Reflections on responses to the Power Threat Meaning Framework one year on

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The project group reflects on the responses to the Power Threat Meaning Framework (PTMF) one year after publication. The group welcomes the interest shown in the document, and takes this opportunity to clarify some points, reflect on and learn from others, and suggest areas for future development.

WE ARE PLEASED to be welcoming this issue of *Forum* exactly a year since the launch of the *Power Threat Meaning Framework* (PTMF; Johnstone & Boyle, 2018a; Johnstone & Boyle, 2018b). As readers will be aware, it comprises a lengthy and dense set of documents which inevitably present complex arguments. The ambitious aim of the project was to outline a conceptual alternative to the diagnostic system, so this level of detail and complexity was unavoidable. However, we have offered accessible ways in via a two-page summary, the talks from the launch, and the 'Guided Discussion', along with interviews and videos (www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework) and more are in the process of development.

The framework is not official British Psychological Society policy, nor official policy of the Division of Clinical Psychology, and in offering it as a conceptual resource and a focus for discussion we had no idea what kind of reception it would get. As it has turned out, it has been successful in stimulating interest and debate beyond anything we could have hoped for. A dozen blogs on the PTMF appeared in the first fortnight, and even in the relatively short time since publication, there are various examples of translating it into practice across a range of different fields, as illustrated in this issue. There is already a Spanish version, with Italian and Danish translations planned, and the authors have received many invitations to give talks across the UK and further afield in Ireland, Denmark, Spain, Greece, New Zealand and Australia.

It is worth emphasising the framework's status – unlike the dominant diagnostic model – as an optional perspective; a conceptual resource which people may or may not wish to engage with or begin to translate into practice. Confusion appears to have arisen in some quarters about the descriptions of the PTMF as an 'alternative'. Clearly we are attempting to describe what an alternative – in the sense of a system which could replace the diagnostic one – would look like. Whether and how it is implemented, as a complete 'alternative' in this sense, or perhaps more realistically in the short-term as an option running alongside the diagnostic one, or simply encouraging thinking about alternatives within current services, is not our decision but a position to be reached within particular settings in discussion with relevant stakeholders.

The PTMF builds on many other ideas and existing practices (some of which are illustrated in Appendices 2–14 of the overview). The aim is to offer additional validation and support for these and other examples, as well as potentially suggesting developments and additional ways forward. If its ideas take us a few steps down the road to more humane, evidence-based and effective approaches to many forms of thoughts, feelings and behaviours that are currently diagnostically labelled, it will be because people (service users, professionals, policy makers and others) believe that it meets a need and want to take its ideas further.

Responses to the framework

Inevitably, and as predicted, the response has not all been positive, and we wish to take the opportunity to address some of the feedback and critiques, both constructive and less so, of what is necessarily a developing document. We will return to the latter at the end of the article. Readers may also like to refer to the Frequently Asked Questions, which address some common queries and anxieties (www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework).

The sentence that has arguably been seen as most contentious is: '…it can no longer be considered professionally, scientifically or ethically justifiable to present psychiatric diagnoses as if they were valid statements about people and their difficulties' (Johnstone & Boyle, 2018b, p.85). We stand by this statement about professional responsibility to be open about these debates and about the current status of diagnostic categories. It is the very least that is required in relation to a system that has been described by those who draw it up as neither 'safe or scientifically sound'. (Frances, 2014). This uncomfortable state of affairs may cause understandable confusion and uncertainty. Nevertheless, service users, and indeed all of us, have the right to know about it.

This professional obligation does not, as alleged, involve policing ordinary people's language uses, since as we have also made clear: 'We support individuals' right to make their own choice of terminology' (p.85). However, as we note, 'At present this right typically works one way only: those who want their difficulties defined in diagnostic terms are unlikely to be denied this.' Strong responses from those who find their diagnosis useful (a position which we respect) have at times seemed to imply a picture of people being routinely stripped of their labels. But the actual situation is as one service user described: 'Service users who identify with their diagnosis – you have pretty much an *entire* mental health system that agrees and supports your perspective. Those of us who feel utterly hopeless and oppressed by our diagnosis – where do we go?' (@bootlegboudica, 17 September 2018.)[1]

More subtly dismissive are claims that the framework is 'sociopolitical' 'extremist' and 'polemical'. We make no apology for producing a framework which is sociopolitical in the sense that it situates people's distress firmly in that context and links directly to ideas about social justice and community and social action. And it does offer a critique in a very controversial area, which frequently invites the term 'polemical'. But it is not unevidenced – although it does question the narrow definitions of 'evidence'; the separation of fact and value and the assumed neutrality of much mainstream psychology and psychiatry.

