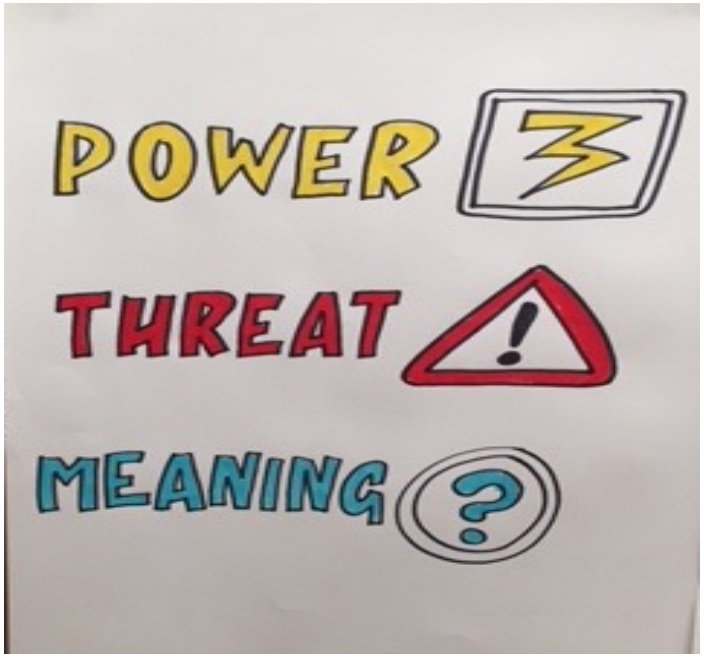
The British Psychological Society
Promoting excellence in psychology

Division of Clinical Psychology

The Power Threat Meaning Framework

https://www.youtube.com/watch?v=tkNWQdVB4F0



(Slides: © Lucy Johnstone and Mary Boyle 2018)

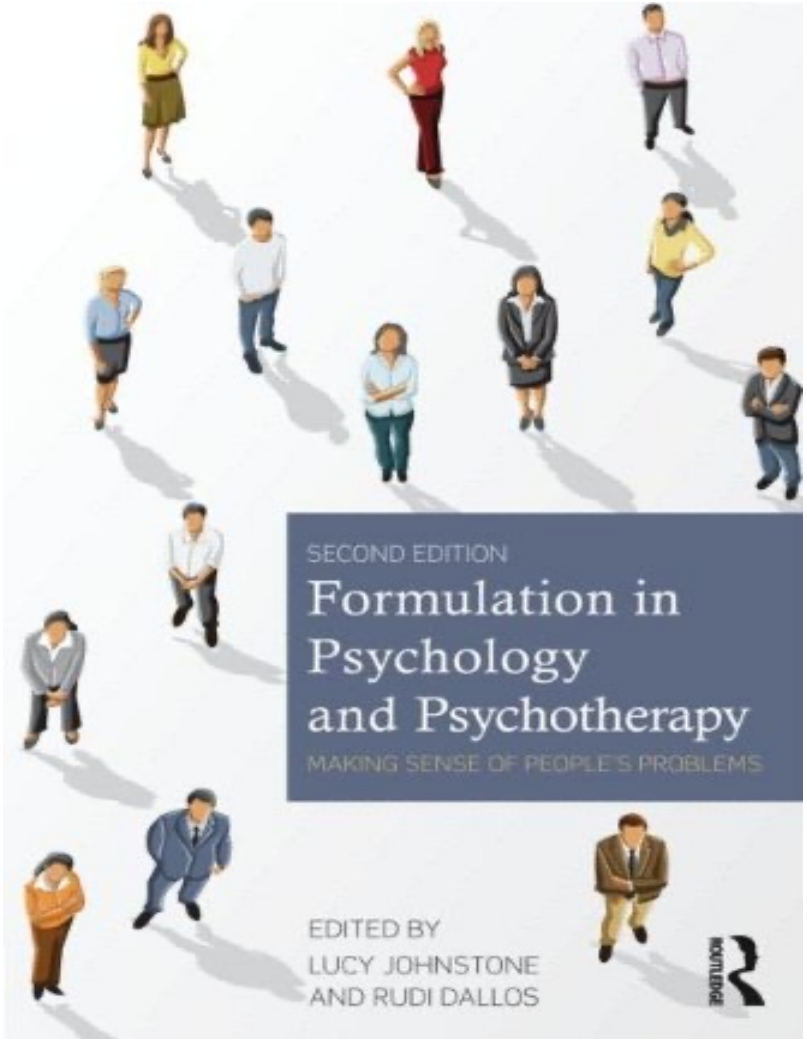
Developments in the UK: Formulation as an alternative to psychiatric diagnosis

Division of Clinical Psychology

The British Psychological Society

Good Practice Guidelines on the use of psychological formulation

https://www1.bps.org.uk/system/files/Public%20files/DCP/cat-842.pdf



A formulation is a personal narrative which integrates two equally important forms of evidence: the clinician brings theory, research and clinical experience, and the client brings their knowledge of their life history and events and the sense they have made of it.

It is a shared, evolving hypothesis or 'best guess' which suggests ways forward.

'……a process of ongoing collaborative sense-making' (Harper and Moss, 2003)

'....at some level it all makes sense' (Butler, 1992)

Team Formulation meetings, facilitated by clinical psychologists, can help teams develop a shared understanding of a client.

