The Power Threat Meaning Framework: An Alternative Nondiagnostic Conceptual System

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Abstract

This article summarizes the results of a recently published project to develop a conceptual system incorporating social, psychological, and biological factors as an alternative to functional psychiatric diagnosis. The principles underlying the Power Threat Meaning Framework are briefly described, together with its major features and differences from diagnostic approaches. These include the assumptions that what may be called psychiatric symptoms are understandable responses to often very adverse environments and that these responses, both evolved and socially influenced, serve protective functions and demonstrate human capacity for meaning making and agency. We describe how the elements of the Power Threat Meaning Framework interact to restore links between environmental threats and threat responses, and to enable us to outline some probabilistic Provisional General Patterns, grouped by personal, social, and cultural meaning, describing what people do, not the "disorders" they "have." We conclude by outlining some implications of the Framework for narrative construction and for thinking about distress across cultures.

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In 2013, coinciding with the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*; American Psychiatric Association, 2013), the Division of Clinical Psychology (DCP) of the British Psychological Society released a position statement "Classification of behavior and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift." Its central message was as follows:

> The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a "disease" model. (DCP, 2013, p. 1)

A number of recommendations were made, of which one was "to support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors" (p. 9). This article describes the outcome of a DCP-funded project to take forward this recommendation. The project group members were Lucy Johnstone (project lead), Mary Boyle (deputy lead), John Cromby, Jacqui Dillon, David Harper, Peter Kinderman, Eleanor Longden, David Pilgrim, and John Read. Six of the members are clinical psychologists, one is an academic psychologist, and two are survivor campaigners who also work professionally in research and training. The project also drew on the expertise of a consultancy group of eight service users/carers, a group of critical readers and other specialists, and research and editorial assistance from Dr Kate Allsopp.

Over a 5-year period, the project group developed a framework that aims to provide a conceptual foundation for opening up new ways of understanding and identifying patterns in mental distress, anomalous experiences, and problematic behavior. We have named it the "Power Threat Meaning Framework" (PTM). The project outcomes were published by the British Psychological Society as two documents in January 2018, both openly available online. The first, the main publication (Johnstone & Boyle, 2018a, www.bps.org.uk/PTM-Main), provides an analysis of the problems of medicalization and psychiatric diagnosis and a detailed account of the underlying philosophical principles, theories, and evidence supporting the PTM Framework.

As well as describing the framework itself, it reports on the views of the service user consultants who gave feedback on the framework as it developed and concludes with suggestions about how it can be used not only for therapeutic interventions but also to support nondiagnostic practice in a range of areas such as criminal justice reports and decisions, research, service commissioning and design, access to welfare payments, use of medication, and public health initiatives. The document is inevitably dense, given its aim of providing a solid intellectual foundation for a new conceptualization of mental distress, but the framework itself can be read in a stand-alone form in a shorter document, also available in hardcopy (Johnstone & Boyle, 2018b, www.bps.org.uk/PTM-Overview). This describes the PTM Framework and the Provisional General Patterns derived from it and offers a summary of the principles and evidence from which the framework emerged. It also includes appendices illustrating some of the ways in which nondiagnostic practice has already been successfully adopted both within and beyond services.

Our longer term aim is to make these ideas and related resources freely available in accessible forms beyond professional and service contexts, so that anyone in distress can have access to alternative understandings and support. A two-page summary (PTM summary) is offered as a brief introduction to the main principles of the framework for clinicians, service users, and others, and a guided discussion suggests ways of reflecting on the ideas in the framework as they may apply to particular individuals (PTM guided discussion: see https://www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework for these and, in due course, other resources).

A brief description of the framework and some of its underlying principles is given in this article. These are necessarily only headlines, and we encourage interested people to read the framework itself in order to get a full picture.