The framework, diagnosis and the provisional patterns

Some comments on the framework, while admitting that diagnostic systems were flawed, implied that an alternative was not necessarily needed. However, psychiatric classification and diagnosis have not persisted over so many years in the face of almost continuous criticism without many protective strategies, which are unlikely to be abandoned in the near future. These include claiming that diagnosis is necessary for communication, to develop and select treatment and to 'be scientific', but also include being open about some problems and giving an impression of tackling them. A particularly effective claim, widely used since DSM-III, is that diagnostic categories are 'just descriptions'. Taken together, strategies like these create an impression of diagnostic systems of one type or another as natural and inevitable. So natural and inevitable that senior devisers of the system are able to admit very publicly that it has comprehensively failed in its own terms (American Psychiatric Association, 2013) – only for things to carry on pretty much as before.

Supporters of psychiatric diagnostic systems have, knowingly or otherwise, been able to make use of this protection; for example, presenting official diagnostic systems as imperfect but improving, with some diagnostic categories more 'successful' or acceptable than others, as compatible with formulation and as playing an important if not essential role in the development of psychological understanding and treatment. Many of these responses have emerged in criticisms of the PTMF. So too has the claim that, because some medical diagnoses, such as migraine or fibromyalgia, are not based on known biological patterns, then psychiatric categories are as valid as those in general medicine. All of these claims depend on ignoring or overlooking the fundamental problem that has led to the current state of crisis; in other words, framing psychological and emotional distress and many forms of troubling behaviour in medical terms.

This reluctance to talk about the ideas and assumptions underlying psychiatric diagnostic systems is very much encouraged by the systems' interdependence with versions of positivism. It's not surprising then, that some criticism of the framework is couched partly or more or less entirely in the language and requirements of positivism, at least as interpreted by modern psychology. This is illustrated in the words of one critic who described positivism as 'the gathering and synthesis of evidence', as if this process were a straightforward and neutral undertaking. It is exactly this view that the PTMF challenges; it arises partly from psychology's and psychiatry's reluctance to acknowledge positivism as a philosophy rather than a set of self-evident rules for discovering facts about the world.

If this is the unexamined starting point, it is much more difficult to consider or even notice some key prior assumptions underlying diagnostic systems; for example, that the methods and frameworks of the physical and medical sciences, and metaphors derived from them, are appropriate for studying people's thoughts feelings and actions, or that these are characterised by features and processes (including 'mental disorders') that can be objectively described in universal causal terms across time and place. It also makes it more difficult to consider questions about what constitutes evidence, how it should be presented and what it means about the privileging of certain kinds of quantification and measurement, the possibility of separating facts from values and 'self' from others and the external world, and so on. In the main framework document, we discuss these issues and their implications in detail.

These two areas of relative silence – about assumptions underlying diagnostic systems and positivism more generally – are reflected in some of the comments on our suggested provisional patterns. To claim they are just like diagnostic clusters, or labels for people, or that they appear to correspond to syndromes, shows a failure to move beyond the diagnostic lens. In fact, we discuss in detail the fundamental differences between our regularities in distress and diagnostic clusters, and the very different ideas about causality that inform them.

Asking people to let go of the hope of finding medical-type patterns in distress organised by biology or 'psychopathology', and suggesting instead patterns organised by meaning, necessitates abandoning the false hope of finding discrete, universal causal pathways which are a precise fit for any individual, and which are stable across time and cultures. It means moving from clusters based on what people supposedly have or are, towards clusters based on what they do and experience in particular contexts. It means abandoning medical terms such as 'symptoms', 'disorders', 'comorbidity', 'dual diagnosis' and even 'transdiagnostic'. This is a considerable conceptual leap, but we argue that it reflects and allows for the indefinite complexity of human agentic, meaning-based responses to their changing circumstances.

Is the framework meant to replace all current practice?

