De-medicalising public mental health with the Power Threat Meaning Framework

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Abstract

Aims: To propose that much of the language and concepts in public mental health is medicalised and to suggest that the Power Threat Meaning Framework (PTMF), can be a useful resource for those wishing to take a de-medicalising approach.

Method: Examples of medicalisation are drawn from the literature and from practice and key constructs in the PTMF are explained, drawing from the report which presented its research base.

Results: Examples of medicalisation in public mental health include: the uncritical use of psychiatric diagnostic categories; the 'illness like any other' approach in anti-stigma campaigns; and the implicit privileging of biology in the biopsychosocial model. The negative operations of power in society are seen as posing threats to human needs and people make sense of such situations in varied ways though there are some commonalities. This gives rise to culturally available and bodily enabled threat responses which serve a variety of functions. From a medicalised perspective these responses to threat are characteristically seen as 'symptoms' of underlying disorders. The PTMF is both a conceptual framework and a practical tool that can be used by individuals, groups and communities.

Conclusion: Consistent with social epidemiological research, prevention efforts should focus on preventing adversity rather than 'disorders' but the added value of the PTMF is that varied problems can be understood in an integrated manner as responses to a variety of threats whose functions could be met in different ways. Its message that mental distress is a response to adversity is comprehensible to the public and can be communicated in an accessible way.

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Medicalisation in public mental health and the need for an alternative approach

A key challenge for public mental health is medicalisation – a biomedical framing where problems are seen as illnesses, biological disease processes are emphasised and psychiatric medication is a default treatment. An over-emphasis on medication can be seen in the continued rise over recent decades in community prescriptions for antidepressants in England. They rose from 18.4 million in 1998 to 36 million in 2008[1] and then to 70.9 million in 2018.[2] Researchers analysing the 1998-2008 increase concluded that it could not be fully explained by population growth nor by increased rates of diagnosis of depression but rather by longer periods of treatment and because people with anxiety diagnoses were increasingly being prescribed anti-depressants.[1]

Although successful in physical health, a biomedical approach to mental health is more contested because medicine's theoretical models are 'designed for understanding bodies rather than people's thoughts, feelings and behaviour'[3] In this article I give examples of medicalisation and make a case for a new approach before describing the *Power Threat Meaning Framework* (PTMF)[3] and discussing some of its implications. Since the term 'mental health' is itself contested I will, throughout, use a range of non-medical alternatives.

Public mental health (PMH) professionals are familiar with criticisms that mental health services construct the causes of problems in living as lying within the individual and so offer individualistic interventions. Although psychiatric medication can be helpful in some circumstances it can also cause iatrogenic harm through side effects and withdrawal effects. By focusing at the population level, PMH can avoid individualisation but its concepts, language and metaphors often draw on a medical discourse which can: pathologise intelligible responses to distress; reduce service

users' agency; and obscure the social and structural causes of distress as well as its subjective meaning. I will briefly discuss three examples.

Firstly, psychiatric diagnostic categories are often used uncritically in epidemiology, service commissioning and in mental health literacy and first aid interventions, despite evidence that these categories lack validity and have poor reliability in clinical practice.[4] Secondly, although anti-stigma campaigns are often based on an 'illness like any other' approach which assumes that adopting a biomedical understanding will reduce levels of prejudice, these explanations are overwhelmingly associated with a range of negative attitudes.[5] Thirdly, the biopsychosocial model, which is often implicitly or explicitly drawn on within stress-vulnerability and similar models, assumes biological factors are primary *causes* in themselves rather than as *responses* to the social environment.

