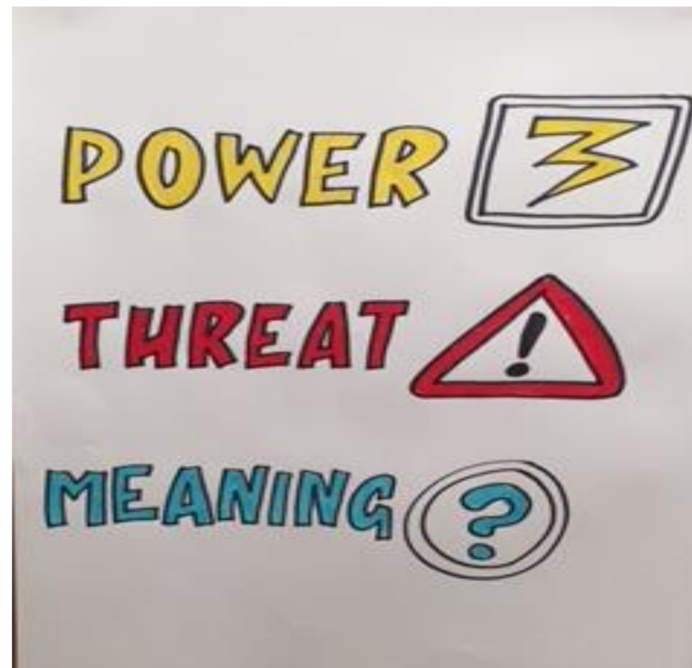
The Power Threat Meaning Framework



(Slides: © Lucy Johnstone and Mary Boyle 2018)

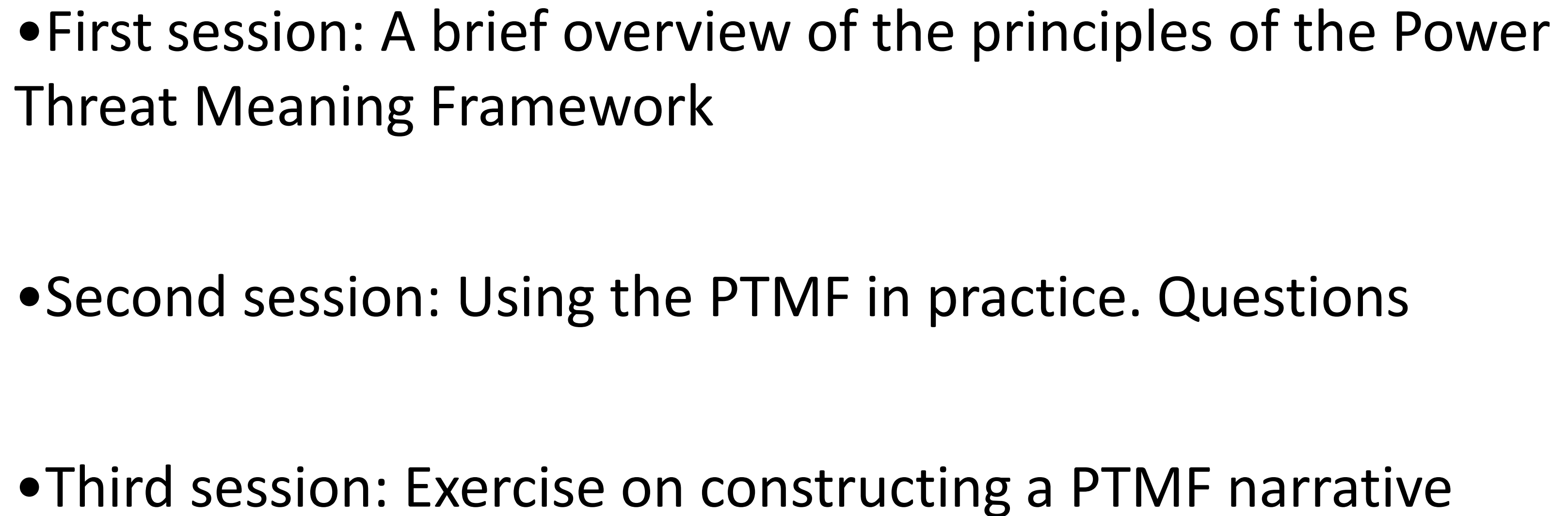
Publication of DSM-5 in May 2013

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.’

‘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/



- First session: A brief overview of the principles of the Power Threat Meaning Framework

- Second session: Using the PTMF in practice. Questions

- Third session: Exercise on constructing a PTMF narrative

Slides are available afterwards

United Nations Report of the Special Rapporteur (2017)

'Diagnostic tools, such as the ICD and the DSM, continue to expand the parameters of individual diagnosis, often without a solid scientific basis……

….We have been sold a myth that the best solutions for addressing mental health challenges are medications and other biomedical interventions.'

The urgent need for a shift in approach should…target social determinants and abandon the predominant medical model that seeks to cure individuals by targeting 'disorders'.

Mental health policies should address the "power imbalance" rather than "chemical imbalance".

