levels and integrate forms of information that conventional categorical diagnosis captures imperfectly (Öngür et al., 2026). In parallel, the Future DSM work on functioning and quality of life explicitly raises the prospect of incorporating information that has historically sat outside the core diagnostic classification. Drexler et al. (2026) argue that symptoms, functioning and quality of life represent distinct sources of clinically meaningful information and that functioning and quality of life should be assessed longitudinally. These developments should not be interpreted as evidence that PHCF is needed or that an international classification body would adopt it. Instead, contemporary psychiatric nosology (classification of diseases and disorders) is already questioning whether a disorder label and symptom criteria alone provide a sufficiently complete clinical description. The emerging environment provides an appropriate setting in which to ask whether another class of information remains insufficiently represented. That question concerns the positive capacities people retain, develop and express alongside mental illness.

Positive Capacity as Clinical Information

A central proposition of PHCF is that strengths and adaptive capacities should not be treated merely as affirming descriptions of the person. Where they can be defined and assessed reliably, they may constitute clinically relevant information. The distinction can be illustrated through trauma. A person who has experienced prolonged adversity may develop strategies that allow participation, relationship maintenance, help seeking, emotional regulation or continuation of valued activities. Some strategies may remain adaptive. Others may once have supported survival and later become costly. Hypervigilance, emotional suppression, extreme self-reliance or avoidance may have been useful within one environment and restrictive within another. PHCF should not equate exposure to adversity with resilience. Nor should it assume that survival constitutes flourishing. Instead, it should distinguish the person's current positive-health state from their demonstrated adaptive capacity. A person may currently be distressed, socially withdrawn and experiencing significant symptoms while also possessing a strong history of problem solving, persistence, help seeking or successful adaptation. That information may be relevant to formulation and intervention even when current wellbeing is poor. The same reasoning applies across conditions,

- A person with recurrent depression may possess sophisticated recognition of early warning signs.
- A person living with bipolar disorder may demonstrate strong capacity to recognise changes in sleep and mood and mobilise support.
- A person experiencing psychosis may retain meaningful relationships, a coherent sense of identity, hope and strong participation in valued roles.

- A person recovering from a substance use disorder may possess substantial personal, relational and community resources supporting continued recovery.
- A young person experiencing bullying may already have developed cognitive or imaginative strategies for distancing themselves from hostile interpersonal experiences.
- A classification of these capacities would not reduce the legitimacy of the person's symptoms. It would provide additional information concerning what can potentially be recruited within treatment.

A pair of questions arise, (1) 'what difficulties require intervention? And (2) 'what existing capacities and resources can support that intervention?'. A complete formulation may require both.

Why Classification Rather Than Another Measure

The mental health field already contains many scales of wellbeing, resilience, hope, recovery, social support and related constructs. The existence of these instruments raises a reasonable challenge. Why propose a classification framework rather than simply encourage clinicians to use existing measures? Three reasons warrant investigation.

First, individual measures tend to assess individual constructs. A resilience measure does not necessarily describe recovery, protective resources, self-management or current positive mental health. Positive psychiatry itself has identified a broad and fragmented measurement landscape (Eglit et al., 2018). Second, measures do not necessarily provide a common language for clinical communication. A numerical score can be useful for monitoring change but may have limited meaning when transferred between settings unless its construct and interpretation are understood consistently. Third, classification can provide an organising architecture within which measures, observations, clinical histories and person-reported experiences can be interpreted together. DSM and ICD demonstrate the practical value of common terminology even while their categories remain subject to scientific revision. ICF provides a comparable example for functioning. The proposition does not imply that classification is automatically preferable. A poorly designed classification could oversimplify human experience, create artificial thresholds, introduce cultural bias or medicalise normal variations in wellbeing. PHCF requires empirical justification rather than conceptual enthusiasm. Its value should be determined by whether systematic classification produces information that is reliable, valid, culturally defensible and clinically useful.

A Proposed Definition

For the purposes of the initial framework development, positive health classification is defined

“as the systematic description of positive mental health states, adaptive capacities, demonstrated adaptations and accessible protective resources that may support participation, recovery, adaptation or maintenance of mental health, considered independently from the presence or absence of psychopathology”.

Several features of the definition are deliberate. The framework describes states and capacities, and not classifying people as good, successful, normal or superior, including demonstrated adaptation, recognising that behavioural and longitudinal evidence may contribute information that is different from self-perceived resilience. The approach also includes protective resources, recognising that health is not located solely within an individual and that relational, cultural, community and structural resources may shape adaptation. It uses may support rather than asserting causal protection. A resource should not be

labelled protective merely because it exists. The definition also states explicitly that positive-health classification is considered independently from the presence or absence of psychopathology. A high positive-health classification should never be interpreted as evidence that a person's disorder is insignificant, that their distress is less legitimate or that treatment is unnecessary.

The Proposed Classification Gap

The central argument can now be stated more precisely. Modern mental health systems possess sophisticated classifications of mental disorder. They increasingly recognise functioning, quality of life, context, recovery, strengths and wellbeing. Evidence supports the proposition that positive mental health is not simply the inverse of psychopathology (Franken et al., 2018; Keyes, 2005; Mason-Stephens et al., 2025; Westerhof & Keyes, 2010). Recovery research further demonstrates that meaningful recovery can involve identity, agency, connection and purpose alongside continuing symptoms (Bird et al., 2014; Leamy et al., 2011; van Weeghel et al., 2019). What remains uncertain is whether these positive dimensions can or should be brought together within an interoperable classification framework that accompanies existing psychiatric classification. That uncertainty is the starting point for PHCF. PHCF begins as a research proposition, not an established classification system. Its central proposition is as a clinically complete description of mental health may require systematic classification of positive-health capacities and resources in addition to classification of psychopathology, functioning and quality of life. The proposition generates a stronger empirical test,

“Does a Positive Health Classification provide reliable and clinically meaningful information beyond diagnosis, symptom severity, functioning and quality of life?”

If the answer is no, a separate classification framework is difficult to justify. If the answer is yes, the implications may be substantial. The framework could provide a common language for recording positive capacities during initial assessment, using those capacities within formulation and treatment planning, monitoring their development during care, preserving them during clinical handover and describing outcomes that extend beyond symptom reduction. The aim is to determine whether psychiatric classification currently tells only part of the clinically relevant story.

Scope of the Positive Health Classification Framework

The first development phase of PHCF will focus on mental health rather than attempting to classify health across every medical discipline.

1. PHCF will initially examine four broad classes of positive-health information.
2. Current Positive Health State concerns the person's present experience of positive mental health, including meaningful engagement, connection and valued direction.
3. Positive Health Capacities concern capabilities such as agency, adaptive regulation, psychological flexibility, relational capacity and recovery self-management.
4. Demonstrated Adaptation concerns evidence that the person has previously mobilised effective responses to adversity, illness or significant challenge.
5. Protective Resource Ecology concerns personal, relational, cultural, community and structural resources that are available, accessible and potentially relevant to maintaining or restoring positive health.

The constructs remain provisional. Their boundaries, number and hierarchical relationships must ultimately be determined through systematic evidence synthesis, lived-experience involvement, expert consensus, psychometric investigation and clinical testing. PHCF should be designed from inception as a revisable framework. The approach is consistent with the broader movement toward psychiatric classifications that are more dimensional, contextual, evidence responsive and capable of evolving as scientific knowledge changes (Oquendo et al., 2026; Öngür et al., 2026). The ambition of PHCF is consequently substantial, but its first scientific task is deliberately modest. Before attempting to classify positive health, it must establish that there is something clinically important left to classify.

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Chapter Two - The Evolution of Mental Health Classification and Lessons for Positive Health Classification

Classification as an Evolving Clinical Technology

Classification systems are not static descriptions of reality, they are structured attempts to organise available knowledge so that clinicians, researchers, health systems and communities can communicate about health conditions with sufficient consistency to support useful decisions. Classification architecture reflects the scientific knowledge, clinical priorities, technologies and social assumptions available at the time they are created. Psychiatric classification demonstrates this process particularly clearly. The contemporary *Diagnostic and Statistical Manual of Mental Disorders* and the World Health Organization's *International Classification of Diseases* emerged through decades of revision. Each major revision responded to limitations identified in earlier systems. Some changes concerned terminology. Others altered the conceptual structure of diagnosis. The introduction of explicit diagnostic criteria in DSM-III changed psychiatric practice substantially. DSM-IV strengthened formal evidence review and field testing. DSM-5 increased attention to dimensionality, spectra, culture and cross-cutting clinical phenomena. ICD-11 placed strong emphasis on clinical utility, global applicability, lifespan presentation, cultural context and selected dimensional approaches. More recent systems and research frameworks, including the Hierarchical Taxonomy of Psychopathology, or HiTOP, and the Research Domain Criteria, or RDoC, have questioned whether traditional diagnostic categories provide the optimal level at which psychopathology should be organised (American Psychiatric Association, 2013, 2022; Cuthbert & Insel, 2013; Kotov et al., 2017, 2021; Reed et al., 2019; World Health Organization [WHO], 2024). The history is directly relevant to the development of the Positive Health Classification Framework, or PHCF. PHCF should not imitate the architecture of an existing edition of DSM or ICD. It should learn from the problems those systems encountered, the solutions that proved useful and the limitations that remain unresolved. The historical record suggests several principles, and classification requires a defined purpose. Terminology requires operational clarity, while reliability is necessary however does not establish validity. Clinical utility matters alongside psychometric performance and categories should not be created simply because clinicians recognise a phenomenon. Evidence needs to determine whether a construct is sufficiently coherent and useful to justify classification. Classification systems also need mechanisms for revision because scientific knowledge changes. These principles provide the methodological foundation for PHCF.

From Administrative Classification to Clinical Language

Psychiatric classification in the United States initially developed primarily to support statistical and administrative purposes. Early census systems recorded broad categories of mental disturbance. By the late nineteenth and early twentieth centuries, attempts were being made to standardise terminology across institutions. The American Medico-Psychological Association, later renamed the American Psychiatric Association, worked with other organisations to improve the consistency of psychiatric statistics and nomenclature. Military psychiatry during and after the Second World War expanded the range of presentations requiring classification, particularly among people who were not living in long-term psychiatric institutions (American Psychiatric Association, n.d.; Mayes & Horwitz, 2005). The first DSM was published in 1952. DSM-I contained 106 diagnoses within a manual of approximately 130 pages. DSM-II followed in 1968 and expanded the classification to approximately 182 diagnoses. The early manuals relied substantially on descriptive clinical formulations and prevailing psychiatric theories. They did not provide the operational symptom criteria associated with modern DSM diagnosis (Mayes & Horwitz, 2005). The growth in the number of classifications is historically interesting,

although the number itself should not be treated as an indicator of scientific progress. A classification can become more useful by creating new categories when evidence demonstrates meaningful distinctions. It can also become more complicated without corresponding gains in validity or clinical utility.

Table 2.1

Selected Developments in the Evolution of DSM

Classification Year		Approximate Number of Diagnoses	Major Development Relevant to PHCF
DSM-I	1952	106	Established a formal clinical psychiatric nomenclature in the United States
DSM-II	1968	182	Expanded diagnostic coverage and increased alignment with ICD terminology
DSM-III	1980	265	Introduced explicit diagnostic criteria and a multiaxial assessment system
DSM-III-R	1987	292	Revised operational criteria using accumulated clinical and research experience
DSM-IV	1994	297	Strengthened systematic literature review, data reanalysis and field trials
DSM-5	2013	Counting varies by method	Removed the multiaxial system and increased dimensional and spectrum-oriented elements
DSM-5-TR	2022	Not usefully represented by a simple count	Updated text, evidence, terminology and selected diagnostic criteria within an ongoing revision model

Note. Historical diagnosis counts through DSM-IV are based on Mayes and Horwitz (2005). Counts in DSM-5 and DSM-5-TR depend on decisions about diagnoses, subtypes, specifiers and other coded conditions, so a single total can be misleading.

The lesson for PHCF is immediate. The success of a classification framework should not be judged by the number of categories it contains. PHCF does not need a positive equivalent for every DSM or ICD disorder. The initial architecture can remain deliberately compact. Additional constructs should be introduced when evidence demonstrates that they describe clinically meaningful information that cannot be adequately represented within existing domains.

DSM-III and the Problem of Reliability

DSM-III, published in 1980, represents one of the most consequential changes in modern psychiatric classification. Its importance was methodological as well as clinical. Psychiatric diagnosis

had long faced concerns about reliability. Different clinicians could examine similar presentations and reach different diagnostic conclusions because diagnostic concepts were interpreted differently. Spitzer et al., (1975) identified variation in the use of inclusion and exclusion criteria as a major source of diagnostic unreliability. Their work supported the use of specified diagnostic criteria as a means of increasing consistency. DSM-III incorporated explicit criteria sets, clearer decision rules and a descriptive approach that sought to reduce dependence on any single theory of aetiology. It also introduced a multiaxial assessment system. These changes promoted a more standardised diagnostic language across clinical practice and research (American Psychiatric Association, n.d.; Mayes & Horwitz, 2005). The expansion was substantial. DSM-II had contained approximately 182 diagnoses. DSM-III contained approximately 265 and was considerably longer. The increase reflected both greater differentiation of clinical phenomena and a fundamentally different approach to defining psychiatric disorders (Mayes & Horwitz, 2005). DSM-III demonstrates one of the first essential design requirements for PHCF. A clinically meaningful idea is not yet a classifiable construct. Terms such as resilience, courage, agency, tenacity, recovery and flourishing have intuitive meaning. Intuitive meaning is insufficient for a classification framework. If two clinicians interpret *adaptive capacity* differently, the classification has limited communicative value. If *demonstrated adaptation* means persistence to one clinician and symptom improvement to another, the construct cannot perform the role intended for it. PHCF requires operational definitions that specify the construct being assessed, the evidence that supports its presence, the phenomena that fall outside its boundaries and its relationship with neighbouring constructs. Reliability represents the first threshold. It cannot be the final threshold. Adamson (1989) noted an important limitation of the DSM-III approach. Increased reliability does not establish diagnostic validity. Clinicians can agree consistently about a category that does not correspond to a coherent underlying phenomenon or that provides little clinical value. The same warning applies to PHCF. High inter-rater agreement would show that clinicians can use the framework consistently. It would not establish that the classified capacities are genuinely distinct, predict outcomes, improve treatment planning or provide information beyond existing measures. PHCF needs both reliability and validity.

The Multiaxial Experiment and Its Eventual Abandonment

DSM-III also introduced a multiaxial system designed to encourage assessment across several aspects of clinical presentation. DSM-IV retained five axes covering clinical disorders, personality disorders and intellectual disability, relevant medical conditions, psychosocial and environmental problems and a global assessment of functioning. The intent was clinically broad. A diagnosis alone did not describe the whole clinical situation. The architecture did not survive and DSM-5 discontinued the formal multiaxial system. Diagnostic information had previously been distributed across the first three axes was combined into a nonaxial diagnostic structure. Psychosocial and contextual information could still be documented and disability was separated from the former Global Assessment of Functioning (GAF) approach. APA noted that the GAF combined symptom severity, risk and functioning into a single score even though these components may vary independently over time (American Psychiatric Association, 2013). The lesson for PHCF is that clinically important information does not need to be organised into separate axes. The proposed PHCF should avoid an architecture in which psychopathology occupies one axis, positive health another and functioning a third. Such a structure would reproduce an organisational model that modern DSM has already left behind. A contemporary PHCF can instead operate through linked dimensions and nested domains. Positive-health constructs can be described independently while remaining connected within one integrated clinical formulation. The history of the GAF offers a second lesson. Different clinical phenomena should not be compressed into a single global score without strong empirical justification. Symptoms, adaptive capacity,

functioning, positive wellbeing and protective resources may correlate. Correlation does not make them interchangeable. PHCF should preserve that distinction from its first version.

DSM-IV and the Importance of Evidence Development

DSM-IV, published in 1994, retained the core descriptive and operational structure established by DSM-III. Its revision process placed greater emphasis on systematic empirical evaluation. The development program involved more than 1,000 contributors and professional organisations. Working groups reviewed literature, analysed existing datasets and conducted field trials for proposed changes. First (2017) described the DSM-IV revision process as involving comprehensive literature reviews, secondary data analyses and field trials designed to provide evidence relevant to reliability and validity. The process is particularly relevant to PHCF because it demonstrates that classification development cannot rely solely on expert agreement. Expert judgement remains important. Experts identify relevant constructs, interpret complex evidence and determine clinical feasibility. Expert agreement becomes vulnerable when consensus takes the place of systematic evidence. Kendler and Solomon (2016) argued that DSM development depended heavily on expert consensus and that psychiatric nosology should make stronger use of systematic evidence-review methods. PHCF should adopt that principle explicitly and the proposed construct could enter the framework because evidence supports it. A construct should remain provisional when evidence remains weak or conflicting. Consensus should determine how evidence is interpreted and implemented. Terms including resilience, flourishing, growth and recovery are used across large literatures with different theoretical definitions and measurement approaches. A classification framework could easily collapse related concepts into broad labels that sound clinically attractive yet lack construct precision. Each proposed PHCF construct should undergo a staged evidentiary process. The process should begin with evidence synthesis and construct definition and proceed through content validity, measurement development, field testing and clinical utility studies. Criteria or thresholds should be introduced only when empirical evidence supports them. DSM-IV provides a useful historical lesson. The credibility of a classification depends partly on the transparency of the process used to construct it, see Figure 2.1.

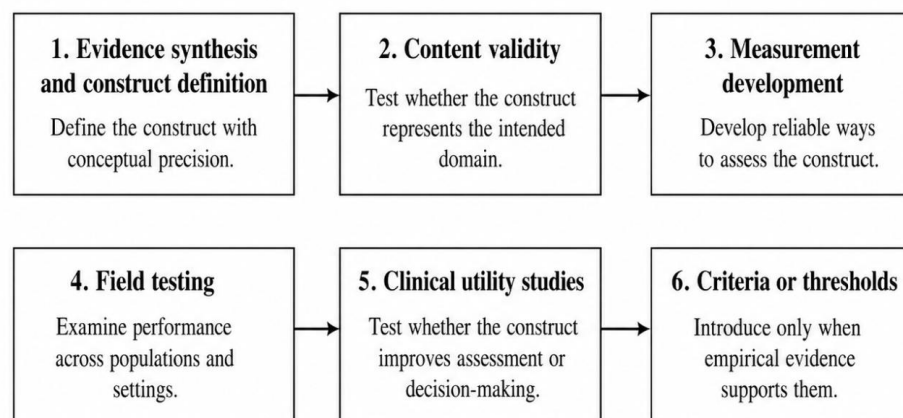


Figure 2.1. Staged evidentiary process for PHCF construct development. The figure summarises a staged process for developing PHCF constructs. The process begins with evidence synthesis and construct definition, then proceeds through content validity, measurement development, field testing and clinical utility studies. Criteria or thresholds are introduced only when supported by empirical evidence.

Field Testing and Clinical Utility

Classification becomes clinically meaningful when it can be used by the people for whom it was designed. Field trials provide one mechanism for examining this requirement. First (2016) distinguishes developmental field trials from summative field trials. Developmental field trials provide information that can be used to revise a proposed classification before finalisation. They can examine feasibility, reliability, validity and clinical utility. Summative field trials primarily describe how a completed classification performs. The distinction has direct implications for PHCF. Early versions of PHCF should be deliberately unstable. Clinicians should be able to identify confusing terms, redundant constructs and areas where required information cannot realistically be obtained. People with lived experience should be able to identify classifications that misrepresent recovery, resilience, culture or adaptation. Researchers should be able to demonstrate that apparently separate domains measure the same underlying phenomenon. Evidence should be capable of removing constructs from the framework. A classification that cannot change during development is not undergoing validation. It is undergoing confirmation. PHCF should use developmental field testing as part of its architecture. Clinical utility must also be treated as an empirical outcome. A construct may be theoretically coherent and psychometrically reliable while contributing little to clinical work. If recording *demonstrated adaptation* does not change formulation, treatment planning, clinical communication, prognosis or recovery monitoring, its place in a clinical classification becomes questionable, see Figure 2.2. The key question is whether knowing the classification changes or improves clinically relevant understanding or decisions.

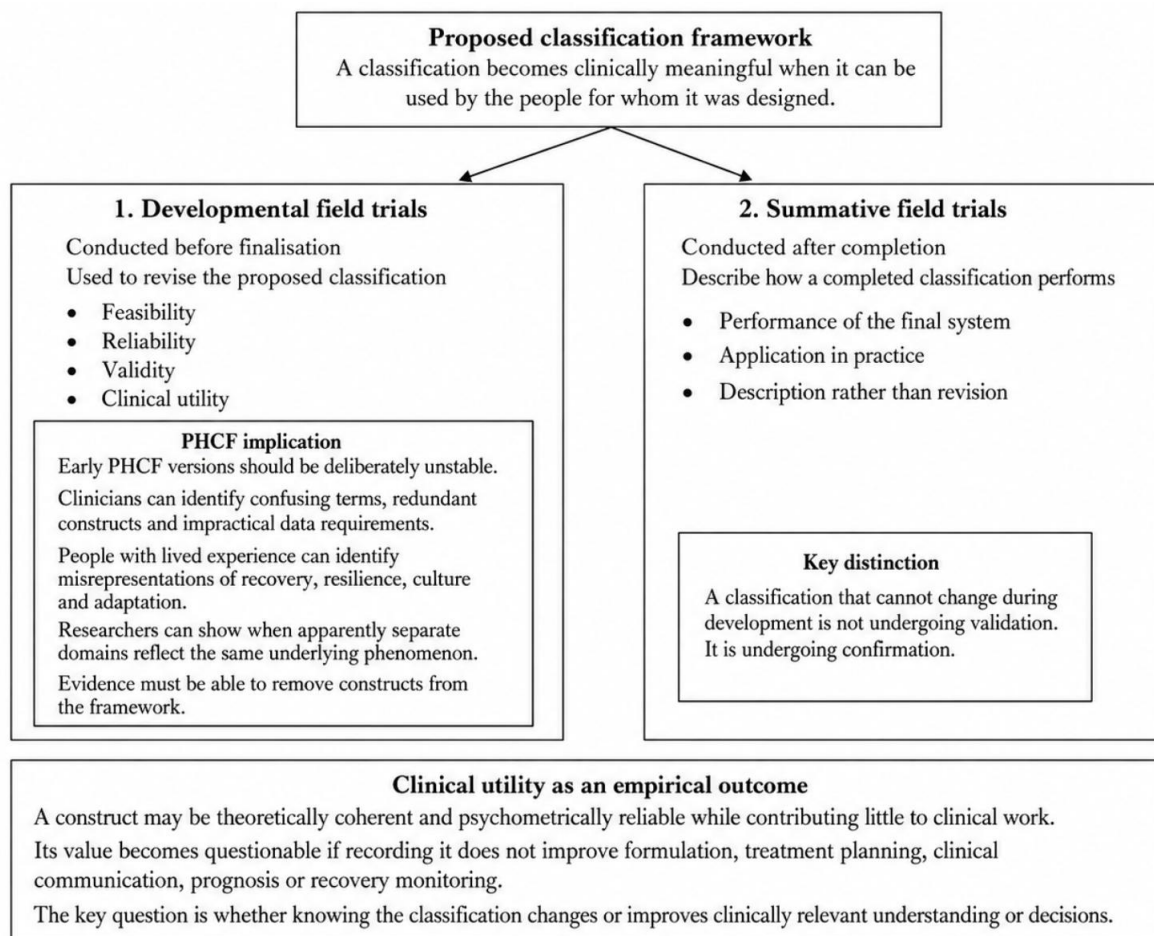


Figure 2.2. Developmental and summative field trials in PHCF, showing how early testing supports revision while later testing evaluates performance and clinical utility.

ICD and the Requirement for Global Clinical Utility

The ICD has a different mandate from DSM. It is a global health classification produced by WHO and is designed for use across countries, professions, languages and health systems. Mental disorders first appeared as a dedicated part of the ICD in the mid-twentieth century. Successive revisions developed increasingly detailed psychiatric classifications while retaining ICD's broader role in morbidity and mortality reporting. ICD-10 represented an important international standardisation effort. Its mental and behavioural disorders materials included clinical descriptions and separate diagnostic criteria for research. The research criteria were tested internationally and were designed to improve comparability across research settings (WHO, 1993). The development of ICD-11 placed clinical utility and global applicability at the centre of the revision process. First et al. (2015) described clinical utility as an organising priority for the development of the ICD-11 mental and behavioural disorders guidelines. The development process used standardised content structures, internet-based studies and clinical field studies. Large international field trials subsequently tested reliability and clinical utility. Reed et al. (2018a) examined diagnostic reliability for high-burden mental disorders across mental health settings in 13 countries. A companion clinical utility study involved 339 clinicians assessing 1,806 patients across 28 mental health settings in 13 countries. Clinicians generally rated the proposed ICD-11 guidelines positively for clarity, goodness of fit, level of detail, efficiency and usefulness in differentiating disorders (Reed et al., 2018b).

The final ICD-11 Clinical Descriptions and Diagnostic Requirements mental, behavioural and neurodevelopmental disorders (CDDR) were published by WHO in 2024. WHO reports that development involved hundreds of experts and thousands of clinicians internationally. The CDDR incorporate lifespan perspectives, culture-related guidance and dimensional approaches in selected areas. ICD-11 personality disorder classification provides a prominent example of movement toward dimensional severity and trait qualifiers (Reed et al., 2019; WHO, 2024). ICD-11 adds several design requirements for PHCF. First, clinical utility should be designed into the framework, not assessed only after construction. Second, global applicability cannot be assumed from evidence generated in a small number of high-income Western settings. Third, culture must influence construct interpretation from the beginning. Fourth, classification requirements need sufficient flexibility to accommodate genuine variation in clinical presentation. These principles are especially important when classifying positive health. Concepts such as independence, achievement, autonomy, family obligation, spirituality, emotional expression and social participation have different meanings across cultures and communities. A positive-health classification built around one cultural definition of the successful individual could reproduce social values under the language of health. PHCF requires international and cultural validation at the level of the construct itself.

The Increasing Role of Dimensional Classification

Traditional psychiatric classification has relied heavily on categories. A person meets diagnostic requirements or does not. Categories have substantial practical utility because they support communication and clinical decisions. Psychopathology frequently behaves dimensionally. Symptoms vary in intensity. Clinical boundaries can be uncertain. People with the same diagnosis can present very differently, while people assigned different diagnoses can share substantial psychopathology. DSM-5 incorporated more dimensional and spectrum-oriented thinking while retaining categorical diagnoses as its main clinical architecture. ICD-11 has also adopted dimensional approaches in selected areas. Personality disorders provide the clearest example, with ICD-11 placing severity at the centre of classification and adding trait-domain qualifiers (American Psychiatric Association, 2013; Reed et al., 2019). The implication for PHCF is strong. Positive health is unlikely to divide naturally into a series of discrete states created in advance. Agency can be weak, accessible in some settings, established

across settings or highly developed. Adaptive regulation can vary with context. Protective resources can strengthen or deteriorate. A person's capacity to manage future episodes may improve substantially without crossing a natural categorical threshold. PHCF should begin dimensionally. If future research identifies clinically meaningful thresholds, categorical descriptors can be added, their existence should be demonstrated empirically. The decision has another advantage; a dimensional framework allows clinically significant change to be recorded even when a person remains within the same broad classification.

HiTOP and the Challenge to Disorder-Level Organisation

The Hierarchical Taxonomy of Psychopathology (HiTOP) represents a major contemporary challenge to conventional psychiatric nosology. HiTOP developed from evidence that traditional categorical diagnoses can contain substantial heterogeneity and frequently coexist with other diagnoses. Kotov et al. (2021) proposed a quantitative, hierarchical model in which psychopathology could be organised according to empirically observed patterns of covariation. Subsequent development has organised psychopathology across levels extending from symptoms and maladaptive behaviours through components, syndromes and subfactors to broader spectra and superspectra (Cicero et al., 2024; Kotov et al., 2021). The significance of HiTOP for PHCF lies in its method. HiTOP does not assume that existing diagnostic categories identify the natural higher-order structure of psychopathology. Statistical relationships among phenomena help determine how the hierarchy is organised. PHCF should adopt the same openness. Initial evidence searches may begin with familiar DSM and ICD families because those groupings organise the clinical literature. Depression, anxiety, trauma, psychosis, bipolar disorder, obsessive-compulsive presentations, substance use and eating disorders provide practical starting points. The final architecture will not reproduce those families/structures, and research may show that certain positive capacities operate across many conditions. Agency may prove transdiagnostic. Psychological flexibility may appear across anxiety, depression, trauma and obsessive-compulsive presentations. Relational capacity may be relevant across psychosis, mood disorders, trauma and personality functioning. Self-management may emerge as a broad higher-order capacity. If these patterns occur, PHCF should reorganise around them. Condition-specific modules should remain where evidence supports meaningful specificity. The hierarchy should follow the data.

RDoC and the Shift Toward Functional Systems

The National Institute of Mental Health launched the Research Domain Criteria (RDoC) initiative in 2009. RDoC was created as a research framework for investigating mental disorders through dimensions of observable behaviour and neurobiological systems cutting across traditional diagnostic categories (Insel et al., 2010). RDoC currently organises research around broad domains of human functioning and more specific constructs and subconstructs. These constructs are examined across a continuum extending from typical to atypical functioning and can be studied through multiple units of analysis, including physiology, behaviour and self-report. Developmental and environmental influences are integral to the framework (Cuthbert & Insel, 2013; National Institute of Mental Health [NIMH], 2026). RDoC is not intended to function as a clinical diagnostic manual. Its relevance to PHCF lies in several design principles. The first is construct-based organisation. A framework can begin with psychologically meaningful functions instead of beginning with disorder categories. The second is transdiagnostic analysis. The same process can contribute to several clinical presentations. The third is dimensionality. Human functioning can be studied across a continuum. The fourth is multimethod measurement. Self-report provides one source of information among several. The fifth is developmental and environmental context. A psychological process cannot be understood completely without considering when and where it occurs. The sixth is revision with accumulating science. NIMH describes

the RDoC matrix as dynamic and capable of changing as research evolves. These principles align closely with the emerging PHCF architecture. PHCF should not copy the RDoC matrix, see Figure 2.3.

No.	RDoC Principle	Implication for PHCF
1.	Construct-based organisation	A framework can begin with psychologically meaningful functions instead of disorder categories.
2.	Transdiagnostic analysis	The same process can contribute to several clinical presentations.
3.	Dimensionality	Human functioning can be studied across a continuum.
4.	Multimethod measurement	Self-report is one source of information among several.
5.	Developmental and environmental context	Psychological processes should be understood in relation to life stage and context.
6.	Revision with accumulating science	Classification frameworks should remain dynamic and open to revision as evidence evolves.

Figure 2.3. *Principles from the RDoC framework and their alignment with PHCF. The figure summarises six principles associated with the Research Domain Criteria approach that are relevant to the development of PHCF.*

DSM-5-TR and Continuous Improvement

DSM-5 was published in 2013. DSM-5-TR followed in 2022. The text revision updated descriptive material, terminology, references and selected diagnostic content, and added prolonged grief disorder as a formal diagnosis (American Psychiatric Association, 2022). A significant structural development has occurred alongside the text revision. APA now accepts proposals for changes to DSM-5-TR on a rolling basis. The organisation describes this as a continuous improvement model enabled by digital publishing. Proposed changes require supporting information addressing issues including validity, reliability, clinical utility and potential unintended consequences (American Psychiatric Association, 2026a). The development moves psychiatric classification away from the assumption that scientific knowledge should be frozen for a decade or more between major printed editions. This principle has direct application to PHCF. PHCF should be version controlled from inception. A construct added in PHCF 1.2 should be identifiable as different from one used under PHCF 1.0. Definitions should have persistent identifiers. Historical classifications should preserve the version under which they were made. Evidence reviews should be capable of triggering modifications. Constructs should be removed when evidence no longer supports them. A living classification also requires stronger governance. Frequent revision can improve responsiveness to science, but excessive or poorly controlled revision can reduce reliability, disrupt communication and make longitudinal comparison difficult. PHCF will eventually require explicit thresholds for minor revisions, major revisions and changes that alter the meaning of a classification.

The Future DSM and the Changing Boundaries of Diagnosis

The most important development for PHCF may be occurring now. In 2024, the American Psychiatric Association established the Future DSM Strategic Committee to develop a roadmap for the next iteration of DSM. The committee released its initial strategy and associated reports in 2026. These documents do not constitute a new DSM and do not establish the final architecture of the next manual.

They identify areas being actively considered for future development (Oquendo et al., 2026). The Structure and Dimensions Subcommittee proposed consideration of a more flexible architecture involving contextual factors, biological factors, diagnoses at differing levels of specificity and severity, and transdiagnostic characteristics. The approach acknowledges increasing evidence that psychiatric phenomena can be represented at several levels and that clinically meaningful characteristics frequently cross conventional diagnostic boundaries (Öngür et al., 2026). A second Future DSM report examined functioning and quality of life. Drexler et al. (2026) argued that symptoms, functioning and quality of life provide distinct forms of clinically relevant information and should be considered across diagnoses and longitudinally. The proposal reflects a broader movement toward clinical descriptions that extend beyond categorical symptom identification. APA has also publicly discussed the possibility of a digital-first, more frequently updated "living" DSM. The proposal remains developmental. Its direction is important because it recognises that contemporary classification infrastructure should be capable of incorporating validated scientific changes without waiting for infrequent wholesale revisions (American Psychiatric Association, 2026b). These developments narrow the conceptual territory available to PHCF. PHCF does not need to classify psychopathology nor duplicate functioning and reproduce quality-of-life assessment. It also does not need to classify socioeconomic, cultural and environmental determinants already receiving explicit attention within future diagnostic development. Its proposed scientific contribution becomes more precise. PHCF concerns positive-health capacities, demonstrated adaptation, recovery capability and protective resources that are not adequately communicated by diagnosis, symptom severity, functioning or quality of life alone. The framework will only be justified if those constructs demonstrate additional clinical value, see Figure 2.4.

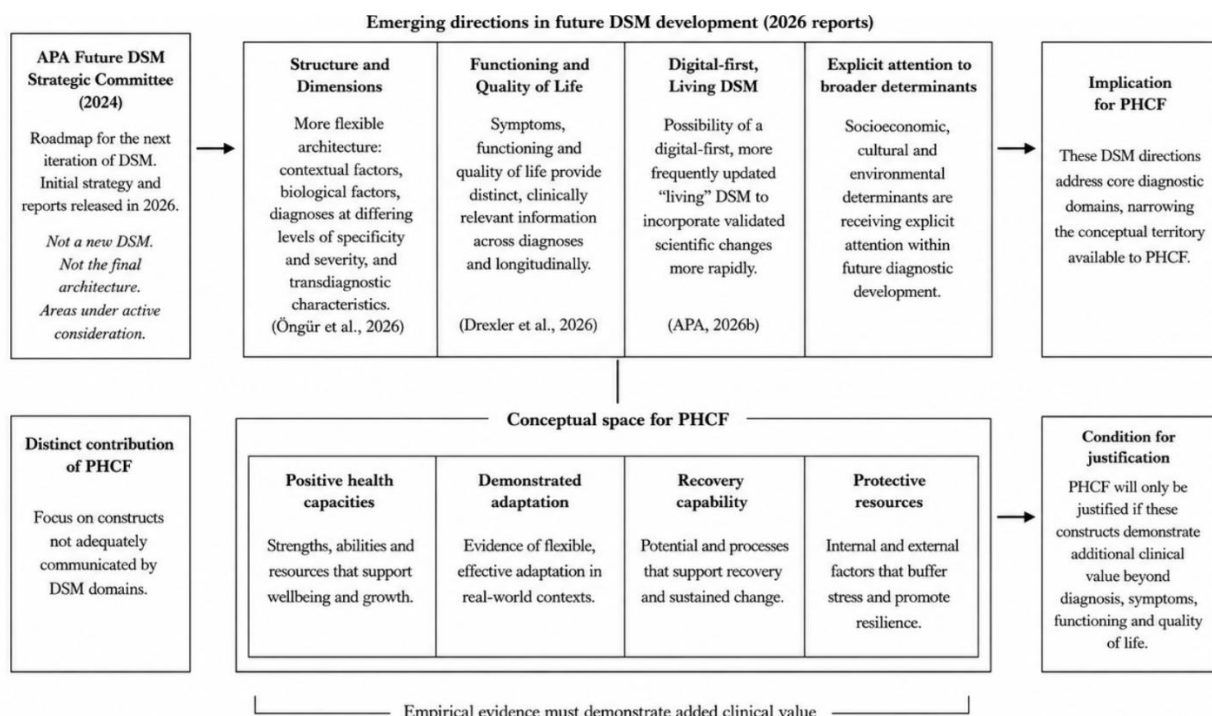


Figure 2.4. Future DSM developments and the conceptual space for PHCF, highlighting emerging diagnostic directions and the distinct PHCF focus on positive health capacities, demonstrated adaptation, recovery capability and protective resources.

Convergence Across Modern Classification Approaches

The major classification developments of the past five decades point toward several areas of convergence. Contemporary systems increasingly recognise dimensionality. They recognise that clinical phenomena exist at several levels of specificity. They acknowledge substantial overlap across diagnostic categories. Culture and context receive greater attention. Development across the lifespan matters. Functioning cannot be inferred solely from diagnosis. Clinical utility is increasingly treated as an explicit design goal. Digital systems make continuous revision possible. No single system resolves every problem. DSM retains substantial clinical and research influence and provides highly operationalised diagnostic criteria. ICD provides the international health-classification infrastructure and explicitly prioritises global clinical utility. HiTOP offers an empirical dimensional hierarchy of psychopathology. RDoC provides a research architecture organised around functional systems and multiple units of analysis. ICF provides a separate international language for functioning and disability. PHCF can be designed to coexist with all of them because it addresses a different classification question.

Table 2.2*Classification Developments and Their Design Implications for PHCF*

Development	Problem Addressed	Design Lesson for PHCF
DSM-III operational criteria	Diagnostic unreliability	Define constructs and classification requirements explicitly
DSM multiaxial system and its removal	Need for broader clinical information and problems with artificial separation	Use integrated domains without recreating axes
DSM-IV evidence review	Need for stronger empirical justification	Require systematic evidence review before formalising constructs
Developmental field trials	Classification may perform differently in practice	Test PHCF with intended users during development
ICD-11 clinical utility	International systems must work in actual clinical settings	Treat usability and clinical value as empirical outcomes
ICD-11 cultural guidance	Clinical phenomena are culturally expressed and interpreted	Build cultural evaluation into construct development
ICD-11 dimensional developments	Binary categories can lose clinically meaningful information	Begin with dimensional classification
HiTOP hierarchy	Diagnostic categories show heterogeneity and comorbidity	Allow empirical evidence to determine higher-order PHCF structure
RDoC	Important functions cross diagnostic boundaries	Develop transdiagnostic constructs and use multiple forms of evidence
DSM continuous improvement	Scientific knowledge changes between major editions	Make PHCF versioned and updateable
Future DSM roadmap	Diagnosis is moving toward dimensional, contextual and longitudinal information	Define PHCF's incremental contribution with precision

What PHCF Should Learn From the History of Classification

The history of psychiatric classification offers a caution against attempting to design a complete system before the evidence exists. DSM-I did not anticipate DSM-III. DSM-III did not anticipate HiTOP or RDoC. ICD-10 did not contain the digital architecture, postcoordination capabilities or dimensional personality classification developed within ICD-11. Each system evolved because new scientific, clinical and technological conditions exposed limitations in what came before. PHCF begins as a deliberately incomplete framework. Its first version needs enough structure to support research. It does not need to provide definitive criteria for every presentation. It does not need twenty clinical modules if evidence supports eight. It does not need a global positive-health score if the domains prove meaningfully independent. It does not need categorical levels if dimensional information proves more valid. The initial framework needs clear constructs, explicit boundaries, a defined relationship with existing classifications and a method for evaluating proposed additions. The framework must also tolerate its own revision. A construct currently labelled *demonstrated adaptation* may eventually divide into several empirically distinct constructs. Protective Resource Ecology (Ungar, 2011; Ungar & Theron, 2020) may prove to belong partly outside the formal classification. Clinical presentation modules may shrink if transdiagnostic domains explain most of their variance. New constructs may emerge from lived-experience research that are not prominent in the current academic literature. These outcomes would represent scientific development.

A Design Standard for PHCF

The evolution of DSM, ICD, HiTOP and RDoC provides a useful foundation for establishing the preliminary design requirements of the PHCF. Any such framework must have a clear clinical purpose, with each construct linked to an identifiable use in assessment, formulation, treatment planning, outcome monitoring or clinical communication. The constructs must also be operationally defined so that different users can determine what is being classified and distinguish one construct from another with sufficient consistency. The framework should begin from a dimensional position. Positive-health capacities are unlikely to divide naturally into fixed categories unless empirical evidence demonstrates meaningful thresholds. A hierarchical structure is also required so that broad domains can contain more specific constructs without forcing every clinically relevant feature into a separate classification. The architecture should remain transdiagnostic, allowing common capacities to operate across different clinical presentations while retaining condition-related modules where evidence supports additional specificity. Assessment within PHCF should draw on multiple sources of information. Self-report, clinical interview, behavioural and developmental history, clinical observation and longitudinal evidence may each contribute to classification. Reliance on a single method would risk reducing complex positive-health constructs to the limitations of one measurement approach. The framework must also remain sensitive to cultural, developmental and contextual influences. Concepts such as autonomy, social participation, productivity, family obligation and emotional expression vary across cultural and social settings and cannot be treated as universal indicators of positive health.

Interoperability is another essential requirement. PHCF should be capable of accompanying DSM, ICD, HiTOP or other recognised classification approaches without requiring those systems to be translated into a separate PHCF diagnosis. Its role is to add clinically relevant information that is not sufficiently represented by the source classification. The framework must remain conceptually distinct from psychopathology, functioning and quality of life while retaining clear relationships with each. The clinical value of PHCF must also remain open to empirical testing. Its constructs should be examined within assessment, formulation, treatment, recovery and transition-of-care settings. Constructs that cannot be measured reliably, fail to demonstrate validity or add no meaningful information beyond existing clinical measures should be revised or removed. PHCF must be falsifiable at both the level of

individual constructs and the broader framework. Its continued development should depend on evidence, not on preserving the original architecture. The framework should also be designed for revision from its inception. Contemporary classification systems increasingly recognise that scientific knowledge changes too rapidly for a manual to remain fixed between infrequent major editions. PHCF should be versioned and capable of incorporating new evidence while preserving the meaning of classifications made under earlier versions. These principles provide the bridge between the historical development of psychiatric classification and the construction of PHCF. The history of psychiatric nosology does not show a steady progression toward a final or definitive classification of mental disorder. It shows successive attempts to solve emerging scientific and clinical problems. Reliability, validity, clinical utility, dimensionality, cultural applicability, hierarchical organisation and continuous revision became more prominent as limitations in earlier systems became apparent.

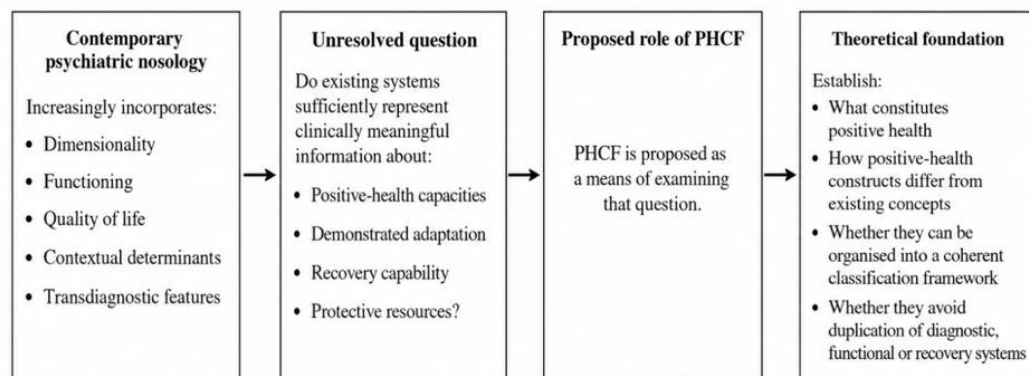


Figure 2.5. *The unresolved gap and proposed role of PHCF, showing how contemporary psychiatric nosology leaves open the question of whether positive-health capacities, adaptation, recovery capability and protective resources require a distinct classification framework.*

The same standard must be applied to positive-health classification (see Figure 2.5). As contemporary psychiatric nosology increasingly incorporates dimensionality, functioning, quality of life, contextual determinants and transdiagnostic features, an important question remains unresolved. It is whether clinically meaningful information concerning positive-health capacities, demonstrated adaptation, recovery capability and protective resources remains insufficiently represented within existing systems.

PHCF is proposed as a means of examining that question. Its theoretical foundations must establish what constitutes positive health, how positive-health constructs differ from existing concepts and whether they can be organised into a coherent classification framework without duplicating established diagnostic, functional or recovery systems. The following chapter develops that theoretical foundation.

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Chapter Three - Theoretical Foundations of Positive Health Classification

Locating Positive Health Within Existing Theory

The PHCF rests on a substantial body of theory and empirical research concerned with health, wellbeing, adaptation, recovery, resilience and human functioning. Its proposed contribution does not depend on demonstrating that these concepts are new. Most have extensive intellectual histories and established measurement traditions. The theoretical task is to determine whether they can be organised into a coherent classification architecture that provides information not adequately represented by psychopathology, functioning or quality-of-life assessment. Several traditions are particularly relevant. Salutogenesis (study of how health is created, maintained and strengthened) health shifted attention toward the processes and resources associated with the creation and maintenance of health. Psychological wellbeing research developed multidimensional models of positive functioning. The two-continua model demonstrated that positive mental health and mental illness cannot be treated as simple opposites. Positive psychology and positive psychiatry expanded systematic investigation of positive psychological characteristics and outcomes. Personal recovery research established the importance of hope, identity, meaning, connectedness and empowerment among people living with mental illness. Resilience research examined adaptive functioning following significant adversity and highlighted the importance of developmental, social and contextual processes. Recovery capital provided a framework for conceptualising the resources available to people during recovery from substance-related disorders. The International Classification of Functioning (ICF), Disability and Health established an international framework in which health conditions interact dynamically with functioning and environmental context. These traditions overlap, but they address different questions. Their concepts should not be collapsed into a general category of strengths or wellness. PHCF depends on preserving their distinctions while identifying the theoretical principles that can support a complementary positive-health classification. Table 3.1 summarises the primary contribution of each tradition.

Table 3.1*Theoretical Traditions Relevant to PHCF*

Theoretical Tradition	Central Contribution	Primary Relevance to PHCF	Important Boundary
Salutogenesis	Explains movement toward health and mobilisation of resources	Health orientation, adaptive resources and dynamic movement	Does not provide a comprehensive clinical classification of positive mental health
Psychological wellbeing	Defines multidimensional positive psychological functioning	Meaning, autonomy, relationships, mastery and positive self-experience	Wellbeing is not equivalent to adaptation or recovery capability
Two-continua model	Separates positive mental health from mental illness	Establishes independence of PHCF from psychopathology	Does not classify the full range of adaptive capacities and resources
Positive psychology	Studies positive experiences, characteristics and institutions	Provides broad positive psychological constructs	Contains constructs with variable clinical relevance
Positive psychiatry	Applies positive constructs within clinical populations	Connects positive characteristics with psychiatric assessment and intervention	Remains a broad field and measurement approach rather than a unified classification
Personal recovery and CHIME	Defines recovery through lived experience	Hope, identity, meaning, connectedness and empowerment	Personal recovery is person-defined and should not be converted uncritically into clinician-rated health
Resilience	Describes adaptive functioning following adversity	Adaptive capacity and longitudinal adaptation	Resilience is dynamic and context dependent, not a fixed trait or proof of wellbeing
Post-traumatic growth	Describes perceived or actual positive change following adversity	Potential evidence of adaptation and meaning reconstruction	Perceived growth does not necessarily demonstrate actual positive change
Recovery capital	Describes resources that support recovery	Protective Resource Ecology	Evidence is strongest in substance-use recovery and constructs remain heterogeneous
ICF	Describes functioning through interaction between health and context	Provides boundaries around capacity, performance and environmental factors	Functioning does not itself constitute positive mental health

Salutogenesis and the Question of What Produces Health

Aaron Antonovsky's (1979) salutogenic model provides one of the clearest theoretical antecedents to PHCF. Antonovsky developed the concept in *Health, Stress, and Coping* and extended it in *Unraveling the Mystery of Health* in 1987. His central question concerned the origins of health and the processes that allowed people to manage persistent stress and adversity (Antonovsky, 1979, 1987). The model challenged a binary distinction between healthy and diseased states. Antonovsky conceptualised people as moving along an ease-dis-ease continuum. Stressors were understood as common features of life. Health depended partly on how people mobilised internal and external resources in response to those stressors. The model located adaptation within an ongoing relationship between the person, available resources and the demands of the environment (Mittelmark & Bauer, 2022; Vinje et al., 2017). Sense of coherence became the best-known construct within the model. It incorporated comprehensibility, manageability and meaningfulness. A stronger sense of coherence was proposed to support effective mobilisation of resistance resources and management of tension. Generalised resistance resources included resources available within the individual and their social and material context (Antonovsky, 1987; Mittelmark & Bauer, 2022). Salutogenesis contributes two fundamental principles to PHCF.

The first is that scientific attention can be directed toward the production and maintenance of health without denying the importance of disease. The second is that health emerges partly from the interaction between demands and resources. Positive health cannot be located entirely within an individual's personality. PHCF extends this logic by separating several forms of information that salutogenesis often considers together. A person may possess substantial adaptive capacity while having limited current wellbeing. Resources may be available in the environment but inaccessible to the person. An individual may understand a stressor well while lacking the material or relational resources required to manage it. These distinctions matter clinically because the intervention required in each situation differs. Salutogenesis also introduces a useful longitudinal orientation. Health is represented as movement. PHCF adopts this principle through its proposed emphasis on trajectory. Positive health can develop, stabilise, fluctuate or decline over time. A person's classification represents a current description within a longer course. Salutogenesis does not provide the full architecture required by PHCF. Its principal constructs were not developed as an interoperable clinical classification of positive mental health (see Figure 3.1).

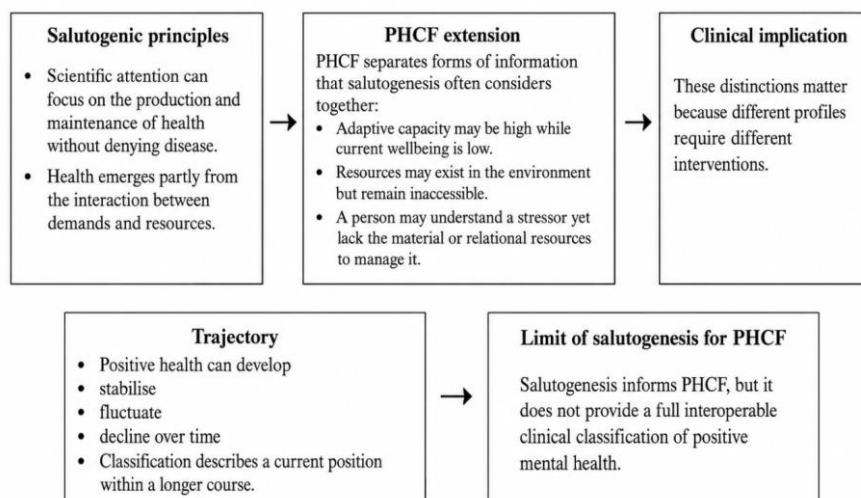


Figure 3.1. *Salutogenesis and its relevance to PHCF, showing how PHCF extends salutogenic principles through distinct positive-health domains, clinical differentiation and trajectory-based perspective.*

The field also became strongly associated with sense of coherence, while the broader salutogenic model received less empirical development (Mittelmark & Bauer, 2022). The theoretical importance of salutogenesis to PHCF consequently lies in its orientation toward health creation, resource mobilisation and movement through changing conditions.

Psychological Wellbeing as Multidimensional Positive Functioning

Research on psychological wellbeing established that positive mental health contains more than positive emotion or life satisfaction. Ryff (1989) developed a multidimensional model of psychological wellbeing after examining theoretical accounts of positive human functioning. The model identified self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. Subsequent research using a nationally representative sample supported the multidimensional structure and demonstrated that several dimensions were not adequately captured by conventional measures of happiness, affect or life satisfaction (Ryff & Keyes, 1995). The distinction between hedonic and eudaimonic aspects of wellbeing is relevant to PHCF. Feeling good represents one form of positive experience. Living with purpose, maintaining meaningful relationships, developing capacities and exercising agency represent additional aspects of positive psychological functioning.

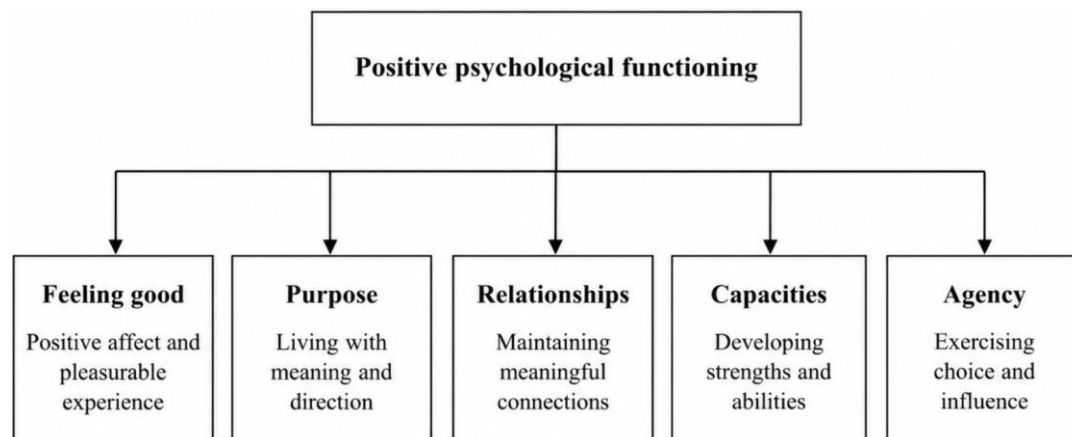


Figure 3.2. *Positive psychological functioning includes not only feeling good, but also purpose, meaningful relationships, developing capacities and exercising agency.*

Ryff's later review concluded that the model had generated substantial research across development, family life, work, biological health and clinical intervention (Ryff, 2014). The literature provides strong theoretical support for PHCF constructs concerned with meaning, identity, positive self-experience, relational capacity and agency. It also provides an important warning against defining positive health through happiness alone. For example, *a person experiencing grief may retain purpose, connection, agency and substantial adaptive capacity while reporting little positive affect. Or, A person experiencing a manic episode may report intense positive affect while demonstrating impaired judgement and reduced adaptive regulation.*

Emotional positivity cannot function as a sufficient indicator of positive mental health. PHCF should preserve the multidimensional character of positive functioning established in the wellbeing literature. It should also distinguish current wellbeing from capacities that may remain available during periods of low wellbeing. A person can temporarily experience low positive affect while retaining strong relational capacity, psychological flexibility or recovery self-management. The distinction creates an important boundary between state and capacity. Current Positive Health State (Bodryzlova & Moullec,

2023) describes what is presently experienced and describes the capabilities that may be available to the person across situations and over time.

The Two-Continua Model and the Independence of Positive Health

The theoretical argument for a separate positive health classification becomes substantially stronger through the work of Keyes (2002) who operationalised mental health as a syndrome involving positive feelings and positive functioning. The Mental Health Continuum (Keyes, 2002) distinguished flourishing, moderate mental health and languishing. The formulation treated positive mental health as something that could be positively identified and measured (Keyes, 2002). Keyes (2005) subsequently examined the relationship between mental illness and mental health using the complete-state model. The results supported two correlated dimensions. Mental illness and positive mental health were connected, but they did not function as opposite ends of a single continuum. The model permitted a person to experience mental illness while also possessing substantial positive mental health. It also permitted low positive mental health in the absence of a mental disorder (Keyes, 2005). The principle is central to PHCF. The presence of psychopathology should not determine the positive-health classification. A diagnosis of PTSD does not establish low adaptive capacity. A diagnosis of major depressive disorder does not establish absence of relational connection. Continuing psychotic experiences do not establish absence of meaning, agency or personal recovery. The reverse inference is equally problematic. Absence of a current mental disorder does not establish strong positive health. A person may have few clinically significant symptoms while experiencing limited purpose, social disconnection, poor self-management and low positive functioning. The two-continua model supplies the foundational independence rule for PHCF (see Figure 3.3). Positive health should be assessed directly.

		Psychopathology	
		Lower / absent	Higher / present
Positive health	Higher	1. Positive health Low psychopathology does not by itself define positive health, but positive health may be strong.	2. Positive health despite psychopathology PTSD, depression, or psychotic experiences do not by themselves establish low adaptive capacity, disconnection, or absence of meaning, agency, or recovery.
	Lower	3. Low positive health without disorder Absence of a current mental disorder does not establish strong purpose, connection, self-management, or positive functioning.	4. High clinical burden Psychopathology may coexist with low positive health, but positive health must be assessed directly rather than inferred from symptoms.

Figure 3.3. *The PHCF independence rule, showing that positive health should be assessed directly rather than inferred from the presence or absence of psychopathology.*

The model also has implications for treatment evaluation. If psychopathology and positive health are partially independent, symptom reduction and positive-health development cannot be assumed to progress at identical rates. Treatment may reduce distress before positive functioning develops. Adaptive capacity may increase while symptoms remain significant. Diagnostic remission may occur while positive health remains limited. PHCF is designed to make those differences visible.

Positive Psychology and the Expansion of the Scientific Question

The emergence of positive psychology around the beginning of the twenty-first century provided another important intellectual shift. Seligman and Csikszentmihalyi (2000) argued for a science addressing positive subjective experience, positive individual characteristics and positive institutions. Their position reflected concern that psychology had developed extensive knowledge about pathology while giving less systematic attention to conditions supporting optimal functioning and quality of life. Positive psychology subsequently generated extensive research on constructs including strengths, optimism, meaning, gratitude, engagement, hope and wellbeing. The movement helped establish positive psychological phenomena as legitimate subjects of empirical investigation. PHCF benefits from this literature, however its clinical purpose requires tighter construct boundaries. A positive psychological characteristic does not automatically warrant classification within PHCF. Gratitude may benefit wellbeing. Humour may support coping. Curiosity may contribute to engagement. Character strengths may have substantial personal significance. Their presence does not necessarily provide clinically important information that warrants inclusion in a health classification. The inclusion threshold for PHCF should be higher than evidence that a construct is positively valued or associated with wellbeing. A proposed construct should demonstrate conceptual coherence, measurable variation, relevance across appropriate clinical contexts and incremental information for understanding adaptation, treatment or recovery. Positive psychology provides a large candidate pool of constructs. PHCF requires evidence to determine which of those constructs belong within a clinical classification.

Positive Psychiatry and the Clinical Relevance of Positive Characteristics

Positive psychiatry brings the positive-health argument directly into clinical care. Jeste et al. (2015) defined positive psychiatry as,

“an approach concerned with understanding and promoting wellbeing through assessment and intervention involving positive psychosocial characteristics among people with, or at elevated risk for, mental and physical illnesses”.

The model identified positive mental health outcomes, psychological characteristics including resilience, optimism, personal mastery and coping self-efficacy, environmental influences including social support, biological dimensions and positive interventions. The importance of this position for PHCF is substantial. Positive characteristics are not reserved for populations without mental illness. They can be investigated among people experiencing serious and enduring psychiatric conditions. The presence of illness does not remove the relevance of positive-health assessment. Eglit et al. (2018) reviewed measurement within positive psychiatry and identified established measures covering wellbeing, resilience, optimism, social support and related constructs. They also identified limitations in the available measurement landscape. Many measures rely heavily on self-report, and further research is required concerning psychometric quality, longitudinal trajectories and clinical relevance across populations. Positive psychiatry consequently provides strong support for PHCF's clinical premise while also demonstrating why a further classification question remains open. The field already measures many of the phenomena that PHCF proposes to classify. The unresolved issue concerns whether those phenomena can be organised into a common clinical architecture. A battery containing a resilience scale, wellbeing scale, hope scale and social-support measure can provide rich information. It does not automatically provide a shared classification language that can be interpreted across settings or linked systematically with treatment and longitudinal clinical records. PHCF draws heavily from positive psychiatry while proposing a different level of organisation. Positive psychiatry provides

constructs and evidence. PHCF asks whether selected constructs can support a coherent classification (see Figure 3.4).

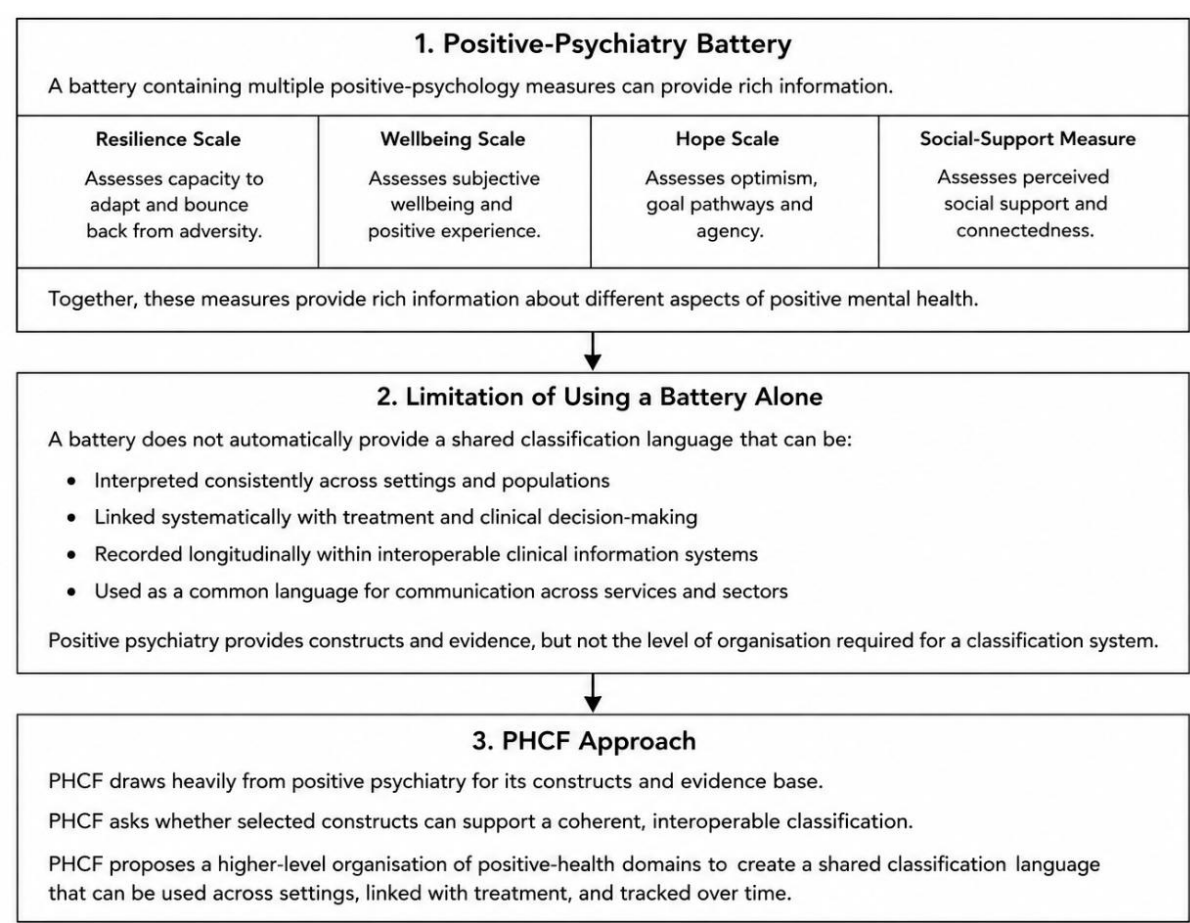


Figure 3.4. *Positive psychiatry provides constructs and evidence, while PHCF proposes a higher level of organisation through a shared, clinically meaningful classification language for use across settings and over time.*

Personal Recovery and the Importance of the Person's Own Life

The development of personal recovery models changed how improvement in serious mental illness could be understood. Leamy et al. (2011) conducted a systematic review and narrative synthesis of personal recovery literature. From 5,208 identified papers, 97 were included in the final synthesis. Five recurrent recovery processes emerged. These were connectedness, hope and optimism about the future, identity, meaning in life and empowerment. The resulting CHIME framework (see Figure 3.5) has become highly influential within recovery-oriented mental health research and practice. The review also identified culturally relevant differences. Studies involving people from minority ethnic groups placed greater emphasis on spirituality, stigma, culturally specific facilitators and collectivist understandings of recovery. These findings are important for PHCF because they demonstrate that positive health cannot be constructed from a single cultural ideal of individual independence (Leamy et al., 2011). Subsequent work testing the CHIME framework with people currently using mental health services supported its relevance while also demonstrating the importance of continued validation with lived-experience populations (Bird et al., 2014). Personal recovery makes several essential contributions to PHCF. It establishes that meaningful improvement can occur in the presence of

continuing symptoms. It identifies identity, agency, hope, meaning and connection as clinically important dimensions of recovery.

