**The Power Threat Meaning Framework and international mental health nurse education: A welcome revolution in human rights**

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**Introduction**

A human rights-based revolution in conceptualising and understanding psychological distress is gathering momentum. In time, it is to be hoped that it will change the face of international mental health nurse education in irrevocable, significant and positive ways. At its heart is the Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018a,b), launched by the Division of Clinical Psychology of the British Psychological Society on the 12th January 2018. This thoroughgoing, major alternative to the American Psychiatric Association’s (APA) and World Health Organisation’s (WHO) biomedical psychiatric diagnostic systems was five years in the making. It follows an earlier position statement on the need for a paradigm shift towards a conceptual system no longer based on a disease model of psychological distress (Division of Clinical Psychology, 2013; see also Grant, 2015).

The PTMF sits well with the recent call for an urgent international shift to a rights-based approach to global mental health. In June 2017 the United Nations Office of the High Commissioner for Human rights issued a press release on a new report from its Special Rapporteur (OHCHR, 2017). The clear message in the report is the need for urgent global political commitments, policy responses, and immediate remedial action to combat three main groups of obstacles currently disadvantaging mental health service users. These are: the dominance of the biomedical model and the corresponding over-reliance on medication-based interventions; huge power asymmetries in the areas of policymaking, service provision, medical and mental/health education and research, which includes preventable forced treatment; and a biased use of knowledge and evidence favouring the biomedical paradigm, that functions to prevent the development of a more helpfully comprehensive knowledge and research base.

**Introducing the PTMF**

It would be beyond the scope of this Contemporary Issues article to do justice to the range, scope and content of the PTMF as it currently stands. Instead, our more modest aims are: to provide a description of its key features; identify the ways in which it differs from diagnostic approaches; and, in the final sections of the paper, sketch out in broad terms some emerging, challenging implications for international mental health nurse education.

The authors of the PTMF stress that it should be regarded as the first stage of a larger ongoing project. As a contextual, multi-factorial, open-ended, meta-approach, in which a range of models, practices and theoretical and philosophical traditions are synthesized, the Framework incorporates a wide spectrum of social, psychological and biological, evidence-based scholarship. It is grounded in the core assumption that people actively make sense of their lives in interdependence with their relational, social, material, cultural and spiritual environments. In taking human meaning making, narrative and subjective experience as central, the key feature of the Framework is the dynamic interrelationship between the following four dimensions mediating psychological and emotional distress, unusual experiences and troubled or troubling behaviour:

* The operation of **POWER**, in its biologically-embodied, coercive, legal, economic-material, ideological, socio-cultural and interpersonal forms.
* The **THREATS** ensuing from the negative operation of power, on individuals and communities, that result in biologically-mediated, sometimes inter-generational, emotional distress.
* The centrality of socially and discursively produced **MEANING,** which shapes the operation, experience and expression of power and threat, and human responses to threat.
* In reaction to all of the above, the **THREAT RESPONSES** that are drawn upon and employed by people, families, groups and communities, in order to survive at emotional, physical, relational and social levels. These are learned and evolved, shaped by social and ideological discourses, and range from automatic physiological and behavioural reactions to actions and responses which demonstrate increasingly greater levels of reflexivity and conscious selection.

At a broad level of future policymaking, administration, education, research, public health and public education, the purpose of the PTMF is to aid in the provisional identification of open-ended and developing evidence-based patterns in human distress. At the applied service level, the collaborative development of explanatory narratives with users should enable them to make better and more coherent sense of their experiences, and provide them with a better template than psychiatric diagnoses for engaging positively with their futures.

**Its differences from diagnostic- or disorder-based approaches**

The authors of the PTMF argue that it is theoretically, empirically and conceptually free of the charges of western culture-centrism associated with the APA and WHO diagnostic systems. The Framework rests on the assumption that, irrespective of geographical or cultural location and time, all forms of adversity are intelligible in contexts of inequality and other forms of the negative operation of power, including deprivation, discrimination, marginalisation and social injustice.

