PHCF

Classification Manual

Version 1.0

POSITIVE HEALTH CLASSIFICATION FRAMEWORK

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

FIRST EDITION

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What positive health does the person have available to work with?

Classification System Manual

Version 1.0

Publication and Development Status

Positive Health Classification Manual (PHCF Classification Manual), Version 0.1. Companion to the Positive Health Classification Framework (PHCF), First Edition, 2026.

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Framework status - PHCF Version 0.1 is a proposed and provisional classification architecture. The constructs, descriptive anchors, qualifiers and Clinical Presentation Modules in this manual have not been established as validated diagnostic criteria or validated clinical thresholds.

Purpose of this Manual

The First Edition develops the scientific rationale, theoretical foundations, architecture, operational requirements and clinical applications of PHCF. This companion manual brings those elements together into a single operational format so the proposed classification can be seen, discussed and tested as a system. It does not change the evidentiary status of PHCF.

Clinical and Scientific Safeguard

PHCF complements rather than replaces established assessment of mental disorder, psychopathology, functioning, disability, risk or quality of life. A high positive-health classification does not establish absence of mental disorder, low symptom severity, low clinical risk or reduced need for treatment. Limited evidence of a positive-health construct does not establish psychopathology, diminished personal worth or failure of recovery. PHCF should not be used in isolation to determine diagnosis, risk, eligibility for care, withdrawal or restriction of treatment, disability entitlement, insurance decisions, employment suitability, compulsory treatment, forensic disposition or other consequential legal or administrative decisions.

Manual Note

The manual preserves the architecture and terminology of the First Edition. Where the book provides a construct definition, boundary or rule, the manual uses that content directly or in close paraphrase. Where the book provides only a developmental direction, the manual labels the material as provisional and does not convert illustrative indicators into formal criteria.

Contents

Part I - Classification System

1. Purpose and Unit of Classification

PHCF asks a specific clinical question - *what health does the person have available to work with?* The question concerns positive mental health currently experienced, psychological capacities that appear available or potentially mobilisable, what the person has previously demonstrated under meaningful challenge, and which resources can realistically be accessed and used. The unit of classification is the specified positive-health construct as expressed within context. PHCF does not classify the worth, morality, character, courage, productivity or social value of the person.

PHCF classifies	**PHCF does not classify**
Positive-health states within a defined time frame	Human worth or social value
Psychological and adaptive capacities	Desirable personality or moral character
Demonstrated adaptations under meaningful challenge	Achievement, status or productivity as proxies for health
Resources and their accessibility, usability and mobilisation	The mere existence of a relationship, service or material asset as proof of protection

Independence rule
Psychopathology and positive health are related but non-equivalent. Positive health should be assessed directly rather than inferred from the presence or absence of psychopathology.

2. Architecture and Classification Workflow

PHCF is hierarchical, dimensional and complementary. The source clinical classification remains external to PHCF and is preserved exactly as used. The Universal Core is then applied. Clinical Presentation Modules are supplementary and are used only where presentation-specific positive-health information adds value beyond the Universal Core.

Layer	Function	Content
Source clinical classification	Clinical context external to PHCF	DSM, ICD, HiTOP or another recognised clinical formulation
Universal Core 1	Current Positive Health State	Positive self-experience, engagement and vitality, belonging and connection, meaning and valued direction
Universal Core 2	Positive Health Capacities	Agency and Self-Direction, Adaptive Regulation, Psychological Flexibility, Relational Capacity, Meaning and Identity Capacity, Recovery and Self-Management Capacity
Universal Core 3	Demonstrated Adaptation	Historical evidence of adaptation under meaningful challenge
Universal Core 4	Protective Resource Ecology	Personal, relational, cultural/community, structural/material, environmental and treatment-related resources
Optional layer	Clinical Presentation Modules	Additional presentation-relevant constructs only when evidence supports incremental specificity
Qualifiers	Interpretive information	Trajectory, context, evidence source, confidence or uncertainty and PHCF version

Standard workflow

- Record the source clinical classification without translating it into a PHCF diagnosis.
- Assess the four Universal Core components from information already arising in comprehensive clinical assessment.
- Use evidence appropriate to the construct. Do not rely on one method when the construct requires multimethod evidence.
- Apply a provisional descriptive anchor only when the available information supports one. Use Not Assessable when it does not.
- Add a Clinical Presentation Module only when presentation-specific positive-health information is clinically relevant and not already captured by the Universal Core.
- Record context, evidence source, uncertainty and trajectory where relevant.
- Produce a multidimensional PHCF profile. Do not calculate an overall PHCF score.
- Use the profile as an input to formulation, treatment planning, recovery planning, monitoring and handover while keeping risk assessment and diagnostic reasoning independent.

3. Provisional Descriptive Anchors

PHCF begins dimensionally. The First Edition does not justify fixed cut-offs. The following anchors support description and research, not diagnosis or eligibility decisions.

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.

Critical rule
Not Assessable is an evidentiary classification. It does not mean the construct is absent, impaired or low.

The term severity should generally remain associated with psychopathology or impairment. PHCF constructs are described by level, extent or degree. The label applies to the construct, not to the person.

