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# From labels to lenses: diagnosis through a constructivist approach to case conceptualization

## De etiquetas a lentes: diagnóstico a través de un enfoque constructivista para la conceptualización de casos

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**Abstract**

**Background:** Psychological diagnosis has traditionally relied on nosological models rooted in medical paradigms, focused on symptom classification. However, this approach has been widely criticized for its reductionism, limited clinical utility, and ethical concerns. **Objective:** To explore case formulation from a constructivist perspective as an alternative to traditional diagnosis, highlighting its clinical, methodological, and relational contributions. **Method:** A theoretical and methodological review of constructivist diagnosis is presented, illustrated with clinical examples and the use of Fuzzy Cognitive Maps (FCMs) to represent personal meanings. **Results:** Case formulation enables the co-construction of shared hypotheses about psychological suffering, integrating personal history, dilemmas, self-positions, and therapeutic goals. FCMs provide a flexible, visual tool that helps capture the systemic complexity of clinical change. **Conclusions:** Constructivist diagnosis, understood as a relational and narrative act, supports a more ethical, personalized, and nuanced understanding of psychological distress, aligning with current trends in integrative and person-centered psychotherapy.

**Keywords:** constructivist diagnosis, case conceptualization, fuzzy cognitive maps, narrative assessment, mental health

**Resumen:**

**Antecedentes:** El diagnóstico psicológico se ha basado tradicionalmente en modelos nosológicos arraigados en paradigmas médicos, enfocados en la clasificación de síntomas. Sin embargo, este enfoque ha sido ampliamente criticado por su reduccionismo, su limitada utilidad clínica y sus inquietudes éticas. **Objetivo:** Explorar la formulación de casos desde una perspectiva constructivista como alternativa al diagnóstico tradicional, resaltando sus aportes clínicos, metodológicos y relacionales. **Método:** Se presenta una revisión teórica y metodológica del diagnóstico constructivista, ilustrada con ejemplos clínicos y el uso de Mapas Cognitivos Difusos (MCD) para representar significados personales. **Resultados:** La formulación de casos posibilita la co-construcción de hipótesis compartidas sobre el sufrimiento psicológico, integrando la historia personal, los dilemas, las auto-posiciones y los objetivos terapéuticos. Los MCD ofrecen una herramienta visual y flexible que ayuda a capturar la complejidad sistémica del cambio clínico. **Conclusiones:** El diagnóstico constructivista, entendido como un acto relacional y narrativo, respalda una comprensión más ética, personalizada y matizada del malestar psicológico, en consonancia con las tendencias actuales de la psicoterapia integrativa y centrada en la persona.

**Palabras claves:** diagnóstico constructivista, formulación de casos, mapas cognitivos difusos, evaluación narrativa, salud mental

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## Introduction

In the field of mental health, diagnosis has long been dominated by a nosological model borrowed from medicine. This model, exemplified by systems such as the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases), seeks to classify psychological suffering into discrete categories based on observable symptoms. These categories are presumed to reflect underlying *disease entities/disorders*, with the aim of providing clinicians with a reliable taxonomy for treatment planning and prognosis. While this approach is supposed to have certain advantages in terms of communication, standardization, and research utility, it is increasingly recognized as limited in all of them, and potentially harmful when applied to the lived experience of individuals seeking psychological help—see, e.g., Johnstone et al. (2018) for a profound critique of the psychosocial effects of reducing people's problems to medical diagnoses; Neimeyer & Raskin (2000) for a detailed critique of the DSM from constructivist and like-minded approaches; and Wampold & Imel 2015 for a historical explanation of the medical origin of psychopathological taxonomies

The nosological model tends to reduce complex human struggles to simplistic diagnostic labels. This reductionism can obscure the subjective meaning of symptoms, decontextualize distress from the life history and narrative of the person, and foster a false sense of objectivity. Many clients feel invalidated or stigmatized by diagnoses that seem disconnected from their sense of self and personal narrative. Moreover, such labels can inadvertently become self-fulfilling prophecies, shaping how individuals see themselves and how others respond to them. (Cooper, 2012; Corrigan & Rao, 2012; Spandler, 2014; Stein et al., 2022)

Besides, this model often fails to guide clinical practice in a meaningful way. Knowing that a client meets criteria for 'major depressive disorder' tells us little about why they are suffering, what personal meanings are attached to their symptoms, or how they might mobilize their resources for change. In many cases, diagnosis becomes a bureaucratic requirement rather than a tool for therapeutic understanding. (Liu & Jiang, 2016; O'Connor et al., 2020).

Constructivist psychology and psychotherapy (see, e.g., Botella, 2020; Neimeyer, 2009; Neimeyer & Mahoney, 1995) offers a fundamentally different approach. Rooted in the idea that human experience is actively interpreted and organized through personal meaning systems, constructivism challenges the assumption that psychological disorders are objective entities to be identified.

Instead, it views suffering as emerging from the individual's unique way of construing the world, the self, and relationships. Symptoms are not merely signs of dysfunction but expressions of conflict, adaptation, or loss of coherence within a personal meaning system.