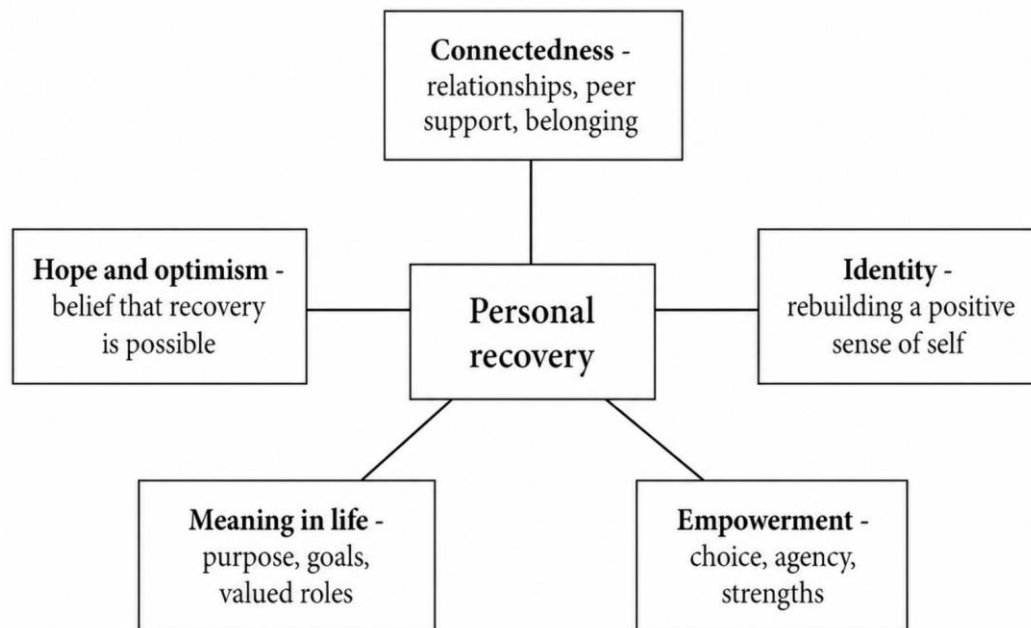


Figure 3.5. *The CHIME framework for personal recovery, comprising connectedness, hope and optimism, identity, meaning in life and empowerment.*

It places the person's own goals and interpretation of life at the centre of recovery. It also challenges systems that define outcome exclusively through clinician-assessed symptom change. WHO's current recovery-oriented mental health guidance reflects these principles. It emphasises autonomy, inclusion, meaningful participation, person-centred services and involvement of people with lived experience in service development and delivery (WHO, 2021). PHCF must preserve this person-centred foundation. A clinician should not be able to classify somebody as flourishing because the clinician considers employment, marriage or independent living desirable. Positive health must be evaluated against the person's own values, goals, relationships and cultural context. This principle limits the authority of the classifier. PHCF can structure information about positive health. It cannot determine what constitutes a worthwhile life for another person. Personal recovery should also remain distinguishable from the broader PHCF construct. Recovery is particularly relevant when a person is living with or moving through a mental health condition. Positive health can also be assessed among people without a current disorder. PHCF incorporates personal recovery as an important domain of evidence while retaining a broader scope.

Resilience as Dynamic Adaptation

Resilience provides one of the closest existing constructs to the adaptive capacity proposed within PHCF. It also presents one of the greatest risks of conceptual confusion. Southwick et al. (2014) reviewed interdisciplinary perspectives on resilience and found considerable variation in definitions. The authors identified broad agreement that resilience concerns adaptive or integrated positive functioning over time following adversity. They also emphasised that resilience could operate at individual, family, organisational, community and cultural levels and that its determinants involve multiple biological, developmental, social, economic and cultural processes. The multidimensional understanding is important because resilience is frequently used in ordinary clinical language as though

it were a stable personality trait. A person is described as resilient or not resilient. Such language can obscure the process being described. A person may adapt effectively within one domain and struggle within another. Adaptation may depend on available relationships or material resources. An individual may demonstrate considerable persistence while experiencing severe psychological distress. A strategy that supports functioning during acute threat may become restrictive after the threat has passed. PHCF uses Adaptive Capacity and Demonstrated Adaptation (see Figure 3.6) as related yet distinguishable constructs. Adaptive capacity should be distinguished from demonstrated adaptation because possession of resources or capacities does not necessarily result in successful adaptive outcomes (Mortreux & Barnett, 2017).

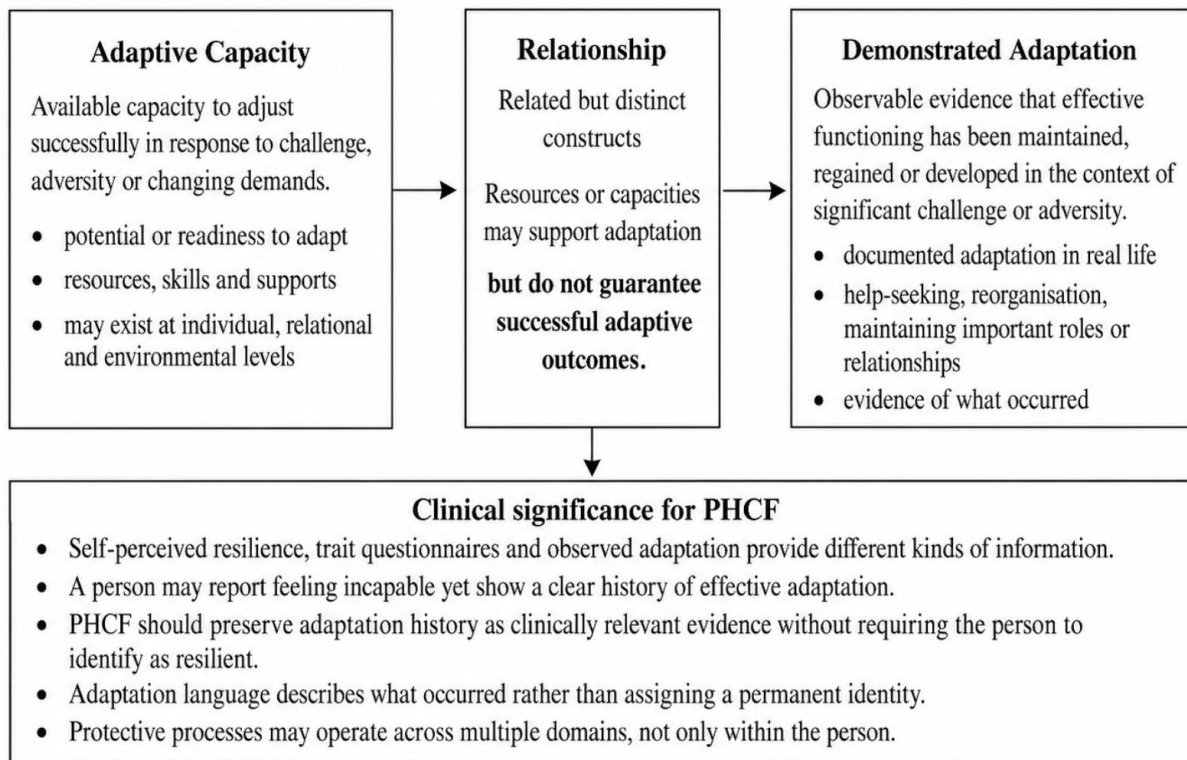


Figure 3.6. *Adaptive capacity concerns the potential to adapt, whereas demonstrated adaptation concerns observable evidence of effective adaptation in response to challenge or adversity.*

Adaptive Capacity concerns the available capacity of an individual or system to adjust successfully in response to challenge, adversity or changing demands (Masten, 2014; Masten et al., 2021). Demonstrated Adaptation concerns observable evidence that an individual has maintained, regained or developed effective functioning in the context of significant challenge or adversity (Bonanno, 2004, 2021; Southwick et al., 2014). The distinction is designed to avoid a common problem in resilience assessment. Self-perceived resilience, trait questionnaires and observed adaptation provide different types of information. A person who reports feeling incapable may nevertheless have a documented history of repeatedly seeking help, reorganising life after major setbacks and maintaining important relationships under considerable pressure. PHCF should preserve that history as clinically relevant evidence without forcing the person to identify as resilient. Recent trauma research continues to support a multilevel view of protective processes. A systematic review of modifiable protective factors among trauma-exposed adults found resilience to be associated with factors operating across multiple domains, reinforcing the importance of avoiding an exclusively intrapersonal account of

adaptation (Godoy-Henderson et al., 2026). The language of adaptation is deliberately chosen. It describes what occurred without attaching a permanent identity to the person.

Trauma, Growth and the Need for Evidentiary Caution

Trauma research provides an important test case for PHCF because it demonstrates that distress and perceived positive change can coexist. Post-traumatic growth refers to positive psychological changes reported following highly challenging experiences. Research has identified changes involving relationships, personal strength, appreciation of life, possibilities and meaning. The relationship between post-traumatic growth and PTSD symptoms is complex. Shakespeare-Finch and Lurie-Beck's (2014) meta-analysis of 42 studies involving 11,469 participants found positive associations between reported growth and PTSD symptoms, including evidence of a curvilinear relationship. Later person-centred research has identified groups characterised by high post-traumatic stress and high post-traumatic growth, low stress and high growth, and low levels of both constructs (Shakespeare-Finch & Lurie-Beck, 2014). These findings support the broader PHCF principle that positive and negative psychological phenomena can coexist (see Figure 3.7).

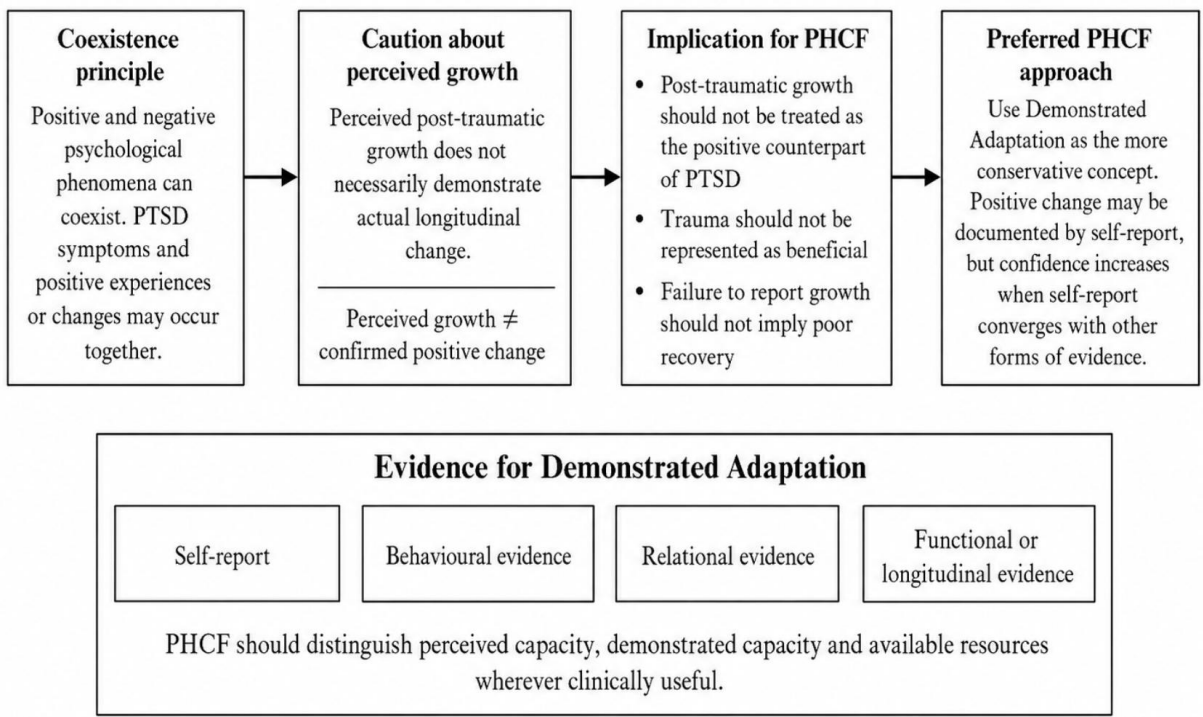


Figure 3.7. *Perceived growth should not be equated with demonstrated adaptation, which is supported more strongly when self-report converges with behavioural, relational, functional or longitudinal evidence.*

They also require caution. Perceived growth does not necessarily demonstrate actual longitudinal change. Park et al. (2023) directly compared perceived post-traumatic growth during the COVID-19 pandemic with measured positive changes and found that the relationship between perceived and actual growth was limited. The authors concluded that the validity of perceived growth as evidence of actual positive change remains uncertain. PHCF should avoid treating post-traumatic growth as the positive counterpart of PTSD. A person does not need to experience growth to have recovered well. Trauma should not be represented as beneficial because some people later identify positive changes. Failure to report growth should never imply poor recovery. The PHCF concept of

Demonstrated Adaptation offers a more conservative approach. Where appropriate, positive change can be documented through self-report. Greater confidence should emerge when self-report converges with behavioural, relational, functional or longitudinal evidence. The principle applies beyond trauma. PHCF should distinguish perceived capacity, demonstrated capacity and available resources wherever clinically useful.

Recovery Capital and the Ecology of Resources

Recovery capital offers one of the strongest existing models for the resource component of PHCF. The construct developed primarily within substance-use recovery and describes resources that people can draw upon to initiate and sustain recovery. Contemporary models commonly incorporate human, social, physical and community or cultural forms of capital. A systematic review by Bunaciu et al. (2024) identified 69 quantitative studies and ten recovery-capital questionnaires. Across those measures, 41 separate constructs were represented. The review concluded that recovery-capital measurement had advanced considerably while noting continuing gaps in psychometric evidence across diverse populations and settings. More recent measurement development has attempted to improve the conceptual and psychometric quality of recovery-capital assessment. The Multidimensional Inventory of Recovery Capital (MIRC) was developed through mixed methods with people who had resolved alcohol problems and explicitly incorporated social, physical, human and cultural resources (Bowen et al., 2023). Recovery capital provides an important theoretical basis for PHCF's proposed Protective Resource Ecology. The insight is that recovery does not occur solely because of characteristics inside the individual. People draw on relationships, knowledge, financial resources, housing, community connections, cultural resources and access to services. PHCF extends that principle beyond substance use while treating the generalisation as a hypothesis requiring validation. The framework also introduces distinctions between resource availability and resource effects (see Figure 3.8).

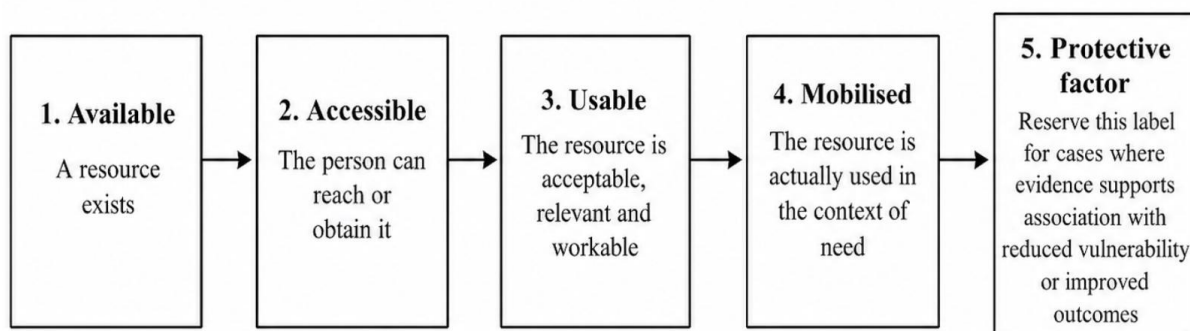


Figure 3.8. PHCF distinguishes resources that are available, accessible, usable and mobilised from protective factors, which require evidence of association with reduced vulnerability or improved outcomes.

A supportive family may exist but remain inaccessible during crisis. A mental health service may be geographically available but culturally unacceptable. Employment may provide social connection for one person and become a major source of distress for another. Online communities may provide important belonging while also exposing people to harmful content. The existence of a resource does not establish protection. PHCF initially distinguishes a resource that is available, accessible, usable and mobilised. The label protective factor should be reserved for circumstances in which evidence supports an association with reduced vulnerability or improved outcomes. Research on protective factors supports the importance of this distinction. Social support has been associated with protection from depression across the lifespan, while systematic reviews in anxiety and suicide research have

identified social support, coping, purpose, positive relationships and related factors as potentially protective within particular populations and outcomes (Gariépy et al., 2016; Ki et al., 2024; Zimmermann et al., 2020). PHCF consequently uses Protective Resource as the broader descriptive term. Causal or predictive language should require stronger evidence.

ICF and the Separation of Health From Functioning

The International Classification of Functioning (IFC), Disability and Health provide another critical theoretical boundary for PHCF. ICF conceptualises functioning as a dynamic interaction between a person's health condition, environmental factors and personal factors. Functioning encompasses body functions, activities and participation. Environmental factors can facilitate or constrain functioning. The WHO also distinguishes capacity from performance, recognising that what a person is capable of doing under specified conditions can differ from what occurs in their actual environment (WHO, 2001). The ICF practical manual explicitly warns against making simple linear inferences from diagnosis to disability or from one component of functioning to another. Relevant information should be collected independently before relationships among components are examined empirically (WHO, 2013). The principle should be adopted directly within PHCF. A psychiatric diagnosis cannot determine positive health (see Figure 3.9).

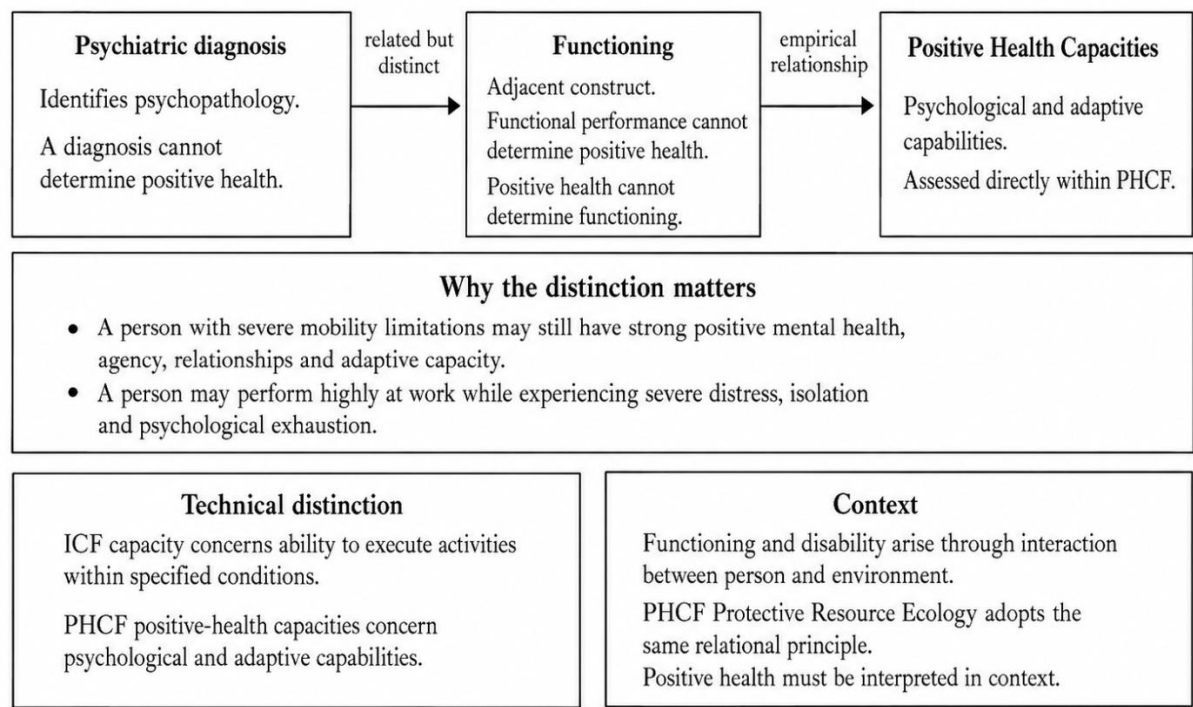


Figure 3.9. *Psychiatric diagnosis, functioning and positive health are related but non-equivalent constructs that should be assessed separately and interpreted within context.*

Functional performance cannot determine positive health. Positive health cannot determine functioning. The constructs may influence one another and should be examined empirically. Consider a person with severe mobility limitations who maintains strong positive mental health, agency, relationships and adaptive capacity. A classification equating functional independence with positive health would systematically misrepresent that person. Consider another person who performs highly at work while experiencing severe distress, isolation and psychological exhaustion. Occupational functioning alone would again provide an incomplete picture. PHCF treats functioning as an adjacent

construct. The proposed Positive Health Capacities concern psychological and adaptive capabilities. ICF capacity concerns ability to execute activities within specified conditions. The use of the same ordinary word, capacity, requires careful technical distinction in future PHCF terminology. The ICF also reinforces the importance of context. Functioning and disability arise through interaction between the person and environment. PHCF's Protective Resource Ecology adopts a similar relational principle. Positive health cannot be interpreted without considering the environments in which it is expressed.

Construct Boundaries Within PHCF

The theoretical traditions reviewed above indicate that positive health cannot be represented adequately by a single construct. They also show substantial conceptual overlap. PHCF requires explicit boundaries to prevent the framework from becoming a collection of synonymous positive terms. Table 3.2 provides the provisional distinctions.

Table 3.2*Provisional Construct Boundaries Within PHCF*

Construct	Primary Question	Temporal Orientation	Principal Evidence
Current Positive Health State	What positive mental health is being experienced now?	Current	Self-report, clinical interview, validated wellbeing measures
Positive Health Capacity	What adaptive psychological capabilities are available to the person?	Current and potential	Interview, behavioural evidence, observation, measures and history
Demonstrated Adaptation	What has the person's history shown they have been able to mobilise under challenge?	Retrospective and longitudinal	Behavioural history, lived experience, collateral and longitudinal information
Personal Recovery	How does the person understand their movement toward a meaningful and self-directed life?	Current and longitudinal	Person-defined experience and recovery measures
Protective Resource Ecology	What resources exist around and within the person that may support positive health or recovery?	Current and longitudinal	Contextual assessment, person report, collateral and environmental information
Functioning	What activities and participation are possible and occurring within context?	Current and longitudinal	ICF-compatible assessment and functional measures
Quality of Life	How does the person evaluate important aspects of life?	Current and longitudinal	Person-reported quality-of-life assessment
Psychopathology	What clinically significant symptoms, syndromes or dimensions are present?	Current and longitudinal	DSM, ICD, HiTOP or other recognised clinical assessment

These boundaries are provisional. Empirical research may demonstrate that some constructs overlap too substantially to warrant separate classification. Other constructs may divide into meaningful subdomains. That possibility should be treated as an expected part of framework development.

An Integrated Theoretical Model of Positive Health

The theoretical synthesis suggests that PHCF should represent positive mental health as a dynamic system involving current state, internal capability, demonstrated history and contextual resources. Current Positive Health State describes the positive-health experience visible at the time of assessment. It includes dimensions such as positive self-experience, engagement, belonging and valued direction. Positive Health Capacities describe the capabilities potentially available when demands arise. Agency, adaptive regulation, psychological flexibility, relational capacity, meaning and recovery self-management are current candidate constructs. Demonstrated Adaptation introduces historical evidence. It asks what the person has previously been able to do under meaningful challenge and how their strategies have changed over time. Protective Resource Ecology describes the personal, relational, cultural, community, material, structural and environmental resources capable of supporting those capacities. Personal recovery provides the person's interpretation of movement toward a meaningful life. Functioning and quality of life remain linked but separately assessed constructs. Psychopathology remains independently classified through the relevant clinical system. The relationships among these components should be understood as dynamic and bidirectional. Strong resources may support adaptive capacity. Adaptive capacity may allow a person to mobilise resources more effectively. Successful adaptation can increase confidence and self-management. Psychopathology can constrain access to capacities without eliminating them. Environmental deterioration can reduce functioning even when internal capacities remain strong. Treatment can influence several components simultaneously. No single component should automatically determine another. This creates a model capable of describing clinically important combinations that conventional diagnostic language may leave unclear. A person may experience severe psychopathology, low current wellbeing and very strong demonstrated adaptation. Another may have few current symptoms, high quality of life and limited recovery self-management. A third may have continuing symptoms, high personal recovery, strong adaptive capacity and limited material resources. A fourth may demonstrate excellent functional performance while reporting poor wellbeing and substantial psychological distress. The purpose of PHCF is to preserve these distinctions within a coherent language. Figure 3.10 summarises the proposed architecture and the relationships among these components.

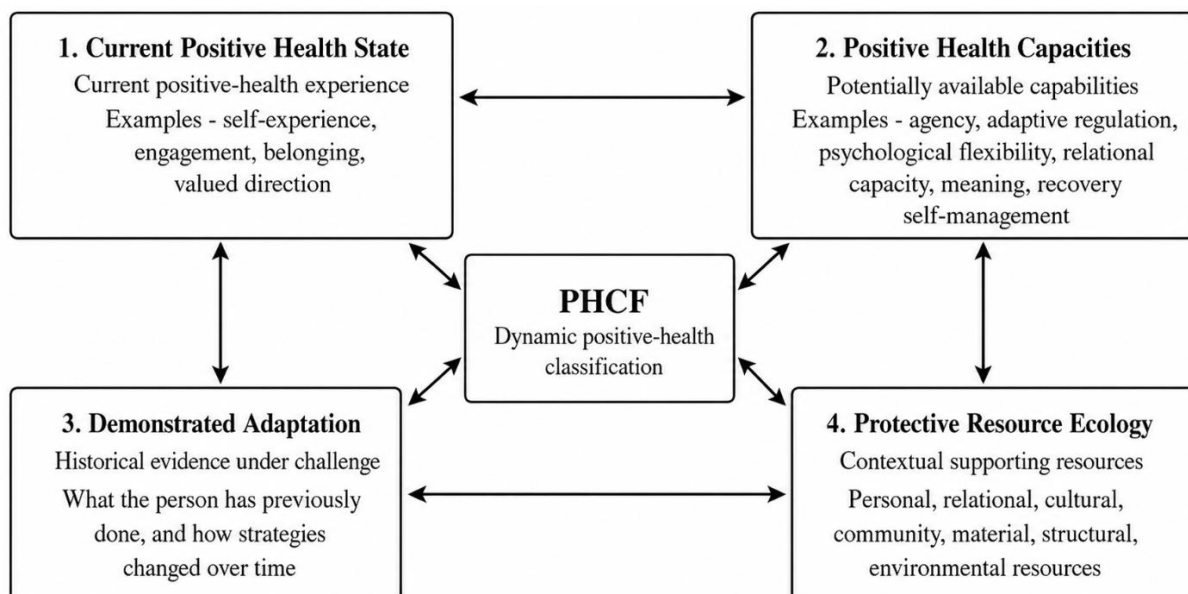


Figure 3.10. *Proposed PHCF system architecture.*

Theoretical Safeguards

The theoretical foundations also identify several risks that must be controlled during PHCF development. The first concerns individualisation. Positive-health classification could inadvertently imply that people are responsible for generating their own wellbeing irrespective of poverty, discrimination, unsafe environments, poor access to healthcare or other structural conditions. Recovery capital, ICF and contemporary resilience research indicate that health and adaptation depend partly on resources outside the individual. The second concerns cultural normativity. Constructs such as autonomy, independence, emotional expression and achievement do not hold identical meanings across cultures. The CHIME literature has already demonstrated variation in the role of spirituality, collectivism and culturally specific recovery processes (Leamy et al., 2011). The third concerns moralisation. Positive health must not become a classification of desirable personality. A person who is introverted, dependent on assistance, emotionally reserved or uninterested in occupational achievement should not receive a lower classification because they do not conform to culturally dominant ideals. The fourth concerns romanticising adversity. Trauma, illness and discrimination should not be portrayed as opportunities for growth that people ought to appreciate. The post-traumatic growth literature demonstrates that reported growth and significant distress can coexist and that perceived growth does not always correspond with measured positive change (Park et al., 2023; Shakespeare-Finch & Lurie-Beck, 2014). The fifth concerns treatment access. Strong adaptive capacity must never be interpreted as evidence that a person does not require care. Some people survive prolonged adversity through exceptional levels of effort. Their ability to continue functioning may conceal substantial psychological cost. The sixth concerns construct inflation. Every desirable human characteristic cannot become a PHCF construct. The framework will require a stringent evidentiary threshold. These safeguards are part of the theory and they are not secondary ethical considerations. Figure 3.11 summarises six safeguards that should be treated as part of the framework's theoretical architecture rather than as secondary considerations.

1. Individualisation Avoid implying that wellbeing is solely the person's responsibility. Positive health depends partly on external and structural resources.	2. Cultural normativity Avoid treating culturally specific values as universal standards. Meanings of autonomy, expression, achievement and recovery vary across cultures.
3. Moralisation Positive health must not become a classification of desirable personality. Difference in style, dependence, reserve or ambition should not lower classification unfairly.	4. Romanticising adversity Trauma, illness and discrimination should not be portrayed as beneficial. Growth and distress can coexist, and perceived growth may not equal measured change.
5. Treatment access Strong adaptive capacity must not be used to deny care. Continued functioning may conceal substantial psychological cost.	6. Construct inflation Not every desirable human quality should become a PHCF construct. Construct inclusion should require a stringent evidentiary threshold.

Figure 3.11. *Risks and safeguards in PHCF development, highlighting the need to prevent individualisation, cultural normativity, moralisation, romanticising adversity, inappropriate restriction of treatment access and construct inflation.*

The Emerging Theoretical Proposition

The theoretical literature supports several conclusions. Positive mental health has measurable dimensions that cannot be reduced to absence of mental illness. Psychological wellbeing includes positive functioning beyond happiness. Personal recovery can progress while symptoms continue. Resilience describes dynamic adaptation following adversity and depends on multiple levels of context. Recovery capital demonstrates the importance of resources surrounding the individual. ICF establishes that functioning and environmental context require independent description. Positive psychiatry demonstrates that positive psychosocial characteristics can be clinically relevant among people living with serious mental illness. No single theoretical tradition currently provides the entire proposed PHCF architecture. The observation does not establish that a new classification framework is necessary. It establishes that a coherent theoretical basis exists for testing one. PHCF proposes that a clinically meaningful description of mental health may require four forms of positive-health information that are currently distributed across separate literatures. These are current positive-health state, positive-health capacities, demonstrated adaptation and protective resources. Personal recovery informs how those elements are understood by the individual. Functioning and quality of life remain related but independently assessed. Psychopathology remains separately classified. The model leads to a central theoretical claim. Positive health is not the residual state left when psychopathology has been removed. It consists of identifiable states, capacities, adaptations and resources that can coexist with psychopathology, change independently over time and contribute to recovery and sustained mental health. The validity of this claim must now be tested. The next stage in development requires precise definition of the proposed PHCF architecture, identification of candidate domains and constructs, examination of construct overlap and systematic evaluation of the evidence supporting each proposed component. A classification framework can only follow once the underlying constructs have survived that scrutiny. The following chapter examines the classification gap in detail and establishes where PHCF sits in relation to DSM, ICD, HiTOP, RDoC, ICF, positive mental health measurement and recovery-oriented frameworks.

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Chapter Four -The Classification Gap - What Existing Systems Capture and What Remains Unclassified

Defining the Gap With Precision

The theoretical foundations examined in the previous chapter establish that positive mental health, personal recovery, adaptive capacity, functioning and protective resources are legitimate areas of scientific inquiry. The existence of these literatures does not establish the need for a new classification framework. A new framework is justified only if clinically meaningful information remains inadequately represented within existing systems and if organising that information provides additional value. The classification gap proposed by the PHCF is narrow. It does not arise because contemporary mental health systems ignore wellbeing, recovery, functioning, resilience or contextual resources. Each of these areas has established conceptual and measurement traditions. The gap concerns the way these forms of information are organised, preserved and communicated within clinical classification. DSM and ICD provide structured classifications of mental disorders. HiTOP provides a dimensional and hierarchical organisation of psychopathology. RDoC investigates neurobehavioural systems across the range from typical to atypical functioning. ICF provides an international framework for describing functioning, activity, participation and environmental influences. Positive mental health instruments assess wellbeing and flourishing. Personal recovery frameworks describe processes including hope, identity, meaning, connectedness and empowerment. Positive psychiatry identifies measurable positive psychosocial characteristics. Resilience and recovery-capital research describe adaptive processes and resources that may influence health outcomes. Each contributes part of the clinical picture. None of the major systems examined in this chapter currently provides an integrated classification of positive-health capacities, demonstrated adaptation and accessible protective resources that can accompany a psychiatric classification, remain meaningful when diagnostic systems differ and be followed longitudinally through treatment and recovery. The existence and clinical importance of this proposed gap remain empirical questions. PHCF will require evidence that the information it seeks to classify is conceptually distinct, measurable and useful beyond what existing systems already provide.

DSM and the Classification of Mental Disorder

DSM-5-TR is designed principally for the classification and diagnosis of mental disorders. It provides diagnostic criteria, descriptive features, specifiers, information concerning development and course, risk and prognostic factors, culture-related diagnostic issues, functional consequences and differential diagnosis. Its strength lies in providing a common clinical language through which patterns of psychopathology can be identified and communicated (American Psychiatric Association, 2022). The Future DSM program indicates that the boundaries of this clinical description may expand. In 2026, the APA Future DSM Structure and Dimensions Subcommittee proposed a potential diagnostic construction model incorporating contextual determinants, biological information, diagnoses at different levels of specificity and severity, and transdiagnostic features. The proposal acknowledges that clinically important information frequently extends beyond a single categorical diagnosis (Öngür et al., 2026). A separate Future DSM subcommittee has considered a greater role for functioning and quality of life. Drexler et al. (2026) concluded that symptoms, functioning and quality of life represent distinct sources of clinically meaningful information and argued for their longitudinal consideration across diagnoses. The emerging DSM direction reduces the validity of any argument that psychiatric classification is concerned exclusively with symptoms. The development also sharpens the proposed PHCF contribution. Functioning is not the principal gap PHCF should attempt to fill. Quality of life is not the principal gap. Contextual determinants are increasingly being considered within future

psychiatric classification. PHCF requires a contribution that remains meaningful after these components are considered. Consider two people who satisfy identical diagnostic criteria for major depressive disorder and demonstrate comparable symptom severity and functional impairment. One has experienced several previous depressive episodes and has developed reliable strategies for recognising deterioration, mobilising social support and re-engaging with valued activity. The second is experiencing depression for the first time and has limited understanding of the condition, few established coping strategies and restricted access to supportive relationships. Their DSM classifications may appropriately be similar. Their recovery capability is not. The distinction may affect formulation, treatment planning, relapse prevention and prognosis. PHCF proposes that this type of information deserves systematic description. The example illustrates the proposed boundary. DSM identifies and describes the disorder. PHCF would attempt to classify capacities and resources relevant to living with, responding to and recovering from that disorder.

ICD-11 and the International Classification of Clinical Conditions

ICD-11 provides the global standard for recording diseases and health-related conditions. Its *Clinical Descriptions and Diagnostic Requirements for ICD-11 Mental, Behavioural and Neurodevelopmental Disorders* were published by WHO in 2024 following an international development process involving hundreds of experts and thousands of clinicians (WHO, 2024). The ICD-11 CDDR emphasise clinical utility, global applicability, lifespan presentation and culture-related considerations. ICD-11 has also introduced dimensional approaches within selected areas. Its personality disorder model, for example, gives severity a central role and permits trait-domain qualifiers. These developments demonstrate that international classification can combine categorical and dimensional information where evidence and clinical utility support doing so. ICD-11 also permits the recording of factors that influence health status and contact with health services. Its broader architecture extends well beyond a narrow list of diseases. Its proposed role remains complementary. A clinician using an ICD-11 diagnosis should be able to apply PHCF without converting the diagnosis into DSM terminology. The same principle applies when the diagnostic boundaries of ICD and DSM do not correspond exactly. The requirement leads to an important design principle. PHCF should attach primarily to the person's clinical presentation and positive-health profile, not to a proprietary diagnostic code. For example, a Trauma and Stressor Presentation Module could be relevant when trauma-related symptoms and adaptation are clinically important. The source diagnosis could remain an ICD-11 diagnosis, a DSM-5-TR diagnosis or another recognised clinical formulation. PHCF would preserve the source classification and add information concerning safety, regulation, agency, relational trust, demonstrated adaptation and protective resources where those constructs have sufficient evidence. Interoperability becomes possible because PHCF does not require DSM and ICD to resolve their differences before positive-health information can be described.

HiTOP and the Dimensional Organisation of Psychopathology

HiTOP provides a different challenge to PHCF. The HiTOP was developed in response to limitations associated with conventional categorical diagnoses, including heterogeneity within disorders, high rates of comorbidity and instability around categorical thresholds. HiTOP organises psychopathology dimensionally and hierarchically according to empirical patterns of covariation among symptoms and maladaptive characteristics (Kotov et al., 2017, 2021). The hierarchy allows information to be represented at different levels of specificity. Broad spectra can describe major patterns of psychopathology, while more specific syndromes, components, symptoms and behaviours provide increasing detail. HiTOP is also explicitly described as a living model that can be revised as new quantitative evidence accumulates (Kotov et al., 2022). Its significance for PHCF is methodological.

HiTOP demonstrates that the architecture of a classification does not need to follow historical diagnostic categories. Empirical relationships can determine which constructs cluster together and the level at which they are most usefully described. The HiTOP revision process also emphasises systematic evaluation of quantitative evidence, transparency, stability and capacity for revision (Forbes et al., 2024). PHCF should adopt those principles. Its initial presentation modules may use familiar clinical groupings because the research literature is commonly organised around depression, anxiety, trauma, psychosis, substance use and related diagnostic constructs. These groupings should not determine the final positive-health hierarchy. If agency emerges consistently across depression, trauma, psychosis and substance-use recovery, it may belong within a transdiagnostic PHCF domain. If a particular form of self-management is distinctive to bipolar disorder, a condition-relevant module may remain useful. If two proposed positive-health capacities consistently measure the same latent construct, they should be combined. HiTOP does not itself resolve the proposed positive-health classification gap because its purpose remains the quantitative organisation of psychopathology. Its components describe pathological signs, symptoms, traits and syndromes. Positive functioning may be clinically relevant to HiTOP assessment and outcome research, but it is not the organising target of the taxonomy (Kotov et al., 2021). PHCF and HiTOP could consequently coexist. HiTOP could describe the structure and degree of psychopathology while PHCF describes positive-health capacities and resources. The value of such coexistence would need to be demonstrated empirically.

RDoC and the Boundary Between Functional Systems and Positive Health

RDoC comes closer to crossing the traditional boundary between illness and health. The National Institute of Mental Health describes RDoC as a research framework designed to investigate mental disorders through dimensions of basic neurobehavioural functioning. The framework is not a diagnostic guide and is not intended to replace existing diagnostic systems. Its constructs are studied across the full range from typical to atypical functioning and through multiple units of analysis, including behaviour, physiology, neural systems and self-report (National Institute of Mental Health [NIMH], 2026). The current RDoC matrix contains six major domains. These include Negative Valence Systems, Positive Valence Systems, Cognitive Systems, Systems for Social Processes, Arousal and Regulatory Systems, and Sensorimotor Systems. The Positive Valence Systems domain includes processes concerned with reward responsiveness, reward learning and reward valuation. The Social Processes domain includes constructs such as affiliation and attachment, agency and self-knowledge (NIMH, 2026). The existence of Positive Valence Systems creates an important conceptual distinction for PHCF. Positive valence is not equivalent to positive health. Reward anticipation, reinforcement learning and reward valuation are basic functional systems. They may contribute to wellbeing and adaptive behaviour. They may also contribute to psychopathology. Heightened reward sensitivity can occur in clinically problematic states. Habit learning can support adaptive behaviour and can also contribute to persistent maladaptive patterns. RDoC describes underlying functional processes across normal and abnormal ranges. PHCF proposes a higher-order clinical description concerning positive capacities, adaptations and resources. The two frameworks could eventually inform one another. RDoC research may help explain the mechanisms underlying agency, regulation, cognitive flexibility or social connection. PHCF should not claim those mechanisms as part of its own classification unless sufficient evidence supports their inclusion. RDoC also provides a methodological warning. Constructs that appear coherent in clinical language may reflect several underlying systems. A PHCF construct such as Adaptive Regulation could eventually require subdivision if neurobehavioural or psychological evidence demonstrates distinct mechanisms with different clinical consequences. The classification should remain open to that possibility.

ICF and the Existing Classification of Functioning

The ICF presents the strongest reason to keep PHCF's scope narrow. The ICF provides an established international framework for describing functioning. It addresses body functions and structures, activities, participation and environmental factors. It also distinguishes what a person is capable of doing from what occurs in their actual environment through the concepts of capacity and performance (WHO, 2001). The distinction is clinically powerful. A person may possess the capacity to perform an activity while environmental barriers prevent actual performance. The reverse can also occur when environmental support enables performance beyond what might otherwise be expected. WHO explicitly describes environmental factors as potential facilitators or barriers. PHCF should not recreate this framework using new terminology. If a clinician needs to describe whether a person can work, communicate, maintain self-care, engage in education, participate socially or manage particular activities, functioning frameworks already exist. Positive-health capacity concerns a different question. A person may possess strong agency while requiring physical assistance with daily activities. They may demonstrate exceptional adaptive regulation while experiencing major functional limitations from chronic illness. Another person may display excellent occupational functioning while experiencing profound disconnection, hopelessness and psychological distress. Functioning and positive health can influence one another without becoming equivalent. This boundary is central to the defensibility of PHCF. If positive health is operationalised mainly through successful functioning, the framework risks reproducing ableist and culturally specific assumptions about independence and productivity. It could also penalise people whose functioning is constrained by environmental barriers while their psychological capacities remain substantial. ICF does more than occupy adjacent territory. It protects PHCF from claiming territory that already has an established classification language.

Positive Mental Health Measurement and the Difference Between Measurement and Classification

The positive mental health literature creates another potential objection to PHCF. Positive mental health can already be measured. Keyes' Mental Health Continuum provided one of the most influential approaches. Positive mental health was conceptualised through emotional, psychological and social wellbeing, allowing people to be described as flourishing, moderately mentally healthy or languishing. The complete-state model subsequently demonstrated that positive mental health and mental illness are related but distinguishable dimensions (Keyes, 2002, 2005). The WHO-5 Well-Being Index provides another established measure. A systematic review by Topp et al. (2015) identified 213 studies and found substantial evidence for its validity and responsiveness across clinical and research settings. A more recent systematic review identified use of WHO-5 across 552 studies spanning numerous disease areas, demonstrating the considerable reach of positive wellbeing measurement (Domenech et al., 2025). These instruments demonstrate that positive mental health is measurable and clinically relevant. They also clarify the distinction between measurement and classification. A wellbeing score provides information about the level of a defined construct. It does not necessarily describe the person's adaptive capacities, history of successful adaptation, recovery self-management or protective resources. Nor does it automatically organise different positive constructs into a clinically interpretable structure. Classification provides a language for organising information from potentially several sources. The distinction can be illustrated through depression. A person may report low wellbeing during a depressive episode while retaining strong insight into their condition, a sophisticated relapse-management plan, reliable help-seeking behaviour and an established history of recovery from previous episodes. A wellbeing scale accurately captures the low current state. It does not necessarily capture the capacities that remain available. Conversely, a person may report relatively good subjective wellbeing while possessing limited resources to manage a future deterioration. PHCF has no reason to

replace wellbeing measures. Validated measures should become potential evidence sources within the framework. The question is whether placing such measures alongside other forms of evidence produces a classification that carries additional clinical value.

Positive Psychiatry and the Problem of Measurement Fragmentation

Positive psychiatry makes the potential gap clearer. Jeste et al. (2015) proposed expanding psychiatric attention toward wellbeing and positive psychosocial characteristics among people with and without mental illness. Relevant constructs include resilience, optimism, personal mastery, coping self-efficacy, social engagement and social support. Eglit et al. (2018) subsequently reviewed measurement-based positive psychiatry and identified numerous available measures of wellbeing, resilience, optimism, wisdom, social support and related characteristics. They also noted that many instruments rely on self-report and that further psychometric and longitudinal research is required across clinical populations. This literature supports the clinical relevance of positive psychosocial factors while exposing an organisational problem. A clinician could administer five separate validated measures and obtain five valid scores. The scores would not necessarily form a common classification. There may be substantial construct overlap. Different instruments may use different terminology for related processes. Norms and thresholds may not be comparable. Some measures describe traits, others states and others resources. A high resilience score does not carry the same meaning as high wellbeing, strong social support or high personal recovery. PHCF proposes to solve part of this problem by establishing a construct architecture first and positioning validated measures beneath the relevant constructs. The framework would ask what is being classified before deciding which instrument should measure it. That order is methodologically important. Selecting convenient existing measures and allowing them to define PHCF would risk constructing the framework around the historical accidents of scale development.

Personal Recovery and the Boundary Between Classification and Lived Experience

Personal recovery occupies essential territory that PHCF must approach carefully. Leamy et al. (2011) synthesised 97 studies and identified the CHIME processes of Connectedness, Hope and optimism, Identity, Meaning and Empowerment. Personal recovery has subsequently become a major element of recovery-oriented mental health practice. A scoping review by van Weeghel et al. (2019) found that CHIME was widely endorsed while also identifying the importance of culture, personal preference, choice, risk taking, coping and difficulties experienced during recovery. The authors described personal recovery as complementary to clinical recovery and emphasised that it concerns processes rather than a single conventional clinical outcome. PHCF draws extensively from this work, particularly in relation to hope, agency, identity, connection and meaning. The framework must not convert personal recovery into a clinician-owned judgement. The person remains the primary source concerning whether their life feels meaningful, whether their identity has been restored or reconstructed and what recovery means within their circumstances. PHCF can provide structured terminology. It cannot determine the person's values. This establishes another important boundary. Personal recovery asks how the person experiences movement toward a meaningful life. PHCF asks whether specific positive-health capacities and resources can be described systematically and used clinically. The overlap may be substantial. The constructs are not necessarily identical. A classification framework may eventually include person-reported recovery information as one major evidence source. Its usefulness depends on preserving the distinction between classification of clinically relevant information and external judgement of whether somebody has recovered.\

Resilience, Adaptation and the Problem of Retrospective Evidence

Resilience research appears close to the territory proposed for Adaptive Capacity and Demonstrated Adaptation. The overlap requires careful justification. Resilience has been conceptualised in numerous ways, including as a trait, process, outcome or pattern of adaptation following significant adversity. Contemporary resilience research increasingly emphasises dynamic and contextual processes. This approach weakens the usefulness of describing individuals globally as either resilient or non-resilient. PHCF's proposed distinction between Adaptive Capacity and Demonstrated Adaptation attempts to capture two forms of clinical information. Adaptive Capacity concerns capabilities that appear available in the present. Demonstrated Adaptation concerns evidence that the person has previously mobilised capacities or resources effectively in response to meaningful challenge. The second construct addresses a particular clinical problem. Mental health assessment frequently identifies historical adversity. The history is commonly used to explain vulnerability, development of symptoms or maintenance of psychopathology. The same history may contain evidence of problem solving, persistence, relationship maintenance, help seeking and recovery. That evidence is clinically relevant without proving flourishing. A person may have survived severe adversity while remaining deeply distressed. A person may have maintained employment through enormous psychological effort. A coping strategy may have been highly adaptive during an unsafe childhood and restrictive during adulthood. Demonstrated Adaptation cannot be derived from adversity alone. Its classification would require evidence concerning what the person actually did, what resources were mobilised, the context within which the response occurred and the costs associated with that adaptation. If research demonstrates that existing resilience constructs capture this information adequately, a separate PHCF construct may not be necessary. The framework remains deliberately open to that result.

Recovery Capital and the Existing Classification of Resources

Recovery capital presents a related conceptual challenge for PHCF because it already provides a well-developed way of understanding the resources that support recovery, particularly within substance-use contexts. Bunaciu et al. (2024) identified 69 quantitative studies, ten recovery-capital instruments and 41 represented constructs, demonstrating both the maturity of the field and the considerable variation in how recovery resources are defined and measured. PHCF's proposed Protective Resource Ecology draws directly from this tradition, but its intended scope is broader. The framework seeks to examine whether resource-based recovery concepts can be applied across presentations such as depression, trauma, psychosis and other mental health conditions. That extension requires empirical support. Resources such as social support, safe housing, meaningful roles, financial security and access to treatment are likely to have relevance across diagnostic groups, although their relative importance and mechanisms may differ substantially between populations and clinical contexts.

For this reason, PHCF should begin with broad resource categories and allow evidence to determine which resources have particular relevance to specific presentations. The language used to describe these resources also requires precision. The presence of a relationship, service, employment opportunity, income source or community connection does not establish that it has a protective effect. A resource may exist but remain inaccessible, may be accessible but unacceptable to the person, or may be used without producing meaningful benefit. In some circumstances, an apparently positive resource may contribute to stress or vulnerability. PHCF should use the term *resource* descriptively and reserve stronger terms such as *protective factor* for circumstances in which empirical evidence supports an association with a relevant clinical or recovery outcome. This distinction limits premature causal interpretation and strengthens the scientific defensibility of the framework.

The Central Problem of Fragmentation

Comparison across existing systems shows that much of the territory proposed for PHCF already has a scientific basis. Psychopathology is classified through DSM, ICD and dimensional alternatives such as HiTOP. Functioning can be assessed through ICF-related tools or service-specific measures. Wellbeing can be measured using instruments such as the WHO-5 and Mental Health Continuum-Short Form. Personal recovery is represented within CHIME-informed approaches and recovery measures, while resilience, social support, protective factors, strengths and recovery resources are assessed through separate instruments, formulations and clinical processes. Clinical histories may also contain important evidence of previous successful adaptation. The central problem is fragmentation. Clinically relevant positive-health information is distributed across different conceptual frameworks, measures and documentation practices. Psychopathology usually occupies a stable and recognisable position within the clinical record, while information about positive capacities, recovery resources and demonstrated adaptation depends more heavily on local practice, clinician preference, service models and available assessment tools. Important positive-health information may consequently be recorded inconsistently or lost during treatment transitions and clinical handover.

PHCF proposes that selected forms of positive-health information may benefit from a common organising architecture. Such an architecture could provide a more consistent way of identifying, documenting and communicating positive capacities, demonstrated adaptation and protective resources alongside existing diagnostic information. The proposition requires empirical testing. Fragmentation alone does not establish that classification is the optimal solution. Structured formulation may prove sufficient in some settings, improvements in electronic health records may address part of the problem, and existing recovery or wellbeing measures may already provide adequate information for particular purposes. An additional classification could also increase clinical burden without producing meaningful benefit. The justification for PHCF depends on demonstrating that a structured positive-health classification provides advantages beyond these existing alternatives. Its value must ultimately be established through evidence showing improvements in clinical understanding, communication, treatment planning, longitudinal monitoring or prediction of recovery-related outcomes.

The Proposed PHCF Classification Space

The comparison permits the proposed PHCF space to be defined with greater precision.

Table 4.1*Existing Classification Territory and the Proposed PHCF Space*

Information	Principal Existing Framework	PHCF Position
Mental disorder	DSM and ICD	Preserve source classification
Psychopathology dimensions	HiTOP and related dimensional systems	Preserve source dimensions
Neurobehavioural mechanisms	RDoC	Use as potential explanatory evidence
Functioning and participation	ICF	Assess separately
Quality of life	Established QoL measures	Assess separately
Subjective wellbeing	WHO-5, MHC-SF and related measures	Potential evidence for Current Positive Health State
Personal recovery	CHIME and recovery measures	Major conceptual and person-reported evidence source
Resilience	Multiple resilience models and scales	Potential evidence informing Adaptive Capacity
Recovery resources	Recovery-capital approaches	Foundation for Protective Resource Ecology
Positive psychosocial characteristics	Positive psychiatry measures	Candidate evidence for PHCF constructs
Previous effective adaptation	Distributed across clinical history and resilience literature	Proposed focus of Demonstrated Adaptation
Integrated positive-health classification	No major system reviewed here currently serves this function	Proposed PHCF territory

The final row of the table is the research gap. It should not yet be treated as a discovery. A formal evidence review is required to determine whether another existing framework already occupies part or all of this territory and whether an integrated classification has previously been proposed in a comparable form.

What PHCF Must Add

The classification gap can now be expressed through four requirements. PHCF must provide integration. It should organise selected positive-health constructs within a common architecture. PHCF must provide interoperability. It should operate alongside DSM, ICD, HiTOP and future classification systems without depending on exact diagnostic equivalence. PHCF must provide longitudinal meaning. The framework should allow capacities, adaptations and resources to be followed independently from symptom trajectories. PHCF must provide clinical utility. The classification should improve assessment,

formulation, treatment planning, clinical communication, recovery monitoring or prediction of outcomes. Failure on the fourth requirement would substantially weaken the justification for the first three. A sophisticated classification that does not improve understanding or decisions would add administrative complexity without sufficient benefit.

What PHCF Must Not Duplicate

The framework also requires clear exclusion boundaries to preserve its conceptual integrity. PHCF is not intended to create another classification of mental disorders or reproduce HiTOP using positively framed terminology. It should remain distinct from the ICF by avoiding duplication of established activity and participation categories, and it should not convert quality-of-life or wellbeing scores into positive-health diagnoses. Existing frameworks such as CHIME should inform PHCF without being transformed into clinician-controlled criteria that override the person's own understanding of recovery. PHCF must also avoid assumptions that would weaken its scientific and ethical basis. Resilience should not be treated as a fixed personal trait, and social conformity, employment, independence or productivity should not be used as proxies for positive mental health. Exposure to or survival of adversity does not in itself demonstrate growth, while the mere availability of social, material or environmental resources does not establish that those resources are protective. Their relevance and effects must be demonstrated within the person's circumstances and, where stronger causal claims are made, supported by evidence. These boundaries deliberately constrain the scope of PHCF. That constraint strengthens the framework by clarifying what it is intended to classify, separating it from established systems and reducing the risk that broad concepts of wellbeing, recovery or socially valued functioning are incorrectly absorbed into a single positive-health construct. Figure 4.1 summarises these requirements and boundaries.

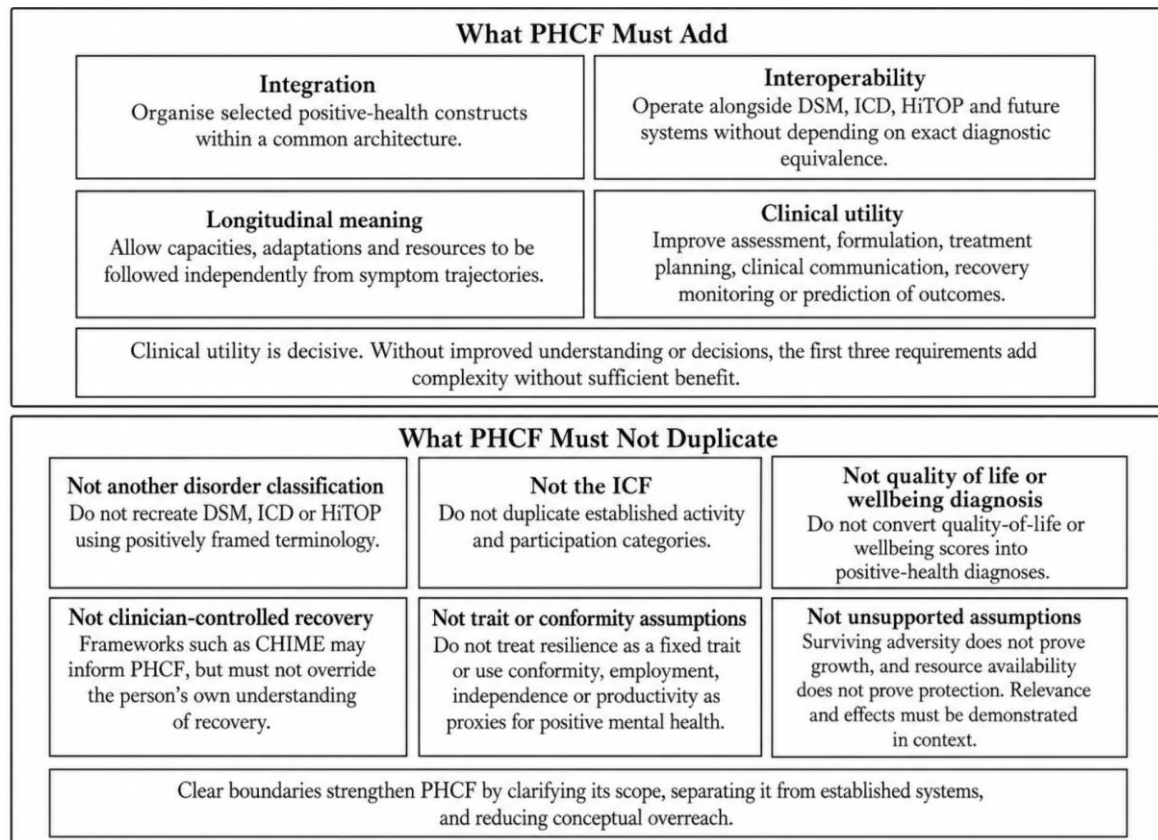


Figure 4.1. *What PHCF must add and what it must not duplicate.*

A Test of Incremental Validity

The classification gap ultimately becomes an empirical question of incremental validity. If PHCF is applied to people receiving treatment for depression, clinicians and researchers will already have access to information about diagnosis, symptom severity, functioning, quality of life and, in some cases, wellbeing. PHCF becomes scientifically useful only if its constructs contribute information beyond these existing measures. Its value would depend on whether it improves understanding or prediction of outcomes such as treatment engagement, therapeutic response, speed of recovery, recurrence, capacity to mobilise support, sustained participation after treatment, quality of clinical handover or the person's own evaluation of recovery. The same standard should apply to each individual PHCF construct. Adaptive Capacity requires reconsideration if it adds no meaningful information beyond established measures of resilience. Demonstrated Adaptation becomes more defensible if it predicts recovery after accounting for symptoms, wellbeing, functioning and self-reported resilience. Protective Resource Ecology requires revision if it simply reproduces existing measures of social support, socioeconomic circumstances or environmental resources. Likewise, a Universal Positive Health Core may not be justified if it provides no additional information beyond established measures of wellbeing and positive mental health. Incremental validity is central to the scientific development of PHCF. The framework should retain only those components that demonstrate conceptual distinctiveness and meaningful clinical value beyond existing approaches. Evidence may support some constructs, combine others or show that particular components are unnecessary. PHCF should be designed to accommodate such findings, allowing the framework to change as its assumptions are tested.

The Classification Gap as a Research Proposition

The evidence reviewed in this and preceding chapters supports a cautious conclusion. Mental health classification has developed multiple sophisticated systems for describing disorder, psychopathology dimensions, functional processes, disability, wellbeing and recovery. The field also possesses extensive research concerning resilience, strengths, positive psychosocial characteristics and recovery resources. The scientific landscape is not empty. The proposed gap exists between these systems. There is currently no major internationally established classification reviewed here whose primary clinical purpose is to organise positive-health capacities, demonstrated adaptation and protective resources into a longitudinal profile that can accompany diagnostic classification across different nosological systems. PHCF is designed to test whether such a layer is useful. Its proposed position can be expressed simply.

Table 4.2*The Proposed Clinical Information Architecture*

Clinical Question	Principal Information Source
What psychopathology is present?	DSM, ICD or HiTOP
What mechanisms may underlie the presentation?	RDoC and relevant clinical science
What can the person do within their environment?	ICF and functional assessment
How does the person evaluate their life?	Quality-of-life assessment
What positive mental health are they currently experiencing?	Positive mental health and wellbeing measures
How do they understand their recovery?	Personal recovery assessment
What positive capacities appear available?	Proposed PHCF classification
What adaptations have they previously demonstrated?	Proposed PHCF classification
What resources can realistically be mobilised?	Proposed PHCF classification informed by contextual assessment
How are these positive-health components changing over time?	Proposed PHCF longitudinal profile

The architecture avoids the need to choose one system as a complete explanation of the person. Different systems answer different clinical questions. PHCF would add another question to that structure.

What health does the person have available to work with?

The answer may include capacities that remain intact during illness, adaptations developed through earlier adversity, resources accessible within the person's environment and capabilities strengthened through treatment. The information has often existed in clinical practice under the language of strengths, protective factors, resilience, resources or recovery. PHCF proposes that it deserves greater conceptual precision and more systematic clinical visibility. The proposition now requires translation into a formal classification architecture. The next chapter defines the structure of PHCF, establishes its primary domains and specifies the relationships among Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology.

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Chapter Five - The Positive Health Classification Framework - Architecture, Domains and Classification Logic

From the Classification Gap to a Classification Architecture

The preceding chapters establish the conceptual and clinical problem that the PHCF is intended to examine. Contemporary mental health systems provide sophisticated methods for describing psychopathology, symptom severity, functioning and quality of life. Extensive research also exists concerning wellbeing, personal recovery, resilience, psychological flexibility, self-management, social support and recovery resources. The proposed gap arises from the absence of a common clinical architecture through which selected forms of positive-health information can be described systematically, retained over time and communicated alongside existing psychiatric classifications. PHCF is proposed as a complementary classification framework. It does not alter diagnoses made using DSM or ICD, replace dimensional descriptions of psychopathology such as HiTOP or assume responsibility for the classification of functioning already addressed through the ICF. Its proposed role is to organise clinically meaningful information concerning current positive mental health, positive-health capacities, demonstrated adaptation and resources that may contribute to recovery or the maintenance of health. The architecture is intended to remain compatible with existing and future diagnostic systems and to permit positive-health information to be considered independently from psychopathology. The theoretical basis for this separation is supported by the two-continua model of mental health. Keyes (2005) demonstrated that mental illness and positive mental health can be represented as separate but correlated dimensions. The formulation permits clinically important combinations that are obscured when mental health is interpreted as the opposite of mental illness. A person may experience considerable psychopathology while retaining meaningful positive-health characteristics. Another person may have little current psychopathology while experiencing limited positive mental health. Positive-health information requires direct assessment rather than inference from diagnosis or symptom severity.