Principles

Diagnosis in medicine is fundamentally an attempt to make sense of a person's presenting problems, to understand how they have come about and what might help, by drawing on research into patterns/regularities in bodily function and dysfunction. While basing diagnoses on these biological patterns is appropriate for physical problems, psychiatric diagnosis is inherently limited in its capacity to make sense of emotional/behavioral problems because it largely draws on theoretical models that are designed for understanding bodies rather than people's thoughts, feelings, and behavior. This includes the ideas that people's presenting emotional and behavioral problems represent "symptoms" of an internal pathology or dysfunction, that it makes sense to search for biological "signs" associated with these symptoms,

and that people can be placed in discrete categories represented by these hypothesized clusters. The analogy is taken further, in suggesting drugs as a first-line intervention. Challenging this view emphatically does not imply dualism, since all human experiences are mediated by our biology. It simply reflects the fact that the "rules" governing bodily functioning are not the same as the "rules" governing the ways in which we feel, think, and act. Alternatives to psychiatric diagnosis should therefore be based on theoretical models and research designed for understanding people's thoughts, feelings, and behavior in their cultural, relational, social, and biological contexts.

Abandoning what we have called the "*DSM* mind-set" is not easy, since it is deeply embedded not just in mental health services but also in fundamental Western philosophical assumptions including, but not limited to, the separation of mind from body, thought from feeling, the individual from the social group, and human beings from the natural world. These influential but not universal worldviews also inform what can broadly be described as positivism, which tends to promote a view of human beings as objects acted on by causal forces (Ingleby, 1981), rather than agents who have reasons for their actions. This causal model can lead to reductionism—the view that complex human experiences can be explained at their simplest, usually biological, level such as "chemical imbalances." It is also reflected in the idea of "mental disorders" as having an independent existence, separate not only from the person but also from historical time and place.

The positivist paradigm has led to major advances in medicine, science, and technology. However, it is not well suited to understanding human emotional distress. It is this philosophical basis, not just diagnosis and medicalization as such, that needs to be rethought if we are not to end up with variations on the same unsatisfactory system, such as new terms for certain "disorders" or new patterns still based on the belief that "mental disorders are brain disorders," as in the National Institute of Mental Health Research Domains Criteria project (Insel, 2013).

There is also a recent trend for investigating links between particular psychosocial events and circumstances (e.g., poverty or sexual abuse) and particular outcomes (e.g., low mood or hearing voices) in the hope of identifying nonmedical causal pathways (e.g., Bentall et al., 2015). However, failure to achieve enough distance from positivist assumptions means that existing attempts to outline alternative causal patterns, whether biological or psychological, have all foundered on what we have called the "everythings" problem—as enumerated below.

- *Everything causes everything*: Our main document summarizes a vast and growing range of evidence for the causal impact of a whole range

of relational and social adversities in all mental health presentations, in marked contrast to the ongoing failure to provide evidence for primary biological factors. This has perhaps been demonstrated most powerfully in the Adverse Childhood Experiences studies (Anda et al., 2007; Dube et al., 2001; Felitti et al., 1998). Social inequality has been shown to increase the likelihood of all kinds of mental health problems as well as numerous other kinds of social problems and physical ill health; attachment disruptions are common in all kinds of mental health presentations; and themes such as guilt, shame, and self-blame appear to underpin the whole range of difficulties (as well as being common in general/nonpatient populations.) Conversely, the risk of experiencing any specific type of mental health problem appears to be raised by a whole range of social factors and adversities; 20 have been identified for "psychosis" alone.

- *Everyone has experienced everything*: The picture is further complicated by the fact that few people in clinical (or other welfare/criminal justice) settings have had single social disadvantages or adversities. Indeed, experiencing one adversity is known to increase the likelihood of experiencing more. Poverty is sometimes known as "the cause of the causes" since it is likely to lead to a whole range of other problems and to limit the ways in which their impact can be alleviated. There is also the well-established phenomenon of revictimization, whereby people who have experienced childhood abuse or neglect often experience further abuse in adulthood. Within this picture, we need to include the possibility of revictimization by psychiatric services themselves (something not addressed by this literature at all), in the form of pathologizing, disabling, or coercive interventions that may create further traumatization, disempowerment, and social exclusion.