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)

Formulation instead of diagnosis

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)

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

A possible formulation of ‘schizophrenia’

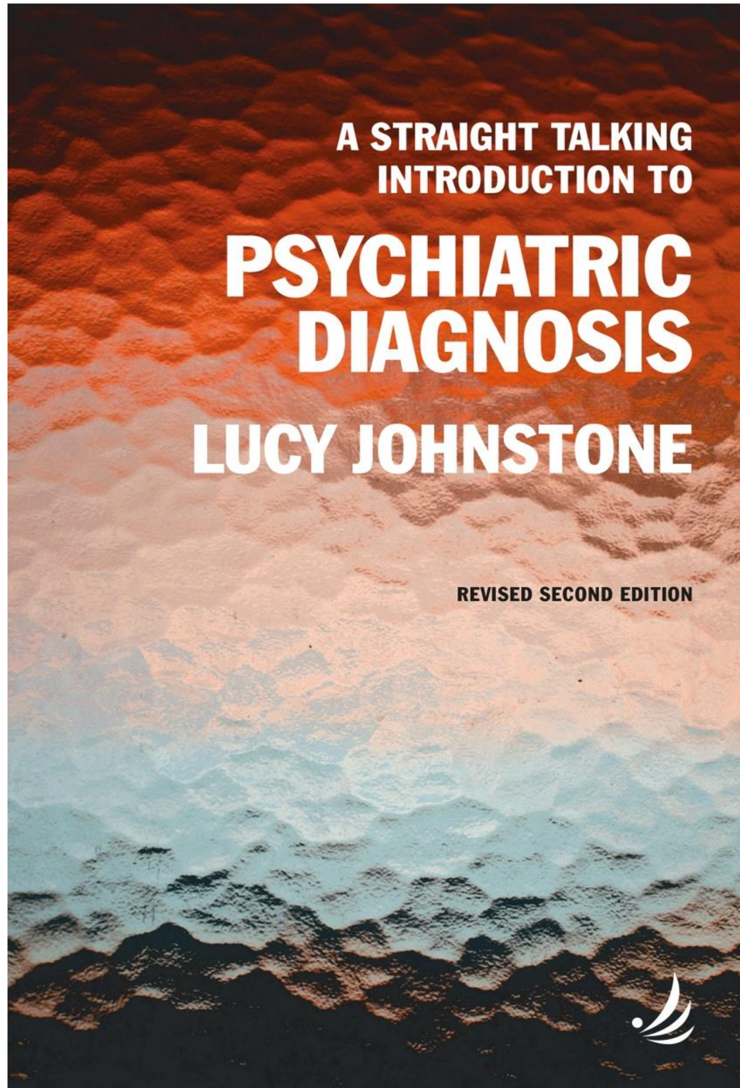
You had a happy childhood until your father died when you were aged 8. As a child, you felt very responsible for your mother's happiness, and pushed your own grief away. Later your mother re-married and when your stepfather started to abuse you, you did not feel able to tell anyone. You left home as soon as you could, and got a job in a shop. However, you found it increasingly hard to deal with your boss, 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 life increasingly difficult as past memories and feelings came to the surface. Despite this you have many strengths, including intelligence, determination and self-awareness, and you recognise the need to re-visit some of the unresolved feelings from the past.

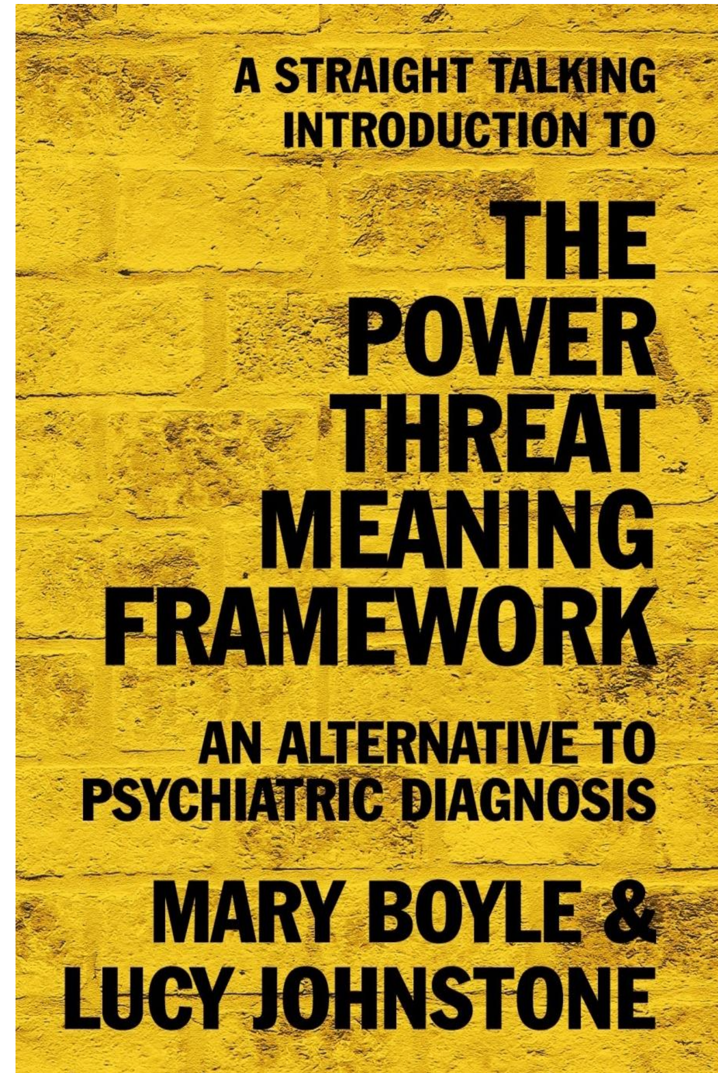
Division of Clinical Psychology 'Good practice guidelines on the use of psychological formulation' 2011