PHCF extends this proposition by suggesting that positive health itself contains several forms of clinically relevant information. A person's current experience of wellbeing is not equivalent to their capacity to regulate distress. Their capacity to regulate distress is not equivalent to a history demonstrating successful adaptation. A history of adaptation is not equivalent to the availability of supportive relationships, material resources or access to care. These components may interact strongly, but they answer different clinical questions. The initial PHCF architecture proposes four principal components. Current Positive Health State describes the positive mental health presently experienced by the person. Positive Health Capacities describe capabilities that appear available or capable of mobilisation. Demonstrated Adaptation describes evidence from the person's history showing how they have responded to significant challenge. Protective Resource Ecology describes the personal, relational, cultural, community, material and structural resources that may support positive health or recovery. Clinical Presentation Modules may add further specificity where research supports positive-health constructs that have particular relevance to identifiable forms of mental health presentation. Course, trajectory, contextual information and the evidence supporting each judgement provide further interpretive information across the framework. These components are provisional. PHCF Version 0.1 should be understood as an architecture capable of supporting research rather than a validated classification system. The four-component structure should survive only if empirical investigation demonstrates that its components are sufficiently distinct, reliable and clinically useful.

The Unit of Classification

A positive health classification requires clarity about what is actually being classified. PHCF does not classify the worth, character, morality or social value of the individual. It classifies specified positive-health states, psychological capacities, demonstrated adaptations and resources within identifiable contexts. The distinction protects the framework from turning socially preferred characteristics into indicators of health. Terms such as successful, productive, independent, strong or courageous may carry positive meanings in ordinary language, although each can also reflect cultural values and social expectations. Employment, educational attainment, relationship status or independent living should not be treated as direct indicators of positive mental health. A person who requires extensive support may demonstrate considerable agency, adaptive regulation and relational capacity. A person who appears highly successful occupationally may experience profound distress, disconnection and limited positive wellbeing. The proposed unit of classification is the construct as expressed within context. Agency can be assessed. Psychological flexibility can be assessed. Recovery self-management can be assessed. A history demonstrating adaptation can be examined. The accessibility of relational or structural resources can be considered. These classifications describe aspects of the person's current and historical health context. They do not constitute a global judgement about the person. The distinction has parallels with the ICF, which separates a health condition from functioning and recognises the influence of environmental context on what a person can do and what they actually do. The ICF further distinguishes capacity from performance, acknowledging that capability under defined conditions may differ from functioning within the person's actual environment (WHO, 2001). PHCF adopts a related principle. Diagnosis, functioning, positive-health capacity and resource availability may be associated, but none should be inferred automatically from another. The proposed PHCF requires a precise definition of its unit of classification. The framework is intended to classify specified positive-health constructs as they are expressed within context, not the worth, character or social value of the person. Figure 5.1 distinguishes what PHCF is intended to classify from socially valued characteristics and outcomes that should not be treated as direct indicators of positive mental health.

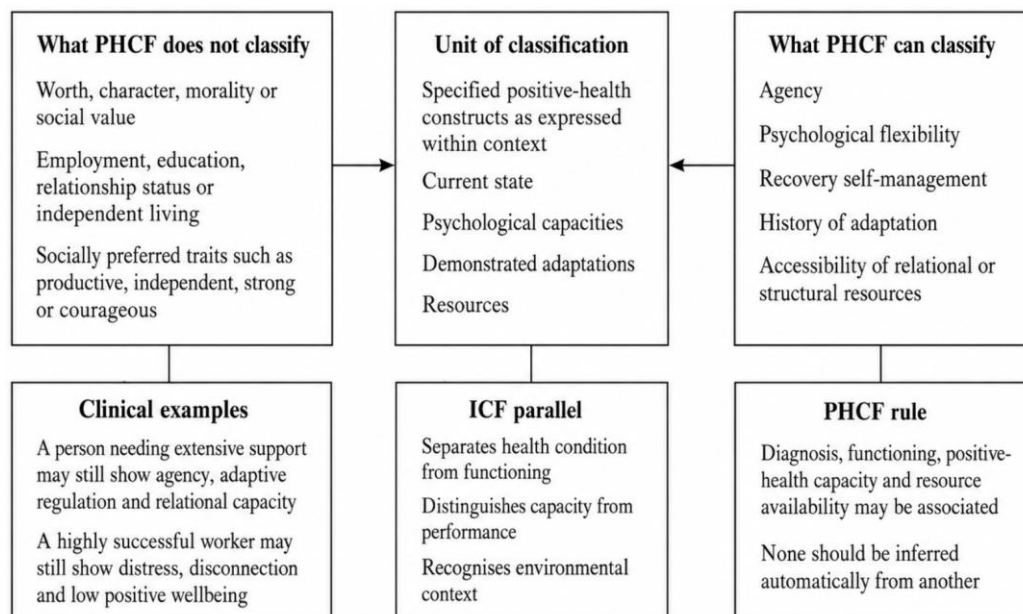


Figure 5.1. *The unit of classification in PHCF, showing that the framework classifies specified positive-health constructs within context rather than making global judgements about the person.*

The Hierarchical Structure of PHCF

PHCF is designed as a hierarchical and dimensional framework. Broad components provide an organising structure, while more specific constructs sit beneath them. Presentation-relevant information can be added when evidence demonstrates that additional specificity has clinical value. The hierarchy is informational rather than developmental. A person does not progress through the components in sequence and no component is automatically more important than another. A hierarchical structure supports several objectives. It permits communication at different levels of detail, accommodates constructs that operate across multiple diagnoses and allows future evidence to reorganise the framework without requiring a new top-level classification for every positive-health phenomenon. This approach is consistent with broader movements within contemporary psychiatric classification toward hierarchical and dimensional representations of clinical phenomena (Öngür et al., 2026).

Table 5.1

Provisional Architecture of the Positive Health Classification Framework

PHCF Component	Primary Function	Proposed Content
Source Clinical Classification	Establishes the clinical context while remaining external to PHCF	DSM, ICD, HiTOP or another recognised clinical formulation
Current Positive Health State	Describes positive mental health presently experienced	Positive self-experience, engagement, connection, meaning and valued direction
Positive Health Capacities	Describes psychological capabilities currently available or potentially mobilisable	Agency, adaptive regulation, psychological flexibility, relational capacity, meaning and identity, recovery self-management
Demonstrated Adaptation	Describes historical evidence of adaptation during meaningful challenge	Strategy development, help seeking, recovery following deterioration, persistence and restoration of valued activity
Protective Resource Ecology	Describes resources that may support or enable positive health	Personal, relational, cultural, community, material, structural and treatment-related resources
Clinical Presentation Modules	Adds presentation-relevant specificity when evidence supports it	Constructs associated with broad clinical presentations
Course and Evidence Qualifiers	Provides longitudinal and evidentiary interpretation	Trajectory, context, evidence source and confidence

The structure permits combinations that may initially appear contradictory but are clinically meaningful. A person may report limited current positive wellbeing while demonstrating strong adaptive capacity. Another may experience good current wellbeing while having few resources available if their mental health deteriorates. A person may possess an extensive history of successful adaptation while currently being unable to mobilise those capabilities. PHCF is intended to preserve these distinctions.

Current Positive Health State

Current Positive Health State concerns the positive mental health experienced at the time of assessment and this component has the strongest relationship with existing wellbeing literature and should be developed carefully to avoid unnecessary duplication. Keyes (2002) conceptualised positive mental health through emotional, psychological and social wellbeing. His Mental Health Continuum demonstrated that flourishing involves more than positive affect and includes positive functioning within psychological and social domains. Ryff's model of psychological wellbeing similarly identified multidimensional positive functioning involving self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth. Subsequent research has reinforced the importance of conceptualising wellbeing as multidimensional rather than reducing it to happiness or life satisfaction (Ryff, 2014). PHCF does not require a new theory of wellbeing. Existing measures may ultimately provide much of the evidence required for this component. Current Positive Health State instead provides an organising location within the broader classification for positive experience that needs to be interpreted alongside capacities, adaptation and resources. The initial structure incorporates positive self-experience, engagement and vitality, belonging and connection, and meaning and valued direction. Positive self-experience concerns the person's current relationship with themselves and may include self-acceptance, coherence and a sense of personal legitimacy. It does not require consistently positive self-evaluation. A person may experience grief, disappointment, guilt or self-criticism while maintaining a fundamentally coherent relationship with themselves.

Engagement and vitality concern meaningful psychological involvement in life and access to sufficient energy or interest to participate in personally valued experiences. Engagement should not be operationalised through productivity. Participation in relationships, creativity, culture, family life, community activities or private interests may be highly meaningful even when occupational participation is limited. Belonging and connection concern the person's experience of meaningful interpersonal or social connection. Connectedness has a well-established position in personal recovery research and forms one of the principal components of the CHIME framework (Leamy et al., 2011). PHCF should avoid assuming that more relationships indicate greater positive health. The quality, meaning and accessibility of relationships are more relevant than numerical network size. Meaning and valued direction concern the experience that life contains personally significant commitments, values or purposes. These may involve relationships, culture, spirituality, creativity, responsibility, contribution or personal development. The person remains the principal authority concerning what constitutes a valued direction. Current Positive Health State is expected to fluctuate. Acute symptoms, environmental stress, bereavement, interpersonal conflict or physical illness may temporarily reduce positive affect or engagement while leaving other PHCF components relatively intact. State and capacity should remain separate in the framework.

Positive Health Capacities

Positive Health Capacities form the central capability component of PHCF. They concern psychological capabilities that appear available to the person and may be mobilised during ordinary life, periods of challenge, treatment or recovery. These capacities are not equivalent to current

wellbeing. Someone may feel profoundly distressed while retaining substantial capability for adaptive action. The initial PHCF architecture proposes Agency and Self-Direction, Adaptive Regulation, Psychological Flexibility, Relational Capacity, Meaning and Identity Capacity, and Recovery and Self-Management Capacity. These constructs have overlapping theoretical foundations and should be treated as provisional until their distinctiveness has been tested empirically. Agency and Self-Direction concern the capacity to experience oneself as an active participant in one's life, to make meaningful choices and to participate in decisions affecting personal direction. Agency has clear conceptual relationships with autonomy, empowerment and personal recovery. CHIME identifies empowerment as a central recovery process, while broader recovery literature repeatedly emphasises choice and personal agency (Leamy et al., 2011; van Weeghel et al., 2019).

Agency should not be confused with independence. A person may depend extensively on family, disability supports, clinical services or community resources while exercising considerable agency in how those supports are used. Interdependence may reflect strong agency where relationships and collective decision making are personally and culturally valued. Adaptive Regulation concerns the capacity to recognise and influence emotional, cognitive, physiological and behavioural responses in ways that remain appropriate to context and personal goals. Regulation should not be equated with suppression or control. Some emotional states require tolerance not modification, and some environments require changes in circumstances not changes within the person. Contemporary emotion-regulation theory emphasises that the effectiveness of particular strategies depends heavily on context and flexibility in their use (Gross, 2015). Psychological Flexibility concerns the capacity to recognise changing demands, modify ineffective responses and continue behaviour that remains consistent with important values. Kashdan and Rottenberg (2010) described psychological flexibility as involving adaptation to situational demands, shifting behavioural or cognitive repertoires when existing strategies no longer work and maintaining behaviour connected with personally meaningful values. The construct is especially relevant to PHCF because recovery frequently involves adapting existing strategies rather than acquiring a single universally effective coping technique. Relational Capacity concerns the capacity to establish, maintain, use and where possible repair meaningful relationships. It differs from the existence of a relational resource. A person can possess considerable capacity for trust, reciprocity and connection while currently being socially isolated. Another person may have a large family or social network but experience little capacity to use those relationships safely or effectively. This distinction between capability and resource availability is central to PHCF.

Meaning and Identity Capacity concern the ability to maintain, access or reconstruct a coherent sense of self and valued direction during periods of illness, transition or adversity. Identity and meaning have prominent positions within the CHIME framework, while purpose and positive self-experience are central within psychological wellbeing research (Leamy et al., 2011; Ryff, 2014). This construct becomes particularly relevant when a mental health condition threatens to dominate the person's account of who they are. Recovery can involve integrating an experience of illness while preserving or rebuilding an identity that extends beyond it. Recovery and Self-Management Capacity concerns the person's ability to recognise relevant changes in their mental health, understand personal patterns, use established strategies, seek appropriate support and participate actively in decisions concerning ongoing care. Effective self-management should not be confused with coping alone. Recognising that external assistance is required and mobilising that assistance may itself demonstrate strong self-management. The concept has particular clinical relevance for recurrent and enduring conditions. A person experiencing recurrent depression may recognise early changes in sleep, withdrawal and thinking and activate a previously developed plan before substantial deterioration occurs. A person with bipolar disorder may recognise changes in sleep, activity or mood and seek assistance. A person with trauma-related symptoms may identify triggers and use established grounding or support strategies. Recurrence

of symptoms does not automatically indicate absence of self-management capacity. These proposed capacities should remain distinguishable from functioning. A person may possess strong self-management capability while experiencing significant functional limitations. Another may function effectively across several life domains while having limited psychological flexibility or poor recognition of deteriorating mental health.

Table 5.2

Provisional Positive Health Capacities

Construct	Primary Question
Agency and Self-Direction	Can the person participate meaningfully in directing their life and decisions?
Adaptive Regulation	Can emotional, cognitive and behavioural responses be managed in ways that fit current demands?
Psychological Flexibility	Can ineffective strategies be modified when circumstances or goals change?
Relational Capacity	Can meaningful supportive relationships be formed, maintained and used?
Meaning and Identity Capacity	Can a coherent sense of self and valued direction be maintained or reconstructed?
Recovery and Self-Management Capacity	Can changes in mental health be recognised and appropriate responses or supports mobilised?

The constructs in Table 5.2 represent the current theoretical structure. The framework should not assume that six capacities will survive empirical analysis. Some may combine. Others may divide. A higher-order structure may eventually emerge.

Demonstrated Adaptation

Demonstrated Adaptation represents one of the more distinctive elements of PHCF. It concerns evidence from the person's history showing that they have previously adapted, reorganised, persisted or restored valued aspects of life during significant adversity, illness or change. The construct draws heavily from resilience research, although it does not define resilience as a stable characteristic of the person. Contemporary resilience literature increasingly describes adaptation as a dynamic process that occurs through interactions among individuals, relationships, communities and environments. Southwick et al. (2014) demonstrated substantial variation in resilience definitions while identifying broad agreement that adaptation following adversity cannot be reduced to a fixed personality trait. PHCF uses Demonstrated Adaptation to ask a practical clinical question concerning what the person's history shows they have previously been able to do. Clinical histories commonly document adverse events as sources of vulnerability. Childhood bullying, family conflict, trauma, loss, psychiatric episodes and other disruptions may be recorded to help explain current symptoms. The same history

may also contain evidence that the person developed strategies, sought assistance, protected important relationships, re-entered education or employment, maintained meaningful roles or recovered from previous deterioration. These historical achievements should not be romanticised. Their presence does not establish that the person benefited from adversity or that current wellbeing is high. They provide evidence about previous adaptation. This distinction is particularly important during periods of acute distress. A person experiencing severe depression may describe themselves as incapable and unsuccessful. Their history may demonstrate repeated help seeking, effective use of treatment, restoration of relationships and recovery following previous episodes. PHCF can preserve this information without contradicting the person's present experience.

Demonstrated Adaptation must always be interpreted in context. Adaptation occurs in relation to particular challenges, resources and environments. The cost of adaptation is also relevant. A behaviour can have been useful within one environment and restrictive within another. A young person repeatedly exposed to bullying may develop a cognitive image of a protective shield that helps distance them from hostile comments. The strategy may indicate imaginative coping, perceived control and an attempt to regulate interpersonal threat. Its meaning depends on its effects. If it supports continued engagement without increasing avoidance, it may represent useful adaptation. If it becomes a means of disengaging from all social contact, the strategy may carry increasing costs. Similarly, extreme self-reliance may develop in a person who had little access to trustworthy support. The strategy may have enabled survival and functional continuity under earlier conditions. It may later interfere with intimate relationships or help seeking. PHCF should permit an adaptation to be described as historically effective and currently costly. Demonstrated Adaptation is not equivalent to achievement. Educational attainment, employment status, income or social prestige do not automatically indicate adaptation. The classification requires a meaningful challenge, evidence of a response and some indication that the response helped preserve or restore something the person valued. The construct will require careful methodological development because retrospective interpretation is vulnerable to bias. Exposure to substantial adversity may lead clinicians to infer resilience automatically. PHCF should require evidence concerning what the person actually did, what resources contributed, how the strategy functioned and what costs were associated with it.

Protective Resource Ecology

Protective Resource Ecology addresses the resources that exist within and around the person and that may support positive health, adaptation or recovery. The concept has foundations across salutogenesis, resilience, ICF and recovery-capital research. Recovery capital provides one of the strongest established examples. Bunaciu et al. (2024) identified 69 quantitative studies, ten recovery-capital instruments and 41 represented constructs within substance-use recovery. The findings demonstrate both the importance of recovery resources and substantial heterogeneity in how those resources are conceptualised. PHCF extends the resource question across broader mental health presentations. This generalisation remains a proposition requiring evidence. Resources relevant to substance-use recovery may overlap considerably with those supporting recovery from depression, trauma, psychosis or other conditions, while their relative importance and mechanisms may differ. Protective Resource Ecology initially encompasses personal resources, relational resources, cultural and community resources, structural and material resources, environmental resources and treatment-related resources. Digital resources may also warrant explicit consideration as social connection, information access, healthcare and self-management become increasingly digitally mediated. Personal resources may include knowledge, learned strategies, health literacy and practical tools. They should remain distinguishable from capacities. A written safety or relapse plan is a resource. The ability to recognise when the plan is required and use it effectively reflects a capacity. Relational resources

include trusted family members, partners, peers, mentors, friends and therapeutic relationships where these are experienced as supportive and accessible.

Cultural and community resources may include community membership, cultural identity, collective practices, spiritual communities, social organisations and places of belonging. Structural and material resources can include housing, financial security, education, transport, physical safety and access to appropriate health services. Treatment-related resources may include continuity of care, therapeutic relationships, access to psychological intervention, medication when relevant, crisis pathways and specialist services. The presence of a resource does not establish a protective effect. A family may exist but be unsafe. A service may exist but be inaccessible. Employment may provide income and identity while producing severe psychological strain. A community may provide belonging and expose the person to stigma. An online group may provide connection while reinforcing harmful behaviour. Protective Resource Ecology requires attention to whether a resource is available, accessible, usable and capable of mobilisation. The term protective factor should be reserved for circumstances where evidence supports a meaningful association with a relevant outcome. The approach is consistent with the ICF recognition that environmental factors can operate as facilitators or barriers and can influence how capability is translated into actual functioning (WHO, 2001). PHCF applies a related principle to the resources that may enable positive mental health and recovery.

Personal Recovery Across PHCF

Personal Recovery provides an interpretive foundation across the PHCF architecture. It should not become another clinician-controlled classification. The CHIME framework identifies Connectedness, Hope and optimism, Identity, Meaning and Empowerment as central recovery processes (Leamy et al., 2011). Subsequent review evidence has continued to support these concepts while highlighting individual variation, cultural context, choice and the complexity of recovery trajectories (van Weeghel et al., 2019). These concepts appear throughout PHCF. Connectedness informs Current Positive Health State and Relational Capacity. Empowerment contributes to Agency and Self-Direction. Identity and meaning inform Meaning and Identity Capacity. Hope may contribute to current positive health and future-directed recovery capability. Their distribution across PHCF is intentional. Personal recovery is not treated as a single trait. It describes how the person understands movement toward a meaningful life. PHCF must preserve discrepancies between clinician-rated capacities and person-reported recovery. A clinician may observe substantial agency, adaptive regulation and support. The person may still report that their life does not feel recovered or meaningful. The framework should retain both forms of information. The person remains the principal authority concerning the meaning of recovery in their own life.

Functioning and Quality of Life as Adjacent Information

Functioning and quality of life remain adjacent to PHCF rather than components of its core classification. Functioning already has an international conceptual and classification architecture through the ICF. Quality of life has extensive measurement traditions. Future DSM development is also considering a more prominent role for both constructs. Drexler et al. (2026) argue that symptoms, functioning and quality of life each provide clinically meaningful information and require longitudinal consideration. PHCF should preserve their independence. Functioning concerns what the person can do and what occurs in their environment. Quality of life concerns how the person evaluates important aspects of life. Positive Health Capacities concern psychological and adaptive capabilities that may influence these outcomes without being reducible to them. Several clinically meaningful combinations follow. Strong adaptive capacity can coexist with functional impairment. Strong occupational functioning can coexist with poor positive mental health. Continuing symptoms can coexist with good

quality of life. Structural deprivation can reduce quality of life while psychological capacities remain strong. These distinctions are essential if PHCF is to avoid equating health with productivity, independence or conventional social achievement.

Dimensional Classification and Descriptive Levels

PHCF should begin with dimensional classification because current evidence does not justify fixed categories or thresholds. Positive-health constructs are likely to vary by degree and context. Agency may be available in some settings and constrained in others. Regulation may be effective under moderate stress and less accessible under intense threat. Protective resources may strengthen or deteriorate. Self-management may improve substantially during treatment without crossing a naturally occurring categorical boundary. PHCF can initially use descriptive anchors to support research and clinical interpretation. These anchors should not be represented as validated cut-offs.

Table 5.3

Provisional Descriptive Anchors for PHCF Development

Descriptor	Provisional Interpretation
Not Assessable	Available information is insufficient to support a classification
Limited Evidence	Little evidence that the construct is currently accessible or demonstrated
Emerging	The construct is evident inconsistently, in restricted situations or with substantial support
Established	The construct is reliably evident across relevant situations
Strongly Demonstrated	Evidence indicates consistent availability or expression across meaningful challenge, settings or time

These descriptors require empirical testing. Future research may support continuous numerical scores, revised descriptive categories or clinically meaningful thresholds. Numerical thresholds alone, however, are unlikely to provide a sufficient basis for classification. As in established clinical classification systems, interpretation will require clinical judgement concerning the meaning, context and convergence of available evidence. PHCF should combine empirically derived measurement with structured clinical judgement, while making the basis for classification explicit and reproducible. The term severity should generally remain associated with psychopathology or impairment. Positive-health constructs may be more appropriately described by level, extent or degree. A high or low level should describe the construct being assessed rather than constitute a global judgement about the person.

Evidence Supporting PHCF Classifications

PHCF proposes the use of multiple forms of evidence because psychological assessment research indicates that different assessment methods can provide distinct and clinically meaningful information. Multimethod assessment can extend understanding beyond reliance on a single interview,

questionnaire or observer, while discrepancies between sources may themselves provide information about context and functioning (Hunsley & Mash, 2007; Meyer et al., 2001). Research on multi-informant assessment further demonstrates that disagreement between self-report, collateral information and observation should not automatically be treated as measurement error because different sources may capture behaviour, experience and functioning expressed under different conditions (De Los Reyes et al., 2013). A classification based solely on self-report would be insufficient for several proposed PHCF constructs. A classification based solely on clinician observation would also inadequately capture subjective experience. The evidentiary basis should instead reflect the nature of the construct being assessed and draw on appropriate combinations of self-report, clinical interview, behavioural and developmental history, clinical observation, collateral information, validated psychometric instruments and longitudinal clinical information. Current Positive Health State necessarily relies heavily on the person's own experience because constructs such as positive self-experience, engagement, belonging and valued direction contain an inherently subjective component. Standardised measures may assist in describing these experiences, while clinical interview can clarify their meaning, context and stability. Clinician interpretation should not override the person's account merely because it differs from an external observation.

Positive Health Capacities may require a broader evidentiary approach. Self-report can provide information about perceived agency, psychological flexibility, adaptive regulation, relational capacity, meaning and recovery self-management. Behavioural examples, clinical interview and evidence concerning how these capacities are expressed under different demands may provide additional information. A person's perceived capacity and demonstrated capability should not automatically be assumed to be equivalent. Demonstrated Adaptation requires historical evidence. Relevant information may include previous responses to adversity, changes in coping strategies, help-seeking, maintenance or restoration of important relationships, reorganisation following major life events and evidence of adaptation across time. The construct is unlikely to be adequately assessed through a single cross-sectional questionnaire. Longitudinal clinical information, behavioural history and appropriately obtained collateral information may contribute to determining whether adaptation has been demonstrated. Protective Resource Ecology requires examination of the person's environment and their relationship with available resources. The existence of a resource does not establish that it is accessible, usable, mobilised or protective. Assessment may consider relational, cultural, community, material, structural and environmental resources together with the person's ability to access and use them. The meaning and effect of a resource should be interpreted within the person's circumstances.

Clinical observation can contribute information concerning regulation, interpersonal interaction and behaviour within the assessment setting. Its limits must also be recognised. Behaviour displayed during a structured clinical encounter may differ substantially from behaviour expressed at home, at work, within relationships or during periods of significant stress. Observation should contribute to a broader evidentiary picture rather than be treated as a privileged source of truth. Collateral information may also contribute where it is clinically relevant, ethically obtained and interpreted cautiously. Different observers may experience the same relationship or behaviour differently. A family member may describe a relationship as supportive while the person experiences it as intrusive or unsafe. Such disagreement should not automatically be resolved by selecting one account as correct. The discrepancy may itself reveal clinically important differences in perspective, context or relational functioning. Different evidence sources may disagree. A person may report very little confidence in their ability to cope while their history demonstrates repeated effective problem solving. A clinician may observe strong emotional regulation during an assessment while the person reports substantial difficulty regulating distress in other environments. A psychometric measure may indicate high perceived resilience while longitudinal evidence shows repeated difficulty mobilising available resources during

periods of adversity. PHCF should preserve these discrepancies where they are clinically meaningful rather than forcing all evidence into a single apparently consistent conclusion.

The evidentiary requirements are expected to vary according to the construct and will require empirical testing during PHCF development. Current Positive Health State is likely to depend substantially on self-report because it concerns subjective positive-health experience. Demonstrated Adaptation requires evidence concerning adaptation across time and challenge. Protective Resource Ecology requires examination not only of whether resources exist, but whether they are accessible, usable and mobilised within the person's context. Positive Health Capacities are likely to require evidence concerning both perceived capability and its expression under relevant conditions. No single assessment method is expected to adequately represent the complete PHCF profile. PHCF should adopt a multimethod and multisource evidentiary model while avoiding the assumption that more sources automatically produce a more accurate classification. The value of each source should depend on its relevance to the construct being assessed, the quality of the information available and the context in which that information was obtained. These principles provide an evidentiary basis for how PHCF classifications might eventually be assigned. They do not constitute evidence that PHCF classifications themselves are valid. Establishing the reliability, validity, clinical utility and incremental value of PHCF classifications will require prospective empirical research. The distinction is important. Existing psychological assessment research supports the use of multiple methods and informants. Whether the proposed PHCF constructs can be classified reliably and whether doing so improves clinical understanding or decision-making remain questions for future testing.

Course and Trajectory

Positive health should be represented longitudinally. A classification made at one point in time provides limited information about whether a construct is emerging, stable, strengthening or deteriorating. Psychiatric classification increasingly recognises the importance of course, and the Future DSM roadmap proposes greater use of longitudinal and dimensional information (Oquendo et al., 2026). PHCF should apply the same principle to positive-health information. The framework may eventually distinguish trajectories such as emerging, improving, stable, oscillating, declining and sustained. These terms require operational definitions and should not currently imply fixed duration thresholds. Level and trajectory provide different information. A person may have limited Agency and Self-Direction but demonstrate consistent improvement. Another may have established Adaptive Regulation that is deteriorating following major environmental stress. A person living with bipolar disorder may show considerable fluctuation in Current Positive Health State while maintaining strong and stable Recovery and Self-Management Capacity. A person with chronic trauma-related symptoms may demonstrate persistent relational capacity despite little improvement in symptom severity. Trajectory may eventually become one of the clinically important features of PHCF. Sustained self-management capacity could provide information different from a single assessment score, while rapid deterioration in accessible resources may identify vulnerability before substantial symptom change occurs. These possibilities require longitudinal research.

Clinical Presentation Modules

The Universal PHCF Core is intended to apply across mental health presentations. Clinical Presentation Modules provide additional specificity where evidence shows that a particular positive-health construct has additional relevance to a recognisable clinical presentation. The modules should be organised around broad presentations and remain compatible with different diagnostic systems. Their purpose is not to identify the positive opposite of a disorder. A depressive presentation may ultimately require examination of re-engagement, recurrence recognition, restoration of agency or recovery of

positive affect if these constructs provide information beyond the Universal Core. A trauma and stressor presentation may require greater attention to safety, threat discrimination, relational trust or trauma-related meaning. Bipolar presentations may require attention to mood-state awareness, early-warning recognition and management of sleep or routine. Substance-related presentations may have particular relationships with recovery capital and recovery identity. These constructs should enter modules only when evidence demonstrates additional utility. The Universal Core remains essential because many positive-health capacities are likely to operate across diagnoses. Agency, psychological flexibility, relational capacity and self-management have plausible relevance across numerous mental health conditions. Repeating these constructs separately within every presentation module would recreate the fragmentation PHCF is intended to reduce. Comorbidity should not result in repeated assessment of the same positive-health construct. A person presenting with depression and PTSD would receive one Universal Core profile, with relevant presentation-specific information added only where required. Presentation-specific constructs are transdiagnostic.

Interoperability With Existing Classification

Interoperability is a central requirement of PHCF. The framework should remain usable whether the source clinical formulation uses DSM, ICD, HiTOP or another recognised classification. The source classification should be preserved exactly as used. A DSM diagnosis remains a DSM diagnosis. An ICD diagnosis remains an ICD diagnosis. A HiTOP dimensional profile remains a dimensional profile. PHCF adds a separate positive-health description. This approach reduces dependence on exact equivalence between diagnostic systems and allows PHCF to remain useful as those systems evolve. The principle is particularly relevant given the direction of current Future DSM work, which is examining greater harmonisation with ICD-11, HiTOP, RDoC and other developments while increasing attention to dimensionality, context, functioning and quality of life (Oquendo et al., 2026; Öngür et al., 2026). PHCF can be conceptualised as a positive-health information layer capable of operating across different nosological environments.

The Integrated PHCF Profile

A completed PHCF assessment should produce a multidimensional profile. A single global positive-health score should not be assumed. Combining wellbeing, adaptive capacity, demonstrated adaptation and resource availability into one number could conceal important clinical differences. Two people with the same overall score might have completely different positive-health profiles and require different forms of support. An illustrative profile is provided in Table 5.4. The classifications are examples and do not represent validated criteria.

Table 5.4*Illustrative PHCF Profile*

Information	Illustrative Description
Source Clinical Classification	Major Depressive Disorder, recurrent
Current Positive Health State	Engagement emerging, connection established, valued direction emerging
Agency and Self-Direction	Established
Adaptive Regulation	Emerging
Psychological Flexibility	Established
Relational Capacity	Strongly Demonstrated
Meaning and Identity Capacity	Established
Recovery and Self-Management Capacity	Established
Demonstrated Adaptation	Strongly Demonstrated across previous episodes
Protective Resource Ecology	Strong relational resources, stable housing and treatment access, limited community connection
Positive Health Trajectory	Improving
Psychopathology Trajectory	Improving

The profile does not compete with the source diagnosis. It adds information concerning capabilities and resources that may influence formulation, treatment and longer-term recovery.

Clinical Interpretation

The PHCF architecture is intended to influence clinical reasoning by making positive-health information visible within formulation. A person with established Psychological Flexibility and limited relational resources may already possess strong internal capabilities while requiring intervention around isolation or access to support. A person with strongly demonstrated adaptation and low Current Positive Health State can be recognised as having considerable historical capability without being described as currently well. Emerging Recovery and Self-Management Capacity may indicate an opportunity to strengthen warning-sign recognition, relapse planning and help-seeking pathways. Limited Protective Resource Ecology caused by unstable housing should remain visible as a contextual problem and should not be reframed as poor individual resilience. This creates an important shift in how information can be used. Positive-health information becomes clinically active. The clinician can consider what capacities are already available, which resources can be mobilised, what adaptations have worked previously and what requires strengthening. The proposed benefit remains hypothetical until tested. PHCF must demonstrate that clinicians actually formulate or plan treatment differently when this information is presented systematically and that people receiving care experience the classification as accurate and useful.

Preventing Misclassification

The architecture requires safeguards because positive-health information can be misinterpreted in ways that disadvantage the person. Strong adaptive capacity cannot be used to infer low symptom severity or low clinical risk. Demonstrated Adaptation cannot be used to reduce eligibility for treatment. Strong occupational or academic performance cannot be substituted for positive health. Dependence on assistance cannot be interpreted automatically as low agency. Exposure to adversity cannot be classified as adaptation without evidence concerning how the person responded. A resource cannot be classified as protective merely because it exists. Positive affect cannot provide sufficient evidence of positive mental health when other aspects of judgement, regulation or functioning indicate substantial disturbance. These safeguards follow directly from the theoretical boundaries developed throughout PHCF. Their function is to prevent the framework from minimising suffering, rewarding social conformity or transforming survival into evidence that treatment is unnecessary.

PHCF Version 0.1 as a Scientific Model

The architecture presented in this chapter establishes PHCF Version 0.1 as a model capable of empirical examination. It does not establish a validated classification system. The component constructs have different levels of existing evidence. Positive mental health, psychological wellbeing, personal recovery, psychological flexibility, emotion regulation, resilience, self-management and recovery capital each have substantial research traditions. Their organisation into the PHCF architecture remains a new proposition and requires independent evaluation. The strongest test of PHCF will not be whether clinicians consider the framework intuitively attractive. Its value depends on whether it produces reliable, valid and clinically useful information beyond established diagnosis, symptom, functioning, quality-of-life and wellbeing assessments. The proposed architecture may survive largely intact. Positive Health Capacities may collapse into fewer higher-order dimensions. Current Positive Health State may prove to be captured adequately by existing wellbeing measures. Demonstrated Adaptation may provide substantial incremental information beyond self-reported resilience. Protective Resource Ecology may ultimately require closer integration with ICF or social-determinants frameworks. Clinical Presentation Modules may prove useful for some presentations and unnecessary for others. The entire model may ultimately function more effectively as a structured formulation system than as a formal classification. Each outcome remains scientifically acceptable. PHCF Version 0.1 exists to make the propositions sufficiently explicit that they can be tested.

The Emerging Classification Logic

The architecture developed in this chapter reduces the PHCF proposition to four connected clinical questions. The first concerns what positive mental health the person currently experiences. The second concerns which positive-health capacities appear available. The third concerns what the person's history demonstrates about adaptation under meaningful challenge. The fourth concerns which resources can realistically be mobilised to support positive health or recovery. Clinical Presentation Modules can add specificity where evidence supports them, while longitudinal information describes how the profile changes over time. Psychopathology, functioning and quality of life remain independently described. This architecture converts the broad concept of positive-health classification into a testable clinical model. The next requirement is operational precision. Each proposed construct must be defined clearly enough that independent users can recognise what it includes, what it excludes, what evidence supports it and how it differs from neighbouring constructs. The following chapter moves from architecture to operationalisation. It examines how PHCF constructs can be defined, assessed and eventually translated into defensible classification requirements without imposing premature diagnostic criteria or arbitrary thresholds.

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Chapter Six - Operationalising Positive Health Classification - Construct Definition, Evidence and Classification Requirements

From Architecture to Operational Definition

The preceding chapter established the provisional architecture of the PHCF. Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology were proposed as related but distinguishable components of positive health. The next problem is methodological. A framework can possess theoretical coherence and clinical appeal while remaining unusable as a classification system if its constructs cannot be defined, distinguished and assessed with sufficient consistency. Operationalisation represents a critical transition in the development of PHCF. Terms such as agency, flexibility, adaptation, recovery capability and protective resources have intuitive clinical meaning. Intuitive meaning is insufficient for classification. If different clinicians understand the same term differently, the framework cannot provide a reliable common language. If apparently separate PHCF constructs measure essentially the same phenomenon, the architecture becomes unnecessarily complex. If classifications depend on information that cannot be obtained realistically in clinical settings, the framework may demonstrate theoretical sophistication while having little practical utility.

The purpose of operationalisation is consequently broader than developing a questionnaire. PHCF is intended to organise information derived from multiple sources, including the person's own account, clinical interview, behavioural and developmental history, observation, validated measures, contextual information and longitudinal evidence. The operational task is to specify what each construct means, what evidence is relevant to it, what falls outside its boundaries and how uncertainty should be represented. The methodological sequence is important. PHCF should not begin by writing hundreds of candidate items and then use statistical analysis to determine what they happen to measure. Construct definition must precede instrument development. Content validity must precede confidence in numerical scores. Reliability must be demonstrated without being mistaken for validity. Convergent evidence should show that PHCF constructs relate appropriately to neighbouring concepts, while discriminant evidence must demonstrate that they are not simply alternative labels for existing constructs. Finally, classification must demonstrate clinical value beyond psychometric performance. This approach is consistent with contemporary measurement standards. The COSMIN methodology (Mokkink et al., 2024; Terwee et al., 2018) identifies content validity as fundamental to the evaluation of patient-reported outcome measures and defines it through the relevance, comprehensiveness and comprehensibility of the content of an instrument. The updated COSMIN guidance published in 2024 emphasises clear construct definitions, content validity and separate evaluation of the measurement properties of individual subscales (Mokkink et al., 2024; Terwee et al., 2018). PHCF extends this reasoning beyond patient-reported measurement. Before positive health can be classified, there must be sufficient agreement about what is being classified.

What Makes a Construct Classifiable

A clinically meaningful phenomenon does not automatically constitute a classifiable construct. Many concepts are useful within therapeutic conversation without requiring formal classification. Courage, humour, kindness, persistence, creativity and spirituality may each play important roles in particular people's lives. Their clinical relevance does not by itself justify their inclusion within PHCF. A PHCF construct should meet a more demanding standard. It should describe a recognisable aspect of positive health that can be defined with sufficient precision, distinguished meaningfully from neighbouring constructs and assessed using evidence appropriate to its nature. It should demonstrate

variation between people or within the same person over time and should have a plausible relationship with clinically relevant processes or outcomes. Most importantly, it should contribute information that justifies the additional complexity created by its inclusion. This final requirement constrains construct proliferation. A framework containing twenty highly correlated positive capacities may create an appearance of precision without improving clinical understanding. If Agency and Self-Direction, Psychological Flexibility and Recovery Self-Management ultimately reflect one broader latent capacity, the framework should be reorganised accordingly. If Meaning and Identity Capacity separates reliably into two distinct constructs with different clinical implications, the framework should permit that division. The architecture should follow evidence rather than defend its original terminology. Construct validity has long been understood as an accumulating process in which theoretical propositions about a construct are evaluated through relationships with other variables and observations. Cronbach and Meehl's (1955) foundational account of construct validity emphasised the importance of locating psychological constructs within a broader network of theoretically expected relationships. Campbell and Fiske (1959) subsequently demonstrated the importance of establishing both convergence among different methods intended to assess the same construct and discrimination between theoretically distinct constructs. These principles are especially relevant to PHCF because the framework proposes several related positive-health phenomena whose boundaries cannot be assumed. Operationalisation must begin with a specification of the construct rather than a specification of the score. Before a construct can be incorporated into PHCF, it should meet a defined evidentiary standard. The proposed requirements are intended to prevent construct proliferation and ensure that each domain represents a recognisable, distinguishable and clinically meaningful aspect of positive health. Figure 6.1 summarises the minimum requirements proposed for inclusion of a construct within PHCF.

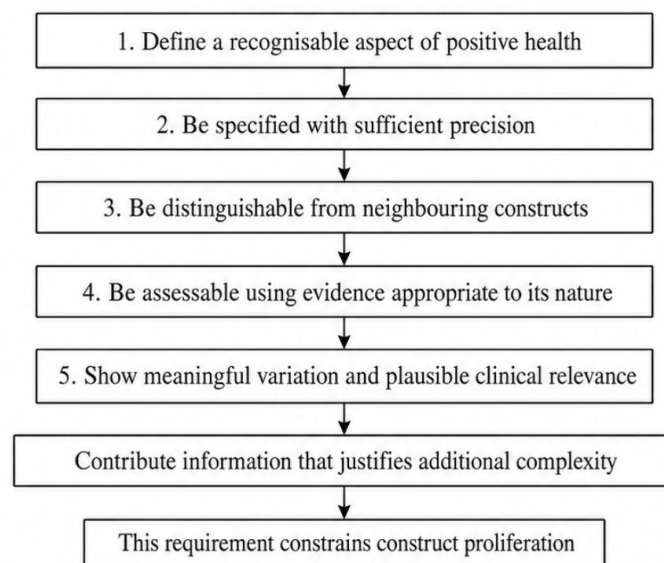


Figure 6.1. *Proposed requirements for inclusion of a construct within PHCF, including conceptual precision, distinction from related constructs, appropriate assessment, meaningful variation, clinical relevance and sufficient added value to justify additional classification complexity.*

Construct Specification Within PHCF

Each PHCF construct should eventually have a standard specification describing its meaning and classification boundaries. The specification should be sufficiently detailed that clinicians, researchers and people with lived experience can determine whether they are discussing the same

phenomenon. A construct definition should first identify the phenomenon being described. It should then identify the construct's temporal orientation. Current Positive Health State is primarily concerned with present experience. Demonstrated Adaptation is inherently historical and longitudinal. Recovery and Self-Management Capacity concerns present capability informed partly by previous behaviour. Protective Resource Ecology concerns current contextual conditions while also requiring consideration of their stability and accessibility over time. The specification should identify what the construct includes and what it explicitly excludes. Agency and Self-Direction, for example, may include meaningful participation in decisions and the capacity to initiate valued action. It should not be defined through living independently, earning an income or refusing assistance. Psychological Flexibility may include the capacity to modify strategies when circumstances change. It should not be inferred merely from behavioural variability, because inconsistent behaviour may arise for many reasons unrelated to flexibility. Each construct also requires a clear relationship with neighbouring concepts. Recovery Self-Management should be distinguished from general coping. Relational Capacity should be distinguished from the availability of relationships. Demonstrated Adaptation should be distinguished from resilience as self-perception and from exposure to adversity itself. Current Positive Health State should be distinguished from quality of life and functional performance. Construct inclusion should remain provisional and responsive to accumulating evidence. PHCF should not preserve constructs simply because they were included in an initial theoretical model. Convergent and discriminant validity testing may indicate that apparently separate constructs should be combined, while other constructs may require further differentiation. Figure 2 illustrates the proposed evidence-driven process through which PHCF constructs can be retained, merged, separated or revised.

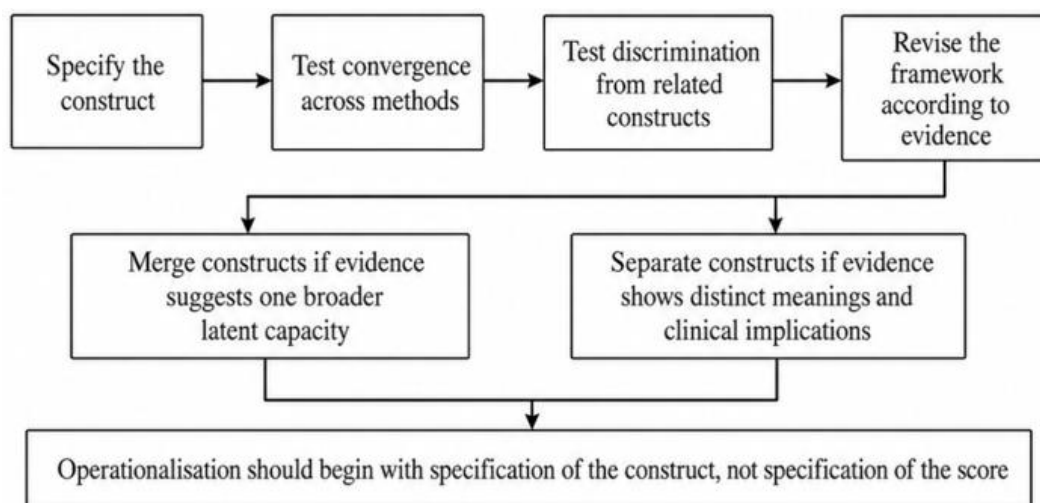


Figure 6.2. *Proposed construct-validation and revision process for PHCF, in which convergence and discrimination are tested and the framework is revised according to evidence rather than preservation of its original terminology.*

Table 6.1 presents a provisional specification structure.

Table 6.1*Provisional PHCF Construct Specification Standard*

Specification Element	Purpose
Construct Name	Provides standard terminology
Conceptual Definition	States the phenomenon intended for classification
Temporal Orientation	Specifies whether the construct concerns current state, current capacity, historical adaptation or longitudinal course
Inclusion Boundary	Identifies evidence relevant to the construct
Exclusion Boundary	Identifies related phenomena that should not be classified under the construct
Neighbouring Constructs	Specifies concepts from which discrimination must be demonstrated
Relevant Context	Identifies environmental, cultural, developmental or clinical conditions affecting interpretation
Evidence Sources	Specifies which forms of evidence can support classification
Indicators	Identifies observable, reportable or measurable manifestations of the construct
Uncertainty Conditions	Specifies circumstances in which classification should remain uncertain or not assessable
Expected Clinical Relevance	States the hypothesised clinical value of knowing the classification
Evidence Status	Records the level of empirical support for the construct and its operationalisation

The purpose of this structure is to ensure that PHCF terminology becomes progressively more precise as evidence accumulates. A classification manual developed before these specifications are stable would risk formalising ambiguity.

Worked example - Demonstrated Adaptation

The following worked example (Figure 6.3) illustrates how a construct specification might eventually appear within a PHCF classification manual. It is illustrative rather than final and is intended to demonstrate the level of conceptual and evidentiary precision required before classification rules are developed.

PHCF Construct Specification: <i>Demonstrated Adaptation</i>	
PHCF construct	Demonstrated Adaptation
Construct definition	Observable or documented evidence that a person has maintained, regained or developed effective responses or functioning when exposed to meaningful challenge, adversity or changing demands.
Classification focus	Demonstrated Adaptation concerns what has occurred, not just what the person believes they might be capable of doing. It therefore differs from Adaptive Capacity, which concerns capabilities potentially available when demands arise.
Temporal orientation	Historical and longitudinal.
Relevant evidence	Evidence may include behavioural history, clinical interview, longitudinal records, self-report, appropriately obtained collateral information and documented changes in functioning or coping over time.
Possible indicators	Examples may include seeking assistance when required, modifying ineffective coping strategies, reorganising life following disruption, maintaining or restoring important relationships, adapting to major changes, or successfully mobilising available resources.
Do not infer from	Demonstrated Adaptation should not be inferred solely from self-rated resilience, personality characteristics, absence of symptoms, exposure to adversity, occupational achievement or the availability of supportive resources.
Related PHCF constructs	Adaptive Capacity, Recovery Self-Management and Protective Resource Ecology.
Adjacent non-PHCF constructs	Psychopathology, functioning, quality of life, resilience and post-traumatic growth.
Contextual interpretation	Adaptation must be considered relative to the demands experienced and the opportunities and resources available. Similar observable outcomes may represent very different levels of adaptation depending on environmental, developmental, cultural and structural circumstances.
Classification uncertainty	The construct should remain unclassified or uncertain where historical information is inadequate, available accounts conflict substantially, the relevant challenge cannot be established or there is insufficient evidence to determine whether adaptation occurred.
Proposed clinical relevance	Knowing a person's history of demonstrated adaptation may identify previously effective strategies, reveal capacities not reflected in current self-appraisal, contribute to formulation and assist treatment or recovery planning.
Evidence status	Provisional PHCF construct. The conceptual distinction is supported by resilience and adaptation literature, but the PHCF definition, indicators, classification levels and clinical utility require empirical validation.

Figure 6.3. Illustrative PHCF construct specification for Demonstrated Adaptation, showing the proposed definition, evidentiary basis, contextual boundaries, uncertainty conditions and clinical relevance of the construct.

Indicators Are Not Yet Classification Criteria

An important distinction is required between indicators and classification criteria. An indicator is a form of information that may provide evidence concerning a construct. A classification criterion specifies the amount, combination or pattern of evidence required before a formal classification can be assigned. PHCF currently has sufficient theoretical development to propose indicators. It does not yet have sufficient evidence to establish formal classification criteria. Recovery and Self-Management Capacity provides a useful example. Relevant indicators might include recognition of personal warning signs, knowledge of strategies that have previously been useful, appropriate help seeking, engagement with treatment decisions, use of relapse-prevention plans and ability to identify circumstances associated with deterioration. These observations provide evidence concerning self-management capacity. They do not establish that three indicators constitute an Established classification while five constitute Strongly Demonstrated capacity. Creating such rules at this stage would produce false precision. The same applies to Demonstrated Adaptation. Previous recovery following a significant deterioration, maintenance of important relationships under adversity, adaptive problem solving and effective mobilisation of support may all represent relevant evidence. The number of experiences required, their duration and the degree of challenge necessary to support a particular classification have not been established. PHCF should remain at the level of construct definition and candidate indicators during its earliest development. Formal classification requirements should emerge through evidence synthesis, qualitative research, expert and lived-experience consultation, psychometric investigation and developmental field testing. This sequence is consistent with the history of psychiatric classification discussed earlier in the book. Operational criteria can improve reliability, but criteria developed without sufficient construct validity can simply make clinicians reliably classify a poorly defined phenomenon.

Different PHCF Components Require Different Evidence

One of the central methodological propositions of PHCF is that evidence should be matched to the phenomenon being classified. Current Positive Health State concerns subjective experience. The person's own report has a privileged evidentiary position. A clinician cannot validly determine that somebody experiences belonging, meaning or positive self-regard solely through observation. Validated wellbeing instruments may support assessment, while interview provides contextual interpretation. Positive Health Capacities require a broader evidentiary basis. Self-report remains relevant, although a person's perception of capability may differ from what they have demonstrated in practice. Interview, behavioural history, observation and validated measures may contribute alongside self-report. Demonstrated Adaptation requires historical or longitudinal evidence because the construct concerns what has actually occurred. A resilience questionnaire administered at one point in time cannot establish previous successful adaptation by itself. The person's account of previous challenges, behavioural history, clinical records and collateral information where appropriate may provide stronger evidence. Protective Resource Ecology requires direct consideration of the person's context. The existence of housing, relationships, services, cultural connections or material resources can be established through interview and contextual information. Their accessibility, usability and meaning require the person's perspective. The protective value of the resource requires stronger evidence again. This structure means that PHCF cannot be reduced readily to a single psychometric instrument. A questionnaire may ultimately measure some PHCF domains very effectively. Other domains may require structured clinical assessment or extraction of historical and contextual evidence. The framework should use measurement where measurement is appropriate without requiring every clinically relevant phenomenon to take the form of a self-report scale.

Content Validity and the Role of Lived Experience

Content validity should be established before substantial effort is directed toward scoring systems or statistical refinement. COSMIN defines content validity through the extent to which the content of an instrument adequately reflects the construct being measured, with particular attention to relevance, comprehensiveness and comprehensibility. The methodology also distinguishes the perspectives of professionals and members of the target population when judging content validity (Terwee et al., 2018). The principle is directly relevant to PHCF. A construct such as Demonstrated Adaptation may appear coherent to classification researchers while failing to reflect how people with lived experience understand their own adaptation. A clinician may identify self-reliance as evidence of strength while the person experiences it as an exhausting consequence of having been unable to trust others. A researcher may classify family connection as a resource while the person experiences that relationship as controlling. A construct may have apparent professional relevance while lacking experiential validity. Lived-experience involvement should consequently occur during construct development rather than after the framework has been designed. People with experiences of different forms of mental illness, recovery, disability, cultural contexts and service systems should be involved in evaluating whether proposed constructs represent meaningful aspects of positive health, whether important concepts are missing and whether the language creates unintended judgement. The same principle applies to clinicians. PHCF is intended partly as a clinical communication framework. Clinicians from psychiatry, psychology, nursing, social work, occupational therapy, primary care, peer work and other relevant disciplines may interpret positive-health constructs differently. Those differences need to be identified before formal criteria are produced. Content validity provides the first serious opportunity for the architecture developed in Chapter Five to change.

Operationalising Current Positive Health State

Current Positive Health State is likely to be the PHCF component most amenable to established psychometric assessment because substantial positive mental health and wellbeing measures already exist. The first research task should not be to create another wellbeing scale. It should be to examine whether established measures adequately represent the aspects of Current Positive Health State required by PHCF. The Mental Health Continuum-Short Form, WHO-5 Well-Being Index, psychological wellbeing measures and other validated instruments already assess overlapping aspects of positive affect and positive functioning. If systematic evidence demonstrates that these instruments adequately capture the required PHCF constructs, they should be incorporated as evidence sources rather than duplicated. The operational problem is one of mapping. PHCF must determine which existing constructs correspond with its proposed Current Positive Health State, whether important elements remain uncovered and whether existing measures perform adequately in the populations and clinical contexts in which PHCF would be used. This approach reduces unnecessary measurement proliferation. A new instrument is justified only where an existing measure cannot adequately perform the required function. Current Positive Health State also requires a defined temporal frame. Positive mental health can change rapidly. Asking about the present moment, the previous day, the previous two weeks or a general sense of life may produce different classifications. The appropriate reference period should be established according to the clinical purpose of the construct and the measurement properties of the selected evidence source.

Operationalising Positive Health Capacities

Positive Health Capacities present a more difficult operational problem because capacity is not always directly observable. A person may possess a capability without currently needing to use it. Conversely, performance on one occasion may be influenced by unusually supportive or adverse

circumstances. Classification requires evidence that distinguishes the underlying capability from a single behaviour. Agency and Self-Direction could be reflected in meaningful participation in decisions, initiation of personally valued activity and the capacity to articulate preferences. The construct should remain compatible with supported decision making and interdependence. A person who relies on substantial assistance may nevertheless exercise strong agency. Adaptive Regulation may be evidenced through recognition of internal states, ability to tolerate or influence distress, selection of contextually appropriate strategies and capacity to recover following emotional activation. Effective regulation should not be defined as emotional suppression or visible calmness. Someone can express substantial emotion while regulating effectively. Psychological Flexibility may be evidenced through willingness to modify ineffective strategies, ability to shift attention or behaviour when circumstances change and continued engagement with valued directions despite difficult internal experiences. The construct should not be inferred from flexibility in one behavioural domain alone. Relational Capacity may involve trust, reciprocity, communication, use of support and repair following interpersonal difficulty. The number of relationships is secondary to the capacity expressed within relationships that matter to the person. Meaning and Identity Capacity may be evidenced through continuity or reconstruction of personal identity, ability to locate illness within a broader understanding of self and access to personally significant values or directions. The content of that identity cannot be prescribed externally. Recovery and Self-Management Capacity may be demonstrated through warning-sign recognition, understanding of personal vulnerability patterns, use of previously effective strategies, participation in treatment decisions and mobilisation of assistance. These examples represent candidate indicators. Their value must be established empirically. PHCF should not assume that clinicians can assess each capacity accurately from an ordinary interview without structured guidance.

Operationalising Demonstrated Adaptation

Demonstrated Adaptation requires a different classification logic because its defining evidence is historical. The construct begins with the identification of a meaningful challenge. The presence of adversity alone is insufficient. Assessment then examines the person's response, the resources available, what was preserved or restored, how the response changed over time and the costs associated with the adaptation. This creates a sequence of interpretation. The classifier must first establish what challenge occurred. They must then determine what the person actually did or what processes occurred. The consequences of those responses must be considered in relation to the person's own values and circumstances. Finally, current relevance must be considered. This approach prevents survival from automatically becoming evidence of resilience. A person may have endured prolonged adversity because there was no available alternative. Another may have maintained occupational functioning through extreme emotional suppression and exhaustion. A third may have repeatedly sought assistance, changed environments, rebuilt supportive relationships and developed effective strategies that continued to support recovery. All have survived adversity. The evidence concerning adaptation is different. Demonstrated Adaptation should require a description of the challenge-response-context relationship. A future PHCF classification should be able to state not simply that adaptation was demonstrated, but where it was demonstrated and whether the adaptation remains useful. This is likely to require a structured narrative component even if dimensional scoring is eventually developed.

Operationalising Protective Resource Ecology

Protective Resource Ecology also resists reduction to a conventional scale because the clinical significance of a resource depends heavily on context. PHCF should distinguish resource existence from resource access. It should then distinguish access from usability and usability from demonstrated mobilisation. Evidence that a resource reduces vulnerability or supports recovery represents a stronger

conclusion again. Consider access to psychological treatment. A service may exist within the person's region. That establishes availability. The person may be eligible and able to travel to the service, establishing a degree of accessibility. They may consider the service culturally appropriate and financially feasible, supporting usability. They may then attend and incorporate the service into their care, demonstrating mobilisation. Evidence that the intervention has previously supported recovery would provide stronger evidence of protective relevance. The same logic can be applied to relationships, cultural communities, financial resources, housing and digital supports. Resource assessment should describe the relationship between the person and the resource rather than simply count assets. This distinction also prevents structural barriers from being reclassified as personal deficits. If appropriate treatment is unavailable, PHCF should identify a resource limitation. It should not reduce Recovery and Self-Management Capacity because the person cannot access a service that does not exist.

Reliability and Classification Agreement

Once constructs and indicators have sufficient content validity, PHCF must determine whether they can be classified consistently. Reliability is particularly important because PHCF proposes to improve communication across clinicians and services. A classification that depends heavily on individual clinician interpretation would recreate the inconsistency it is intended to address. Different forms of reliability will be relevant. Inter-rater reliability concerns whether independent assessors reach sufficiently similar conclusions when examining the same information. Test-retest reliability may be appropriate for constructs expected to remain relatively stable across short periods. Internal consistency may be relevant to reflective psychometric subscales but should not be applied automatically to heterogeneous resource inventories or formative constructs. COSMIN explicitly distinguishes among these measurement properties and notes that structural validity should precede interpretation of internal consistency for reflective measures. The framework also distinguishes reliability, measurement error, construct validity and responsiveness as separate properties requiring appropriate evaluation. This distinction is important for PHCF. A Protective Resource Ecology profile may contain several resources that are not expected to correlate strongly. Safe housing, social connection and treatment access can each matter without representing manifestations of a single latent trait. A low internal-consistency coefficient would not necessarily show that the resource classification has failed. The measurement model must match the nature of the construct. Reliability should consequently be evaluated separately for each PHCF component and assessment method.

Convergent and Discriminant Validity

A PHCF construct should relate to neighbouring constructs in theoretically predictable ways while remaining distinguishable from them. Agency and Self-Direction might reasonably correlate with empowerment and some measures of self-efficacy. Psychological Flexibility should relate to established flexibility measures. Recovery and Self-Management Capacity may correlate with self-efficacy, recovery measures and illness-management constructs. Current Positive Health State should correlate with established wellbeing instruments. Strong correlations are not automatically desirable. If PHCF Current Positive Health State is essentially indistinguishable from an established wellbeing scale, a separate PHCF construct may have little justification. If Demonstrated Adaptation correlates almost perfectly with a trait-resilience measure, its proposed distinctiveness would be weakened. If Protective Resource Ecology can be represented adequately through existing social-support and socioeconomic measures, its architecture should be reconsidered. Campbell and Fiske's (1959) distinction between convergent and discriminant validation is relevant here. Evidence that two methods agree when measuring the same construct is important, but evidence that theoretically different constructs remain empirically distinguishable is equally necessary. PHCF should expect moderate relationships among

many of its domains. Complete independence would itself be theoretically surprising. The objective is distinguishability, not isolation.

Incremental Validity

Discriminant validity establishes that PHCF constructs are not simply identical to existing measures. Incremental validity asks the more important clinical question of whether they add useful information. This principle was established in Chapter Four and becomes operational here. Demonstrated Adaptation would become particularly important if it predicted aspects of treatment response, recurrence or recovery after accounting for diagnosis, symptom severity, functioning, wellbeing and self-reported resilience. Recovery and Self-Management Capacity would gain clinical importance if it predicted the ability to recognise deterioration, use treatment effectively or maintain gains after intervention. Protective Resource Ecology would become more compelling if it explained recovery trajectories beyond individual capacities and socioeconomic indicators. Incremental value does not have to be limited to prediction. PHCF may improve formulation quality, treatment selection, shared decision making, communication between services or the person's experience of being understood. These outcomes can also be studied. The standard should remain demanding. PHCF is proposing additional clinical information and creates additional assessment burden. Additional complexity should produce additional value.

Responsiveness and Longitudinal Validity

PHCF is intended to describe change as well as status. Its constructs require evidence that meaningful change can be identified. Responsiveness concerns the ability of a measure to detect change in the construct being assessed. Contemporary measurement guidance treats responsiveness as distinct from reliability and other forms of validity and requires hypotheses concerning how scores should change in relation to other measures or known changes in the underlying construct (Mokkink et al., 2024). The PHCF question extends beyond whether a score changes. The framework must distinguish genuine positive-health development from measurement noise, temporary fluctuation and changes in contextual opportunity. A person's Agency and Self-Direction may improve during therapy. Relational Capacity may remain stable. Current Positive Health State may fluctuate with symptoms. Protective Resource Ecology may deteriorate following housing instability. Demonstrated Adaptation may accumulate as new adaptive experiences occur. The domains have different expected temporal properties. PHCF should not impose one universal reassessment interval. The appropriate interval will depend on the construct and clinical setting. State measures may change within days or weeks. Stable resources may require review only when circumstances change. Demonstrated Adaptation is likely to change more slowly because new evidence requires the occurrence of meaningful challenges and responses. Longitudinal research should determine which changes are clinically significant and whether particular trajectories carry prognostic value.

Cross-Cultural and Developmental Validity

Positive-health classification carries substantial risk of cultural bias because many apparently positive constructs contain assumptions about how people should live. Autonomy provides a clear example. In some cultural contexts, individual decision making may be highly valued. In others, relational or collective decision making may be central to identity and wellbeing. A measure that interprets independent decision making as greater agency could systematically misclassify people whose agency is exercised through family or community processes. Similar problems arise with emotional expression, spirituality, family responsibility, employment, individual achievement, independence and social participation. Cross-cultural validation must examine more than translation.

COSMIN distinguishes cross-cultural validity and measurement invariance as questions concerning whether items or measures function similarly across relevant groups. Differential item functioning and multigroup factor analysis provide examples of methods through which such questions can be investigated. PHCF also requires developmental sensitivity. Agency in a 14-year-old cannot be interpreted according to the same behavioural expectations used for a 40-year-old. Relational dependence on caregivers has different meanings across development. Identity formation, self-management responsibility and access to resources also change across the lifespan. The constructs may remain relevant across age groups while their indicators differ. PHCF should seek conceptual equivalence before assuming measurement equivalence.

Classification Levels and the Problem of Thresholds

PHCF currently uses the provisional descriptive anchors Not Assessable, Limited Evidence, Emerging, Established and Strongly Demonstrated. These descriptors provide a language through which early research can examine whether clinicians are capable of making meaningful distinctions. They are not validated thresholds. A classification system can create thresholds mathematically long before their clinical meaning has been established. PHCF should avoid doing so. Statistical distributions may identify percentiles or clusters, but a statistically convenient boundary does not automatically correspond with a meaningful clinical distinction. Future thresholds should require evidence that they improve interpretation or decision making. An Emerging-to-Established boundary would be useful if people classified on either side differ meaningfully in ways relevant to clinical understanding, intervention or prognosis. If the distinction adds no clinical information, a continuous score may be preferable. The same principle applies to any future global PHCF level. A total positive-health score should only be developed if evidence demonstrates that combining the domains produces an interpretable construct. The current architecture provides no basis for assuming that a person with high wellbeing and limited resources should receive the same total score as somebody with low wellbeing and extensive adaptive resources merely because the numerical average is equivalent. Profile information should remain primary during early development.