We have emphasised that the framework is not intended as a wholesale replacement for current practice. Some current approaches are directly compatible with PTMF principles and we give a number of examples. We have also suggested ways in which the framework might enlarge and enhance existing practice, providing new ideas and encouraging a less individualistic focus. However, we disagree that diagnosis has been necessary for progress in psychological understanding and interventions, or that it is needed in order to identify the 'correct treatment'. It is difficult to see how it could be, given persistent problems with validity and the very large amount of overlap across categories and heterogeneity within them. In fact, it may well be a limiting factor, distracting attention from this variability and what it might mean. There has been undoubted progress; for example, in understanding and alleviating problems such as panic, distressing rituals, low mood, post-traumatic distress, problems with alcohol and drugs to name a few. However, matching therapeutic strategies to particular problems rather than hypothesised disorders can be done just as well without diagnostic language and assumptions. This can also free us up to develop different kinds of understandings; for example, about the relationship between social contexts and people's difficulties or about the relationships amongst difficulties which cross diagnostic boundaries. In fact, taking the example of hearing voices, there has arguably been more recent progress from a non-diagnostic approach than from the last 50 years of diagnostic-based research. In the main document, we discuss many reasons why diagnosis persists, including the expectation, or demand, that it is used to define research participants or assess interventions. All of this can give an impression of necessity, which is not justified by the evidence.

Is the framework all about formulation?

Contrary to suggestions that the PTMF is promoting formulation as a particular psychological skill, it occupies a very small part of the documents. The concept and term 'narrative' was purposely chosen in order to be inclusive of story-telling as a universal human capacity and 'the almost infinite number of examples of narrative and dialogical practices across the globe' (Johnstone & Boyle, 2018b, p.74). It is not obvious how this argument can be seen as a bid for professional (of any brand) dominance. Narratives can be of many kinds – including medical ones – but people can only choose from ones that are culturally available to them. As with previous DCP/BPS documents, our aim is to expand this choice by moving beyond narrow psychiatric or indeed psychological ones.

Some people have made the point that not everyone wishes to tell, or can tell, a 'story.' That is certainly true. Our argument – which applies to formulations as well as narratives in a more general sense – is that there is a crucial difference between a system based on diagnosis, and one based on the assumption that people's experiences and expressions of distress arise out of reasons, functions and meanings, all of which are deeply rooted in their relational and social environments. Making sense of this, sometimes alongside a validating witness who may or may not be a professional, can be profoundly healing, and the General Patterns are intended to support this process. But while we argue for opportunities to do this, that choice is always an individual one. There is no proposed requirement for anyone to 'produce a personal story'.

Is the framework all about trauma?

The framework has been widely described as focusing on trauma. This is seen both positively (it encourages us to attend to what has happened to people) and negatively (it's 'just about trauma' – what about people who haven't experienced specific trauma?). We certainly do focus on the potential impact of many experiences which are generally described as 'trauma' (although our preferred word is 'adversity' because of its inclusivity), including sexual abuse and assault, childhood physical abuse, domestic violence and bullying. And we note that the approach of many 'trauma-informed services' is compatible with many aspects of the framework. But we also note reservations about the term 'trauma', about its medical overtones and potential to create a misleading impression of discrete, possibly very unusual, extreme or life-threatening events impinging from outside rather than of continuous or repeated very negative experiences, embedded in people's lives and relationships. We have tried to show how these often everyday features of our lives, which may be taken as normal, can create and maintain many forms of distress or troubling behaviour, even when more obvious forms of 'trauma' are not evident. In fact, elucidating the meaning of distress or troubling behaviour in such contexts – often relating to social norms and expectations – is a strength of the PTMF. Some of these expressions of distress will attract diagnostic labels, others will not. In line with this, we stress that the provisional patterns represent continua and can be relevant to people who have never had contact with mental health services or who have not had experiences they would describe as 'trauma'.

Is the framework evidence based?

We discuss a great deal of evidence in relation to our arguments, drawn from many different sources. We point to the value of some positivist-based research and draw on it in our analysis, but without necessarily accepting unspoken assumptions about diagnostic categories, the meaning of measurement scales, and so on. Questioning positivism's underlying assumptions is not the same as rejecting empirical research. However, we do draw on research across disciplinary, methodological and epistemological boundaries, including forms of evidence which have traditionally been marginalised, such as historical analyses and survivor and other personal accounts. This flexibility has puzzled some and been welcomed by others. We agree that we have not produced a new epistemology; this was not our intention. We hope that discussion of the large amount of evidence we have presented in support of the framework and patterns will develop as the framework is applied in different settings and as non-medicalised, non-diagnostic alternatives become more available.

'Race', culture and ethnicity

We were grateful to our Critical Reader Group for their detailed comments on these issues. This large and complex area is considered in depth in chapters 2 ('Philosophical and conceptual principles'), 3 ('Meaning and narratives') and 4 ('The social context') of the main document. In any future editions of the document we will be pleased to expand this with additional references to key figures from non-Western psychologies, as suggested in some of the feedback since publication.