4. Evidence, Context, Uncertainty and Trajectory

Evidence sources

The evidentiary basis should fit the nature of the construct. Appropriate sources may include self-report, clinical interview, behavioural and developmental history, clinical observation, appropriately obtained collateral information, validated psychometric instruments and longitudinal clinical information. Disagreement between sources should not automatically be treated as error. Different sources may describe different contexts.

Component	Principal evidence emphasis
Current Positive Health State	Person report, clinical interview and validated wellbeing measures.
Positive Health Capacities	Interview, behavioural evidence, observation, relevant measures and history.
Demonstrated Adaptation	Behavioural history, lived experience, collateral information and longitudinal records.
Protective Resource Ecology	Contextual assessment, person report, collateral and environmental information.

Uncertainty

Uncertainty should remain visible. Where the evidence is sparse, contradictory, contextually restricted or temporally unclear, the record should state the limitation. The classifier should not force a positive-health judgement simply because a form requires one.

Trajectory

PHCF treats a classification as a current description within a longer course. Positive health can develop, stabilise, fluctuate or decline over time. For Version 0.1, trajectory should be recorded descriptively. Suggested provisional labels are Improving or Developing, Stable, Fluctuating and Declining. The time interval and evidence supporting the trajectory should be recorded.

Trajectory rule
Positive-health trajectory and psychopathology trajectory should be recorded independently. Symptom improvement does not prove positive-health improvement, and positive-health improvement does not prove symptom remission.

5. Interpretation and Prohibited Inferences

- Strong positive-health capacities must not be used to infer low symptom severity or low clinical risk.
- Demonstrated Adaptation must not be used to reduce eligibility for treatment or to imply that adversity was beneficial.
- Occupational, academic, financial or social achievement must not be substituted for positive health.
- Dependence on assistance must not be interpreted automatically as low Agency and Self-Direction.
- Exposure to adversity must not be classified as adaptation without evidence of how the person responded.
- A resource must not be called protective merely because it exists. Availability, accessibility, usability, mobilisation and evidence of effect are different questions.
- Positive affect alone is insufficient evidence of positive mental health.
- Personal recovery remains defined. PHCF must not turn recovery into a clinician-controlled standard of success.
- Risk assessment remains independent from PHCF.
- Structural deprivation, poverty, discrimination or inaccessible services must not be reframed as individual failure of positive health.

Part II - Universal Core

6. Current Positive Health State

Current Positive Health State describes positive mental health experienced at the time of assessment. It is the most state-like PHCF component and may fluctuate with symptoms, stress, bereavement, physical illness and environmental conditions. Existing well-being measures may eventually supply much of the evidence needed for this component.

PHCF Construct Specification - *Positive Self-Experience*

PHCF construct	Positive Self-Experience
Construct definition	The person's current relationship with themselves, including self-acceptance, coherence and a sense of personal legitimacy.
Classification focus	What is the person's present relationship with themselves?
Temporal orientation	Current
Relevant evidence	Person report, clinical interview and, where relevant, validated measures of wellbeing or self-related positive functioning.
Illustrative indicators	Self-acceptance; a coherent sense of self; capacity to hold grief, guilt or disappointment without total loss of personal legitimacy.
Do not infer from	Consistently positive self-evaluation, confidence, achievement, absence of guilt or absence of psychopathology.
Related PHCF constructs	Meaning and Identity Capacity; Agency and Self-Direction.
Adjacent non-PHCF constructs	Psychopathology, self-esteem measures, quality of life and social functioning.
Contextual interpretation	Interpret within the person's cultural, developmental and relational context. Emotional reserve or self-criticism should not automatically be treated as absence of positive self-experience.
Classification uncertainty	Use Not Assessable when the person's current self-experience cannot be established or the assessment context makes interpretation unreliable.
Proposed clinical relevance	May help distinguish low current wellbeing from retained capacities and may identify restoration of self-coherence as a treatment or recovery target.
Evidence status	Provisional PHCF domain. The domain is grounded in established positive mental health and recovery literature, while PHCF-specific indicators, levels and clinical utility require validation.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Engagement and Vitality*

PHCF construct	Engagement and Vitality
Construct definition	Meaningful psychological involvement in life and access to sufficient energy or interest to participate in personally valued experiences.
Classification focus	Is the person currently psychologically engaged with experiences that matter to them?
Temporal orientation	Current
Relevant evidence	Person report, interview, behavioural description and relevant wellbeing measures.
Illustrative indicators	Interest in personally valued activity; psychological involvement; access to energy or motivation sufficient for meaningful participation.
Do not infer from	Employment, productivity, busyness, social conformity or the number of activities undertaken.
Related PHCF constructs	Meaning and Valued Direction; Agency and Self-Direction.
Adjacent non-PHCF constructs	Functioning, activity and participation under the ICF; symptom severity.
Contextual interpretation	Engagement may occur through relationships, creativity, culture, family life, community activity or private interests. Occupational activity is not privileged.
Classification uncertainty	Use Not Assessable where values and meaningful activities have not been established or current circumstances obscure the state.
Proposed clinical relevance	Can identify restoration of engagement as an outcome that is distinct from symptom reduction.
Evidence status	Provisional PHCF domain. The domain is grounded in established positive mental health and recovery literature, while PHCF-specific indicators, levels and clinical utility require validation.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Belonging and Connection*

