Hierarchy in Context Rethinking the Relationship Between Psychiatric Diagnosis and Psychological Formulation in UK Mental Health Services

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***Abstract*—Objective: This paper examines the conceptual relationship between psychiatric diagnosis and psychological formulation, arguing that they are not competing but hierarchically complementary tools in clinical practice.**
Method: A conceptual analysis was conducted, drawing on literature regarding diagnostic reliability, symptom heterogeneity, and the distinct functions of classification versus idiographic explanation in mental health services.
Results: Findings indicate that diagnosis serves essential organizational functions, including triage, access to care, commissioning, and interprofessional communication, which formulation cannot replace. In contrast, formulation provides explanatory, person-centered understanding that categorical or dimensional systems fail to deliver. The analysis further demonstrates that the limitations of diagnosis are conceptual, not merely technical, and persist despite reform efforts.
Conclusions: Clinical practice requires both approaches in a context-dependent hierarchy. Diagnosis should be used for system-level tasks, while formulation should guide individualized intervention. Integrating both reduces reductive practice and improves clinical utility.

***Index Terms*—psychiatric diagnosis, psychological formulation, clinical utility, mental health services, idiographic assessment**

I. INTRODUCTION

UK mental health services face a foundational tension: they are organized around diagnostic categories that much of the evidence base suggests are neither sufficiently reliable nor valid to bear the clinical weight placed upon them.1,2 Psychiatric diagnosis, grounded in the medical model

and operationalized through ICD-11 and DSM-5, provides the organizational infrastructure through which NHS services allocate resources, apply National Institute for Health and Care Excellence (NICE) guidelines, and communicate across multidisciplinary teams.3,4 Psychological formulation offers an alternative epistemology: an individualized, theoretically informed account of a person's difficulties that integrates biological, psychological, and social factors, structured through frameworks such as the 5Ps.5,6 This paper argues that the relationship between diagnosis and formulation is not one of equivalence but of hierarchy in context: diagnosis serves necessary organizational functions that formulation cannot replace, yet formulation addresses fundamental limitations of categorical thinking that diagnosis cannot resolve. The argument is developed through the 5Ps framework and Acceptance and Commitment Therapy (ACT),7 with critical attention to trauma-informed practice, neurodiversity, and cultural considerations—and it is deliberately tested against the strongest contemporary alternative on each side: the dimensional Hierarchical Taxonomy of Psychopathology (HiTOP) as classification's best reform, and the Power Threat Meaning Framework (PTMF) as formulation's most ambitious systematization.

II. PSYCHIATRIC DIAGNOSIS: UTILITY AND FUNDAMENTAL LIMITATIONS

Diagnosis enables triage, supports cross-team communication, and provides access to NICE-recommended interventions within stepped-care pathways.8 These are not trivial functions: without diagnostic thresholds, equitable service allocation becomes difficult to operationalize at scale. However, the validity of the categories underpinning these functions is seriously contested. Regier et al2 found that DSM-5 test–retest reliability varies substantially across disorders: post-traumatic stress disorder demonstrated acceptable reliability ($\kappa = 0.67$), whereas major depressive disorder raised serious concerns ($\kappa = 0.28$). Critically, unreliability is not a technical inconvenience but a clinical harm: two patients presenting identically may receive different diagnoses, different treatment pathways, and different access to services depending on which clinician they see. Allsopp et al1 demonstrate, further, that patients sharing a diagnosis frequently have almost no symptoms in common, suggesting that many diagnostic labels may not identify coherent clinical entities at all.

This critique must nonetheless be stated fairly. Kendler9 argues that psychiatric disorders, while not natural kinds with sharp boundaries, index real and partially stable causal structures, and that categorical imperfection does not entail categorical meaninglessness. The argument advanced here accepts this point: the claim is not that diagnosis describes nothing, but that what it describes is too coarse-grained to direct individual intervention—a task for which it was never epistemically equipped.

