The Power Threat Meaning Framework:
Addressing adversity, challenging prejudice and stigma and transforming services

Abstract

Advocates of a biomedical approach have argued that: it provides an evidence-based approach to classifying and understanding the causes of problems; adopting a biomedical understanding will reduce stigma; and biomedical interventions are effective and evidence-based. This article reviews the literature and finds not only that there is little or no evidence for these assumptions but that, in fact, the research evidence points to the need for the kind of alternative approach proposed by the PTMF. Alternative causal models which recognise the role of psychosocial adversities are described and alternative approaches to diagnostic classification and destigmatisation programmes are suggested and innovative attempts to redesign services in a manner consistent with the PTMF approach are described. The article concludes by discussing implications for policy-level change.

Keywords

Power, Threat, Meaning Framework; mental health services; adversities; prejudice; stigma

The PTMF was a response to the continued dominance of a reductionist biomedical approach to psychological distress and distressing conduct. Advocates of this approach have argued that it provides an evidence-based approach to classifying and understanding the causes of these problems, that adopting a biomedical understanding will reduce stigma and that biomedical interventions are effective and evidence-based. In this article the research literature on each of these aspects is reviewed and, as each are examined we will see not only that there is little or no evidence for these assumptions but that, in fact, the evidence points to the need for the kind of alternative approach proposed by the PTMF. The article describes alternative causal models which recognise the role of psychosocial adversities, alternative approaches to diagnostic classification and destigmatisation programmes and innovative attempts to redesign services in a manner consistent with the PTMF approach. It concludes by discussing implications for policy-level change.

How a biomedical approach obscures the causal role of psychosocial adversities

A reductionist biomedical understanding of the causes of psychological distress and distressing behaviour is dominant in mainstream psychiatry (Bentall, 2003, 2009; Read & Dillon, 2013) Yet, despite decades of optimistic claims that simple biological causes will be found for a range of diagnostic categories, researchers are still no nearer to their goal. For example, a review aiming to find evidence of a genetic basis for depression found, instead, ‘a strong association between the number of stressful life events and risk of depression across the studies’ (Risch et al., 2009, p. 2462). A similar pattern is seen in relation to the diagnosis of schizophrenia (Bentall, 2003; Read & Dillon, 2013) This is biological psychiatry’s flagship construct, with, supposedly, a strong bio-genetic etiology and one where the hypothesis that childhood adversities played a causal role has previously been seen as quite controversial. A 2012 meta-analysis, however, looked at six types of childhood adversity: sexual abuse, physical abuse, emotional abuse, neglect, bullying and parental death. The reviewers located18 case-control studies (n = 3,904), 10 prospective or quasi-prospective studies (n = 41,803) and eight population-based cross-sectional studies (n = 35,546). The review found that there were significant associations between childhood adversity and psychosis across all three research designs, with an overall effect of OR = 2.78 (95% CI, 2.34-3.31). It concluded that '[t]hese findings indicate that childhood adversity is strongly associated with increased risk for psychosis.' (Varese et al., 2012, p. 661). The failure to find a biological cause and the evidence for psychosocial causes has led at least one prominent schizophrenia researcher to rethink their assumptions. Recently, British psychiatrist Robin Murray admitted:

> In the last two decades, it has become obvious that child abuse, urbanization, migration, and adverse life events contribute to the etiology of schizophrenia and other psychoses. This has been a big shift for me! My preconceptions had made me blind to the influence of the social environment.
>
> Murray (2016. p. 255).

Two recent reviews have summarised evidence that psychosocial factors play a causal role in the kinds of problems attracting diagnoses of psychosis (Cooke, 2017; Read, 2013a). A number of studies and reviews have identified some of the specific adversities that have been proven to have a causal role, usually in combination, in most sorts of distress and despair in adulthood, including psychosis (Bentall, 2009; Johnstone & Boyle, 2018, pp. 92-151; Kessler et al., 2010; Read, 2020; Read, 2013a; Read, Morrison, & Waddingham, 2020; Varese et al., 2012; Wilkinson & Pickett, 2009). They include factors occurring during pregnancy (e.g. maternal prenatal health and stress); during childhood (neglect, sexual, physical and emotional abuse, witnessing violence as a child and early parental loss) and factors occurring across the lifespan: bullying; heavy early cannabis use; rape and physical assault; war trauma; absolute and relative poverty; ethnicity (mediated by poverty, isolation and racism); discrimination (racism, sexism, homophobia, etc.); and urban living.

Child abuse plays a causal role in most mental health problems, including: depression, anxiety, eating difficulties, sexual problems, 'personality disorders', dissociation, substance abuse, PTSD, mood swings and psychosis (Kessler et al. 2010; Read 2013a; Varese et al. 2012). Adults who were abused when they were children are higher users of adult mental health services; have earlier, longer and more frequent psychiatric hospital admissions; have higher global symptom severity; and are more likely to self-harm and kill themselves (Hepworth & McGowan 2013; Read 2013a). Adults scoring high on the Adverse Childhood Experiences scale are 10 times more likely to be prescribed antipsychotics and 17 times more likely to be prescribed antidepressants (Anda et al, 2007).