Representing Uncertainty

A classification system should be capable of acknowledging what is not known. Not Assessable is an important category rather than a missing-data inconvenience. A clinician should not be forced to estimate Demonstrated Adaptation when little historical information is available. Protective Resource Ecology should not be rated confidently when the person's housing, relationships or cultural context have not been explored. Uncertainty can also arise from conflicting evidence. Self-report may indicate strong coping capacity while historical evidence suggests repeated difficulty mobilising support. The person and clinician may interpret the same behaviour differently. Collateral information may conflict with the person's account. PHCF should preserve uncertainty rather than resolve it artificially. Future development may distinguish insufficient evidence, conflicting evidence and context-dependent evidence. Confidence qualifiers may also prove useful. These possibilities should be tested during developmental field studies. The capacity to record uncertainty should improve rather than weaken classification. Overconfidence creates false precision. Explicit uncertainty identifies where further assessment may be required.

Expert Consensus Without Consensus Substituting for Evidence

Expert consensus will be necessary during PHCF development, particularly when defining terminology, interpreting conflicting evidence and deciding which constructs should proceed to empirical testing. Consensus should not determine whether a construct is scientifically valid. A Delphi

process could provide a structured method for gathering judgements from clinicians, researchers, classification experts and people with lived experience. Delphi methods are widely used for the development of health guidance, although methodological reviews have identified considerable variation in how studies are conducted and reported. The CREDES recommendations were developed to improve transparency and methodological rigour in Delphi research (Jünger et al., 2017). For PHCF, consensus could address questions such as whether proposed definitions are sufficiently clear, which candidate indicators are clinically meaningful, whether important constructs are missing and which distinctions require priority testing. Consensus should not be used to declare that Agency and Self-Direction is a valid construct because 80 per cent of experts agree that it sounds important. The evidentiary sequence remains important. Literature synthesis identifies existing evidence. Qualitative work establishes experiential and clinical meaning. Consensus assists with interpretation and prioritisation. Psychometric and clinical studies determine whether the constructs perform as proposed.

Clinical Utility as an Operational Requirement

Classification is ultimately a clinical technology. Its utility must be examined in the environments in which it is intended to operate. ICD-11 development provides an important precedent. Clinical utility was treated explicitly as a design objective, and international field studies examined whether clinicians considered proposed guidelines clear, understandable, appropriately detailed, efficient and useful in distinguishing relevant clinical presentations. One major field study involved 339 clinicians applying ICD-11 guidelines to 1,806 patients across 28 mental health settings in 13 countries (Reed et al., 2018). PHCF requires a comparable commitment to utility. The questions will be different because PHCF is not diagnosing disorders. Clinicians should be asked whether the framework improves their understanding of what the person can draw upon during treatment, whether classifications alter formulation, whether they improve treatment planning, whether the information is useful during handover and whether longitudinal profiles improve recovery monitoring. People receiving care should be asked different but equally important questions. They should be able to determine whether the framework recognises meaningful aspects of their health, whether its language feels accurate, whether important capacities are missed and whether classification feels supportive, irrelevant or judgemental. Time burden also matters. A framework requiring ninety minutes of additional assessment is unlikely to be useful in many routine settings regardless of its psychometric quality. Clinical utility should include interpretability, feasibility, efficiency, relevance to decisions and acceptability to the people being classified. Validity and utility are related but not interchangeable. Psychiatric classification has repeatedly demonstrated the difficulty of balancing scientific validity with the practical requirements of clinical systems (Jablensky, 2016). PHCF should treat both as necessary conditions for development.

From Construct to Classification Requirement

Formal PHCF classification requirements should be among the later products of the development process. A construct should first possess a sufficiently clear definition. Its content should then be evaluated through evidence synthesis, lived-experience research and clinical consultation. Candidate indicators should be identified and their comprehensiveness examined. Appropriate methods of assessment should be determined. Reliability and construct validity should then be investigated, followed by cross-cultural and developmental testing, longitudinal analysis and studies of clinical utility. Only after these stages should PHCF determine whether formal classification levels can be justified. This sequence protects the framework from the temptation to look like a finished manual before the evidence necessary for a manual exists. The distinction is particularly important because diagnostic manuals create an expectation of authority. Once a criterion appears in a classification document, clinicians may assume that the threshold has scientific meaning. PHCF Version 0.1 should

instead make the evidentiary status of each component explicit. Some constructs may reach maturity more rapidly than others. Current Positive Health State can draw upon mature wellbeing measurement traditions. Psychological Flexibility already has substantial theoretical and psychometric literature. Demonstrated Adaptation requires more fundamental construct development. Protective Resource Ecology may require integration of several resource traditions before a coherent classification method emerges. PHCF does not need every component to mature simultaneously.

A Provisional Operationalisation Model

The emerging PHCF methodology can be represented as a progression from concept to clinical use. The process begins with theoretical definition and systematic evidence mapping. Construct boundaries are then examined with particular attention to overlap with existing positive-health, functioning, resilience and recovery constructs. Lived-experience and clinician research establish whether the proposed content is meaningful and sufficiently comprehensive. Candidate indicators and assessment methods can then be developed. Measurement studies examine structure, reliability, convergent validity, discriminant validity, cross-cultural validity and responsiveness where those properties are relevant. Classification studies subsequently examine whether descriptive levels or thresholds can be justified. Developmental field testing examines feasibility and clinical utility. Longitudinal studies determine whether PHCF classifications contribute to prediction or explanation of recovery-related outcomes. The sequence should remain iterative. A poor discriminant-validity result may require redefinition of a construct. Lived-experience research may identify an important missing domain. Cross-cultural research may show that a proposed indicator reflects one cultural assumption more than the intended construct. Clinical field testing may demonstrate that two constructs are too difficult to distinguish reliably in practice. Returning to an earlier development stage should be regarded as refinement rather than failure.

The Standard PHCF Must Meet

Operationalisation places a demanding standard on PHCF. A positive-health classification cannot be justified because positive language feels more balanced than diagnostic language. It cannot be justified because clinicians already discuss strengths. It cannot be justified because people with mental illness possess resilience or because recovery involves more than symptom reduction. The framework must demonstrate that its proposed constructs can be defined coherently, assessed appropriately and distinguished from information already available through diagnosis, functioning, wellbeing and recovery measurement. It must also demonstrate that the resulting classifications can be understood and used consistently. They must perform adequately across relevant cultural and developmental contexts. They must be sensitive to meaningful change where change is expected. They must be acceptable to people whose positive health is being described. Most importantly, they must contribute to clinical understanding or decisions sufficiently to justify the additional assessment. This standard deliberately creates the possibility that parts of PHCF will fail. That possibility is necessary. A construct that cannot survive attempts at operational definition should be removed. A construct that cannot be distinguished from an existing measure should be absorbed or abandoned. A classification level without evidence of meaningful separation should disappear. A module that increases burden without increasing clinical value should not survive into a mature framework. The objective is not to preserve PHCF Version 0.1. The objective is to determine whether positive health can be classified in a way that is scientifically defensible and clinically useful.

From Operationalisation to Clinical Practice

The architecture developed in Chapter Five identifies the information PHCF proposes to organise. The present chapter establishes the methodological conditions under which that information could eventually become classifiable. The distinction between constructs, indicators and classification requirements provides an important boundary. PHCF currently proposes constructs and candidate forms of evidence. Formal criteria remain a future empirical product. This position allows the framework to enter clinical research without presenting itself as an established diagnostic or assessment system. Early PHCF studies can explore how clinicians and people with lived experience recognise positive-health capacities, how those capacities are incorporated into existing formulations and whether systematic attention to them changes clinical understanding. The next question is practical. If PHCF information were available, how would it enter assessment, formulation and treatment without creating a parallel clinical process or reducing person-centred care to another scoring exercise? The following chapter examines the clinical application of positive-health classification across assessment, formulation, treatment planning, recovery monitoring and clinical handover.

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Chapter Seven - Clinical Application of the Positive Health Classification Framework

From Classification to Clinical Use

The preceding chapters establish the theoretical, classificatory and methodological foundations of the Positive Health Classification Framework. The next question concerns its clinical purpose. A classification framework has limited value if it produces information that remains separate from the decisions clinicians and people receiving care need to make. PHCF requires a clear pathway from classification to clinical use. The proposed clinical function of PHCF is not to create an additional diagnostic assessment. Mental health services already collect substantial information concerning presenting problems, symptoms, risk, diagnosis, functioning, developmental history, social circumstances and treatment history. Adding another comprehensive interview could increase assessment burden without improving care. PHCF should instead organise positive-health information that can be identified during existing clinical processes and make that information more visible within formulation, treatment planning, review and handover and the difference is important. PHCF does not propose that clinicians should spend equal amounts of time discussing difficulties and strengths, nor does it require every assessment to become an exercise in positive psychology. Clinical attention should continue to be directed toward the problems, risks and symptoms requiring intervention. PHCF asks an additional question concerning “*the health that remains available within the person and their environment*”. The question can be expressed clinically as an examination of what positive mental health is currently present, which capacities can be recruited, what previous adaptation demonstrates, and which resources can realistically support intervention or recovery. The information may be particularly valuable when a diagnostic description accurately identifies a person's difficulties but provides little indication of how the person has previously responded to adversity or what can be mobilised during treatment. Understanding the difference between identifying ‘positive-health information’ and ‘adopting a generally strengths-based orientation’ also requires attention. Strengths-based approaches have a real history within mental health care, however, the evidence concerning clinical outcomes is mixed. Reviews have identified promising features and potential benefits while also finding considerable variation in definitions, assessment approaches and intervention models. A systematic review of strengths assessments identified individual, interpersonal and environmental domains across existing instruments but also noted ongoing conceptual and psychometric limitations. Meta-analytic work examining strengths-based service models in serious mental illness has not demonstrated consistent superiority across functioning and quality-of-life outcomes (Chen et al., 2022; Ibrahim et al., 2014). PHCF cannot justify itself merely by directing clinicians toward positive characteristics. Its clinical contribution depends on whether systematic classification improves the quality, continuity or usefulness of positive-health information.

PHCF Within Clinical Assessment

Clinical assessment is the first point at which PHCF information is likely to emerge. Much of the required information is already discussed during a comprehensive mental health assessment. Clinicians routinely ask about coping, relationships, previous episodes, treatment history, social supports, current functioning and the person's understanding of their difficulties. PHCF proposes that selected information arising from these discussions can be organised more consistently. The initial assessment should remain directed by clinical need. Presenting concerns, symptom severity, risk, relevant history, functioning, contextual factors and diagnostic questions retain priority. Positive-health assessment should occur alongside these processes rather than displacing them. Current Positive Health

State may be explored through questions concerning connection, engagement, meaningful activity, positive self-experience and valued direction. The intention is not to require a person presenting in significant distress to identify things they feel grateful for or to demonstrate optimism. In some circumstances, very little Current Positive Health State may be evident. That is clinically meaningful information. Positive Health Capacities require attention to what the person appears capable of mobilising. A clinician may explore how the person makes important decisions, responds to strong emotion, changes strategies when existing approaches fail, uses relationships, maintains a sense of identity during illness and manages changes in mental health. Demonstrated Adaptation requires a different form of enquiry. Instead of asking whether the person considers themselves resilient, assessment examines previous episodes of significant challenge and what occurred during them. Previous recovery, successful help seeking, development of coping strategies, maintenance of valued relationships and adaptation following major change may all provide relevant information. The assessment also examines costs associated with those adaptations. Protective Resource Ecology requires consideration of the person's actual environment. Relationships, housing, income, community, culture, treatment access, transport, educational or occupational environments and digital resources may all be relevant. The assessment should distinguish the existence of a resource from the person's capacity to access and use it. This approach creates a broader clinical picture without requiring a separate positive-health interview. PHCF information may emerge throughout ordinary assessment and subsequently be organised within the framework. PHCF is intended to complement comprehensive mental health assessment rather than create a separate parallel interview. Much of the information required for positive-health classification already emerges through routine enquiry about coping, relationships, previous episodes, functioning, supports and the person's understanding of their difficulties. Figure 7.1 illustrates how PHCF information can be identified and organised alongside core clinical assessment while preserving the priority of presenting concerns, risk, symptoms, history and diagnostic questions.

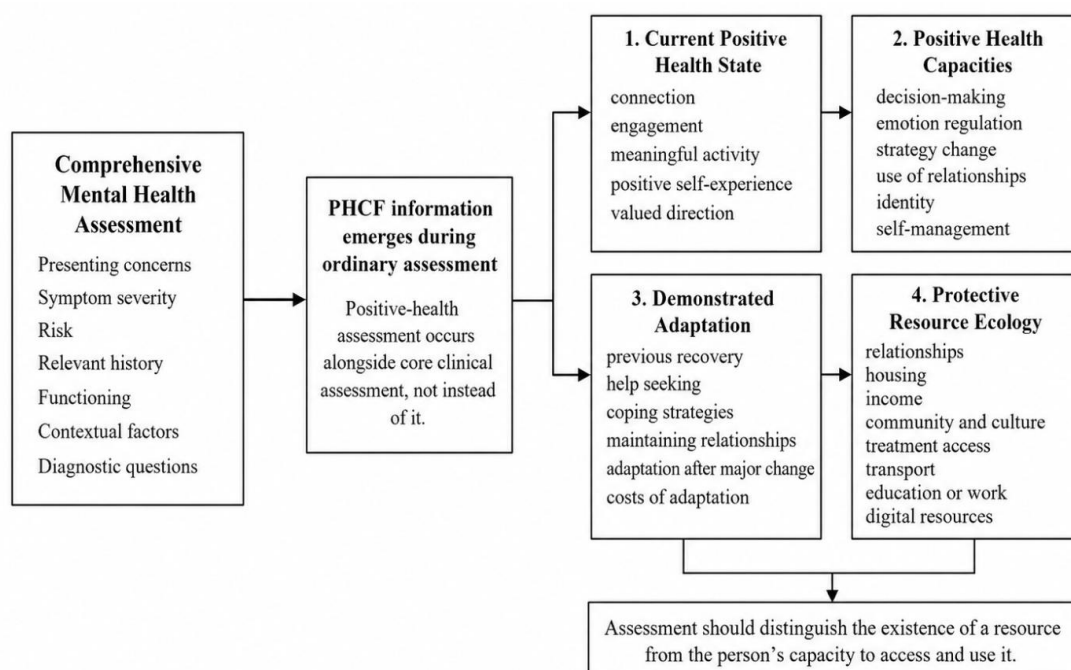


Figure 7.1. PHCF within clinical assessment, showing how Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology can be identified through ordinary assessment and organised alongside, rather than in place of, core clinical information.

Assessment Should Not Become Forced Positivity

Positive-health assessment introduces a particular clinical risk. Asking about strengths and capacities can become invalidating if the timing or language implies that the person should identify something positive while describing severe distress. A person who has recently experienced trauma may not want to discuss growth. Someone experiencing severe depression may have difficulty identifying hope or meaning. A person living in unsafe housing may reasonably experience little sense of control. A clinician should not interpret difficulty identifying positive-health features as resistance, lack of insight or therapeutic pessimism. PHCF should be responsive to the person's clinical state and preferences. The framework creates a location for positive-health information when such information is available. It does not compel a positive interpretation of suffering. The approach is consistent with person-centred and recovery-oriented mental health practice. WHO's guidance on community mental health services emphasises autonomy, participation, inclusion, recovery and human rights, together with the importance of broader social conditions and community supports. The person's goals and preferences remain central to the organisation of care (WHO, 2021). The language used during PHCF assessment should consequently be exploratory. A clinician may ask what has helped previously, how the person recognised that help was needed, which relationships are useful, what they have learned about managing the condition or what aspects of life remain important. These questions generate clinically relevant information without requiring the person to endorse a predefined identity such as resilient or flourishing.

PHCF and Clinical Formulation

Formulation provides one of the most important potential applications of PHCF. Diagnosis and formulation perform different clinical functions. Diagnostic classification identifies recognisable patterns of psychopathology. Formulation attempts to organise information about the individual presentation, including factors that may contribute to the development, maintenance or treatment of difficulties. Literature on case formulation has long argued that diagnosis alone may be insufficient to determine why a particular person developed a problem or which factors should become treatment targets (Macneil et al., 2012; Rainforth & Laurenson, 2014). The empirical literature on formulation also provides an important caution. Formulations are not automatically reliable merely because they are individualised. A systematic review by Flinn et al. (2015) found substantial variation in inter-rater reliability across formulation approaches, with evidence that training and experience can improve agreement. PHCF should improve the structure of positive-health information without assuming that any formulation containing strengths becomes inherently more valid. Traditional formulations may already contain protective factors and strengths. PHCF provides greater precision by distinguishing different forms of positive-health information and by preventing them from becoming a miscellaneous list at the end of a formulation. Consider a person experiencing recurrent depression. A formulation may identify biological vulnerability, loss, social withdrawal, disrupted sleep and negative self-appraisal as relevant to the current episode. A conventional formulation might add supportive family and good insight as protective factors. A PHCF-informed formulation would examine those elements more precisely. The person's recognition of early sleep disturbance and withdrawal may indicate Recovery and Self-Management Capacity. Their ability to continue making treatment decisions despite low motivation may demonstrate Agency and Self-Direction. Previous recovery following depressive episodes may provide evidence of Demonstrated Adaptation. A supportive sibling may constitute an accessible relational resource. Stable housing may represent a structural resource. Current disengagement and diminished meaning may remain evident within Current Positive Health State. The resulting formulation contains both vulnerability and capability. The positive-health information does

not neutralise the depression. It identifies clinically relevant features that may affect how intervention is constructed.

Moving From Protective Factors to Mechanisms

One potential contribution of PHCF is to increase precision in the use of protective-factor language. Clinical formulations frequently distinguish predisposing, precipitating, perpetuating and protective factors. The protected category can become broad. Family support, intelligence, insight, employment, motivation and coping skills may all appear together despite representing quite different phenomena. PHCF separates some of these elements according to their proposed clinical role. A supportive family member is a relational resource. The capacity to recognise that support is required and request it concerns Recovery and Self-Management Capacity. The ability to participate reciprocally in the relationship concerns Relational Capacity. Previous evidence that the person mobilised family support successfully during deterioration contributes to Demonstrated Adaptation. These distinctions may improve formulation because they permit the clinician to consider how positive-health information operates. A resource that cannot be accessed is unlikely to influence the formulation in the same way as one that is routinely mobilised. A capacity that exists but becomes unavailable during periods of severe symptoms may require a different treatment strategy from a capacity that remains stable across illness states. PHCF encourages movement from identifying positive characteristics toward examining their function within the clinical presentation.

Treatment-Relevant Capacities

The clinical value of PHCF is likely to depend substantially on whether positive-health information can inform treatment. A central concept within this process is the identification of Treatment-Relevant Capacities. The term refers to existing PHCF capacities or resources that can be recruited, strengthened, protected or restored during intervention. It does not represent a separate PHCF domain. It describes the clinical use of information already contained within the positive-health profile. A person entering cognitive behavioural therapy may already demonstrate substantial Psychological Flexibility but limited Adaptive Regulation during intense interpersonal conflict. Treatment could build on the person's existing flexibility while developing more specific regulation strategies. A person with recurrent depression may have established Recovery and Self-Management Capacity through reliable recognition of early warning signs. Treatment planning can incorporate that capacity directly into relapse prevention. A person experiencing trauma-related symptoms may have strong Relational Capacity with a small number of trusted people but limited Current Positive Health State. Treatment can use those relationships as a stabilising resource without assuming that social connection alone resolves trauma symptoms. A person with psychosis may retain a strong sense of identity, valued roles and therapeutic engagement despite continuing unusual experiences. Those capacities may inform treatment goals that extend beyond symptom elimination. The clinical question becomes not only what intervention addresses the problem, but also what existing health can support that intervention. This approach is compatible with individualised formulation. Contemporary work on mechanism-based formulation argues that treatment planning becomes most useful when the information contained within formulation actually changes intervention decisions. The empirical evidence for formulation-guided treatment remains limited and mixed, providing another reminder that PHCF must test rather than assume treatment utility (Macneil et al., 2012).

Shared and Supported Decision Making

PHCF should be used collaboratively. Agency and Self-Direction cannot credibly form part of a positive-health classification if the classification process itself removes agency from the person. The

individual should be able to contribute to how capacities and resources are understood, correct interpretations and identify which aspects of the profile are clinically meaningful. This requirement aligns PHCF with shared and supported decision-making approaches. A 2024 systematic review by Francis et al. synthesised 140 studies examining interventions intended to increase involvement of people with mental ill health in treatment planning. The review identified favourable evidence for some outcomes and preliminary evidence across others, including recovery, engagement, hospital use and experiences of coercion, while also recognising important limitations and implementation challenges (Francis et al., 2024). PHCF can potentially support shared decision making by providing additional information around which collaborative treatment discussions can occur. If a person identifies family support as intrusive rather than protective, the profile should reflect their experience. If the clinician considers a particular coping strategy effective while the person experiences it as exhausting, the discrepancy should remain visible. The goal is not agreement at all costs. Different perspectives may provide clinically important information. Supported decision making is particularly relevant when illness, developmental stage, cognitive difficulty or environmental circumstances affect the way decisions are made. Agency should not be interpreted as requiring unsupported decision making. Assistance that enables the person to understand options and express preferences may strengthen rather than diminish agency.

PHCF Within Risk Assessment and Formulation

PHCF has a potentially important role within risk assessment, although its purpose should be carefully bounded. The framework is not proposed as a suicide, self-harm or violence risk assessment instrument and should not be used to predict whether a person will engage in future harmful behaviour. Contemporary guidance cautions against the use of risk scales or global categories such as low, medium or high risk to predict suicide or repetition of self-harm. Instead, assessment should consider the person's needs, vulnerabilities, immediate and longer-term safety, and an individualised formulation of how risk has developed and may change (National Institute for Health and Care Excellence [NICE], 2022). PHCF can contribute information to that formulation. A conventional risk assessment may identify suicidal ideation, intent, planning, previous attempts, access to means, acute stressors, substance use, hopelessness and other relevant vulnerabilities. PHCF can provide a parallel description of capacities, demonstrated adaptations and resources that may influence how those vulnerabilities are experienced and managed. Positive Health Capacities may identify problem-solving, emotional regulation, help-seeking, psychological flexibility or recovery self-management that can potentially be mobilised. Demonstrated Adaptation may identify strategies that have previously helped the person survive crises or regain stability. Protective Resource Ecology may identify relationships, services, cultural resources, safe environments and material supports that are actually accessible to the person. The distinction is important. Identification of positive-health capacities does not establish safety, and their absence does not establish imminent danger. PHCF information should contribute to understanding how risk might be mitigated, not determine whether risk exists.

Protective Factors and PHCF

There is empirical support for including protective information within a broader clinical formulation. Suicide is understood as a multifactorial phenomenon influenced by individual, relational, community and societal conditions. Protective factors identified in the literature include effective coping and problem-solving, reasons for living, cultural identity, supportive relationships, connectedness and access to healthcare. Systematic review evidence provides further support. Bakhiyi et al. (2016) reviewed 39 studies of reasons for living and found evidence that reasons for living were associated with lower suicidal ideation and suicide attempts, although evidence concerning suicide

death was unavailable. The review also indicated that reasons for living interact with coping, social support and psychiatric characteristics rather than functioning as isolated protective variables. Ki et al. (2024) reviewed psychosocial protective factors among older adults and found consistent associations between lower suicidality and factors including purpose in life, resilience, positive relationships, coping, hope, belonging, social support and social connectedness. Particularly consistent findings were reported for purpose in life, resilience and positive relationships. Evidence relating to self-harm is more cautious. McEvoy et al. (2023) synthesised 61 systematic reviews concerning self-harm among adolescents and young adults. Protective-factor research was considerably less developed than risk-factor research, although positive family and friendship relationships were the most frequently identified protective factors. The review also found substantial overlap between factors associated with suicidal and non-suicidal self-harm. PHCF has a defensible basis for identifying potentially protective capacities and resources. The terminology must remain conservative. A resource should not be called *protective* merely because it exists. The framework's distinction between resources that are available, accessible, usable and mobilised becomes particularly important in risk formulation. A supportive parent who cannot be contacted during crisis is different from one who is immediately available and trusted. A crisis service that exists but cannot be reached because of transport, cultural or financial barriers cannot be assumed to provide protection.

PHCF, Safety Planning and Risk Mitigation

The stronger clinical application of PHCF may occur after risk has been identified. Rather than attempting to predict harmful behaviour, PHCF could help identify resources and capacities that can be deliberately mobilised to improve safety. Safety planning already incorporates several elements that closely resemble the proposed PHCF architecture. Contemporary guidance recommends collaboratively identifying warning signs, individual coping strategies, social contacts and environments that can provide distraction or support, family members or friends who can help resolve a crisis, professional services and strategies for reducing access to lethal means. Evidence for safety planning is strongest in adults. Stanley et al. (2018) compared the Safety Planning Intervention with structured follow-up against usual emergency department care. Over six months, the intervention group experienced approximately 45 percent fewer suicidal behaviours and had more than twice the odds of attending outpatient mental health treatment. A systematic review by Ferguson et al. (2022) also examined the evidence supporting safety planning for adults experiencing suicide-related distress. Evidence in children and adolescents is less certain, and a recent systematic review found insufficient evidence that standalone safety planning reduced subsequent suicidal outcomes in younger populations. PHCF could add structure to the protective component of safety planning. Current Positive Health State might identify valued relationships, belonging, meaning or reasons for continuing. Positive Health Capacities might identify coping, problem-solving, help-seeking and emotional regulation that remain available during escalating distress. Demonstrated Adaptation might identify what the person has previously done that successfully interrupted a crisis, including contacting another person, leaving an unsafe setting, using an established coping strategy or engaging with treatment. Protective Resource Ecology could identify the people, services, environments and material resources that can realistically be mobilised.

Complementary Dual Classification

PHCF is proposed as a complementary classification rather than an alternative diagnostic system. Where clinically appropriate, a person's psychiatric classification and positive-health classification could be recorded concurrently. The psychiatric classification would describe clinically significant psychopathology, while PHCF would describe independently assessed positive-health states, capacities, demonstrated adaptations and protective resources. Neither classification would modify the

validity or severity of the other. For example, a person might meet diagnostic criteria for major depressive disorder while also demonstrating substantial relational capacity, established help-seeking, strong demonstrated adaptation and accessible family support. Another person with the same psychiatric diagnosis might currently have limited positive-health capacities and few accessible resources. The diagnosis may be identical while the broader clinical profiles differ substantially. The purpose of paired classification is not to produce a mathematical balance between illness and health. Positive-health classifications should not subtract from symptom severity, suicide risk, impairment or treatment need. Instead, the two classifications provide different classes of clinical information that can be considered together within formulation, treatment planning and longitudinal care. In this sense, PHCF proposes a dual-domain clinical description. Psychopathology describes what is clinically disturbed. PHCF describes positive-health phenomena that remain present, have previously been demonstrated or may be mobilised within care. Their relationship is clinically important, but neither should be inferred from the other. PHCF is proposed as a complementary classification rather than an alternative to psychiatric diagnosis. A person's psychiatric classification and positive-health classification may be recorded alongside one another to provide a broader clinical description. The diagnostic classification identifies psychopathology, while PHCF describes positive-health state, capacities, demonstrated adaptation and protective resources. Figure 7.2 illustrates how these two forms of classification can be combined without implying that one cancels, reduces or determines the other.

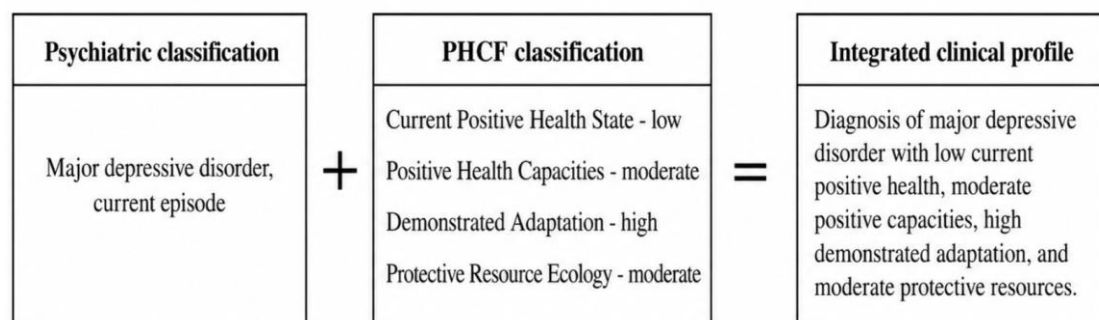


Figure 7.2. *Complementary dual classification in PHCF, showing how psychiatric diagnosis and positive-health classification can be recorded together to produce a broader integrated clinical profile.*

Treatment Planning

Once relevant capacities and resources have been identified, the clinician and person can determine whether they should be recruited, strengthened, restored or protected during treatment. Some capacities may function as foundations for intervention. A person with strong Agency and Self-Direction may be able to engage quickly with collaborative goal setting. Established Psychological Flexibility may support behavioural experiments, exposure or acceptance-based strategies. Strong Relational Capacity may permit treatment to incorporate family, peers or other meaningful relationships where the person wishes. Other PHCF findings may identify targets for development. Emerging Recovery and Self-Management Capacity may suggest a need to improve recognition of warning signs or establish clearer plans for deterioration. Limited Psychological Flexibility may indicate difficulty moving away from strategies that no longer work. Restricted Current Positive Health State may indicate that symptom-focused treatment should eventually be accompanied by deliberate restoration of meaningful engagement, connection or valued activity. Protective Resource Ecology can also change the treatment plan. A person experiencing anxiety may understand and practise therapeutic strategies effectively while living in circumstances that continually reactivate threat. Intervention directed

exclusively toward internal coping may have limited effect when environmental conditions remain unsafe. Resource assessment can identify when treatment planning requires social, community or structural responses in addition to psychological intervention. The principle protects PHCF from locating health exclusively within the individual. PHCF findings can contribute directly to treatment planning by identifying capacities and resources that may be recruited, strengthened, restored or protected during intervention. The framework may also identify areas requiring development and circumstances in which social, community or structural responses are needed alongside psychological treatment. Figure 7.3 summarises how PHCF information can inform these different treatment-planning functions.

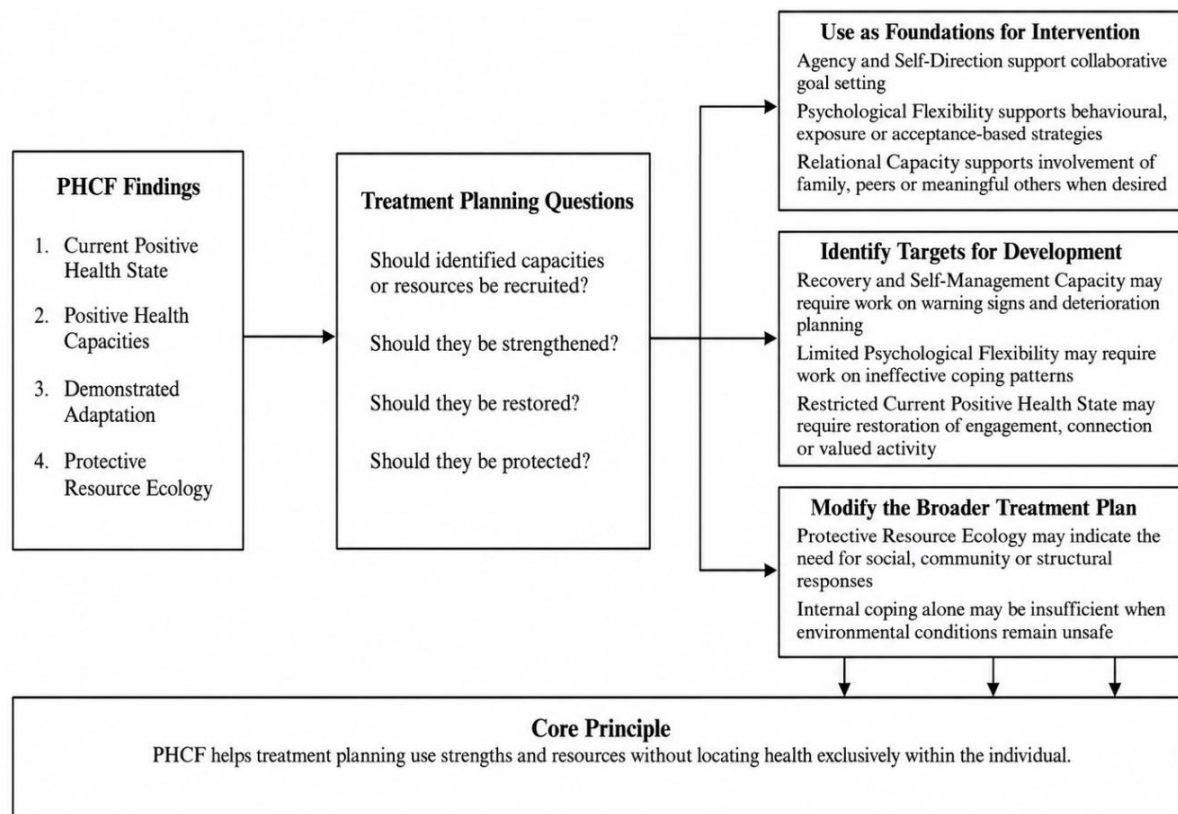


Figure 7.3. *PHCF and treatment planning, showing how positive-health findings can be used as foundations for intervention, identify targets for development and modify the broader treatment plan when contextual or structural conditions require attention.*

Treatment Should Not Become Strength Maximisation

PHCF does not require treatment to maximise every positive-health construct. The purpose of mental health intervention is not to produce the highest possible score on agency, connection, flexibility, self-management, meaning or any other PHCF domain. Different people value different forms of life. Some may desire extensive social connection, while others prefer a small number of relationships. Some may value autonomy strongly, while others understand wellbeing through family or collective relationships. The clinical objective should remain connected to the person's needs and goals. A construct may also be sufficient without requiring further development. Someone with established Relational Capacity does not need therapy directed toward increasing social connection simply because a higher classification could theoretically be achieved. PHCF should support treatment selection, not generate treatment obligations.

Monitoring Change During Treatment

PHCF creates the possibility of monitoring change in positive health independently from changes in psychopathology. The distinction between classification and measurement is important. A PHCF classification provides a structured description of the person's positive-health profile at a particular point in time. Treatment monitoring requires more sensitive methods capable of detecting movement within relevant constructs across time. Measurement-based care provides a useful methodological parallel. Measurement-based approaches use systematic assessment of clinical progress to inform treatment decisions. Reviews of measurement-based care in psychiatry indicate that repeated measurement can support monitoring of treatment progress, evaluation of intervention effects and clinical decision-making, although implementation remains inconsistent in routine practice (DeSimone & Hansen, 2024). PHCF could extend this logic to positive-health information without requiring another mandatory battery of questionnaires. Monitoring should be proportionate, construct-specific and clinically relevant. A broad PHCF profile might be established during assessment, while only those constructs expected to change or directly relevant to treatment are monitored more frequently.

Classification and Measurement Serve Different Purposes

PHCF should distinguish classification from repeated measurement. Classification provides a shared clinical language. Measurement provides sensitivity to change. A PHCF classification might describe a person as having a low Current Positive Health State, moderate Positive Health Capacities, high Demonstrated Adaptation and moderate Protective Resource Ecology. These classifications could be reconsidered at clinically meaningful points such as initial assessment, formal treatment review, substantial change in circumstances and discharge. Repeated monitoring would operate at a finer level. Rather than repeatedly assigning the entire classification, clinicians could monitor selected constructs relevant to the treatment plan. A person's level of engagement, agency or recovery self-management might improve substantially before enough evidence has accumulated to justify changing the broader PHCF classification. The distinction is analogous to the separation between psychiatric diagnosis and symptom monitoring. A diagnosis may remain unchanged during treatment while the severity of associated symptoms changes substantially. PHCF should permit the same distinction between the classification of positive health and the measurement of change within positive-health constructs.

A Hybrid PHCF Monitoring Model

The most defensible approach is likely to combine several forms of information rather than rely on a single score. PHCF monitoring could include structured classification, repeated standardised measurement, person-specific indicators and clinical or contextual evidence.

Monitoring component	Purpose	Illustrative use
Structured PHCF classification	Provides a common clinical description	Positive Health Capacities - moderate
Repeated quantitative measure	Detects movement within a construct	Agency 3/10 to 6/10
Behavioural or contextual evidence	Establishes what observed change means	Person begins independently seeking assistance when deterioration occurs
Person-specific indicator	Tracks a personally meaningful outcome	Re-establish weekly contact with an important family member
Structured clinical judgement	Integrates evidence and determines its clinical significance	Evidence supports improvement in recovery self-management

The model deliberately separates measurement from interpretation. A numerical change provides evidence of movement. It does not determine the clinical meaning of that movement by itself.

Development of PHCF Monitoring Measures

Formal PHCF monitoring measures should be developed and evaluated using established measurement methodology. COSMIN provides an appropriate framework for evaluating patient-reported outcome measures, including content validity and broader measurement properties (Mokkink et al., 2024; Terwee et al., 2018). The development process should establish that each measure adequately represents its intended construct before scores are used to support clinical classification. Responsiveness will be particularly important for PHCF because a measure intended for treatment monitoring must be capable of detecting meaningful change in the construct over time. Reliability, measurement error, construct validity and interpretability will also affect whether observed score changes can be treated as meaningful. Brief numerical or visual analogue ratings may eventually provide one practical form of PHCF monitoring. For example, a person might rate current connection, valued engagement or perceived agency using a brief numerical scale. Such ratings could reduce assessment burden and allow trajectories to be graphed across treatment. These ratings should initially be regarded as research and monitoring tools rather than validated PHCF classifications. The apparent simplicity of a zero-to-ten rating does not establish that the underlying construct has been measured reliably or validly. Numerical thresholds should not be introduced until empirical evidence supports their interpretation.

Standardised and Person-Specific Measurement

PHCF should combine common constructs with the person's own treatment priorities. Standardised measures allow a shared construct to be followed across people and settings. Person-specific measures allow treatment to preserve what improvement means for the individual. Idiographic patient-reported outcome measures provide a relevant methodological precedent. These approaches allow personally identified goals or difficulties to be repeatedly rated while retaining a consistent method of monitoring change. Reviews suggest that idiographic measures can complement standardised outcome measures and may support reflection, identification of treatment priorities and monitoring of personally meaningful outcomes, although their psychometric evidence remains less developed than many established nomothetic measures (Lloyd et al., 2019; Sales et al., 2023). PHCF could identify Relational Capacity as the common construct while the person identifies a personally meaningful indicator such as rebuilding contact with a sibling, being able to ask a partner for assistance or returning

to a valued community activity. The common PHCF construct provides classification language. The personal indicator establishes what movement within that construct looks like in the person's life.

Different Constructs Require Different Monitoring Schedules

The temporal characteristics of PHCF constructs differ. Monitoring frequency should follow the construct rather than applying the same schedule to every component of the framework. Current Positive Health State is likely to be relatively responsive to changes occurring over days or weeks. Engagement, belonging, positive self-experience and valued direction may be appropriate for relatively frequent monitoring when relevant to treatment. Positive Health Capacities may change more gradually. Agency, Adaptive Regulation, Psychological Flexibility, Relational Capacity and Recovery Self-Management may be reassessed periodically when they represent treatment targets or foundations for intervention. Demonstrated Adaptation should not be treated as a weekly symptom measure. The construct concerns accumulated evidence of what the person has actually done under meaningful challenge. It should be updated when new adaptive behaviour occurs or when additional historical evidence becomes available. Protective Resource Ecology may require event-sensitive rather than session-based monitoring. Housing, relationships, financial resources, treatment access, community connection and other contextual resources may remain stable for extended periods and then change abruptly. Reassessment should occur when relevant environmental circumstances change. An illustrative monitoring schedule might include the following.

Point in care	Proposed PHCF activity
Initial assessment	Establish broad PHCF profile
Routine treatment session	Monitor one to three treatment-relevant constructs where useful
Formal treatment review	Reassess Current Positive Health State and relevant Positive Health Capacities
Major environmental change	Reassess Protective Resource Ecology
Significant challenge or adaptive response	Update Demonstrated Adaptation
Discharge or transition	Reassess the PHCF profile and compare with baseline

The schedule is provisional. Research will be required to determine appropriate monitoring intervals and whether frequent assessment improves clinical decisions sufficiently to justify the associated burden.

Interpreting Change

Observed change should not automatically be interpreted as reliable or clinically meaningful change. These concepts should remain distinct. An observed change occurs whenever a score differs between assessment points. Reliable change concerns whether the magnitude of that difference exceeds what could reasonably be attributed to measurement error. Jacobson and Truax (1991) proposed the Reliable Change Index as one method for evaluating whether change at the individual level exceeds expected measurement variability. PHCF could ultimately distinguish at least four forms of change.

- Observed change means that a score or indicator has moved.
- Reliable change means that the magnitude of movement exceeds expected measurement error.

- Clinically meaningful change means that the change makes an important difference to the person's health, treatment or clinical management.
- Classification change means that sufficient evidence has accumulated to justify altering the PHCF classification itself.

These outcomes should not be treated as equivalent. A person might show a small but reliable increase in Agency without moving from one PHCF descriptive level to another. Another person might make a clinically important change, such as independently activating a safety plan during deterioration, even if a questionnaire score changes only modestly. Structured clinical judgement remains necessary to interpret measurement within context.

Convergence Across Evidence Sources

PHCF monitoring should retain the multimethod principle used within the broader classification framework. Greater confidence in change may be warranted when evidence from different sources converges. For example, a person may report an increase in Agency from three to seven on a brief monitoring measure. The interpretation becomes stronger if the person also begins participating actively in treatment decisions, independently recognises deterioration, initiates contact with services when required and describes a greater sense of choice in managing their mental health. The resulting evidence might appear as follows.

- Agency monitoring rating - 3/10 to 7/10
- Behavioural evidence - increased participation in treatment decisions
- Clinical evidence - independently recognised deterioration and sought assistance
- Person's interpretation - increased sense of choice and influence over their response to difficulties

Convergence should increase confidence without becoming a requirement that every source agree. Disagreement may itself remain clinically meaningful. A clinician may observe good emotional regulation during a session while the person reports considerable difficulty regulating distress at home. PHCF should preserve the discrepancy rather than assume that either account provides the complete picture.

Parallel Monitoring of Symptoms and Positive Health

PHCF should allow positive-health trajectories to be displayed alongside symptom trajectories without combining them into a single score. Such parallel monitoring preserves the independence principle underlying the framework. For example, treatment monitoring could reveal the following pattern.

Assessment point	Depressive symptoms	Current Positive Health	Recovery Self-Management	Protective Resources
Initial assessment	High	Low	Moderate	Low
Early treatment	Moderate	Low	Moderate	Moderate
Treatment review	Moderate	Moderate	High	Moderate
Discharge	Low	Moderate	High	High

The pattern provides information that symptom measurement alone would not communicate. Rapid symptom reduction accompanied by little restoration of engagement or valued direction represents a different clinical trajectory from stable symptoms accompanied by substantial improvements in Agency and Recovery Self-Management. Another person may show little change in internal capacities because the major treatment effect has occurred in Protective Resource Ecology following successful housing, financial or social intervention. A further person may show symptom improvement while simultaneously losing important relational or material resources. The apparent symptomatic improvement should not obscure increasing contextual vulnerability. PHCF allows several trajectories to be considered independently. Symptoms may improve while positive health remains stable. Positive-health capacities may improve while symptoms remain present. Environmental resources may improve while internal capacities remain relatively unchanged. Symptoms may improve while protective resources deteriorate. These combinations may provide clinically useful information about treatment progress, vulnerability and the next phase of intervention.

Targeted Monitoring Rather Than a Mandatory Battery

PHCF should not create an expectation that every construct is repeatedly measured during every clinical encounter. Such an approach would create unnecessary burden and risk transforming the framework into another administrative battery. Monitoring should instead follow the treatment formulation. If Psychological Flexibility is directly relevant to intervention, it may warrant repeated monitoring. If housing stability is the central contextual problem, Protective Resource Ecology may be more important. If a person is rebuilding life after a major episode, Current Positive Health State and Recovery Self-Management may provide the most useful indicators. Treatment relevance should determine what is monitored and when. The model deliberately avoids choosing between traditional classification and continuous measurement. Each serves a different purpose. PHCF classification provides a shared clinical language. Repeated measurement provides sensitivity to change. Person-specific indicators preserve personally meaningful outcomes. Behavioural and contextual evidence establish what the observed changes represent. Structured clinical judgement integrates the available evidence. PHCF monitoring should operate as an iterative process that links classification, measurement, clinical interpretation and treatment decision-making. A structured PHCF profile can establish the baseline, after which only clinically relevant constructs are selected for repeated monitoring. Quantitative measures, person-specific indicators and behavioural, contextual or longitudinal evidence can then be integrated through structured clinical judgement. Figure 7.3 summarises the proposed monitoring architecture and shows how PHCF classifications may be updated when sufficient evidence supports meaningful change.

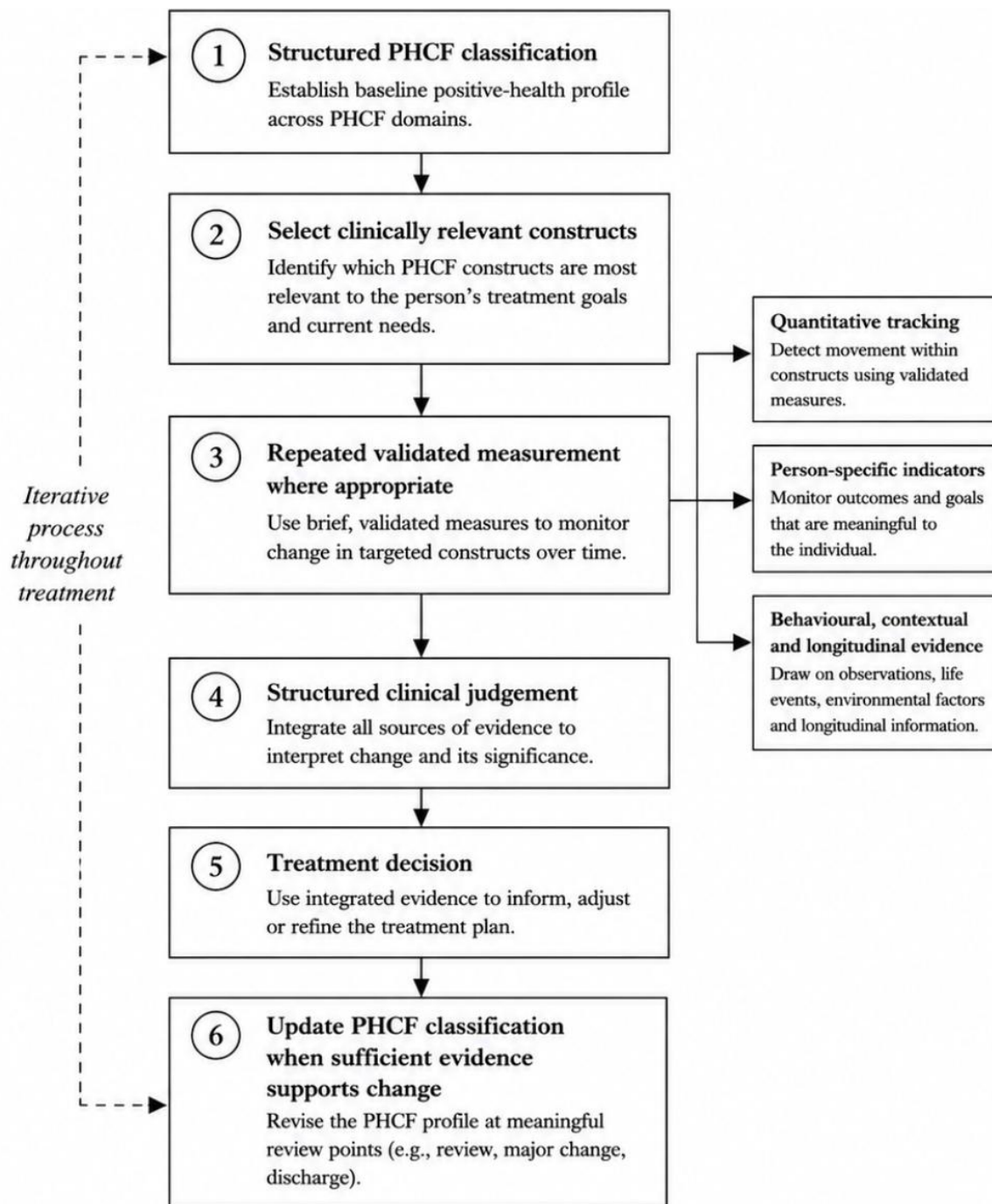


Figure 7.3. Proposed PHCF monitoring architecture, showing an iterative process from baseline classification and targeted measurement through structured clinical judgement, treatment decisions and evidence-based updating of the PHCF profile.

Evidentiary Standard

PHCF should not establish numerical cut-offs, change thresholds or categorical monitoring rules until the relevant measures have demonstrated adequate measurement properties. Early PHCF ratings may be useful for research and exploratory clinical monitoring, but their scores should not be interpreted as validated classifications. The eventual evidentiary standard should include content validity, reliability, measurement error, construct validity, responsiveness and interpretability. The architecture should remain open to the possibility that different PHCF constructs require different forms

of measurement. Some may be represented effectively using patient-reported scales. Others may require longitudinal behavioural evidence, structured clinical assessment or contextual indicators. The central principle is that PHCF should monitor the phenomenon rather than merely monitor a score. Measurement is valuable when it improves understanding of change and informs treatment decisions. A monitoring system that generates repeated numerical data without adding clinically meaningful information would reproduce the administrative complexity that PHCF is intended to avoid.

Recovery and Relapse Prevention

Recovery and relapse prevention provide particularly strong potential applications for PHCF because they require attention to information extending beyond current symptoms. A person who has experienced several episodes may accumulate considerable knowledge about the condition. They may recognise warning signs, understand which strategies are useful, know when professional assistance is required and have developed relationships capable of supporting recovery. Much of this information can be captured within Recovery and Self-Management Capacity, Demonstrated Adaptation and Protective Resource Ecology. The value becomes clearer when diagnostic status remains unchanged. A person may still meet criteria for a mental disorder while becoming considerably more capable of managing it. Another may achieve symptom remission without developing confidence or strategies for responding to recurrence. A purely symptom-based interpretation risks treating these two outcomes as more similar than they are. PHCF allows recovery capability to change independently. This does not imply that stronger self-management guarantees prevention of recurrence. Mental disorders can recur despite sophisticated management. The framework describes capability, not control over all future outcomes.

Clinical Handover and Continuity of Care

The preservation of positive-health information during clinical handover may become one of the most practical applications of PHCF. Transitions between clinicians and services create substantial risk of information loss. A systematic review of systematic reviews found that poor clinical handover has been associated with information omissions, diagnostic and treatment errors and treatment delays, while no single handover method has emerged as universally optimal (Desmedt et al., 2021). Mental health-specific work has similarly identified the importance of structured handover and communication across acute and community settings (Hunt et al., 2012). Mental health handovers understandably prioritise diagnosis, medications, current symptoms, risk, legal status, recent events and required actions. Positive capacities and resources can become less visible unless the individual clinician deliberately includes them. The loss may have clinical consequences. A clinician who has worked with a person over many months may know that the person responds well to direct collaborative planning, reliably contacts a sibling when deteriorating, has previously recovered through structured routines and strongly values continuing education. These features may have become central to treatment. If the person changes service and the handover communicate only diagnosis, medication, risk history and presenting symptoms, the receiving clinician must rediscover much of the information that previously supported care. PHCF could provide a standard location for such information. A handover might preserve the person's established self-management strategies, demonstrated adaptation, key accessible resources and valued directions. This information would supplement essential risk and treatment information rather than compete with it. The hypothesis is testable. Research could examine whether PHCF-informed handover improves receiving clinicians' understanding of the person, reduces repeated assessment, improves continuity of treatment strategies or is experienced by service users as providing a more accurate representation of their care.

Multidisciplinary Use

A clinically useful positive-health classification should be interpretable across professional disciplines. Psychiatrists, psychologists, mental health nurses, social workers, occupational therapists, general practitioners, peer workers and other professionals often contribute different forms of information to a person's care. PHCF potentially provides a common structure within which these observations can be located without requiring each discipline to adopt the same theoretical model. A psychologist may contribute information concerning Psychological Flexibility or Adaptive Regulation. An occupational therapist may identify how capacities are expressed in everyday activities. A social worker may have detailed knowledge of housing, financial and community resources. Nursing staff may observe changes in self-management or relational engagement across time and settings. Peer workers may identify aspects of personal recovery or resource accessibility that are less visible within conventional clinical encounters. The classification should not determine which discipline owns a construct. Multidisciplinary information may also expose disagreement. One clinician may observe strong agency during appointments while another sees considerable difficulty participating in decisions during acute episodes. PHCF should permit contextual differences to be recorded instead of forcing a global judgement.

Cultural Formulation and Context

Positive-health information is particularly sensitive to cultural interpretation. Constructs such as wellbeing, agency, autonomy, belonging, meaning, recovery, relational capacity and successful adaptation cannot be assumed to have identical meanings or behavioural expressions across cultures. PHCF requires cultural formulation to operate as part of classification rather than as an optional adjustment applied after a classification has been made. The Cultural Formulation Interview provides an established precedent within psychiatric assessment. The CFI was introduced within DSM-5 to elicit the person's cultural understanding of their difficulties, cultural explanations of causes, sources of support, stressors, identity and factors influencing help seeking and treatment. Aggarwal's (2024) state-of-the-science review identified twelve studies examining how clinicians used CFI information in diagnostic or treatment-planning tasks. Ten reported that the information was helpful for those purposes, while all twelve highlighted its contribution to understanding the social context of the person's life. The evidence supports the clinical value of systematically eliciting cultural and contextual information rather than assuming that clinicians can infer it from observable behaviour alone. The importance of culture is also becoming more explicit within the emerging architecture of psychiatric classification. In 2026, the American Psychiatric Association's Future DSM Strategic Committee published a dedicated report on socioeconomic, cultural and environmental determinants of mental health and intersectionality. Wainberg et al. (2026) argue that these conditions influence risk, symptom expression, access to care, illness course and recovery. Their framework extends the meaning of culture beyond demographic identity to include shared meanings and practices, historical narratives, religious and spiritual worldviews, moral frameworks and culturally embedded understandings of health and illness. The report also considers ways in which these determinants might eventually be incorporated into routine diagnostic workflows and monitored over time.

WHO has moved in a similar direction. The 2024 *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders* provides culture-related guidance across diagnostic groupings and recognises that experiences considered unusual or pathological in one setting may be culturally normative in another. WHO also emphasises a lifespan approach and the need to interpret mental health presentations within cultural and contextual conditions. The ICD-11 development process involved experts and clinicians internationally, reflecting its intended function as a global rather than culturally local classification system. Psychology has developed parallel

principles. The American Psychological Association's *Multicultural Guidelines* adopt an ecological approach to context, identity and intersectionality and emphasise that human behaviour and identity develop within social, developmental, historical and cultural environments. The APA *Race and Ethnicity Guidelines in Psychology* further emphasise cultural humility, responsiveness, global perspectives and the influence of racial and ethnocultural context on psychological practice and assessment. These developments move professional psychology away from treating culture as a demographic variable added to an otherwise universal psychological model. Culture contributes to the meaning of the psychological phenomena being assessed.

Culture and the Meaning of Positive Health

The cultural problem may be even more important for positive-health classification than for psychopathology. A classification of disorder generally begins with clinically significant disturbance, although its presentation and meaning remain culturally influenced. Positive health requires judgements about constructs that can be much more closely connected to cultural values. Agency provides a simple example. In one cultural context, agency may be expressed through individual choice, independence and direct assertion of preferences. In another, agency may be expressed through fulfilling obligations to family, consulting Elders, preserving collective harmony or making decisions through relational processes. Treating independence as the behavioural marker of agency would confuse one culturally specific expression of the construct with the construct itself. Relational Capacity presents the same problem. Living independently cannot automatically indicate stronger relational or adaptive capacity than living within an extended family system. Extensive reliance on family may represent dependence in one context and culturally valued reciprocity in another. Emotional restraint may be interpreted as avoidance within one cultural framework while representing maturity, respect or effective regulation within another. Meaning and valued direction are particularly unlikely to be culturally neutral. Meaning may be grounded in personal achievement for one person, family continuity for another, religious obligation for another, community contribution for another and relationship with land, ancestry or cultural tradition for another. A PHCF classification that privileged occupational achievement, individual self-actualisation or autonomous goal pursuit would risk converting culturally Western ideals into apparent indicators of psychological health.

This problem is not theoretical. Indigenous conceptions of social and emotional wellbeing provide a clear demonstration that wellbeing may extend beyond an individual psychological state. Australian Aboriginal and Torres Strait Islander social and emotional wellbeing frameworks include relationships among body, mind and emotions, family and kin, community, culture, Country, spirituality and ancestors. These domains demonstrate why positive health cannot always be understood as a property contained within the individual. Research also provides some support for the health relevance of these cultural dimensions. A systematic review of programs supporting cultural identity among Indigenous Australians found evidence of beneficial psychosocial, behavioural or clinical outcomes in many of the included studies, although study quality varied (MacLean et al., 2017). Research concerning caring for Country has similarly identified preliminary evidence linking participation with reduced psychological distress and stronger social and emotional wellbeing. The implication for PHCF is not that Indigenous frameworks should be absorbed into PHCF or translated into universal criteria. The opposite principle is required. Such frameworks demonstrate that the architecture must allow culturally grounded understandings of health that may not be adequately represented by dominant Western constructs.

Cultural Validity of Measurement

Cultural responsiveness must extend beyond clinical interviewing to measurement. A construct can have an apparently clear theoretical definition while its measurement performs differently across languages, cultures or populations. The American Psychological Association's guidelines for psychological assessment explicitly caution that psychological instruments and interpretive methods arise from particular sociocultural contexts. Reliability and validity demonstrated in one normative population cannot simply be assumed for another. The guidelines recommend attention to cultural and linguistic characteristics, normative populations, measurement equivalence, translation and differential item functioning when instruments are used across populations (American Psychological Association, 2020). This principle has major implications for PHCF. Translation alone will not establish equivalence. A translated item asking whether someone acts independently may retain its literal linguistic meaning while changing its psychological meaning substantially. Likewise, an item measuring frequent expression of positive emotion may not represent equivalent positive health where restraint in emotional expression is culturally valued. PHCF measures will require explicit testing of cultural measurement invariance. Evidence should establish whether the same construct is being measured, whether items operate similarly across groups and whether numerical differences can be interpreted in comparable ways. Where equivalence cannot be established, PHCF should permit culturally specific indicators, adaptations or methods rather than preserving superficial numerical comparability. Recent Australian evidence illustrates the seriousness of this problem. O'Grady-Lee et al. (2026) systematically reviewed measures of mental health and social and emotional wellbeing used with Aboriginal and Torres Strait Islander children. More than three quarters of the assessed tools demonstrated poor or limited cultural validity. The authors called for First Nations-led and co-designed assessment grounded in Indigenous knowledge, strengths and cultural frameworks. The finding provides a particularly important warning for PHCF because a positive-health classification could reproduce the same measurement problem if instruments developed in predominantly Western populations were treated as universal.

Cultural Formulation Within PHCF

PHCF should incorporate cultural formulation at several levels. At the level of construct definition, the framework should distinguish the underlying phenomenon from culturally particular ways in which it is expressed. Agency may remain a candidate construct while independence does not become its universal indicator. Relational Capacity may remain a construct while family structure does not determine its level. At the level of assessment, clinicians should establish how the person understands wellbeing, recovery, relationships, meaning, responsibility, autonomy and support. The clinician should not assume that an apparently positive or negative behaviour carries the same meaning across cultural contexts. At the level of evidence, PHCF should allow culturally relevant evidence sources. Information may arise through the person, family, community, Elders, cultural practitioners or other sources where involvement is appropriate, desired and ethically obtained. Clinical authority should not automatically supersede culturally situated knowledge. At the level of measurement, instruments should have evidence supporting their use with the relevant population. Where culturally valid standardised measurement is unavailable, classification uncertainty should be preserved rather than hidden by the use of an inappropriate normative measure. At the level of clinical judgement, clinicians should distinguish evidence about a construct from their own cultural interpretation of that evidence. Behaviour inconsistent with the clinician's expectations should not automatically be interpreted as deficit. At the level of classification, PHCF should avoid assuming that identical behavioural indicators are required for equivalent classifications across cultures. The construct should be sufficiently stable to support a common clinical language while its legitimate expressions remain culturally variable.

Cultural Responsiveness in PHCF

PHCF should adopt cultural responsiveness as a core principle of assessment and classification. Cultural responsiveness requires more than knowledge about cultural groups. It involves actively examining how culture, identity, relationships, history, social position and context shape the meaning and expression of the positive-health phenomenon being assessed. Cultural humility forms part of this approach by requiring continuing enquiry, recognition of limits in the clinician's knowledge and willingness to examine assumptions, power and bias. A culturally responsive PHCF assessment should avoid assuming that constructs have identical behavioural expressions across people or communities. Agency may be expressed through independent decision-making for one person and through consultation with family, Elders or community for another. Relational Capacity may involve independence in some contexts and strong interdependence in others. Meaning may arise through personal goals, spirituality, family obligations, cultural continuity, community contribution or connection to Country. These different expressions should not automatically produce different classifications when they reflect culturally coherent manifestations of the same underlying construct.

Cultural responsiveness also requires attention to variation within cultural groups. Membership of a particular cultural, ethnic, religious or linguistic community does not determine the meaning that cultural practices hold for an individual. Two people from the same community may differ substantially in spirituality, family relationships, cultural identification, migration experience, language, gender roles, experiences of discrimination, connection with tradition and expectations concerning help seeking. PHCF should ask how culture operates for this person in this context, rather than infer meaning from group membership. The principle should extend beyond clinical interview to the interpretation of evidence. Behaviour that appears avoidant, dependent, emotionally restrained or insufficiently assertive from one cultural perspective may have a different meaning within another. Likewise, employment, independence, productivity or individual goal attainment should not be treated as culturally neutral indicators of positive health. Clinicians should distinguish the underlying construct from the culturally shaped behaviour through which it is expressed.

Cultural responsiveness also has implications for measurement. Standardised instruments should not be assumed to function equivalently across cultural and linguistic populations simply because they have established reliability and validity elsewhere. Translation does not establish conceptual equivalence. Where culturally appropriate measurement evidence is limited, greater reliance may be required on clinical interview, contextual information, person-defined indicators and other relevant sources of evidence. Classification uncertainty should be preserved where the cultural validity of available information is inadequate. PHCF should consequently treat cultural responsiveness as an ongoing process throughout classification. Cultural context should inform construct interpretation, selection of evidence sources, interpretation of behaviour, use of psychometric measures, structured clinical judgement and communication of the resulting classification. The objective is not to create separate standards of positive health for different cultural groups. It is to ensure that a common construct is not confused with one culturally preferred way of expressing it. A culturally responsive PHCF should preserve a stable clinical language while allowing legitimate variation in how positive health is understood, demonstrated and supported across cultural contexts. The framework should classify the positive-health phenomenon, not conformity with dominant cultural expectations.