A possible formulation of ‘first episode psychosis’

You had a happy childhood until your father died when you were aged 8. You felt very responsible for your mother's happiness, and pushed your own grief away. Later your mother re-married and when your stepfather started to abuse you, you did not feel able to confide in anyone. You found it increasingly hard to deal with your teacher, whose bullying reminded you of your stepfather. One day you started to hear a male voice telling you that you were dirty and evil. This seemed to express how the abuse made you feel, and it also reminded you of things that your stepfather said to you. You found it impossible to focus on schoolwork and started truanting as memories and feelings came to the surface. Despite this you have many strengths, including intelligence, determination and self-awareness, and you have taken the brave step of asking for help.

Developments in the UK: Trauma-informed care as an alternative to the medical model of distress

The emerging 'trauma-informed' model recognises the causal role of adversity of all kinds across all human welfare systems

'*Trauma and recovery*' Judith Herman (2001)

'*The body keeps the score*' Bessel van der Kolk (2015

www.acestoohigh.com

Neglect - Failure to provide for: physical (adequate food), emotional (affection), educational and medical needs

Physical Abuse – physical aggression and violence; bullying; 'discipline'

Psychological Abuse – E.g. hostility; excessive criticism; inappropriate or excessive demands; routine humiliation; ignoring or withholding communication

Domestic violence – experiencing as an adult, or witnessing as a child

Sexual Abuse As a child (eg making a child participate in or watch adult sexual activities; indecent exposure; displaying pornography; general lack of sexual boundaries). As an adult (e.g. using force/sexual behaviour without consent)

A formulation-based, trauma-informed approach

We are dealing with people with problems, not patients with illnesses

'Symptoms' are better understood as ways of surviving – essential in the face of overwhelming events and circumstances, but they may have outlived their usefulness.

'Instead of asking "What is wrong with you?" we need to ask "What has happened to you?"' Jacqui Dillon, survivor and campaigner

Instead of diagnosing people we need to listen to their stories

'You are experiencing a normal reaction to abnormal circumstances. Anyone else who had been through the same events might well have ended up reacting in the same way.'

Division of Clinical Psychology of the British Psychological Society Position Statement on psychiatric diagnosis (2013)

'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' (May 2013)

The Power Threat Meaning Framework

Lucy Johnstone, Mary Boyle, John Cromby, Jacqui Dillon, Dave Harper, Peter Kinderman, Eleanor Longden, David Pilgrim, John Read, with editorial and research support from Kate Allsopp

Consultancy group of service users/carers

Critical reader group to advise on diversity

Other expert contributions

Documents, videos, resources, training materials, examples:

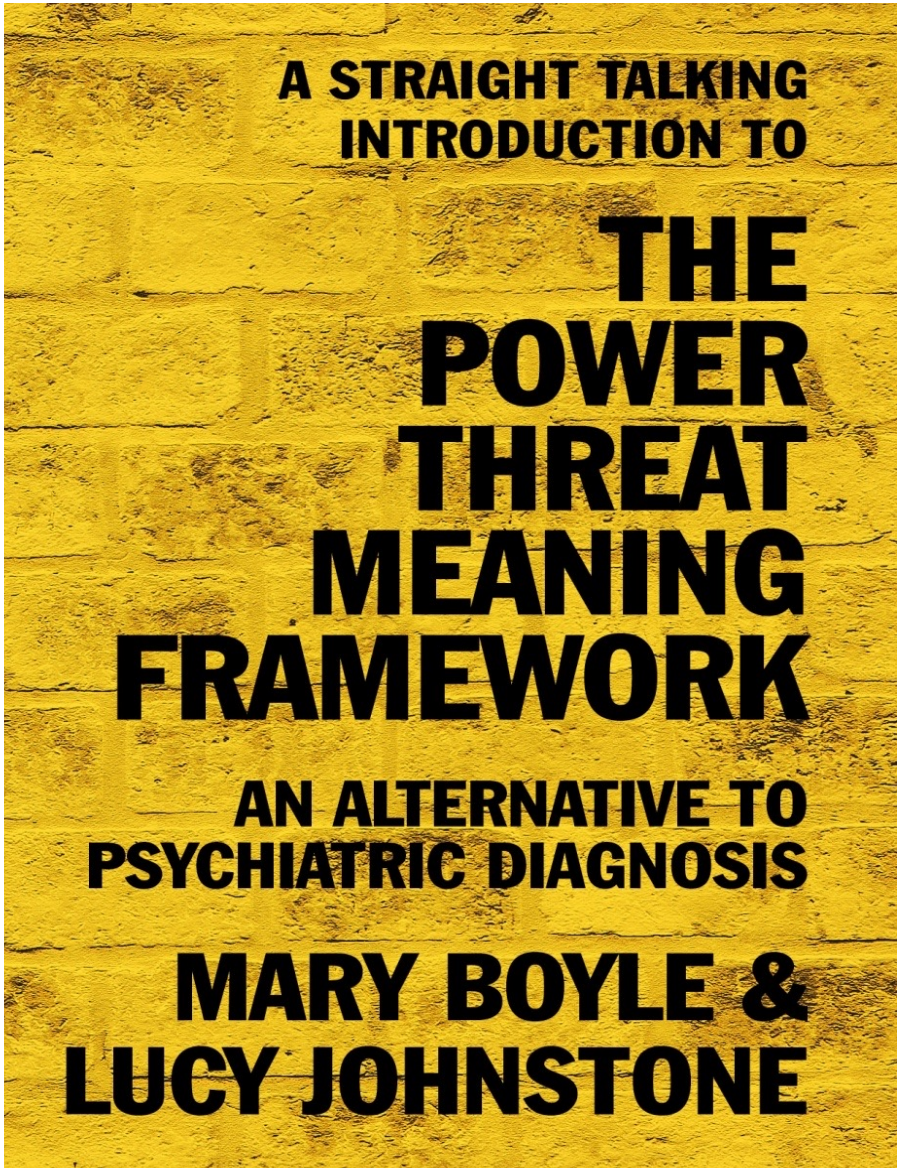
https://www.bps.org.uk/power-threat-meaning-framework