This is not to say that biological processes do not play a role but they are not the primary cause of distress in the way that a biological reductionist model assumes. Rather, as the PTMF notes, biology is a 'mediator and enabler of all human experience' (p. 7), something we discuss at length in our 30-page chapter on 'The role of biology'. Indeed, our biology is affected by what has happened to us -- biological differences can be caused by the social environment. For example, biological researchers have argued that differences between the brains of people diagnosed with 'schizophrenia' and the brains of 'normal' people, show that 'schizophrenia' is a 'brain disease'. Many such claims of biological differences and causes have been wildly exaggerated or are completely unsubstantiated. But they also make a simple mistake – to assume that biological differences are simplistically caused by biology. However, the same brain differences have been found in abused young children, providing evidence for a Traumagenic Neurodevelopmental model of psychosis (Read, Fosse, Moskowitz & Perry, 2014).

Chapter 4 of the PTMF devotes sixty pages to reviewing the literature on the role of the social context (Johnstone & Boyle, 2018, pp. 92-151), focussing primarily on childhood adversity, gender, 'race' and ethnicity and social class and poverty. It is argued that researchers have often neglected the role that power plays in how adversities impact on people. Six different kinds of power are described: coercive; legal; economic and material; biological/embodied; interpersonal; and ideological (see Mary Boyle's article on power, this issue)

This last form of power -- ideological power -- refers to the way in which power works through language, to allow issues to be framed only in certain ways, while closing down other perspectives. This is relevant to the discussion of biomedical models: by framing issues only in terms of biology and by assuming biology plays the primary causal role, the link between adversities and distress is obscured and other ways of conceptualising distress. For example, the notion that since we are biological beings anything that happens to us also has an impact on our biology is closed down (see David Harper's article on framing, this issue).

Ideological power is also exerted through the way in which experiences of distress or distressing behaviour are diagnosed and explained by mental health professionals, thus affecting the kinds of meanings available to people to understand their troubles (see John Cromby's article, this issue). Given the significant role diagnostic labelling plays in meaning-making, we turn to this next.

How diagnosis appears to explain but often only obscures

The use of a psychiatric diagnosis can have some advantages for some of us some of the time. It might make us feel that we have an explanation for our difficulties. 'I am hearing voices because I have an illness called schizophrenia which is what is making me hear the voices' or 'I am feeling depressed because I am suffering from a thing called 'depressive disorder' which is making me feel depressed.' Anxiety is caused by 'anxiety disorder' and so on. An explanation, any explanation, can be reassuring and soothing when we are confused and distressed. A diagnosis can also convey that the doctor knows what is going on, knows what is wrong with us, and, therefore, knows what to do to make us better. It might also help us feel less alone with our problems; other people also have the thing we've been told we've got. The last thing we want to hear when we tell a mental health professional, or our GP, our problems is 'I've no idea what's going on here; I've never seen anything like this before,'.

In reality, however, the diagnoses tell us little or nothing about the causes of our problems. What they do, instead, as we explain in the PTMF, is to locate our problems firmly within us as an individual person, ignoring our social context, past and present. The language of symptoms, disorders, illnesses etc. also conveys a general sense that there is something wrong, medically, with us as individuals. A psychiatric diagnosis thereby tends to render our distressing behaviours, feelings and thought meaningless, other than as 'symptoms' of our ‘disorder’ (Bentall, 2003; Johnstone, 2014). It also focuses on deficits rather than strengths and, as we will see in the next section, these labels are also a major contributor to prejudice and stigma. A great deal of the research on social causation, biomedicalization, clinical iatrogenesis and stigma has been conducted by medical sociologists and readers are referred to Pescosolido et al (2008) and Rogers and Pilgrim (2014) for overviews of this work.

A significant problem for the diagnostic approach is is that many of its categories are scientifically meaningless. In other words, many have inadequate reliability (the extent to which people can agree on who has got the thing in question) and/or validity (the degree to which the thing has the properties that it is supposed to have – eg a biological etiology – see above) (Bentall, 2003; Johnstone, 2014; Read, 2013b). Arguably the most extreme example of the poor science involved in psychiatric diagnoses relates to psychiatry’s flagship diagnosis – schizophrenia (Bentall, 2009; Read, 2013b). As early as 1968, British psychologist Don Bannister had concluded that ‘[s]chizophrenia as a concept, is a semantic Titanic, doomed before it sails, a concept so diffuse as to be unusable in a scientific context’ (Bannister,1968, p. 181). Bannister went on to observe that:

> We diagnose one person as schizophrenic because he manifests characteristics A and B and diagnose a second person as schizophrenic because he manifests characteristics C, D and E. The two people are now firmly grouped in the same category while not specifically possessing any common characteristic. . . . Disjunctive categories are logically too primitive for scientific use.
>
> (1968, pp. 181–2)

The category remains disjunctive today. There are five types of symptoms for ‘schizophrenia’ listed in DSM-5. You only need two of them to get the diagnosis. So you and I can have no ‘symptoms’ in common whatsoever but we will receive the same diagnosis (and almost certainly the same treatment). This is scientific nonsense.