'Is not premised on a functional psychiatric diagnosis (eg schizophrenia, personality disorder)'

https://shop.bps.org.uk/good-practice-guidelines-on-the-use-of-psychological-formulation

www.pccs-books.co.uk





The Power Threat Meaning Framework

5 year project funded and published by the British Psychological Society.

Lucy Johnstone, Mary Boyle, John Cromby, Jacqui Dillon, Dave Harper, Peter Kinderman, Eleanor Longden, David Pilgrim, John Read.

Consultancy group of service users/carers

Critical reader group to advise on diversity

Other expert contributions

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

The Power Threat Meaning Framework

- An alternative to the diagnostic model of distress and unusual experiences
- Not a replacement for all current models and practices. It offers a wider overall framework to support and enhance them...
- ..... as well as suggesting new ways forward
- Has attracted national and international interest, although controversial in some quarters
- Currently being translated into 6 languages

The PTM Framework and trauma-informed approaches

- Draws on this research and practice, along with a wide range of other sources
- Emphasis on structural factors eg inequality, social exclusion, discrimination, colonisation, devalued identities
- Suggests patterns of distress not related to obvious ‘trauma’
- Cleaer links to wider institutional and organisational contexts, political and socioeconomic structures and ideologies

The PTM Framework: narratives not diagnoses

We are all story-tellers and meaning-makers. The PTMF supports the use of all kinds of narratives or personal stories instead of diagnostic labels. This can help people to create new, non-medical, hopeful narratives about their lives and circumstances, instead of seeing themselves as ‘mentally ill.’

‘Instead of asking what’s wrong with you, ask what happened to you.’

.....The PTMF is about all of us.

The PTMF suggests this loose structure for narratives

- '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?)

- ***Legal power*** rules and sanctions supporting or limiting other aspects of power, offering or restricting choices
- ***Economic and material power*** having enough money and resources for you and your family
- ***Interpersonal power*** the power to hurt, neglect or abuse someone or to protect and support them etc
- ***Coercive power or power by force*** use of violence, aggression or threats to frighten, intimidate or ensure compliance
- ***Biological or embodied power*** eg: physical attractiveness, fertility, strength, embodied talents and abilities, physical health
- ***Social/cultural capital*** – a mix of qualifications, knowledge and connections which ease people’s way through life and give you opportunities
- ***Ideological power*** involves control of language, meaning, and perspective

Why is power so central in the PTMF?

Power is everywhere in our lives, even when we're not aware of it

All the major causes of 'mental health problems' involve inequalities of power. E.g. - Poverty and low social status; large differences in wealth/incomes; child abuse and neglect; gender-based and 'race-based discrimination and violence; colonisation; war and conflict….

…..all arise from power differences between:

- Rich and poor
- Adults and children
- Men and women
- White people/people of colour and indigenous people
- States/governments and citizens

The importance of ideological power - power over meaning, language and perspective . . .

Probably the least obvious and least acknowledged form of power. It is part of every other form of power.

It is commonly expressed through social standards, expectations and norms, transmitted through all the sources already mentioned. This may include racism, sexism and all kinds of discriminatory beliefs

It shapes the ways we make sense of our life situations. Those who feel they are failing to live up to expected standards often end up feeling very bad about themselves.

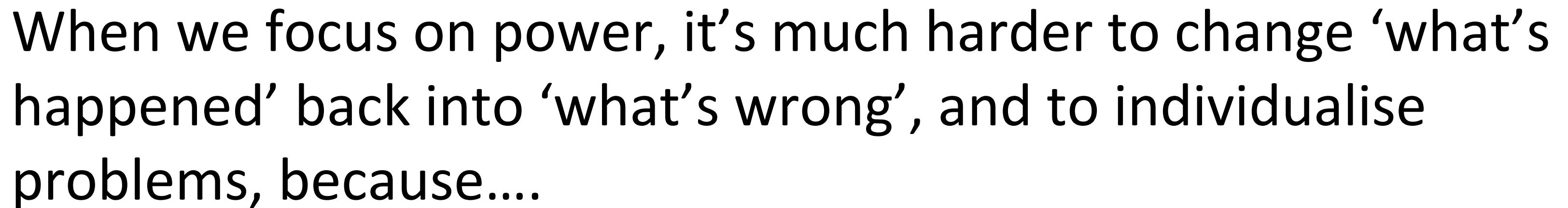
Even the most fortunate person, with a loving family and a good future, may experience distress through taking on ideologically-based messages

Ideological power shapes how we make sense of our experiences

For example: rape (‘She asked for it’); poverty (‘They’re welfare scroungers’); coercive abuse (‘I didn’t say that – you’re just imagining it’); the consequences of trauma in mental health services (‘They are psychotic/personality disordered/mentally ill.’)