From this perspective, psychological diagnosis (or, rather, *assessment*) must shift from a process of classification to one of understanding. The goal is not to assign a label but to formulate a shared hypothesis about how the person's difficulties make sense within their biographical and relational context. This process, known as *case conceptualization*, becomes the central assessment activity in constructivist psychotherapy.

In particular, constructivist case conceptualization (see Botella, 2020) emphasizes collaboration, narrative coherence, and future orientation. Rather than imposing an external framework, the therapist works with the client to explore the meanings they attach to their experiences, the patterns that sustain their distress, and the possibilities for change. The formulation that emerges is dynamic, personalized, and provisional—open to revision as the therapeutic dialogue unfolds.

George Kelly (1991), for example, saw people not as passive recipients of *mental illness* but as active "personal scientists," continuously interpreting and anticipating their world using personal constructs. According to his theory, psychological distress does not arise from a disorder in itself, but from the failure of the individual's construct system to predict or make sense of new experiences—a process he described as involving constructive transitions, such as threat, anxiety, guilt, or hostility.

In this light, diagnosis is better understood as a *working hypothesis* about how the person's construct system is currently organized, how it is struggling or failing to adapt to the demands of recent experience, and how it might be reconstructed through the therapeutic process. Rather than assigning a fixed label, this approach to diagnosis emphasizes the unique and evolving nature of each individual's personal meaning-making.

This notion—referred to as a *transitive diagnosis*—is idiographic, meaning it is tailored to the particularities of the person rather than based on general categories. It is dynamic, evolving as the person explores and revises their own narrative. It is collaborative, emerging from dialogue between therapist and client. It is action-oriented, aimed at facilitating movement rather than cementing pathology. And

above all, it is respectful, valuing the client's perspective, agency, and personal history (see also Botella, 2020).

This article proposes that such a constructivist approach to assessment is not only clinically superior but also ethically more responsible. It respects the client as an active meaning-maker rather than a passive recipient of expert classification. It fosters engagement, insight, and agency. It also aligns with contemporary movements in psychotherapy toward personalization, transdiagnosis, pluralism, and integration.

The remainder of this paper is structured as follows. I begin by grounding the constructivist position within its broader epistemological assumptions and contrasting it with the medical model. I then critique the nosological framework and its consequences. In subsequent sections, I outline the principles and methods of constructivist case conceptualization, with special attention to the use of Fuzzy Cognitive Maps (FCMs) as an innovative tool for capturing complexity. I explore the relational and ethical dimensions of diagnostic formulation, and discuss how this approach integrates with clinical practice and research. Finally, I offer a vision for assessment as a process of meaning-making that restores human depth and dignity to the heart of psychological care.

## Theoretical Foundations: Constructivism and Diagnosis

Constructivism, as an epistemological stance in psychology, posits that individuals actively construct their realities through personal meaning systems shaped by experience, culture, and relational contexts (see Botella, 2020; Kelly, 1991; Neimeyer, 2009; Neimeyer & Mahoney, 1995). Rather than assuming a singular, objective reality to be discovered, constructivist approaches emphasize the multiplicity of lived worlds, each valid within its own coherence. Psychological phenomena are thus understood not as fixed entities, but as dynamic constructions that emerge from the ongoing process of meaning-making.

At the heart of constructivist thought lies the legacy of George Kelly's Personal Construct Theory (1991), which proposed that people function as 'personal scientists,' continuously developing and testing hypotheses about themselves and the world around them. Constructs, in this framework, are the interpretative lenses through which individuals give structure and significance to their experience. When constructs fail to accommodate new experiences or generate coherence, psychological distress can arise. Assessment, then, is not the identification of

pathology per se, but the exploration of how and why a person's system of meanings has become strained, rigid, or fragmented.

Constructivism stands in contrast to the positivist and realist assumptions underpinning the nosological model. Traditional psychiatric diagnosis treats mental disorders as discrete, identifiable entities with presumed biological underpinnings. It privileges observable symptoms and standard criteria over subjective meaning and context. While this may enhance inter-rater reliability, it sacrifices the depth and nuance necessary for personalized understanding.

Constructivist assessment, in contrast, begins with the premise that what matters most is not what a symptom 'is,' but what it means to the person experiencing it (see Botella, 2020; Neimeyer & Raskin, 2000). A panic attack may signify the collapse of control, the legacy of past trauma, or the expression of a conflicted self-position... or a combination of all of the above. In the same way, depression may represent a loss of narrative coherence, the burden of unattainable ideals, the retreat from overwhelming interpersonal demands or a combination. These meanings are not reducible to symptom checklists—they must be discovered through dialogue (see Botella, 2020).

Furthermore, constructivist assessment is inherently provisional and perspectival. It resists reification and acknowledges the multiplicity of interpretations that can coexist. The aim is not to produce a definitive answer, but to co-construct a useful and evolving understanding that supports therapeutic change. This understanding is not 'given' but negotiated, drawing on the client's voice, metaphors, and narratives (Neimeyer & Raskin, 2000).

A particularly important implication of this perspective is the therapist's epistemological positioning. In the medical model, the therapist is positioned as expert diagnostician, applying knowledge to classify the client. In constructivist therapy, however, the therapist becomes a co-explorer of meaning, a partner in inquiry. This shift changes not only the process of assessment, but the nature of the therapeutic relationship itself—rendering it more collaborative, respectful, and empowering (Botella, 2020).