In 2012, Dr Fibiger of the Psychiatry Department at the University of British Columbia, and ex-Vice President of Neuroscience at drug company Eli Lilly, wrote:

> Today, few would argue that syndromes such as schizophrenia and depression are single, homogeneous diseases …. concepts such as schizophrenia will surely be discarded and future generations will look back and might rightfully ask “What were they thinking?” (Fibiger, 2012, p. 50).

The problems of psychiatry’s diagnostic categories were recognised in a position statement published by the British Psychological Society’s Division of Division of Clinical Psychology (DCP, 2013). This statement suggested that psychologists and others could use psychological formulation as an alternative to diagnosis. The origins of the PTMF also lie in this document – one of its recommendations was that there should be support for ‘work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors’ (D.C.P., 2013, p.9). In its final chapter, the PTMF includes a section suggesting ways in which we can avoid using medicalising language. The PTMF also suggests that Provisional General Patterns may be a useful alternative to diagnostic categories – these attempt to describe regularities in people’s responses to certain kinds of threats (see Lucy Johnstone’s article, this issue).

So far we have seen how biomedical models obscure the role of psychosocial adversities and how diagnostic categories are unscientific. But advocates of the biomedical approach have made another claim, as noted in a recent report to the UN by one of its Special Rapporteurs, Dainius Pūras, a professor of child and adolescent psychiatry and public mental health in Lithuania:

> The biomedical model regards neurobiological aspects and processes as the explanation for mental conditions and the basis for interventions. It was believed that biomedical explanations, such as “chemical imbalance”, would bring mental health closer to physical health and general medicine, gradually eliminating stigma. However, that has not happened and many of the concepts supporting the biomedical model in mental health have failed to be confirmed by further research. (U.N., 2017, p. 6)

Is Pūras right? Has a biomedical approach failed to reduce stigma? In the next section, we will review the research and find not only that it has not reduced stigma but that it may even have reinforced stigmatising attitudes.

How bio-genetic causal beliefs and diagnostic labelling have exacerbated stigma

Prejudice and discrimination refer to unequal treatment or exclusion from full participation in society because of membership of a particular group, such as people who have been labelled with a psychiatric diagnosis. Stigma involves negative attitudes towards these people, which can be internalised in the form of shame and a sense of difference. Both are a major barrier to recovery (Corrigan & Kosyluk, 2013; Pyle & Morrison, 2014). Some people describe stigma and discrimination as more distressing than their original difficulties (Schulze & Angermeyer, 2003).

Stigma and discrimination have been documented in relation to most mental health diagnostic groups, but the worst is experienced by people struggling with street drugs or alcohol and those diagnosed with 'schizophrenia'. The stereotype of the 'schizophrenic', with the toxic combination of dangerousness and unpredictability at its core, is remarkably consistent over place and time. The stereotype of the violent 'madman', still sometimes fuelled by the media, remains despite people diagnosed with psychosis actually being more likely to be assaulted than to assault others (Morgan et al. 2012). These attitudes lead to a range of forms of discrimination when seeking work, housing or insurance and rejection by friends and families are commonplace (Read, Haslam, Sayce, & Davies, 2006; Schulze & Angermeyer, 2003).

Stigma, prejudice and discrimination are human rights issues. As with the struggle for the rights of people with physical disabilities, the cause of the disability is irrelevant to the question of one's civil rights. Similarly, those who attract psychiatric diagnoses should have the right to access social and economic life (Read et al. 2006; Read, Haslam, & Magliano, 2013; Sayce , 2003). However, a body of research has consistently shown that, in relation to mental health, the diagnostic label one has and the public's beliefs about the causes of problems play a crucial role in the development of stigmatising attitudes.

Diagnostic labels and essentialism

A key component of 'medical model' anti-stigma campaigns like 'mental health literacy' and 'mental health first aid' is the attempt to persuade the public to adopt psychiatric diagnostic categories. However, taking an evidence-based approach shows that this makes things worse not better. In correlational and experimental studies alike (Angermeyer & Matschinger, 2005; Read et al., 2006, Read, Haslam, & Magliano, 2013; Magliano et al., 2017), labelling someone with a diagnosis is associated with fear, rejection, desire for social distance, pessimism about their chances of recovery and a range of negative perceptions (dangerous, unpredictable, dependent, lacking responsibility for their actions, lacking humanity and perceiving their problems as severe).