In mental health and the criminal justice system, it is often used to turn social problems into individual ones and diagnose or define people as ‘bad or mad’.

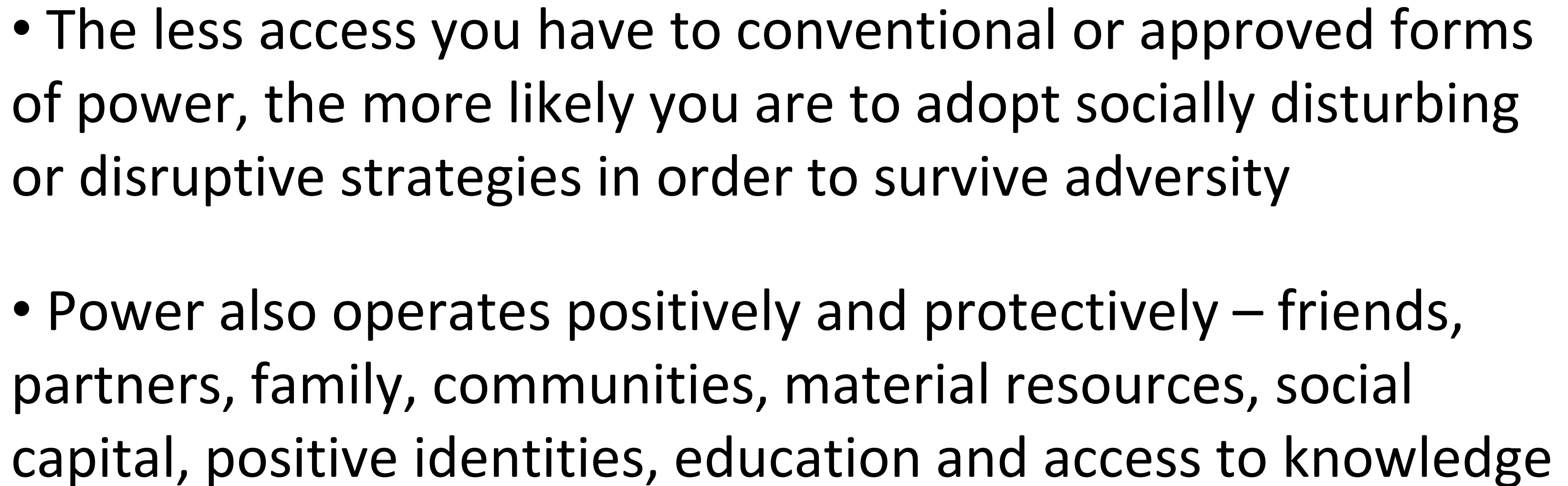
The imposition of a diagnosis, without offering alternatives, is an act of injustice which leads to further abuses of power



When we focus on power, it's much harder to change 'what's happened' back into 'what's wrong', and to individualise problems, because….

Power is the process that….

- Links the personal and political
- Links distress to inequalities and social injustice
- Links the social, psychological and biological
- Makes distress fully intelligible
- Helps restore agency



- 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

…. That is why most MH professionals take on their jobs - to use their power helpfully and supportively. But they too are subjected to having ideologically-driven ideas imposed on them.

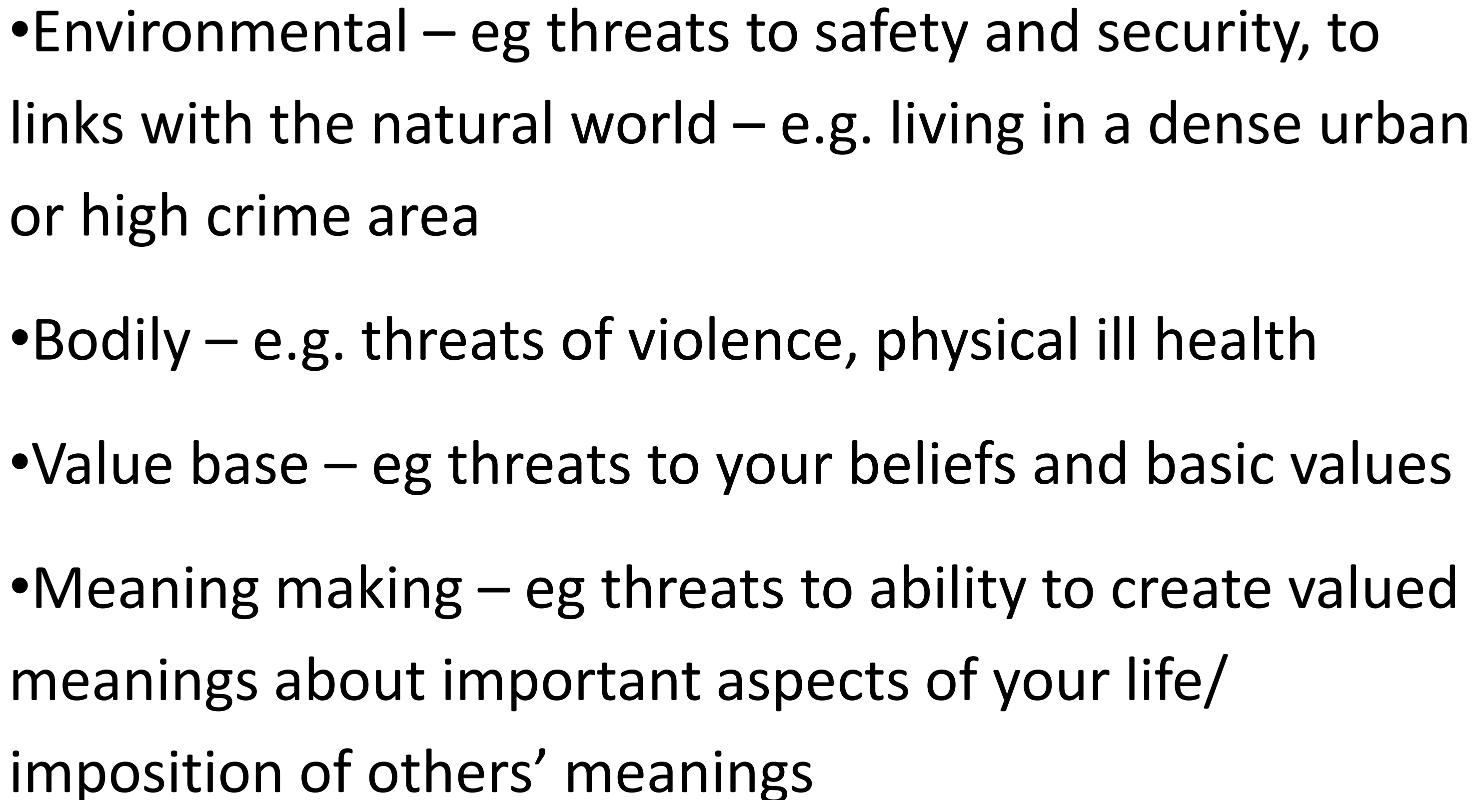
‘How did it affect you?’
(What kind of **Threats** does this pose?)