The PTMF Documents and resources

The PTMF documents are also available at cost price from Amazon

https://www.amazon.com/s?k=boyle+johnstone+power&ref=nb_sb_noss

www.pccs-books.co.uk



The PTM Framework and trauma-informed approaches

- Draws on this research (ACEs, neurobiology of stress etc) but also on a much wider range of philosophical, sociological and psychological literature
- Non-diagnostic ('PTSD', 'Complex Trauma' etc..)
- Prefers 'adversity' (wider range of causal factors)...
- .....including inequality, social exclusion, discrimination, devalued identities
- Suggests patterns of distress not related to obvious 'trauma'
- Suggests non-diagnostic alternatives for welfare access, commissioning, legal work, research….etc..
- Explicit links to wider institutional and organisational contexts, macro political and socioeconomic structures and ideologies

The Power Threat Meaning Framework is not:

- An official Division of Clinical Psychology or British Psychological Society model
- A replacement for existing models. It draws together many of them within a larger overall framework.
- For professional or service use only

It IS

- A set of ideas (a conceptual resource) for everyone to draw on
- Inclusive of but wider than formulation and trauma-informed practice
- A first stage – an outline of general, evidence-based principles
- The second, ongoing stage is translating these into practice, evaluating it, and feeding back into development of the PTMF

Reception of the PTM Framework

It has attracted interest across the UK and internationally. Tours of New Zealand and Australia and visits to Brazil, Denmark, Ireland, Spain, Greece, and (by video) South Korea. Interest from Norway, Sweden, India and Pakistan. Translations into eight languages, including Danish and Norwegian, are in progress.

It has informed training programmes, policy documents, services of all kinds (forensic, adult mental health, learning disability, housing) research, peer groups and so on.

It has also attracted considerable disagreement and social media trolling #PTMFramework

Moving beyond the ‘DSM mindset’……

Away from medicalisation – assuming that models designed for understanding bodies can be applied to people’s thoughts, feelings and behaviour.

Instead, a framework that understands people in their social and relational environments….

……and sees them as people acting and making meanings, within their life circumstances.

In addition to the usual purposes of diagnosis…

- Recognising that emotional distress and troubled or troubling behaviour are, ultimately, understandable responses to a person's history and circumstances
- Restoring the link between distress and social injustice
- Increasing people's access to power and resources
- Creating validating narratives which inform and empower people, groups and communities
- Promoting social action

The Power Threat Meaning Framework poses these core questions:

- '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 experiences to you?)
- 'What did you have to do to survive?'

  (What kinds of **Threat Response** are you using?)

In one to one clinical, peer support or self help work this then leads to the questions:

- What are your strengths?' (What access to **Power resources** do you have?)
- …..and to integrate all the above: 'What is your story?'

"What has happened to you?" (How is **POWER** operating in your life?)

Power is everywhere in our lives, sometimes in obvious ways and sometimes in less obvious ways. Neither diagnosis nor most therapies place enough emphasis on power, as defined in the PTMF. Instead, we too often see the problem as being in the individual (their mental illness or personality disorder, their negative cognitions or their lack of resilience, and so on.)

The PTMF puts power first and foremost, and all the other parts of the narrative flow from that.

‘What happened to you?’ (How is power operating in your life?)

- ***Legal power*** coercion; laws supporting or limiting other aspects of power
- ***Economic and material power*** ability to obtain valued possessions and services, to control others’ access to them and to pursue valued activities
- ***Interpersonal power*** power within close relationships; to look after/not look after someone, to hurt/abuse/protect them etc
- ***Biological or embodied power*** eg: physical attractiveness, fertility, strength, embodied talents and abilities, physical health
- ***Coercive power or power by*** force or use of violence, aggression or threats to frighten, intimidate or ensure compliance
- ***Social/cultural capital*** – a mix of valued qualifications, knowledge and connections which ease people’s way through life and can be passed indirectly to the next generation
- ***Ideological power*** involves control of language, meaning, and perspective

Ideological power – control of language, meaning and perspective

The least visible but most important form of power, because it is about our thoughts and beliefs, how we ought to think and feel, how we see ourselves, others and the wider world and what we take as 'natural' or 'facts.'

What stereotypes do we hold about certain groups in society – refugees and asylum seekers, women and men, members of particular ethnic groups, and so on?

What language and stereotypes are used to sell certain social policies to us? And in whose interests do they operate?

Ideological power can be used to individualise problems and label people bad or mad/mentally ill.