Causal beliefs

Anti-stigma campaigns, such as the current UK 'Time to Change' (www.time-to-change.org.uk) and the National Association on Mental Illness's 'CureStigma' (https://www.nami.org/stigmafree) usually focus on stigma rather than discrimination, and adopt the 'mental illness is an illness like any other' strategy. This attempts to educate the public to think in terms of biologically based, medical illnesses, a message sometimes reinforced by high-profile celebrities. The thinking behind this well-intentioned strategy is that if we can't control our behavior, we can't be held responsible and, therefore, can't be blamed. It is the 'mad not bad' argument, with the mad component portrayed as biologically based illnesses. Of course, this ignores the fact that many people are discriminated against on the basis of things over which they have no control – ethnicity, gender, disability and so on (Lebowitz & Appelbaum, 2019).

However, this approach has consistently been shown to increase, rather than decrease, prejudice, fear and pessimism about recovery (Angermeyer, Holzinger, & Schomerus, 2011; Kvaale, Haslam, & Gottdiener, 2013; Magliano, Citarelli, & Read, 2020; Read et al., 2006; Read et al., 2013) both in the UK and worldwide. Our 2013 review of the relationship between attitudes and causal beliefs about 'schizophrenia' 'psychosis' or 'mental illness' in 16 countries found that bio-genetic causal beliefs were strongly related to negative attitudes while the opposite holds for psycho-social beliefs, like believing that people become distressed as an understandable response to trauma and other adversities in their life (Read, Haslam, & Magliano, 2013). A meta-analysis of this same body of research concurs that 'medicalisation' of human distress via 'biogenetic explanations' increases pessimism about recovery and perceived dangerousness (Kvaale et al., 2013).

In a recent study, 343 US mental health clinicians read vignettes describing patients with four 'disorders' and were given biogenetic or psychosocial explanations. For example, for 'social phobia' the psychosocial explanations included bullying, neglectful parents, and failure to learn to trust others whilst the biological explanations included low serotonin levels, an abnormally active amygdala and a hereditary component. The biological explanation led to significantly lower feelings of empathy towards the person, across all four conditions (Lebowitz & Ahn, 2014).

Professor Nick Haslam has suggested that psychological essentialism may help to understand why it is that bio-genetic causal beliefs and associated diagnostic labelling lead to fear and prejudice. He notes that some types of category imply a shared, unobservable essence beneath their superficial properties. Essentialism involves several ideas: immutability (i.e., category membership is fixed); naturalness (i.e., the category is part of nature); objective (i.e., the category is not a human construction, it is 'real'); discreteness (i.e., either/or category membership); uniformity (i.e., all members are essentially the same); and informative (i.e., knowing someone belongs to the category tells us a lot about them).

When the immutable, natural, categorical characteristics involve dangerousness and the idea there is something wrong with people's brains, it is not hard to see how the medical model leads to fear and discrimination and to pessimism about recovery. (Haslam & Whelan, 2008; Kvaale et al., 2013).

Given the research findings summarised above, it is of concern that, for more than 70 years, biological psychiatrists have been trying to persuade us all to adopt a biomedical approach. For example, in 1961, the US Joint Commission on Mental Illness and Health (JCMIH) concluded:

> The principle of sameness as applied to the mentally sick versus the physically sick has become a cardinal tenet of mental health education … Psychiatry has tried diligently to make society see the mentally ill in its way and has railed at the public's antipathy or indifference. (JCMIH 1961, p. 59)

Fortunately in 24 of 25 countries where surveys have been conducted the public still believes that mental health problems, including 'schizophrenia', are caused more by social factors like poverty, stress and violence than by biogenetic factors (Read et al., 2006; Read, Magliano, & Beavan, 2013). Thus the approach of the PTMF is very much consistent with public views in many countries. Perhaps unsurprisingly, given the JCMIH findings, the exception is the

USA, which has arguably the most rigidly bio-genetic approach to mental health in the world and where drug companies can advertise direct to consumers – for example on TV -- promoting the idea that all forms of human distress are illnesses in need of their products. Everywhere else the public has the same view: that bad things happen and they can mess us up. And we continue to believe this despite millions of dollars, often drug company money, being spent, for decades, trying to get us to change our minds.

Alternatives

An evidence-based approach to destigmatisation dictates that the 'mental illness is an illness like any other approach' be abandoned. We have seen that there is evidence that psycho-social explanations are associated with positive attitudes. It is not clear why social causal beliefs improve attitudes. It has been argued that the 'social' is more important than the 'causal' in that it seems any normal information about a person increases 'ascribed humanity' (Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011). Indeed, the strongest predictor of low fear and discrimination is the amount of contact with the people who are the object of the discrimination (Angermeyer & Dietrich 2006; Read & Harre, 2001; Read, Haslam, & Magliano, 2013). This is a long-established finding in social psychology. Imagined differences between people can lead to fear which leads to a desire for social distance from the other which leads to continued ignorance and so on. It is unfortunate, therefore, that one goal of the illness model approach, that of increasing confidence in medical professionals and 'treatments', seems to reduce confidence in our own abilities to help one another (Riedel-Heller, Matschinger, & Angermeyer, 2005), thereby inhibiting exactly the sort of contact needed to combat prejudice.