Constructivist approaches to assessment are also deeply influenced by postmodern and narrative traditions. Authors such as Michael White, Jerome Bruner, and Kenneth Gergen have emphasized the role of language, culture, and discourse in shaping psychological reality. Diagnoses are understood not merely as scientific labels, but as culturally situated narratives that position individuals in

specific ways—often with consequences for identity, agency, and self-understanding.

Assessment, from this view, is always a speech act—an intervention in the client's life story. It matters how we name things, because those names carry assumptions, expectations, and possibilities. Constructivist assessment seeks to name experience in ways that are generative rather than limiting, and that preserve the complexity of human suffering rather than reducing it to codes.

For example, Marta, a 37-year-old woman, seeks therapy after several months of persistent sadness, exhaustion, and intense self-criticism. According to DSM criteria, she could easily be diagnosed with "major depressive disorder." However, working from a constructivist perspective, the therapist refrains from imposing a categorical label at the outset and instead begins exploring how Marta herself makes sense of her suffering.

As the dialogue unfolds, deeply rooted meanings begin to emerge: Marta describes herself as "never being enough," someone who believes that "if I'm not strong, I'll disappoint people," and who has learned not to "burden others with my feelings." Her sadness, then, does not appear as a discrete clinical entity, but as a message embedded in a broader system of personal dilemmas, familial loyalties, and efforts to maintain a coherent sense of worth.

When the therapist asks, "How would you name what you're going through?", Marta reflects and eventually replies, "It feels like an exhaustion from always pretending I'm okay." That statement becomes a pivotal point in the session. Rather than telling her she "has depression," the therapist validates her description and incorporates it into a shared case formulation: a narrative about how she has constructed her way of being in the world, what tensions she has been holding, and what possibilities might emerge if she allowed herself to express vulnerability without losing her sense of dignity.

In this context, assessment is not a definitive declaration ("you have X"), but a co-construction of meaning. The way we name experience has effects. Calling her process "depression" might lead Marta to identify with a chronic disorder. In contrast, framing it as "emotional exhaustion from self-imposed overcontrol" opens up space for agency, for change, and for the rewriting of her story.

This example illustrates how, in a constructivist framework, *assessment is already intervention* (Botella, 2020). It is not a neutral data-gathering exercise, but a

meaning-laden, relational, and ethical act. How we name things matters—because names carry assumptions, histories, and futures.

In summary, constructivist theoretical foundations provide a radically different lens through which to understand psychological assessment (see Botella, 2020; Neimeyer & Raskin, 2000). Rather than a taxonomic act, assessment becomes an interpretative, collaborative, and ethical process. It calls for clinical methods that are attuned to individual meaning systems, sensitive to context, and open to uncertainty. The next section will further elaborate on the limitations of the nosological model and the urgent need for alternatives grounded in personal meaning.

## Critique of the Nosological Model

As stated before, the nosological model of psychological assessment, deeply rooted in biomedical traditions, has shaped the field of mental health for decades. Drawing its conceptual architecture from general medicine, it organizes psychological suffering into discrete categories based on symptom clusters, ostensibly reflecting underlying disease processes. Systems such as the DSM and ICD have become the dominant frameworks for assessment in clinical psychology and psychiatry. However, a growing body of critical scholarship has challenged the assumptions, validity, and clinical utility of this model, especially considering the complex, meaning-laden nature of psychological distress.

Deacon (2013) summarized the state of the art in shortcomings of the medical model in psychodiagnostics stating that the biomedical model frames mental disorders as brain-based diseases and promotes pharmacological interventions aimed at correcting presumed biological dysfunctions. This paradigm has shaped science, healthcare policy, and clinical practice in the United States and most of the rest of the world for over thirty years, during which time psychiatric medication use has surged and mental health conditions have come to be widely understood as chemical imbalances treatable by targeted drugs. But according to the author (Deacon, 2013) despite this widespread belief in the promise of neuroscience, the biomedical era has delivered little in the way of clinical breakthroughs and has been marked by persistently poor mental health outcomes. Moreover, Deacon states that this model has deeply influenced clinical psychology, encouraging the adoption of drug trial methodologies in psychotherapy research. While this has supported the rise of empirically validated treatments, it has also led to the neglect of therapeutic process, hindered innovation and dissemination, and

contributed to a growing divide between researchers and practitioners (Deacon, 2013).

One of the most significant critiques of the nosological model concerns its reliance on categorical classification. Human experience, especially in the realm of suffering, rarely conforms to neat boundaries. Conditions like depression, anxiety, or trauma-related responses often exist on a spectrum, with blurred lines between so-called disorders. Comorbidity rates are astonishingly high, calling into question whether these are truly distinct conditions or artificial distinctions imposed by diagnostic criteria. Moreover, the thresholds for what counts as 'clinical' are often arbitrary, influenced by social, cultural, and economic factors. (Forman-Hoffman et al., 2018; Kapadia et al., 2020; Lahey et al., 2022).