Nor is the choice exhausted by categorical diagnosis on one side and individual formulation on the other. The most rigorous reform programme within classification itself, HiTOP, replaces categorical disorders with empirically derived dimensions and demonstrably improves reliability and predictive power relative to DSM categories;10 practicing clinicians have also rated it as more clinically useful than DSM-5 for case conceptualization and communication.11 HiTOP matters for

the present argument precisely because of what it does and does not repair. It addresses the psychometric architecture of classification—the unreliability and heterogeneity documented above—but it remains a nomothetic instrument: it locates a person on dimensions shared across a population and is silent on why this person occupies this position now, and on what would change it. The persistence of that explanatory gap under classification's best available reform indicates that the gap is structural rather than an artefact of categorical formats—and it is exactly the gap that formulation exists to fill.

Contemporary debates expose a deeper problem: diagnostic frameworks embed assumptions about what counts as pathology that are neither culturally neutral nor scientifically settled. The neurodiversity movement argues that autism and attention-deficit hyperactivity disorder represent natural human variation rather than disorder, and that applying diagnostic norms derived from neurotypical populations risks causing iatrogenic harm through misaligned interventions.12 Trauma-informed approaches challenge the personality disorder construct more directly, demonstrating that many such presentations are better understood as adaptive responses to adverse relational experiences—shifting the clinical question from "what is wrong with you?" to "what happened to you?"13 Cultural considerations compound this further: diagnostic criteria developed predominantly within Western, Educated, Industrialized, Rich and Democratic (WEIRD) samples14 may actively misrepresent distress in diverse cultural contexts, raising concerns about diagnostic equity in NHS services.15 Taken together, these critiques suggest that the problem with psychiatric diagnosis is not merely one of technical reliability but of conceptual foundations—a problem that better measurement alone cannot solve.

III. PSYCHOLOGICAL FORMULATION: THE 5PS AND ITS LIMITS

Psychological formulation addresses diagnosis's conceptual limitations by situating distress within a person's unique history, relational context, and psychological processes.16 The 5Ps framework—presenting, predisposing, precipitating, perpetuating, and protective factors—operationalizes this in practice. Consider a person presenting with persistent low mood and social withdrawal: a 5Ps formulation identifies presenting factors (low mood, anhedonia, fatigue); predisposing factors (childhood adversity, attachment insecurity); precipitating factors (recent job loss); perpetuating factors (avoidance behaviors, negative schemas); and protective factors (family support, previous therapeutic engagement). Crucially, diagnostic information is not discarded: the presentation may meet criteria for a depressive episode, but it is contextualized within a clinically meaningful account of this specific person's difficulties. The inclusion of protective factors actively reorients intervention toward resilience rather than deficit reduction,5 and it has been argued that this approach strengthens the therapeutic alliance by helping service users feel genuinely understood rather than categorised.17

Yet formulation is not immune to critique, and intellectual honesty requires that it be held to the same evidential standards demanded of diagnosis. The absence of standardization means formulation quality varies substantially with clinician orientation and experience,5 and the

available empirical evidence is sobering: inter-rater reliability for the inferential components of cognitive case formulation is modest at best.18 An argument that indicts diagnosis on reliability grounds cannot exempt formulation from the same scrutiny; the defensible claim is that formulation's value lies in its explanatory and idiographic function, which must be matched by ongoing efforts to evidence its quality. More fundamentally, Boyle19 argues that formulation can reproduce the individualizing logic of diagnosis in a different register: by translating structural adversity—racism, poverty, gendered violence—into psychological language, formulation may locate the problem within the person rather than the systems acting upon them. This is not an argument against formulation but a demand for reflexivity: a formulation that identifies "negative schemas" in someone experiencing ongoing discrimination, without naming the discrimination as a maintaining factor, is a formulation that has failed. In resource-constrained NHS Talking Therapies settings,20 where time pressure systematically limits this depth of engagement, such failures are not exceptional but structural.21