•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’?

Meanings are never just personal and individual

INDIVIDUAL MEANINGS ARE NEVER JUST FREELY CHOSEN

Instead, meaning is both ‘made and found’

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

Meaning-making through narrative is the central thread of the PTMF

Our personal meanings are shaped by:

- Common societal understandings about what it means to be ‘mentally ill’, ‘successful’, a ‘good mother’, a ‘happy family’, a ‘normal child’, a refugee, and so on

- Ideological meanings – deeply embedded assumptions about the world that serve certain interests. For example, it has been argued that our current economic system supports values of consumerism, competition and individualism, rather than on co-operation and concern for the well being of the whole group

‘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 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 vary from automatic (more bodily-based) to more personally and culturally-shaped.

In mental health services they are often seen as ‘symptoms’ rather than, as the PTMF sees it, survival strategies

(This aspect of the PTMF draws heavily on the evidence from trauma-informed theory and practice)

Some examples of threat responses

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

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

When we give someone a psychiatric diagnosis, we obscure the links between threats and threat responses and instead, say we are 'treating' an 'illness.' The PTMF shows how we can **restore the links between personal distress and social/political contexts.**

At one level this is common sense. We all know that people living in poverty are more likely to feel miserable and desperate ('depression') and we recognise that young people under pressure from target-driven education and social media messages are likely to feel worried and insecure ('anxiety disorders.')

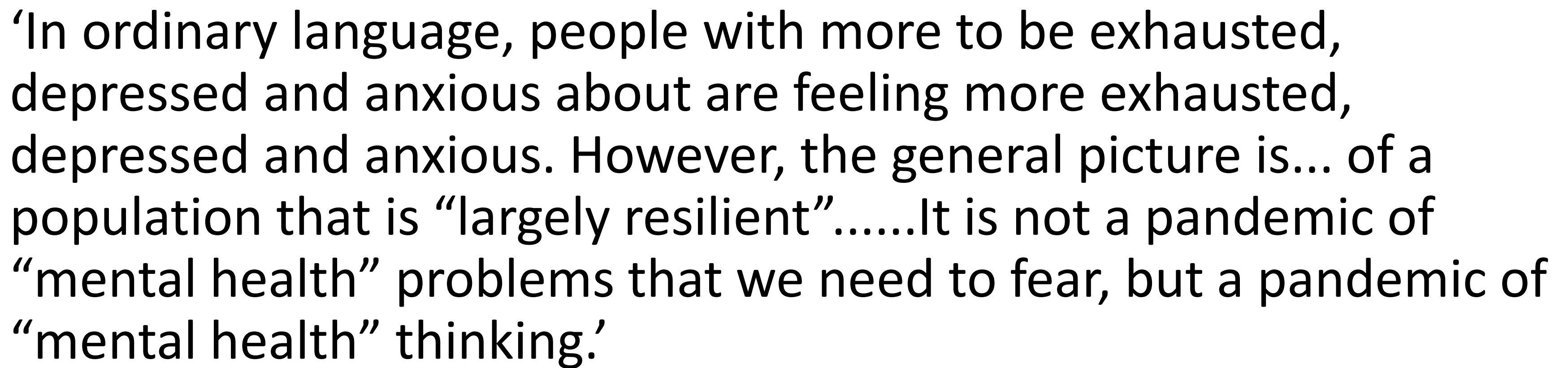
But a diagnosis tends to conceal these links – from the person and from society as a whole.