Another major concern lies in the construct validity of diagnostic categories. Despite repeated revisions of diagnostic manuals, many categories lack a solid empirical basis. There is often limited agreement about what constitutes the 'core' features of a disorder, and even less evidence for underlying biological markers that would justify their status as discrete disease entities. For instance, while the DSM-5 attempted to introduce a more dimensional perspective in certain areas, the overall structure remains wedded to a disease model that oversimplifies complex psychological processes. (Abi-Dargham et al., 2023; Amini et al., 2014).

This oversimplification has real consequences in clinical settings. When therapists rely heavily on assessment, there is a risk of reducing clients to static labels, losing sight of their lived experience, unique context, and evolving personal narratives. Clients may internalize these labels, seeing themselves through the lens of pathology rather than potential. The diagnostic act can subtly shift the therapeutic relationship, reinforcing hierarchies of expertise and promoting passivity in the client. (Johnstone et al., 2018; Schnell et al., 2020).

In addition, the nosological model tends to prioritize symptom description over understanding. Assessment becomes a checklist activity—identifying symptoms, counting their frequency and duration, and matching them to a category. This process often neglects the client's subjective interpretation of their experience, the function symptoms may serve in their relational world, or the historical and cultural context that gives rise to suffering. It is a model better suited to bureaucratic efficiency than to therapeutic insight. (Engstrom, 2018; Moe, & de Cuzzani, 2022; Patel et al., 2022; Wang et al, 2023).

The influence of this model also extends to training and supervision, where new clinicians may be taught to 'think diagnostically' in ways that prioritize

symptom labeling over empathic understanding. It shapes research priorities, favoring large-scale studies of diagnostic categories over idiographic, process-focused investigations. And it aligns conveniently with insurance and medical systems that require diagnoses to justify treatment, often at the expense of individual nuance. (Winter et al., 2022).

Ethically, the nosological model raises significant concerns. It may contribute to stigma, both internalized and social, by reifying complex experiences into fixed identities. It can obscure systemic and sociocultural contributors to distress, placing the burden of dysfunction within the individual rather than examining their broader ecology. For marginalized populations, this can mean being doubly pathologized—first by their context, and then by their assessment. (Ahmedani, 2011; Burns, 2014; Johnstone et al., 2018).

Despite these critiques, it is important to acknowledge that diagnostic categories can have pragmatic value within specific realms—though usually more administrative than therapeutic. They can facilitate communication among professionals, guide certain treatment decisions, and even in some cases provide a sense of validation for some clients. The issue is not assessment *per se*, but the uncritical adoption of a model that treats assessment as an objective discovery rather than a constructed, context-dependent act.

In light of these limitations, alternative models are urgently needed—approaches that honor the complexity of psychological life, recognize the constructed nature of categories, and restore the role of narrative, context, and collaboration in clinical reasoning. Constructivist case formulation, as explored in the next section, offers one such path forward, enabling clinicians to move beyond labels and toward deeper, more humane understanding.

## Case Conceptualization as a Constructivist Alternative

In response to the limitations of the nosological model, constructivist psychology proposes an alternative diagnostic framework grounded in case conceptualization. Rather than focusing on classification, constructivist case formulation seeks to understand the unique, evolving, and contextualized meanings that individuals give to their psychological suffering. This shift reframes assessment not as a final judgment, but as a collaborative and provisional hypothesis about how distress is maintained, and how change might become possible. (See Botella, 2020; Thrower et al., 2024).

Constructivist case conceptualization is rooted in several core principles. First, it assumes that psychological symptoms cannot be understood outside of the person's history, relationships, and values. Symptoms are not isolated signs of pathology, but expressions of ongoing struggles with coherence, agency, identity, or adaptation. They often represent attempts—however painful or limiting—to cope, protect, or maintain a threatened self-structure.

Here's an example that brings this constructivist principle to life: Elena, a 29-year-old graphic designer, enters therapy complaining of chronic procrastination, especially around professional tasks. She describes herself as "lazy" and "unmotivated," and fears she is sabotaging her own career. From a diagnostic perspective, her difficulties might be framed as part of an *avoidant personality pattern* or *executive dysfunction*. However, through a constructivist case formulation, the therapist invites a deeper exploration of how this pattern fits within Elena's lived experience.

As their work unfolds, it becomes clear that Elena grew up in a highly demanding environment where achievement was equated with love and worth. Success was mandatory, but mistakes were met with criticism or withdrawal of affection. Over time, she developed a self-structure centered on being competent and performing flawlessly, while simultaneously fearing the emotional cost of failure.

In this context, her procrastination is not simply a behavioral problem—it is a *protective strategy*, a way of avoiding situations in which her sense of self might collapse under perceived inadequacy. The delay, though frustrating, becomes a way of preserving coherence: as long as the work remains undone, she cannot fail at it. Seen through this lens, the symptom expresses a tension between her drive for agency and her fear of annihilation through criticism.

By understanding her procrastination not as a deficit but as an *adaptive effort to preserve a fragile self*, therapist and client begin to explore alternative ways of facing performance-related fear—ones that affirm her values, protect her dignity, and allow space for imperfection without emotional collapse.

This example reflects how constructivist case formulation situates symptoms within a personal ecology of meaning, agency, and developmental history. It shifts the focus from *what's wrong* to *what makes sense*, illuminating how suffering is often a deeply human response to impossible choices or unseen emotional debts.