- *Everyone suffers from everything*: In diagnostic terms, this is known as comorbidity. Almost every adult user of mental health services (and other welfare services) struggles with anxiety, hopelessness, distrust, low mood, low self-confidence, and relationship difficulties. A great many also have unusual perceptual experiences and beliefs (depending on how broadly these are defined), use various forms of self-harm (socially sanctioned or not), and control their eating. The same frequently applies to children. Initial presentations often evolve and take new forms over time, so that people collect more diagnoses.

- *Everything is a "treatment" for everything*: This "everything" follows from the others. Claimed specificities for particular drug regimes are not borne out in practice; for example, "antipsychotics" have been recommended for diagnoses of schizophrenia, depression, anxiety, bipolar

disorder, personality disorder, and attention deficit/hyperactivity disorder, while the indications for "antidepressants" are said to include borderline personality disorder, depression, obsessive-compulsive disorder, anorexia, panic and social phobia, among other problems (Timimi, 2014). Similarly, research suggests that the therapeutic relationship may be as or more important than particular theoretical approaches or therapeutic techniques (Norcross, 2011). While none of this is necessarily a problem for a nonmedical, nondiagnostic framework, it raises serious questions about the legitimacy of medicalized, diagnostic approaches.

In summary, all types of adverse events and circumstances appear to raise the risk for all types of mental health presentations (as well as for criminal behavior and physical health problems). This appears to be mediated, for better or worse, by all types of attachment relationships, all kinds of social support, all kinds of biological mechanisms, and all varieties of emotional and cognitive styles.

Drawing on this and other evidence, we argue that while research seeking very specific causal pathways between adversity and outcomes has useful aspects, it fails to acknowledge that such pathways do not, and in all likelihood cannot, exist in relation to human thoughts, feelings, and behaviors. This is because causality in human affairs is generally highly probabilistic, with an "on average" character; it is contingent, that is, the effects of any one factor are mediated by and dependent on others; and it is synergistic in that influences can magnify one another's effects. In other words, the factors that contribute to any aspect of human behavior, and their outcomes, are generally multiple, complex, highly interactive and overdetermined, and, crucially, always shaped by personal meaning and agency. This does not mean that there are no regularities. However, it means that these will be seen most clearly at a population or larger group level and that specific effects at the individual level will rarely be predictable. It also implies letting go of "*DSM* mind-set" assumption about universal causal laws and instead identifying trends and associations, their directions of influence, and the processes that might underlie them. A further important implication is that the kinds of patterns that may be observed from this viewpoint will not only be very different from diagnostic clusters but will also be used to illuminate individual distress in a very different way.

With this in mind, we argue that any attempt to outline alternatives to the current diagnostic system should have the following characteristics:

- Be based on the identification of broad psychobiosocial patterns and regularities as opposed to specific biological (or psychological) causal mechanisms linked to discrete disorder categories

- Show how these patterns are evident to varying degrees and in varying circumstances for all individuals across the lifespan
- Not assume "pathology"; rather, describe coping and survival mechanisms that may be more or less functional as an adaptation to particular conflicts and adversities in both the past and the present
- Integrate the influence of biological/genetic and epigenetic/evolutionary factors in mediating and enabling these response patterns
- Integrate relational, social, cultural, and material factors as shaping the emergence, experience, and expression of these patterns
- Account for cultural differences in the experience and expression of distress
- Assign a central role to personal meaning, emerging out of social and cultural discourses, material conditions, and bodily potentialities
- Assign a central role to personal agency or the ability to exercise choice within inevitable psychobiosocial constraints
- Acknowledge the centrality of the relational/social/political context in judgments about what counts as a "mental health" need or crisis in any given case
- Provide an evidence base for drawing on these patterns to inform individual/family/group narratives
- Offer alternative ways of fulfilling the service-related, administrative and research functions of diagnosis
- Suggest alternative language uses, while arguing that there can be no one-to-one replacements for current diagnostic terms
- Include meanings and implications for action in a wider community/social/political setting