Many people, especially those in less powerful positions, may be deprived of sound, evidence-based, alternative frameworks in order to make sense of their own and others' distressing or unusual experiences

This is a form of 'epistemic injustice' – experienced by groups who lack shared social resources to make sense of their experiences, due to unequal power relations (Miranda Fricker.)

The PTMF sees the imposition of a diagnosis as an example of epistemic injustice

- The less access you have to conventional or approved forms of power, the more likely you are to adopt socially disturbing or disruptive strategies in order to survive adversity

- Power also operates positively and protectively – friends, partners, family, communities, material resources, social capital, positive identities, education and access to knowledge

- ….including access to this Framework!

‘How did it affect you?’
(What kind of **Threats** does this pose?)

- Relationships eg threats of rejection, abandonment, isolation
- Emotional – eg threats of overwhelming emotions, loss of control
- Social/community – eg threats to social roles, social status, community links
- Economic/material – eg threats to financial security, housing, being able to meet basic needs

- Environmental – eg threats to safety and security, to links with the natural world – e.g. living in a dense urban or high crime area
- Bodily – e.g. threats of violence, physical ill health
- Value base – eg threats to your beliefs and basic values
- Meaning making – eg threats to ability to create valued meanings about important aspects of your life/ imposition of others' meanings

‘What sense did you make of it?’
(What is the **Meaning** of these experiences to you?)

Human beings actively make sense of their world, and their behaviour is purposeful and meaningful

But what do we mean by ‘meaning’?

Meaning is never just freely chosen, it is always both ‘made and found’ (Shotter, 1993)

We cannot understand any aspect of Power, Threat or Threat Response separately from their meanings.

Our personal meanings are shaped by:

- Wider discourses (common understandings about what it means to be ‘mentally ill’, a ‘good mother’, a ‘happy family’, a ‘normal’ child, and so on)

- Ideological meanings – deeply embedded assumptions about the world that serve certain interests (neoliberalism is a good example – and biomedical theories about ‘mental illness’ are another.)

‘What did you have to do to survive?’
(What kinds of Threat Response are you using?)

We have all evolved to be able to respond to threats, by reducing or avoiding them, adapting to or surviving them, and trying to keep safe.

These threat responses are biologically-based but are also influenced by our past experiences, by cultural norms, and by what we can actually do in any given circumstances.

They are on a spectrum from automatic (more biologically-based)

to more personally and culturally-shaped.

Some examples of threat responses

- Preparing to fight, flee, escape, seek safety
- Giving up ('learned helplessness', apathy, low mood)
- Being hypervigilant
- Having flashbacks, phobic responses, nightmares
- Having rapid mood changes
- Amnesia/fragmented memory
- Hearing voices, dissociating, holding unusual beliefs
- Restricting our eating, using alcohol
- Denial, avoidance
- Overwork, perfectionism

Some of these may be seen as ‘normal’ or even desirable (overwork, perfectionism, ruthlessness with colleagues, etc..)

They are likely to be to some degree culture-specific (self-starvation in Westernised countries; so-called ‘culture-bound syndromes’.)

Threat responses are there for a reason, and it makes more sense to group them by function – what purpose do they serve? than by ‘symptom.’

Both the function and the meaning of the response vary over time and across cultures, but there are common themes.

Threat responses grouped by common functions

Regulating overwhelming feelings: (e.g. by dissociation, self-injury, memory fragmentation, bingeing and purging, differential memory encoding, ritualising, intellectualisation, 'high' mood, low mood, hearing voices, use of alcohol and drugs, compulsive activity of various kinds, overeating, denial, projection, splitting, somatic sensations, bodily numbing).

Protection against attachment loss, hurt and abandonment: (e.g. by rejection of others, distrust, seeking care and emotional responses, submission, self-blame, interpersonal violence, hoarding, appeasement, self-silencing, self-punishment).

Restoring the link between Threats and Threat Responses – a main purpose of the Framework

Or to put it another way – restoring the links between personal (family/community) distress and social injustice.

This is the opposite process to psychiatric practice – and much psychological/psychotherapeutic practice – which obscures these links by individualising the problem (Your ‘chemical imbalance’ or ‘negative cognitions’ etc.)

Restoring the link between Threats and Threat Responses

At one level this is common sense. We all know that people living in poverty are more likely to feel miserable and desperate (‘clinical depression’) and we now recognise that abuse and trauma makes it more likely that people will hear voices (‘psychosis’/‘schizophrenia.’)

But a number of factors combine to conceal these links – from the person themselves and from society as a whole.

- Mental health professionals are trained to obscure the link by giving and using diagnoses which imposes a powerful expert narrative of individual deficit and illness

- There is widespread resistance to recognising the reality and impact of threats and the negative impacts of power

- There are many vested interests (personal, family, professional, organisational, community, business, institutional, economic, political) in disconnecting Threats from Threat Responses - and thus preserving the ‘illness’ model.

Disconnecting threat responses from threats

‘Covid-19: Mental health services must be boosted to deal with ‘tsunami’ of cases after lockdown’ British Medical Journal 16.5.20

‘*Those most at risk: Children and adolescents; Older people; People at risk of domestic abuse; People from lower socioeconomic groups and others who are hit hard financially; Frontline healthcare workers who have faced heavy workloads, life or death decisions, and risk of infection; Women, particularly those juggling home schooling with working from home and household tasks; people with previous mental health problems whose usual support is not available.’*

….or to put in another way……

'In ordinary language, people with more to be exhausted, depressed and anxious about are feeling more exhausted, depressed and anxious. However, the general picture is... of a population that is "largely resilient".....It is not a pandemic of "mental health" problems that we need to fear, but a pandemic of "mental health" thinking.'