Second, constructivist formulation is idiographic. It avoids one-size-fits-all models in favor of personalized understandings that emerge through the therapeutic dialogue. This requires the clinician to approach the client not with diagnostic criteria in mind, but with curiosity and openness to the client's own way of making sense of their experiences. The formulation is built around the client's language, metaphors, emotions, and core themes.

Third, constructivist conceptualization is future-oriented and change-focused. It is not just a descriptive exercise, but a means of identifying leverage points for transformation. The formulation aims to reveal how current patterns of meaning and behavior may be sustaining suffering, and how new possibilities can be envisioned and enacted. This includes mapping emotional loops, self-other configurations, internal conflicts, and personal dilemmas.

Fourth, the process is inherently collaborative. Formulations are not imposed by the therapist but co-constructed with the client. This ensures that the client remains an active agent in understanding and transforming their difficulties. The act of jointly constructing a coherent narrative can itself be therapeutic, helping the client regain a sense of authorship over their story.

Constructivist formulations often take narrative or visual forms. One of the most innovative tools in this regard is the use of Fuzzy Cognitive Maps, or FCMs (Kosko, 1986), which offer a graphic representation of the key elements and relationships in a client's psychological world. Unlike linear or purely verbal formulations, FCMs allow for the depiction of uncertainty, gradation, and systemic interactions between constructs. They help both therapist and client visualize the landscape of meaning and explore what happens when one part of the system changes. (see Botella, 2020, 2021; Botella et al., 2022; Saúl et al., 2023; Saúl et al., 2022).

A typical constructivist case conceptualization may explore the client's core constructs (e.g., 'strong vs. weak,' 'worthy vs. insufficient'), their biographical origins, the dilemmas they create (e.g., 'if I show weakness, I will lose respect'), and the positions they occupy or avoid in key relationships. It may include exploration of life narratives, self-states, idealized futures, and ruptures in coherence. Formulation becomes a space for integrating emotion, cognition, memory, and desire into a comprehensible whole.

Crucially, this approach allows for complexity and contradiction. A person may simultaneously long for connection and fear engulfment; may grieve a loss while clinging to an idealized past; may criticize themselves while striving to live up to

internalized standards. Constructivist formulations do not force these tensions into simplistic categories—they give them space, depth, and voice.

The advantages of constructivist case conceptualization are manifold. It enhances the relevance and personalization of clinical interventions, improves the therapeutic alliance by validating the client's perspective, and fosters a shared map for navigating change. It is also compatible with integrative practice, as it can incorporate insights and techniques from diverse modalities within a unifying framework of meaning.

Ultimately, constructivist case formulation reclaims assessment as a humanizing practice. It moves us away from the sterile logic of categorization and back toward the heart of psychotherapy: understanding the person in front of us, in all their richness and complexity... and fuzziness.

## Methodological Developments: The Case of FCMs

To illustrate the application of FCMs in clinical practice, consider the case of 'Marta,' a 38-year-old woman who sought therapy due to persistent feelings of failure, guilt, and relational disconnection following a divorce. In initial sessions, Marta described herself as someone who 'has to be perfect or is worthless.' Through collaborative exploration, several core constructs emerged: 'being in control vs. being lost,' 'being needed by others vs. being isolated,' 'not showing weakness vs. being a mess,' and 'being judged vs. being untouchable.' These constructs formed a tightly interconnected system, where the need to be in control led her to over-function in relationships, which in turn fostered resentment and emotional exhaustion.

Using an FCM, Marta and the therapist visualized these links, identifying how her effort to avoid judgment (via perfectionism) resulted in emotional suppression, and how this emotional distancing led to further feelings of rejection. The map also showed that 'expressing vulnerability' was negatively linked to 'being respected'—a belief that dated back to childhood experiences with critical caregivers. Over time, the FCM was revised to include emerging constructs such as 'self-compassion' and 'authenticity,' which began to interrupt older loops. This process not only clarified Marta's internal logic but helped her develop a more compassionate, flexible self-narrative.

As I mentioned before, one of the major contributions to constructivist assessment in recent years has been the development and application of FCMs as

tools for case conceptualization. This method offers a powerful way to represent the nuanced, interdependent, and often ambiguous constructs that define a client's personal world. By combining narrative exploration with visual systems modeling, FCMs bridge the gap between meaning-making and systemic complexity.

FCMs are based on the notion that personal constructs and experiences are not isolated elements, but components of an interactive and dynamic system. In this system, beliefs, emotions, behaviors, and relational patterns influence one another in feedback loops, often non-linear and context-sensitive. Traditional linear models of formulation fail to adequately capture these recursive processes, especially when they involve contradiction, ambivalence, or internal conflict.

In an FCM, nodes represent key constructs or elements relevant to the client's experience (e.g., 'feeling safe,' 'disappointing others,' 'being in control'), and arrows represent the perceived influence between them. Crucially, these influences are not binary or deterministic: they are weighted to indicate degree and direction of influence, and the 'fuzziness' of the model acknowledges the uncertainty and fluidity of human experience. A construct may simultaneously support and undermine another, depending on context or internal state.