With these principles as a starting point, we draw extensively on relevant psychological, social, and biological research to suggest a broad framework for the preliminary identification of patterns that could be drawn on in making sense of people's difficulties. The framework's core assumption is that emotional distress and troubled or troubling behavior are intelligible responses to life circumstances and adversities.

The Power Threat Meaning Framework

The main document analyzes and summarizes evidence on the social, biological, relational, and narrative aspects of the emergence, expression, and persistence of mental distress. In summary, this framework for the origins and maintenance of distress replaces the question at the heart of traditional psychiatric practice, "What is wrong with you?" with four others:

- "What has happened to you?" (How is power operating in your life?)
- "How did it affect you?" (What kind of threats does this pose?)
- "What sense did you make of it?" (What is the meaning of these situations and experiences to you?)
- "What did you have to do to survive?" (What kinds of threat response are you using?)

In therapeutic, peer support or self-help work, these two questions may be added:

- "What are your strengths?" (What access to power resources do you have?)

And to pull it all together, "What is your story?"

These key concepts and the evidence supporting them are elaborated as follows:

1. The operation of POWER (embodied, legal, economic/material, relational, and ideological, both proximal and distal, with impacts that are moderated by our available resources). In an extensive discussion of the research, we highlight the fact that many of the adversities and social inequalities associated with emotional and behavioral difficulties involve the operation of these various forms of power. We also describe how these processes are compounded in that different adversities are related. For example, neglected children may become targets for bullying; discrimination against some minority ethnic groups shows itself not just in their clustering in lower paid jobs and poorer quality housing but also in humiliating and frightening personal experiences of racial insults and abuse; this compounding of adversity applies in general to members of subordinated groups such as women, older people, or people with disabilities. As we noted, poverty is sometimes known as "the cause of the causes" since it so often leads to a whole range of other problems, whose impacts, like those of any adversities, are not linear or additive but synergistic. We discuss the well-established phenomenon of "revictimization" whereby people who have experienced early abuse or neglect are more likely to experience further abuse. This includes retraumatization by mental health services themselves. We place particular emphasis on ideological power—power over language, meaning, and perspective—as part of the operation of other forms of power.

2. The kinds of THREAT that the negative operation of power may pose to the individual, the group, and the community, with particular reference to emotional distress, and the ways in which this is mediated by our biology. There is consistent evidence about the conditions under which people tend to struggle or flourish. These may be thought of as related to "core needs"—broadly speaking, needs for safety and security; as infants and children, close attachments to caregivers; positive relationships within partnerships, families, friendships, and communities; to have some control over important aspects of our lives, including our bodies and emotions; to meet basic physical and material needs for ourselves and our dependents; to experience some sense of justice or fairness about our circumstances; to feel valued by others and be effective in our social roles; to engage in meaningful activity and, more generally, to have a sense of hope, meaning, and purpose in our lives. We are likely to experience the potential or actual loss of any of these as threats.

3. The central role of MEANING (as produced within social and cultural discourses and primed by evolved and acquired bodily responses) in shaping the operation, experience, and expression of power, threat, and our responses to threat. Meaning and narrative are the central thread and final common pathway in the experience and expression of mental distress at all levels, social, biological, and personal. For example, child sexual abuse, poverty, and domestic violence are all associated with anxiety, low mood, shame, withdrawal, and social isolation. Indeed, themes such as social avoidance, guilt, shame, and self-blame are common ingredients in all forms of distress. Meaning is understood here as being constituted through both beliefs and feelings, as well as through bodily reactions, and symbols. Shame, for example, is constituted of both feeling and a belief about oneself, as are humiliation, failure, worthlessness, and so on. Fear, trappedness, panic, and despair are embodied emotions that arise out of beliefs about one's situation. The personal meaning of "What has happened to you?" thus emerges as the joint product of circumstances, resources, bodily potentialities, and social discourses, within which meaning is both discovered and created. Equally, meaning can be communicated through behavior, symbols, and bodily reactions, as well as verbally.