So how might we design programmes that will reduce stigma and discrimination? A number of studies (Corrigan & Kosyluk, 2013; Sayce, 2003; Read et al., 2006; Read, Haslam, & Magliano, 2013) suggest that effective community-based efforts tend to be based on a number of key principles. Firstly, those who are discriminated against are fully involved in the design and management of the programme. Secondly, they should provide opportunities for increased contact, but in a context where differences between people are acknowledged and valued and where the participation of and contribution by people with mental health problems is positively promoted. Thirdly, stereotypes about violence need to be addressed (including campaigns to change negative media coverage). Fourthly, the power differentials that underpin discrimination need to be addressed and so campaigns should include, in their materials, a range of different groups (e.g. varying by gender, age, ethnicity, etc.). Lastly, educational campaigns are not enough on their own and need to be combined with legislation to outlaw discrimination on the basis of mental health.

So far we have seen that a biomedical approach to distress and distressing behaviour is not consistent with the research literature on psychosocial causes, that its categories are deeply problematic and that its anti-stigma campaigns are counter-productive. We turn now to consider biomedical interventions and services.

The inadequacy of biomedical approaches and the need to transform and re-design mental health services

A biomedical approach is dominant in the mental health services of many countries and yet a number of studies have demonstrated the inadequacy and dangers of psychiatric drugs (Bentall, 2009; Davies & Read, 2019; Hutton et al., 2013; Kirsch, 2009; Moncrieff, 2008; Read & Williams, 2019) and ECT (Read & Bentall, 2010; Read, Kirsch, & McGrath, 2020). This inadequacy has also been recognised by the UN Special Rapporteur, Dainius Pūras who has concluded that '[r]eductive biomedical approaches to treatment that do not adequately address contexts and relationships can no longer be considered compliant with the right to health' (2017, p.17).

The use of these interventions is enabled, as we discuss in the PTMF, by the use of diagnoses which give the appearance that psychiatric interventions are like those in the rest of medicine. This is not to say that drugs may not occasionally be helpful in certain contexts. Critical psychiatrist Joanna Moncrieff (2008), for example, has argued that the current approach to psychiatric medication adopts a 'disease-based' model where drugs are described as 'treatments' claiming to address presumed, but empirically discredited, biological causes. She argues, instead, that we could adopt a 'drug-based' approach which acknowledges that drugs have a range of positive and negative effects (in the absence of any chemical imbalance that needs correcting) and so could be used carefully and pragmatically, for relatively brief periods of time, to provide relief from the kinds of experiences seen as 'symptoms' within a biomedical model.

What is the experience of people using mental health services given what we know of the causal role of psychosocial factors? Some long-term users of New Zealand mental health services gave the following responses:

> There were so many doctors and registrars and nurses and social workers and psychiatric district nurses in your life asking you about the same thing, mental, mental, mental, but not asking you why.
>
> I think there was an assumption that I had a mental illness and, you know, because I wasn't saying anything about the abuse I'd suffered no one knew.
>
> I just wish they would have said "What happened to you? What happened?" But they didn't. (Lothian & Read, 2002, p. 101).

Here again, we see that a biomedical approach obscures the role of adversities. Often people who have suffered significant adversities in their life are re-traumatised when they have contact with mental health services since they are not asked about the reasons why they may have become distressed. If they had been asked about these then they might have understood that, rather than being symptoms of a purported disorder, their experiences of distress were intelligible responses to previous adversities, as we argue in the PTMF.

In some recent work I and my colleagues have reviewed a range of studies and found, unfortunately, that this is a common experience for many of those seeking help. In one review we focused on whether adult mental health services identified child abuse and neglect and found that most cases were not identified (Read, Harper, Tucker, & Kennedy, 2018b). In another we examined research on how mental health services responded when child abuse or neglect became known and found that rates of referral to appropriate therapy ranged from 8% to 23% (Read et al., 2018a). Rates of both identification and adequate response were particularly low for neglect, and for men and people experiencing psychosis. Less than 2% of all cases were referred to legal authorities.

If services were to change so that they responded more humanely and effectively to child maltreatment, what kinds of barriers would need to be overcome? Our research (Read et al., 2018a, p. 1615) suggests that mental health professionals' beliefs are one obstacle. For example, holding strong bio-genetic causal beliefs, believing that talking about child abuse is irrelevant for people with psychosis diagnoses, or believing that disclosures by psychiatric service users are often false, imagined or delusional are major impediments. Similarly, many professionals fear that talking about it will distress people and make their problems worse, or they may believe that there are more immediate concerns to deal with. What is also clear is that many professionals lack knowledge about the prevalence and effects of child maltreatment, and lack confidence in how to ask about and respond to childhood adversities. This indicates the need for a large-scale programme of training for mental health professionals.