PHCF construct	Belonging and Connection
Construct definition	The person's current experience of meaningful interpersonal or social connection.
Classification focus	Does the person currently experience meaningful belonging or connection?
Temporal orientation	Current
Relevant evidence	Person report, interview and relevant measures of connectedness or wellbeing.
Illustrative indicators	Experienced belonging; emotionally meaningful connection; a sense of being linked to people, culture or community.
Do not infer from	Network size, relationship status, frequency of contact or the mere presence of family and peers.
Related PHCF constructs	Relational Capacity; Protective Resource Ecology.
Adjacent non-PHCF constructs	Social functioning and social support measures.
Contextual interpretation	Quality, meaning and accessibility of connection matter more than the number of relationships. Cultural and collective forms of belonging require equal consideration.
Classification uncertainty	Use Not Assessable when current connection cannot be established or when relationship quantity is known but subjective meaning is unclear.
Proposed clinical relevance	May distinguish social isolation, lack of belonging and relational-resource problems from capacity to form or use relationships.
Evidence status	Provisional PHCF domain. The domain is grounded in established positive mental health and recovery literature, while PHCF-specific indicators, levels and clinical utility require validation.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Meaning and Valued Direction*

PHCF construct	Meaning and Valued Direction
Construct definition	The current experience that life contains personally significant commitments, values, purposes or directions.
Classification focus	Does the person currently experience a valued direction that is meaningful to them?
Temporal orientation	Current
Relevant evidence	Person report, clinical interview and relevant wellbeing or recovery measures.
Illustrative indicators	Personally significant values, commitments, purposes, responsibilities, cultural or spiritual directions, creative pursuits or desired development.
Do not infer from	Clinician-defined goals, occupational success, conventional milestones or externally imposed ideas of a worthwhile life.
Related PHCF constructs	Meaning and Identity Capacity; Agency and Self-Direction; personal recovery.
Adjacent non-PHCF constructs	Quality of life, role functioning and goal attainment.
Contextual interpretation	The person remains the principal authority concerning what constitutes a valued direction. Cultural, spiritual and collective meanings must be interpreted on their own terms.
Classification uncertainty	Use Not Assessable when the person has not had a reasonable opportunity to describe what matters to them or the assessment context is coercive or unstable.
Proposed clinical relevance	May identify a recovery dimension that remains limited after symptom reduction or remains intact during significant psychopathology.
Evidence status	Provisional PHCF domain. The domain is grounded in established positive mental health and recovery literature, while PHCF-specific indicators, levels and clinical utility require validation.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

7. Positive Health Capacities

Positive Health Capacities describe psychological capabilities that appear available to the person and may be mobilised during ordinary life, challenge, treatment or recovery. They are not equivalent to current wellbeing and should not be inferred from functioning alone.

PHCF Construct Specification - ***Agency and Self-Direction***

PHCF construct	Agency and Self-Direction
Construct definition	Capacity to experience oneself as an active participant in one's life, make meaningful choices and participate in decisions affecting personal direction.
Classification focus	Can the person participate meaningfully in directing their life and decisions?
Temporal orientation	Current and potential
Relevant evidence	Interview, behavioural evidence, observation, person report, relevant measures and history.
Illustrative indicators	Expressing preferences; participating in decisions; choosing among supports; setting or revising personally meaningful goals; initiating actions consistent with values.
Do not infer from	Independence, living alone, refusing support, occupational status, assertiveness style or absence of dependence.
Related PHCF constructs	Meaning and Identity Capacity; Recovery and Self-Management Capacity.
Adjacent non-PHCF constructs	Functioning, autonomy measures and social role performance.
Contextual interpretation	Interdependence may reflect strong agency when collective decision making and relationships are personally or culturally valued.
Classification uncertainty	Use Not Assessable when choice is substantially constrained, the person has not been given genuine options or available evidence does not show how decisions are made.
Proposed clinical relevance	May guide collaborative treatment planning and identify whether supports increase or constrain meaningful participation in decisions.
Evidence status	Provisional PHCF capacity. The theoretical construct is supported by adjacent literature, while PHCF-specific boundaries, indicators, classification levels and incremental clinical utility require empirical testing.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Adaptive Regulation*

PHCF construct	Adaptive Regulation
Construct definition	Capacity to recognise and influence emotional, cognitive, physiological and behavioural responses in ways that fit context and personal goals.
Classification focus	Can emotional, cognitive and behavioural responses be managed in ways that fit current demands?
Temporal orientation	Current and potential
Relevant evidence	Interview, behavioural examples, observation, relevant measures and history across differing levels of demand.
Illustrative indicators	Recognising rising emotion or arousal; tolerating states that do not require change; selecting responses suited to context; using strategies that reduce disruption without creating greater cost.
Do not infer from	Emotional suppression, appearing calm, absence of distress, compliance or a single preferred coping technique.
Related PHCF constructs	Psychological Flexibility; Recovery and Self-Management Capacity.
Adjacent non-PHCF constructs	Symptom control, emotion-regulation measures, functioning and behavioural compliance.
Contextual interpretation	Some environments require external change rather than greater internal control. Strategy effectiveness depends on context and intensity of demand.
Classification uncertainty	Use Not Assessable when regulation has been observed only in one narrow context or when the environmental demand itself is unclear.
Proposed clinical relevance	May identify capacities that can be recruited in treatment and distinguish inability to access regulation from absence of current wellbeing.
Evidence status	Provisional PHCF capacity. The theoretical construct is supported by adjacent literature, while PHCF-specific boundaries, indicators, classification levels and incremental clinical utility require empirical testing.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Psychological Flexibility*