4. An individual (or family, group, or community) experiencing threat arising within the PTM process may need to use certain evolved THREAT RESPONSES, mediated through meaning-based bodily capabilities, to protect themselves. Threat responses are shaped by our earliest attachment relationships. Faced with threat, humans can draw

on a spectrum of threat responses, which ensure emotional, physical, relational, and social survival in the face of the negative impact of power. We may call on any combination of these embodied responses depending on the resources and cultural meanings available to us. They may range from evolved, largely automatic biological responses such as fight/flight/freeze/dissociate, to linguistically based or consciously selected responses such as holding suspicious thoughts, self-blame, shame, rage, self-harm, and controlling our eating. The latter are likely to appear later in developmental terms, to be more open to shaping by local meanings, and hence to be more culture-specific.

It is important to emphasize the fundamental differences between this and the more traditional biopsychosocial model of mental distress. These are the following:

- Unlike (some versions of) the biopsychosocial model, there is no assumption of pathology, and the "biological" aspects are not privileged. They constitute one level of explanation, inextricably linked to all the others.
- Although a tripartite model is a convenient heuristic, the three elements are not independent but evolve out of one another. There is no actual divide either within or across the proposed core aspects. The individual does not exist, and cannot be understood, separately from his or her relationships, community, and culture; meaning only arises when social, cultural, and biological elements combine; and biological capacities cannot be separated from the social and interpersonal environment.
- The capacity for creating meaning (within available discourses) and the exercise of agency (within material and biosocial restraints) are core attributes of human beings. "Meaning" is intrinsic to the expression and experience of all forms of emotional distress, giving unique shape to the individual's personal responses.
- While most mental health work is aimed at the individual, we argue that meaning and distress must also be understood at social, community, and cultural levels. Thus, we see the PTM Framework as applying equally to understanding intervention and social action in a wider sense as well as bringing social context into work with individuals.

Restoring the Links Between Threats and Threat Responses

The functional and strategic nature of responses to adversity means that they cannot be understood separately from the circumstances in which they arose.

One of the main aims of the PTM Framework is therefore to restore the links between meaning-based threats and meaning-based threat responses.

In some situations, we already do this. It hardly needs stating that the death of a loved one is experienced as loss and commonly evokes a reaction of grief; absence of attachment figures is experienced as abandonment and leads to anxiety and searching in young children; threat to physical safety results in terror and a fight/flight/freeze reaction; and so on. However, we do not usually ascribe pathology where the immediate psychosocial causal event is obvious. We argue that the whole range of functional psychiatric "disorders" (and many other difficulties) can be understood in this way once we identify the meaning-based threats and restore their links with the protective threat responses. To take just one example, researchers into "paranoia" have commented that its well-established links to experiences of bullying, violence, discrimination, and unsafe environments render it "understandable, and, indeed, adaptive" (Shevlin, McAnee, Bentall, & Murphy, 2015, p. 213). However, behaviors and responses that promote survival in certain contexts may subsequently become problematic in their own right, for the person themselves and/or for those around them.

There are a number of reasons why these links may not be obvious. Commonly, the threat (or operation of power) is distant in time, and perhaps not even available to conscious memory, even though the threat response is still active. The threat may be less obvious because it is subtle, cumulative, and/or socially acceptable. The threats may be so numerous, and the responses so many and varied, that the connections between them are confused and obscured. The threat response may take an unusual or extreme form that is less obviously linked to the threat—for example, apparently "bizarre" beliefs, hearing voices, self-harm, and self-starvation. The person in distress might have become accustomed to disavowing the possibility of a link, because acknowledging it might have felt dangerous, stigmatizing, or shaming. And when contact with services has been made, mental health professionals are trained to obscure the link by the application of a diagnosis that imposes a powerful expert narrative of individual deficit and "illness."