The most ambitious attempt to systematize non-diagnostic understanding, the PTMF,22 illustrates both the promise and the unresolved difficulties of formulation-based alternatives at scale. The PTMF reframes distress as intelligible threat responses to the negative operation of power, and a recent scoping review identifies an emergent empirical literature applying it across diverse settings and populations.23 Yet the same review notes that this heterogeneity complicates evidence synthesis, and philosophical critique has argued that the PTMF risks reintroducing the very normative judgements about what counts as distress that it claims to reject.24 The lesson for the present argument is not that non-diagnostic frameworks fail, but that they face evidential and conceptual demands of their own: replacing diagnosis wholesale would exchange one set of unsolved problems for another—which is precisely why this paper defends a division of labour rather than substitution.

IV. ACT AS AN INTEGRATIVE MODEL

Acceptance and Commitment Therapy illustrate how a therapeutic model can work productively with both diagnosis and formulation without being reducible to either. At the diagnostic level, NICE guidance—most recently NG222 for depression25—provides the framework through which evidence-based interventions are selected and accessed within NHS services. ACT is not currently a first-line NICE-recommended treatment for depression or anxiety, but meta-analytic evidence indicates that it reduces depressive symptoms relative to control conditions with maintained effects at follow-up,26 and it is increasingly delivered within NHS settings;27 diagnosis here functions as the organizational entry point through which individuals access care, not as the engine of the intervention itself. At the formulation level, ACT organizes intervention around transdiagnostic processes of psychological inflexibility—experiential avoidance, cognitive fusion, and disrupted contact with values—rather than disorder-specific symptom clusters.7 These processes map directly onto the 5Ps (Table 1): avoidance and fusion function as perpetuating factors; values clarification and committed action constitute protective factors; and early invalidating

environments inform the predisposing context. The clinical significance of this mapping is that diagnosis can serve as an administrative entry point while formulation drives the actual intervention—each framework doing the work it is genuinely suited to.

Table 1
Mapping ACT processes of psychological flexibility onto the 5Ps formulation framework
ACT process (psychological flexibility) Inflexibility counterpart Primary 5Ps location Clinical function within the formulation

Acceptance Experiential avoidance Perpetuating Avoidance of unwanted internal experience maintains withdrawal and symptom escalation

Cognitive diffusion Cognitive fusion, Perpetuating Fusion with self-critical narratives (e.g., "I am worthless") drives mood-congruent behavior

Present-moment awareness Rumination and worry Perpetuating Past- and future-oriented processing sustains distress and blocks corrective experience

Self-as-context Attachment to a conceptualized self-Predisposing / Perpetuating Rigid self-story, often formed in early invalidating environments, constrain the behavioral repertoire

Values Loss of values contact Precipitating / Protective Precipitants frequently involve losses in valued domains (e.g., job loss); values clarification re-establishes direction

Committed action Inaction and avoidance persistence Protective Values-consistent behavior builds resilience and functions as an active protective factor

ACT, Acceptance and Commitment Therapy. Process definitions follow Hayes et al;7 the 5Ps structure follows the Division of Clinical Psychology.5 Locations indicate the primary, not exclusive, position of each process within an individual formulation.

ACT's transdiagnostic architecture is particularly relevant to the UK context, where high comorbidity renders single-diagnosis protocols insufficient for many presentations in NHS Talking Therapies and secondary care.20,27 Because ACT targets underlying processes rather than surface symptoms, it does not require reformulation for each comorbid condition. There is also emerging evidence that process-level intervention travels across populations for whom diagnostic criteria carry limited validity: systematic review evidence supports the feasibility and acceptability of ACT for autistic adults and adults with intellectual disabilities,28 and preliminary work suggests that ACT outcomes generalize across culturally diverse groups29—directly addressing the equity concerns raised in the diagnosis section, although this evidence base remains early-stage and

requires replication. ACT therefore exemplifies the integrative model this paper advocates: not a compromise between two frameworks but a principled account of how each contributes at the level where it is most defensible.