The PTMF would be a useful resource for such a training initiative. It suggests that we replace the question at the heart of biomedical approaches -- 'what is wrong with you?' -- with four others:

> 'What has happened to you?' (How has power operated 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?)
>
> Johnstone and Boyle (2018, p.9)

But for such an approach to become fully embedded in mental health services there needs to be systemic organisational change. Some ideas for how we might go about this come from organisations that have attempted to transform their services using the principles of ‘Trauma-Informed Care’. These principles are very much consistent with the PTMF conceptual framework though we suggest that it may be more helpful to include a broader range of adversities since the term ‘trauma’ can imply a discrete event and many service users may not identify with the term although they would acknowledge that they have experienced adversities

The example of trauma-informed services

Services based on the principles of trauma-informed care may include specific types of therapies for individuals who have experienced trauma but the focus is on the culture of the service as a whole. The US National Centre for Trauma-Informed Care established by SAMHSA (Substance Abuse and Mental Health Services Administration) notes that, when services adopt these principles ‘its entire organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services.' (SAMHSA, 2015).

The Australian Blue Knot Foundation (www.blueknot.org.au) has developed useful guidelines which are applicable to a range of services including mental and physical health, social care and so on (Blue Knot Foundation, 2012, p.xxviii). Four key assumptions of a trauma-informed approach include, firstly, that the effects of complex (cumulative, underlying) trauma are pervasive, and if unresolved, negatively impact mental and physical health across the lifespan. Secondly, the majority of people treated by public mental health and substance abuse services have trauma histories. Thirdly, that child abuse, in all its forms, and chronic neglect, are the key antecedents of complex trauma, although they are not the only causes. Finally, that when unresolved, complex trauma causes ongoing problems, not only for those who experience it, but for their children (intergenerational effects) and society as a whole.

Thus, while it is not assumed that all service users will have experienced trauma, it is expected that many will have. The idea is that all staff engage with people in such a way that facilitates recovery from any trauma or adversity that has led to the problems that they present with, that acknowledges that different traumas and adversities might require different responses, and that, at the very least, it avoids retraumatizing people through practices that either reproduce the trauma with the use of force or that dismiss the occurrence or impact of abuse. Whether such changes are a prerequisite for, or dependent on, a fundamental paradigm shift in research and services is debatable (Read, Harper, Tucker, & Kennedy, 2018a; Read, & Dillon, 2013).

Such principles remind us, once again, of the crucial role of power (Boyle, this issue). Psychosocial adversities arise from unequal relationships of power and, currently, many mental health service users are placed in similar situations when they try to access help. Thus, there is a need for broader service-level changes including abolishing coercive psychiatric interventions on the basis of diagnosis and upholding the principle of informed consent (especially, but not only, in relation to medication and ECT). A key way in which power is exerted on people in mental health services, as we saw earlier in the discussion of causal theories and diagnosis, is by obscuring the meaning of their distress and its links with life adversities. As a result, as we argue in the PTMF, it is important to create contexts in which people have agency to develop their own meanings (Cromby, this issue; Johnstone, this issue), developing their own personal narratives. People can do this on their own, perhaps by using the Guided Discussion available on the PTMF website (https://www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework) and they can also do this in psychological therapy, using psychological formulations rather than diagnoses. However, this can also be done collectively with others and a number of peer-led groups of service users have found the PTMF a helpful way of structuring discussions about the links between adversity and distress (SHIFT, this issue). Indeed, given the importance of addressing inequalities of power, services run by experts-by-experience have a crucial role to play, such as those inspired by the Hearing Voices Network (Longden, Read & Dillon, 2018).

From service-level to policy-level: The need for a social movement for change

Change at the level of services is necessary but not sufficient. There is also a need for societal change in how we think about psychological distress and troubling conduct. UN Special Rapporteur, Dainius Pūras (2017, p.16), has argued that we need to move beyond 'individualized responses towards action on a range of structural barriers and inequalities' (p.16). Instead, he identifies an 'urgent need for a shift in approach' which 'should prioritize policy innovation at the population level, targeting social determinants and abandon the predominant medical model that seeks to cure individuals by targeting "disorders"' (Pūras, 2017, p.19). Pūras suggests that we need to develop public policies which 'promote non-violent and respectful relationships in families, schools, workplaces, communities and health and social services' (2017, p.16). In the final chapter of the PTMF, 'Ways forward', we make a number of suggestions for changes which could be made at the level of national policy in terms of public health and mental health policy; the legal system; research and research-funding; and access to social care, housing and welfare benefits. We recognise that this will require the kind of concerted long-term action which can only be sustained by new social movements of service users, professionals, family members and the general public.

References

Anda, R., Brown, D., Felitti, V., Bremner, J., Dube, S., & Giles, W. (2007). Adverse childhood experiences and prescribed psychotropic medications in adults. *American Journal of Preventative Medicine, 32*, 389–394.

Angermeyer, M., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness. *Acta Psychiatrica Scandinavica, 113,* 163-79.

Angermeyer, M., & Matschinger, H. (2005). Labeling – stereotype – discrimination. *Social Psychiatry and Psychiatric Epidemiology, 40,* 391-395.

Angermeyer, M., Holzinger, A., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness. *British Journal of Psychiatry, 199,* 367-372.