Culture, Structure and Intersectionality

Culture should also not be separated artificially from structural conditions. Poverty, racism, colonisation, migration, displacement, discrimination, unsafe environments and unequal access to healthcare can influence the opportunities through which positive-health capacities are expressed. The

2026 Future DSM work is particularly relevant because it explicitly connects socioeconomic, cultural and environmental determinants with intersectionality and considers their relevance to vulnerability, resilience and recovery. A person may have substantial Agency while having few realistic choices available. Strong Recovery Self-Management may coexist with inadequate access to culturally safe healthcare. Relational Capacity may be substantial while geographic displacement separates the person from family or community. Protective Resource Ecology may include culturally meaningful resources that conventional service assessment does not recognise. These circumstances should not lower the person's positive-health classification merely because structural conditions restrict its observable expression. PHCF must distinguish capacity from opportunity, resource existence from resource access, and individual adaptation from structural advantage. This distinction is particularly important if PHCF is eventually used internationally. Differences in income, healthcare infrastructure, family structures, social policy, migration, religion, community organisation and political conditions could otherwise be mistaken for differences in individual positive health.

A Cultural Equivalence Rule for PHCF

A formal cultural equivalence rule should form part of the PHCF architecture. A PHCF construct should represent a clinically meaningful phenomenon that can be recognised across cultural contexts, while allowing its behavioural expression, personal meaning, relevant evidence and normative expectations to vary. Cultural equivalence should concern the underlying construct rather than requiring identical behaviours across people or cultural groups. Agency, for example, should not be classified at a lower level merely because a person prefers collective or family-based decision-making over individual decision-making. Relational Capacity should not be reduced because relationships are characterised by interdependence rather than independence. Meaning should not be judged as weaker because it is grounded primarily in spirituality, community, family, cultural continuity or connection with Country rather than individual goals or achievement. The reverse problem must also be avoided. Behaviours that are highly valued within a dominant cultural setting, including independence, employment, assertiveness or productivity, should not automatically result in a higher positive-health classification. These behaviours may reflect social opportunity, cultural expectations or structural advantage rather than the underlying positive-health construct being assessed. Similarly, a resource should not be classified as protective simply because the clinician regards it as desirable. Its relevance, accessibility and effect must be established within the person's circumstances. Where culturally appropriate interpretation, evidence or measurement is unavailable, PHCF should preserve uncertainty rather than impose a classification based on inappropriate assumptions. The objective is to maintain a common clinical language without treating one cultural expression of positive health as the universal standard.

Implications for PHCF Development

Cultural validity should be treated as part of construct validity rather than as a later implementation issue. A PHCF construct that functions only within one cultural worldview cannot yet be considered a universal positive-health construct. Developmental studies should include culturally diverse populations from the beginning. Qualitative work should examine whether proposed constructs are recognisable and meaningful across cultural groups before large-scale psychometric testing occurs. Measures should undergo cultural adaptation and measurement-equivalence testing. Classification descriptors should be examined for cultural normativity. Field trials should include clinicians, people with lived experience and communities from different cultural settings. Where universal equivalence cannot be demonstrated, the architecture should permit culturally specific expressions or modules rather than force artificial standardisation. The objective is not to remove culture from PHCF in pursuit of a

culturally neutral classification. No psychologically meaningful classification is completely culture-free. The stronger objective is to develop a framework whose constructs are explicit enough to support communication while remaining flexible enough to recognise that positive health is experienced, expressed and valued within cultural worlds. The requirement is particularly important for PHCF because the framework seeks to classify what is positive. Definitions of disorder can themselves be culturally contested, but classification of positive health creates an additional risk of embedding assumptions about what a good, successful or healthy person ought to be. PHCF should classify clinically meaningful positive-health phenomena without becoming a classification of culturally preferred ways of living.

Developmental Application

PHCF also requires developmental interpretation. The meaning of Agency and Self-Direction in adolescence differs from its meaning in adulthood. A young person may exercise agency within substantial dependence on parents or caregivers. Recovery self-management may be shared across the young person, family and clinical team. Identity may be actively developing and should not be judged against adult expectations of stability. Protective Resource Ecology is also likely to differ developmentally. School, caregivers, peers and family systems can have central importance during childhood and adolescence. Older adults may rely on different combinations of family, community, health and material resources. The underlying PHCF domains may remain relevant across the lifespan while their manifestations and evidentiary requirements change. Clinical Presentation Modules and future developmental qualifiers will need to address these differences explicitly.

PHCF Within Brief and Extended Care

The depth of PHCF assessment should vary according to the clinical setting. A single-session intervention, emergency assessment or brief primary-care consultation cannot reasonably generate the same positive-health profile as extended psychological treatment. PHCF should support graduated use. In brief settings, the clinician may identify only the positive-health information necessary for the immediate clinical decision. Relevant capacities could include help seeking, current agency, existing coping strategies and accessible supports. Demonstrated Adaptation may be noted when obvious historical evidence emerges, without requiring a comprehensive life-history assessment. Longer-term treatment allows the profile to develop progressively. The clinician may observe capacities across different circumstances, revisit previous adaptations and refine understanding of resource accessibility. This principle reduces the risk that PHCF becomes another intake burden. Not Assessable should remain an acceptable classification when information is unavailable.

Documentation and the Clinical Record

If PHCF eventually demonstrates clinical utility, its information will require a stable location within clinical documentation. The current fragmentation problem partly exists because positive-health information can appear in many locations. It may be recorded under strengths, protective factors, formulation, social history, goals, mental state examination, recovery plan or case notes. A mature PHCF could provide a recognisable section of the clinical record containing the positive-health profile and relevant trajectory. The documentation should remain concise. The value of classification lies partly in reducing the need to repeatedly reconstruct complex information from narrative notes. A clinician should be able to see which capacities are currently established, which resources are accessible, what previous adaptation is relevant and what changes have occurred. Narrative information will still be required. Demonstrated Adaptation, in particular, cannot be represented adequately through a label without context. The profile should link structured information with concise explanatory narrative.

Digital health systems may eventually make longitudinal PHCF display possible. Changes in symptoms, functioning and positive-health capacities could be viewed separately across treatment. This possibility is consistent with broader movement toward more dynamic and digitally supported classification systems. The technological capability should follow validation rather than precede it.

An Illustrative Clinical Application

The potential contribution of PHCF can be illustrated through a person experiencing recurrent major depression. The person presents with depressed mood, loss of interest, sleep disturbance, reduced concentration, withdrawal and thoughts of worthlessness. These symptoms require direct assessment and appropriate intervention. Functional assessment identifies difficulty maintaining university attendance and reduced participation in social activity. Further assessment shows that the person has experienced two previous episodes. During the second episode, they learned that reduced sleep and withdrawal typically preceded substantial deterioration. They contacted their general practitioner when these signs returned, maintained regular contact with one trusted friend and retained a previously developed behavioural activation plan. Current Positive Health State is limited. Engagement and valued direction have reduced considerably. Agency remains evident because the person has actively participated in seeking treatment and retains clear preferences concerning care. Recovery and Self-Management Capacity appears established through recognition of warning signs and timely help seeking. Relational Capacity remains available despite current withdrawal. Previous episodes provide evidence of Demonstrated Adaptation because the person has successfully identified deterioration, engaged with treatment and restored valued activity. Protective Resource Ecology includes a trusted friend, supportive general practitioner and stable housing, although financial pressure is increasing. The diagnosis has not changed, and the symptom score has not changed. The functional impairment has not changed and the PHCF profile nevertheless adds information. Treatment can build on existing warning-sign recognition and the behavioural activation strategies that previously worked. The trusted relationship can be incorporated into relapse planning if the person wishes. Financial pressure can be addressed as an emerging resource vulnerability. Low current engagement can be treated as a recovery target without interpreting the person's present distress as evidence that previous adaptive capability has disappeared. This is the type of additional clinical information PHCF is intended to organise. Whether organising it formally produces better care remains an empirical question. The potential clinical contribution of PHCF can be illustrated using recurrent major depression. The example shows how diagnosis, symptom severity and functional impairment can remain unchanged while PHCF identifies additional information concerning current positive health, retained capacities, previous adaptation and accessible resources. Figure 7.4 demonstrates how these elements may contribute to treatment planning without altering or reducing the significance of the underlying psychiatric presentation.

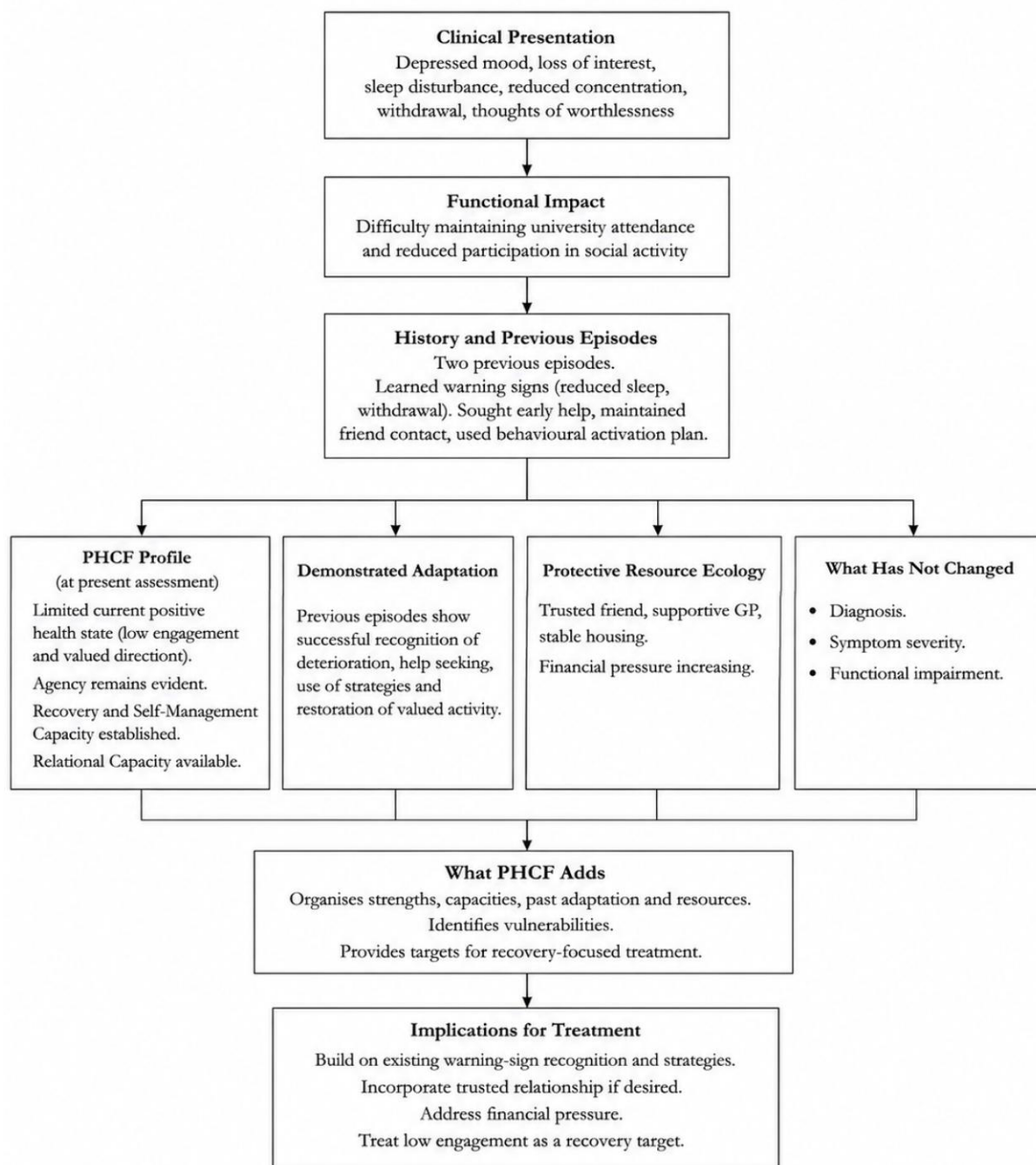


Figure 7.4. Illustrative application of PHCF in recurrent major depression, showing how positive-health capacities, demonstrated adaptation and protective resources can add clinically relevant information to an unchanged diagnosis, symptom profile and level of functional impairment.

What PHCF Should Change in Practice

A clinically useful PHCF should change more than documentation. It should improve the clinician's understanding of what can be mobilised during care. It should improve the person's experience of having existing capabilities recognised accurately. It should increase the precision with which protective resources are incorporated into formulation. It should improve continuity when care transfers between clinicians. It may allow positive-health development to be monitored even when symptoms change slowly. If PHCF merely adds a strengths section to an assessment, it has failed to

justify its architecture. The clinical test is whether information produced by the framework changes understanding or decisions in useful ways. This distinction is particularly important because existing strengths-based assessments already attempt to identify individual, interpersonal and environmental strengths. The 2022 systematic review by Chen et al. found multiple existing measures and concluded that conceptualisation and psychometric quality remain important areas for development. PHCF should build on this literature while testing whether its proposed separation of state, capacity, demonstrated adaptation and resource ecology provides information not captured adequately by existing strengths assessment.

Clinical Utility as a Research Question

Chapter Six established that clinical utility must be treated as an empirical property. Clinical application provides the settings in which that property can be tested. An early clinical utility study could compare usual assessment with PHCF-informed assessment. Clinicians could be asked to produce formulations and treatment plans from each form of information. Researchers could examine whether PHCF changes the identification of treatment resources, formulation content, treatment recommendations or confidence in understanding the person's recovery capabilities. People receiving care could evaluate whether PHCF-informed summaries represent them more accurately, identify capabilities that matter to them and avoid minimising their difficulties. Handover studies could examine whether positive-health information is retained more effectively when PHCF is used. Longitudinal studies could examine whether PHCF trajectories provide information about recovery, engagement or recurrence beyond symptoms and functioning. These studies could also demonstrate limited utility. Clinicians may already identify this information adequately through good formulation. PHCF classifications may prove too time-consuming. Some domains may be too difficult to assess reliably. Service users may prefer narrative descriptions over classifications. The profile may contribute little beyond existing recovery measures. These are legitimate outcomes. PHCF should continue only where evidence demonstrates additional value.

A Complementary Clinical Language

The clinical proposition of PHCF can be stated narrowly. Existing clinical approaches already address several distinct forms of information. Diagnosis identifies the recognised clinical condition, symptom assessment describes the nature and degree of current psychopathology, and risk assessment identifies relevant safety concerns. Functional assessment describes activities and participation, while quality-of-life assessment captures the person's evaluation of important areas of life. Clinical formulation then integrates these and other factors to develop an individualised understanding of the presentation. PHCF is proposed as an additional source of structured information within this broader clinical picture. Its focus is the positive health currently present, the capacities that may be available for mobilisation, the adaptations previously demonstrated and the resources that can realistically support treatment or recovery. These forms of information can coexist with diagnosis, symptom assessment, risk, functioning, quality of life and formulation without displacing any of them. The potential advantage is a more complete clinical description that identifies both the difficulties requiring intervention and the existing health that may be recruited in responding to those difficulties. The usefulness of this proposition also depends on whether the Universal PHCF Core is sufficient across different forms of mental health presentation. Some positive-health processes may have particular relevance within specific clinical contexts. Recognition of early changes in mood, sleep or activity may be especially important in recurrent mood disorders. The capacity to distinguish current safety from perceived threat, rebuild trust and restore a sense of safety may have particular relevance following trauma. Recovery capital is especially well developed within substance-use recovery, while psychosis

may raise distinctive questions concerning identity, meaning, social connection and self-management. These differences suggest that a wholly universal positive-health profile may omit clinically important presentation-specific information. The following chapter examines the role of Clinical Presentation Modules within PHCF. It considers how presentation-relevant positive-health information can be incorporated into the framework while preserving a transdiagnostic core and avoiding the creation of a positive mirror image of disorder-based classification.

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Chapter Eight - Clinical Presentation Modules - Adding Specificity Without Recreating Disorder-Based Classification

Why a Universal Core May Not Be Enough

The Positive Health Classification Framework has so far been developed around a Universal Core. The approach reflects the expectation that many positive-health constructs operate across diagnostic boundaries. Agency, adaptive regulation, psychological flexibility, relational capacity, recovery self-management, demonstrated adaptation and access to supportive resources are potentially relevant whether a person is experiencing depression, anxiety, trauma-related symptoms, psychosis, substance-related difficulties or another form of mental health presentation. A transdiagnostic core offers several advantages. It reduces duplication, allows positive-health information to remain meaningful when diagnoses change and avoids reproducing the categorical architecture of existing diagnostic systems. It is also consistent with contemporary developments in psychopathology research showing that clinically important psychological processes frequently extend across conventional diagnostic boundaries. A completely universal framework may nevertheless lose clinically meaningful specificity. The capabilities required to recognise an emerging manic episode are not identical to those involved in distinguishing current safety from trauma-related perceptions of threat. Recovery from an eating disorder may involve distinctive changes in identity, autonomy and the relationship with the body and eating. Substance-use recovery has generated a particularly developed literature concerning recovery capital. Psychosis presents distinctive questions concerning meaning, identity, social connection, self-management and the relationship between personal recovery and continuing symptoms. The purpose of Clinical Presentation Modules is to provide additional positive-health information where the Universal Core is insufficient. A module should add specificity only when a presentation-related construct has evidence of clinical importance beyond the transdiagnostic domains already assessed. This creates an important design boundary. PHCF does not require a positive equivalent of every mental disorder. A major depressive disorder diagnosis does not need to be matched with a positive depressive classification, and PTSD does not require a diagnostic opposite. Clinical Presentation Modules are supplementary layers within the positive-health profile, not mirror images of disorder categories.

PHCF combines a proposed Universal Core with transdiagnostic constructs and supplementary Clinical Presentation Modules. The Universal Core provides a common architecture, transdiagnostic constructs allow clinically relevant positive-health phenomena to be represented across diagnostic boundaries, and presentation modules add specificity only where evidence demonstrates additional clinical value. PHCF is proposed as a layered framework combining a common architecture with constructs that can operate across diagnostic boundaries and additional presentation-specific information where needed. The Universal Core provides the shared foundation, while transdiagnostic constructs allow clinically relevant positive-health phenomena to remain meaningful across different disorders. Clinical Presentation Modules are added only when the Universal Core does not provide sufficient specificity and there is evidence that the additional information has clinical value. Figure 8.1 summarises this proposed relationship.

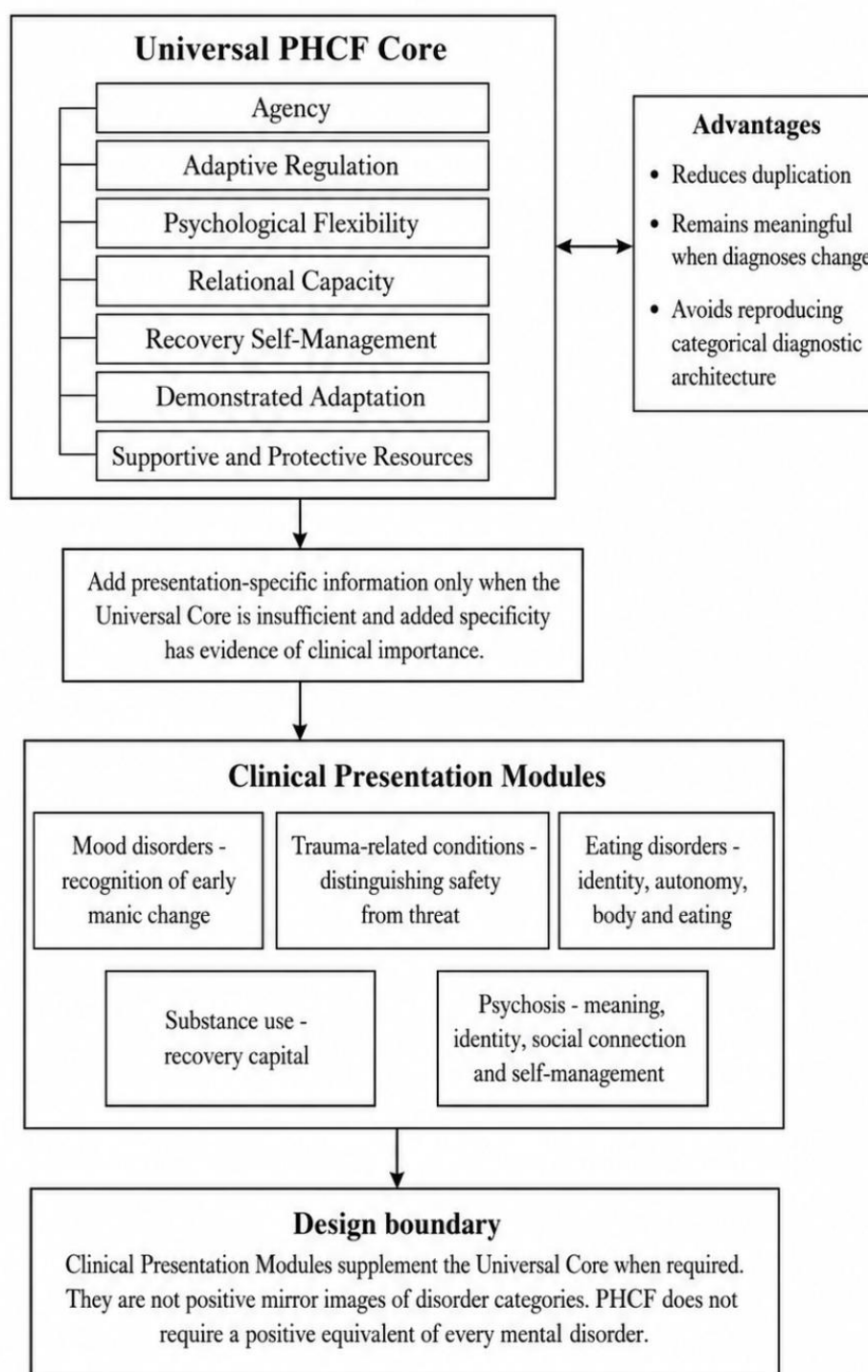


Figure 8.1. Proposed relationship between the PHCF Universal Core, transdiagnostic positive-health constructs and supplementary Clinical Presentation Modules, which add presentation-specific information only where evidence supports additional clinical value.

Clinical Presentation Modules and Established Modular Assessment

The term *module* has an established precedent in psychiatric assessment and clinical documentation. The Structured Clinical Interview for DSM-5 Disorders is organised into diagnostic modules covering different groups of disorders, allowing assessment to be structured according to the clinical presentation and purpose of the interview (First et al., 2016). The American Psychiatric

Association also uses supplementary modules within the Cultural Formulation Interview. These modules allow clinicians to explore particular cultural domains or population-specific issues in greater depth when relevant to the assessment, rather than requiring every supplementary component to be administered in every case (American Psychiatric Association, 2022). Modular organisation is also used in routine mental health documentation. NSW Health's Mental Health Outcomes and Assessment Tools framework distinguishes core clinical documentation modules from additional modules that are selected according to clinical need. The underlying principle is that a common clinical record can be supplemented with more detailed assessment of particular information domains when required, while clinical judgement determines which modules are relevant (NSW Health, 2014). PHCF adopts this established modular principle but uses the term *Clinical Presentation Module* for a different purpose. PHCF modules are not diagnostic categories, do not establish psychiatric diagnoses and are not intended to reproduce the modular organisation of DSM or other diagnostic interviews. Instead, they provide supplementary positive-health information when a clinically recognisable presentation requires greater specificity than can be obtained from the Universal Core alone. A Trauma and Stressor Module, for example, could examine positive-health processes specifically relevant to adaptation to threat, restoration of safety and rebuilding trust without determining whether the person meets criteria for PTSD or another trauma-related disorder. The source diagnostic classification remains separate. The modular architecture allows PHCF to retain a common transdiagnostic foundation while adding presentation-related specificity only where evidence demonstrates additional clinical value. The use of modules also reduces dependence on the categories of any particular version of DSM or ICD. Clinical Presentation Modules can remain relevant when diagnostic terminology, boundaries or classification systems change because their inclusion is determined by clinically meaningful positive-health information rather than diagnostic equivalence.

Clinical Presentations and Disorder Families

The term Clinical Presentation Module is deliberate. Mental health classification is changing. DSM, ICD, HiTOP and RDoC organise clinical phenomena differently, and future classification systems may reorganise existing categories further. A PHCF architecture tied rigidly to the disorder families of one version of DSM would become unnecessarily dependent on that system. Clinical presentation provides a more flexible organising principle. A person may have a recognised DSM or ICD diagnosis, a dimensional psychopathology profile or a clinically significant presentation that crosses conventional diagnostic boundaries. PHCF can retain the source clinical classification and apply modules where the positive-health information is relevant. A trauma and stressor module, for example, may be useful because adaptation to threat, restoration of safety and rebuilding trust are clinically relevant to the presentation. PHCF does not need to determine whether a particular case is coded identically by DSM and ICD before those positive-health processes can be considered. Modules should consequently be linked to clinically recognisable patterns and supported by evidence rather than to the administrative structure of a particular manual. Clinical Presentation Modules are intended to give PHCF flexibility across changing diagnostic systems. Rather than being tied to the categories of a single manual, modules are applied when a clinically recognisable presentation requires additional positive-health information beyond the Universal Core. Figure 8.2 shows how PHCF can retain the source clinical classification while adding presentation-specific information where evidence supports its relevance.

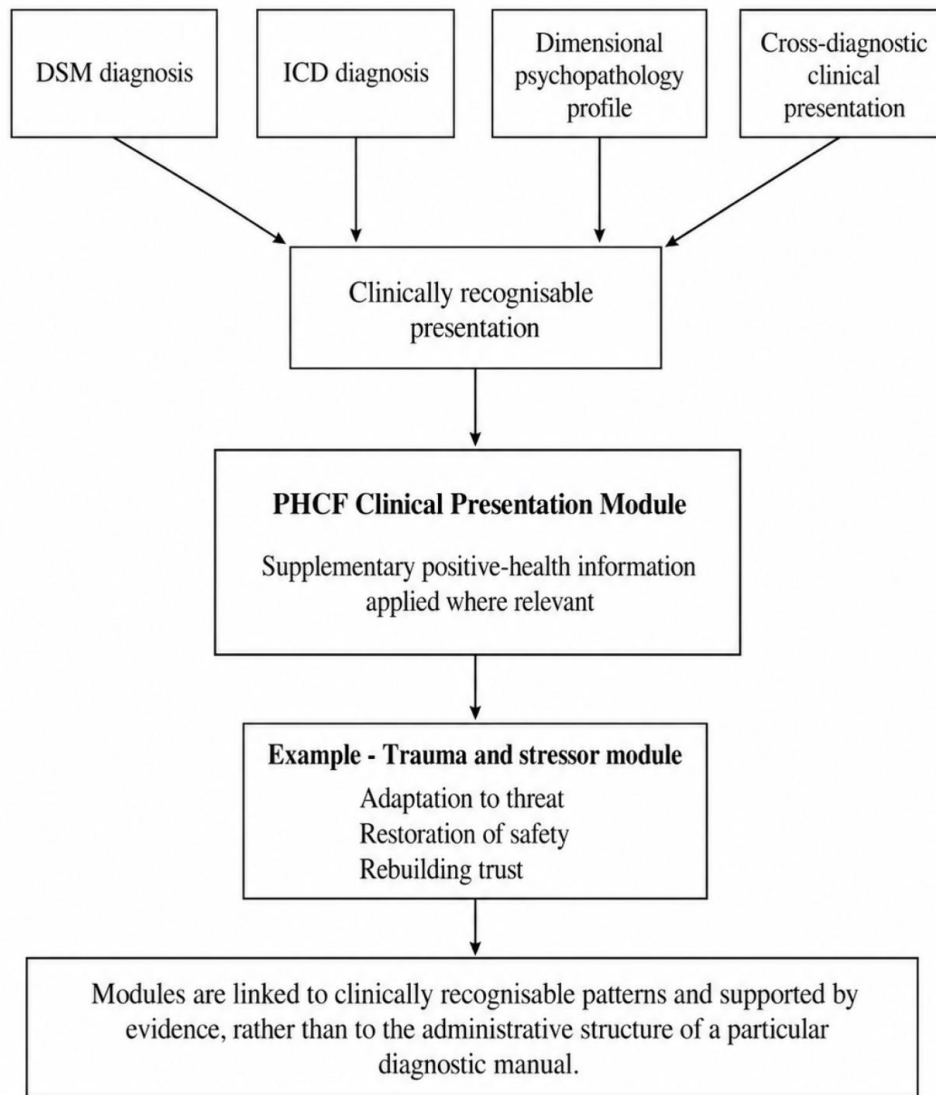


Figure 8.2. *Clinical Presentation Modules as a flexible PHCF organising principle, showing how modules can supplement DSM, ICD, dimensional or cross-diagnostic presentations without being tied to the administrative structure of a single classification system.*

The Requirement for Incremental Specificity

The same standard of incremental validity applied to PHCF as a whole should also govern the development of modules. A presentation-specific construct should not enter a module merely because it is frequently discussed in treatment literature. It should provide information that is not already represented adequately within the Universal Core. Consider recognition of early warning signs in bipolar disorder. PHCF already proposes Recovery and Self-Management Capacity as a transdiagnostic construct. Recognition of deterioration is already represented. A bipolar module will only require a more specific construct if research demonstrates the recognition and management of changes associated with mood episodes carry distinctive clinical information that cannot be represented sufficiently through the broader self-management construct. The principle prevents unnecessary expansion. Clinical Presentation Modules should become relatively small extensions of the Universal Core. Their role is to capture clinically meaningful specificity, not to reassess the entire person from the perspective of each diagnosis.

A Provisional Module Architecture

The initial PHCF research program can begin with several broad presentation areas because substantial literatures already exist around recovery, adaptation, relapse prevention and protective resources within them. These modules remain research priorities rather than established parts of the classification.

Table 8.1

Provisional Clinical Presentation Modules for PHCF Development

Clinical Presentation	Potential Areas for Evidence Mapping
Depressive Presentations	Re-engagement, restoration of agency, recurrence recognition, maintenance of valued activity and mobilisation of support
Anxiety and Fear Presentations	Approach capacity, tolerance of uncertainty or distress, flexible responding to threat and restoration of restricted activity
Trauma and Stressor Presentations	Safety, threat discrimination, relational trust, adaptive meaning, demonstrated adaptation and contextual protection
Bipolar and Mood-Instability Presentations	Mood-state awareness, early-warning recognition, sleep and routine management, support mobilisation and continuity of identity across mood states
Psychosis Presentations	Personal recovery, identity, meaning, connectedness, empowerment, self-management and early recognition of deterioration
Substance and Addictive Presentations	Recovery capital, recovery identity, mobilisation of social and community resources and sustained recovery self-management
Obsessive-Compulsive Presentations	Flexibility in responding to intrusive experiences, tolerance of uncertainty and restoration of valued behaviour
Eating and Feeding Presentations	Identity beyond the disorder, autonomy, self-compassion, relational recovery, meaning and recovery self-management
Personality Functioning and Interpersonal Presentations	Identity coherence, agency, relational capacity, repair, adaptive regulation and contextual stability
Neurodevelopmental Presentations	Self-understanding, environmental fit, self-advocacy, adaptive regulation, supportive resources and meaningful participation

The table does not establish ten permanent PHCF modules. Some may eventually merge. Some may be unnecessary. Others may divide into more specific presentations. Additional modules may emerge from evidence and lived-experience research. The final structure should be determined by whether presentation-specific information adds value beyond the Universal Core. In what follows next is a review of some common provisional presentations.

Depressive Presentations

Depression provides a strong test of the PHCF Clinical Presentation Module because evidence already demonstrates that recovery extends beyond symptom reduction. A 2024 systematic review and meta-analysis of 42 studies involving 17,999 people with major depressive disorder found that functioning remained impaired even during full or partial remission, demonstrating that symptom status and broader recovery are not equivalent (Schwarz et al., 2024). More directly, a 2026 qualitative evidence synthesis of 27 studies involving 939 adults identified social connection, reconstruction of self, autonomy, professional support, self-management, physical health, instrumental circumstances and temporal factors as important influences on recovery from depression (Wedema et al., 2026). These findings closely correspond with PHCF domains concerned with relational capacity, agency, self-management, positive self-experience, demonstrated adaptation and protective resources. Recurrent depression also provides evidence for the clinical importance of accumulated recovery knowledge. People may learn characteristic warning signs, recognise circumstances associated with deterioration, retain strategies that previously assisted recovery and develop knowledge about when professional or interpersonal support should be mobilised. An individual-participant-data meta-analysis of 14 randomised trials involving 1,720 participants found that psychological relapse-prevention interventions reduced relapse over 12 months, with greater benefit among people with three or more previous depressive episodes (Breedvelt et al., 2024). Self-help relapse-prevention interventions have also shown modest benefit, although the certainty of that evidence remains limited (Lo et al., 2024).

Restoration of valued activity provides a second evidence-supported component. Behavioural withdrawal is central to many depressive presentations, while behavioural activation explicitly targets renewed engagement with meaningful and reinforcing activity. A 2026 meta-analysis of 105 trials involving 13,933 participants found behavioural activation effective for adult depression, with significant effects remaining at 12-month follow-up (Cuijpers et al., 2026). The evidence supports re-engagement as clinically important, although it does not establish a separate PHCF construct. Engagement may remain appropriately represented within Current Positive Health State, while Agency, Psychological Flexibility and Adaptive Regulation may describe capacities supporting renewed participation. The Depressive Presentation Module should add specificity rather than duplicate the Universal Core. Its principal contribution may be to organise depression-related expressions of Recovery and Self-Management Capacity, including recognition of personal deterioration patterns, use of previously effective strategies, timely help-seeking and knowledge accumulated across previous episodes. Demonstrated Adaptation can record evidence that these capacities have previously been mobilised successfully, while Protective Resource Ecology identifies the relational, professional and material conditions that facilitate or constrain recovery. The evidentiary question for PHCF is consequently no longer whether these phenomena exist or matter in depression. Existing research supports their clinical relevance. The unresolved question is whether organising them systematically within a PHCF profile adds useful information beyond diagnosis, symptom severity, functioning and existing recovery assessment. The Depressive Presentation Module should be retained only to the extent that it demonstrates that additional clinical value. The evidence reviewed above can be organised within the PHCF by distinguishing established depression-recovery processes from the Universal Core domains through which they may be classified. Figure 8.1 summarises this relationship and identifies the remaining question of whether structured PHCF classification provides incremental clinical value.

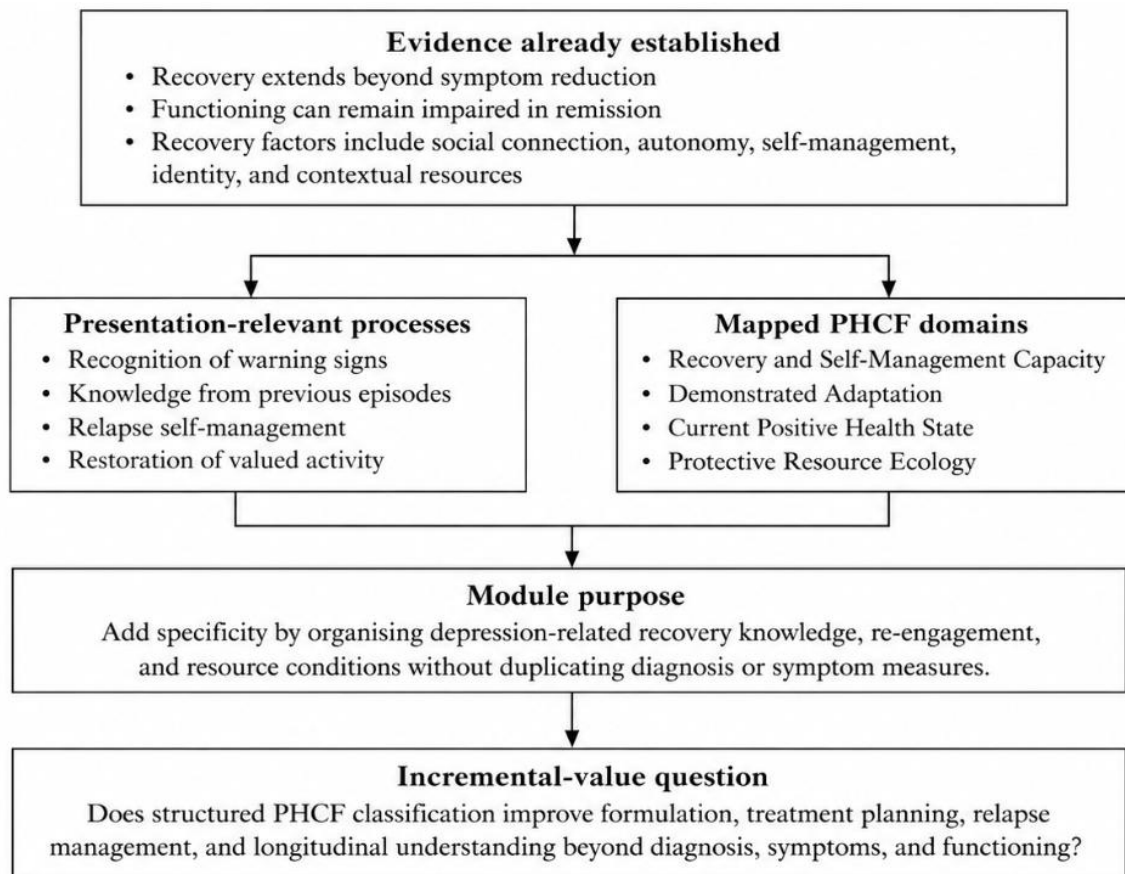


Figure 8.1. *Depressive Presentation Module within PHCF. Evidence-supported recovery processes in depression map primarily onto Recovery and Self-Management Capacity, Demonstrated Adaptation, Current Positive Health State and Protective Resource Ecology, with the module adding presentation-specific information concerning recurrence, recovery knowledge and re-engagement.*

Anxiety and Fear Presentations

Anxiety and fear presentations provide an important test of PHCF because the evidence supports clinically meaningful processes beyond symptom severity, while also strongly supporting a transdiagnostic rather than disorder-specific interpretation. Anxiety disorders are associated with substantial impairment in quality of life, particularly in mental health and social functioning. A meta-analysis of 23 studies involving 2,892 participants found markedly poorer quality of life across anxiety disorders compared with non-clinical controls (Olatunji et al., 2007). Importantly, symptom remission does not necessarily restore broader functioning. In a longitudinal study of 385 people with remitting anxiety disorders, only 45.8% achieved functioning comparable with healthy controls, while 28.5% continued to function at levels similar to people with chronic anxiety disorders (Iancu et al., 2014). These findings support the PHCF principle that psychopathology, functioning and positive health should be considered separately rather than inferred from one another. Avoidance provides one of the clearest evidence-supported processes relevant to anxiety. A comprehensive systematic review and meta-analysis of 441 studies involving 135,347 participants found moderate-to-large associations between experiential avoidance and anxiety symptoms, worry, generalised anxiety disorder, social anxiety disorder, panic and agoraphobia, specific phobias and related conditions (Akbari et al., 2022). Longitudinal evidence also indicates that experiential avoidance and related psychological vulnerabilities predict maintenance and recurrence of anxiety disorders. Spinhoven et al. (2017), following 2,157 adults over four years, found substantial overlap among experiential avoidance, worry,

rumination, neuroticism and anxiety sensitivity, with a broader latent psychological-vulnerability factor predicting onset, maintenance and relapse. The findings are especially relevant to PHCF because they support the existence of processes operating across conventional anxiety diagnoses rather than separate positive capacities corresponding to each disorder.

Psychological Flexibility and Adaptive Regulation provide plausible PHCF locations for much of the positive-health information relevant to anxiety. The clinically meaningful distinction is not simply whether fear or physiological arousal remains present. A person may continue to experience anxiety while becoming increasingly able to alter ineffective responses, tolerate distressing internal experiences and participate in necessary or valued activities. This distinction is consistent with evidence showing that experiential avoidance is transdiagnostic and context-sensitive. PHCF should describe the capacity available in the presence of anxiety without treating successful performance of a particular therapeutic technique as a positive-health classification. Exposure, cognitive restructuring or reduction of safety behaviours remain treatment processes. The PHCF concern is whether broader capacities for flexible and adaptive responding are present, developing or being mobilised. Contextual resources are also relevant. Zimmermann et al. (2020) systematically reviewed modifiable risk and protective factors for adult anxiety disorders and identified social support, coping and physical activity among potentially protective factors, alongside avoidance, negative appraisals and occupational factors associated with greater vulnerability. The authors also identified substantial limitations in the evidence base, with relatively few studies examining modifiable protective factors directly. The findings nevertheless support inclusion of relational, behavioural and environmental information within Protective Resource Ecology while cautioning against assuming that the presence of a resource necessarily produces protection.

Treatment research further reinforces the distinction between symptom change and broader recovery. A meta-analysis of 100 studies found an overall remission rate of approximately 51% following cognitive behavioural therapy for adult anxiety disorders, with estimates varying considerably according to how remission was defined (Springer et al., 2018). Longer-term evidence also supports sustained benefits of cognitive behavioural therapy for several anxiety-related conditions, although effects vary between disorders and long-term relapse data remain limited (van Dis et al., 2020). These findings demonstrate the clinical importance of reducing anxiety while also showing why a positive-health framework should not define recovery simply as the inverse of anxiety severity. The Anxiety and Fear Presentation Module should be deliberately parsimonious. Existing evidence already supports avoidance, flexibility, adaptive responding, coping, social support and broader functioning as clinically important phenomena, but much of this information maps directly onto the PHCF Universal Core. Psychological Flexibility and Adaptive Regulation can represent the capacity to respond differently in the presence of fear, Agency can represent movement toward chosen or necessary action, Current Positive Health State can identify restoration of engagement and valued direction, and Protective Resource Ecology can represent contextual supports and constraints. The evidentiary question for PHCF is consequently not whether adaptive processes exist in anxiety. The evidence shows that they do. The more demanding question is whether any anxiety-specific positive-health construct provides clinically useful information beyond these transdiagnostic domains. Current evidence may ultimately support a relatively small Anxiety and Fear Presentation Module or demonstrate that the Universal Core is largely sufficient. Either outcome would be informative. Evidence that no substantial additional module is required would strengthen, rather than weaken, the transdiagnostic architecture of PHCF. Anxiety and fear presentations illustrate the importance of distinguishing presentation-relevant processes from genuinely presentation-specific positive-health constructs. Figure 8.2 shows how adaptive responding in the presence of fear maps strongly onto existing transdiagnostic PHCF capacities and provides an important test of framework parsimony.

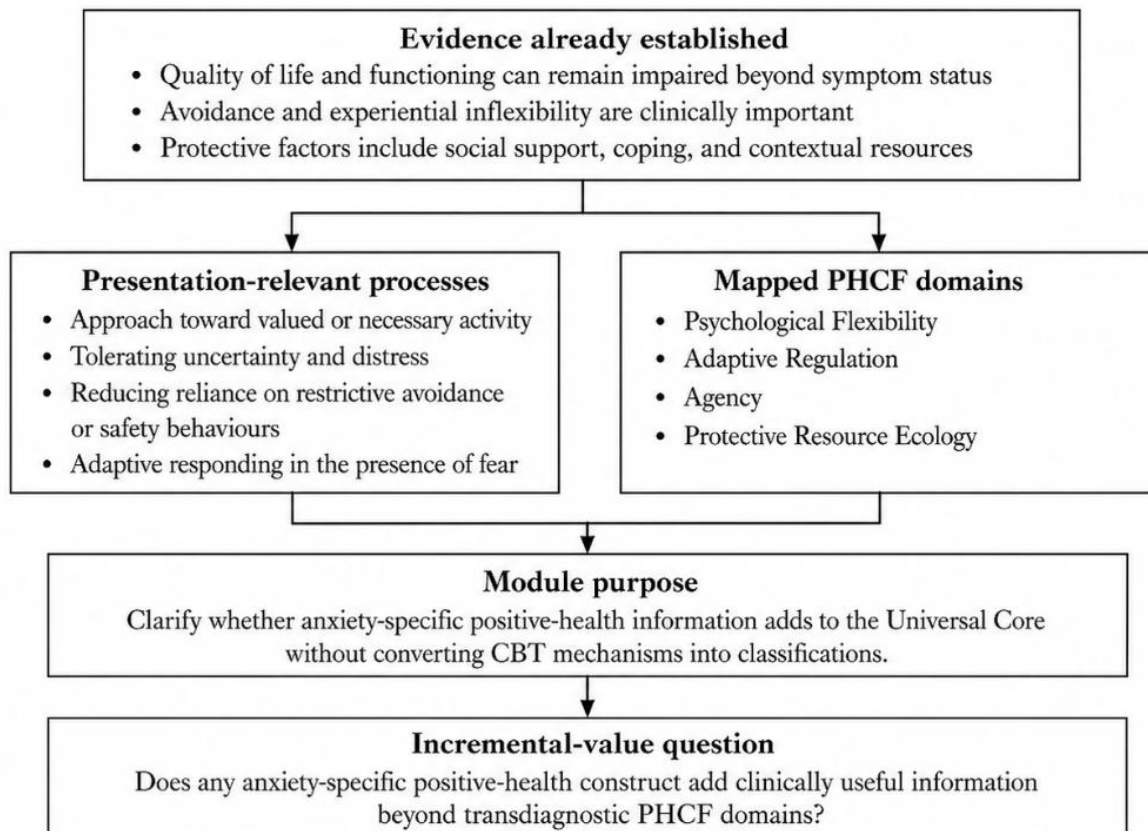


Figure 8.2. *Anxiety and Fear Presentation Module within PHCF. Evidence-supported processes including flexible responding, approach toward valued activity and adaptive engagement with uncertainty map substantially onto the Universal Core, making the need for additional anxiety-specific classification an empirical question.*

Trauma and Stressor Presentations

Trauma and stressor presentations provide a particularly strong case for presentation-specific PHCF assessment because evidence demonstrates substantial variation in adaptation following potentially traumatic events. Trauma exposure does not produce a single psychological trajectory, and the presence or absence of PTSD provides only part of the clinical picture. Contemporary resilience research has identified heterogeneous longitudinal trajectories following adversity, including persistent distress, recovery and relatively stable resilient functioning. Bonanno et al. (2024) argue that resilient adaptation is better understood through flexible responding to changing contextual demands than through possession of a fixed resilience trait. This evidence aligns closely with PHCF distinctions between current psychopathology, Positive Health Capacities and Demonstrated Adaptation. Safety-related learning provides one area in which trauma presentations may require greater specificity than the Universal Core alone. PTSD research demonstrates abnormalities in learning, memory and fear-extinction processes. A 2023 translational meta-analysis incorporating 92 clinical studies and 6,732 participants found impaired learning, memory and extinction in people with PTSD, with impaired fear extinction also evident across human and preclinical evidence (Sep et al., 2023). These findings provide an empirical basis for examining the person's ability to respond differently to threat under changed conditions. PHCF should not classify fear extinction itself as positive health. The clinically relevant positive-health question concerns whether the person can increasingly recognise and respond to present conditions rather than remaining governed by responses that were adaptive under previous threat.

Trauma adaptation is also strongly contextual. Godoy-Henderson et al. (2026) systematically reviewed modifiable protective factors associated with resilience in trauma-exposed adults and identified factors across interpersonal, organisational, community and policy levels. Social support and religious attendance were identified at the interpersonal level, workplace belonging and employment-related factors at the organisational level, access to resources meeting basic needs at the community level, and employee assistance at the policy level. The review specifically recommended multisystemic approaches to resilience rather than locating adaptation solely within the individual. These findings provide direct support for the PHCF Protective Resource Ecology and for integrating that domain closely with Positive Health Capacities and Demonstrated Adaptation in trauma presentations. Social relationships warrant particular attention. A longitudinal meta-analysis of 75 samples involving 32,402 participants found that social support predicted subsequent PTSD symptoms and PTSD symptoms also predicted subsequent social support, with similar effect sizes in both directions (Wang et al., 2021). Social resources cannot be understood as static protective possessions. Trauma-related difficulties can reduce access to or use of support at the same time that supportive relationships influence subsequent psychological outcomes. This reciprocal relationship fits the PHCF distinction between the existence of a resource and whether it remains accessible, usable and mobilised in the person's current circumstances.

The post-traumatic growth literature establishes an equally important boundary. Positive change should not be treated as the expected opposite of PTSD. A meta-analysis of 42 studies involving 11,469 participants found that post-traumatic growth and PTSD symptoms could coexist, demonstrating that positive and negative post-trauma phenomena are not opposite ends of a single continuum (Shakespeare-Finch & Lurie-Beck, 2014). More recent longitudinal work has questioned whether perceived post-traumatic growth reliably represents objectively measured positive change. Park et al. (2023) found limited correspondence between perceived growth and measured changes in relevant psychosocial resources. PHCF should preserve the distinction between perceived growth and Demonstrated Adaptation and should never imply that successful recovery requires finding benefit, meaning or growth in traumatic experience. The Trauma and Stressor Presentation Module can consequently be more specific than a generic resilience assessment. The evidence supports attention to context-sensitive regulation, changing responses to safety and threat, relational resources, flexible adaptation and adaptation demonstrated across time. Demonstrated Adaptation can preserve the historical value of strategies that were effective under previous danger while allowing their usefulness in the present environment to be assessed separately. Hypervigilance, avoidance or rapid threat detection may have served an important protective function in genuinely dangerous circumstances. Their historical adaptive value should not automatically establish their current usefulness when environmental conditions have changed. The evidentiary question for PHCF is not whether trauma-related adaptation, social resources and flexible responding are clinically meaningful. Existing research supports those propositions. The remaining question is whether PHCF can organise them in a way that contributes useful information beyond trauma diagnosis, symptom severity, functioning and existing trauma assessment. Compared with some other Clinical Presentation Modules, trauma provides a relatively strong case for additional specificity because the relationship between past threat, present safety, contextual resources and demonstrated adaptation may not be represented adequately by a transdiagnostic positive-health profile alone. Trauma-related recovery requires attention to both the capacities of the person and the context in which previous and current adaptations occur. Figure 8.3 integrates the evidence concerning safety, relational trust, flexible adaptation and ecological resources while preserving the distinction between adversity exposure, adaptation and post-traumatic growth.

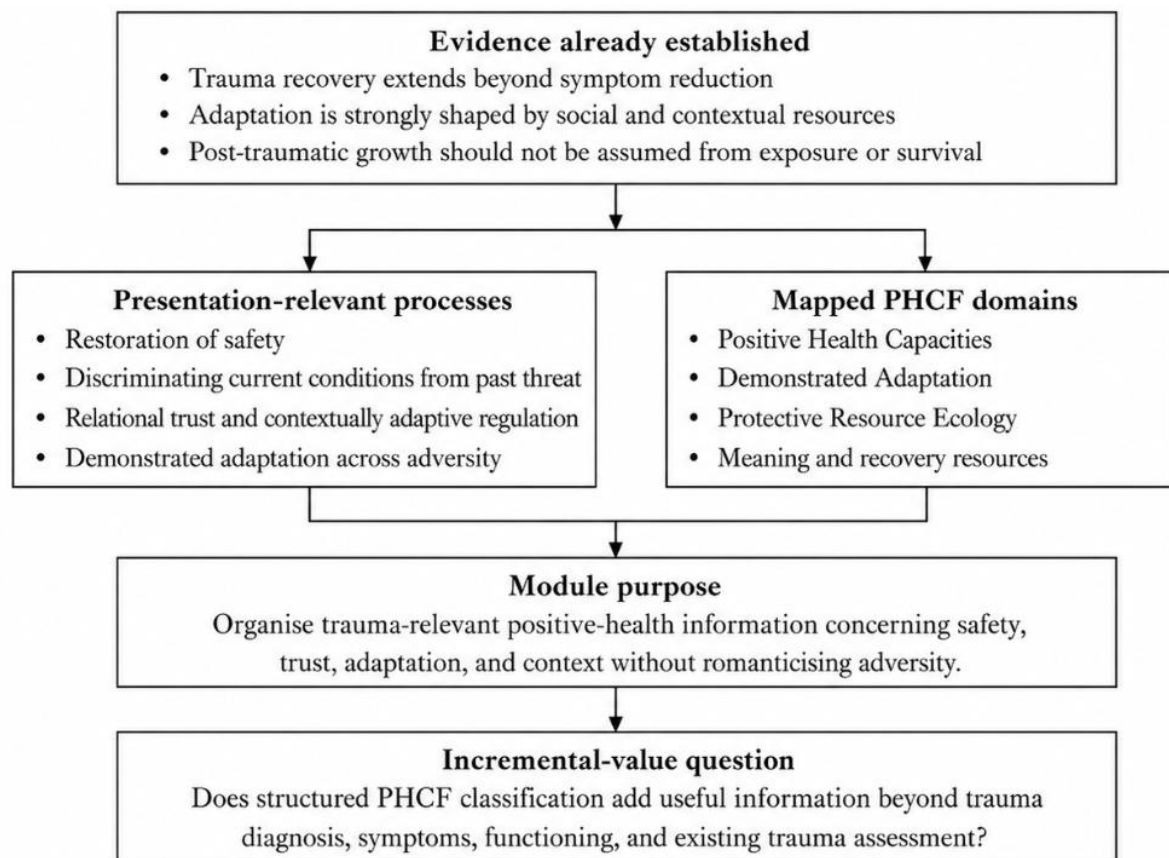


Figure 8.3. *Trauma and Stressor Presentation Module within PHCF. Trauma-related positive-health assessment integrates context-sensitive regulation, restoration of safety, relational resources, Demonstrated Adaptation and Protective Resource Ecology without assuming that exposure or survival necessarily produces growth.*

Bipolar and Mood-Instability Presentations

Bipolar disorder provides a particularly important test of PHCF because positive health cannot be inferred from positive mood or increased activity. Elevated mood, confidence, energy and goal-directed behaviour may form part of mania or hypomania, meaning that greater positive affect cannot automatically be interpreted as stronger positive health. Conversely, the absence of an acute mood episode does not establish restoration of wellbeing. A 2026 systematic review and meta-analysis of 27 studies involving 2,055 people with euthymic bipolar disorder found significantly poorer quality of life across physical, psychological, social and environmental domains compared with healthy controls. The finding supports the PHCF principle that current symptom state, functioning, quality of life and positive health provide related but non-equivalent information (Wang et al., 2026). Bipolar-specific recovery research provides stronger evidence for information that extends beyond conventional symptom assessment. Jagfeld et al. (2021) synthesised qualitative studies of personal recovery in bipolar disorder using the CHIME framework. Connectedness, hope, identity, meaning and empowerment remained relevant, but bipolar recovery also involved distinctive tensions concerning elevated mood, self-management, medication, work and other valued roles. The resulting POETIC framework retained Purpose and meaning, Optimism and hope, Empowerment, Identity and Connectedness while adding *Tensions* to capture the coexistence of valued and difficult aspects of bipolar experiences. The findings demonstrate that recovery in bipolar disorder includes clinically meaningful positive and negative

experiences that cannot be represented adequately by mood-state classification alone. A broader systematic review reached similar conclusions. Chirio-Espitalier et al. (2022) identified 24 studies specifically examining personal recovery in bipolar disorder and found that personal recovery was only weakly related to symptomatology. Meaning in life, self-determination, hope and reduced self-stigma were important across severe mental illness, while bipolar-specific recovery processes included the person's relationship with mood fluctuations, acceptance, reduced hypervigilance concerning mood change, trust and openness to others. The review also identified the importance of communication with clinicians and knowledge gained through peers. These findings provide direct support for PHCF's distinction between psychiatric symptoms and positive-health capacities while also indicating that bipolar presentations may require some presentation-specific elaboration.

Mood-State Awareness and Recovery Self-Management

Recognition and management of emerging episodes provide one of the clearest evidence-supported candidates for bipolar-specific PHCF information. Interventions that teach people to recognise early warning signs have long been associated with longer time to recurrence and reduced hospitalisation, although these strategies are often delivered as part of broader psychological interventions and their independent effects are difficult to isolate. Psychoeducation provides further support. Bond and Anderson (2015) reviewed 16 randomised controlled trials and found evidence that psychoeducation reduced overall and manic or hypomanic relapse, particularly in group interventions, although effects varied across outcomes and depressive relapse was not consistently reduced. More recent evidence also indicates modest relapse-prevention effects for self-help interventions in bipolar disorder, although certainty remains low (Lo et al., 2024). The PHCF-relevant phenomenon is not simply adherence to psychoeducation or possession of factual knowledge about bipolar disorder. It is the capacity to recognise personally meaningful changes, interpret them in relation to previous episodes and mobilise an adaptive response. A person who recognises that reduced sleep, increasing activity and accelerating thought have previously preceded mania, contacts their treating team and modifies activity accordingly is demonstrating presentation-specific Recovery and Self-Management Capacity. Previous successful use of that knowledge can additionally contribute to Demonstrated Adaptation.

Sleep and Early-Warning Information

Sleep provides particularly strong evidence for this approach. Ulrichsen et al. (2025) systematically reviewed 17 publications representing 13 prospective studies and found that changes in sleep frequently preceded predictable changes in mood. Longer sleep, earlier sleep onset and later waking were generally followed by more depressive mood, while changes in the opposite direction were associated with mania. The authors concluded that sleep changes may provide useful early-warning information, although heterogeneity prevented meta-analysis. A separate 2025 systematic review and meta-analysis involving 44 studies also demonstrated significant sleep abnormalities across bipolar mood phases, including persisting sleep-quality problems during euthymia (Marchetti et al., 2025). These findings clarify the PHCF construct. Regular sleep is not itself a positive-health classification. The relevant positive-health information concerns whether the person knows their own sleep and mood patterns, can detect meaningful departures from those patterns and can act on that information when required. This distinction separates a clinical indicator from the capacity to use it adaptively.

Personal Recovery and Identity Across Mood States

The bipolar literature also provides evidence that recovery involves the person's relationship with mood experiences and identity rather than symptom control alone. Jagfeld et al. (2021) identified tensions within bipolar recovery concerning experiences that may be simultaneously valued and

destabilising. Chirio-Espitalier et al. (2022) similarly identified acceptance of mood variation, reduced hypervigilance, self-determination and interpersonal openness as relevant recovery processes. It is particularly relevant to PHCF because mania and hypomania can complicate simple interpretations of positive experience. Increased confidence, creativity, productivity, sociability or subjective wellbeing may be experienced positively while occurring within a clinically significant episode. PHCF should assess Meaning and Identity Capacity, Agency and Current Positive Health State in relation to mood state and longitudinal context rather than equating their momentary behavioural expression with positive health. The existence of the Bipolar Recovery Questionnaire provides further evidence that bipolar-specific personal recovery can be measured separately from conventional symptom outcomes. Jones et al. (2013) developed the measure from recovery literature and qualitative work with people with bipolar disorder. Recovery scores were associated with mood, wellbeing, functioning and personal growth but were not reducible to any one of those variables.

The Role of the Bipolar and Mood-Instability Module

The evidence supports a relatively focused Bipolar and Mood-Instability Presentation Module. Most positive-health information remains appropriately located within the PHCF Universal Core. Agency, relationships, meaning, psychological flexibility, adaptive regulation and protective resources are not unique to bipolar disorder. The presentation-specific contribution is stronger in mood-state awareness and longitudinal self-management. The module can record whether the person recognises personally characteristic early-warning patterns, understands relationships among sleep, activity, thought and mood, knows which responses have previously assisted, can mobilise support when deterioration emerges and has demonstrated effective management across previous episodes. It can also preserve recovery information concerning identity and the person's relationship with mood fluctuations without treating elevated positive affect as evidence of positive health. The evidentiary question for PHCF is no longer whether bipolar recovery extends beyond symptom control. Existing research demonstrates that it does. Nor is it necessary to establish whether early-warning recognition and self-management are clinically relevant. Evidence already supports those processes. The remaining question is whether organising this information systematically within PHCF adds incremental value beyond diagnosis, mood monitoring, relapse-prevention plans, functioning assessment and existing personal-recovery measures. That is the appropriate test for retaining a Bipolar and Mood-Instability Clinical Presentation Module. Bipolar presentations demonstrate why positive affect cannot itself function as an indicator of positive health. Figure 8.4 instead locates the most clinically relevant positive-health information in longitudinal self-management, recognition of personally meaningful mood-state changes and adaptive use of accumulated recovery knowledge.

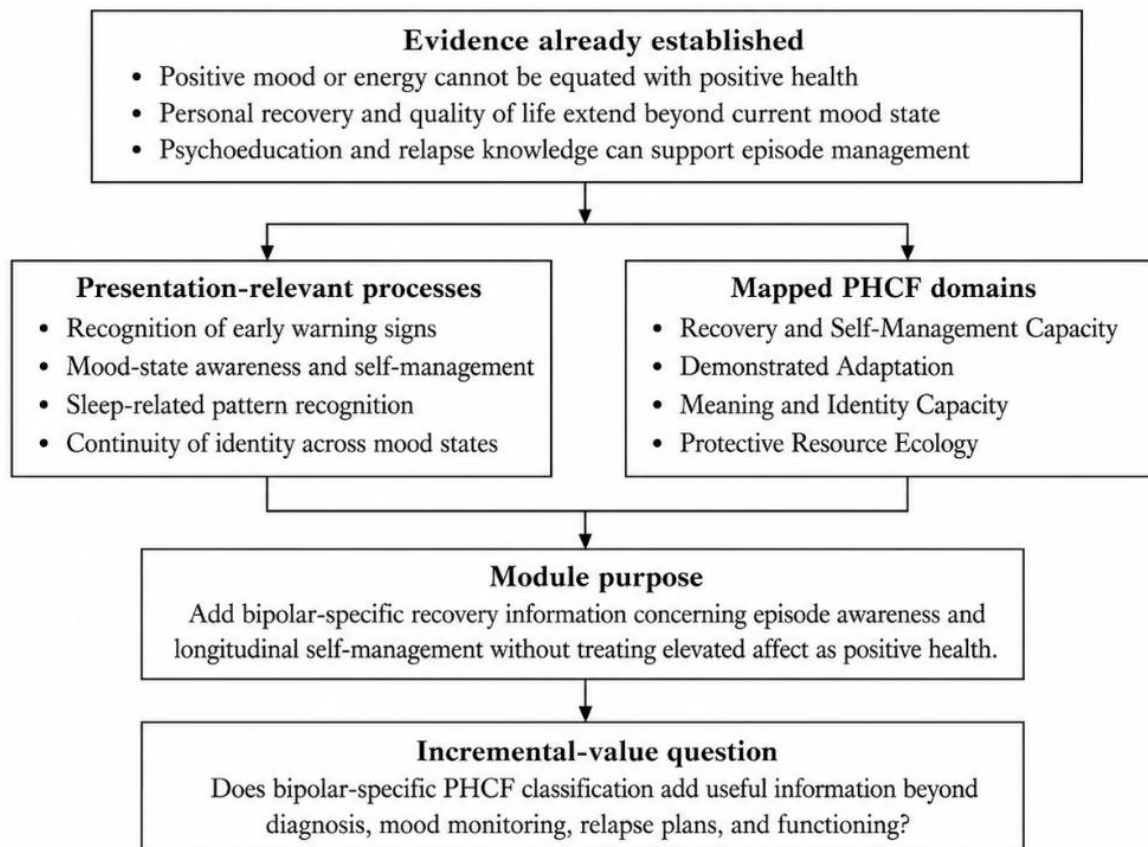


Figure 8.4. *Bipolar and Mood-Instability Presentation Module within PHCF. The module emphasises evidence-supported mood-state awareness, early-warning recognition and longitudinal self-management while maintaining a clear distinction between elevated mood and positive health.*

Psychosis Presentations

Psychosis provides one of the strongest demonstrations of the need to distinguish clinical recovery from positive and personal recovery. Symptom reduction is important, but it does not adequately describe whether a person has hope, agency, identity, meaning, relationships or the capacity to pursue a valued life. Van Eck et al. (2018) found only a small association between overall symptom severity and personal recovery in schizophrenia-spectrum disorders ($r = -.21$), with similarly small associations for positive and negative symptoms. Leendertse et al. (2021) subsequently found substantially stronger associations between personal recovery and hope ($r = .56$), empowerment ($r = .53$) and meaning in life ($r = .48$) than between personal recovery and positive or negative psychotic symptoms, both $r = -.22$. These findings provide strong empirical support for the PHCF principle that psychopathology and positive-health phenomena are related but non-equivalent and require separate assessment. Much of the established personal-recovery evidence maps directly onto the PHCF Universal Core. Hope, identity, meaning, empowerment and connectedness correspond with Current Positive Health State and capacities concerned with Agency, Meaning and Identity, and Relational Capacity. Qualitative evidence reinforces these relationships. Murray and Menadue (2024), synthesising 11 studies of lived recovery experiences in psychosis, identified connection with the self and connection with the social world as an overarching theme, alongside restoration and transformation of identity and personally defined meaning. These findings indicate that recovery cannot appropriately be inferred from clinician-rated psychopathology or externally defined functioning alone. Psychosis nevertheless contains presentation-specific information that may justify a focused Clinical Presentation

Module. One such area concerns the person's relationship with unusual experiences. A systematic review and thematic synthesis of voice-hearing recovery found that recovery could occur despite continuing voices and involved changing relationships with those experiences, including acceptance, integration, sense-making, connection with others, empowerment and development of a more positive identity (Hall et al., 2023). More recent evidence demonstrates the diversity of explanations people use to understand psychotic experiences. Ingall et al. (2025), synthesising 25 studies involving 682 participants across 15 countries, identified medical, traumatic, emotional, spiritual and other explanatory frameworks, with many participants holding several explanations simultaneously. This supports a PHCF approach that records the person's capacity to understand, contextualise and respond to unusual experiences without requiring the clinician to impose a single interpretation of their meaning.