Johnstone, 2020, British Journal of Psychiatry Bulletin

https://www.cambridge.org/core/journals/bjpsych-bulletin/article/does-covid19-pose-a-challenge-to-the-diagnoses-of-anxiety-and-depression-a-psychologists-view/8DA1C1589B34DD753A50B803B33DCFA4#

Leading ADHD campaigner, American actress Jessica McCabe, spent '*years trying to be normal – to fit in*', only to conclude that she was '*a failed version of normal….. I thought I was what needed to change to be successful.*' Indeed, the title of her talk is 'Failing at normal.' But her solution does not question the accepted versions of 'fitting in' or 'normal' or 'successful.' Rather, she found her way forward through a diagnosis of 'ADHD'.

Disconnecting threat responses from threats

Sam Gould took her own life with an overdose of prescription drugs in September 2018. Coroner Nicholas Moss QC said there were "shortcomings" in her case.

An inquest for Chris Gould, Sam's twin sister, who died in January 2019, will take place next month. Sam had borderline personality disorder, which Mr Moss said in his findings at the end of the inquest was the 'main cause of her death……The disorder caused a persistent, but unpredictable and fluctuating risk of serious deliberate self-harm and suicide.'

In 2016 Chris said she and Sam 'had been seriously sexually abused from a young age and into their teenage years.'

BBC News, 16th April 2021

‘A straight-talking introduction to psychiatric diagnosis’ (2022)

‘It is no wonder that people are left with a sense of ‘not fitting in’ when neoliberalism dictates a narrower and narrower range of acceptable ways of how to be a human being. There are few things more painful than feeling excluded by the social group, since we are, despite individualising messages, deeply social animals. At the same time (we have) eroded the sources of secure identity that once used to protect us – membership of an extended family, a community, a part of the country. These benefits are common themes in accounts of people who report relief from receiving a psychiatric diagnosis –or finding a like-minded group on the internet. Suddenly there seems to be a explanation for why they feel as they do, which frees them from guilt, failure and selfblame, and offers a new identity and community of others.’

General Patterns within the Power Threat Meaning Framework

General Patterns can be seen as ‘meta-narratives’ – broader patterns in distress which help to inform personal narratives, and are also informed by them.

Since the patterns are shaped by meaning, they will always reflect and be shaped by specific worldviews, social, historical, political and cultural contexts and ideological meanings.

They are not based on simple cause-effect links. The patterns will always be overlapping and evolving

They describe what people DO not what they HAVE.

The General Patterns are described as verbs not nouns, to show that they represent active (although not necessarily consciously chosen or controlled) attempts to survive the negative operation of power.

They are not a one-to-one replacement for diagnostic clusters. People will vary in their ‘fit’ with one or more patterns, and general patterns will always need adapting to the individual.

They help to avoid pathologisation, relieve guilt, and give a sense of not being alone

We are developing more of them!

Patterns and ‘culture’

The Power Threat Meaning framework predicts that there will be widely varying cultural experiences and expressions of distress. These are not seen as bizarre, primitive, less valid, or as exotic variations of the Western diagnostic model.

In contrast to the Global Mental Health Movement which is currently exporting diagnostic models across the world, the Framework is intended to convey a message of respect for the many different ways people express and heal distress both within the UK and across the globe.

Workshops on exploring, comparing and contrasting the PTMF with indigenous understandings in New Zealand and Australia are described here:

https://www.madintheuk.com/2019/02/crossing-cultures-with-the-power-threat-meaning-framework/

https://www.madintheuk.com/2019/03/crossing-cultures-with-the-power-threat-meaning-framework-australia/

The PTM Framework and the relevance of:

- Histories of colonisation and intergenerational trauma, and the resulting loss of identity, culture, heritage and land
- Inseparability of individual from the social group
- Relationship to the natural world
- Integration of mind, body, spirit, natural world
- Indigenous psychologies and research paradigms
- Culturally-supported practices, rituals and ceremonies
- Community narratives, values, faiths and spiritual beliefs, to support the healing and integration of the social group

(Main, p.216-217; Overview, p 77-79.)

The PTMF can act as a 'distant cousin' which supports respect for local understandings of distress (Johnstone & Kopua, 2019.)

The PTM Framework and narrative. It's about all of us!

Story-telling and meaning-making are universal human capacities.

The PTMF validates and provides evidence for the central role of narrative of all kinds as an alternative to diagnosis, and as a means of witnessing and healing, both within and beyond services.

'*The restorative power of truth-telling*' (Herman, 2001).

Recovery as '*reclaiming our experience in order to take back authorship of our own stories*' (Dillon and May, 2003)

The PTM Framework in practice

Examples from peer support work:

'We found that sharing experiences utilising the framework is an emotive and thought-provoking way to connect with others who have endured similar experiences, and this may be the first time that the narrative and pain have truly been heard. It demonstrates that we are not alone in our pain and suffering, whilst offering a new perspective of our distress. This takes us from being isolated and lonely individuals to being part of a wider community of equals'

(Griffiths, 2019).