Bannister, D. (1968). The logical requirements of research into schizophrenia. *British Journal of Psychiatry, 114,* 181–8.

Bentall, R. (2003). *Madness explained: Psychosis and human nature.* London: Penguin.

Bentall, R. (2009). *Doctoring the mind: Why psychiatric treatments fail.* London: Penguin.

Blue Knot Foundation (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery.* Authors: Kezelman, C. A. & Stravropoulos, P. A. Milsons point, NSW: Blue Knot Foundation. www.blueknot.org.au

Cooke, A. (2017). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.

Corrigan, P., & Kosyluk, K. (2013). Erasing the stigma. *Basic and Applied Social Psychology 35,* 131-140.

Davies, J., & Read, J. (2019). A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? *Addictive Behaviours.* doi.org/10.1016/j.addbeh.2018.08.027

Division of Clinical Psychology (2013). *Classification of behaviour and experience in relation to functional psychiatric diagnosis: Time for a paradigm shift*. Leicester: British Psychological Society.

Fibiger, H. (2012). Psychiatry, the pharmaceutical industry, and the road to better therapeutics. *Schizophrenia Bulletin, 38,* 649-650.

Haslam, N. & Whelan, J. (2008). Human natures: Psychological essentialism in thinking about differences between people. *Social and Personality Psychology, 2,* 1297-1312.

Hepworth, I., & McGowan, L. (2013). Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of Psychiatric Mental Health Nursing, 20,* 473-483.

Hutton, P., Weinmann, S., Bola, J. & Read, J. (2013) Antipsychotic drugs. In J. Read & J. Dillon (Eds.) *Models of Madness: Psychological, social and biological approaches to psychosis* (2nd edn), pp. 105-124. Hove: Routledge.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Johnstone, L. (2014). *A straight-talking introduction to psychiatric diagnoses.* Ross-on-Wye: PCCS Books.

Kessler, R., McLaughlin, K., Green, J., Gruber, M., Sampson, N., Zaslavsky, A., … Williams, D. (2010). Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys. *British Journal of Psychiatry, 197,* 378-385.

Kirsch, I. (2009). *The emperor's new drugs: Exploding the antidepressant myth*. London: The Bodley Head.

Kirsch, I., Deacon, B., Huedo-Medina, T., Scoboria, A., Moore, T., & Johnson, B. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the food and drug administration. *PLoS Med. 5,* 0260-0268.

Kvaale, E., Haslam, N. & Gottdiener W. (2013). The 'side effects' of medicalization: A meta-analytic review of how biogenetic explanations affect stigma. *Clinical Psychology Review, 33,* 782–794.

Lebowitz, M. & Ahn, W. (2014). Effects of biological explanations for mental disorders on clinicians' empathy. *Proceedings of the National Academy of Science of the* USA, 111, 17786-91770.

Lebowitz, M. S., & Appelbaum, P. S. (2019). Biomedical explanations of psychopathology and their implications for attitudes and beliefs about mental disorders. *Annual Review of Clinical Psychology*, *15*, 555-577.

Longden, E., Read, J., & Dillon, J. (2018). Assessing the impact and effectiveness of Hearing Voices Network self-help groups. *Community Mental Health Journal, 54,* 184-188.

Lothian, J., & Read, J. (2002). Asking about abuse during mental health assessments. Clients' views and experiences. *New Zealand Journal of Psychology, 31,* 98-103.

Magliano, L., Citarelli, G., & Read, J. (2020). The beliefs of non-psychiatric doctors about the causes, treatments and prognosis of schizophrenia. *Psychology and Psychotherapy: Theory, Research and Practice.* doi: 10.1111/papt.12252.

Magliano, L., Strino, A., Punzo, R., Acone, R., Affuso, G., & Read, J. (2017). Effects of the diagnostic label "schizophrenia", actively used or passively accepted, on general practitioners' views of this disorder. *International Journal of Social Psychiatry, 63,* 224-234.

Martinez, A., Piff, P., Mendoza-Denton, R., & Hinshaw, S. (2011). The power of a label. *Journal of Social and Clinical Psychology, 30,* 1-23.

Moncrieff, J. (2008). *The myth of the chemical cure*. London: Palgrave Macmillan

Morgan, V., Waterreus. A., Jablensky, A., Mackinnon, A., McGrath, J., Carr, V., … Saw, S. (2012). People living with psychotic illness in 2010: the second Australian national survey of psychosis. People living with psychotic illness in 2010. *Australian & New Zealand Journal of Psychiatry, 46,* 735-752.

Murray, R. (2016). Mistakes I have made in my research career. *Schizophrenia Bulletin, 43,* 253-256.

Pescosolido, B., Martin, J., Lang, A., Olafsdottir, S., et al (2008) Rethinking theoretical approaches to stigma: a framework integrating normative influences on stigma. *Social Science & Medicine 67,* 431-440.