Threat responses are most usefully considered not as discrete "symptoms" or complaints but in terms of the main functions they serve. They are strategies that link to core human needs to be protected, valued, find a place in the social group, and so on. Their function will vary from person to person, although some within-culture commonalities can be expected (e.g., in Western settings, restricted eating is often associated with a need to take control). In addition, the same threat response may serve multiple purposes for a single individual. Thus, self-harm may be used simultaneously as self-punishment, communication, release of feelings, and a means of eliciting care. All of these strategies represent people's attempts—conscious or otherwise—to survive

the negative impacts of power by using the resources available to them. Rather than being "diagnosed" as passively suffering biological or psychological deficits, we suggest that service users (and all of us) can be recognized and validated as using threat reactions for protection and survival.

Identifying Provisional Patterns Within the Power Threat Meaning Framework

As discussed, patterns and causality in relation to human behavior, experience, and distress are best understood as highly probabilistic, with influences operating contingently and synergistically—that is, in ways that it is often impossible to predict accurately in advance. This is complicated further by the fact that all the elements in any pattern are shaped by culture, meaning, and developmental stages. Since these aspects are constantly changing, sometimes slowly, sometimes more rapidly, patterns will always be provisional and to an extent local—that is, they have forms of expression that are specific to an individual, a social group, a community, a culture, and a historical period. There are, therefore, no separate "culture-bound syndromes"—all expressions of distress are culture bound, as are all judgments about what constitutes problematic, or adaptive, behaviors and reactions. And if cultural and personal meaning also mediate the impact of any given situation or event, it may be impossible to predict precise outcomes in terms of actions or expressions of distress.

This does not mean that no regularities exist. However, our central assumption is that these are not, as in medicine, fundamentally patterns in biology. Rather, they are patterns organized by personal, social, and cultural meanings.

We suggest that specific threat responses and their origins within a PTM Framework can be tentatively grouped into broad, provisional, evidence-based patterns of embodied, meaning-based threat responses to the negative operation of power. They are expressed as verbs not nouns—descriptions of what people *do*, not what they *have*. In another departure from diagnostic patterns, they cut across diagnoses, across specialties, and across the usual divisions of "ill" or "well," "mad or sane," in recognition that all of us are subject to the negative operation of power in some areas of our lives, and all of us struggle at times to survive and meet core human needs. The provisional identification of these evidence-based patterns provides a context for the co-construction of individual narratives, as well as suggesting alternatives to diagnosis for clustering/administrative/legal/service planning/research purposes.

We describe some provisional evidence-based general patterns that emerge when viewed through a PTM lens. They are not presented as a definitive and complete set; rather, they offer a starting point for further research and

development. However, they are solidly based in theory and evidence. Each general pattern includes a range of possible threat responses (e.g., hypervigilance, hearing voices, restricted eating, etc.) grouped in terms of the function they are serving. Conversely, each type of threat response may appear within several different general patterns and may serve a range of different functions. As described further in the project documents, these patterns provide a basis for validating and supporting narratives of distress at all levels, from individual to community, as well as suggesting alternative ways of fulfilling the other purposes for which psychiatric diagnosis is currently used (see Chapter 8 of the main document).