Impact of POWER

I am a survivor of many traumatic experiences. In addition, I am being disempowered by two very powerful systems (statutory mental health services and children's social care). This resulted in two male professionals exploiting their position of trust, power and authority to coerce and sexually abuse me. Subsequently these organisations used their power to deny my autonomy, and pathologize my behaviours as being symptomatic of a 'personality disorder' which is victim blaming. Consequently, I had to form a subservient relationship with a controlling psychiatric system in order access support to try to heal from the effects of these harrowing experiences.

Core THREATS

I am unable to trust or heal from my experiences. I struggle with relentless post-traumatic stress, such as dissociation (blank states) hypervigilance, flash backs and vivid disturbing dreams. I have been prevented from articulating my story because the impact of the abuse is being ignored. This leaves me feeling misunderstood, angry, apathetic, anxious and struggling to regulate my emotions. My physical energy levels are chronically depleted because the hyper arousal is extremely painful and exhausting. Consequently, my body's fight and flight response is chronically stuck on resulting in autonomic dysfunction. These psychological and physical factors combined test my resilience, often resulting in suicidality.

Meanings and DISCOURSES

I believed that I am a worthless person who is undeserving of help and treatment. I felt that I am defective, something is wrong with me, that I deserve to be hurt because my character deficits are the root cause of those damaging experiences. The world seems an unsafe place as others are untrustworthy. Ultimately, I often believe that I would be better off dead because death seems the only means of escape from these harrowing experiences and from myself.

THREAT Responses

My survival mechanisms involve forming subservient relationships with others who are in a position of power and authority. My body is hyper vigilant at all times, constantly scanning for early signs of danger, threats, power imbalances and coercion. I am cautious and wary, often resulting in avoidance of situations and other people. I responded to threats to my safety and wellbeing by automatically employing self-protective or self-defeating behaviours. On occasions when I have felt that I was in immediate danger I responded with verbal aggression (described by some mental health staff as 'being abusive towards them'). I often disconnect by dissociating or sleeping. I restrict my dietary intake because that feels like the only control I have in life. In extremely distressing circumstances I use alcohol to block the world out to numb the pain.

Strengths and Power resources

I have a well-developed insight into the psychology of trauma and human distress. My intelligence and resilience enable me to self-advocate and stand firm against coercion. I am encouraged through the reciprocal relationships I am developing with my peers that motivate me to learn new skills in order to support others facing similar adverse life experiences. Additionally, I am inspired by trauma informed professionals whose ground-breaking work informs me to develop a new understanding of my experiences. Some of whom have helped and supported me in this process. I have a beautiful family who give me the strength and determination to get through each day.

My story

Adverse childhood experiences led to complex trauma throughout my life. Constant repetitive cycles of coercion, powerlessness and multiple forms of abuse have not only had a lasting effect upon my interactions with others, but are also impacting on my physical, emotional and psychological wellbeing. My energy levels are depleted from being consistently broken and distressed by a disempowering, authoritative and controlling mental health system that has been coercive and traumatizing when I needed compassionate trauma informed provision. As a consequence, I am dispirited and struggle to trust others. Even though the on-going clinical dispute with statutory mental health services has deeply hurt and retraumatised me, my relationships with my peers and family are protective factors that motivate me to find the strength to utilise my experiences to self-educate and self-advocate, whilst campaigning for trauma informed services and improved mental health provision for other survivors.

NHS
Central and North West London
NHS Foundation Trust

Context

Setting

Northwick Park Mental Health Centre, North West London

Two adult mixed acute wards (22/23 beds)

High acuity

Staffing levels (5 day/ 4 night)

KPI length of stay – 21 days

In 2017

Medical model

Focus on diagnosis

Context not seen as relevant

Limited psychological interventions

Low staff morale, poor results for NHS staff survey

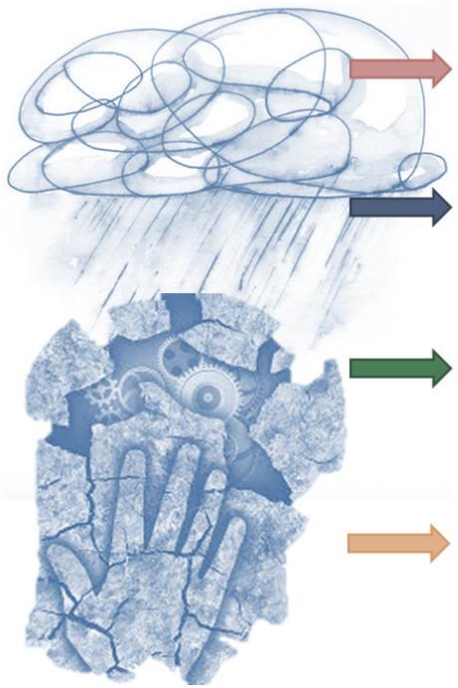
Nursing staff clinical expertise not being utilised

Dispensing and policing culture

Higher than average rate of violent incidents on the ward

NHS
Central and North West London
NHS Foundation Trust

Structure of the Meeting



POWER: *what has happened to you?*
trauma, racism, economic inequality, discrimination, transphobia/ homophobia, sexism, loss of right, poverty

THREAT: *How does it affect you?*
Threat to safety & security
Threat to sense of self & sense of being/ social inclusion

MEANING: *What sense did you make of it?*
I don't feel safe, I don't feel I belong, I can't trust people, I feel emotionally over-whelmed, I feel powerless & afraid