PHCF construct	Psychological Flexibility
Construct definition	Capacity to recognise changing demands, modify ineffective responses and continue behaviour that remains consistent with important values.
Classification focus	Can ineffective strategies be modified when circumstances or goals change?
Temporal orientation	Current and potential
Relevant evidence	Interview, examples across situations, behavioural history, relevant measures and observation.
Illustrative indicators	Changing strategy when it no longer works; tolerating new information; shifting behaviour to match current conditions; maintaining valued action despite discomfort where appropriate.
Do not infer from	Constant change, passivity, agreeableness, symptom absence or abandonment of personally important values.
Related PHCF constructs	Adaptive Regulation; Agency and Self-Direction.
Adjacent non-PHCF constructs	Cognitive flexibility, coping style, acceptance and functioning.
Contextual interpretation	Flexibility is context-dependent. Persistence can be adaptive when circumstances support it, and change can be maladaptive when it abandons safety or values.
Classification uncertainty	Use Not Assessable when there is insufficient evidence about how the person responds when strategies fail or circumstances change.
Proposed clinical relevance	May inform behavioural, exposure, acceptance-based and relapse-prevention work where adaptive strategy change is clinically relevant.
Evidence status	Provisional PHCF capacity. The theoretical construct is supported by adjacent literature, while PHCF-specific boundaries, indicators, classification levels and incremental clinical utility require empirical testing.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Relational Capacity*

PHCF construct	Relational Capacity
Construct definition	Capacity to establish, maintain, use and where possible repair meaningful relationships.
Classification focus	Can meaningful supportive relationships be formed, maintained and used?
Temporal orientation	Current and potential
Relevant evidence	Interview, relational history, behavioural examples, person report, collateral where appropriate and observation of relevant interpersonal patterns.
Illustrative indicators	Trusting selectively; reciprocity; seeking or accepting support; maintaining boundaries; repairing ruptures where safe and possible.
Do not infer from	Number of relationships, relationship status, family size, extroversion, sociability or the existence of a support network.
Related PHCF constructs	Belonging and Connection; Protective Resource Ecology.
Adjacent non-PHCF constructs	Social support, attachment, interpersonal functioning and participation.
Contextual interpretation	A person may have strong relational capacity while socially isolated, or many available relationships while being unable to use them safely. Cultural forms of relationality require contextual interpretation.
Classification uncertainty	Use Not Assessable where relationship history is unavailable, unsafe relationships dominate the available evidence or current isolation prevents a meaningful judgement.
Proposed clinical relevance	May identify whether relational resources can be used in treatment and whether intervention should focus on capacity, access to relationships or both.
Evidence status	Provisional PHCF capacity. The theoretical construct is supported by adjacent literature, while PHCF-specific boundaries, indicators, classification levels and incremental clinical utility require empirical testing.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Meaning and Identity Capacity*

PHCF construct	Meaning and Identity Capacity
Construct definition	Capacity to maintain, access or reconstruct a coherent sense of self and valued direction during illness, transition or adversity.
Classification focus	Can a coherent sense of self and valued direction be maintained or reconstructed?
Temporal orientation	Current and potential
Relevant evidence	Person report, interview, longitudinal history, recovery measures and evidence of identity continuity or reconstruction across challenge.
Illustrative indicators	Maintaining identity beyond illness; reconnecting with valued roles or commitments; reconstructing a coherent narrative after disruption; retaining personal meaningful values.
Do not infer from	Conformity to a preferred identity, occupational role continuity, positive self-esteem or clinician-defined meaning.
Related PHCF constructs	Positive Self-Experience; Meaning and Valued Direction; personal recovery.
Adjacent non-PHCF constructs	Identity disturbance, quality of life, functioning and social role performance.
Contextual interpretation	Identity and meaning are culturally and personally situated. Multiple, relational, collective or spiritual identities may be central.
Classification uncertainty	Use Not Assessable when the person has not been able to define valued identity or direction or when acute conditions make continuity impossible to evaluate.
Proposed clinical relevance	May be especially relevant when illness threatens to dominate the person's account of who they are or when recovery involves reconstruction after disruption.
Evidence status	Provisional PHCF capacity. The theoretical construct is supported by adjacent literature, while PHCF-specific boundaries, indicators, classification levels and incremental clinical utility require empirical testing.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