The impact of adversities is described as cumulative and synergistic, with the combined effect of more than one adversity being greater and qualitatively different from the impact of one alone. Several adversity sources will trigger a corresponding increase in the number of threat responses utilised by an individual or a group.

 In achieving a useful understanding of the relationship between power, threat, meaning and threat response, the focus of the PTMF is always on broad, provisional, contingent and overlapping patterns and regularities in the expression and experience of distress and troubled or troubling behaviour. This contrasts with the linear cause-effect relationships often presupposed in diagnostic- and disorder-based systems, where links are sought between specific biological or psychological causal mechanisms and discrete categories of disorder. The provisional general patterns in the PTMF are therefore organised by meaning, not biology. They can be described as *patterns of embodied, meaning-based threat responses to the negative operation of power.*

This shift away from what in diagnostic language is described as ‘multiple-’ or ‘co-morbidity’ illustrates how threat responses are conceptualised as an alternative to diagnostic symptoms in the PTMF, rather than assuming that they functionally replace them. Whereas ‘symptoms’ signal strongly biologically-mediated pathology, threat responses always amount to individuals and groups trying to protect themselves and adapt as best they can to shifting and often toxic life circumstances. Rather than being understood as separate types of ‘symptom’, they are grouped within PTMF in terms of their common survival functions, such as regulating emotions, or seeking attachments.

The revised role of biology in the PTMF is not merely an attempt at a more balanced ‘biopsychosocial’ perspective. It is also an acknowledgement of important themes within contemporary genetic science that do not support the largely reductionist perspectives of biomedical psychiatry. The PTMF is therefore best viewed as an attempt not to reduce our focus upon bodies, but to bring it towards the current biological evidence-base.

In failing to capture the experiential realities of embodied humans behaving purposefully in social and relational contexts, the negative consequences of psychiatric diagnoses include decontextualizing, marginalising, and by extension stigmatising and ‘othering’ people and the meanings of their psychological distress. In contrast, in normalising experiences and behaviour regarded as pathological in diagnostic systems, the PTMF authors argue for a continuum in the human use of threat responses rather than the binary division between pathological and non-pathological experiences and behaviours expressed in diagnostic systems. Although suffering is central to the PTMF, from its perspective there is no separate group of the ‘mentally ill’.

**Some emerging implications for international mental health nurse education**

We believe that the PTMF provides the basis for international mental health nurse educators to develop curricula in ways that enhance the experience of services users in line with a rights-based manifesto. This should include the right for users to be: accorded dignity and respect around human meaning-making; given help to story and re-story their experience free of their entrapment in stigmatising and othering pathology narratives; and, as will be described below, provided with the support needed to challenge ‘epistemic injustice’.

In the pursuance of these interrelated rights, the shape and content of curricula needs to be informed by the intent to help nurses develop as activists and resource builders, and achieve sophisticated levels of narrative and narrative-ethical competence. With regard to their future activism and resource building role, the PTMF recognises the importance of helping people fight against adversity through the identification and development of threat-ameliorating factors. These include the building of social, cultural and educational capital, the development of existing and potential support networks, and using opportunities for social and material environmental escape.

In taking us beyond our contemporary biopsychosocial approach, the PTMF makes it necessary for nurses to also develop as intra-disciplinary activists. Contained within the PTMF are acknowledgements of the ways in which mental health services are a source of negative power and threat. Services are frequently iatrogenic, traumatising and re-traumatising the people they purport to help. One of the ways in which services do this is by dismissing the relevance and credibility of service users’ life stories (Grant et al., 2015). Mental health nurses will therefore need help to develop the levels of narrative-ethical competence to be sensitised to, and work against, what Fricker (2007) describes as ‘epistemic injustice’.