Disconnecting threat responses from threats

Covid-19: Mental health services must be boosted to deal with 'tsunami' of cases after lockdown BMJ 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.'

Almost all minority ethnic groups had higher risks of dying from COVID-19 than the white British majority of a comparable age.



‘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

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#

Disconnecting threat responses from threats

‘Rate of mental disorders among 17 to 19 year olds increased in 2022, new report shows’

‘One in four 17 to 19 year olds in England had a probable mental disorder in 2022’

The young people with a ‘probable mental health disorder’ were much more likely to:

-have been bullied, to feel unsafe in school, lack friends, and be worried about exams

- be living in a family that couldn’t afford to buy enough food; had fallen behind with rent, bills or mortgage; couldn’t afford to keep the house warm

NHS Digital

https://digital.nhs.uk/news/2022/rate-of-mental-disorders-among-17-to-19-year-olds-increased-in-2022-new-report-shows

General Patterns within the Power Threat Meaning Framework

General Patterns can be seen as 'meta-narratives' – broader, evidence-based patterns in distress which help to us to construct personal narratives, and are also informed by them.

They describe what people DO in the face of threat, not what condition they HAVE

Some examples (still under development)

- Surviving bullying as a child/young person
- Surviving poverty

…and so on

There are always individual aspects to a personal story – but at the same time, there are always common elements to personal stories in a given context. It may be comforting to realise that certain Power influences (eg trauma and abuse) tend to result in typical meanings (‘I am ashamed, it was my fault’) and typical threat responses (‘I feel temporary relief when I self-harm.’)

‘Surviving Poverty’

Power Lack of economic power affects access to housing, transport, heating, food and clothing, holidays, cultural and leisure opportunities and medical care. Poverty also means potential exposure to the negative operation of almost every other form of power, and reduced ability to protect oneself or one’s family. Pressure of social expectations about achievement and success, etc

Threats to almost every area of your life, including interpersonal, material, social, bodily, identity, values and meanings

Meanings may include: overwhelmed; shamed, humiliated; controlled; defeated, trapped; unsafe; inferior; excluded; sense of injustice/unfairness

Threat Responses eg use of alcohol and drugs; insomnia, anxiety, attention and concentration disruption, distrust

The PTMF and 'culture'

Diagnostic manuals like DSM and ICD are based on the social standards of the white, Western culture in which they are produced. Our failed models and interventions are being exported in very narrow forms under the Global Mental Health Movement.

Psychiatrists like Suman Fernando argue that this is simply another form of colonialism, less obvious but just as damaging as earlier forms (Fernando 2003)

'*Western psychiatry can certainly provide low- and middle income countries with instructive examples – but they are mainly examples of what not to do*' (Ingleby 2014, p.203)

The PTM Framework and the relevance of:

- Histories of colonisation, slavery and intergenerational trauma, and the resulting discrimination, 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.)

Returning to the theme of narratives.....

Story-telling and meaning-making are universal human skills

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

Art, music, theatre etc are just as valid as written narratives, as are community ceremonies and rituals.

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

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

Since publication in January 2018….

The PTMF Committee develops and collates relevant resources, offers training and training materials, upholds the principles of the PTMF and encourages sharing of ideas and good practice, including in other countries.

The project team has given 300 + invited conference/training events since the launch. In the UK this includes the Hay Festival, the Women of the World Festival, the RCP annual AMH conference, the Critical Psychiatry Network conference, the DCP annual conference, the Tavistock, and annual conferences of art therapists, UK Psychological Trauma Society, social workers, CAT and various counselling/therapy groups including Integrative, CAT, Solution-focused, forensic psychologists.

PTMF in other countries

Tours of New Zealand (Lucy), Australia (Lucy and John Cromby), and visits to Brazil, Denmark, Ireland, Spain, Greece, Lithuania, the Yukon, the USA – with Japan and Sweden to come. Interest from Italy, South Korea, India, and Pakistan.

Both versions of the PTMF documents are available in Spanish, as is the PTMF Overview in Italian and (very soon) Norwegian. Danish, Swedish, Portuguese and Korean translations are planned.

The 'Straight Talking Introduction to the PTMF' (Boyle and Johnstone, 2020) is available in Italian and Japanese, with Spanish, Swedish and Danish planned.

The PTM Framework in peer support

‘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.

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)

In 2017

Medical model

Focus on diagnosis

Context not seen as relevant

Limited psychological interventions

Low staff morale

Medicating and policing culture

High rates of violent incidents on the ward

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North West London
NHS Foundation Trust

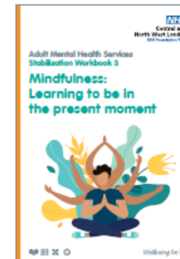
The Stabilisation Manual: Supporting internal safety

Introductory information pack plus 10 stabilisation skills workbooks

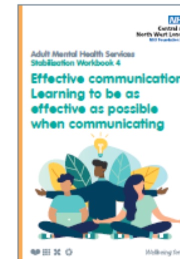
- Self-Compassion
- Soothing & Safety
- Mindfulness
- Effective Communication
- Breathing & Relaxation
- Food & Sleep
- Valued Activity
- Distraction & Distancing
- Grounding
- Maintaining Wellbeing