This modeling technique allows for both therapist and client to visualize complex psychological dynamics, revealing loops that sustain distress or block change. For instance, a client may maintain rigid control to avoid anxiety, but this control may also lead to isolation and self-criticism, which in turn amplify the very anxiety they seek to manage. These self-reinforcing cycles can be difficult to grasp through dialogue alone; FCMs provide a map that makes these patterns visible and discussable.

Methodologically, the process of creating an FCM begins with an in-depth exploration of the client's concerns, themes, and constructs—often using narrative prompts, metaphoric dialogue, and exploration of key emotional episodes. These constructs are then organized visually, and their interconnections are defined collaboratively. The map itself is provisional and open to revision, evolving as therapy progresses and new insights emerge.

What distinguishes FCMs from other formulation diagrams is their capacity to represent gradation, uncertainty, and causality. Instead of implying fixed cause-effect relationships, FCMs acknowledge that psychological life is often 'messy': driven by partial understandings, ambiguous motivations, and multiple simultaneous pressures. They offer a more epistemologically honest way of

modeling experience, one that resists premature closure and keeps open the possibility of reinterpretation.

FCMs also support the integration of first- and third-person perspectives. From a first-person standpoint, the client can recognize and externalize the inner logic of their emotional world. From a third-person perspective, the therapist can trace patterns and propose hypotheses that support therapeutic planning. This dual vantage point fosters a shared language for understanding complexity.

Empirically, the use of FCMs has shown promise in facilitating therapy processes across a range of difficulties, particularly where emotional ambivalence or identity conflicts are central. In previous work, FCMs have been applied successfully in cases of depression, anxiety, grief, and relational trauma. They have helped clients articulate inner conflicts, navigate ruptures in meaning, and co-construct new frameworks of understanding.

Additionally, FCMs can be used to monitor change over time. By revisiting and updating the map at different points in therapy, both client and therapist can observe shifts in the system—new connections, reduced influence of dysfunctional loops, emergence of alternative constructs. This dynamic use transforms the map into a living document of therapeutic transformation.

In sum, FCMs represent a methodological advance that embodies core constructivist values: complexity, collaboration, openness to ambiguity, and focus on personal meaning. They offer a way to 'see' the architecture of suffering and hope, and to do so in a manner that invites shared exploration rather than expert imposition. Their integration into clinical practice enhances both diagnostic richness and therapeutic alliance, supporting a truly personalized approach to psychological care.

## Assessment as a Relational and Narrative Act

Constructivist perspectives reframe assessment not as a neutral classification but as a deeply relational and narrative process. In this view, it is less about discovering a fixed truth and more about co-creating a shared understanding between client and therapist—a process shaped by language, social context, and the dynamics of the therapeutic relationship.

Traditional diagnostic systems often assume that the clinician can stand outside the relationship as an objective observer, gathering information and

applying diagnostic criteria. However, from a constructivist standpoint, the therapist is always positioned within the interaction, influencing and being influenced by the dialogical space. Assessment is not delivered from above; it emerges through mutual exploration.

This relational approach is inherently ethical. It calls for a stance of humility, respect, and openness to the client's lived experience. The therapist becomes an epistemological partner—someone who helps the client explore and articulate their inner world, not someone who imposes predefined categories. This shift fosters collaboration, reduces power imbalances, and supports a more meaningful therapeutic alliance.

Language plays a central role in this process. The words we use to describe distress are never neutral—they carry historical, cultural, and emotional weight. Terms like 'disorder,' 'deficit,' or even 'symptom' can shape how people view themselves and their possibilities for change. A constructivist approach invites the careful co-construction of a vocabulary that honors the person's experience without reducing it. The therapist listens not only for what is said but for how it is said—metaphors, tone, gaps, and contradictions all become material for reflection.

Narrative is the organizing principle of human meaning-making. We understand our lives through stories—stories about who we are, what we value, how we have been hurt, and what we hope for. When psychological suffering arises, it often reflects a breakdown, disruption, or conflict in those stories. Constructivist assessment aims to restore coherence by helping clients author new narratives that are more flexible, compassionate, and empowering.

In this sense, assessment becomes an act of narrative reconstruction. Rather than labeling the person as 'depressed' or 'anxious,' the formulation explores how those experiences fit within a broader storyline—perhaps as the legacy of early attachment patterns, a response to overwhelming demands, or a strategy for managing emotional pain. These formulations offer an interpretive frame that resonates with the client's history, values, and aspirations.

The therapeutic dialogue is the medium through which these meanings are shaped and reshaped. As the relationship deepens, so too does the complexity and subtlety of the narrative. New insights emerge, previously unspeakable emotions find voice, and different selves or positions become accessible. Assessment, in this context, is not a static conclusion but a fluid, ongoing inquiry.

This relational-narrative stance also invites attention to social and cultural contexts. Diagnostic labels are never just personal; they are embedded in societal discourses about normality, gender, race, power, and difference. Constructivist assessment must be attuned to these layers, recognizing how social scripts shape personal suffering and how alternative stories can foster resistance and liberation.

Importantly, embracing assessment as a narrative act does not mean abandoning structure or rigor. On the contrary, it requires a deep sensitivity to patterns, meanings, and functions. The formulation becomes a map—not of pathology, but of how a person makes sense of their world, and how that sense-making can evolve. The therapist brings both curiosity and craft to this task, integrating clinical skill with dialogical presence.