Cultural Perspectives: North and South

The PTM Framework provides a possible solution to the hitherto irresolvable dilemma about the application of Western psychiatric classification systems to non-Western cultures and expressions of distress, both within the United Kingdom and around the world. The framework predicts and allows for the existence of widely varying cultural experiences and expressions of distress without positioning them as bizarre, primitive, less valid, or exotic variations of the dominant diagnostic paradigm. The same applies to historical phenomena such as "hysteria." Viewed as a meta-framework that is based on universal evolved human capabilities and threat responses, the core principles of PTM apply across time and across cultures. Within this, open-ended lists of threat responses and functions allow for an indefinite number of locally and historically specific expressions of distress, all shaped by prevailing cultural meanings. From this viewpoint, as we have noted, there are no separate "culture-bound syndromes"; rather, all expressions of distress are culture bound.

As we have argued, examples of power operating at a proximal level include adversities such as abuse, neglect, discrimination, exclusion, and violence. At a more distal level, socioeconomic structures influence the prevalence and type of adversities. In the Global North, but increasingly in the Global South as well, these adversities arise within the context of industrialization and its related socioeconomic structures. These have brought many advances, particularly in the fields of technology, science, and health care, but there have also been costs and losses. Depending on the currently dominant political ideology, industrialization implies varying degrees of income inequality with all its well-documented destructive consequences for the social fabric (Wilkinson & Pickett, 2010). Along with the work of many others, our analysis suggests that socioeconomic structures influence social norms, discourses, and ideological meanings in ways that serve and shape

both the negative and the positive operation of power in line with certain interests—social, economic, political, and so on.

It follows from all the above that the expressions and experiences of distress within a given society will be likely, at some level, to reflect the inability (perceived or actual) to live up to its norms, values, and expectations, as partly conveyed through social discourses and ideological meanings. Thus, we might expect common patterns of distress in industrialized societies to center around themes such as struggling to achieve in line with accepted definitions of success; separate and individuate from one's family of origin; fit expectations about body size, shape, and weight; fulfill wage labor roles; meet normative gender expectations, including those relating to sexual orientation; compete successfully for material goods; meet emotional and support needs within a nuclear family structure; reconcile the values and expectations of having a different culture of origin; persuade children to behave according to received expectations; and so on. Similarly, we might expect to find common patterns of distress relating to the core human needs that are most likely to be threatened by the negative impacts of industrialization, such as social exclusion, marginalization, and isolation. Finally, we might expect to see an increased risk of attracting a diagnosis as a response to experiences that challenge Western conceptions of personhood—for example, "nonrational" beliefs, unusual spiritual beliefs, and experiences such as hearing voices that do not fit with the notion of a unitary self.

Existing feelings of shame, self-blame, and deficit about the struggle to live up to ideologically driven assumptions and expectations can be strongly reinforced by receiving a psychiatric diagnosis. The unevidenced "disease" model that is typically promoted in industrialized societies is associated with much higher levels of stigma and lower expectations of recovery (Kvaale, Haslam, & Gottdiener, 2013; Read, Haslam, Sayce, & Davies, 2006). This loss of hope is self-fulfilling, and thus, the vicious circle is complete.

The evidence that "severe mental distress" often has much better outcomes in the Global South where local healing rituals and practices are used alongside, or in place of, diagnosis and medication (Davidson & McGlashan, 1997; Warner, 2004) is entirely consistent with the PTM perspective, with its emphasis on social support and shared narratives—lessons that need to be rediscovered in industrialized societies, as the evidence suggests. There is therefore no implication that the PTM Framework needs exporting in the manner of another movement for global mental health. Rather, we hope that the framework conveys a sense of respect for the numerous nonmedical culturally specific ways in which individual and community distress is expressed, experienced, and healed in the United Kingdom and around the globe.

PTM Narratives as a Source of Healing

As discussed, we believe that there is sufficient evidence to suggest a broad, provisional set of response patterns, described as verbs not nouns: for example, "surviving social exclusion, shame, and coercive power," "surviving defeat, entrapment, disconnection, and loss," and "surviving rejection, entrapment, and invalidation." Individuals will vary in their fit or match to them. Their main purpose is to provide evidence-based summaries that can be used to support the development of personal narratives as a more effective way of fulfilling some of the claimed functions of diagnosis, such as providing an explanation, having distress validated, facilitating contact with others in similar circumstances, relief from shame and guilt, and conveying hope for recovery.