1. Developing self-compassion

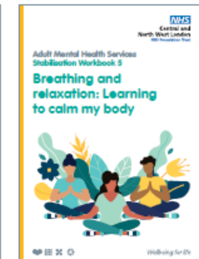
2. Soothing and safety



3. Mindfulness



4. Effective communication



5. Breathing and relaxation

6. Food and sleep

7. Distraction and distancing

8. Valued activity

9. Grounding

10. Maintaining my wellbeing

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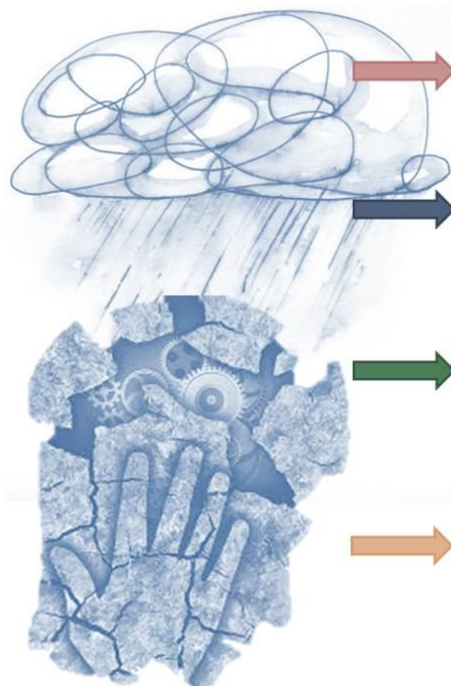
Structure of the Meeting



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

Wellbeing for life

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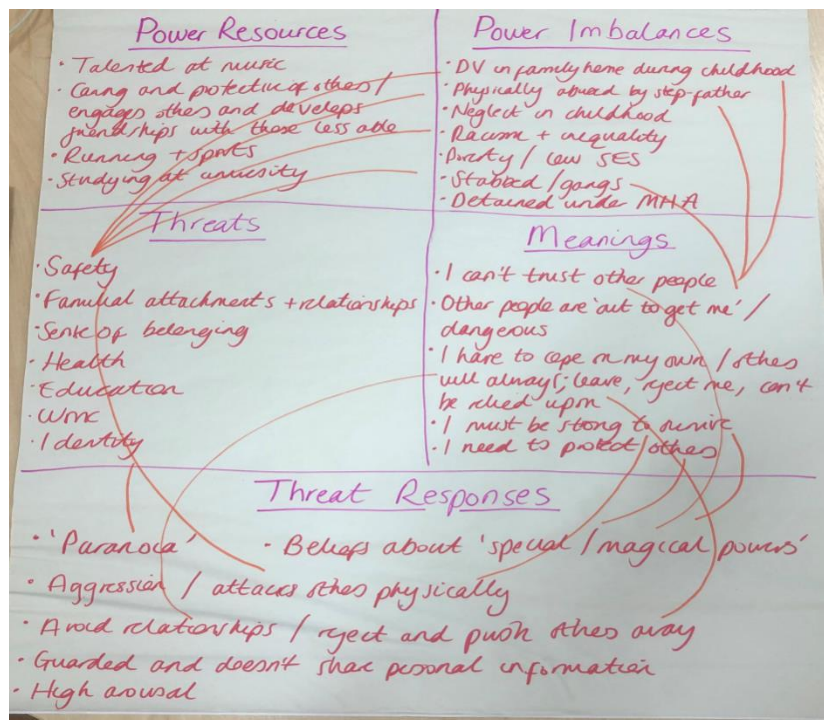
Structure of the Meeting



Review background

Feelings

Stuck

Power resources

Power imbalances

Threats

Meaning

Threat responses

Feelings

Ways forward

Wellbeing for life

Staff interviews

Theme: Increased understanding of the relationship between trauma and distress

“This framework has helped us to understand our patients as individuals… and address what’s behind the diagnosis, not the diagnosis itself.”

“[…] to make you realise, to remind you that there’s always a story behind the presentation.”

“Maybe this aggression or intimidation comes from a place of fear, of fear through trauma.”

Service user interviews

Theme: Learning skills to support internal safety

"I learnt a lot about self-compassion and being kind to myself."

"Meditation and mindfulness skills very helpful. I would get into a bit of a rage, get upset, then use the skill and it would calm me down."

"Very calming, made you think about things. Self-compassion skill, had never heard of the term before. I don't like myself very much, but we are who we are, and helped me to deal with it."

Inpatient wards in Central and North West London, UK

After 4 years, the changes are…

- **Self-harm:** Over 90% reduction in self-harm incidents
- **Restrictive interventions:** Statistically significant reduction in use of restraint and seclusion
- **Staff:** Increased understanding, compassion, and skills. Most satisfied staff in acute adult wards across the Trust
- **Service users**: 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).