PHCF Construct Specification - *Recovery and Self-Management Capacity*

PHCF construct	Recovery and Self-Management Capacity
Construct definition	Capacity to recognise relevant changes in mental health, understand personal patterns, use established strategies, seek appropriate support and participate actively in decisions about ongoing care.
Classification focus	Can changes in mental health be recognised and appropriate responses or supports mobilised?
Temporal orientation	Current and longitudinal potential
Relevant evidence	Interview, treatment and relapse history, behavioural evidence, care plans, person report and longitudinal clinical information.
Illustrative indicators	Recognising early warning signs; using previously effective strategies; activating a plan; seeking help; communicating deterioration; participating in care decisions.
Do not infer from	Symptom recurrence, total self-sufficiency, perfect adherence, coping without support or absence of relapse.
Related PHCF constructs	Agency and Self-Direction; Adaptive Regulation; Demonstrated Adaptation; Protective Resource Ecology.
Adjacent non-PHCF constructs	Insight, adherence, health literacy, functioning and symptom severity.
Contextual interpretation	Mobilising external assistance can represent strong self-management. Capacity should be judged relative to available knowledge, resources and opportunity.
Classification uncertainty	Use Not Assessable when the person has had no relevant opportunity to learn their patterns, the condition is first occurring or longitudinal information is unavailable.
Proposed clinical relevance	May be particularly useful in recurrent or enduring conditions and in relapse-prevention and transition planning.
Evidence status	Provisional PHCF capacity. The theoretical construct is supported by adjacent literature, while PHCF-specific boundaries, indicators, classification levels and incremental clinical utility require empirical testing.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

8. Demonstrated Adaptation

PHCF Construct Specification - *Demonstrated Adaptation*

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 differs from Adaptive Capacity, which concerns capabilities potentially available when demands arise.
Temporal orientation	Historical and longitudinal.
Relevant evidence	Behavioural history, clinical interview, longitudinal records, self-report, appropriately obtained collateral information and documented changes in functioning or coping over time.
Illustrative indicators	Seeking assistance when required; modifying ineffective coping strategies; reorganising life after disruption; maintaining or restoring important relationships; adapting to major changes; restoring valued activity; successfully mobilising available resources.
Do not infer from	Self-rated resilience alone, personality characteristics, absence of symptoms, exposure to adversity, occupational achievement or the availability of supportive resources.
Related PHCF constructs	Positive Health Capacities, especially Adaptive Regulation, Psychological Flexibility and Recovery and Self-Management Capacity; Protective Resource Ecology.
Adjacent non-PHCF constructs	Psychopathology, functioning, quality of life, resilience and post-traumatic growth.
Contextual interpretation	Interpret adaptation relative to the demands experienced and the opportunities and resources available. Similar outcomes may represent very different levels of adaptation across environmental, developmental, cultural and structural circumstances. The cost of adaptation must also be considered. A strategy may have been historically effective and currently costly.
Classification uncertainty	Use Not Assessable when historical information is inadequate, accounts conflict substantially, the relevant challenge cannot be established or there is insufficient evidence to determine whether adaptation occurred.
Proposed clinical relevance	May identify previously effective strategies, reveal capacities not reflected in current self-appraisal, contribute to formulation and support treatment, relapse-prevention 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.

Classification level - Use the PHCF provisional descriptive anchors. Do not convert the construct to a numerical score unless a future validated method supports one.

Required historical logic
A Demonstrated Adaptation entry should identify the meaningful challenge, what the person did or mobilised, what was maintained, regained or developed, and any significant cost or later limitation associated with the response.

Field	Record
Challenge or changing demand	What meaningful adversity, illness, disruption or demand was present?
Response or mobilisation	What did the person do, change, maintain, seek or mobilise?
Outcome	What valued activity, relationship, safety, functioning or recovery process was maintained, regained or developed?
Resources involved	Which personal, relational, cultural, material, structural or treatment resources contributed?
Cost or limitation	Did the response require substantial effort or create later restriction?
Current relevance	Is the adaptation still usable, modifiable or clinically informative now?

9. Protective Resource Ecology

Protective Resource Ecology describes resources within and around the person that may support positive health, adaptation or recovery. The First Edition distinguishes resource existence from resource effects. A resource may be present and still be inaccessible, unacceptable, unusable or harmful.

Resource domain	Examples
Personal resources	Knowledge, learned strategies, health literacy, written plans and practical tools. These remain distinct from the capacity to use them.
Relational resources	Trusted family members, partners, peers, mentors, friends and therapeutic relationships when supportive and accessible.
Cultural and community resources	Community membership, cultural identity, collective practices, spiritual communities, social organisations and places of belonging.
Structural and material resources	Housing, financial security, education, transport, physical safety and access to appropriate services.
Environmental resources	Features of physical, social and digital environments that may enable positive health or recovery.
Treatment-related resources	Continuity of care, therapeutic relationships, psychological intervention, medication where relevant, crisis pathways and specialist services.
Digital resources	Digital social connection, information access, telehealth, digital self-management and other digitally mediated supports where relevant.

Resource status pathway

Status	Meaning
Available	The resource exists.
Accessible	The person can realistically reach or obtain it.
Usable	The resource is acceptable, relevant and workable for the person.
Mobilised	The resource is actually used in the context of need.
Protective factor	Use only when evidence supports an association with reduced vulnerability or improved outcomes. Do not assume protection from existence alone.

Resource-capacity distinction
A written relapse plan is a resource. Recognising when it is needed and using it effectively reflects Recovery and Self-Management Capacity. A supportive person is a relational resource. The ability to form, maintain and use meaningful relationships reflects Relational Capacity.

A full Protective Resource Ecology recording table is provided in the clinical record template and Appendix B.