In summary, when assessment is understood as a relational and narrative act, it becomes a deeply humanizing practice. It transforms from a bureaucratic necessity into a collaborative inquiry that honors the complexity of the person's life. It holds the potential not just to name suffering, but to open new paths for meaning, connection, and transformation.

## Integrative Possibilities: Bridging Constructivist Formulation with Practice and Research

Constructivist case formulation is not only a philosophical stance or clinical tool; it also offers powerful integrative potential within contemporary psychotherapy. As the field increasingly moves toward personalization, transdiagnostic approaches, and process-based interventions, constructivist formulation provides a flexible framework capable of incorporating diverse theoretical perspectives, methods, and empirical findings without reducing the person to a fixed category.

At the level of clinical practice, constructivist formulation functions as a core reasoning process—one that organizes the therapist's understanding of the client's difficulties, informs treatment planning, and facilitates moment-to-moment therapeutic choices. It helps clinicians move beyond rote application of techniques by contextualizing interventions within the client's unique meaning system. For example, behavioral activation strategies can be reframed not just as symptom management tools, but as opportunities to test and revise personal constructs about worth, agency, or relational safety.

This integrative function is especially valuable in training and supervision, where therapists are often overwhelmed by the proliferation of models and protocols. Constructivist formulation does not require allegiance to a single school of thought. Instead, it encourages clinicians to draw selectively from a wide array of interventions—cognitive, experiential, systemic, somatic—guided by the evolving logic of the formulation. This allows for both responsiveness and coherence, avoiding the risks of eclecticism without integration—see Botella (2020) for a review of the state of the art in psychotherapy integration from a constructivist approach.

From a research perspective, constructivist approaches also align well with emerging trends in idiographic, process-oriented studies. Traditional randomized controlled trials, while valuable for some questions, are poorly suited to capture the complexity, fluidity, and context-dependence of real-world psychological change. Constructivist formulation invites alternative methodologies: single-case designs, narrative analysis, mixed methods, and visual mapping tools such as FCMs that can track shifts in personal meaning systems over time—see also Botella, 2020, and Wampold & Imel, 2015, for reviews of the state of the art in psychotherapy research.

Such methods are particularly relevant to the goals of precision psychotherapy (Quiñones & Caro, 2024), which seeks to tailor treatment not just to a diagnostic label but to the individual's cognitive-emotional dynamics, relational patterns, values, and change readiness. Constructivist formulation can function as a diagnostic map that organizes this complexity, identifies leverage points, and tracks progress in terms of evolving coherence and self-agency rather than symptom reduction alone.

There is also significant potential for bridging constructivist formulation with integrative frameworks such as the Process-Based Therapy (PBT) model proposed by Hayes and colleagues (Moscow *et al.*, 2023). PBT emphasizes core biopsychosocial processes of change—such as psychological flexibility, self-regulation, or narrative reconstruction—across different disorders. Constructivist formulation provides a way to contextualize these processes within the client's personal narrative and belief systems, making abstract mechanisms clinically relevant.

Moreover, constructivist models resonate with pluralistic and culturally sensitive approaches to psychotherapy. In multicultural contexts, where dominant diagnostic categories may feel alien or stigmatizing, a constructivist stance invites therapists to enter the client's cultural and linguistic world, co-constructing a shared

language of suffering and healing. This has implications for equity, access, and therapeutic engagement in diverse settings.

Finally, the emphasis on meaning-making and collaboration in constructivist formulation aligns with humanistic, existential, and relational traditions in psychotherapy. These traditions have long emphasized the importance of understanding the person as a whole, situated within their lifeworld, and actively engaged in creating their future. Constructivist formulation offers a way to operationalize these values within a structured, yet flexible, clinical practice.

In sum, constructivist case formulation acts as a bridge: between theory and practice, between different models of therapy, and between individual meaning and empirical rigor. It supports an integrative, person-centered, and evolving vision of psychotherapy—one that honors complexity, fosters creativity, and remains anchored in the therapeutic relationship. As such, it is not only an alternative to nosological assessment, but a catalyst for innovation in clinical science and care.

In advancing this approach, it is also essential to acknowledge the systemic barriers that often prevent the widespread adoption of constructivist practices. For example, mental health services embedded in public or insurance-driven systems frequently require categorical diagnoses for reimbursement. These structures not only constrain clinicians' flexibility but also risk pressuring therapists into making premature or superficial diagnostic decisions.

Furthermore, the research paradigms favored by funding bodies and high-impact journals often prioritize symptom-focused, nomothetic studies over idiographic, process-oriented work. This marginalizes innovative methodologies like FCMs, despite their rich clinical value. Advocacy for methodological pluralism in clinical research is crucial to support the empirical legitimacy of constructivist and narrative-based formulations.

There is also a pedagogical imperative. Training programs must prepare future therapists not only to memorize diagnostic categories, but to cultivate narrative sensibilities, dialogical skills, and ethical reflexivity. Supervision structures could be enhanced by including collaborative case formulation exercises, reflexive mapping activities, and critical dialogues about epistemology, context, and power.