Pūras D. (2017, 28 March). Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. United Nations General Assembly. Human Rights Council. Thirty-fifth session. A/HRC/35/21. Retrieved from: https://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx

Pyle, M., & Morrison, A. (2013). 'It's just a very taboo and secretive kind of thing': Making sense of livingwith stigma and discrimination from accounts of people with psychosis. *Psychosis: Psychological, Social and Integrative Approaches, 6,* 195–205.

Read, J. (2013a). Childhood adversity and psychosis; From heresy to certainty. In J. Read & J. Dillon (Eds.) *Models of madness: Psychological, social and biological approaches to psychosis* (2nd edn), pp. 249-275. Hove: Routledge.

Read, J. (2013b). Does 'schizophrenia' exist? Reliability and validity. In J. Read & J. Dillon (Eds.) *Models of madness: Psychological, social and biological approaches to psychosis* (2nd edn), pp. 249-275. Hove: Routledge.

Read, J. (2020). Bad things happen and can drive you crazy: The causal beliefs of 701 people taking antipsychotics. *Psychiatry Research*. https://doi.org/10.1016/j.psychres.2020.112754

Read, J., & Bentall, R. (2010). The effectiveness of electroconvulsive therapy: A literature review. *Epidemiology and Psychiatric Sciences, 19,* 333-347.

Read, J., & Dillon, J. (Eds.). (2013). *Models of madness: Psychological, social and biological approaches to psychosis* . Hove: Routledge.

Read, J., Fosse, R., Moskowitz, A. & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry, 4,* 65-79.

Read, J., Harper, D., Tucker, I. & Kennedy, A. (2018a). How do mental health services respond when child abuse or neglect become known? A literature review. *International Journal of Mental Health Nursing*, 27, 1606-1617.

Read, J., Harper, D., Tucker, I. & Kennedy, A. (2018b). Do mental health services identify child abuse and neglect? A systematic review. *International Journal of Mental Health Nursing, 27,* 7-19.

Read, J. & Harre, N. (2001). The role of biological and genetic causal beliefs in the stigmatisation of 'mental patients'. *Journal of Mental Health, 1*0, 223-235.

Read, J., Haslam, N. & Magliano, L. (2013). Prejudice, stigma and 'schizophrenia'. In J. Read & J. Dillon (Eds.), *Models of madness: Psychological, social and biological approaches to psychosis* (2nd edn)*,* pp. 157-177. London: Routledge.

Read, J., Haslam, N., Sayce, L. & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'Mental illness is an Illness like any other' approach. *Acta Psychiatrica Scandinavica, 114,* 303-318.

Read, J., Kirsch, I., & Mcgrath, L. (2020). Electroconvulsive Therapy for depression: A Review of the quality of ECT vs sham ECT trials and meta-analyses. *Ethical Human Psychiatry and Psychology*. In Press

Read, J., Magliano, L. & Beavan, V. (2013). Public beliefs ab0ut the causes of 'schizophrenia': Bad things happen and can drive you crazy. In J. Read & J. Dillon (Eds.), Models of madness: Psychological, social and biological approaches to psychosis (2nd edn), pp. 143-156 London: Routledge.

Read, J., Morrison, A., & Waddingham, R. (2020). Traumas, adversities and psychosis: practical implications. *Psychiatric Times*, in press.

Read, J., & Williams, J. (2019). Positive and negative effects of antipsychotic medication: an international online survey of 832 recipients. *Current Drug Safety, 14*, 173-181.

Riedel-Heller, S., Matschinger, H. & Angermeyer, M. (2005). Mental disorders – who and what might help? Help-seeking and treatment preferences of the lay public. *Social Psychiatry and Psychiatric Epidemiology 40*, 167-174.

Risch, N., Herrell, R., Lehner, T., Liang, K-Y., Eaves, L., Hoh, J., … Merikangas, K. (2009). Interaction between the serotonin transporter gene (5-httlpr), stressful life events, and risk of depression: A meta-analysis. *Journal of the American Medical Association, 301*, 2462–2471.

Rogers, A., & Pilgrim, D. (2014) *A Sociology of Mental Health and Illness*. Open University.

SAMHSA (Substance Abuse and Mental Health Services Administration) (2015). *Trauma-informed approach and traumas: Specific interventions.* Rockville, MD: Author. Retrieved 5 May 2016 from http://www.samhsa. gov/nctic/trauma-interventions

Sayce, L. (2000). *From psychiatric patient to cit*izen. New York: St Martin's Press.

Schulze, B., & Angermeyer, M. (2003). Subjective experiences of stigma. *Social Science & Medicine, 56,* 299-312.

Sorsdahl, K. Flisher, A., Wilson, Z., & Stein D. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumulanga, South Africa. *African Journal of Psychiatry, 13,* 284-290.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., … Bentall, R. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective- and cross-sectional cohort studies. *Schizophrenia Bulletin, 38,* 661-671.

Wilkinson, R., & Pickett, K. (2009). *The spirit level; Why greater equality makes societies stronger.* London: Bloomsbury Press.