Part III - Clinical Presentation Modules

10. Module Activation Rules

Clinical Presentation Modules are supplementary layers. They do not create a positive counterpart to DSM or ICD disorders. They are linked to clinically recognisable presentations and are used only when presentation-specific positive-health information adds incremental specificity beyond the Universal Core.

- Complete one Universal Core profile even when several diagnoses or presentations are present.
- Do not repeat a Universal Core construct inside each module.
- Preserve the source clinical classification exactly as recorded in the source system.
- Use a module only where the additional construct or enquiry has a clear clinical reason.
- Where no presentation-specific information adds value, no module is required.
- Treat all Version 0.1 module content as developmental. The First Edition explicitly states that modules may merge, divide or be removed as evidence develops.

Module activation question
What positive-health information is clinically important in this presentation that is not already represented adequately by the Universal Core?

11. Provisional Module Architecture

Provisional module	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, flexibility 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 is a research and manual-development map. It does not establish formal module constructs, criteria or thresholds. A module should not be scored until the relevant constructs have been defined and validated.

Presentation Module Worksheet

Presentation	
Reason module is required	What clinically meaningful positive-health information is not captured adequately by the Universal Core?
Candidate presentation-specific construct(s)	
Evidence source(s)	
Context and cultural interpretation	
Provisional descriptive conclusion	
Uncertainty / Not Assessable reason	
How the information changes formulation or planning	

Part IV - Recording and Use

12. Integrated PHCF Profile

A completed PHCF assessment produces a multidimensional profile. The First Edition explicitly rejects the assumption of a single global positive-health score because aggregation could conceal clinically important differences among current state, capacities, adaptation and resources.

> **No total score**
> Do not calculate PHCF 73/100, "overall positive health - moderate" or another global total in Version 0.1. The pattern is the classification.

Standard profile format

Information	**Classification / description**	**Evidence / context / trajectory**
Source Clinical Classification		
Positive Self-Experience		
Engagement and Vitality		
Belonging and Connection		
Meaning and Valued Direction		
Agency and Self-Direction		
Adaptive Regulation		
Psychological Flexibility		
Relational Capacity		
Meaning and Identity Capacity		
Recovery and Self-Management Capacity		
Demonstrated Adaptation		
Protective Resource Ecology		
Clinical Presentation Module		
Positive-health trajectory		
PHCF version	Version 0.1	

13. Clinical Record Template

PHCF information should occupy a stable location in the clinical record while remaining linked to explanatory narrative. The template below is designed for the proposed Version 0.1 profile and deliberately excludes a global score.

Identifying and assessment information

Field	Entry
Person / client	
Record identifier	
Assessment date	
Clinician / assessor	
Assessment context	
Source clinical classification	
Relevant functioning / QoL source	

Current Positive Health State

Domain	Level	Trajectory	Evidence / context
Positive Self-Experience			
Engagement and Vitality			
Belonging and Connection			
Meaning and Valued Direction			

Positive Health Capacities

Capacity	Level	Trajectory	Evidence / context
Agency and Self-Direction			
Adaptive Regulation			
Psychological Flexibility			
Relational Capacity			
Meaning and Identity Capacity			
Recovery and Self-Management Capacity			

Demonstrated Adaptation

Challenge / period	Response demonstrated	Outcome / relevance	Cost / limitation

Protective Resource Ecology

Resource / domain	Status	Context / access / mobilisation

Integrated narrative

What remains available to work with?	
What is emerging or strengthening?	
What is currently limited or difficult to access?	
What resources require mobilisation, protection or structural response?	
What should be preserved in treatment or handover?	
Uncertainty / Not Assessable items	

14. Worked Example - Recurrent Major Depression

The example below is illustrative. It shows how PHCF can add information without changing the source diagnosis, symptom assessment or functional description.

Clinical information	**Illustrative description**
Source Clinical Classification	Major Depressive Disorder, recurrent.
Presentation	Depressed mood, loss of interest, sleep disturbance, reduced concentration, withdrawal and thoughts of worthlessness.
Functional impact	Difficulty maintaining university attendance and reduced participation in social activity.
History	Two previous depressive episodes. During a previous episode, reduced sleep and withdrawal were recognised as early warning signs. The person contacted their GP, maintained contact with one trusted friend and used a previously developed behavioural activation plan.

PHCF information	**Illustrative classification**
Current Positive Health State	Engagement - Limited Evidence; Belonging and Connection - Limited Evidence; Positive Self-Experience - Emerging; Meaning and Valued Direction - Emerging.
Agency and Self-Direction	Emerging to Established, depending on current participation in decisions.
Adaptive Regulation	Emerging.
Psychological Flexibility	Emerging.
Relational Capacity	Established - maintains and uses at least one trusted relationship.
Meaning and Identity Capacity	Not Assessable from the available example.
Recovery and Self-Management Capacity	Established to Strongly Demonstrated - recognises warning signs and mobilises help and a previously effective plan.
Demonstrated Adaptation	Strongly Demonstrated across previous episodes - recognised deterioration, sought help, maintained connection and restored valued activity.
Protective Resource Ecology	Trusted relationships are available and mobilisable; supportive GP available; stable housing available; material pressure increasing.
Positive-health trajectory	Not Assessable from a single time point unless a comparison period is available.