THREAT RESPONSE: *what did you have to do to survive?*
Self-harm, isolate myself, hit out/ hurt others, over eat, drink alcohol in excess, take substances, hear voices, sexually promiscuous behaviour,

Review background

Feelings

Stuck

Power resources

Power imbalances

Threats

Meaning

Threat responses

Feelings

Ways forward

NHS
Central and North West London
NHS Foundation Trust

Evaluation

Staff survey

Most satisfied staff in acute adult wards across CNWL

RI data

Lowest number of **restraint** and **seclusion** in trust

Significant ($p<0.05$) reduction in the use of **seclusion** and **restraint**

Staff questionnaires. 100% reported;

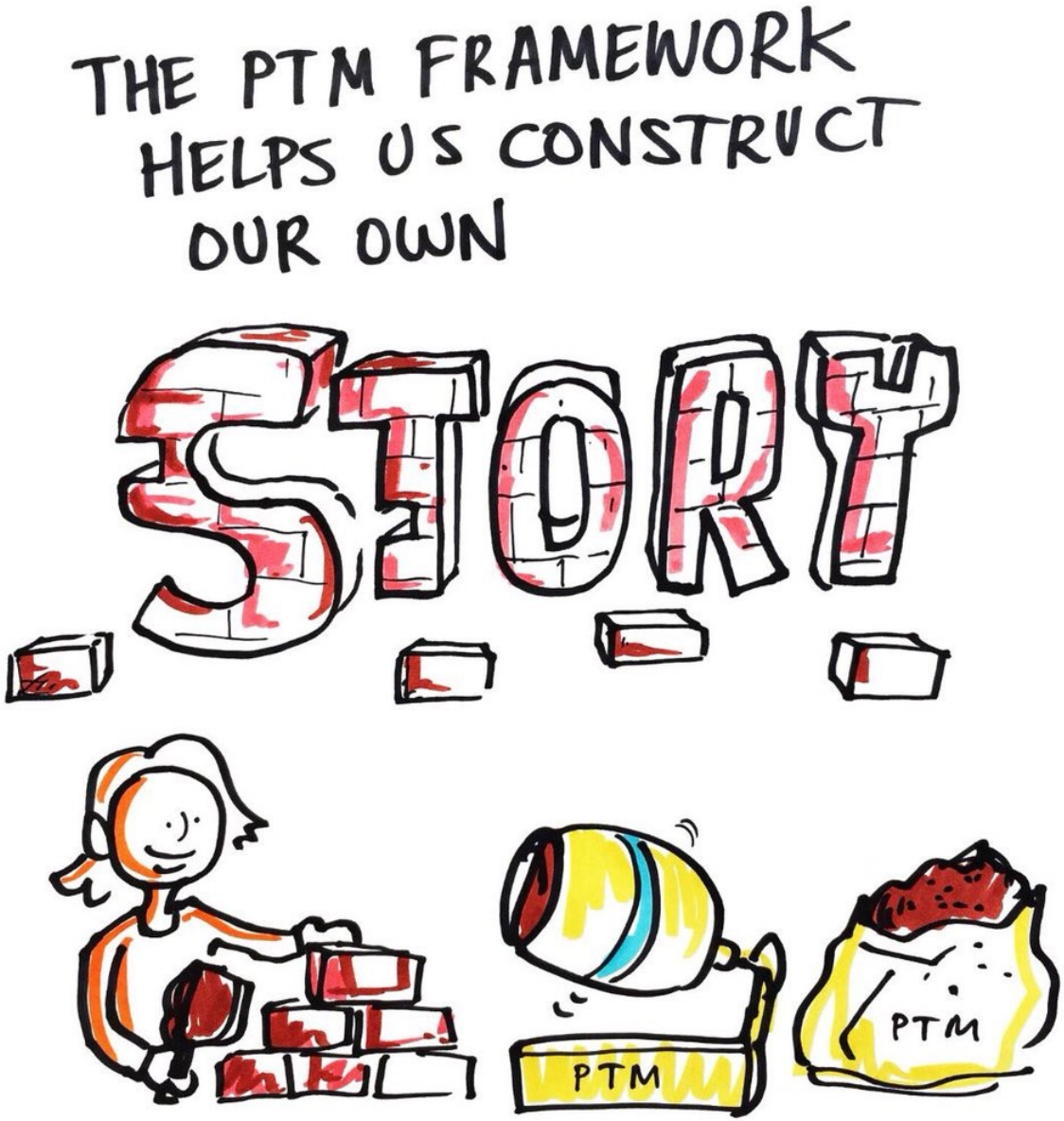
Better understanding of MH diffs

Better understanding TI interventions

NHS
Central and North West London
NHS Foundation Trust

Patient Questionnaires

100% of inpatients interviewed **agreed or strongly agreed that the approach has supported them to learn new and helpful ways of better managing their mental health (including difficult thoughts, feelings, and unusual experiences such as paranoia and voices).**


THE PTM FRAMEWORK
HELPS US CONSTRUCT
OUR OWN
START
PTM
PTM
#PTMFramework
#adisorder4everyone

A narrative or team formulation exercise: Oliver

- Read the account of Oliver
- Divide into groups of about 6 people. Using the PTMF Narrative prompts, each group thinks about the possible Power influences in Oliver's life.
- THEN after about 15 minutes, the top left hand side of the room considers 'Threats.' Top right hand side of the room considers 'Meanings'. Bottom left hand side of the room considers 'Threat responses'. Bottom right hand side of the room considers 'Strengths'.
- Jot your ideas on the whiteboards (in English if you can!)