A second evidence-supported area concerns recognition and management of deterioration. Gleeson et al. (2024) reviewed 72 studies involving 6,903 people with schizophrenia-spectrum disorders and found that changes in sleep, mood and suspiciousness were important antecedents of symptom worsening. Early-warning-sign approaches predicted relapse with pooled sensitivity of 71% and specificity of 64%. For PHCF, the relevant positive-health phenomenon is not the warning sign itself, but whether the person can recognise personally characteristic changes, interpret them in relation to previous episodes and mobilise an adaptive response. This information can be represented through Recovery and Self-Management Capacity and, where the person has previously acted effectively on such knowledge, through Demonstrated Adaptation. The intervention literature further establishes that positive and personal recovery outcomes deserve direct attention. Isaacs et al. (2022) reviewed 21 systematic reviews examining 13 forms of personal-recovery facilitators for schizophrenia and other psychoses. Most intervention research addressed hope and connectedness, while identity, empowerment and meaning were assessed considerably less often; only one included review directly measured personal recovery across the CHIME framework. The evidence demonstrates both an established recovery literature and an important measurement gap: interventions may influence positive dimensions of recovery that are not routinely captured when outcomes remain dominated by symptoms, hospitalisation and conventional functioning.

The Psychosis Presentation Module should add specificity without duplicating either psychosis diagnosis or the PHCF Universal Core. Its strongest evidence-supported contribution concerns the person's relationship with unusual experiences, personally meaningful explanations of those experiences, recognition of individual deterioration patterns and the capacity to respond adaptively when those patterns emerge. The Universal Core can continue to classify hope, agency, identity, meaning, relational capacity and protective resources, while the presentation module records how these capacities operate specifically in relation to psychotic experiences. The evidentiary question for PHCF is consequently no longer whether people can experience personal recovery while psychotic symptoms persist; the evidence clearly establishes that they can. Nor is it necessary to speculate that meaning, identity, hope, self-management and social connection matter in psychosis recovery. These phenomena are already well supported. The remaining question is whether systematically organising presentation-specific recovery information alongside diagnosis and symptom assessment adds incremental value to formulation, treatment planning, relapse management, communication and longitudinal care. Psychosis is a particularly strong test of the PHCF proposition that describing psychopathology and describing positive health are complementary clinical tasks rather than competing accounts of the person. Psychosis provides particularly strong evidence that symptom severity and personal recovery describe related but non-equivalent aspects of clinical experience. Figure 8.5 shows how presentation-specific information concerning unusual experiences and deterioration patterns can be integrated with established PHCF capacities relating to identity, relationships, agency and recovery self-management.

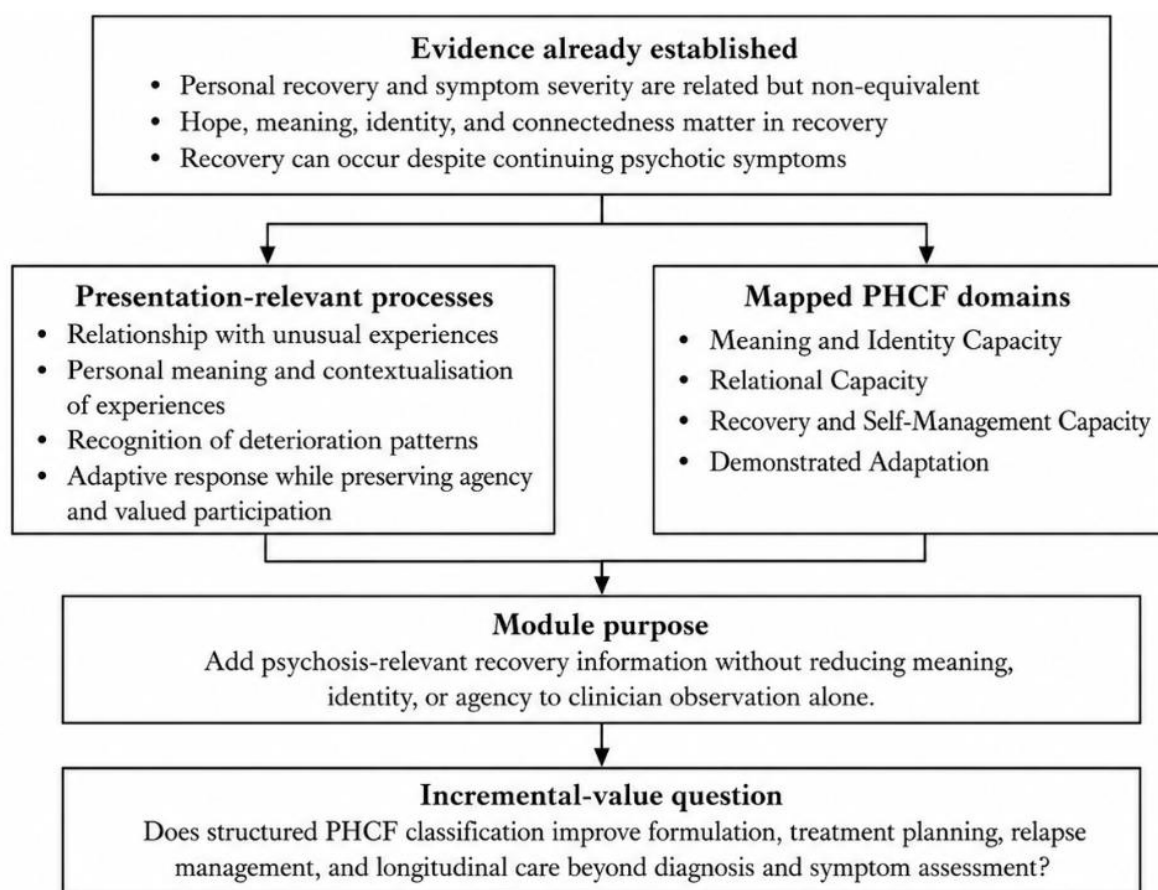


Figure 8.5. *Psychosis Presentation Module within PHCF. Personal meaning, relationships with unusual experiences, early recognition of deterioration and adaptive self-management supplement symptom assessment while preserving hope, identity, meaning and agency as independently assessed positive-health phenomena.*

Substance and Addictive Presentations

Substance-use presentations provide one of the strongest existing foundations for a PHCF Clinical Presentation Module because the field has already developed a substantial strengths-and-resources-based literature alongside conventional assessment of substance use, dependence and harm. Recovery capital describes personal, social, material and community resources that can be brought to bear on the initiation and maintenance of recovery. Bunaciu et al. (2024) identified 69 quantitative studies and ten dedicated recovery-capital measures encompassing 41 distinct constructs. Housing and health appeared in nine of the ten measures, social support in eight, and financial circumstances, recovery support, community involvement, education and training among other frequently represented domains. Recovery capital provides direct empirical precedent for systematically assessing what resources and strengths are available to support recovery rather than describing substance-related pathology alone. At the same time, the substantial overlap and heterogeneity among existing measures demonstrates the need for greater conceptual organisation rather than another broad inventory of strengths (Bunaciu et al., 2024).

Recovery Capital and Protective Resource Ecology

Recovery capital maps particularly strongly onto PHCF's Protective Resource Ecology, but the two constructs should not be treated as interchangeable. Existing recovery-capital measures include

housing, financial resources, social support, community participation, recovery-supportive networks, education, health and other resources that correspond closely with relational, material, community and structural components of the PHCF ecology. The Assessment of Recovery Capital was developed specifically as a complement to deficit-based addiction assessment and outcome monitoring, providing early psychometric evidence that recovery strengths could be assessed systematically (Groshkova et al., 2013). More recent evidence confirms substantial measurement development while also showing that psychometric evidence across diverse cultural and demographic populations remains incomplete (Bunaciu et al., 2024). PHCF adds an important distinction to this literature. Possession of recovery capital does not necessarily establish that a resource is currently protective. Stable housing, family relationships, employment, peer networks or community membership may be available but inaccessible, unusable, harmful in a particular context or insufficiently mobilised. A Substance-Use Presentation Module can retain established recovery-capital information while distinguishing resource availability from accessibility, usability, mobilisation and demonstrated protective effect. This provides a potential bridge between the mature recovery-capital literature and the broader PHCF Protective Resource Ecology.

Social Connection and Recovery Identity

Recovery from substance use is also strongly social. Vigdal et al. (2022) synthesised 18 qualitative studies of people in sustained substance-use recovery and found that safe, non-stigmatising communities contributed to positive self-change, development of trust and relationship skills, social dignity and a renewed sense of citizenship. The findings indicate that recovery is not adequately represented as an intrapersonal process of resisting substance use; relationships and participation in recovery-supportive communities can form part of the recovery process itself. Identity change provides an especially well-developed presentation-specific phenomenon. Donaldson et al. (2023) systematically reviewed 32 studies and found that movement from a substance-use identity toward a recovery identity was repeatedly described as part of recovery, supported through social relationships, therapeutic and community groups, changes in social networks and opportunities to reclaim valued social roles. Their synthesis characterised addiction recovery as a socially mediated process involving connections, identity and citizenship. This evidence maps onto PHCF Meaning and Identity Capacity, Relational Capacity and Protective Resource Ecology while demonstrating how these universal constructs acquire particular significance within substance-use recovery. Importantly, PHCF should not require adoption of a particular *recovery identity*. Some people may identify as being “in recovery”, others may describe themselves without reference to previous substance use, and others may pursue change without adopting a recovery identity at all. The relevant positive-health information concerns whether the person's current identity, relationships, roles and environments support their chosen direction. The framework should classify the underlying adaptive phenomenon rather than conformity to a particular recovery culture.

Recovery Beyond Abstinence

The substance-use literature also provides strong support for separating recovery from the simple inverse of disorder. Abstinence, reduced use and remission are important clinical outcomes, but contemporary recovery frameworks generally encompass broader changes in health, functioning, wellbeing, relationships and valued participation. A systematised review concluded that addiction recovery is broader than abstinence alone and includes health, quality of life, meaning, citizenship and pursuit of wider life goals. Similarly, the NIAAA research definition of recovery from alcohol use disorder incorporates both remission and cessation of heavy drinking while explicitly including biopsychosocial functioning and quality of life; it permits a non-abstinent recovery pathway (Hagman et al., 2022). The distinction is highly compatible with PHCF. PHCF does not determine whether

abstinence, reduction in use, medication-assisted treatment or another clinical goal constitutes the appropriate treatment objective. Substance use, diagnostic status, intoxication risk, withdrawal, harm and remission remain matters for established clinical assessment. PHCF instead asks what positive-health capacities, demonstrated adaptations and recovery-supportive resources are present and capable of supporting the person's clinically appropriate and personally meaningful recovery goals.

The Role of the Substance-Use Presentation Module

The Substance-Use Presentation Module enters PHCF with a stronger empirical foundation than many other proposed modules. The evidence already establishes the clinical relevance of recovery capital, social environments, supportive communities, recovery-related identity processes and broader recovery outcomes. PHCF does not need to recreate these constructs. Its task is to determine how they can be integrated coherently within the Universal Core. Protective Resource Ecology can accommodate much of recovery capital; Relational Capacity can represent the ability to establish and use supportive relationships; Meaning and Identity Capacity can capture identity reconstruction and valued social roles; Recovery and Self-Management Capacity can represent knowledge and strategies used to sustain change; and Demonstrated Adaptation can record evidence that these capacities and resources have previously been mobilised successfully. The presentation-specific contribution is consequently likely to concern the configuration of these domains around substance-use recovery: the person's recovery-supportive and substance-use-related social networks, environmental exposure to use, recovery identity where personally relevant, access to recovery communities, accumulated knowledge of high-risk situations and strategies for maintaining chosen recovery goals. These features have a developed empirical foundation and are sufficiently characteristic of substance-use recovery to justify testing as module-level information. The remaining evidentiary question is not whether recovery resources, identity and social context matter. The literature clearly establishes that they do. The question for PHCF is whether organising this established recovery evidence within a common positive-health classification adds useful information beyond substance-use diagnosis, severity, treatment outcomes and existing recovery-capital instruments. Substance-use presentations may provide one of the clearest demonstrations of how a well-developed presentation-specific evidence base can be nested beneath the PHCF Universal Core without either duplicating that literature or forcing it into a new diagnostic category. A further boundary is important: much of this evidence concerns alcohol and drug use disorders, and the Bunaciu et al. (2024) review explicitly excluded other forms of addiction. Application of the same module architecture to gambling, gaming or other behavioural addictions should require separate evidence rather than being assumed from the substance-use literature. Substance-use recovery provides an unusually developed evidence base for presentation-specific positive-health assessment through the recovery-capital literature. Figure 8.6 shows how this established literature can be nested within PHCF while preserving distinctions among resources, capacities, identity processes and demonstrated recovery adaptation.

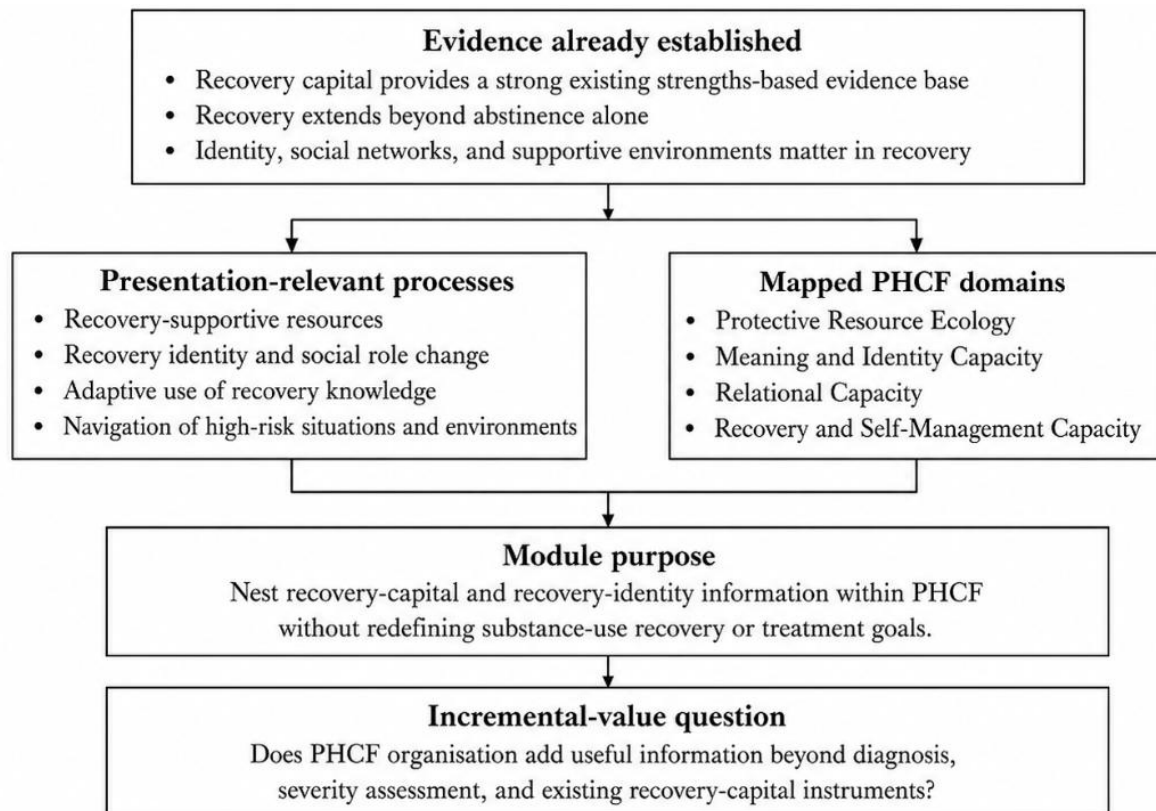


Figure 8.6. *Substance and Addictive Presentation Module within PHCF. Recovery capital, recovery-supportive social environments, identity processes and self-management can be organised across Protective Resource Ecology and other PHCF domains without redefining substance-use recovery or treatment goals.*

Obsessive-Compulsive Presentations

Obsessive-compulsive disorder provides an important test of parsimony within PHCF. OCD is associated with substantial impairment beyond the presence of obsessions and compulsions. A systematic review and meta-analysis of 13 studies involving 26,015 participants found significantly poorer quality of life among people with OCD, with particularly large effects in emotional, work and social, and family domains (Coluccia et al., 2016). More recent treatment evidence also demonstrates that improvement in obsessive-compulsive symptoms does not necessarily produce equivalent improvement in quality of life. Dos Santos-Ribeiro et al. (2025), reviewing 19 randomised controlled trials, found that some interventions reduced OCD symptoms without corresponding improvement in quality of life, while CBT-based interventions produced clearer quality-of-life benefits. This supports the PHCF principle that symptom change and broader positive-health outcomes should be assessed separately. The strongest PHCF-relevant evidence concerns the person's capacity to experience difficult internal events without organising behaviour around avoidance or compulsive responding. Angelakis and Pseftogianni (2021) synthesised 36 studies involving 11,859 participants and found a moderate association between OCD and experiential avoidance ($SMD = 0.75$), with associations also evident across specific obsessive-compulsive symptom dimensions. A much larger transdiagnostic meta-analysis of 441 studies involving 135,347 participants similarly found experiential avoidance associated with obsessive-compulsive and related disorders as well as depression, anxiety and PTSD (Akbari et al., 2022). These findings support the clinical importance of flexible responding to unwanted thoughts and emotions, but they also indicate that this process is not specific to OCD.

This distinction is important for PHCF. Exposure and response prevention can help a person encounter intrusive thoughts, uncertainty or feared situations while reducing compulsive responses, but successful performance of exposure or response prevention should not itself become a positive-health classification. The PHCF-relevant phenomenon is broader: whether the person can experience intrusive thoughts, distress or uncertainty while retaining sufficient Psychological Flexibility, Adaptive Regulation and Agency to choose behaviour that is not entirely governed by those experiences. Evidence that mindfulness- and acceptance-based approaches can increase psychological flexibility and that increases in flexibility are associated with OCD symptom improvement provides additional support for this interpretation (Bürkle et al., 2025). Intolerance of uncertainty provides a similar example. Although uncertainty is highly relevant to many obsessive-compulsive presentations, it should not automatically become an OCD-specific PHCF capacity. McEvoy et al. (2019) synthesised 181 studies involving 52,402 participants and found a robust moderate association between intolerance of uncertainty and psychopathology ($r = .51$), but the association extended across generalised anxiety, social anxiety, panic, agoraphobia, OCD, depression and eating disorders. The evidence supports uncertainty-related responding as a transdiagnostic phenomenon, strengthening the case for locating it within broader PHCF constructs such as Psychological Flexibility or Adaptive Regulation rather than creating an OCD-specific positive-health construct.

The Obsessive-Compulsive Presentation Module should remain deliberately small. Existing evidence supports assessment of quality of life and valued participation separately from symptom severity, and it supports flexible responding, reduced experiential avoidance and adaptive engagement with uncertainty as clinically relevant processes. However, much of this information maps directly onto the PHCF Universal Core. Psychological Flexibility can capture the ability to remain in contact with difficult internal experiences without rigid behavioural control; Adaptive Regulation can represent modification of ineffective responses; Agency can capture movement toward chosen action despite intrusive experiences; and Current Positive Health State can record restoration of engagement and valued direction. The evidentiary question for PHCF is consequently not whether adaptive responding to intrusive thoughts and uncertainty matters in OCD. Existing research demonstrates that it does. The more important question is whether any presentation-specific positive-health information remains after the Universal Core has been assessed. Current evidence provides stronger support for transdiagnostic capacities than for a distinct OCD-specific positive-health construct. OCD may demonstrate an important design principle of PHCF: a Clinical Presentation Module should not be created merely because a diagnostic condition exists. If the Universal Core captures the clinically meaningful positive-health information adequately, the appropriate OCD module may be minimal or unnecessary. Such a result would provide positive evidence for the parsimony and transdiagnostic architecture of PHCF rather than represent a limitation of the framework. Obsessive-compulsive presentations provide an important test of whether a Clinical Presentation Module is required at all. Figure 8.7 demonstrates many evidence-supported adaptive processes associated with OCD appear to map directly onto transdiagnostic PHCF capacities rather than requiring a separate positive-health classification.

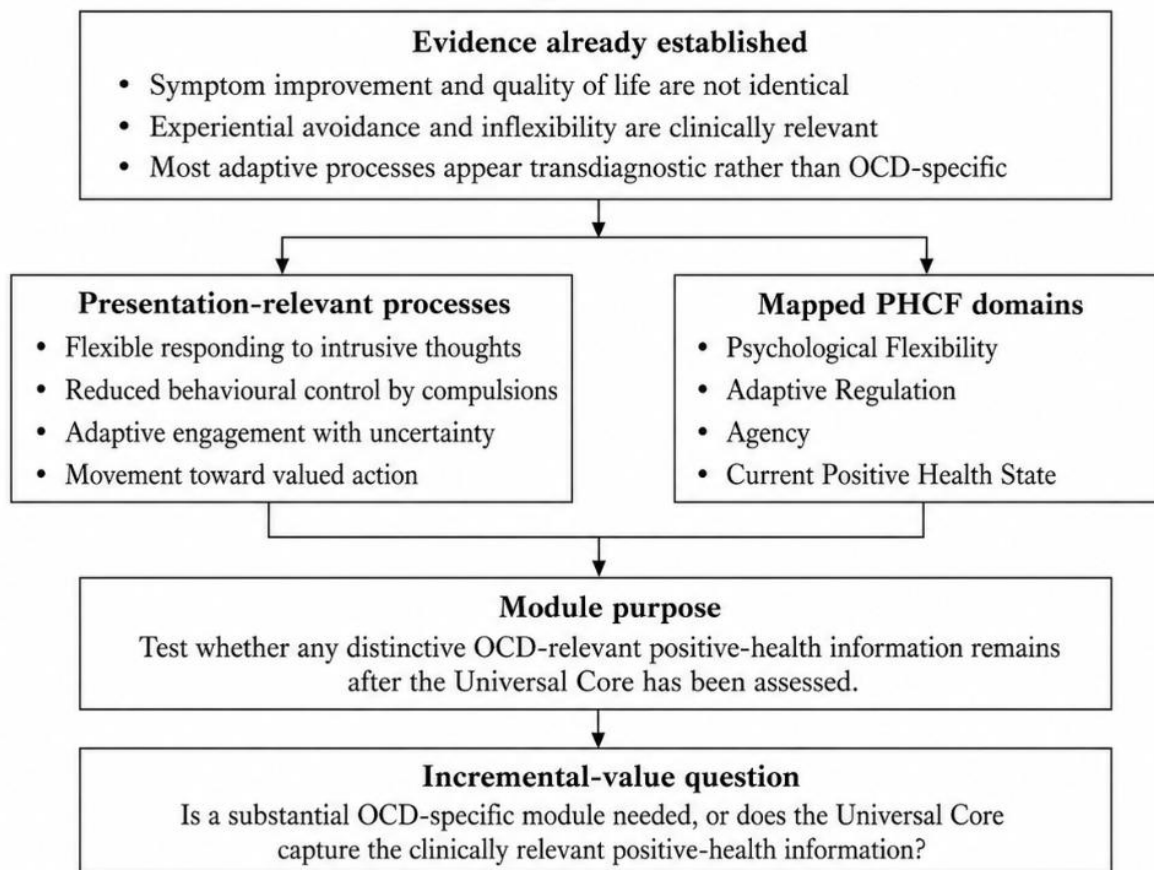


Figure 8.7. *Eating and Feeding Presentation Module within PHCF. Eating-disorder recovery involves identity beyond the disorder, relational autonomy, self-compassion, valued-life re-engagement and contextual influences, providing presentation-specific expressions of Agency, Meaning and Identity Capacity, Relational Capacity and Protective Resource Ecology.*

Eating and Feeding Presentations

Eating-disorder presentations provide a strong case for distinguishing symptom remission from positive and personal recovery. The literature consistently indicates that recovery involves more than reduction in eating-disorder behaviours, cognitions or physical symptoms. De Vos et al. (2017) synthesised 18 qualitative studies of people who considered themselves recovered and found strong support for positive relationships, self-acceptance, autonomy, personal growth and self-adaptability or resilience alongside improvement in eating-disorder pathology. Positive relationships appeared in all included studies, self-acceptance in 88.9%, autonomy in 83.3%, and personal growth and self-adaptability in 77.8%. Psychological wellbeing accounted for substantially more of the identified recovery criteria than eating-disorder pathology. These findings provide unusually direct support for the PHCF proposition that psychopathology and positive-health phenomena should be assessed as related but distinct dimensions. Wetzler et al. (2020) subsequently synthesised 20 studies specifically from lived-experience perspectives and identified six central components of personal recovery: supportive relationships, hope, identity, meaning and purpose, empowerment and self-compassion. Symptom recovery remained important, but did not encompass the whole recovery process. The substantial correspondence with PHCF is evident. Supportive relationships map onto Relational Capacity and Protective Resource Ecology; empowerment onto Agency; identity and meaning onto Meaning and Identity Capacity; and self-compassion and broader psychological adaptation onto Current Positive

Health State and Positive Health Capacities. The evidence establishes that these phenomena are integral to eating-disorder recovery rather than hypothetical additions to conventional symptom assessment.

Identity, Expansion and Recovery

Identity appears to have particular presentation-specific importance. Eating disorders can become deeply intertwined with self-concept, routines, relationships and valued roles, making recovery partly a process of developing a life and identity that are no longer organised predominantly around the disorder. Recent lived-experience research strengthens this interpretation. LaMarre et al. (2024) described recovery as an expansion from a constrained world toward broader relationships, interests, values and ways of living. Participants described discovering who they were becoming rather than simply returning to a pre-illness self. Recovery was simultaneously individual, relational and socially situated, with support, autonomy, weight stigma and diet culture influencing the process. For PHCF, the relevant information is not whether a person has developed a particular socially preferred identity. Meaning and Identity Capacity can describe whether the person is increasingly able to construct and sustain a sense of self, values and valued direction that is not wholly organised by the eating disorder. Demonstrated Adaptation may record evidence of this process across time, such as re-engagement with relationships, interests, education, work or other personally meaningful activities. The eating-disorder presentation provides a particularly clear example of why positive-health classification should concern the person's developing capacities and lived experience rather than simply defining recovery as the disappearance of pathology.

Autonomy Within Relationships and Treatment

Autonomy is also supported strongly enough to move beyond speculative treatment in PHCF. Its interpretation, however, is unusually complex in eating-disorder care because severe presentations can involve substantial medical risk and periods in which external intervention or treatment structure is necessary. Burke et al. (2024) reviewed 20 studies concerning autonomy in longstanding and severe eating disorders and identified four interconnected themes: Self versus ED, Self in Treatment, Self in Recovery and Others in Relation to Self. Their analysis emphasised relational autonomy: agency develops and is exercised in interaction with supportive others rather than necessarily through complete independence. This distinction is important for PHCF. Agency should not be classified simply according to how much independent control a person exercises over food, treatment or clinical decisions. In some circumstances, accepting assistance, negotiating treatment, relying on trusted others or gradually assuming greater responsibility may represent substantial agency. Conversely, apparent independence does not necessarily indicate stronger positive health. The Eating and Feeding Presentation Module can specify how Agency is expressed within the particular relational and safety context of eating-disorder recovery without weakening the separate clinical importance of medical risk, nutritional restoration or established treatment requirements.

Self-Compassion, Relationships and Context

The recovery literature also supports the importance of self-compassion and supportive relationships. Wetzler et al. (2020) identified self-compassion as a central component that was not fully represented by the generic CHIME recovery framework, suggesting some additional eating-disorder relevance. At the same time, relationships were consistently prominent across both Wetzler et al. (2020) and de Vos et al. (2017). More recent research extends the analysis beyond the individual. LaMarre et al. (2024) found recovery processes intertwined with relational and systemic environments, including experiences of diet culture and weight stigma. These findings align particularly strongly with Protective Resource Ecology. Social environments may facilitate recovery by supporting autonomy, identity,

connection and valued participation, while environments characterised by stigma, exclusion or persistent weight-focused expectations may constrain those capacities. PHCF can avoid interpreting difficulties arising within harmful environments solely as deficits within the person.

The Role of the Eating and Feeding Presentation Module

The evidence supports a focused Eating and Feeding Presentation Module rather than simply duplicating the Universal Core. Most recovery phenomena remain appropriately classified within universal PHCF domains: Agency, Relational Capacity, Meaning and Identity Capacity, Adaptive Regulation, Current Positive Health State, Demonstrated Adaptation and Protective Resource Ecology. The presentation-specific contribution lies in how these domains become configured around the eating disorder. The module can organise evidence concerning identity beyond the disorder, relational autonomy during treatment and recovery, self-compassion, restoration and expansion of valued life roles, supportive and constraining relationships, and broader social conditions affecting recovery. These phenomena should be assessed alongside, not instead of, eating-disorder symptoms, physical health, nutritional status, medical risk and functional impairment. The evidentiary question for PHCF is consequently no longer whether eating-disorder recovery includes positive-health phenomena beyond symptom remission. Multiple systematic syntheses and lived-experience studies establish that it does. The remaining question is whether organising these phenomena systematically within PHCF adds incremental clinical value beyond eating-disorder diagnosis, symptom assessment, physical and nutritional assessment, functioning measures and existing recovery approaches. Eating disorders provide one of the stronger cases for a Clinical Presentation Module, particularly because identity, relational autonomy and recovery context may require greater specificity than the Universal Core alone provides. One boundary should nevertheless remain explicit. The strongest evidence currently concerns anorexia nervosa and the broader eating-disorder recovery literature. Research concerning ARFID and other feeding presentations is substantially less developed. Emerging lived-experience research in adults with ARFID identifies clinically important tensions between safety and freedom, but the evidence is not yet equivalent to the established eating-disorder recovery literature. The broader *Eating and Feeding Presentations* label should not be used to imply that the same positive-health configuration has already been demonstrated across all feeding and eating disorders. Eating-disorder recovery research identifies a substantial positive and personal recovery domain beyond symptom and nutritional recovery. Figure 8.8 shows how identity, relational autonomy, self-compassion, supportive relationships and recovery context can be organised within PHCF while remaining distinct from medical and symptom assessment.

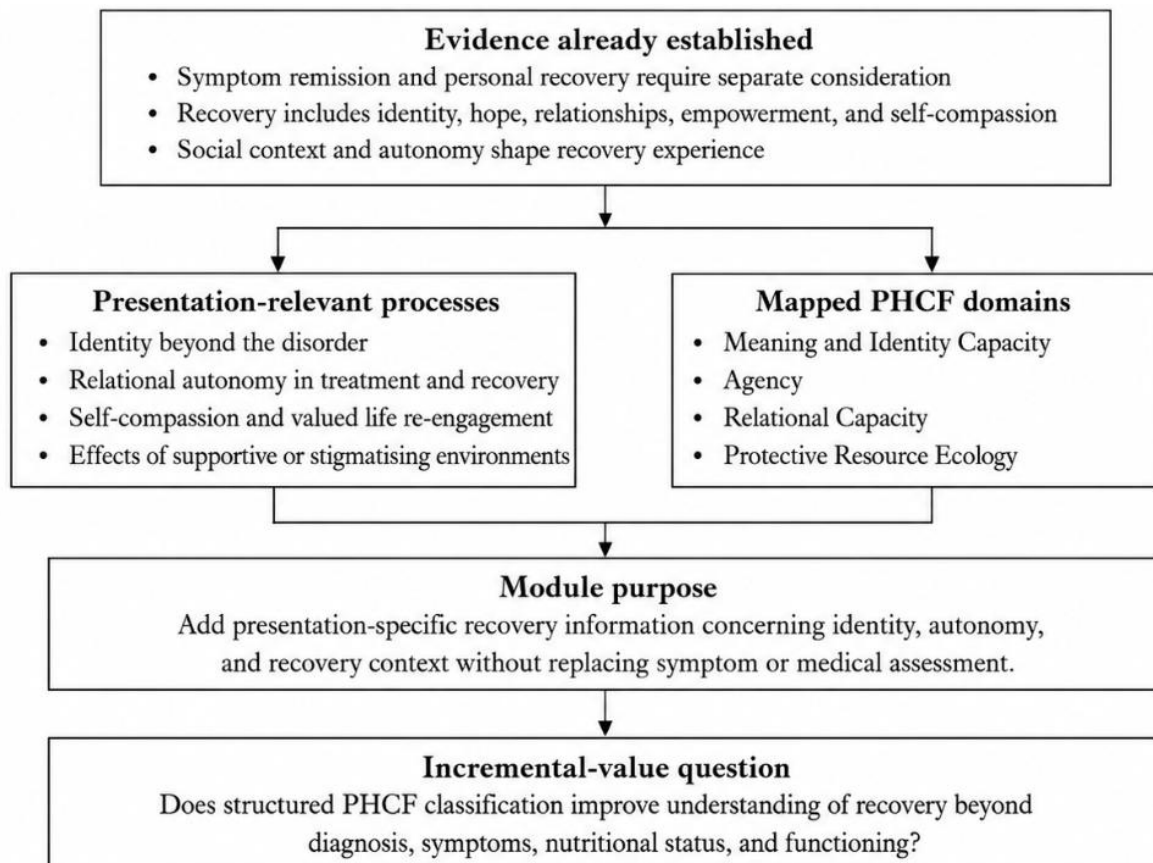


Figure 8.8. Eating and Feeding Presentation Module within PHCF. Eating-disorder recovery involves identity beyond the disorder, relational autonomy, self-compassion, valued-life re-engagement and contextual influences, providing presentation-specific expressions of Agency, Meaning and Identity Capacity, Relational Capacity and Protective Resource Ecology.

Personality Functioning and Interpersonal Presentations

Personality-related presentations require particularly careful treatment within PHCF because self and interpersonal functioning are already central components of contemporary personality-disorder classification. In the DSM-5 Alternative Model for Personality Disorders, Criterion A assesses impairment in identity, self-direction, empathy and intimacy, while ICD-11 similarly places disturbances in self and interpersonal functioning at the centre of personality-disorder severity (Sharp & Wall, 2021; Bach & Tracy, 2022). PHCF should not create positive versions of these diagnostic constructs by simply reversing impairment. Clear identity, goal direction, empathy or intimacy cannot automatically become PHCF classifications merely because impaired forms of those constructs contribute to personality-disorder diagnosis. The PHCF task is narrower: to identify positive-health capacities, resources and demonstrated adaptations that provide clinically useful information beyond the assessment of personality pathology itself.

Personal Recovery Beyond Symptomatic Remission

Existing recovery research nevertheless provides strong evidence that clinically meaningful change in personality-related presentations extends beyond loss of diagnostic criteria. Ng et al. (2016) systematically reviewed 19 longitudinal studies representing 11 cohorts and 1,122 people with borderline personality disorder. Symptomatic remission was common, but broader recovery involving meaningful work, relationships and psychosocial functioning was substantially less assured. The review

demonstrated an important distinction between no longer meeting diagnostic criteria and recovering a satisfying and functional life. This is directly compatible with the PHCF independence principle: improvement in psychopathology should not be assumed to establish positive health. Qualitative recovery evidence provides greater specificity. Shepherd et al. (2016) identified three higher-order themes in their systematic review and meta-synthesis of personality-disorder recovery: safety and containment, social networks and autonomy, and identity construction. Katsakou and Pistrang (2018), synthesising 14 qualitative studies of treatment and recovery in borderline personality disorder, similarly identified change involving greater self-acceptance and confidence, improved management of difficult thoughts and emotions, new ways of relating to others, practical life changes and development of hope. Recovery was experienced as an ongoing process involving achievements and setbacks rather than a binary transition from illness to health. These findings map substantially onto PHCF domains concerned with Agency, Adaptive Regulation, Relational Capacity, Meaning and Identity, Current Positive Health State and Protective Resource Ecology.

Relationships, Connectedness and Relational Capacity

Interpersonal recovery is particularly well supported. Di Bartolomeo et al. (2024) systematically reviewed 62 studies examining borderline personality disorder and social connectedness. Difficulties were identified across structural, functional and qualitative dimensions of relationships, with the strongest evidence concerning the quality of social connectedness. Importantly, people with borderline personality disorder were not necessarily unable to form relationships; difficulties were often located within the quality and experience of those relationships. This distinction is important for PHCF because Relational Capacity should not be reduced to the number of relationships a person possesses. It may instead concern capacities to establish, maintain, use and navigate relationships in ways that support connection while preserving selfhood and agency. Interpersonal functioning is also capable of changing through treatment. A 2026 systematic review and individual-participant-data meta-analysis identified 32 randomised trials involving 2,762 people with borderline personality disorder, with individual data available for 1,431 participants. Psychotherapy was associated with improvement in interpersonal difficulties, although the evidence contained substantial risk-of-bias and missing-data limitations (Pereira Ribeiro et al., 2026). The finding confirms interpersonal functioning as a clinically meaningful treatment domain while also reinforcing an important PHCF boundary: improvement in interpersonal pathology is not itself sufficient to establish a positive-health construct. PHCF needs to determine what adaptive relational capability is actually present and whether it contributes information beyond existing measures of interpersonal functioning.

Identity, Agency and Relational Recovery

Identity also occupies an unusually important position in personality presentations. Contemporary personality classification already includes identity disturbance within impairment in self-functioning, meaning that PHCF cannot simply classify the absence of identity disturbance as positive health (Sharp & Wall, 2021). Recovery studies nevertheless indicate a more developmental process in which people describe constructing or recovering a sense of self, increasing self-acceptance, developing autonomy and establishing relationships that allow greater personal agency (Shepherd et al., 2016; Katsakou & Pistrang, 2018). PHCF can distinguish identity pathology from positive identity capacity. The former concerns disturbance or impairment assessed within personality-disorder frameworks; the latter would concern the person's demonstrated capacity to sustain personally meaningful values, roles and direction while adapting to changing relationships and circumstances. This distinction also clarifies the possible role of relational repair. Existing evidence strongly supports relationships, social connectedness and development of new ways of relating as important recovery

domains, but the literature does not yet establish relational repair as a validated independent construct. PHCF should not formalise it prematurely. Repair after conflict, revision of interpersonal expectations, restoration of trust and maintenance of connection while preserving appropriate boundaries can instead be investigated as possible behavioural indicators of Relational Capacity and Demonstrated Adaptation. If these indicators later demonstrate incremental clinical value beyond established assessments of intimacy, empathy and interpersonal functioning, greater presentation-specific classification may be justified.

Protective Relationships and Context

The recovery literature also argues against locating personality-related difficulties entirely within the individual. Safety, containment, supportive social networks and the quality of treatment relationships repeatedly emerge as conditions shaping recovery (Shepherd et al., 2016; Katsakou & Pistrang, 2018). Recent work on social connectedness similarly differentiates the existence of relationships from the resources and quality those relationships provide (Di Bartolomeo et al., 2024). These findings align closely with Protective Resource Ecology. Housing stability, supportive relationships, continuity of care, peer connection and safe treatment environments may influence whether a person's relational and self-regulatory capacities can be expressed. Their presence should be assessed separately from the person's individual capacities and should not automatically be interpreted as evidence of protection.

The Role of the Personality Functioning and Interpersonal Module

The evidence supports a focused and deliberately bounded Personality Functioning and Interpersonal Presentation Module. The strongest justification is not the creation of new positive equivalents for identity, self-direction, empathy, intimacy or emotional regulation. Those domains already have established positions within personality-disorder assessment. The presentation-specific contribution of PHCF is instead to organise evidence concerning personal recovery, relational connectedness, positive identity development, autonomous yet relational agency, adaptive use of relationships, and adaptation demonstrated across interpersonal challenges, while retaining the broader environmental conditions that facilitate or restrict these processes. Much of this information may ultimately remain within the Universal Core. Relational Capacity can represent adaptive connection; Agency can represent personally meaningful direction and participation in decisions; Meaning and Identity Capacity can represent development and maintenance of valued self-understanding; Adaptive Regulation can describe flexible regulation across interpersonal stress; Demonstrated Adaptation can document how relationships and self-management have been navigated over time; and Protective Resource Ecology can identify safe and supportive relational environments. The evidentiary question for PHCF is especially demanding in this presentation. The literature already establishes that symptomatic remission, personality functioning and personal recovery are not interchangeable, and that identity, autonomy, relationships, safety and social context matter in recovery. The remaining question is whether PHCF can organise these positive-health phenomena without duplicating DSM-5/DSM-5-TR personality functioning, ICD-11 personality-disorder severity, established interpersonal assessment or existing personal-recovery constructs. A substantial module should be retained only where it provides demonstrable incremental value. A further limitation should be made explicit. Much of the strongest evidence currently comes from borderline personality disorder, rather than the full range of personality disorders or interpersonal presentations. The module should not generalise borderline-specific recovery findings automatically across all personality pathology. Broader personality presentations require dedicated evidence synthesis before presentation-specific PHCF constructs are established. Personality-related presentations require particularly strong conceptual boundaries because contemporary

diagnostic systems already assess identity, self-direction and interpersonal functioning. Figure 8.9 illustrates how PHCF can focus on recovery-related positive capacities and contextual resources without relabelling existing personality-functioning constructs.

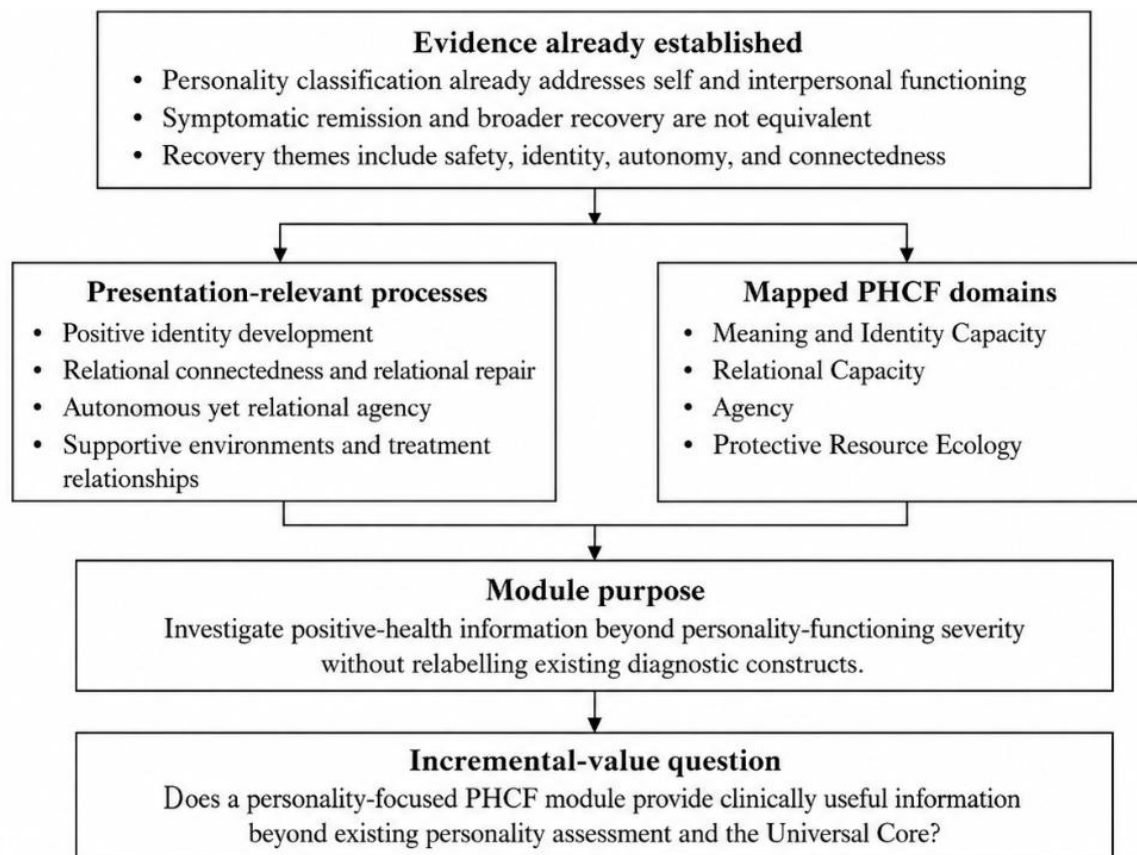


Figure 8.9. *Personality Functioning and Interpersonal Presentation Module within PHCF. The module distinguishes positive identity development, relational connectedness, agency and supportive environments from existing measures of personality pathology and interpersonal impairment, with additional classification dependent on demonstrated incremental value.*

Neurodevelopmental Presentations

Neurodevelopmental presentations provide a particularly important test of PHCF because positive health cannot be defined as approximation to neurotypical behaviour. Autism, ADHD and other neurodevelopmental conditions involve enduring differences in cognition, communication, attention, sensory processing, regulation and interaction with the environment. A positive-health classification should distinguish the presence of neurodevelopmental differences from the person's capacity to understand themselves, exercise agency, regulate adaptively, participate in valued activities and access environments that support those capacities. This position is consistent with contemporary neurodiversity scholarship, which has criticised an exclusive focus on individual deficits and emphasised the interaction between neurodevelopmental characteristics and social and environmental context (Pellicano & den Houting, 2022).

Wellbeing Without Neurotypical Conformity

Evidence from autism research demonstrates why conventional indicators of successful functioning require caution. Simpson et al. (2026) systematically reviewed 256 studies assessing quality

of life or wellbeing in autistic people. More than 80% used generic measures, approximately one-third relied on proxy reporting, autistic people with intellectual or communication differences were underrepresented, and only around one-quarter of studies reported accommodations. The review concluded that more inclusive and accessible approaches are required to understand autistic wellbeing and explicitly questioned the assumption that non-autistic conceptions of wellbeing necessarily map adequately onto autistic experience. PHCF should not treat eye contact, conventional social communication, independent living, standard employment patterns, behavioural conformity or suppression of self-regulatory behaviours as intrinsic indicators of positive health. These characteristics may sometimes relate to functioning or particular environmental demands, but their presence does not establish wellbeing, agency or adaptive capacity. The appropriate PHCF question concerns whether the person can pursue personally meaningful goals and relationships in ways that are sustainable and compatible with their neurodevelopmental characteristics.

Camouflaging and the Cost of Apparent Adaptation

The autism literature provides particularly strong evidence that outward conformity can conceal psychological cost. Zhuang et al. (2023) synthesised 58 studies involving 4,808 autistic and 1,780 non-autistic participants and found that camouflaging was strongly shaped by social pressure, acceptance and rejection. Although some autistic people described camouflaging as a pragmatic expression of agency, it was also associated with burnout, difficulties in relationships, reduced self-esteem and identity confusion. A subsequent meta-analysis involving 5,897 autistic participants found significant associations between greater camouflaging and higher anxiety, depression and social anxiety, together with lower psychological wellbeing (Khudiakova et al., 2024). This evidence has a direct implication for Demonstrated Adaptation. Observable success should not automatically be classified as adaptive merely because the person meets external expectations. An autistic person may sustain employment, social interaction or education through intense and exhausting compensatory effort. The behaviour may demonstrate considerable capability while simultaneously being psychologically costly or unsustainable. PHCF should consider not only whether adaptation occurred, but the conditions under which it occurred and the cost required to sustain it. Recent evidence on autistic burnout strengthens this distinction. Ali et al. (2025) synthesised 48 studies involving approximately 4,000 autistic people and identified exhaustion, loss of functional abilities and chronic or recurrent difficulties associated with sensory and social overload, chronic camouflaging, stigma and everyday demands. Greater self-understanding, opportunities for rest and sensory relief, and access to individual and community support were identified as factors assisting recovery. The findings demonstrate that apparently adequate functioning within an unaccommodating environment may coexist with substantial depletion of adaptive resources.

Agency, Self-Understanding and Self-Advocacy

Agency has an established positive role in neurodevelopmental research, particularly in autism. A critical synthesis of autistic adults' lived experiences found self-determination relevant to employment, social participation, advocacy, positive identity and stress management, with participants perceiving links between self-determined behaviour and quality of life (Kim, 2019). More recent systematic-review evidence suggests that self-determination can also be strengthened. Cristescu et al. (2025) reviewed 27 studies evaluating 19 interventions for autistic young people and young people with learning disabilities aged 15–25 and found emerging evidence that self-determination could be improved through targeted interventions, while emphasising that self-determination develops through interaction between the individual and their environment. For PHCF, Agency should encompass more than behavioural independence. Knowing one's needs, communicating preferences, seeking

accommodations, choosing when assistance is required and participating meaningfully in decisions can all represent agency. Dependence on another person, use of assistive communication or receipt of substantial environmental support should not by themselves imply reduced Agency. The classification concerns meaningful influence over one's life within the person's developmental and contextual circumstances.

Person–Environment Fit and Protective Resource Ecology

Neurodevelopmental presentations provide particularly strong support for Protective Resource Ecology because the expression of capacity can change substantially according to environmental conditions. Weber et al. (2024) systematically reviewed physical workplace adjustments for neurodivergent workers, including autistic people, people with ADHD, dyslexia and dyspraxia. Twenty studies were identified, with adjustments commonly addressing sound, lighting, environmental control, crowding and opportunities for decompression. Although the evidence base remained methodologically limited, the review explicitly conceptualised outcomes through person–environment fit and found evidence linking environmental adjustments with occupational performance, longevity and wellbeing.

Lived-experience evidence reinforces the same conclusion. Thorpe et al. (2024) synthesised 34 studies of autistic adults' experiences of employment and identified the disabling characteristics of workplaces designed around neurotypical expectations, alongside the importance of adjustment, understanding and acceptance. The findings shift the explanatory focus from asking whether an autistic worker can adapt sufficiently to a workplace toward asking whether the workplace is sufficiently adaptable to enable the worker's capacities to be expressed. This distinction is central to PHCF. A person may possess substantial Agency, Adaptive Regulation or Relational Capacity while being unable to express those capacities effectively within a noisy, unpredictable, inaccessible or socially hostile environment. Conversely, appropriate sensory conditions, communication accommodations, predictable structures, supportive relationships and flexible expectations may allow existing capacities to become usable. Capacity and environmental fit should be assessed separately.

ADHD and the Separation of Symptoms From Positive Outcomes

Evidence from ADHD further supports this separation, although the positive-health literature is less developed than in autism. López-Pinar et al. (2026) synthesised 70 studies involving 5,152 adults with ADHD and found that cognitive behavioural interventions produced moderate improvements in global functioning, with effects persisting at follow-up. Importantly, improvement in ADHD symptoms predicted quality of life but did not predict improvement in functioning. The dissociation among symptom change, functioning and quality of life provides another example of why outcomes cannot be inferred from psychopathology or neurodevelopmental symptom severity alone. PHCF should not turn executive-function strategies, organisational techniques or attention-management skills into positive-health classifications simply because they are used in ADHD treatment. The relevant positive-health information concerns whether the person has developed effective, sustainable and contextually appropriate ways of regulating activity, mobilising support, structuring environments and pursuing personally valued goals. Where such strategies have worked across meaningful real-world challenges, they may also contribute evidence to Demonstrated Adaptation.

The Role of the Neurodevelopmental Presentation Module

The evidence supports a Neurodevelopmental Presentation Module, but its distinctive contribution differs from modules organised around episodic psychiatric conditions. Its central purpose is not to identify a positive counterpart to neurodevelopmental symptoms. Instead, it should ensure that difference is not mistaken for diminished positive health, and conformity is not mistaken for positive

health. The module can organise information concerning self-understanding, self-determination and self-advocacy; sustainable adaptive regulation; personally meaningful participation; sensory and communication needs; the costs of compensatory or camouflaging strategies; access to accommodating environments and supportive relationships; and the interaction between individual capacities and environmental demands. Protective Resource Ecology is particularly important because environmental fit may determine whether existing capacities can be expressed, while Demonstrated Adaptation should incorporate the sustainability and cost of adaptation rather than rewarding outward conformity alone. The evidence is strongest for autism, with a developing but different evidence base for ADHD and considerably thinner positive-health evidence across other neurodevelopmental conditions. PHCF should not assume that a single configuration applies equally to autism, ADHD, intellectual disability, learning disorders, communication disorders or motor-developmental conditions. The common module can establish the contextual and non-normative principles, while presentation-specific specifications should be added only where their evidence base supports them. The evidentiary question for PHCF is consequently no longer simply whether environment, agency, self-understanding and accommodations matter in neurodevelopmental presentations. Existing evidence demonstrates that they do. The more important question is whether PHCF can classify positive capacities and demonstrated adaptation while simultaneously representing the environmental conditions that enable or suppress their expression, without converting neurotypical conformity into a standard of positive health. Neurodevelopmental presentations may provide one of the strongest tests of PHCF's capacity to distinguish what resides within the person from what arises through the relationship between the person and their environment. Neurodevelopmental presentations make the distinction between individual capacity and environmental context particularly important. Figure 8.10 summarises an approach in which positive health is assessed through agency, sustainable regulation, adaptation and environmental fit rather than conformity to neurotypical behavioural expectations.

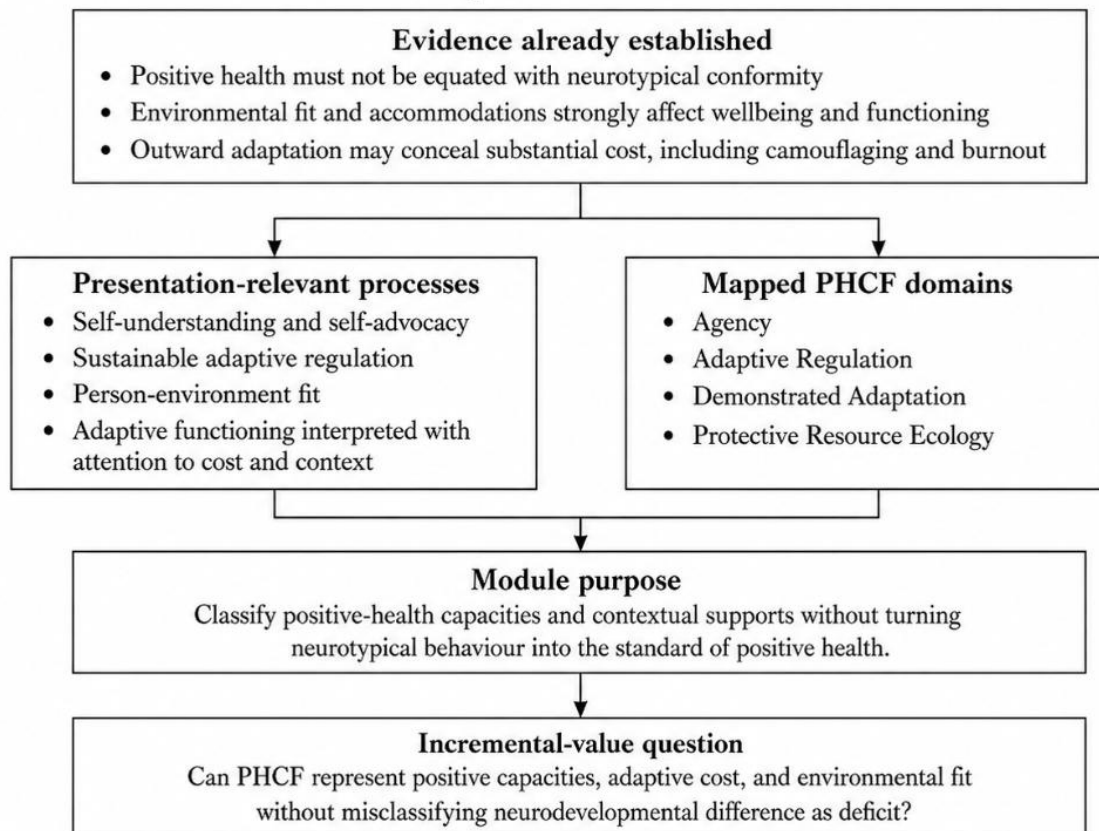


Figure 8.10. *Neurodevelopmental Presentation Module within PHCF. Positive-health classification should distinguish neurodevelopmental difference from deficit and consider self-understanding, agency, sustainable adaptation, adaptive cost, accommodations and person–environment fit when interpreting positive-health capacities and Demonstrated Adaptation.*

When a Module Should Not Exist

The development process must allow a Clinical Presentation Module to disappear. This is more important than it may initially appear. Once a framework is organised into familiar clinical categories, there is a natural tendency to seek content for every category. That would recreate the disorder-family structure that PHCF is designed to avoid. A module is unnecessary when presentation-specific candidate constructs are explained adequately by the Universal Core. Suppose research finds that approach behaviour in anxiety disorders is captured fully through Agency and Psychological Flexibility, while no anxiety-specific construct adds predictive or clinical value. PHCF should then use the Universal Core without an anxiety module. Similarly, if identity recovery in psychosis is adequately captured by Meaning and Identity Capacity and personal recovery assessment, a separate psychosis-specific identity construct would create duplication. The absence of a module does not indicate that the presentation is unimportant. It indicates that the transdiagnostic architecture is sufficient. Parsimony should be treated as a design strength.

Comorbidity and Multiple Presentations

Clinical comorbidity provides an additional reason for keeping Clinical Presentation Modules small and supplementary to the Universal Core. Psychiatric conditions frequently co-occur, and contemporary dimensional approaches to psychopathology have emphasised that substantial covariance exists across traditional diagnostic categories rather than each disorder representing an entirely

independent clinical entity (Kotov et al., 2017, 2021). A person may simultaneously experience depression, trauma-related symptoms, obsessive-compulsive symptoms and problematic substance use. Requiring a complete positive-health assessment for every diagnosis would reproduce the fragmentation that PHCF is intended to reduce, create extensive duplication and substantially diminish clinical usability. The evidence reviewed across the presentation modules reinforces this problem. Several positive-health and recovery phenomena recur across diagnostic presentations. Psychological flexibility and experiential avoidance are relevant across anxiety, depression, obsessive-compulsive and trauma-related conditions rather than being specific to a single disorder (Akbari et al., 2022). Hope, meaning, identity, connectedness and agency recur across psychosis, bipolar disorder and eating-disorder recovery (Leendertse et al., 2021; Wetzler et al., 2020; Jagfeld et al., 2021). Similarly, supportive relationships and environmental resources repeatedly appear as recovery-relevant factors across depression, trauma, psychosis, substance-use and neurodevelopmental presentations. Reassessing these constructs separately for every diagnosis would create artificial duplication of fundamentally transdiagnostic positive-health information.

The Universal Core should consequently be completed once, providing the person's primary PHCF profile across Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology. Clinical Presentation Modules should then be added selectively only where the evidence indicates that a particular presentation introduces clinically relevant information not adequately represented within that profile. For example, a person experiencing both depression and PTSD may require only a Trauma and Stressor Presentation Module if depression-related recovery knowledge and re-engagement are already adequately represented within the Universal Core. In contrast, a person experiencing PTSD alongside a substance-use disorder may benefit from both trauma-specific information concerning safety and context and substance-use-specific information concerning recovery capital, recovery-supportive networks and high-risk environments (Bunaciu et al., 2024). This approach also permits shared processes to be classified once while presentation-specific expressions are documented where necessary. Recovery and Self-Management Capacity, for example, may be present as a single Universal Core capacity while manifesting differently across conditions: recognising depressive deterioration, identifying sleep-related changes preceding mania, detecting early warning signs of psychosis or managing high-risk substance-use situations. The capacity does not need to be classified repeatedly. The relevant presentation module can record how that capacity is expressed within the particular clinical context. Demonstrated Adaptation can similarly integrate evidence accumulated across multiple forms of adversity rather than generating separate adaptation classifications for every diagnosis.

Module selection should follow incremental clinical relevance rather than diagnostic count. The presence of a diagnosis does not automatically activate its corresponding PHCF module. Nor should module assignment become another diagnostic procedure. The source clinical assessment establishes the diagnosis or clinical presentation using the appropriate diagnostic or dimensional system. PHCF then asks a separate question: does this presentation require additional positive-health information beyond that already captured by the Universal Core? Where the answer is no, no additional module is required. Comorbidity provides an important test of PHCF's proposed architecture. A clinically usable system should be capable of representing a person with several co-occurring conditions without multiplying assessments in proportion to the number of diagnoses. The intended structure is one Universal Core, supplemented by the minimum number of evidence-supported Clinical Presentation Modules necessary to add meaningful information to formulation, treatment planning and longitudinal care. This principle preserves parsimony while allowing clinically important presentation-specific information to remain visible.

Modules Across the Course of Care

Presentation-specific positive-health information may also change in relevance across treatment. During an acute bipolar episode, immediate assessment may focus on safety, symptoms, treatment and functional consequences. Detailed evaluation of mood-state self-management may be inappropriate until the person is sufficiently able and willing to participate. During recovery, the same information may become central to relapse-prevention planning. Following trauma, immediate care may focus on safety and stabilisation. Questions concerning meaning reconstruction or long-term adaptation may be premature. Substance-related recovery resources may change substantially when a person changes housing, social networks, employment or treatment settings. Modules should be capable of appearing and receding across the course of care. A presentation-specific construct does not need to be assessed simply because the person carries a corresponding diagnosis.

Evidence Mapping Before Module Construction

Clinical Presentation Modules should initially exist as research programs rather than clinical forms. Each proposed module requires a systematic evidence map examining the positive-health constructs already investigated within that presentation. The review should identify theoretical models, qualitative lived-experience evidence, longitudinal studies, intervention research, protective-factor studies and existing measures. The review must then determine how proposed constructs relate to the Universal PHCF Core. Three outcomes are possible. A construct may map directly onto an existing Universal Core domain and require no module-level inclusion. It may represent a presentation-specific expression of a universal construct and require a qualifier or specialised indicator. Alternatively, it may provide sufficiently distinctive information to warrant a new module construct. This process should precede item generation or classification thresholds. The priority order can also follow the maturity of the evidence. Depressive, trauma and stressor, substance and addictive, and anxiety and fear presentations provide useful initial evidence-mapping targets because of their large treatment and recovery literatures. Bipolar, psychosis, obsessive-compulsive and eating presentations can provide a second wave, with personality/interpersonal and neurodevelopmental modules requiring particularly careful conceptual and lived-experience development. This order is pragmatic rather than hierarchical. It reflects the availability and complexity of evidence, not the clinical importance of one presentation over another.