What PHCF adds
The profile preserves low current engagement while separately recording retained self-management, relational capacity, previous adaptation and available resources. The source diagnosis and clinical risk assessment remain unchanged.

Treatment-planning implications

- Build on existing warning-sign recognition and behavioural activation strategies that previously worked.
- Use the trusted relationship in relapse planning where the person wishes.
- Address financial pressure as a resource vulnerability rather than reframing it as poor resilience.
- Use previously demonstrated adaptation to support realistic hope without implying that current depression is mild.
- Focus on restoration of engagement and valued direction as recovery goals alongside symptom-focused treatment.

15. Longitudinal Review and Handover

PHCF should preserve what changed and what did not. A review should update individual constructs rather than replace the whole profile with a broad judgement. The meaning of a trajectory depends on the comparison period and evidence source.

Review question	**Record**
Which Current Positive Health State domains changed?	
Which capacities strengthened, weakened or became more accessible?	
Has new Demonstrated Adaptation occurred?	
Which resources became available, inaccessible, usable or mobilised?	
Did a presentation-specific module add new information?	
How did psychopathology change over the same interval?	
What must the next service know about retained capacities and resources?	

Handover principle
A transition note should preserve not only current difficulties, risk and diagnosis but also capacities that remain available, strategies that have worked previously and resources that can be mobilised.

16. Digital Data Fields and Versioning

The First Edition proposes a digital-first PHCF in which the construct remains identifiable even when the interface changes. A PHCF entry should eventually preserve enough structured information to remain interpretable longitudinally.

Minimum data field	**Purpose**
PHCF construct	Identifies what was classified.
Descriptive level or dimensional value	Records the current classification without implying a global score.
Date and relevant time frame	Preserves the temporal meaning of state, capacity or history.
Trajectory	Records change where longitudinal evidence exists.
Context	Preserves environmental, developmental, cultural and relational meaning.
Evidence source	Shows what information supported the classification.
Confidence or uncertainty	Makes evidentiary limits explicit.
PHCF version	Preserves semantic meaning when the framework changes.
Classifier / contributor	Identifies who made or contributed to the classification.
Historical challenge and response	Required when recording Demonstrated Adaptation.
Resource category and status	Required for Protective Resource Ecology.
Clinical presentation	Required when module-specific information is used.

Version information should travel with the classification. A future revision should not silently redefine an existing construct while leaving older records indistinguishable from newer ones.

Appendix A - Quick Reference

PHCF Universal Core

Component	Key question
Current Positive Health State	What positive mental health is being experienced now?
Positive Health Capacities	What adaptive psychological capabilities appear available or potentially mobilisable?
Demonstrated Adaptation	What has the person's history shown they have been able to mobilise under meaningful challenge?
Protective Resource Ecology	What resources exist within and around the person, and are they available, accessible, usable or mobilised?

Five descriptive anchors

Not Assessable	Limited Evidence	Emerging	Established	Strongly Demonstrated
Insufficient information	Little current evidence	Inconsistent or restricted evidence	Reliable evidence across relevant situations	Consistent evidence across challenge, settings or time

Positive Health Capacities

Capacity	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?

Do not infer

- Diagnosis does not determine positive health.
- Functioning does not determine positive health.
- Positive health does not determine risk.
- Adversity does not prove adaptation.
- A resource does not prove protection.
- Independence does not prove agency.
- Achievement does not prove positive health.
- A total PHCF score is not part of Version 0.1.

Appendix B - Blank PHCF Classification Worksheet

Use alongside ordinary clinical assessment. The form is a structured recording aid for the proposed PHCF Version 0.1 and is not a validated diagnostic instrument.

Field	Entry
Person / client	
Record ID	
Date	
Clinician	
Source clinical classification	
Assessment context	

A. Current Positive Health State

Domain	Level	Evidence / context
Positive Self-Experience		
Engagement and Vitality		
Belonging and Connection		
Meaning and Valued Direction		

B. Positive Health Capacities

Capacity	Level	Evidence / context
Agency and Self-Direction		
Adaptive Regulation		
Psychological Flexibility		
Relational Capacity		
Meaning and Identity Capacity		
Recovery and Self-Management Capacity		

C. Demonstrated Adaptation

Challenge	Response	Outcome	Current relevance / cost

D. Protective Resource Ecology

Resource	Domain	Status	Context

E. Clinical Presentation Module, if required

Presentation	
Reason module adds information beyond the Universal Core	
Presentation-specific information	
Evidence / uncertainty	

F. Integrated PHCF Profile

Positive-health trajectory	
Key capacities available to work with	
Previous adaptations to preserve or reuse	
Resources to mobilise or protect	
Current positive-health limitations / targets	
Not Assessable or uncertain elements	

Implications for formulation / treatment / handover	
PHCF version	Version 0.1

Appendix C - Worked Example PHCF Classification Worksheet

Use alongside ordinary clinical assessment. The form is a structured recording aid for the proposed PHCF Version 0.1 and is not a validated diagnostic instrument.