Narratives can take various forms, one of which is psychological formulation (Johnstone & Dallos, 2013), a popular and widespread practice in the United Kingdom. However, the long-term aim is to make the knowledge and evidence that supports the PTM Framework available and accessible to all, so that it can be used to develop a narrative by anyone in distress, whether in contact with mental health services and other agencies or not. We argue that narratives of any kind will be more holistic, helpful, healing, empowering, and evidence-based if they draw on all aspects of the PTM Framework. This will necessarily involve a more explicit link to, and focus on, the many aspects of the operation of power that are typically excluded by current conceptualizations of distress, both medical and psychological.

Conclusion

The PTM Framework main publication stands at about 190,000 words and may be a challenging read. It has certainly been challenging to write it. In this article, it has only been possible to give a brief flavor of the arguments, and the document itself is only intended as the first in a longer series of projects that will support its further development. However, we hope that we have conveyed some of the central aims of the framework, which are the following: reinstating the multilayered role of power in the emergence of distress, restoring the links between threat and threat response, suggesting patterns that are organized by meaning not by biology, supporting the construction of personal narratives as an alternative to diagnosis, and promoting social action.

Since we are conceptualizing PTM as a meta-framework, which can be used not just in its own right but also to inform more holistic and inclusive versions of existing models and practices, it is compatible with many of the

other articles in this series and the models and approaches they describe. We hope that it will play a part in the much-needed radical shift toward nondiagnostic theory and practice, which has gathered speed and support since the publication of *DSM-5*.

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Lucy Johnstone, DPsych, is a consultant clinical psychologist, author of *Users and Abusers of Psychiatry* (2nd ed., Routledge, 2000), and coeditor of *Formulation in Psychology and Psychotherapy: Making Sense of People's Problems* (Routledge, 2nd ed., 2013) and *A Straight-Talking Guide to Psychiatric Diagnosis* (PCCS Books, 2014), along with a number of other chapters and articles taking a critical perspective on mental health theory and practice. She is the former program director of the Bristol Clinical Psychology Doctorate and was the lead author of *Good Practice Guidelines on the Use of Psychological Formulation* (Division of Clinical Psychology,

2011.) She has worked in adult mental health settings for many years, most recently in a service in South Wales. She was lead author, along with Professor Mary Boyle, for the Power Threat Meaning Framework, a Division of Clinical Psychology–funded project to outline a conceptual alternative to psychiatric diagnosis, which was published in January 2018. Lucy is an experienced conference speaker and lecturer, and she currently works as an independent trainer. Her particular interest and expertise is in the use of psychological formulation, in both its individual and team versions, and in promoting trauma-informed practice.
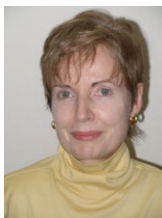
Mary Boyle is Emeritus Professor of clinical psychology at the University of East London, the United Kingdom, where she was head of the masters and then doctoral program in clinical psychology for more than 20 years. She also worked as a National Health Service clinical psychologist in adult services and in women's health. Her main areas of interest are in critical clinical psychology, especially in problems with medicalization of distress and psychiatric diagnosis. She is the author of *Schizophrenia: A Scientific Delusion?* (Routledge, 2002) and of many articles and chapters on medicalization and alternatives. She has also published widely on feminist approaches in clinical psychology and women's health, particularly in relation to disorders of sexual development, sexual difficulties, contraception, and abortion, including *Rethinking Abortion: Psychology, Gender, Power and the Law* (Routledge, 1997). With Lucy Johnstone, Boyle was a lead author of the Power Threat Meaning Framework (2018), a conceptual system, and alternative to psychiatric diagnosis, which offers a fundamentally different understanding of emotional and behavioral difficulties.