Avoiding a Positive DSM

The principal architectural risk of Clinical Presentation Modules is the creation of a positive replica of conventional psychiatric classification. Such a system might assign a positive counterpart to depression, another to PTSD, another to psychosis and continue until every disorder had a matching positive category. That approach would undermine PHCF for several reasons. It would assume that positive health is organised according to the same boundaries as psychopathology. It would create substantial duplication because many positive-health capacities are transdiagnostic. It would make PHCF dependent on changes in DSM or ICD architecture. It could also encourage simplistic assumptions about the positive opposite of a disorder.

1. The opposite of depression is not happiness.
2. The opposite of PTSD is not post-traumatic growth.
3. The opposite of psychosis is not conventionality of thought.
4. The opposite of bipolar disorder is not emotional stability defined as absence of mood variation.

PHCF is built on a different proposition. Positive health has its own structure. Clinical Presentation Modules modify that structure where context requires additional detail. They do not allow psychopathology to determine the architecture of positive health.

Presentation Modules as a Test of the Framework

The modules also provide an important scientific test of PHCF's central assumptions. If nearly every presentation requires a large specialised module, the proposed Universal Core may be too broad or clinically weak. If almost no presentation requires additional constructs, the Universal Core may be sufficiently powerful and modules may have little purpose. The likely outcome lies somewhere between these extremes. Some capacities may be highly transdiagnostic. Agency, relational capacity, psychological flexibility and recovery self-management are plausible examples. Other processes may become particularly important within specific presentations, such as mood-state awareness in bipolar disorder or recovery-capital configurations within substance-use recovery. The architecture should be permitted to find this balance empirically. This is also where a hierarchical PHCF becomes particularly useful. A construct that begins within one module can move upward if later evidence demonstrates broad applicability. A construct initially placed within the Universal Core can move downward if its meaning differs substantially by presentation. PHCF should treat its hierarchy as revisable.

The Provisional Module Proposition

Clinical Presentation Modules extend PHCF without changing its fundamental classification logic. The Universal Core continues to describe Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology. Modules add only those presentation-relevant constructs or qualifiers that provide additional clinical information. The strongest modules will not be the largest. A successful module may ultimately contain only one or two constructs that substantially improve understanding, treatment planning or recovery monitoring within a particular presentation. The scientific test remains incremental value.

- Does the trauma module provide useful information beyond the Universal Core and PTSD symptom assessment?
- Does a bipolar module improve understanding or prediction of recurrence beyond symptom monitoring and general self-management capacity?
- Does recovery-capital information improve substance-use recovery formulation beyond Protective Resource Ecology?
- Does an eating-disorder module capture identity or autonomy processes that would otherwise be lost?

Where the answer is no, the module should contract or disappear. Where the answer is yes, PHCF gains greater clinical precision without abandoning its transdiagnostic architecture.

From Presentation Modules to Empirical Development

The architecture established across Chapters Five to Eight now provides a provisional classification model. The Universal Core identifies the central classes of positive-health information. Chapter Six established the methodological requirements for operationalising those constructs. Chapter Seven located PHCF within clinical assessment, formulation, treatment and handover. The present chapter provides a mechanism for adding presentation-specific information where the Universal Core proves insufficient. The framework has now reached the point at which further theoretical expansion becomes less important than empirical testing. The next stage concerns the research program required

to determine whether PHCF survives contact with data. The framework must first establish the boundaries and content of its constructs through systematic evidence synthesis and lived-experience research. It must then examine expert agreement, measurement structure, reliability, construct validity and incremental validity. Longitudinal studies must determine whether PHCF domains change independently from symptoms and functioning and whether they contribute to recovery-related outcomes. Clinical utility studies must establish whether the framework improves formulation, treatment planning, monitoring or communication sufficiently to justify the additional assessment. The following chapter sets out the PHCF validation and research program, moving from theoretical framework to a staged empirical classification-development process.

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Chapter Nine - The PHCF Validation and Research Program - From Conceptual Framework to Empirical Classification

From Proposition to Evidence

The PHCF has now progressed far enough conceptually to generate testable propositions. The preceding chapters have defined the classification gap, established the theoretical foundations of positive-health classification, proposed a provisional architecture, considered how its constructs might be operationalised, examined their potential clinical application and introduced Clinical Presentation Modules. None of these developments establishes that PHCF is valid. The distinction between framework development and framework validation is fundamental. PHCF Version 0.1 represents a theoretically informed model of information that may have clinical value. Its proposed domains have been derived from established literatures concerning positive mental health, psychological wellbeing, personal recovery, resilience, psychological flexibility, self-management, protective resources and functioning. The evidence supporting those antecedent constructs does not automatically validate their organisation within PHCF. The proposed architecture must be treated as a series of hypotheses. This position requires a research program capable of changing the framework substantially. Current Positive Health State may ultimately be represented adequately by established wellbeing measures. Positive Health Capacities may contain fewer or more dimensions than presently proposed. Demonstrated Adaptation may emerge as a distinct clinically useful construct or may prove to overlap substantially with resilience, recovery self-efficacy or behavioural history. Protective Resource Ecology may function best as part of PHCF, as an adjacent contextual framework or through closer integration with existing classifications such as the ICF. Clinical Presentation Modules may prove important for some presentations and unnecessary for others. A scientifically credible PHCF development program must allow all of these outcomes. The objective is not to accumulate evidence confirming PHCF Version 0.1. The objective is to determine which parts of the framework survive increasingly demanding empirical tests.

A Staged Development Program

Classification systems cannot be validated through a single study. Their development requires a sequence of investigations addressing different questions. Evidence that a construct exists does not establish that clinicians can recognise it reliably. Reliable classification does not establish validity. Validity does not establish incremental value. Incremental prediction does not necessarily establish clinical utility. Clinical usefulness in one country or population does not establish cross-cultural validity. The PHCF development program should proceed through stages in which later studies depend partly on the findings of earlier work. The sequence should remain iterative rather than strictly linear. Evidence emerging during psychometric testing may require a return to qualitative construct development. Cross-cultural research may demonstrate that a construct definition requires revision. Clinical field trials may reveal that a theoretically coherent distinction cannot be used reliably in routine practice. Contemporary measurement guidance provides a useful methodological principle for this sequence. COSMIN places particular emphasis on content validity, arguing that the content of a measure must first be relevant, comprehensive and comprehensible for the intended construct and population. Its updated guidance also recommends an ordered assessment of measurement properties because some properties are prerequisites for interpreting others (Mokkink et al., 2024). PHCF is broader than a patient-reported outcome measure, but the underlying methodological lesson is directly applicable. Sophisticated statistical analysis cannot rescue a construct whose content has not first been defined adequately. The first PHCF research phases should establish what is being classified before attempting to determine how

strongly it can be measured. The PHCF development program is intended to proceed through a staged but iterative sequence in which each phase addresses a different evidentiary requirement. As shown in Figure 9.1, development begins with evidence mapping and lived-experience research, progresses through construct definition, consensus and measurement development, and then moves into psychometric testing, clinical field trials and cross-cultural validation. Later findings may require revision of earlier stages, ensuring that the framework remains responsive to evidence rather than becoming fixed prematurely.



Figure 9.1. PHCF staged development program. The framework progresses from evidence mapping and lived-experience research through construct definition, consensus development, measurement and psychometric testing, clinical utility and field trials, and cross-cultural validation. The process is iterative, with findings from later stages able to trigger refinement of earlier constructs, methods or assumptions.

Evidence Mapping and the First Test of Novelty

The first empirical task is to determine the actual boundaries of the proposed classification gap. Earlier chapters have argued that positive-health information is distributed across wellbeing measures, recovery frameworks, resilience research, strengths assessment, recovery capital, ICF and related

literatures. That argument has been based on existing evidence, but a formal review is required before PHCF can make a defensible claim that its proposed classification territory remains insufficiently occupied. An initial scoping review would be particularly appropriate because the relevant literature extends across multiple traditions that use overlapping terminology. Research may describe resilience, adaptation, recovery capacity, self-management, empowerment, strengths, assets, personal resources, recovery capital, psychological flexibility, coping self-efficacy, social resources and positive functioning without using the language of positive-health classification. A narrowly constructed systematic review could miss relevant conceptual traditions before the field has been mapped adequately. Scoping review methodology is designed for this kind of problem. PRISMA-ScR provides reporting guidance for reviews intended to map the scope and characteristics of available evidence, while updated JBI guidance describes scoping review methods for identifying and examining broad bodies of literature and clarifying whether more focused systematic reviews are warranted (Peters et al., 2020; Tricco et al., 2018). The first PHCF evidence map should ask which positive-health constructs have been studied in mental health populations, how they have been defined, which measures have been used, what clinical outcomes they are associated with and whether any existing framework already integrates them in a form comparable to PHCF. The review should also examine whether the present PHCF domains reflect the structure of the literature or merely the structure of the initial conceptual model. If the evidence clusters repeatedly around agency, regulation, social connection, self-management and contextual resources, the current architecture gains preliminary support. If the literature reveals major positive-health domains currently absent from PHCF, the framework should expand. If several proposed PHCF constructs are rarely distinguished empirically, their separation should be questioned. The purpose of the review is not to demonstrate that PHCF is novel. It is to test whether the proposed gap actually exists. More focused systematic reviews can follow once the landscape is sufficiently clear. These could examine individual constructs such as demonstrated adaptation, recovery self-management or protective resources, or assess evidence within major Clinical Presentation Modules. PRISMA 2020 provides the current principal reporting framework for systematic reviews and should guide those later evidence syntheses (Page et al., 2021).

Lived Experience as Construct Development

The second major phase should examine whether the proposed architecture corresponds with how positive health is understood by people who have experienced mental illness and recovery. This work is not simply an acceptability exercise. PHCF proposes to classify aspects of people's positive health. It would be methodologically weak to define those constructs entirely through professional theory and then ask people with lived experience whether the final framework appears acceptable. Experiential knowledge is required during construct formation. Recent evidence concerning mental health outcome measurement demonstrates why this matters. Molloy et al. (2025) systematically reviewed involvement of people with lived experience in co-developing mental health outcome measures and found that co-development can improve the relevance and acceptability of measures, while also identifying substantial variation and gaps in how lived-experience involvement occurs. The underlying concern is particularly relevant to PHCF. Outcomes selected by researchers may fail to represent what people experiencing mental health difficulties consider important. Qualitative research should occur before the PHCF domains become fixed. Participants could be asked how they understand being mentally healthy while experiencing mental illness, what capabilities remain available during periods of significant symptoms, what they have learned through previous episodes, what resources actually support recovery and which supposedly positive characteristics feel irrelevant or harmful. Such work may identify distinctions that are difficult to derive from existing quantitative measures. People may describe knowing how to survive a deterioration while feeling profoundly unwell. They may

distinguish between having supportive people around them and feeling able to use that support. They may describe coping strategies that were essential at one stage of life and damaging at another. They may reject language such as resilience because it appears to minimise the cost of continuing under adversity. These findings would influence construct definition directly. The involvement of people with lived experience should also extend beyond participation as research subjects. Co-production, advisory roles and lived-experience research leadership should form part of PHCF development. Contemporary reviews of patient and public involvement in mental health research identify considerable benefits but also persistent problems involving power, tokenism, organisational culture and unequal recognition of experiential knowledge. Effective involvement requires attention to power sharing, research environments and the conditions that allow participation to influence actual decisions (Evans et al., 2025; Hopkins et al., 2024). PHCF governance should create mechanisms through which lived-experience contributors can alter, reject or introduce constructs rather than merely comment on language developed elsewhere.

Clinician and Multidisciplinary Construct Research

Lived-experience research should be accompanied by qualitative work involving clinicians and other professionals who would potentially use PHCF. Psychiatrists, psychologists, nurses, social workers, occupational therapists, general practitioners, peer workers and other practitioners encounter positive-health information through different clinical activities. Their existing language may reveal where PHCF adds clarity and where it creates unnecessary distinctions. Clinicians could be asked how they currently identify strengths, protective factors, adaptive capacity and recovery resources, where this information is recorded and whether it is preserved during handover. Case-based interviews could explore whether clinicians distinguish current wellbeing from adaptive capability, whether they recognise historical adaptation separately from resilience and how they determine whether a resource is genuinely useful. The purpose is not to ask clinicians whether they like PHCF. The stronger purpose is to examine whether the constructs correspond with recognisable clinical information and whether independent practitioners interpret them similarly. Disagreement would be useful evidence. If clinicians consistently struggle to distinguish Psychological Flexibility from Adaptive Regulation, the boundary may require revision. If Demonstrated Adaptation appears immediately recognisable across professional groups, this would support further development while still requiring formal reliability testing. Qualitative clinician and lived-experience studies should be analysed together to identify areas of convergence and divergence. A concept considered clinically useful may be experienced differently by people receiving care. Conversely, people with lived experience may identify forms of positive health that are rarely documented by clinicians. These differences belong within the development process.

Consensus Development

Once evidence synthesis and qualitative research have produced a stronger construct map, structured consensus methods can be used to refine definitions, indicators and priorities for testing. A Delphi study offers one potential method. Delphi approaches permit several rounds of structured judgement while allowing participants to reconsider their positions in response to anonymised group feedback. CREDES guidance was developed following methodological review of Delphi studies and emphasises transparent reporting of objectives, participant selection, consensus procedures, iteration and interpretation (Jünger et al., 2017). For PHCF, a Delphi panel should not consist solely of senior academics. It should include classification researchers, clinicians from relevant professions, psychometricians, recovery researchers, people with lived experience, carers where appropriate, cultural experts and representatives of populations for whom the framework is intended. The Delphi

process could examine whether the proposed construct definitions are sufficiently clear, whether candidate indicators reflect the intended domains, whether important information is missing and which boundaries require further empirical testing. Consensus should remain subordinate to evidence. A high percentage of expert agreement does not demonstrate that a construct is valid. It demonstrates that a group agrees on how the available evidence should provisionally be interpreted. This distinction is especially important for PHCF because many of its terms are intuitively appealing. Experts may readily agree that hope, agency, resilience or meaning are important. Their importance does not establish that each requires a separate classification. The Delphi stage should reduce ambiguity and prioritise empirical questions rather than certify the framework.

Developing Indicators and Assessment Methods

Following construct refinement, PHCF can begin developing candidate indicators and assessment methods. This phase should preserve the multimethod principle established in Chapter Six. Different PHCF components require different forms of evidence. Current Positive Health State may be represented substantially through existing validated self-report measures. Positive Health Capacities may require combinations of self-report, structured interview and behavioural history. Demonstrated Adaptation requires historical evidence. Protective Resource Ecology requires contextual information and the person's interpretation of resource accessibility and usefulness. The first question is not whether PHCF should have a questionnaire. The question is which method best represents each construct. Where existing instruments provide adequate measurement, PHCF should use them. Developing a new measure of psychological wellbeing or social support merely because PHCF has introduced a classification architecture would create unnecessary duplication. New measure development should occur only where systematic review demonstrates an important construct without an adequate assessment instrument or where existing instruments do not map sufficiently onto the intended PHCF definition. Content validity should then be established before extensive psychometric refinement. COSMIN's methodological framework places content validity at the centre of measurement development because items must be relevant, comprehensive and comprehensible for the construct and intended population before other statistical properties become meaningful (Mokkink et al., 2024; Terwee et al., 2018). For PHCF, this principle applies not only to questionnaire items but also to interview prompts, historical indicators and contextual classifications.

Testing the Internal Structure

Once sufficiently coherent candidate measures or structured indicators exist, research can examine whether the proposed PHCF architecture corresponds with empirical structure. Exploratory and confirmatory factor analysis may be appropriate for reflective psychometric constructs where indicators are expected to represent an underlying latent variable. Item response theory may eventually assist in examining how individual items perform across different levels of a construct and whether some indicators provide more information than others. These methods should not be applied mechanically to every PHCF domain. Protective Resource Ecology illustrates the problem. Stable housing, social support, treatment access and cultural connection need not correlate strongly because they may represent distinct resources rather than manifestations of one underlying trait. Forcing these variables into a high internal-consistency scale would misunderstand the construct. Demonstrated Adaptation may present a similar challenge. Several different forms of adaptation could provide evidence of a broader capability without being interchangeable manifestations of one latent characteristic. The measurement model must follow the construct definition. Where latent structures are appropriate, PHCF should examine whether the proposed domains are empirically separable. The current Positive Health Capacities architecture proposes Agency and Self-Direction, Adaptive

Regulation, Psychological Flexibility, Relational Capacity, Meaning and Identity Capacity, and Recovery and Self-Management Capacity. The model should not assume that six factors will emerge. If empirical evidence supports three, the framework should have three. If seven are required, the framework should expand. The hierarchy should follow the data.

Reliability

Reliability represents a necessary threshold for classification because PHCF is intended partly to provide a common clinical language. Inter-rater reliability is particularly important for clinician-rated constructs. Independent clinicians examining the same information should reach sufficiently similar classifications. Low agreement would indicate that the construct is insufficiently defined, the indicators are ambiguous or the classification requirements demand excessive judgement. Test-retest reliability is relevant where the construct is expected to remain reasonably stable across short periods. A classification should not fluctuate substantially between assessments simply because the measurement process is unstable. Reliability should also be investigated within real clinical conditions. Agreement achieved by specialist researchers after extensive training may not translate to routine services. The ICD-11 development process provides an important precedent. Developmental field studies examined reliability across mental health settings in 13 countries rather than relying only on specialist research environments. Reported joint-rater reliability varied across diagnostic groupings but was generally moderate to very strong, demonstrating the importance of evaluating classification where it will actually be used (Reed et al., 2018). PHCF should adopt the same principle during later development. Reliability is a property of the classification as used by intended users, not merely of definitions printed in a manual.

Convergent and Discriminant Validity

PHCF constructs should relate to established measures in theoretically predictable ways.

Current Positive Health State should correlate with established wellbeing measures. Psychological Flexibility should relate to validated flexibility instruments. Agency should relate to empowerment and relevant self-efficacy measures. Recovery and Self-Management Capacity should relate to established recovery and illness-management constructs. Protective Resource Ecology should relate to measures of social support, material resources and recovery capital where appropriate. Evidence of convergence alone would not be sufficient. PHCF must also demonstrate discriminant validity. Demonstrated Adaptation should not simply reproduce trait resilience. Recovery and Self-Management Capacity should not be indistinguishable from general self-efficacy. Protective Resource Ecology should not merely become a renamed socioeconomic status index. Current Positive Health State should not require a separate PHCF classification if an established wellbeing instrument already represents the construct adequately. Discriminant validity has an unusually important role within PHCF because the framework is being introduced into an already crowded conceptual field. The objective is not to prove that PHCF constructs are unrelated to established concepts. Strong theoretical relationships are expected. The objective is to establish that the distinctions made by PHCF carry sufficient empirical meaning to justify retaining them.

Incremental Validity as the Central Test

Incremental validity represents one of the strongest tests of the framework. Hunsley and Meyer (2003) argued that psychological assessment research has often paid insufficient attention to whether new measures add information beyond that already available through existing methods. Incremental validity asks whether an additional assessment contributes meaningful explanatory or predictive information once relevant established predictors have been considered. This is the central empirical

challenge for PHCF. A study of depressive presentations might first include diagnosis, symptom severity, functioning, quality of life and wellbeing. PHCF variables could then be entered to determine whether they contribute additional information concerning treatment engagement, response, recurrence or recovery. The order of analysis matters because PHCF is not competing against an empty model. It is competing against mature clinical information already available to practitioners. Demonstrated Adaptation becomes scientifically important if it adds clinically useful information after established resilience, symptom and functioning measures are considered. Recovery and Self-Management Capacity becomes more compelling if it predicts successful mobilisation of care or maintenance of treatment gains beyond general self-efficacy. Protective Resource Ecology becomes important if resource accessibility adds information beyond simple measures of social support and socioeconomic status. Effect size must also matter. A statistically significant increment in a sufficiently large sample may have little clinical relevance. PHCF should examine whether improvements are large enough to alter understanding or decisions. The central question remains the one established earlier in the book. Does positive-health classification provide reliable and clinically meaningful information beyond diagnosis, symptom severity, functioning and quality of life?

Longitudinal and Prognostic Validation

Cross-sectional validity is insufficient for a framework that proposes to represent positive-health trajectories. Longitudinal research should examine how PHCF constructs change across treatment and recovery and whether those changes are independent from symptom trajectories. This is an especially important test of the two-continua assumption underlying the framework. Several patterns could occur. Current Positive Health State may improve closely alongside symptom reduction. Self-Management Capacity may improve before symptoms change. Demonstrated Adaptation may remain stable during acute illness and become more accessible during recovery. Protective resources may change independently because housing, relationships or access to services change. Some capacities may deteriorate before symptom relapse and potentially contribute to early-warning information. The research program should examine these possibilities rather than assume them. Longitudinal models can test whether PHCF constructs predict future outcomes after baseline psychopathology, functioning and relevant contextual factors are controlled. Repeated-measures designs can examine within-person change. Growth models may reveal whether different positive-health domains follow distinguishable trajectories. These studies could also identify clinically meaningful change thresholds. A future classification level should not be established simply because score distributions suggest convenient cut points. Longitudinal evidence could determine whether movement between levels corresponds with meaningful changes in recovery, treatment participation or recurrence. The strongest PHCF classifications would have longitudinal meaning.

Responsiveness to Intervention

PHCF should also determine whether its constructs change when interventions are expected to influence them. A therapy directed toward psychological flexibility should produce corresponding change if the construct and measure are valid and the treatment is effective. A relapse-prevention intervention may affect self-management more strongly than Current Positive Health State. Social or community interventions may produce substantial changes in Protective Resource Ecology while having slower effects on symptoms. Responsiveness must be tested using hypotheses established in advance. COSMIN guidance treats responsiveness as a distinct measurement property concerning the ability to detect change in the construct of interest. It should be evaluated through relationships between observed change and theoretically expected changes in other measures or external indicators (Mokkink et al., 2024). PHCF may also reveal an important clinical phenomenon when positive-health change

occurs without substantial symptom change. Such findings would provide direct evidence supporting the framework's proposition that positive health and psychopathology can change partly independently.

Clinical Utility Field Trials

Psychometric validity does not establish that PHCF improves clinical practice. The framework must undergo developmental field trials examining how intended users interpret and apply it within real services. The ICD-11 development process again provides a useful methodological precedent. Reed et al. (2018) studied 339 clinicians assessing 1,806 patients across 28 mental health settings in 13 countries and examined characteristics including clarity, goodness of fit, level of detail, efficiency and usefulness. Clinical utility was treated as something that could be studied directly rather than assumed from diagnostic validity. PHCF field trials should examine somewhat different outcomes. Clinicians could evaluate whether construct definitions are understandable, whether classifications can be completed within reasonable time, whether distinctions between domains are clear and whether the resulting profile contributes to formulation, treatment planning, recovery monitoring or handover. Experimental designs could go further. Clinicians could receive identical case information with or without a PHCF profile. Researchers could examine whether the additional information changes formulation quality, identification of treatment resources, treatment recommendations or understanding of the person's recovery capabilities. Handover studies could compare usual documentation with PHCF-informed handover to determine whether receiving clinicians retain more clinically useful information about capacities and resources. People receiving care should also evaluate the output. A technically reliable classification that people experience as inaccurate, demeaning or irrelevant would have limited legitimacy as a positive-health framework. Clinical utility requires both professional and experiential evidence.

Burden and Feasibility

Assessment burden should be treated as an outcome in its own right. The PHCF architecture could become increasingly detailed as research identifies additional constructs. Such growth would not necessarily represent progress. A framework requiring an hour of additional assessment may be feasible within a specialist research clinic and unusable in routine mental health care. The validation program should record the time required to complete each component, the proportion of information already available through routine assessment, rates of missing or Not Assessable classifications, training requirements and clinician experience of complexity. The question is not simply whether PHCF can produce more information. The question is whether the additional information is worth the effort required to obtain it. This consideration may eventually produce different forms of the framework. A brief clinical PHCF profile could contain only constructs with the greatest demonstrated utility, while an extended research version might assess additional dimensions. Such differentiation should emerge from evidence rather than being predetermined.

Cross-Cultural Validation

A positive-health classification developed within one cultural setting cannot be assumed to classify health appropriately elsewhere. This challenge is particularly important for PHCF because its constructs involve concepts such as agency, meaning, identity, relationships, self-management and recovery. Their expression is shaped by culture, family structure, community expectations, spirituality, social conditions and local understandings of mental health. Cross-cultural development should begin before translation. Qualitative studies across cultural groups should first determine whether the constructs themselves are conceptually relevant and whether important forms of positive health are missing. A construct may exist across cultures while being expressed through very different behaviours.

Agency may involve individual assertion in one context and skilful navigation of collective family decision making in another. Once measurement tools exist, measurement invariance and differential item functioning become relevant. COSMIN specifically identifies cross-cultural validity and measurement invariance as distinct measurement properties and recommends examination of whether people from different groups with equivalent levels of an underlying construct respond to items similarly. Methods can include multigroup factor analysis and differential-item-functioning analysis. PHCF should also avoid treating a statistically invariant measure as sufficient proof of cultural validity. Quantitative invariance can demonstrate that items behave similarly within tested groups. It cannot determine whether the framework has omitted culturally important dimensions of positive health. Qualitative and quantitative evidence are both required.

Developmental Validation

PHCF also requires validation across the lifespan. The constructs proposed within the Universal Core may remain relevant across age groups while their expression changes substantially. Agency in adolescence is exercised within different legal, relational and developmental conditions from agency in later adulthood. Recovery self-management may be shared with parents or caregivers. Identity undergoes major developmental change. Resource ecologies also differ because schools, families, peers and caregivers may have greater influence during childhood and adolescence. Developmental validation should examine whether the same constructs retain meaning, whether indicators require age-specific adaptation and whether measurement structure remains comparable. The framework should resist creating entirely separate positive-health systems for children, adolescents, adults and older adults unless evidence requires such separation. A stable higher-order architecture with developmentally appropriate indicators may prove more useful.

Validation of Clinical Presentation Modules

Clinical Presentation Modules should enter the research program after the Universal Core has sufficient stability to serve as a comparison. This order is important. A trauma-specific construct cannot demonstrate incremental value beyond the Universal Core if the Universal Core itself remains undefined. Module research should ask whether presentation-specific information improves understanding after universal capacities and resources have been assessed. Evidence mapping can occur earlier because it may identify candidate constructs. Formal module validation should follow later. A bipolar module might test whether mood-state awareness predicts recurrence or timely help seeking beyond general Recovery and Self-Management Capacity. A trauma module might examine whether restoration of safety or threat discrimination provides information beyond Adaptive Regulation and Psychological Flexibility. A substance-use module could determine whether recovery-capital constructs contain presentation-specific information beyond Protective Resource Ecology. A psychosis module could test whether constructs concerning the person's relationship with unusual experiences provide information beyond identity, meaning and self-management within the Universal Core. Modules should survive only where their incremental contribution is demonstrated.

Establishing Thresholds

Threshold development should occur late in the research program. PHCF currently uses provisional descriptors such as Limited Evidence, Emerging, Established and Strongly Demonstrated. These terms provide a developmental language through which clinicians and researchers can examine whether meaningful distinctions are recognisable. They are not clinical cut-offs. Several forms of evidence could eventually support thresholds. Statistical distributions may identify natural groupings. Longitudinal studies may identify levels associated with meaningful differences in outcome. Clinical

utility studies may demonstrate that certain distinctions alter treatment decisions. Person-reported evidence may establish levels of change experienced as meaningful. A threshold should ideally have clinical interpretation. If the difference between Emerging and Established self-management has no relationship with behaviour, recovery or clinical decisions, the distinction adds little value. The framework should also allow continuous measurement where thresholds provide no advantage. Classification does not require artificial categories.

External Validation

A framework developed and tested repeatedly by the same research group is vulnerable to optimism and methodological dependence. PHCF requires independent replication. Later validation studies should be conducted by research teams that were not involved in developing the framework. Studies should use different services, populations and countries. Researchers should be able to test the architecture critically and publish findings that contradict its assumptions. External validation is especially important before PHCF is represented as a general clinical framework. Effects observed within the development sample may weaken when assessment is performed by clinicians with less familiarity or when populations differ from those involved in construct development. The development program should make PHCF definitions, protocols and scoring methods sufficiently transparent for independent investigation. A classification that requires the original developers to interpret it has not become a common clinical language.

Governance and Versioning

Research findings will eventually require decisions about whether PHCF should change. This creates a governance problem. The framework should not be revised whenever one new paper is published. Excessive change would make longitudinal comparison difficult and reduce confidence in the meaning of classifications. At the same time, a scientific classification should not retain constructs that accumulating evidence no longer supports. PHCF requires formal version control. Version 0.x should designate the conceptual and developmental period. Major changes to constructs, domains and classification logic can occur freely during this stage because the framework is not yet established for clinical use. PHCF 1.0 should only be considered once the Universal Core has sufficient evidence concerning content validity, construct structure, reliability, validity, clinical utility and cultural applicability to justify an initial empirically supported framework. Later minor revisions could modify wording, guidance or indicators without fundamentally altering construct meaning. Major revisions should be reserved for changes that alter the architecture sufficiently to affect comparability with earlier classifications. Governance should involve more than the original developers. A mature PHCF would require multidisciplinary scientific expertise, psychometrics, clinical practice, lived experience, cultural expertise, international representation and transparent processes for reviewing proposed changes. The governance structure is part of the scientific model rather than an administrative consideration to be developed after validation.

Conditions for Construct Removal

The framework should specify in advance the conditions under which a construct would be removed or substantially revised. A PHCF construct should be questioned if content-validity research indicates that people and clinicians do not recognise the proposed phenomenon consistently. It should be reconsidered if empirical studies show extensive overlap with another PHCF construct. It should be removed or absorbed if an established external measure already represents the construct adequately and PHCF adds no meaningful organisational value. Low inter-rater reliability would indicate that a construct cannot yet support classification. Failure to demonstrate predicted relationships with relevant

external variables would weaken construct validity. Failure to demonstrate incremental value would weaken its justification as an additional component of PHCF. Poor clinical utility would question its place even if its psychometric characteristics were strong. Cross-cultural evidence may demonstrate that a construct has been defined too narrowly. In such cases revision may be preferable to removal. These rules create an important scientific asymmetry. Evidence is required for a construct to remain in the framework. The historical fact that it appeared in PHCF Version 0.1 does not grant it permanent status.

The Research Program as a Publication Program

The breadth of PHCF requires a sequence of research publications rather than one definitive validation paper. The first publication should establish the conceptual framework and classification gap. A formal scoping review can then map the evidence landscape and test the novelty of the proposed architecture. Qualitative lived-experience and clinician studies can examine construct meaning. A Delphi study can refine terminology and candidate content. Measurement-development studies can establish the initial structure and content validity of those components requiring new instruments. Reliability and construct-validity studies can test the architecture. Longitudinal work can examine trajectory and prediction. Clinical utility studies can test whether the framework changes assessment, formulation or treatment planning. Cross-cultural and international validation can subsequently examine generalisability. The publication sequence should remain flexible because early findings may change later priorities. If the evidence review demonstrates that an existing model already captures Current Positive Health State adequately, PHCF should use that model rather than develop another measure. If qualitative work reveals that Demonstrated Adaptation contains several distinct forms of evidence, the construct-development program should change before a Delphi study attempts to formalise it. Research sequencing should follow the evidence produced by previous stages.

A Minimum Standard for PHCF 1.0

PHCF should not progress from a conceptual framework to an empirically supported classification simply because several studies have been completed. An initial PHCF 1.0 would require evidence that its principal constructs have coherent definitions supported by literature and lived experience. Independent users should be able to apply the framework with acceptable reliability. The major constructs should demonstrate theoretically coherent relationships with established measures while retaining sufficient discriminant validity. At least some core domains should demonstrate incremental clinical information beyond conventional symptom, functioning or wellbeing measures. The framework should show preliminary longitudinal validity and responsiveness where change is expected. Clinical field studies should demonstrate that intended users can interpret the framework and that its burden is proportionate to its benefit. Initial cross-cultural research should show that the constructs are not simply expressions of one cultural model of positive health. This is deliberately a demanding threshold. PHCF is proposing classification. Classification gives language authority. Once a construct is named, structured and recorded in a clinical system, it can influence how people are understood. That responsibility requires stronger evidence than is necessary for proposing a useful therapeutic concept.

The Possibility That PHCF Becomes Something Else

The research program also needs to preserve a more fundamental possibility. PHCF may not ultimately become a classification system. Evidence may demonstrate that the framework is useful primarily as a structured formulation approach. Clinicians may find value in the four core questions while formal classification levels add little. The framework may become a research taxonomy of

positive-health constructs rather than a routine clinical tool. Certain domains may prove useful only in particular services or presentations. Some constructs may become validated outcome measures while others remain qualitative formulation concepts. These outcomes would not invalidate the original research question. The purpose of PHCF is to examine whether an important class of mental health information remains insufficiently organised and whether systematic classification improves the clinical description of health. If research identifies a better method of organising that information, the framework should follow the evidence. The name should not determine the endpoint.

A Research Program Designed to Be Falsifiable

The most important feature of the PHCF research program is its capacity to generate evidence that could disconfirm, refine or substantially restructure the framework. Each major element of the proposed architecture is a testable proposition. The organisation of positive health into Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology must be supported empirically, as must the assumption that these constructs can be assessed meaningfully alongside and independently from psychopathology. The distinctiveness of individual PHCF components also requires direct testing. Demonstrated Adaptation must provide information that is not adequately captured by existing measures of resilience, while Protective Resource Ecology must contribute something beyond conventional assessment of social support, socioeconomic circumstances and environmental resources. Clinical Presentation Modules require evidence that they add meaningful specificity beyond the Universal Core, and the broader PHCF profile must demonstrate that it improves clinically relevant processes such as formulation, treatment planning, longitudinal monitoring or clinical handover. The longitudinal propositions of the framework are equally open to falsification. PHCF assumes that positive-health trajectories may change partly independently from symptoms, functioning and quality of life and may contribute additional information about recovery, treatment engagement, recurrence or other clinically important outcomes. These assumptions require prospective testing. Some may be supported, while others may prove redundant or clinically unimportant. Failure of particular propositions would not necessarily invalidate the broader project. It would identify where the framework requires revision. A scientific classification should become more precise as unsupported assumptions are removed, constructs are combined or redefined, and unnecessary components are discarded. PHCF requires a research culture in which revision is expected. The success of the project should not be judged by how closely a future empirically supported framework resembles PHCF Version 0.1, but by how accurately the eventual framework represents the evidence that emerges from its development and testing.

From Validation to Responsibility

The validation program described in this chapter provides a pathway through which PHCF could progress from conceptual framework toward an empirically supported classification. Evidence synthesis establishes the landscape. Lived-experience and clinician research establish construct meaning. Consensus processes refine definitions. Measurement studies examine structure and reliability. Construct and incremental validity establish whether the framework adds information. Longitudinal studies determine whether classifications have temporal and prognostic meaning. Field trials establish whether the framework can function in actual clinical services. Cross-cultural and developmental work test whether its claims travel beyond the populations in which they were created. These processes address whether PHCF can be developed. A separate question concerns how it should be developed and used. Positive-health classification creates ethical risks that differ in important ways from those associated with classification of psychopathology. A system intended to identify health could become a system for judging the person. Cultural preferences could be presented as psychological

strengths. Productivity could become confused with wellbeing. Adaptation to adversity could be used to minimise suffering. Strong coping could be used to justify withdrawal of care. Limited access to resources could be attributed incorrectly to the individual. A classification developed to broaden mental health assessment could reproduce some of the very limitations it is intended to address. The following chapter examines these ethical, cultural and rights-based requirements and establishes the safeguards necessary if positive-health classification is to develop without becoming a classification of socially preferred people.

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Chapter Ten - Ethical, Cultural and Rights-Based Safeguards for Positive Health Classification

Positive Health Classification Creates Its Own Ethical Risks

The Positive Health Classification Framework has been developed in response to a limitation in the way clinically relevant information about mental health is organised. Its purpose is to make positive-health capacities, demonstrated adaptation and potentially supportive resources more visible alongside psychopathology. This intention is ethically attractive, but positive terminology does not make a classification ethically neutral. A system designed to describe health can create new forms of judgement if the characteristics it identifies as positive reflect cultural preferences, professional values or social expectations more strongly than health itself. This risk may be greater for positive-health classification than for some forms of psychopathology classification because words such as agency, resilience, independence, connection, meaning, adaptation and self-management carry implicit assumptions about desirable ways of living. A classification of depression identifies a recognised clinical syndrome. A classification of agency could, if poorly defined, begin to rank people according to how independently they live. A classification of relational capacity could reward sociability. A classification of demonstrated adaptation could privilege people who have continued working or studying during adversity. Protective Resource Ecology could become an indirect measure of socioeconomic advantage. Such interpretations would fundamentally distort PHCF. Ethical safeguards must form part of the architecture rather than being added after validation. PHCF should classify specified forms of positive-health information without classifying the worth of the person. It should recognise capacity without idealising self-sufficiency, recognise adaptation without romanticising adversity, recognise resources without blaming people who lack them, and recognise recovery without prescribing what a recovered life should look like. These requirements are already implicit in the theoretical architecture of PHCF, which rejects productivity, independence and social conformity as proxies for positive mental health and cautions against inferring resilience merely from survival of adversity. The ethical task is to convert those principles into enforceable limits on how the framework is developed and used.

Human Worth Must Remain Outside the Classification

The most fundamental PHCF safeguard is that classification applies to specified constructs and circumstances, never to the worth of a person. This boundary is consistent with contemporary human-rights approaches to mental health and disability. The Convention on the Rights of Persons with Disabilities identifies inherent dignity, autonomy, non-discrimination, participation and respect for difference as part of human diversity among its foundational principles (United Nations, 2006). WHO and OHCHR similarly position dignity, choice, inclusion and respect for personhood as requirements of rights-based mental-health systems (World Health Organization & Office of the United Nations High Commissioner for Human Rights, 2023). Human worth exists prior to, and independently of, any PHCF classification. A classification such as *Limited Evidence of Adaptive Regulation* describes the available evidence concerning a particular construct, in a particular context, at a particular time. It does not establish that the person is deficient, weak, unsuccessful, immature or less psychologically developed than somebody classified at another level. This distinction is especially important in a positive-health framework because apparently desirable constructs can readily acquire normative or moral meaning. Once agency, connection, flexibility, purpose or self-management are labelled “positive”, higher levels can mistakenly be interpreted as representing a better kind of person. PHCF must explicitly reject that interpretation.

This position is consistent with recovery-oriented mental-health research. Personal recovery is understood as complementary to clinical recovery and grounded in the person's own preferences, meaning and life direction rather than conformity to a universal model of successful living (van Weeghel et al., 2019). WHO's person-centred guidance similarly emphasises recovery, inclusion, choice and support within people's own social circumstances rather than prescribing a single desirable life outcome (World Health Organization, 2021). Employment, independent living, extensive social participation or complete self-management may be important goals for some people, but they cannot function as universal indicators of positive health. The same principle applies to agency. Agency should not be equated with independence. Cross-cultural research distinguishes autonomous motivation from individualism and behavioural independence; people may exercise meaningful agency while acting with, for or through families and communities (Chirkov et al., 2003; Rudy et al., 2007). International disability-rights guidance similarly makes clear that autonomy and independent living do not require performing daily life without assistance and that people may exercise choice and control with adequate support (United Nations, 2006). Supported decision-making research further demonstrates that assistance can facilitate rather than negate participation in decisions (Francis et al., 2024). Receiving substantial assistance, relying on family, using supported communication or making decisions collectively should not by themselves lower a PHCF Agency classification.

Cultural responsiveness creates an additional safeguard. Psychological characteristics and their behavioural expression are embedded within cultural, relational and environmental contexts. APA's Multicultural Guidelines explicitly caution psychologists to recognise cultural variation in identity, behaviour, values and meaning and to examine how professional assumptions can shape assessment and interpretation (American Psychological Association, 2017). PHCF should distinguish difference from difficulty, and difficulty from limited capacity. Introversion should not be interpreted as deficient Relational Capacity. Emotional reserve does not necessarily indicate absence of connection. Collective decision-making does not demonstrate deficient Agency. Dependence within a valued family or cultural system is not evidence of inferior self-direction. Divergence from culturally dominant behaviour is insufficient grounds for positive-health classification. The safeguard also applies to the interpretation of improvement. PHCF should not establish an ideal endpoint at which a person becomes maximally agentic, socially connected, psychologically flexible, emotionally regulated, self-managing and purposeful. Psychological evidence provides little justification for assuming that more of every desirable characteristic is always better. Grant and Schwartz (2011) reviewed evidence for non-linear relationships in which characteristics ordinarily regarded as positive can reach points at which additional amounts cease to confer benefit or become disadvantageous. The clinically meaningful level of a capacity depends on its function, context and relationship with the person's life rather than its distance from a theoretical maximum.

PHCF consequently classifies sufficiency and relevance, not human optimisation. A person may possess sufficient relational, regulatory or self-management capacity for their circumstances and have neither a clinical need nor a personal desire to increase it. Likewise, a person may choose a quiet life, a small social network, substantial family interdependence, limited occupational participation or priorities that differ from those culturally associated with flourishing. These choices should not lower positive-health classification unless there is evidence that the construct being assessed is genuinely limited in a clinically relevant way. The boundary can be stated formally:

Human Worth Independence Rule. PHCF classifications describe evidence concerning specified positive-health constructs within context. They do not classify human worth, character, virtue, maturity or the overall value of a person's life. Neither divergence from culturally preferred behaviour nor

failure to maximise a positively valued psychological characteristic is sufficient evidence of limited positive health.

I think that final rule is worth making a formal PHCF rule, not merely leaving it buried in prose. It addresses one of the most foreseeable criticisms of a “*positive classification*”: that it could inadvertently become a hierarchy of better and worse people. Your framework can prohibit that interpretation at the architectural level.

A Rights-Based Foundation

PHCF should be consistent with contemporary rights-based mental health care. WHO's guidance on community mental health services places person-centred, recovery-oriented and human rights-based care at the centre of mental health-system reform and explicitly aligns this approach with the United Nations Convention on the Rights of Persons with Disabilities. WHO and the Office of the United Nations High Commissioner for Human Rights have subsequently emphasised dignity, autonomy, free and informed consent, access to quality community-based care and greater support for people to make decisions concerning their own lives and treatment (World Health Organization [WHO], 2021; World Health Organization & Office of the United Nations High Commissioner for Human Rights [OHCHR], 2023). These principles have direct implications for PHCF. A classification concerned with Agency and Self-Direction cannot be implemented through a process in which people have little opportunity to influence how their own agency is described. A framework incorporating Meaning and Identity Capacity cannot permit clinicians to determine which identities or purposes are appropriate. A system concerned with personal recovery cannot impose a professional definition of recovery when it conflicts with the person's own account. PHCF classifications should be transparent to the person wherever clinically appropriate. People should have opportunities to explain, contextualise and challenge interpretations. Where different views remain, the framework should be capable of preserving disagreement instead of giving automatic authority to the clinician's account. A rights-based framework must also accommodate support in decision making. Contemporary WHO-OHCHR guidance describes supported decision making as assistance that can help individuals understand information, consider alternatives, communicate decisions and implement choices while respecting their will and preferences. PHCF should avoid equating autonomous functioning with unsupported decision making. A person may exercise substantial agency through appropriately chosen support.

Positive Health Must Never Determine Entitlement to Care

One of the clearest ethical boundaries concerns access to treatment. A high PHCF profile must never be interpreted as evidence that a person's symptoms are less serious, their suffering is less legitimate or treatment is unnecessary. Strong adaptive capability and serious mental illness can coexist. Indeed, some of the people who appear most capable may be sustaining everyday participation through exceptional levels of effort. This creates a foreseeable misuse of positive-health information. A service operating under resource constraints could potentially interpret strong Demonstrated Adaptation, employment, supportive relationships or established self-management as evidence that another person has greater need. Such reasoning would transform a framework intended to complement assessment into an instrument for rationing care. PHCF should establish a formal non-substitution principle. Positive-health classification should not replace direct assessment of symptoms, risk, impairment, treatment need or service eligibility. A high level of Adaptive Regulation cannot cancel severe depression. Established Recovery and Self-Management Capacity cannot invalidate suicidal ideation. Strong Protective Resource Ecology cannot establish that a person can safely manage without professional care. PHCF may eventually provide information relevant to treatment planning and

prognosis. Its role in determining whether care should be provided is fundamentally different. Until substantial independent evidence supports specific uses, PHCF should not be employed as a threshold for insurance decisions, compulsory treatment, forensic decisions, disability eligibility or withdrawal of mental health services.

The Effort Required to Appear Well

Positive-health classification also needs to distinguish observable adaptation from the psychological cost required to maintain it. A person may continue working, caring for children, studying, maintaining relationships or responding calmly during appointments while experiencing substantial internal distress. Clinical systems can already underestimate need when visible functioning is used as an indicator of psychological wellness. PHCF could unintentionally amplify this error if behavioural adaptation is classified without considering cost. Demonstrated Adaptation must include the possibility that adaptation was effective and costly. A person who continued working throughout a depressive episode may have demonstrated persistence and commitment. They may also have required extraordinary effort, experienced severe distress outside work and sacrificed sleep, relationships or physical health to maintain that role. Employment itself does not establish positive health. The same principle applies to self-control. A person who appears highly regulated may be using rigid suppression. Someone who manages without asking for assistance may possess strong problem-solving capacity or may have learned that support is unavailable. A young person who performs well academically despite bullying may have developed effective coping strategies or may be surviving through fear, perfectionism and exhaustion. PHCF should assess adaptive function and adaptive cost together where relevant. This distinction protects the framework from rewarding masking.

Cultural Validity Is a Construct Question

Culture presents one of the most important challenges to positive-health classification because many of the constructs within PHCF have been developed primarily within psychological and recovery traditions originating in Western settings. Cross-cultural research on personal recovery demonstrates both continuity and variation. The original CHIME review identified greater emphasis on spirituality, culturally specific facilitating factors and collectivist understandings of recovery in studies involving Black and minority ethnic populations (Leamy et al., 2011). More recent work has strengthened this concern. Panadevo et al. (2025), reviewing 76 studies examining personal recovery among people from non-Western cultural backgrounds, found broad applicability of CHIME while identifying stronger emphasis on relationships, family, religion, shared responsibility, shared control and socio-structural influences. The implication for PHCF is significant. Cultural validation cannot consist only of translating an eventual questionnaire into another language. The first question is whether the construct itself means the same thing. Agency provides a clear example. A framework derived from an individualistic model might operationalise agency through personal choice, independence and direct assertion of preference. Within other cultural contexts, agency may be exercised through relational decision making, family consultation, shared responsibility or collective obligations. The underlying capacity to participate meaningfully in shaping one's life may be present even though its behavioural expression differs substantially. Connectedness creates a related problem. Some people may experience positive health through dense family and community relationships. Others may require greater privacy or independence. Neither configuration should automatically receive a higher PHCF classification. Meaning, identity, spirituality, emotional expression and help seeking are similarly shaped by cultural systems. PHCF should distinguish the construct from its culturally situated expression.

Cultural Responsiveness Requires More Than Measurement Invariance

Later PHCF validation may use methods such as measurement invariance analysis and differential item functioning to determine whether instruments operate similarly across groups. These methods are necessary where psychometric measures are used, but they are not sufficient to establish cultural validity. A scale can demonstrate acceptable statistical invariance while omitting an important culturally specific form of positive health. The strongest cultural-development strategy should begin qualitatively. Communities should be involved in determining whether PHCF domains are meaningful, whether their definitions reflect local understandings of health and recovery and whether additional concepts are required. Quantitative equivalence can then be examined after conceptual relevance has been established. The personal recovery literature provides evidence for this approach. Van Weeghel et al. (2019) concluded that recovery frameworks require adaptation according to cultural and population characteristics, while more recent cross-cultural synthesis has identified socio-structural and relational components that can be underrepresented by individualised recovery models. PHCF should consequently avoid the assumption that a universally named construct has a universal behavioural expression.

Structural Conditions Must Not Become Personal Deficits

Protective Resource Ecology provides one of PHCF's principal mechanisms for preventing the individualisation of social and structural disadvantage. Mental health is affected by the conditions in which people are born, grow, live, work and age and by differential access to money, power and resources. WHO's 2025 *World Report on Social Determinants of Health Equity* emphasises the major effects of income, education, housing, discrimination, disability and unequal access to social and material resources on health inequities. Contemporary WHO mental health policy guidance similarly emphasises poverty, housing, education, employment and other social and structural determinants as central to mental health systems and policy. This evidence produces a critical PHCF rule. A person should not receive a lower personal-capacity classification because the environment prevents them from expressing that capacity. Someone may possess strong self-management capability and be unable to obtain treatment because no appropriate service exists. A person may possess considerable occupational capability and be unable to work because discrimination prevents employment. A young person may have strong relational capacities within an unsafe school environment. A person may recognise the need for stable housing while having no access to affordable accommodation. The relevant deficit in each case may exist principally within the resource environment. Protective Resource Ecology should make this distinction visible. Where social or structural conditions constrain positive health, PHCF should record those conditions rather than reinterpret their consequences as personal weakness. This principle is especially important because contemporary mental health policy increasingly recognises that effective care requires coordination with housing, employment, education and social protection rather than intervention confined to the individual.

Poverty Must Not Be Classified as Poor Positive Health

The relationship between structural disadvantage and PHCF requires an additional safeguard.

People with greater income, secure housing, high-quality education, supportive employment and access to healthcare are likely to possess more resources across several elements of Protective Resource Ecology. If PHCF were converted uncritically into a total score, social advantage could produce a higher apparent positive-health classification. The result would be ethically and conceptually unacceptable. Material resources matter because they influence the conditions under which health and recovery occur. Their absence should be recorded where relevant. They should not become evidence that the person themselves has lower psychological health. This reinforces the argument against a single

PHCF total score. A profile that separates personal capacities from environmental resources preserves the distinction between what appears available within the individual and what the surrounding environment enables. A person living in poverty may demonstrate extraordinary Agency, Psychological Flexibility and Demonstrated Adaptation while possessing very limited material resources. Combining these domains into a single score would obscure the most clinically important information in the profile.

Disability, Interdependence and the Risk of Ableism

PHCF must also avoid embedding assumptions about able-bodied or neurotypical functioning within its definition of positive health. Independence provides a particularly important example. Disability may require ongoing assistance with communication, mobility, decision making, self-care or participation. The use of such assistance should not produce a lower positive-health classification. Agency concerns meaningful participation in shaping one's life. It does not require performing every activity without assistance. Relational Capacity does not require conventional social communication. Adaptive Regulation does not require the suppression of behaviours that assist self-regulation merely because those behaviours appear unusual. Meaningful participation does not require full-time employment. Self-management does not require managing health without professional or family support. These distinctions are consistent with rights-based approaches that emphasise legal capacity, community inclusion, participation and access to appropriate support for people with disabilities. WHO and OHCHR guidance explicitly places accessible support and respect for people's will and preferences within contemporary rights-based mental health practice. PHCF should classify positive health relative to the construct of interest and the person's context, not relative to an assumed independent adult without disability.

Neurodiversity and Environmental Fit

Neurodevelopmental presentations require a related safeguard. Positive health should not be defined according to how closely a neurodivergent person approximates neurotypical behaviour. Eye contact, conventional social communication, suppression of repetitive movement, tolerance of sensory environments or adherence to standard educational and workplace expectations should not function automatically as indicators of positive health. The framework should instead examine whether the person has access to environments in which their capabilities can be expressed, whether they can communicate needs effectively using their preferred modes, whether appropriate accommodations are available and whether self-understanding and self-advocacy support personally meaningful goals. This approach again requires interaction between Positive Health Capacities and Protective Resource Ecology. A difficulty can arise because the environment is poorly matched to the person rather than because the person possesses insufficient adaptive capacity. PHCF should be capable of representing that distinction explicitly.

Developmental Ethics

Children and young people require further consideration because many PHCF constructs involve capacities that are still developing and environments in which adults exercise substantial authority. Agency in a young person cannot be evaluated using adult expectations of independence. A child may exercise meaningful agency through expressing preferences, participating in developmentally appropriate decisions and identifying trusted adults. Their self-management may appropriately involve parents, carers, schools and health professionals. Similarly, Protective Resource Ecology may be particularly influential because young people have less control over housing, finances, school placement, family relationships and access to treatment. A young person experiencing bullying illustrates the importance of separating domains. They may demonstrate sophisticated adaptive

strategies and still remain in an unsafe environment. Their coping should not be used as evidence that the environment no longer requires change. PHCF should avoid rewarding successful accommodation to harmful conditions. Developmental interpretation should consider age, maturity, opportunity for decision making and the amount of environmental control realistically available to the person.

Recovery Cannot Become a Professional Standard of Success

Personal recovery has provided a major theoretical foundation for PHCF, but its incorporation creates another ethical boundary. Recovery is person defined. A clinician may observe substantial improvement in agency, relationships and self-management while the person feels that recovery has not occurred. Another person may describe themselves as recovered despite continuing symptoms or support needs. PHCF should preserve these differences. The danger would arise if a positive-health profile became a professional definition of successful recovery. A person could then be told implicitly that they had not recovered because they lacked employment, independence, extensive relationships or a particular level of positive affect. That would contradict the personal recovery tradition from which PHCF draws much of its rationale. Cross-cultural recovery research makes this point even stronger because recovery may involve different balances of personal autonomy, relational responsibility, spirituality, family and community across populations. PHCF can classify relevant capacities and resources. It cannot determine whether a person's life constitutes successful recovery.

Adaptation Must Not Legitimate Adversity

Demonstrated Adaptation carries a distinctive ethical risk because it directs attention toward what people have managed under adversity. The construct should never imply that adversity is beneficial or that people should grow through suffering. Trauma, discrimination, poverty, abuse, bullying and serious illness can produce substantial harm. Some people develop effective ways of responding. Others do not. Many demonstrate adaptation in some areas and significant cost in others. None of these responses determines moral worth. The framework must also avoid retrospective narratives in which suffering becomes justified because adaptive capacities subsequently emerged. A person may have developed impressive coping strategies following childhood abuse. The abuse remains harmful. A community may demonstrate resilience following discrimination. The discrimination remains unjust. Demonstrated Adaptation describes evidence concerning a response to challenge. It does not transform the challenge into a developmental opportunity.

Resource Classification and the Problem of Causal Language

Protective Resource Ecology requires cautious terminology because resources should not automatically be described as protective. The existence of family, employment, housing, community membership or treatment does not establish protection. Their effects vary according to context. Family relationships can support recovery and contribute to distress. Employment can provide purpose and financial security and can also produce exploitation, discrimination or unsustainable demands. Community membership can create belonging and stigma simultaneously. PHCF should continue to use the term resource when describing availability and reserve stronger terminology such as protective factor for circumstances in which empirical evidence supports the relevant relationship. This distinction also protects against clinical assumptions. A clinician should not classify family involvement as protective because family is conventionally regarded as positive. The person's own account and the observed function of the relationship matter. Protective Resource Ecology is relational. It describes the relationship between a person and a resource.

Risk Assessment Must Remain Independent

Positive-health classification must never be used as a substitute for suicide, self-harm or other safety assessment and formulation. A person may demonstrate substantial Agency, Meaning and Identity Capacity, Recovery and Self-Management Capacity, Relational Capacity, Demonstrated Adaptation and access to significant protective resources while simultaneously experiencing acute suicidal intent. Conversely, a person with limited positive-health resources may have no current suicidal thoughts, intent or behaviour. Positive health and acute safety are clinically relevant but non-equivalent domains of information. The separation is consistent with contemporary suicide-prevention guidance. NICE explicitly recommends against using risk-assessment scales or global categories such as low, medium or high to predict future suicide or repetition of self-harm and instead requires assessment to focus on the person's needs, immediate and longer-term safety, and an individualised risk formulation (National Institute for Health and Care Excellence [NICE], 2022). The limitation is not confined to particular instruments. A meta-analysis of 365 longitudinal studies incorporating 3,428 risk-factor effect sizes found that commonly studied risk factors predicted suicidal thoughts and behaviours only slightly better than chance overall and that predictive accuracy had not meaningfully improved across five decades of research (Franklin et al., 2017). These findings caution against assuming that the presence or absence of any small set of apparently protective characteristics can determine whether an individual is currently safe.

There is nevertheless meaningful evidence for protective factors, and PHCF should not ignore it. Reasons for living, social relationships, meaning, purpose, coping, belonging, resilience and other psychosocial characteristics have been associated with lower levels of suicidal ideation or behaviour in particular populations. Bakhiyi et al. (2016), for example, reviewed 39 studies and found evidence that reasons for living were associated with lower suicidal ideation and suicide attempts, although no included study examined suicide death and the effects varied according to other clinical and contextual factors. A 2024 systematic review of 70 studies among older adults similarly identified purpose in life, resilience, positive relationships, social support and related factors as associated with reduced suicidality (Ki et al., 2024). These associations establish clinical relevance, but they do not establish immunity from suicide risk. The evidence also demonstrates why the term protective factor must be used carefully within PHCF. McEvoy et al. (2023), in an umbrella review of 61 systematic reviews concerning self-harm in adolescents and young adults, found substantially more evidence concerning risk factors than protective factors. Good relationships with family and friends were the protective factors identified most consistently, but only a minority of the general systematic reviews considered protective factors at all. Protective effects were also outcome- and population-specific. A resource associated statistically with lower self-harm in one population cannot be assumed to protect a particular individual from suicide in a particular clinical situation.

This distinction is especially important for Protective Resource Ecology. PHCF may establish that a person has a supportive partner, stable housing, meaningful relationships, professional care, religious or cultural connection, reasons for living or previous successful coping strategies. These resources can contribute important information to a risk formulation, but their presence does not establish that they are accessible, usable or sufficiently protective during an acute crisis. A person may ordinarily experience family as highly supportive but be unable or unwilling to contact family during suicidal escalation. Meaning and purpose may usually be strong yet temporarily inaccessible during severe depression. Previous successful help-seeking may provide evidence of Demonstrated Adaptation without guaranteeing that the same response will occur during the present episode. PHCF should distinguish resource presence from resource mobilisation and from demonstrated protection against a specified safety outcome. It is also why protective factors should not be treated arithmetically. Strong

relationships, meaning or previous adaptation do not “cancel out” current suicidal intent, planning, access to means, recent escalation or other acute clinical information. Similarly, an apparent shortage of protective factors does not itself establish imminent danger. The appropriate task is formulation: understanding how current vulnerabilities, acute drivers, historical factors, capacities, relationships and environmental conditions interact for this person at this time. NICE's recommendation to undertake individualised risk formulation rather than rely on numerical or categorical prediction is consistent with this principle (NICE, 2022).

PHCF can nevertheless contribute positively to safety planning and risk mitigation once the safety problem has been identified through appropriate clinical assessment. Positive-health information can help identify resources that might be deliberately mobilised: a person who can recognise deterioration may use that capability as part of an early-warning plan; a trusted relationship may become an agreed contact during crisis; an established professional relationship can be made more accessible; and personally meaningful reasons for living can inform collaborative safety planning. The distinction is between classifying protection and mobilising resources for safety. The latter has an established clinical evidence base. Stanley et al. (2018), for example, found that a Safety Planning Intervention combined with structured follow-up was associated with 45% fewer suicidal behaviours over six months and substantially greater subsequent mental-health treatment engagement than usual care. Safety planning works by translating available coping strategies, social contacts and professional resources into specific actions, not by assuming that their mere existence establishes safety.

Classification Under Conditions of Coercion

Mental health care sometimes occurs within legal or clinical contexts in which people experience reduced control over treatment. PHCF requires particular caution in such settings. A framework containing Agency and Self-Direction could produce distorted classifications if the person's opportunity to exercise agency has been restricted by the service itself. A person receiving involuntary care may have little control over where they live temporarily, when they leave a unit, which activities are available or aspects of treatment. Limited observable self-direction in such circumstances may reflect the environment rather than an intrinsic limitation in agency. WHO-OHCHR guidance emphasises the human rights concerns associated with coercive mental health practices and calls for approaches that maximise autonomy, informed consent and supported decision making. PHCF should record restrictions created by the treatment context wherever they materially affect interpretation. A classification should not attribute to the person a limitation produced by the system assessing them.

Secondary Use of PHCF Information

If PHCF became integrated into electronic health records, positive-health information could become available for purposes beyond the immediate therapeutic relationship. This creates an important governance issue. Information concerning capacity, adaptation and resources could potentially be used by insurers, employers, courts, government agencies, disability systems or service funders. A classification originally intended to improve treatment could take on different meaning when removed from clinical context. Strong adaptation could be interpreted as evidence that financial assistance is unnecessary. Strong self-management could be interpreted as evidence that fewer services are required. Limited resources could be treated as an individual risk score. A low positive-health profile could potentially become stigmatising in ways that differ from the stigma already associated with psychiatric diagnosis. PHCF governance should define acceptable secondary uses explicitly. The framework should initially be developed for clinical and research purposes. Expansion into administrative, legal, occupational, insurance or eligibility contexts would require separate evidence and ethical analysis. Clinical usefulness does not automatically establish administrative legitimacy.

Privacy and the Sensitivity of Positive-Health Information

Positive information can also be sensitive information. Meaning, identity, spirituality, relationships, cultural affiliation, family dynamics, social resources and coping history may reveal deeply personal aspects of a person's life. The fact that information is classified as positive does not reduce the need for privacy. Some resources may also require protection. A person may identify a particular family member, community group or informal network as central to their recovery. Recording that information does not automatically create permission to contact those people. PHCF documentation should follow the same confidentiality, consent and information-sharing principles applicable to other clinical information. The framework should collect only the information necessary for its intended clinical purpose. More information is not inherently better assessment.

Uncertainty as an Ethical Safeguard

The ability to classify a construct as Not Assessable is ethically important. Without such an option, clinicians may feel pressure to infer capacities from incomplete evidence. Assumptions are particularly dangerous within positive-health classification because socially desirable behaviour can easily influence judgement. A person who speaks confidently may be assumed to have strong agency. Someone who is quiet may be interpreted as having limited relational capacity. A person who attends treatment reliably may be judged highly self-managing despite having substantial external support that makes attendance possible. When evidence is insufficient, uncertainty should remain visible. Conflicting evidence should also be retained where necessary. A clinician and person may interpret a coping behaviour differently. Family members may describe support that the person experiences as controlling. A resource may operate positively in one context and negatively in another. PHCF should prefer explicit uncertainty over unjustified precision.

Lived Experience Must Have Governance Power

Lived-experience participation is required not only during validation but within the eventual governance of PHCF. A framework intended to classify positive health will inevitably make decisions about which experiences count, how constructs are described and which outcomes matter. These decisions cannot be made legitimately by clinicians and classification scientists alone. People with lived experience should participate in decisions concerning construct addition and removal, terminology, cultural adaptation, acceptable clinical uses and prohibited applications. The distinction between consultation and governance matters. Consultation permits people to comment on decisions. Governance allows them to influence those decisions. WHO's contemporary mental health policy guidance similarly emphasises the role of people with lived experience in shaping policies and systems that affect them. A mature PHCF governance body should consequently include substantial lived-experience representation with genuine decision-making authority.