Additionally, this model has the potential to inform interdisciplinary collaboration. In integrated care settings, constructivist case conceptualization can serve as a shared language across professions—promoting understanding not just of symptoms but of patients' lived experience and psychosocial needs. Its narrative

and systemic dimensions may complement medical and psychiatric perspectives without being subsumed by them.

## Discussion

In sum, the constructivist reformulation of assessment offers not only a clinical strategy but a cultural and ethical reorientation. It calls for a more dialogical, respectful, and imaginative practice—one that honors complexity rather than fearing it, and that seeks understanding over control. While the dominance of nosological assessment is unlikely to disappear soon, this alternative provides a parallel path: one that therapists, educators, researchers, and clients can walk together, reshaping the terrain of mental health care with each step.

It also invites an ongoing philosophical inquiry: what kind of psychology do we wish to practice? One that classifies and contains, or one that illuminates and liberates? The constructivist approach offers no final answers—but it does offer a way of asking better questions, together.

The exploration of constructivist case formulation as an alternative to nosological assessment invites a fundamental reconsideration of how we understand psychological suffering, how we relate to those who seek help, and how we structure our clinical practices and institutions. Throughout this paper, I have argued that assessment, rather than being a mere classification system, can be reframed as a collaborative and evolving inquiry into the personal meanings of distress.

Constructivist assessment challenges the dominant medical model on multiple fronts. It contests the reification of categories, the abstraction from context, and the assumption of objectivity in clinical assessment. Instead, it proposes an idiographic, meaning-based, and relationally grounded model that privileges the client's voice and narrative coherence. This model does not neglect the need for structure or clinical rigor; rather, it relocates rigor in the depth of understanding, the fit of the formulation to the person's life, and the capacity of the map to guide meaningful change.

The methodological innovations discussed—particularly the use of FCMs—illustrate how constructivist principles can be translated into practical tools. These tools support visualization, dialogue, and reflection, allowing both client and therapist to access a shared understanding of complex emotional dynamics. They

also lend themselves to research, monitoring, and integration with broader clinical models.

Moreover, this approach aligns with current trends in psychotherapy that emphasize personalization, flexibility, and process sensitivity. It resonates with transdiagnostic models, with cultural and narrative therapies, and with the increasing demand for psychological practices that honor both individuality and complexity. Constructivist formulation allows therapists to adapt their interventions not only to what the client is suffering from, but to how they suffer, why they suffer, and what suffering means in the broader arc of their personal story.

However, embracing this paradigm is not without challenges. Institutional systems often require formal diagnoses for treatment authorization, creating tension between bureaucratic demands and clinical integrity. Training programs may emphasize standardized assessment over meaning-based formulation, and clinicians may struggle with time constraints or uncertainty about how to develop constructivist formulations in practice. Moreover, there is the perennial challenge of ensuring that our efforts to personalize do not lead to idiosyncrasy or loss of theoretical coherence.

These challenges point to the need for further development in several areas. First, training curricula should incorporate constructivist and formulation-based competencies, encouraging therapists to think narratively, systemically, and contextually from the outset. Second, research should continue to refine tools like FCMs, evaluating their clinical impact, accessibility, and integration with other therapeutic methods. Third, advocacy is needed to shift institutional priorities toward models that value meaning, agency, and collaboration in psychological care.

Ultimately, what is at stake in this discussion is not merely a different diagnostic system, but a different vision of what it means to do psychotherapy. Constructivist assessment reframes the therapeutic encounter as an act of witnessing, co-creating, and holding meaning. It sees the client not as a bearer of symptoms to be fixed, but as a storyteller whose voice must be heard, whose pain must be situated, and whose future must be imagined. This shift has the potential to deepen our ethical commitment, refine our clinical craft, and restore the human core of psychological care.

Assessment in psychotherapy is at a crossroads. For too long, it has been dominated by a medicalized framework that prioritizes categorization over understanding, standardization over individuality, and symptom description over

narrative coherence. This paper has proposed an alternative: a constructivist approach to assessment rooted in case formulation, collaborative meaning-making, and ethical presence.

Constructivist assessment does not deny the value of structure, clarity, or clinical decision-making. Rather, it relocates these functions within a relational and interpretive frame that foregrounds the person—not the pathology. It invites us to approach each client not with a checklist, but with curiosity; not as a case to be classified, but as a meaning-maker navigating a unique and often painful life context.

Through narrative exploration, visual modeling, and dialogical co-construction, clinicians can formulate hypotheses that make sense of suffering in ways that honor complexity and foster transformation. Tools like FCMs enable us to represent the fluid, systemic, and ambiguous nature of psychological life, while still providing shared maps for therapeutic change.

This approach redefines assessment not as the application of labels, but as a generative and collaborative act. It integrates theory, method, and ethics into a coherent clinical stance—one that is flexible, humanizing, and deeply attuned to context. In doing so, it aligns psychotherapy with its most fundamental aim: to understand and support persons in the ongoing construction of more livable, meaningful, and agentic lives.

The challenge ahead lies not only in further refining this approach but in advocating for its broader adoption in clinical settings, training programs, and research agendas. Doing so will require courage, creativity, and collective effort—but the reward is a model of assessment that genuinely reflects the complexity and dignity of the human condition.

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