The very sensitive area of race and 'culture' has attracted critical responses, both in relation to the document content itself, and in relation to the process of developing it. There are learning points in both areas.

It may need re-emphasising that the General Patterns provisionally outlined in this version of the framework are applicable mainly within Western or Westernised contexts. This follows from our core contention that patterns of distress are organised by meanings at personal, social and cultural levels: 'Since patterns in emotional distress will always be to an extent local to time and place, there can never be a universal lexicon' (Johnstone & Boyle, 2018b, p.11). While the total group of authors and contributors was drawn from a range of backgrounds and ethnicities, it is a majority white group, with all of us living in a society dominated by certain Western cultural values, including those of diagnostic models. Since, as we have shown, expressions of distress necessarily reflect their particular cultural context, the General Patterns that we have developed will inevitably do so too. It would not have been appropriate to do or to claim otherwise. At the same time, we have argued that some of the very basic principles of PTMF are relevant across cultures – those to do with core human needs, evolved biologically-based responses and capacity for meaning-making. Versions with better local fit (if it was felt they might be useful) would need to be developed by the social or cultural group in question.

Whether or not these developments happen, the framework conveys a message of respect for different ways people express and try to heal their distress both within the UK and across the globe. There is no suggestion that PTMF needs exporting along the lines of the global mental health movement. However, we have been pleased at the welcome it has received from some workers with indigenous peoples, who see it as validating their use of culturally-appropriate perspectives and practices. We were also pleased to be invited to contribute a blog about the PTMF by the #WhatWENeed campaign, as part of a challenge to the globalisation of diagnostic models (www.tciasiapacific.blogspot.com/2018/10/beyond-medicalisation-of-distress-new.html). Two of the authors are undertaking a tour of New Zealand and Australia, where it is hoped to present the framework alongside indigenous understandings of distress. We anticipate that this will result in a rich dialogue, with implications for further development of our conceptual resource.

The welfare/benefits aspect

Service users have inevitably been alarmed by reports such as that psychologists will henceforth be refusing to endorse claims based on diagnostic categories due to roll-out of the PTMF. Our actual position is ‘In the short and medium term, psychiatric diagnoses will still be required for people to access services, benefits and so on. These rights must be protected’ (Johnstone & Boyle, 2018a, p.18). However, while acceptable to some, other service users deeply resent the need to take on a diagnostic label in order to obtain essential resources or services (Beresford et al., 2016), and diagnosis often fails to secure this outcome anyway.

Chapter 8 of the main document outlines the pros and cons of a range of welfare system alternatives, starting with creative use of the existing system and leading up to more radical ideas such as universal basic income. We acknowledge that patterns and personal narratives would not be suitable to such a purpose – nowhere have we suggested that people should be required to produce a ‘trauma story’ in order to qualify. One possibility is that ‘for specific purposes, non-medical problem descriptions such as ‘hearing hostile voices’ or ‘suspicious thoughts’ or… ‘feeling suicidal’ or ‘self-harming’ could be appropriate substitutes for diagnostic language (Johnstone & Boyle, 2018a, p.315), compatible with and helpful for welfare and other statutory purposes.

None of these ideas is presented as a recommendation or easy solution, and all are recognised as having limitations as well as advantages. We recognise the argument that dropping diagnostic categories could be used to promote a neoliberal agenda of withdrawing support; but it is also true that diagnostic labels have not prevented the current dire situation in which welfare recipients have been driven to destitution and even suicide (www.theguardian.com/society/2018/nov/16/uk-austerity-has-inflicted-great-misery-on-citizens-un-says). For all these reasons, the PTMF aims to start an important and necessary discussion about ways in which the benefits system might start to move away from diagnostic assumptions.

Service user involvement in the project

To the best of our knowledge, this is the first attempt to outline a major new conceptual framework that is co-produced with service users, both as members of the core team and as consultants to the project. They collectively represented a range of class, gender and ethnic backgrounds and diagnostic attributions. A number of other contributors also had service user experience (but did not choose to state this in every case). The project itself draws extensively on service user/survivor testimony and literature as part of its challenge to traditional notions of what counts as ‘evidence’.

While no process is perfect, we believe that criticisms about ‘only X number of survivors were consulted about changing the entire system' are based on a misunderstanding. As previously stated, the PTMF is not formal policy or a plan for services. Any such plan – which at present is only hypothetical – would obviously need, in keeping with the principles of the framework itself, the involvement of a much larger group of stakeholders, with service users and carers taking a central part.