(You can make some guesses – and bear in mind that the categories overlap)

- In the large group – summarise our thoughts.
- How might this change our or the staff view of Oliver?
- What ways forward might we suggest?

Developments in the UK: Trauma-informed care as an alternative to the medical model of distress

The emerging 'trauma-informed' model recognises the causal role of adversity of all kinds across all human welfare systems

'*Trauma and recovery*' Judith Herman (2001)

'*The body keeps the score*' Bessel van der Kolk (2015

Dr Karen Treisman http://www.safehandsthinkingminds.co.uk

Dr Margot Sunderland http://childmentalhealthcentre.org

Publication of DSM 5 in 2013

Dr Allen Frances, Chair of DSM IV committee: ‘DSM 5 will radically and recklessly expand the boundaries of psychiatry……There is no reason to believe that DSM-5 is safe or scientifically sound.’

Dr Steven Hyman, former NIMH director : DSM is 'totally wrong, an absolute scientific nightmare.'

Dr Thomas Insel, former NIMH director: 'Patients….. deserve better…..The weakness is its lack of validity.’

From now on, ‘NIMH will be re-orienting its research away from DSM categories’ (Insel, 2013.)

‘There is no definition of a mental disorder. I mean, you just can’t define it. It’s bullshit’ Dr Allen Frances, Chair of DSM IV committee
http://www.wired.com/magazine/2010/12/ff_dsmv/

In ‘Anatomy of an Epidemic’ (2010) award-winning US science journalist Robert Whitaker presents compelling evidence that *all psychiatric drugs increase disability over the long term*.

*‘*As the psychopharmacology revolution has unfolded, the number of disabled mentally ill has *skyrocketed.’*

(but don’t stop your drugs without taking professional advice)

Disease-centred vs drug centred model (Moncrieff 2009)

Disease-centred model	Drug-centred model
Drugs correct an abnormal brain state	Drugs create an abnormal brain state
Drugs act directly on a biological disease process	General effects of this brain state may be experienced as helpful
Eg antibiotics for infections, Insulin for diabetes	Eg alcohol for anxiety in social situations

The current UK and Ireland situation

In Westernised societies we are seeing ...'less tolerance of distress along with more reasons to be unhappy; increased medicalisation of our feelings at the very time when the real-life reasons for them seem more obvious; massively expanding markets for drugs, accompanied by parallel rises in disability; damning critiques of diagnostic categories at the same time as more and more people are adopting these labels; all accompanied by rapidly-growing waiting lists for MH services and loud calls for more funding in the absence of any solid evidence that they improve outcomes overall.'

'*A straight talking introduction to psychiatric diagnosis*' (2022)

Dr Sami Timimi 'Insane medicine' (2021)
https://www.madintheuk.com/2020/11/insane-medicine-chapter-one-the-medical-model-of-mental-health-is-finished/

‘*I can say from my own experience that the social pressure of growing up can be a toxic environment for us autists as we are forced to conform to the norms or stand out and risk bullying and trauma. With hindsight, the next warning sign that I was autistic was my first experience of university. I arrived with a car-full of books, and was shocked at the person who parked next to us unloading crates of alcohol. I struggled immensely with the social side of university including the loud bars and clubs, which assaulted my senses and left my ears ringing for days afterwards. I left after two terms…*

Receiving this diagnosis was a huge relief. Finally, someone was sure about something – to an extent, I didn’t care what it was, I just wanted an answer. Now I had an explanation for why I had always felt different’ (Smith, 2019).

‘We all have mental health’……

‘Children are being prescribed anti-depressants in record numbers, new figures from the NHS reveal’ The Times, 31.8.21

‘ADHD’ videos on TikTok have now received 2.4 billion views, encouraging self-diagnosis. One video on ‘ADHD’ generated over 22 million ‘likes’ and over 33,000 comments, including many along the lines of: *‘Watching this made me think I might have ADHD.’ ‘All of a sudden I think I need to get checked.’ ‘Do I call up my doctors or what?’* (Williams, 2021).

‘*I never felt I fitted in but I’ve found my tribe – now I know it’s not my fault – my feelings are validated*.’

General Pattern: Surviving separation and identity confusion

This pattern describes young people's attempts to survive dilemmas about separation and identity, typically in early adulthood. They may face a threat to their sense of self, identity and agency. There may be a struggle to find a balance between dependence/loss of self and autonomy/fear of abandonment. Other core meanings are rejection, worthlessness, failure, shame, inferiority, and feeling controlled, afraid, invaded or trapped. The person may respond with confusion, compliance, using rituals, perfectionism, and/or anger and rebellion.

Families may find it hard to offer support, due to their own trauma histories, lack of support or gender/cultural expectations. This may contribute to parental or carer attitudes of protection, control and/or criticism, along with confusing communication styles. All of this may be more intense in individualistic cultures with a strong emphasis on separation from the nuclear family in late teens/early 20s, coupled with high expectations about independence, striving, hard work, competitiveness and achievement.

The dilemmas may lead to being diagnosed with 'psychosis', 'schizophrenia', 'anorexia', 'bulimia', 'depression' and 'OCD', along with others..