Cultural and Indigenous Governance

International development of PHCF will also require governance structures capable of preventing one cultural tradition from being treated as the default against which all others are adapted. The common model in psychological measurement has often been to develop an instrument in one population and subsequently translate or culturally adapt it elsewhere. PHCF should seek a stronger standard. Where the framework is intended for use across cultural contexts, representatives of those contexts should participate in construct development itself. This principle is especially important for Indigenous peoples, whose concepts of health may place strong emphasis on family, community,

culture, land, spirituality, collective identity and historical context. PHCF should not assume that an individualised psychological model can simply add a cultural-resource category and thereby become culturally appropriate. Cultural governance may determine that some concepts require different organisation, different indicators or limits on interpretation. A global PHCF should aim for common classification language where evidence supports commonality while preserving forms of health that cannot be reduced appropriately to one universal behavioural standard.

PHCF Should Identify Structural Responsibility

One potential contribution of Protective Resource Ecology is the ability to locate intervention responsibility more accurately. If a person lacks an accessible treatment service, the clinical response should not be to increase their coping score. If housing insecurity is destabilising recovery, the problem is not simply insufficient emotional regulation. If discrimination prevents participation, the solution cannot be reduced to improving resilience. WHO's current social-determinants framework emphasises that health inequities are produced through unequal social, political and economic conditions and require policy responses as well as individual care. PHCF should be capable of identifying situations in which the most relevant positive-health intervention lies outside psychotherapy. The framework may identify a psychological capacity that can support adaptation while simultaneously documenting an environmental condition requiring change. Both forms of information can be true.

Prohibited Interpretations

A mature PHCF manual should include explicit interpretation rules because several foreseeable errors can be identified before empirical validation is complete. High positive health should never be interpreted as absence of mental illness. Limited positive health should never establish the presence of mental illness. Strong adaptation should not be interpreted as evidence that adversity caused beneficial development. Limited resources should not be interpreted automatically as limited personal capacity. Employment, relationship status, education or financial success should not serve as substitutes for PHCF constructs. Cultural conformity should not increase a classification. Disability support needs should not reduce a classification solely because support is required. Positive affect should not be treated as sufficient evidence of mental health, particularly where clinical conditions can themselves produce elevated affect or activity. Most importantly, PHCF should not produce a classification of the good patient. Adherence, politeness, compliance with professional recommendations and agreement with the clinician are not positive-health domains. A person can exercise agency by declining an intervention. They can demonstrate self-management by identifying that a previous treatment was ineffective. They can protect their health by setting boundaries with a service or relationship. The framework must permit healthy disagreement.

Ethical Validation Should Be Empirical

Ethical safeguards should themselves be tested. Lived-experience participants can examine whether PHCF summaries feel accurate, respectful or judgemental. Cultural studies can identify constructs that reproduce inappropriate assumptions. Vignette studies can determine whether clinicians inadvertently infer higher positive health from employment, education, race, gender, disability status or communication style when the intended PHCF information is otherwise equivalent. Implementation studies can examine whether high positive-health classifications affect decisions concerning treatment intensity. Health-record research can identify whether nuanced descriptions become simplified during handover or administrative use. These questions transform ethics from a list of principles into a research program. A classification can produce unintended consequences even when its creators explicitly oppose them. PHCF governance must monitor actual use.

A Rights-Based Interpretation Standard

The ethical position developed throughout this chapter can be summarised as an interpretation standard for PHCF. Positive-health classifications describe selected aspects of current state, capacity, adaptation and resources. They do not describe human worth. Their meaning depends on developmental, cultural, clinical and environmental context. Their interpretation must preserve the person's own account, particularly for subjective experiences, identity, meaning and recovery. Environmental restrictions must remain distinguishable from personal capability. Strong positive health cannot negate illness or remove entitlement to care. Limited positive health cannot justify coercion, discrimination or exclusion. Classification uncertainty should remain explicit where evidence is insufficient. This standard should accompany every future iteration of the framework. The principle is simple but consequential. PHCF should make health more visible without making people more judgeable.

From Ethical Safeguards to the Future of PHCF

Positive-health classification creates a scientific opportunity and an ethical responsibility. A framework capable of identifying capacities, adaptation and resources could contribute to more complete mental health assessment. The same framework could cause harm if it converted culturally preferred behaviour into health, treated structural disadvantage as individual deficiency, romanticised survival under adversity or allowed strong capacities to become a justification for reduced care. These risks do not provide a reason to abandon positive-health classification. They define the conditions under which it should proceed. PHCF must remain person-centred, culturally responsive, contextually interpreted and compatible with human rights. Its architecture should preserve the separation between capacity and opportunity, personal health and structural resources, adaptation and wellbeing, clinical interpretation and personal recovery. Lived experience must remain embedded within development and governance, while evidence of unintended consequences must be capable of changing how the framework is used. The scientific program established in the previous chapter determines whether PHCF can classify positive health reliably and usefully. The safeguards developed here determine whether it can do so responsibly. The framework can now be considered at a broader level. If positive-health classification survives conceptual, empirical, clinical and ethical testing, it raises questions concerning how such a framework could be implemented, governed, digitally represented and maintained over time. It also requires consideration of where PHCF should deliberately stop, how versioning should operate and what evidence would justify transition from an experimental framework to a recognised clinical classification. The following chapter examines implementation, governance, digital architecture and the conditions required for PHCF to progress from a research framework toward a sustainable classification infrastructure.

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Chapter Eleven - Implementation, Governance and Digital Architecture of PHCF

From Validated Framework to Sustainable Infrastructure

The preceding chapters have described the Positive Health Classification Framework as a scientific proposition that must earn its place within mental health care. A transition from PHCF Version 0.x to an empirically supported PHCF 1.0 would represent an important milestone, but validation alone would not establish that the framework could be implemented successfully. A classification can demonstrate reliability, validity and clinical utility under research conditions while proving difficult to integrate into routine services. Implementation constitutes a separate stage of development.

This distinction is especially important for PHCF because the framework is intended to organise information already distributed across assessment, formulation, recovery planning and clinical documentation. Poor implementation could simply add another form to an already complex clinical environment. A clinician required to complete a PHCF assessment independently from the existing mental health assessment, risk assessment, functional assessment, outcome measures and treatment plan may reasonably experience the framework as additional administrative work. The resulting burden could undermine the clinical purpose that initially justified it. Implementation science provides a useful basis for addressing this problem. Proctor et al. (2011) distinguish implementation outcomes from clinical and service outcomes and identify concepts including acceptability, adoption, appropriateness, feasibility, fidelity, implementation cost, penetration and sustainability. The updated Consolidated Framework for Implementation Research similarly emphasises the importance of the characteristics of an innovation, the people involved, organisational context and implementation processes in determining whether an evidence-based approach becomes usable in practice (Damschroder et al., 2022). PHCF should treat successful implementation as something requiring evidence rather than as the inevitable consequence of scientific validation. The question changes from whether the framework can classify positive health to whether health systems can use that classification consistently, efficiently and responsibly.

Implementation Should Begin With the Clinical Function

The clinical function of PHCF should determine its implementation architecture. PHCF is intended to make selected positive-health information sufficiently visible that it can contribute to assessment, formulation, treatment planning, recovery monitoring and clinical handover. Implementation should begin with these functions instead of with a requirement that every person receive a complete PHCF profile. Different settings will require different levels of information. A specialist psychological service may have the opportunity to develop a relatively detailed positive-health profile across several sessions. An acute mental health service may need only the capacities and resources immediately relevant to safety, treatment engagement and transition planning. A primary-care setting may require a concise profile that identifies existing self-management capabilities and available supports. A longer-term recovery service may place greater emphasis on trajectory, resource development and changes in personal recovery. The architecture should permit this variation while preserving common construct definitions. The requirement distinguishes flexibility of use from flexibility of meaning. A service may use only part of PHCF because only part is relevant to the clinical task. It should not redefine Agency and Self-Direction or Demonstrated Adaptation according to local preference. The meaning of constructs requires sufficient stability for information to remain interpretable when transferred between settings. PHCF implementation should preserve a stable conceptual core while permitting proportionate application.

A Minimum Clinically Useful PHCF

The earliest clinical implementation should probably be smaller than the complete research framework. Research development may require detailed assessment of candidate constructs in order to determine their psychometric structure and incremental validity. Routine clinical practice has a different requirement. Only information demonstrated to have sufficient clinical value should be retained. A minimum clinically useful PHCF would contain the smallest amount of information necessary to achieve the framework's proposed clinical functions. The exact content cannot be specified before the validation program described in Chapter Nine has been completed. The principle, however, can be established in advance. A construct should not enter routine PHCF documentation simply because it survives factor analysis or demonstrates acceptable reliability. Its inclusion should also be justified by clinical usefulness. This approach could produce a framework in which some constructs remain primarily research variables. Others may become routinely documented. A brief clinical profile might eventually identify Current Positive Health State, a small number of strongly supported Positive Health Capacities, relevant Demonstrated Adaptation and the most important accessible resources. More detailed assessment could remain available where clinical complexity warrants it. The distinction would prevent PHCF from accumulating content merely because that content can be measured. Parsimony should remain an implementation objective.

Integration Into Existing Clinical Workflow

The strongest implementation model would integrate PHCF into clinical work already occurring. Positive-health information frequently emerges during ordinary assessment. A person may describe previous episodes while discussing clinical history, reveal self-management strategies during treatment planning, identify valued relationships while discussing supports and demonstrate agency during shared decision making. Requiring clinicians to ask the same questions again under a PHCF heading would provide little benefit. A digital or paper-based PHCF process should permit information gathered elsewhere to populate the positive-health profile where appropriate. A documented history of recognising early warning signs could contribute to Recovery and Self-Management Capacity. Existing wellbeing measurement could inform Current Positive Health State. Social and contextual assessment could contribute to Protective Resource Ecology. Integration creates an important requirement concerning provenance. The framework should record where the information came from rather than converting all information into equivalent evidence. A person-reported experience of meaning, a clinician observation of relational interaction and a documented history of previous help seeking are different forms of evidence. Their origin should remain recoverable. The result would be a classification layer assembled progressively from clinically relevant information rather than a separate interview conducted solely to produce a PHCF score.

Training and Classification Competence

A common language can only function if users understand it sufficiently consistently. PHCF training should concentrate on construct boundaries and interpretation rather than on memorising labels. Clinicians should understand the difference between current state and capacity, between capacity and performance, between historical adaptation and current wellbeing, and between the existence of a resource and evidence that it is genuinely protective. Training should also expose foreseeable classification errors. Employment cannot substitute for Agency. Social network size cannot substitute for Relational Capacity. Surviving adversity cannot by itself establish Demonstrated Adaptation. Family involvement cannot automatically be coded as supportive. High positive affect cannot establish positive health in the presence of a manic episode. The amount of required training should itself be investigated

during implementation trials. If reliable PHCF use requires extensive specialist certification, the framework may be unsuitable for broad clinical adoption. Conversely, a framework requiring almost no training may achieve simplicity by sacrificing construct precision. Developmental field trials should examine how quickly clinicians learn the classification, where disagreement occurs and which definitions require clarification. Training should also include lived-experience and cultural perspectives. Classification competence is not simply technical competence. A clinician can apply scoring rules accurately and still misinterpret agency, recovery, adaptation or resources when cultural and contextual information is ignored.

Implementation Is an Organisational Process

PHCF cannot be implemented by clinicians alone. Clinical documentation is shaped by health-service workflows, electronic record systems, professional roles, time pressures, funding arrangements, regulatory requirements and organisational priorities. A framework that fits well within one service may encounter substantial barriers in another. The updated CFIR emphasises precisely this interaction between the innovation, individuals, implementation processes and the inner and outer environments in which implementation occurs (Damschroder et al., 2022). PHCF implementation studies should examine organisational context directly. A service may support recovery-oriented practice philosophically while providing clinicians with little time for formulation. Another may have sophisticated outcome-monitoring systems but no structured field for recording positive-health information. A multidisciplinary service may already capture most PHCF information across different professional assessments but lack a mechanism for integrating it. These environments require different implementation strategies. The framework should consequently be piloted in multiple types of service before broad adoption is considered. Implementation findings may also require modification of PHCF itself. If clinicians consistently cannot obtain a particular classification within ordinary workflows, the solution should not automatically be increased training. The construct or assessment process may need simplification.

Adoption Is Not the Same as Utility

A service can adopt PHCF without the framework improving care. Completion rates provide weak evidence of successful implementation. Clinicians may complete required fields because organisational policy demands it. A profile could appear in every clinical record and never influence a treatment decision. Implementation evaluation should preserve the distinction between adoption and clinical value. Proctor et al. (2011) identify adoption as one implementation outcome among several, while RE-AIM similarly distinguishes adoption from effectiveness, implementation and maintenance. RE-AIM has increasingly been used iteratively to examine how interventions operate and are adapted across real-world settings rather than treating implementation as a one-time rollout (Glasgow et al., 2019). PHCF should examine whether clinicians actually use the information. Formulation notes could be studied to determine whether identified capacities are incorporated into the clinical understanding. Treatment plans could be examined for evidence that relevant resources influence intervention. Handover studies could determine whether positive-health information is transferred. Service users could be asked whether PHCF changes the way their capabilities are recognised. The framework has not succeeded merely because the fields are populated.

Fidelity and Appropriate Adaptation

Implementation also requires a balance between standardisation and adaptation. Construct definitions require sufficient fidelity for classifications to remain comparable. The way information is collected may legitimately vary according to setting, age, culture and clinical need. A child and

adolescent service may use developmentally appropriate questions concerning agency and support. An adult service may use different language while assessing the same underlying construct. A culturally adapted interview may explore relational decision making rather than individual autonomy. A digital self-report process may contribute to one component while another service gathers similar information during face-to-face assessment. These variations do not necessarily threaten fidelity. The important distinction concerns whether the function and meaning of the construct remain stable. Implementation science increasingly recognises that adaptation can be necessary when interventions move across contexts and that implementation evaluation should document what has been changed and why. Iterative RE-AIM explicitly recognises the need to balance fidelity to essential functions with adaptations that improve fit with local culture, resources and circumstances. PHCF should adopt the same principle. Local flexibility should improve usability without allowing local services to redefine the classification.

PHCF Should Be Digital-First

A mature PHCF should be designed primarily for digital environments. This does not mean that paper-based use should be impossible. It means that the underlying classification architecture should assume that information can be structured, versioned, linked, updated and exchanged electronically. This direction reflects developments already occurring within major health classifications. ICD-11 was designed as a digital classification infrastructure and provides structured definitions, unique identifiers, programmatic access through an API and embedded classification tools that can be integrated into health applications. WHO's 2026 ICD-11 release describes the system explicitly as designed for digital health at scale and highlights its API-based interoperability and governed digital architecture. The emerging direction of DSM also supports a more dynamic model. APA currently operates DSM-5-TR through a continuous-improvement process in which proposed changes can be considered on a rolling basis, enabled partly by digital publication. The Future DSM work has gone further by discussing the possibility of a more frequently updated, digital-first living manual. These proposals remain developmental, but they demonstrate that contemporary classification infrastructure is moving away from dependence on infrequently revised printed manuals. PHCF should be designed for that environment from inception.

Structured Concepts Rather Than Digital Pages

A digital PHCF should not simply reproduce a printed manual on a screen. Its architecture should treat constructs as structured entities. Each construct would eventually require a persistent identifier, preferred name, definition, inclusion and exclusion boundaries, evidentiary requirements, relationships with neighbouring constructs, applicable qualifiers and version history. The value of this approach can be seen within ICD-11. Individual entities are represented through stable identifiers, while the digital architecture allows content to be accessed by software and presented through different interfaces. ICD-11 also permits additional detail through postcoordination while preserving the meaning of core classification entities. PHCF does not need to replicate ICD's architecture, but it should learn from its design principle. The classification should exist independently from the particular interface through which a clinician accesses it. A PHCF construct such as Recovery and Self-Management Capacity should have a stable identity even if one service displays it within an assessment form, another incorporates it within a formulation tool and a research platform presents it as part of a longitudinal dashboard. The interface can change. The construct should remain identifiable.

Persistent Identifiers and Semantic Stability

Versioning requires more than changing a number on the front of a manual. If the meaning of a construct changes, historical records must remain interpretable according to the definition in use when

the classification was made. This requires semantic stability. A persistent identifier should remain associated with a construct while minor clarifications are made. If a revision changes the construct fundamentally, the system may require a new identifier or an explicit relationship between the previous and revised entities. Consider Demonstrated Adaptation. PHCF 1.0 might treat it as one broad construct. Later evidence could demonstrate two distinguishable dimensions, perhaps involving adaptation expressed through behavioural mobilisation and adaptation expressed through reconstruction after disruption. A future PHCF should not silently redefine the original construct while leaving older records indistinguishable from newer ones. Version information should travel with the classification. A clinical record should be able to indicate that a particular classification was made under PHCF 1.0 even after PHCF 1.4 or PHCF 2.0 has been released. This requirement is essential for longitudinal research and clinical interpretation.

Interoperability Without Dependency

PHCF is intended to operate alongside existing clinical classifications. Digital interoperability should reflect that conceptual position. The framework should be capable of recording the source clinical classification without requiring diagnostic translation. A record might contain an ICD-11 code, DSM-based diagnosis or another source representation alongside PHCF information. PHCF should not attempt to create its own substitute identifier for the disorder. The same principle applies to functioning. Where ICF information is available, it should remain identifiable as ICF information. PHCF does not need to reproduce it. The objective is linked information without semantic collapse. Contemporary digital-health standards provide mechanisms through which structured health information can be exchanged. HL7's Fast Healthcare Interoperability Resources, or FHIR, is a widely used standard for electronic health-information exchange. FHIR Release 5 remains the current published normative release, while development toward Release 6 was continuing through ballot processes in 2026. PHCF does not currently require a dedicated FHIR implementation guide. Such development would be premature before the constructs are validated. A mature PHCF should nevertheless be designed so that its structured information could eventually be represented through widely used interoperability standards rather than requiring proprietary infrastructure. Interoperability should be treated as a design requirement even before technical specifications are created.

A PHCF Data Model

The eventual digital representation of PHCF should preserve the distinctions that define the framework. A PHCF entry would require more than a construct name and level. It should eventually be capable of representing the construct classified, the descriptive level or dimensional value, the date and relevant time period, trajectory where available, context, evidence source, confidence or uncertainty where appropriate, the PHCF version and the person responsible for or contributing to the classification. Some constructs may require additional information. Demonstrated Adaptation requires a connection with the historical challenge and the form of response demonstrated. Protective Resource Ecology requires information concerning the resource category and whether it is available, accessible, usable or mobilised. Current Positive Health State requires a clear temporal frame. Clinical Presentation Module information requires identification of the presentation to which it applies. These distinctions are not simply database details. They preserve the meaning of the classification. A poorly designed digital system could reduce Demonstrated Adaptation to a tick box labelled Present. Such implementation would destroy much of the contextual information that made the construct clinically defensible. The data architecture should emerge from the conceptual architecture.

Evidence Provenance

Multimethod classification creates a particular digital requirement concerning provenance. A PHCF profile may contain information originating from self-report, clinical interview, validated measurement, behavioural history, observation, collateral report or longitudinal records. These sources should not become indistinguishable once entered into the system. A person's report that they feel profoundly disconnected carries particular authority when Current Positive Health State is being considered. A clinician observation that the person communicates effectively during an appointment provides different evidence. A historical record showing repeated successful help seeking contributes differently again. Digital PHCF should permit the origin of evidence to be traced where doing so has clinical value. Provenance also assists disagreement. If the person considers a relationship harmful while another informant describes it as supportive, the system should not resolve the discrepancy by averaging the accounts. Both sources may require representation. This is especially important for PHCF because subjective meaning is central to several constructs.

Longitudinal Representation

One of the strongest advantages of digital implementation would be the capacity to represent positive-health trajectories over time. The current clinical record often makes longitudinal positive-health information difficult to see. A clinician may need to read multiple narrative notes to determine whether self-management has improved or whether social resources have deteriorated. A digital PHCF could eventually display changes in major domains across treatment while keeping symptom, functioning and positive-health trajectories distinct. A person might show declining depressive symptoms, stable Agency, improving Current Positive Health State and deteriorating Protective Resource Ecology following housing instability. Another might show persistent psychotic symptoms alongside increasing Meaning and Identity Capacity and stable relational resources. Displaying these trajectories together could make the two-continua proposition clinically visible. The interface should avoid converting this information into a single dashboard score. Visual simplicity is desirable, but simplification should not erase construct boundaries. Digital representation must follow the science.

Person Access and Correction

A framework concerned with positive health should be designed with the expectation that people may see their own classifications. Increasing patient access to electronic health information strengthens the need for language that remains comprehensible and respectful outside professional contexts. PHCF terminology should be tested not only for clinician reliability but also for interpretation by the people being described. The person should ideally be able to identify the evidence underlying relevant classifications and, where systems permit, comment on or challenge information they consider inaccurate. This does not require every disagreement to be resolved in favour of one perspective. It requires recognition that several PHCF domains concern the person's own experience and that clinician interpretation should not become invisible authority. Digital architecture could eventually permit a distinction between person-reported information, clinician synthesis and shared classification. Such functionality would be consistent with the rights-based principles established in Chapter Ten.

Decision Support Must Follow Validation

Digital implementation creates the possibility of clinical decision support. A system could theoretically identify emerging self-management capacity and suggest relapse-planning resources, detect declining resource access and prompt contextual review, or identify strong treatment-relevant capacities that may be useful within formulation. Such applications should be approached cautiously. PHCF classifications must demonstrate clinical meaning before automated recommendations are

attached to them. A relationship identified statistically does not automatically justify a clinical prompt. Decision-support rules require their own validation and monitoring for unintended consequences. Automation also increases the risk that tentative information becomes authoritative. A clinician may appropriately interpret an Emerging classification within a complex narrative. A digital alert may remove that nuance. PHCF should separate classification from decision support during early implementation. The framework should first demonstrate that the information is useful to human clinical reasoning. Automation can follow where independent evidence shows benefit.

Artificial Intelligence and PHCF

Artificial intelligence may eventually provide another method for identifying or summarising PHCF-relevant information within clinical records. Natural-language systems could potentially identify references to coping history, support mobilisation, valued activities or previous adaptation within narrative notes. Such tools might reduce documentation burden by surfacing information for clinician review. They should not be permitted to infer PHCF classifications autonomously without robust evidence. Positive-health constructs are highly contextual. A statement that a person continued working during severe depression could reflect adaptive persistence, financial necessity, fear of job loss or unsustainable overfunctioning. An automated system that interprets employment continuity as Demonstrated Adaptation could reproduce precisely the conceptual errors PHCF is designed to avoid. Any artificial-intelligence application should retain human review, explicit provenance and auditability. The purpose of technology should be to support the visibility of clinically relevant information rather than to automate judgements prematurely.

Governance as Scientific Infrastructure

A living classification requires an institution capable of maintaining it. PHCF governance should be considered part of the classification architecture. Governance determines what counts as sufficient evidence for a revision, who can propose changes, who evaluates them, how conflicts of interest are managed, how lived-experience and cultural perspectives influence decisions and how users are informed when classifications change. The existing DSM continuous-improvement process provides one model of structured revision. APA currently accepts proposals for DSM-5-TR changes on a rolling basis and requires supporting information addressing validity, reliability, clinical utility and potential unintended consequences. WHO provides another model through the globally governed and versioned ICD-11 digital infrastructure. WHO's 2026 release emphasises stable governance alongside digital-first classification and structured interoperability. PHCF should learn from both while developing governance appropriate to its own purpose. Scientific evidence should remain central, but governance cannot be constituted exclusively through classification scientists.

Composition of PHCF Governance

A mature governance structure would require several forms of expertise. Clinical representation is necessary because PHCF is intended for use in mental health services. Psychometric and classification expertise is required to evaluate evidence concerning construct validity, reliability and measurement. Implementation expertise is required because changes can alter workflows and service burden. Digital-health expertise becomes necessary once structured electronic implementation begins. Lived-experience representation must have genuine decision-making authority. Cultural and Indigenous expertise should influence construct meaning and implementation rather than serving only as consultation after changes have been drafted. Developmental, disability and neurodiversity perspectives are similarly important because constructs may operate differently across populations. International representation becomes necessary if PHCF moves beyond the setting in which it was initially

developed. Governance should also distinguish scientific review from organisational ownership. The framework should not depend permanently on the judgement of its original developer or research group. A successful classification must eventually become larger than its origin.

Managing Conflicts of Interest

Formal classification creates potential commercial and professional interests. Training programs, accreditation, assessment tools, software products and consulting services could develop around PHCF if the framework became widely used. These activities may assist dissemination, but they can also create incentives to preserve constructs or expand use beyond what evidence supports. Governance should include explicit conflict-of-interest policies. Researchers evaluating a PHCF measure should disclose financial interests in the measure. Decisions concerning inclusion or removal of constructs should not be controlled by organisations whose revenue depends on those constructs remaining in the framework. Digital implementations should not create proprietary barriers preventing independent evaluation. The credibility of PHCF will depend partly on whether the framework can change even when change is inconvenient to people or organisations invested in its existing form.

Change Control

A living classification requires structured change control. Not every revision has the same consequence. Correction of a typographical error has little effect on interpretation. Clarifying an example may have limited semantic impact. Altering the definition of Agency and Self-Direction could affect existing clinical classifications and research datasets. Removing a domain could alter the architecture of the entire framework. PHCF governance should distinguish minor editorial changes, substantive minor revisions and major structural revisions. Changes that alter construct meaning should require stronger evidence and more extensive field testing than wording changes. The consequences for existing records must also be considered before changes are adopted. If a revised construct is no longer directly comparable with its previous version, this should be stated explicitly. A living system should evolve without pretending that every new version is identical to what came before.

PHCF Versioning

The current versioning concept provides a useful starting point. PHCF 0.x represents conceptual development, evidence mapping and early empirical testing. PHCF 1.0 would represent the first framework with sufficient empirical support for defined clinical use. Subsequent PHCF 1.x versions could contain refinements that preserve the fundamental architecture, while PHCF 2.0 would indicate a major structural revision. Version numbers should have semantic meaning. Users should be able to determine whether a change affects interpretation. Research publications should state which version was used. Clinical systems should preserve the version attached to historical classifications. Digital tools should not automatically overwrite the meaning of previous data when a new release occurs. WHO's ICD infrastructure already demonstrates the practical importance of version-aware digital classification. The current API and embedded tools permit applications to specify or change the classification version being accessed, and the 2026 release can coexist with previous releases. PHCF should be designed with the same general principle of historical interpretability.

Evidence Thresholds for Revision

A revision process requires predefined evidentiary expectations. A new construct should not enter PHCF because one study reports a significant association. Evidence should be evaluated across construct validity, incremental value, clinical utility, cultural interpretation and potential unintended consequences. Similarly, one null result should not necessarily trigger removal. Replication, study

quality and the maturity of the evidence base matter. The governance process should use structured evidence review. Proposals could identify the construct affected, rationale for change, available evidence, implications for other PHCF domains, potential cultural consequences, effects on interoperability and anticipated implementation burden. Changes with major clinical consequences should undergo developmental field testing before release. The objective is to balance responsiveness with stability. A framework that never changes becomes scientifically obsolete. A framework that changes constantly becomes clinically unreliable.

Open Science and Independent Scrutiny

PHCF development should be as transparent as possible. Construct definitions, development protocols, validation methods and change proposals should be available for independent scientific scrutiny. Pre-registration of major validation studies can reduce the risk that analyses are adjusted retrospectively to preserve the framework. Data and analytic code should be shared where ethical, legal and privacy conditions permit. Negative findings should be publishable and visible. A study demonstrating that Demonstrated Adaptation adds no information beyond existing resilience measures would be scientifically important even if it weakened one of PHCF's most distinctive proposals. A failed Clinical Presentation Module would provide evidence that the Universal Core is more sufficient than originally anticipated. Transparency reduces the risk that PHCF development becomes a program of selective confirmation. Independent replication should remain a requirement before major claims become embedded within classification standards.

Licensing and Access

The method through which PHCF is distributed will influence who can use and evaluate it. A classification intended for broad mental health use should avoid creating unnecessary access barriers. Licensing may be required to protect integrity, prevent unauthorised alteration or support maintenance, but restrictive access could limit use in low-resource services and countries. The experience of international classifications demonstrates the importance of balancing governance with accessibility. WHO now provides digital ICD-11 infrastructure through web-based tools, APIs and embedded classification components, with its 2026 release emphasising free global access and structured digital integration. PHCF governance should eventually determine whether the core classification, terminology and implementation specifications can remain openly accessible while certification or specialised products operate separately. The scientific framework itself should remain available for independent testing.

Implementation Across Different Health Systems

A framework validated within one mental health system cannot be assumed to fit another. Health services vary substantially in workforce composition, documentation systems, appointment length, referral pathways, funding models and professional responsibilities. Some systems may use formal diagnostic classification heavily. Others may place greater emphasis on formulation or community recovery. Some may have sophisticated interoperable electronic records while others rely primarily on paper documentation. PHCF should undergo implementation research across diverse health-system environments. The question is broader than whether translation is required. A resource classified as accessible in one health system may have a very different meaning in another. Self-management expectations may also vary according to service availability. Implementation studies should consequently examine reach, adoption, feasibility, burden, appropriateness, equity and maintenance across settings rather than assuming that a successful pilot can simply be scaled. The RE-AIM emphasis on Reach, Effectiveness, Adoption, Implementation and Maintenance is useful here

because it prevents implementation success from being reduced to whether a small group of enthusiastic services can use the framework.

Equity in Implementation

Implementation itself can create inequity. Services with greater resources may be more able to train staff, integrate PHCF into digital systems and provide interventions that respond to resource deficits identified through the framework. Poorly resourced services could be required to document needs they have little capacity to address. This problem is particularly important for Protective Resource Ecology. Identifying that housing, transport or culturally appropriate services are unavailable provides useful clinical information. Repeatedly documenting those deficits without any system response may have little benefit to the person. PHCF implementation should examine whether the framework improves the capacity to act on identified information. Equity evaluation should also examine who receives a complete PHCF assessment, whose classifications remain Not Assessable and whether patterns differ according to language, culture, socioeconomic circumstances, disability or service setting. A framework designed to broaden clinical understanding should not inadvertently provide its richest descriptions only to people receiving the best-resourced care.

Pilot Implementation

PHCF should enter clinical services gradually. Early pilots should involve services willing to participate in developmental research and should retain the expectation that the framework will change. These sites should not be described as implementing a finished classification. The first implementation question should concern feasibility. Clinicians and people receiving care should evaluate whether the proposed assessment can be integrated into existing interactions, whether terminology is understandable and whether important information is lost or distorted. Subsequent pilots can examine reliability under routine conditions, influence on formulation and treatment planning, handover quality and longitudinal monitoring. Only after these stages should larger-scale implementation be considered. This sequence is consistent with the broader philosophy established throughout the book. PHCF should become increasingly stable as evidence strengthens. It should not create widespread clinical dependence while its basic constructs remain unsettled.

Implementation Evaluation

Implementation should continue to be evaluated after initial adoption. This requirement is important because interventions and frameworks can change when moved from controlled implementation studies into ordinary organisational practice. Clinicians may develop shortcuts. Some fields may be completed routinely while others are ignored. Local terminology may emerge. A carefully contextualised construct may become simplified into a score. Sustainability concerns more than whether PHCF remains in the electronic record. The framework should remain faithful enough to its intended meaning to continue providing useful information. Implementation evaluation could examine documentation quality, time burden, frequency of Not Assessable classifications, clinician understanding, person-reported acceptability, use within formulation, effects on handover and patterns of local adaptation. RE-AIM defines maintenance partly through the extent to which an approach becomes incorporated into routine organisational practice over time. Importantly, sustainability should not be considered successful if the framework survives organisationally after its clinical value has disappeared. Maintenance must include maintenance of purpose.

Monitoring Unintended Consequences

The ethical safeguards described in Chapter Ten should become implementation outcomes. Services should monitor whether PHCF information affects treatment eligibility, whether strong adaptation leads clinicians to underestimate distress, whether cultural groups receive systematically different capacity classifications and whether resource disadvantage is being misinterpreted as individual limitation. Person-reported experience is especially important. A framework may be technically correct and still change the clinical interaction in unintended ways. Some people may appreciate explicit recognition of their capacities. Others may experience classification of strengths as intrusive or reductive. Some may consider particular terminology culturally inappropriate. Monitoring should remain active after implementation rather than assuming that ethical questions were resolved during development. Governance must be capable of responding when actual use differs from intended use.

Conditions for Suspending or Retiring PHCF

A classification should have a pathway not only for expansion but for withdrawal. PHCF implementation should be suspended or substantially revised if evidence demonstrates systematic harm, unacceptable cultural bias, poor reliability in routine use or significant clinical burden without corresponding benefit. Individual constructs should similarly be retired when their evidentiary basis deteriorates. A mature scientific infrastructure should make discontinuation possible. This is a stronger standard than simply allowing revision. It recognises that some ideas should disappear completely when evidence no longer supports them. The ability to retire part or all of PHCF would demonstrate that the framework remains subordinate to its scientific purpose.

The Transition to PHCF 1.0

The designation PHCF 1.0 should signify more than completion of a manual. It should indicate that a defined set of positive-health constructs has survived systematic evidence synthesis, lived-experience and cultural review, operationalisation, reliability testing, construct and incremental validation, initial longitudinal investigation, clinical utility studies and developmental field testing. It should also indicate that a governance system exists. Definitions should be version controlled. The intended clinical uses and prohibited interpretations should be stated. Training requirements should be established. Digital representation should be possible without altering construct meaning. Processes for proposing, evaluating and releasing future changes should exist. PHCF 1.0 would still not represent a final classification. No scientific classification should make that claim. It would represent the point at which the available evidence becomes sufficient to justify moving from an experimental framework toward defined clinical use.

Classification as Infrastructure

The development described throughout this chapter changes the way PHCF should ultimately be understood. A mature classification is more than a taxonomy. It is an infrastructure connecting evidence, language, clinical reasoning, information systems, governance and revision. DSM and ICD demonstrate this at very different scales. Their influence arises not simply from lists of diagnostic entities but from common terminology, clinical guidance, research infrastructure, coding systems, education, health-system integration and mechanisms for revision. Contemporary ICD-11 makes this particularly visible because the classification exists as a structured digital system that can be accessed and integrated programmatically. If PHCF eventually becomes clinically useful, it will require a smaller but comparable form of infrastructure around positive-health information. The classification would need to preserve construct meaning when information moves between clinicians, services, research

studies and digital platforms. It would need to retain longitudinal interpretability as versions change. It would need to make evidence and uncertainty visible. It would need to permit cultural adaptation without allowing the classification to fragment into incompatible local meanings. These requirements are substantial. They should only be undertaken if the clinical information itself proves worth preserving.

The Implementation Proposition

The implementation proposition of PHCF can be stated cautiously. A scientifically valid positive-health classification will have limited impact unless its information can be incorporated into clinical care with acceptable burden, understood consistently across users, exchanged between systems, maintained longitudinally and revised as evidence changes. Implementation should preserve the framework's distinctions rather than simplify them into a global positive-health score. Digital architecture should support structured constructs, evidence provenance, context and versioning. Interoperability should allow PHCF to accompany existing diagnostic and functioning classifications without absorbing them. Governance should make the framework responsive to evidence while protecting stability and should distribute authority across scientific, clinical, lived-experience, cultural and international perspectives. These are requirements for a mature PHCF. They are not claims about the present framework. PHCF Version 0.1 remains a research architecture. The significance of specifying the eventual infrastructure now is that technical and governance decisions can otherwise constrain scientific development later. A framework developed first as a fixed paper instrument could become difficult to restructure when evidence changes. A proprietary data architecture could limit independent testing. Poor version control could make longitudinal research uninterpretable. PHCF should be designed for possible success without assuming that success will occur.

Toward a Complementary Classification of Mental Health

The book has now moved from the initial observation that mental health classification describes psychopathology more systematically than positive-health capacity to the architecture, operationalisation, clinical application, presentation-specific extension, empirical validation, ethical safeguards and implementation conditions of a possible complementary framework. The final question is broader. What would mental health classification look like if positive-health information genuinely demonstrated incremental clinical value? The answer should not be another system competing for ownership of the whole person. Diagnosis, psychopathology dimensions, functioning, quality of life, personal recovery, contextual information and PHCF each answer different questions. Their value lies partly in preserving these distinctions while allowing clinically meaningful information to be considered together. The final chapter returns to the central proposition of the book. It examines what PHCF would contribute if its assumptions are supported, what it should become if only some survive, where the framework must remain deliberately limited and what positive-health classification could mean for the future description of mental health.

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Chapter Twelve - Toward a Complementary Classification of Mental Health

Returning to the Original Question

The PHCF began with a relatively simple clinical observation. Mental health classification provides increasingly sophisticated ways of describing psychopathology, yet the same clinical record can contain much less systematic information about the positive health that remains available to the person. Diagnosis can identify depression, post-traumatic stress, psychosis, obsessive-compulsive symptoms or another recognised clinical presentation. Symptom measures can quantify severity. Risk assessment can identify immediate safety concerns. Functional assessment can describe activities and participation, while quality-of-life measures can examine how a person evaluates important areas of life. These forms of information are essential. They do not necessarily answer another clinically relevant question. *What health does the person have available to work with?* The question is deliberately different from asking whether symptoms are absent. It concerns whether the person retains meaningful positive mental health, whether adaptive psychological capacities remain accessible, what their history demonstrates about responding to previous challenges and which resources can realistically be mobilised within recovery or treatment. The central proposition of PHCF is that this information may constitute a clinically meaningful layer of mental health description in its own right. The proposition emerged from an important distinction established throughout this book. Mental illness and positive mental health are related but cannot be reduced reliably to opposite ends of a single dimension. Keyes' two-continua work demonstrated that the absence of mental illness does not automatically establish the presence of positive mental health and that clinically relevant psychopathology can coexist with meaningful positive-health characteristics (Keyes, 2002, 2005). Positive psychiatry subsequently strengthened the clinical relevance of this position by directing attention toward wellbeing, resilience, optimism, mastery, coping self-efficacy and social resources among people experiencing mental and physical illnesses (Jeste et al., 2015). Personal recovery research provides another part of the argument. Connectedness, hope, identity, meaning and empowerment can remain relevant even when symptoms continue (Leamy et al., 2011). Recovery is not captured completely by whether a diagnostic threshold has been crossed or a symptom score has fallen. None of these literatures demonstrates that PHCF is necessary. The purpose of this book has been to define that question closely enough that it can be tested.

What PHCF Is Proposing

PHCF proposes a complementary classification architecture for selected forms of positive-health information. Its provisional Universal Core consists of Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology. These components are intended to answer different clinical questions and remain separately describable. Current Positive Health State concerns what positive mental health the person presently experiences. It includes concepts such as engagement, connection, positive self-experience and valued direction, while recognising that established wellbeing measures may ultimately provide much of the assessment required for this component. Positive Health Capacities concern capabilities that appear available to the person. The present architecture proposes constructs including Agency and Self-Direction, Adaptive Regulation, Psychological Flexibility, Relational Capacity, Meaning and Identity Capacity and Recovery and Self-Management Capacity. Their final number and boundaries remain unresolved. Demonstrated Adaptation concerns evidence from the person's history. It asks what the person has previously been able to mobilise under meaningful challenge and recognises that historical capability may remain clinically relevant even when current wellbeing is poor. Protective Resource Ecology concerns the

resources available within and around the person. The construct recognises that positive health is influenced by relationships, community, culture, material circumstances, treatment access and wider environmental conditions. It also distinguishes the existence of a resource from its accessibility, usability, mobilisation and demonstrated protective relevance. Clinical Presentation Modules provide a mechanism through which additional information could be incorporated where specific forms of presentation create positive-health questions not represented adequately by the Universal Core. Their purpose is to increase specificity where evidence requires it without reconstructing a positive counterpart to DSM or ICD disorder families. The architecture is dimensional, hierarchical, contextual and longitudinal. It assumes neither a global positive-health score nor fixed categories. It is designed to change if the evidence requires different constructs, fewer constructs or a different hierarchy. PHCF Version 0.1 is a model of what might be worth classifying. It is not evidence that classification has been achieved.

What PHCF Is Not Proposing

The boundaries of the framework are as important as its content. PHCF is not another classification of mental disorder. DSM and ICD already provide established diagnostic languages, while HiTOP and related approaches provide dimensional alternatives for organising psychopathology. PHCF has no reason to reproduce these systems through positively worded terminology. It is not an attempt to classify functioning. The ICF already provides an international framework for describing body functions, activities, participation and environmental factors and distinguishes what a person can do from what occurs within their actual environment (World Health Organization [WHO], 2001). PHCF is not intended to replace quality-of-life assessment. The person's evaluation of their life provides information that remains different from psychological capability. It is also not intended to replace personal recovery. Personal recovery remains grounded in the person's own experience and definition of movement toward a meaningful life. A clinician-assigned positive-health profile cannot determine whether somebody is recovered. PHCF is not a classification of strengths in the everyday sense. Positive characteristics become relevant to the framework only when their meaning can be defined and their clinical contribution investigated. Most importantly, PHCF is not intended to classify successful people. Employment, education, income, independence, social popularity, emotional expressiveness, productivity and conformity to professional expectations cannot become substitutes for positive health. A framework that began ranking people according to these characteristics would have abandoned the problem it was created to investigate.

A More Complete Clinical Description

The potential clinical contribution of PHCF lies in complementarity. Consider two people presenting with the same diagnosis, similar symptom severity and comparable functional impairment. One has experienced several previous episodes and has developed reliable recognition of deterioration, established strategies for seeking help, a trusted support network and substantial evidence of previous recovery. The other is experiencing the condition for the first time and possesses little experiential knowledge of how symptoms develop or which forms of support are useful. Their diagnostic classifications may appropriately be the same. Their clinical situations are not. PHCF proposes that these differences may deserve structured description. The distinction does not imply that one person is healthier in every respect. The person with substantial previous adaptation may currently be more distressed. Their accumulated recovery knowledge may have developed through repeated and costly experiences of illness. Their strong adaptation may have required enormous effort. The framework is not designed to produce a simple hierarchy from less healthy to healthier. It is intended to preserve clinically relevant differences. This is why the profile architecture is preferable to a total score during

early development. Two people could theoretically produce identical total scores through entirely different configurations of Current Positive Health State, Positive Health Capacities, Demonstrated Adaptation and Protective Resource Ecology. Combining those profiles numerically could remove the information most useful for treatment. The clinical advantage, if one exists, lies in preserving structure.

Positive Health Can Coexist With Serious Illness

One of the most important conceptual implications of PHCF is that positive-health information does not reduce the legitimacy of psychopathology.

- A person experiencing severe depression may retain Agency and Self-Direction.
- A person experiencing psychosis may retain identity, meaning and strong relationships.
- A person with PTSD may demonstrate substantial adaptation while continuing to experience intrusive memories, hyperarousal or avoidance.
- A person with bipolar disorder may possess highly developed self-management while remaining vulnerable to future episodes.
- A person recovering from substance-related difficulties may possess substantial recovery capital while still requiring treatment and support.

These combinations are not contradictions; they reflect the multidimensional character of mental health. The same principle operates in the opposite direction. Absence of a current mental disorder does not establish that a person experiences meaningful connection, agency, valued direction or confidence in responding to future deterioration. A mental health classification that preserves both possibilities provides a more nuanced description than a continuum running simply from illness to health. PHCF does not require the diagnostic system to change for this distinction to be made. It requires an additional language.

Demonstrated Adaptation as a Distinctive Proposition

Of the provisional PHCF constructs, Demonstrated Adaptation may represent one of the framework's most distinctive contributions. Resilience research already examines adaptation under adversity, and PHCF should not claim ownership of that scientific territory. The particular proposition advanced through Demonstrated Adaptation concerns the systematic use of historical and behavioural evidence within a clinical positive-health profile. Clinical assessment routinely uses history to understand vulnerability. Previous episodes, childhood experiences, trauma, losses, interpersonal conflict and developmental difficulties may be documented because they help explain how current problems emerged. The same history can contain evidence of adaptation. A person may previously have recognised deterioration and sought treatment.

- They may have reconstructed life after severe disruption.
- They may have developed a strategy that allowed continued engagement under challenge.
- They may have repaired an important relationship.
- They may have changed an unsafe environment.
- They may have learned how and when to mobilise support.

These historical observations may provide information that is not captured fully by asking a person whether they consider themselves resilient. The distinction becomes especially important during acute illness because self-perception can change substantially with clinical state. A person experiencing

severe depression may genuinely feel that they are incapable of managing anything. Their history may simultaneously demonstrate substantial prior capability. PHCF can retain both forms of information. The framework must also retain the costs of adaptation. A response that enabled survival in one environment may become restrictive in another. Emotional suppression, hypervigilance, extreme self-reliance or perfectionistic performance may have served important functions under earlier conditions while creating difficulties later. Demonstrated Adaptation should never become a catalogue of impressive achievements. Its scientific value depends on whether historical adaptive evidence contributes information beyond existing measures of resilience, functioning and recovery. That proposition may prove correct. It may also fail.

Protective Resource Ecology and the Location of Health

Protective Resource Ecology carries a different theoretical importance because it prevents PHCF from locating positive health exclusively inside the person. Psychology has often measured individual characteristics more readily than the conditions surrounding them. A person can be described as resilient, flexible or self-managing even when the environment in which they are attempting to recover remains profoundly constrained. PHCF proposes that the resource environment should remain visible. A person may possess strong self-management capability and no access to appropriate treatment.

- They may possess substantial relational capacity while living in an isolated environment.
- They may understand their condition well while lacking stable housing.
- They may demonstrate agency while being restricted by discrimination, poverty or service availability.

These distinctions matter clinically because they change where responsibility for intervention is located. The response to inaccessible treatment should not be to increase the person's resilience. The response to unsafe housing should not be framed primarily as improving emotional regulation. The response to discrimination cannot be reduced to better coping. Protective Resource Ecology creates a structural safeguard within the framework. It allows limitations in opportunity and support to remain visible as contextual problems rather than being converted automatically into lower personal capacity. Whether this requires formal classification, structured contextual formulation or integration with existing frameworks remains an empirical question. The boundary should remain open.

The Importance of Not Assessable

One of the less dramatic but potentially important features of PHCF is the acceptance of uncertainty. Clinical classifications can create pressure toward completion. When a field exists, clinicians may feel that an answer should be entered. Positive-health information is especially vulnerable to inference because desirable characteristics can be assumed from superficial behaviour.

- A confident speaker may appear agentic.
- A calm person may appear well regulated.
- A person with employment may appear adaptive.
- A person surrounded by family may appear supported.

None of these conclusions is necessarily correct. PHCF should regard Not Assessable as a legitimate classification status. A clinician may not know enough about previous adversity to classify

Demonstrated Adaptation. The meaning of a family relationship may remain uncertain. A person's Current Positive Health State may be difficult to establish during an acute assessment. Different evidence sources may conflict. The framework should preserve that uncertainty. Explicit uncertainty is preferable to false precision. This principle becomes particularly important if PHCF information is eventually represented digitally. Structured electronic systems can give tentative clinical impressions an appearance of permanence and certainty. Evidence provenance, context and classification confidence should remain visible wherever required.

What Would Count as Success?

The success of PHCF should not be measured by whether the framework becomes widely recognised. Scientific success requires stronger evidence. At the most basic level, the proposed constructs must prove coherent enough to define and assess. Independent users must be able to distinguish them with acceptable consistency. Lived-experience research must demonstrate that the concepts represent meaningful forms of positive health rather than professionally imposed categories. Cultural work must establish that the framework can accommodate legitimate variation without ranking one way of living above another. Psychometric evidence must then demonstrate that the proposed domains have meaningful structure. Some constructs should correlate strongly with established measures where theory predicts convergence. They should also retain sufficient distinctiveness to justify separate terminology. Incremental validity is more demanding. PHCF should contribute information beyond diagnosis, symptom severity, functioning, quality of life and established wellbeing or recovery measures. Clinical utility establishes a further threshold. Knowing the PHCF profile should improve some aspect of assessment, formulation, treatment planning, recovery monitoring or clinical communication. Longitudinal research should demonstrate whether changes in positive-health constructs provide clinically meaningful information and whether some trajectories contribute to understanding recovery, recurrence or treatment engagement. Implementation research should then show that the framework can be used without disproportionate burden. A framework that meets these requirements would have demonstrated more than conceptual novelty. It would have shown clinical purpose.

Partial Success May Be the Most Plausible Outcome

The PHCF research program should not assume an all-or-nothing outcome. A likely possibility is that some parts of the framework prove substantially more useful than others. Demonstrated Adaptation may emerge as a clinically distinctive construct while Current Positive Health State proves adequately represented by established wellbeing measures. Recovery and Self-Management Capacity may show strong prognostic or treatment-planning value while Meaning and Identity Capacity remains better located within personal recovery assessment. Protective Resource Ecology may prove important conceptually but function more effectively as structured contextual assessment than as a dimensional classification. Clinical Presentation Modules may add substantial value for bipolar or substance-related presentations and contribute little for anxiety if the Universal Core already captures the required capacities. Such findings would not represent a compromised PHCF. They would represent scientific refinement. The eventual framework might be smaller than Version 0.1. That may be evidence of progress.

What Would Count as Failure?

A framework designed to be falsifiable must identify conditions under which its central proposition would be weakened substantially. If the proposed PHCF constructs cannot be distinguished reliably from established concepts, the need for a new classification is reduced. If Positive Health

Capacities collapse almost entirely into existing resilience, wellbeing or recovery scales, those established measures should be used. If Demonstrated Adaptation provides no meaningful information beyond behavioural history and self-reported resilience, it should not be formalised as a separate classification construct. If Protective Resource Ecology reproduces existing social-support, socioeconomic or ICF-related information without improving clinical interpretation, its role should be reconsidered. If Clinical Presentation Modules add complexity without clinically useful specificity, they should disappear. Most importantly, if PHCF-informed assessment does not improve formulation, treatment planning, communication, recovery monitoring or clinically relevant prediction, the justification for routine positive-health classification becomes weak. The information may remain useful within ordinary formulation. A classification may be unnecessary. That is an acceptable scientific conclusion. The objective is to solve a clinical information problem, not to protect a particular solution.

Classification Is Only One Possible Solution

This distinction returns to a question introduced earlier in the book. Fragmentation alone does not prove that classification is the optimal response. Clinicians may already be able to preserve positive-health information through stronger formulation practices. Electronic health records could introduce better structured fields. Recovery-oriented assessments may provide sufficient information for some clinical contexts. Existing wellbeing and resilience measures may answer the relevant questions adequately. PHCF must compete conceptually with these simpler alternatives. Classification becomes justified when the common language itself contributes value. DSM, ICD and ICF demonstrate the potential utility of shared classification languages. Their categories and domains allow information to be communicated across clinicians, research studies, services and health systems. PHCF proposes that some positive-health information may deserve comparable consistency. Whether it does remains to be demonstrated. A positive-health formulation framework may ultimately solve the problem more effectively than a formal classification. PHCF should be willing to become that framework if the data lead there.

Relationship With the Future of Psychiatric Classification

PHCF has been developed at a period in which the structure of psychiatric classification is itself being reconsidered. DSM-5-TR already includes dimensional and cross-cutting elements, while ICD-11 contains important dimensional developments and places substantial emphasis on clinical utility, culture and lifespan. HiTOP challenges traditional disorder categories through an empirically derived hierarchical model of psychopathology. RDoC approaches mental-health research through transdiagnostic functional constructs and multiple units of analysis. The American Psychiatric Association's Future DSM work has added further questions concerning diagnostic specificity, dimensionality, transdiagnostic characteristics, contextual information, functioning, quality of life and mechanisms for more continuous revision (Drexler et al., 2026; Oquendo et al., 2026; Öngür et al., 2026). These developments make the PHCF proposition harder rather than easier. That is beneficial. As mainstream psychiatric classification becomes broader, the territory PHCF can claim as uniquely underrepresented becomes narrower. Functioning cannot serve as the justification because functioning already has sophisticated frameworks and is receiving increasing attention within future psychiatric classification. Quality of life cannot provide the justification. Context alone cannot provide the justification. PHCF has to demonstrate value in the more specific territory of positive-health capacities, demonstrated adaptation, recovery capability and usable resources. A framework that survives after these neighbouring systems are considered is more defensible than one constructed by ignoring them.

Interoperability as a Statement of Scientific Modesty

PHCF's commitment to interoperability also reflects a broader philosophical position. No single classification should be expected to provide a complete explanation of the person. DSM and ICD answer questions concerning recognised clinical conditions. HiTOP addresses the empirical organisation of psychopathology. RDoC investigates neurobehavioural systems and mechanisms. ICF describes functioning, disability and interaction with environmental factors. Quality-of-life assessment provides the person's evaluation of important life domains. Personal recovery concerns the person's movement toward a meaningful life. PHCF proposes another question concerning positive-health states, capacities, adaptation and potentially supportive resources. These perspectives may overlap. They should not be collapsed unnecessarily. Interoperability represents scientific modesty. PHCF does not need to become the organising framework for all mental health information. Its contribution can remain narrow if that contribution proves useful.

The Language of Health and the Risk of Authority

Classification creates authority through language. When a clinical concept acquires a name, definition and classification level, it can become more influential than it was as an informal observation. That can improve communication. It can also create reification, where a provisional construct begins to be treated as a natural property of the person. PHCF is particularly vulnerable because its language is positive. A statement that someone has Limited Evidence of Agency could easily be interpreted more broadly than intended. An Established Demonstrated Adaptation classification could become a character judgement. A resource profile could become a proxy for social advantage. The ethical safeguards developed in Chapter Ten remain integral to any future PHCF. Constructs describe information. They do not define people. A classification should always remain conditional on evidence, time and context. The person exists beyond the profile.

A Framework That Must Not Become a Reason to Withhold Care

The most important operational safeguard can be stated again because of its consequences. Positive-health capacity must never be used automatically to minimise treatment need. This principle follows directly from the two-continua model. A person can possess substantial positive health and significant psychopathology simultaneously. Strong capacity can also conceal effort. Someone may continue working because financial survival requires it. Another may remain the primary carer for a family despite severe depression. A young person may continue achieving academically despite bullying and substantial distress. A person with trauma may appear highly self-sufficient because dependence on others has historically been unsafe. Clinical systems should not penalise these adaptations. If PHCF is ever used to support arguments that people with substantial capacities deserve less care, the framework will have been applied contrary to one of its central propositions. Positive health is additional information. It is not negative evidence of suffering.

Implications for Mental Health Outcomes

A validated PHCF could also influence how treatment outcome is conceptualised. Clinical improvement is frequently represented through reductions in symptoms, changes in diagnostic status, functioning and quality of life. These outcomes remain important. Positive-health classification introduces the possibility that treatment may also alter capacities. A person may complete treatment with greater ability to recognise deterioration. They may become more psychologically flexible. They may develop stronger relational capacity. They may acquire a clearer identity beyond the disorder. They may develop new strategies that later constitute Demonstrated Adaptation. Their Protective Resource Ecology may strengthen through connection with services, community or supportive relationships.

Some of these changes may already appear within existing outcome measures. Others may not. If positive-health capacities prove clinically consequential, treatment research could begin examining not simply whether symptoms improved but what health the person developed that could remain available after therapy ends. This proposition may have particular importance for relapse and recurrence. Treatment does not always eliminate future vulnerability. It may alter the person's capacity to respond when vulnerability reappears.

From Treatment Response to Recovery Capability

This distinction provides one of the more consequential possible applications of PHCF. Treatment response usually concerns change during or following intervention. Recovery capability concerns what remains available when future difficulties emerge. A person may complete therapy with substantially lower symptoms. Another may show the same symptom reduction while also developing sophisticated recognition of early warning signs, established help-seeking pathways, adaptive regulation strategies and accessible support. The immediate outcomes may appear similar. Their preparedness for future deterioration may differ. PHCF proposes that Recovery and Self-Management Capacity, Demonstrated Adaptation and Protective Resource Ecology may help describe that difference. Longitudinal research would be required before prognostic claims could be made. If evidence supported them, positive-health classification could contribute to a richer concept of treatment durability. Treatment would then concern not only whether the current episode improves, but what capabilities remain available afterward.

The Potential Contribution to Handover

Clinical handover provides a smaller but potentially practical application. Mental health handovers understandably prioritise current diagnosis, symptoms, risk, medication, recent events and immediate actions. Positive-health information can become dependent on narrative knowledge held by individual clinicians. A clinician may know that a person recognises deterioration reliably, responds well to direct collaborative planning, values a particular relationship and previously recovered through specific strategies. When care changes, these details may not travel with the diagnostic record. PHCF could provide a common location for such information. The value of this application is empirically testable. Researchers could determine whether PHCF-informed handovers improve continuity, reduce repeated discovery of established coping strategies or improve the receiving clinician's understanding of treatment-relevant capacities. A classification does not need to transform the whole of psychiatry to be useful. A modest improvement in continuity could itself justify particular components.

The Potential Contribution to Research

PHCF may also have value as a research taxonomy even if widespread clinical classification never occurs. Positive mental health research currently includes numerous measures of wellbeing, resilience, hope, recovery, empowerment, flexibility, social support and related characteristics. These constructs have developed within different theoretical traditions. A common architecture could assist researchers in distinguishing classes of positive-health information and identifying where measures overlap. Current positive state could be distinguished from enduring or accessible capability. Self-perceived resilience could be distinguished from historical evidence of adaptation. Personal capability could be distinguished from environmental resources. Personal recovery could remain identifiable as the person's own experience rather than becoming conflated with clinician-rated capacity. These distinctions could improve research design even if formal clinical classification proves unnecessary. The framework's usefulness has more than one possible endpoint.

What the Framework Should Never Claim

Even if PHCF eventually accumulates substantial evidence, several claims should remain outside its scope.

- It should not claim to define the mentally healthy person.
- It should not provide a universal hierarchy of good psychological characteristics.
- It should not determine which lives are meaningful.
- It should not establish the correct level of social connection, independence or achievement.
- It should not determine whether adversity has benefited somebody.
- It should not replace cultural understandings of health.
- It should not translate economic advantage into psychological health.
- It should not determine whether someone deserves treatment.
- It should not present a total score as a measure of human flourishing unless extraordinary evidence eventually justified such interpretation.

These limitations are strengths. Classification becomes more credible when its boundaries are explicit.

The Case for a Living Framework

If PHCF progresses beyond Version 0.x, it should remain a living framework. Contemporary health classification increasingly recognises that knowledge changes too rapidly for classifications to remain fixed for long periods without mechanisms for revision. The Future DSM work and the digital architecture of ICD-11 both reflect movement toward more responsive classification infrastructure. PHCF can incorporate that lesson from inception.

- Constructs should have version histories.
- Evidence supporting them should remain reviewable.
- Definitions should be capable of revision.
- New constructs should require evidence.
- Existing constructs should be removable.
- Clinical Presentation Modules should be able to expand or disappear.
- Historical records should preserve the version under which classifications were made.

A living framework should not mean constant instability. Governance must balance responsiveness with the need for reliable clinical language. The principle is that no construct becomes permanent simply because it entered an earlier edition.

Success Should Change PHCF

There is an apparent paradox at the centre of the development program. If PHCF research is successful, the final framework should probably differ from the one proposed in this book. Systematic reviews will identify concepts that are missing or redundant. Lived-experience research will change terminology and perhaps architecture. Cultural research will challenge assumptions embedded in initial definitions. Factor analysis may collapse some capacities and divide others. Longitudinal research may show that particular domains matter more than expected. Clinical utility studies may remove constructs that perform well psychometrically but contribute little to practice. Implementation may require substantial simplification. This means fidelity to PHCF Version 0.1 cannot be the measure of success. Version 0.1 provides hypotheses. Evidence provides the framework.

A Different Way of Describing Mental Health

If PHCF's central propositions survive empirical testing, the broader contribution would be a different way of organising the clinical description of mental health. A person's record could state what disorder or psychopathology is present.

- It could state how severe the symptoms are.
- It could describe relevant risk.
- It could describe functioning and quality of life.
- It could record the person's understanding of recovery.
- It could also describe what positive mental health is currently present, what capacities remain accessible, what previous adaptation demonstrates and which resources can realistically support recovery.

These forms of information would not compete for the title of the person's true mental health. Each would describe something different. The result may be a clinical language capable of acknowledging significant illness and significant health simultaneously. That is the central conceptual change proposed by PHCF.

The Final Proposition

The PHCF begins from the position that psychiatric diagnosis tells an important yet incomplete part of the clinical story. The incompleteness should not be exaggerated. Modern mental health care already contains sophisticated theories and measures of wellbeing, functioning, quality of life, recovery, resilience and contextual resources. PHCF does not emerge because these areas have been ignored. The proposed problem is one of organisation. Positive-health information may be clinically relevant but distributed across different concepts, measures and documentation practices. Capacities may be recognised informally. Previous adaptation may remain buried within clinical history. Resources may be grouped together as protective factors despite having very different relationships with recovery. PHCF proposes that some of this information may benefit from a common architecture. The framework will be justified only if that architecture improves what can already be achieved through existing approaches. The ultimate question is not whether positive health exists. There is substantial evidence that it does. The question is whether positive health contains forms of clinically important information that can be classified reliably, communicated consistently and used meaningfully alongside psychopathology without reducing complexity, imposing cultural values or diminishing the legitimacy of illness. That question remains unanswered. PHCF is proposed as a way of answering it.

Conclusion

Mental health classification has evolved repeatedly because clinicians and researchers have encountered information that existing systems could not represent adequately. Earlier classification systems confronted problems of terminology and reliability. Later developments strengthened empirical review, clinical utility, dimensionality, culture, context and functioning. Contemporary psychiatric nosology continues to question how mental-health information should be organised and at what level clinical phenomena should be represented. PHCF enters this history with a deliberately limited proposition. The framework does not seek to replace psychiatric classification. It asks whether a complementary classification of positive-health states, capacities, demonstrated adaptations and accessible resources can improve the clinical description of people experiencing mental health difficulties. The proposal is plausible because positive mental health cannot be inferred reliably from absence of disorder, personal recovery can progress while symptoms remain, adaptive capacities can

persist during significant illness and resources outside the individual can materially influence recovery. Plausibility is only the beginning. The constructs must be defined. Their boundaries must withstand comparison with established concepts. Their measures must demonstrate adequate validity. Their interpretation must remain culturally and developmentally defensible. People with lived experience must recognise the framework as representing meaningful information rather than imposing professional judgement. Clinical utility must be demonstrated. Unintended consequences must be monitored. Components that fail these tests must be removed. If the evidence ultimately shows that ordinary formulation, existing recovery measures and current assessment frameworks already organise this information adequately, PHCF should contract or disappear. If only part of the architecture proves useful, that part should survive. If the framework demonstrates reliable incremental clinical value, then positive-health classification may become a useful companion to existing descriptions of psychopathology. The aspiration is not to create the positive equivalent of DSM. It is to determine whether mental health can be described more completely when the clinical language records not only what is disturbed, but also what remains available for recovery, adaptation and continued life. The final measure of PHCF will be whether that additional description helps people understand and use the health that remains present alongside illness.

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Positive health is not simply the absence of mental illness.

The Positive Health Classification Framework (PHCF) proposes a complementary framework for describing positive mental health, adaptive capacity, demonstrated adaptation and protective resource ecology alongside diagnosis, functioning, quality of life and recovery.

This first edition presents the conceptual architecture of PHCF, its proposed domains, clinical applications, research agenda, ethical safeguards and implementation pathway.

Clinically oriented and future-focused, PHCF asks whether positive-health information can be classified in ways that add meaningful value to mental health assessment and care.

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Paul D. Kremer is the originator of the Positive Health Classification Framework and author of this first edition.