Although Public Health has paid increasing attention to Adverse Childhood Experiences (ACEs) and other Social Determinants of Mental Health (SDMH), ACEs are often framed within a discourse of neuroscience[6] whilst both ACEs and SDMH are often discussed using a medicalised vocabulary of risk. Moreover, asset-based concepts like 'recovery,' 'wellbeing,' 'vulnerability' and 'resilience' and their associated interventions implicitly locate problems and solutions in individuals and communities meaning that insufficient attention is given either to the systems which cause adversity or to collective solutions. [7, 8]

The Power Threat Meaning Framework: From symptoms to strategies and stories

Many service users, practitioners and researchers have called for an alternative to a medicalised approach and, in 2018, the British Psychological Society published the *Power Threat Meaning Framework*, a meta-theoretical framework rather than a model, drawing on 14 different conceptual perspectives.[3] It was produced by an author team comprising clinical and research psychologists and psychiatric survivors

and their aim was to develop a conceptual alternative to the kind of medicalised approach which underpin functional psychiatric diagnoses.

The main report[3] includes an extensive review of research on adversity -- a concept seen by the authors as more broadly applicable than 'trauma' -- identifying both commonalities and variation in the ways in which the general population characteristically responds to different adversities. One of the causes of variation is the role of human agency and meaning-making. Individuals understand the meaning of adversity and its threats in an idiosyncratic manner shaped by their personal biography and circumstances, but these personal narratives are, in turn, shaped by social discourses and ideology.

FIGURE 1 ABOUT HERE

To demonstrate how the PTMF provides an alternative to medicalisation I will draw on two fictitious examples to illustrate the central constructs: power; threat; and meaning (see Figure 1 for an outline of the framework).

> Emily, a single white British woman in her thirties with two young children is overwhelmed by feelings of depression and hopelessness following the death of her mother (her main confidant and source of child-care) and the loss of both her job and her home (as she was unable to keep up mortgage payments).

> Jacob, a young black British man who was neglected by his parents and bullied and racially victimised by peers as a child, becomes increasingly socially isolated during his first year living away at college, believing that other students are conspiring against him as part of a conspiratorial plot by MI5.

Within the PTMF adversities are seen as socially patterned, reflecting the negative operations of power, causing a range of unpredictable and uncontrollable events, at

both individual and community levels. Both Emily and Jacob have experienced negative operations of power. Emily has experienced bereavement and a loss of a source of childcare as well as unemployment, financial adversity, lack of support and social isolation. Jacob has not only experienced parental neglect but also victimisation and social exclusion related to an aspect of his identity.

It is hypothesised that adversities pose threats to human needs. Emily may feel trapped by her situation and may also be experiencing multiple losses of agency, control and access to resources. Jacob may be experiencing being Othered, invalidated and excluded from connections with others, as well as powerlessness and a fear that others may pose a danger to him.

People ascribe meaning to these threats. Such meanings for Emily might include blaming herself and seeing herself as helpless, trapped, defeated, hopeless, lonely, shamed and humiliated. For Jacob, these meanings might include exclusion, injustice, shame, humiliation, anger, inferiority, worthlessness and powerlessness.

In responding to threat, it is hypothesised that people, as individuals and as groups, draw on a range of survival strategies which humans have evolved to protect them and which are both culturally available and embodied – for example, dissociation, hearing voices, hypervigilance, learned helplessness, preparing to fight, flee and escape etc. The body is seen as mediating both the effects of adversity and responses to it. Threat responses are not inherently pathological and may often be exaggerated versions of everyday behaviour. They are seen as serving a range of functions – discussed in more detail in the main report[3] -- which may vary not only across people but also, for the same individual, across time and context.

Emily's threat responses and their functions (in brackets) might include:

- 'giving up' (protection against attachment loss, hurt and abandonment)
- withdrawal and low mood (regulating overwhelming feelings of anger and loss)
- Self-blame (self-punishment)

- Helplessness/weeping (seeking attachments and communicating about distress)

Jacob's threat responses and their functions might include:

- Hypervigilance, anticipating potential threats and avoidance of others (protection from danger)
- Externalising and projecting onto MI5 his fears and suspicions (preserving identity, self-image and self-esteem and maintaining a sense of control)
- Believing that he is important enough that a security agency is interested in him and that he has insight into what is 'really going on' – that others are conspiring against him (preserving a place within the social group)
- Maintaining emotional and/or physical distance from others through distrust and self-isolation (regulating overwhelming feelings like shame, humiliation, anger and loneliness and protection against attachment loss, hurt and abandonment