According to Fricker, acts of epistemic injustice violate the individual as expert knower of their lived experiences in two ways: *testimonial injustice* happens when the words of individuals are not accorded credibility. *Hermeneutic injustice* occurs when individuals do not have the knowledge resources to adequately make sense of their experiences. It is clearly the case that testimonial injustice occurs on a frequent basis in mental health services as they are currently configured (e.g. Grant et al., 2015). The PTMF analysis sees the imposition of a psychiatric diagnosis and the consequent obscuring and denial of the links between threat and threat responses as a prime example of epistemic injustice in both its main senses. The PTMF offers nurses the conceptual framework to act against this and, to counter hermeneutic injustice, collaboratively build knowledge resources with service users which are wider than those afforded by diagnostic systems. It is to be hoped that this will result in the latter group being better equipped to understand and appreciate the sources of social injustice implicated in their distress experiences; such awareness may be the beginning of emancipation.

All of this will of course place a demand on nurses to develop the relational and narrative-competence skills sets necessary for according a central place to and de-pathologising users’ experiences. In line with the PTMF, the vocabulary of pathology will need to be dropped from curricula (Grant, 2015), and it should no longer be acceptable to use diagnostic language uncritically in student essays. The diagnostic question – implicitly informing service delivery and attitudes – ‘What is wrong with you?’ must be replaced by ‘What has happened to you?’.

In turn, this places a need for nurses to develop their role as curious co-inquirers, in the service of helping users become more sophisticated in recognising the interrelated links between power, threats, threat responses and the development of ameliorating factors. A mental health nurse working within the PTMF will be increasingly able to understand how the structures and ideologies of power in society permeate their own and others’ embodied, material and social-psychological lives. The PTMF enables the construction of richer and more empowering stories than may be considered standard practice.

**Concluding comments: Some barriers to be overcome**

To ensure its successful implementation, international mental health nurse educators will need to acknowledge and respond to existing and emerging contradictions between the PTMF and current national and state educational, legal and benefits frameworks. Doing so will help mitigate the distress that will inevitably ensue for students, their practice colleagues and service users in the paradigm shift.

All too frequently mental health nurses are conduits for ideological powers. The realization of the PTMF is likely to bring them into conflict with many more power-savvy service-users ‘returning the gaze’ of the clinic than is the case presently. It is therefore important that students are helped to thoroughly understand the PTMF. Otherwise, they may feel more immediate affinity with ‘threat responses’ and related patterns proposed in the framework, but fail to adequately understand that the sections on power are pivotal and fundamental. Their interpersonal skills will thus need to move on from 1950’s Carl Rogers to the more contemporary understandings of self and agency described in the PTMF.

This points to a broader and extremely challenging conundrum: how best to incorporate the PTMF into existing mental health/nurse education. To do so without fundamental and extensive revision of the curricula brings the danger of diluting the framework to the extent that it does little to challenge the bio-orthodox status quo. On the other hand, it is probably foolish to imagine that the PTMF could be implemented into curricula through anything other than incomplete step-changes. In this context, tensions may ensue between stakeholders who argue that the ability to work with incompatible knowledge systems is a key strength of mental health nursing and others who regard this as its weakness.

However, perhaps the above already presumes too much. People tend not to challenge their paradigmatic assumptions until they perceive that paradigm as problematic (Brookfield 2017). It is still arguably the case that the discipline of mental health nursing seriously fails to grasp the depth of trouble that diagnostic psychiatry is in. Many nurses in practice and education continue to assume psychiatry’s ‘reliability as validity’ (Burstow 2015), despite its low reliability in actuality. Like people in general, nurses and their educators are comfortably wrapped in ideological blankets, and work hard to protect their narrative fidelity. For many, this includes fidelity to an illness model that has directed and justified their professional behavior for seven decades or more. The PTMF is currently invisible to most nurses and will need to have many champions in education and practice for this state of affairs to significantly change.

**Resources**: This link offers access to FAQs about the Framework; the Main and Overview versions of the Framework; a brief 2 page summary of the Framework; a suggested Guided Discussion for introducing the ideas into one to one or groupwork; and the slides from the launch day.

https://www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework

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