This positioning also reflects a wider movement within intervention science. Process-based therapy explicitly proposes replacing protocols-for-syndromes with the idiographic modelling of the biopsychosocial processes that create and maintain an individual's difficulties.30,31 The significance for the present argument is that the field's own trajectory is converging on the division of labour defended here: classification for access, communication, and commissioning; process-level formulation for the design and adaptation of intervention. What this paper adds is the explicit articulation of that division as a hierarchy in context, anchored in the organizational realities of UK service delivery.

V. CRITICAL SYNTHESIS

This paper has argued that diagnosis and formulation are neither equivalent nor simply complementary: they operate at different levels of clinical analysis and serve different functions. Diagnosis provides the organizational scaffolding without which large-scale NHS service delivery becomes incoherent; formulation provides the contextual depth without which that service delivery risks causing harm through misrepresentation. The risk of a superficial integration—appending formulation to a diagnostic referral without genuinely challenging its categorical assumptions—is that clinicians reproduce the limitations of diagnosis at a finer grain, simply substituting psychological jargon for diagnostic labels without interrogating what either actually explains.19 Genuine integration, as illustrated by ACT, requires using diagnosis as an entry point while allowing formulation to contest, complicate, and ultimately supersede categorical thinking in the space of clinical intervention.

Structural barriers remain significant. Formulation is routinely deprioritized under NHS resource constraints, and the absence of standardized outcome measures tied to formulation-based practice makes its impact difficult to evaluate in an evidence-driven commissioning environment.21 This is not a problem formulation can solve from within: it requires organizational and political commitment to the kind of person-centred practice that formulation makes possible. The clinical question is ultimately inseparable from a broader question about what NHS mental health services are for—efficient symptom management within diagnostic categories, or genuine engagement with the complexity of human distress.

VI. IMPLICATIONS FOR PRACTICE, TRAINING, AND POLICY

Three implications follow. For practice, the integration defended here can be operationalized without waiting for structural reform: clinicians can record the diagnostic category required for access and commissioning while organizing the intervention itself around a process-level

formulation, as Table 1 illustrates for ACT. What must be resisted is the superficial version of this arrangement, in which formulation merely re-describes the diagnosis in psychological vocabulary. For training, the argument implies that clinical psychology and psychiatric curricula should teach diagnosis and formulation as answers to different questions—"what category does this presentation fall into for organizational purposes?" versus "why is this person struggling, and what would change it?"—rather than as rival answers to the same question; training should also build the reflexive competence to name structural adversity within formulations rather than translating it into individual pathology.19 For policy, the principal barrier is evaluative: commissioning frameworks reward what can be counted within diagnostic categories, and formulation-based practice will remain marginal until outcome measurement capable of capturing idiographic change—a methodological agenda already under active development within process-based therapy31—is admitted into routine evaluation. None of these implications requires abandoning diagnosis; all of them require ceasing to ask it to do explanatory work it cannot do.

VII. CONCLUSION

The debate between diagnosis and formulation is sometimes framed as a choice between scientific rigour and clinical sensitivity. This paper has argued that this framing is false. Diagnosis does not provide the rigour it promises—its reliability and validity limitations are empirically documented and conceptually fundamental—and formulation does not abandon evidence but applies it differently, at the level of the individual rather than the category. What diagnosis provides is organizational legitimacy: the currency through which NHS services are accessed, funded, and evaluated. Formulation provides something diagnosis cannot: an account of why this person, in this context, is struggling in this way, and what might actually help. A clinical psychology practice that holds both—using diagnosis to navigate systems while using formulation to understand people—is not a compromise but a more intellectually honest response to the irreducible complexity of psychological distress. The challenge for UK services is not theoretical but structural: building the conditions in which that honesty is possible.

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