Worked example - fictional case

Field	Entry
Person / client	*Paul K*
Record ID	*EX010989*
Date	*12 September 2026*
Clinician	*Example clinician*
Source clinical classification	*Major Depressive Disorder, recurrent, currently in partial remission*
Assessment context	*Outpatient psychological treatment following improvement from a recent depressive episode. Current assessment considers positive-health functioning, capacities, previous adaptation and available resources alongside symptoms and risk.*

A. Current Positive Health State

Domain	Level	Evidence / context
Positive Self-Experience	*Emerging*	*Reports improved confidence compared with three months ago and can identify personal strengths. Self-worth remains vulnerable following work setbacks.*
Engagement and Vitality	*Limited to emerging*	*Has resumed walking and some household activities. Energy remains variable and participation in previously enjoyable hobbies is inconsistent.*
Belonging and Connection	*Established*	*Maintains regular contact with partner, sibling and two close friends. Reports feeling supported and able to seek help when required.*
Meaning and Valued Direction	*Emerging*	*Identifies family, meaningful work and helping others as important. Has begun considering future goals but remains uncertain about career direction.*

B. Positive Health Capacities

Capacity	Level	Evidence / context
Agency and Self-Direction	*Established*	*Makes treatment decisions collaboratively, sets weekly goals and has independently resumed exercise and social contact.*
Adaptive Regulation	*Emerging*	*Uses paced breathing, behavioural activation and planned breaks. Regulation becomes less effective during periods of high stress.*
Psychological Flexibility	*Emerging*	*Increasingly able to tolerate distress and act despite low mood. Still tends to withdraw when experiencing self-critical thoughts.*
Relational Capacity	*Established*	*Maintains reciprocal relationships, communicates needs with partner and can accept support from others.*
Meaning and Identity Capacity	*Emerging*	*Retains a clear sense of important values but recent illness disrupted occupational identity and confidence.*

Recovery and Self-Management Capacity	*Established*	*Recognises early warning signs, follows a relapse-management plan and knows when additional support is required.*

C. Demonstrated Adaptation

Challenge	**Response**	**Outcome**	**Current relevance / cost**
Significant depressive episode	*Engaged in therapy, reduced workload, used behavioural activation and accepted family support*	*Symptoms reduced and daily functioning improved*	*Useful recovery strategies remain available. Reduced workload created some financial pressure.*
Previous redundancy	*Retrained and obtained employment in a different field*	*Restored employment and developed new skills*	*Demonstrates ability to adapt to major occupational change.*
Relationship conflict during illness	*Discussed needs with partner and established clearer routines and communication*	*Relationship stabilised and perceived support increased*	*Communication strategies remain useful. Some concern about becoming dependent on partner remains.*

D. Protective Resource Ecology

Resource	**Domain**	**Status**	**Context**
Partner	*Relational*	*Available and effective*	*Provides emotional and practical support.*
Sibling	*Relational*	*Available*	*Weekly contact and reliable support during periods of difficulty.*
Close friends	*Social*	*Available but underused*	*Client has begun reconnecting after withdrawing during depressive episode.*
Employment	*Occupational / material*	*Available but vulnerable*	*Provides income, routine and purpose. Current confidence at work remains reduced.*
Stable housing	*Material*	*Available and stable*	*No current housing insecurity.*
Psychological treatment	*Clinical*	*Available and effective*	*Client is engaged and reports benefit from treatment.*
Physical activity	*Behavioural / community*	*Available*	*Walking is accessible and has previously improved mood and energy.*
Local community group	*Community*	*Available but not currently used*	*Previously attended recreational group and is considering returning.*

E. Clinical Presentation Module, if required

Field	**Entry**
Presentation	*Depressive presentation*
Reason module adds information beyond the Universal Core	*Residual depressive symptoms affect energy, self-evaluation, motivation and the client's ability to use otherwise available positive-health capacities.*
Presentation-specific information	*Residual anhedonia, reduced energy and intermittent self-critical thinking remain present despite improvement in overall functioning.*

Evidence / uncertainty	*Positive-health limitations appear partly state-dependent. Reassessment after further symptom improvement would help determine which limitations persist independently of depression.*

F. Integrated PHCF Profile

Field	**Entry**
Positive-health trajectory	*Improving. Positive-health functioning has increased alongside reduction in depressive symptoms, although recovery is uneven across domains.*
Key capacities available to work with	*Agency, relational capacity and recovery self-management are established strengths. Adaptive regulation and psychological flexibility are developing.*
Previous adaptations to preserve or reuse	*Behavioural activation, structured routines, help-seeking, gradual return to activity and willingness to retrain following major change.*
Resources to mobilise or protect	*Partner and family relationships, employment, stable housing, friendships, psychological treatment and accessible physical activity.*
Current positive-health limitations / targets	*Engagement and vitality remain reduced. Positive self-experience and valued direction remain vulnerable. Further development of adaptive regulation and psychological flexibility may support recovery.*
Not Assessable or uncertain elements	*Stability of occupational meaning and identity cannot yet be determined. Some apparent limitations may reflect residual depressive symptoms rather than enduring limitations in positive-health capacity.*
Implications for formulation / treatment / handover	*Treatment can build on established agency, relationships and self-management while targeting re-engagement, self-worth, psychological flexibility and valued direction. Protective social and occupational resources should be preserved during recovery.*
PHCF version	*Version 0.1*