The framework is not just about professional services, and it was our hope that some user groups might take on this perspective themselves, quite separately from the mental health system. We are delighted that several peer groups have done so and found it helpful. There have also been many positive blogs from individual service users (see www.sociologyandmeblog.wordpress.com/blog; https://blogs.canterbury.ac.uk/discursive/ive-beenwaiting-for-this-since-i-was-a-child; and www.progressnotperfection.co.uk/2018/01/12/power-threat-meaning). Other service users clearly feel differently, as is their right.

Professional power

We discuss the operation of power in relation to psychology and psychiatry, particularly in Chapters 2, 3 and 8 of the main publication. This tends to focus on ideological power in relation to the production of theory, research and cultural narratives of distress, and legal power in relation to mental health legislation. On reflection, we think we should have addressed the issue of power in relation to professional practice – especially the power of clinical psychologists, who make up the majority of the core group – more directly. Partly to avoid a predictable scrap about 'This is psychologists trying to replace psychiatrists as top profession', we decided not to discuss any specific profession in favour of more general points about power in relation to both psychology and psychiatry as disciplines and producers of 'knowledge'. Power as applied to clinical psychology is implicitly critiqued at many points, and specifically through critical consideration of practices traditionally associated with it, such as formulation and the national roll-out of some psychological therapies. We were perhaps too reticent about discussing the serious implications for all mental health professions of moving away from a medicalised, diagnostic practice. We agree with the blogger who wrote: '…one of my thoughts as a nurse is this framework does not give us an allegiance problem – that is, whether to carry on largely supporting the psychiatrist and their manuals or switch to the psychologist and this new framework – since all three professions (and others) are made untenable in their existing forms' (www.criticalmhnursing.org/2018/01/26/a-mental-health-nurses-first-response-to-the-launch-of-the-power-threat-meaning-framework/#more-1364). However, we accept that this still leaves a gap that needs filling in any future edition.

Social media responses

Some readers will be aware that social media reactions have been mixed. It is hard to know how representative they are, given the tendency of online forums to amplify certain voices and views. Accusations of being both Marxist and alt-right, or of promoting both neoliberal and Scientology agendas have been intriguing. However, the very personal and often sexist attacks by some professionals, along with allegations about silencing discussion, obstructing the consultation process and so on, have been disappointing to say the least. We have also been sad to see some survivors dismissing others who contributed to the project (about 15 in all, including the consultation group) as unrepresentative – perhaps not dissimilar to the kind of discounting that professionals have often been guilty of in relation to survivor views. Controversies that touch on both ideological interests and personal identities will inevitably be uncomfortable, and yet given the power and reach of diagnostic models, these are discussions we must have.

Looking to the future

We are pleased that the PTMF is being used to validate and support existing good work, as well as suggest new ways forward. We hope the planned PTMF working party reporting to the DCP Executive Committee will be able to support the following:

- Ensuring wide stakeholder involvement in further developments, especially with service users, with people from different cultural and ethnic contexts, and with professionals of all backgrounds.
- Producing accessible versions suitable for particular groups (service users, people with learning disabilities, children, the general public and so on).
- More work on practical alternatives to diagnostic terminology in the area of benefits, the law, and other statutory agencies.
- A research agenda aimed at further developing and validating the General Patterns and their evidence base.
- Evaluation of other aspects of the PTMF in practice using a range of methodologies as suggested in our section on research (Johnstone & Boyle, 2018a, pp.308–313).
- Encouraging research based on or using the PTMF.
- Linking with groups who may wish to develop the PTMF, in line with their own cultural beliefs and contexts.
- Linking with journalists, policy makers, campaigners, and other key players and organisations in the mental health field.

Final reflections

While we have at no point claimed to have produced a 'paradigm shift', we do feel that widespread interest in PTMF is a sign that people are actively looking for alternatives. As the articles in this issue show, people from a range of professional and service user contexts are taking on the PTMF ideas and adapting them for their own purposes, exactly as we had hoped. The level of attention paid to this lengthy and detailed academic discussion document can be taken as a sign of the challenge it presents in a number of highly sensitive areas, from ideological interests and professional status, to personal identities. While this debate is not easy, and there are no simple solutions, we believe it is essential that it happens, and are pleased to have contributed to this process.

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Author's note

[1] @bootlegboudica has given us permission to use this tweet.

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