The framework can be used with individuals, families, groups and communities and the key PTMF questions provide a structure for a narrative that can work at all these levels:

- 'What has happened to you?' (i.e. how is power operating in your life?)
- 'How did it affect you?' (i.e. what kind of threats does this pose?)
- 'What sense did you make of it?' (i.e. what is the meaning of these situations and experiences to you?)
- 'What did you have to do to survive?' (i.e. what kinds of threat response are you using?)
- 'What are your strengths?' (i.e. what access to power resources do you have?)
- 'What is your story?' (i.e. how does all this fit together?)

Space limitations preclude constructing a narrative for Emily and Jacob but hopefully the examples above show how, in contrast to a medicalising approach, the framework renders what are usually seen simply as symptoms of a disorder into intelligible responses to threat. Moreover, the social and structural causes of distress as well as its subjective meaning are seen as central. People often seek help when their threat responses interfere with the lives they wish to lead. The PTMF enables them to have more agency, by identifying alternative strategies which could address the functions currently served by their threat responses – for example, social support and belonging, having material, cultural, leisure and educational opportunities and so on.

In place of diagnostic categories, the framework proposes seven provisional general patterns -- characteristic patterns of meaning-based threat responses to power -- two of which are relevant here: For Emily, 'surviving defeat, entrapment, disconnection'; for Jacob, 'surviving social exclusion, shame, and coercive power.' These patterns and the cultural acceptability and validity of key PTMF constructs need to be investigated by researchers in a range of settings, including with different ethnic groups – see the framework's website[3] for further suggestions for researchers.

Implications for Public Mental Health

The framework is designed to be a practical tool and it has been used in a wide range of contexts, including by peer-led groups of service users, and further resources can be found at the PTMF website.[3]

The framework has a number of implications for policy including Public Health – see the main document's last chapter[3] -- but I will focus on three. Firstly, it offers a less pathologising way of understanding emotional distress than more common 'brain or blame' explanations. If we only seek to raise mental health awareness without moving away from a medicalised discourse, it is likely that prescription rates of

psychiatric medication will continue to increase, particularly when funding for alternatives is restricted. In contrast to 'an illness like any other' approach, the message of a public education campaign informed by the framework would be 'don't ask what's wrong with me, ask what's happened to me.' The public find adversity-focused explanations comprehensible and less frightening and mystifying than biomedical explanations.[5]

Secondly, we need to develop 'upstream' interventions aimed at preventing adversities rather than 'disorders' and this is consistent with the literature on SDMH and income inequality.[9] Adversity need not inevitably lead to distress – its negative effects can be exacerbated or ameliorated (see Figure 1) and the PTMF can inform policy like, for example, investing in supporting families so attachments are not disrupted, ensuring people have access to a supportive confidant and ensuring that service users are asked about experiences of adversity so appropriate support can be accessed.

Thirdly, the framework provides an alternative way of thinking about communities and societies. A briefing paper on the psychological impact of austerity by Psychologists for Social Change (http://www.psychchange.org/) concluded that these measures had affected society, leading to feelings of entrapment and powerlessness, shame and humiliation. Often social problems (e.g. problem drinking, youth violence etc.) are seen as separate and independent from psychological problems (e.g. depression etc.) but they could be understood as threat responses developed in response to adverse community experiences which, within the PTMF, can be conceptualised as a sub pattern like 'surviving poverty and low socio-economic status.' Using the framework as a resource, community stakeholders and agencies could collaborate to develop a shared narrative, understanding these problems as responses to adversity and threat, which serve particular functions. This can help isolated and stigmatized communities to create more hopeful stories about their strengths, skills and potentials, and to identify community needs like funding for alternative ways in which the functions served by these community threat responses could be met. Such a process could help develop the kind of

societal initiatives called for by Psychologists for Social Change to increase community agency, security, connection, meaning and trust.

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Figure 1: PTMF model (from Johnstone & Boyle, 2018)