"I think it makes a real difference on the ward. For the first time in a very long time, it's given me purpose and hope" (a service user)

Project extension

Harrow local developments

- Home Treatment Team
- Psychiatric Liaison Service
- Mental Health Emergency Centre
- Community teams

Project extended Trust wide from 2019

Inpatient

- 5 boroughs
- Champions
- Training
- Funding

Future Directions

- Perinatal
- Complex Emotional Needs
- Single Point of Access
- Older Adults

Workshops in New Zealand and Australia alongside indigenous people

Joint article with Maori psychiatrist Diana Kopua:

'The publication of the PTMF was a welcome relief for me at a time when I … led a new service, Te Kuwatawata (TKWW) which opened in 2017. Our attempt was to revolutionise the way in which services were shaped, that is, to centralise meaning, values, culture and relationships; making the biomedical model secondary. The PTMF supported our belief that there was a need to challenge the status quo. In New Zealand, Māori Health leaders continue to work hard to have Māori knowledge recognised, but it has not been accepted as a real alternative to the interventions of Western psychiatry.....The PTMF has acted as a "distant cousin" with more commonalities than differences'

Blogs at www.madintheuk.com

A narrative exercise: Andrea

This narrative about Andrea was put together by her daughter Ruth. Ruth needed to heal from transgenerational trauma, understand her mother's long psychiatric history, and create a different story about her instead of 'severe and chronically mentally ill patient.'

• Listen to Ruth's poem about her mother

• Read the account of Andrea

• Different parts of the room will then think about Power, Threats, Meanings, Threat responses and Strengths in relation to Andrea.

You can make some guesses – and remember that the questions overlap

• Then we will pull it together as a whole group

https://www.youtube.com/watch?v=zyde0C9x6iw

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

Legal Court order in which she lost custody of her daughters.

Economic and material A privileged upbringing but later, insecure housing and little money. Many periods in hospital environments.

Interpersonal Emotional neglect, rejection, criticism, possible domestic abuse. Dominance of powerful male figures in her life, both family of origin, and psychiatrists. Family shaming for her ‘mental patient’ status.

Biological/embodied Serious long term effects of drugs and ECT, including many physical symptoms. Contributing to dementia and early death. Loss of mobility due to amputation.

Coercive/power by force Coercion by MH staff. Possible domestic abuse

Social/cultural capital Privileged background but these advantages eroded by ‘mental patient’ status, along with physical disability and later dementia.

Ideological power Gender roles: patriarchal family, with dominant father who was a member of the establishment, at a time of rigid gender stereotypes, and a mother who devoted herself to his career and wishes. Expectations to do with being a ‘good’ daughter, wife and mother. At the same time, pressure to achieve academically and be ‘successful’. Materialistic and class-based values. Her insecure sense of identity overridden by the ‘mental patient’ identity.

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

Relationships Lack of emotional safety, abandonment, rejection, shaming, invalidation, criticism, possible violence

Emotional Feeling emotionally overwhelmed, despairing, hopeless, inadequate. Mood swings from elation to despair

Social/community Initial privilege but loss of social role and status through being psychiatric patient.

Economic/material Initial privilege but later financial insecurity

Environmental Long periods in psychiatric hospital, poor housing later on

Bodily Multiple health problems and impact of psychiatric drugs and ECT, physical disability

Values, identity and meaning-making
Discouraged from making own meanings, being heard, or finding own values and identity; strongly encouraged to comply with gender and social norms throughout her life, with additional pressure to achieve; having meanings and identities imposed, including those associated with ‘mental illness’.

‘What sense did you make of it?’

(What is the **Meaning** of these experiences to you?)

Shame, failure, inadequacy, despair, loss, hopelessness, worthless, rejected, unsafe, afraid, confused, guilty, powerlessness, helplessness.

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

Compliance, obedience within family and services

Low mood, mood swings

Self blame

Suicide attempts

Striving to live up to expectations – academically, domestically

Trying to maintain interest in music and education

‘What are your strengths?’ (What access to Power resources do you have?)

Intelligent

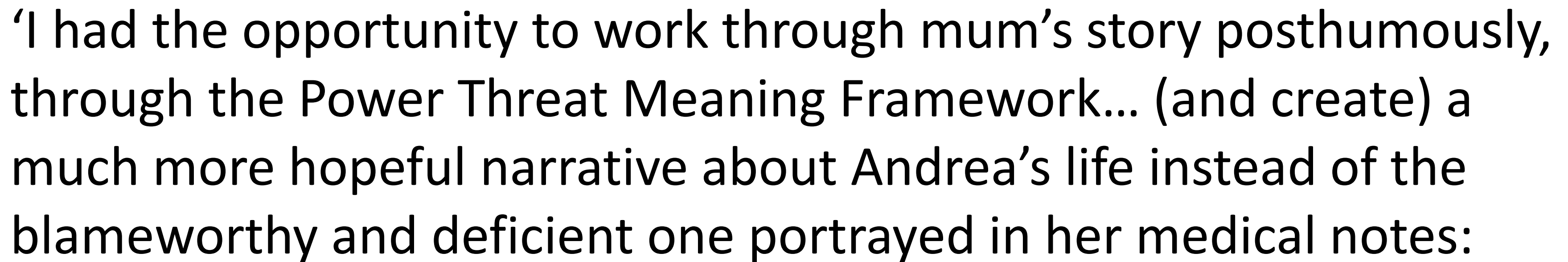
Musical and creative

Outgoing, sociable

Good sense of humour and fun

Good at sports

Loved her children, grandchildren and family

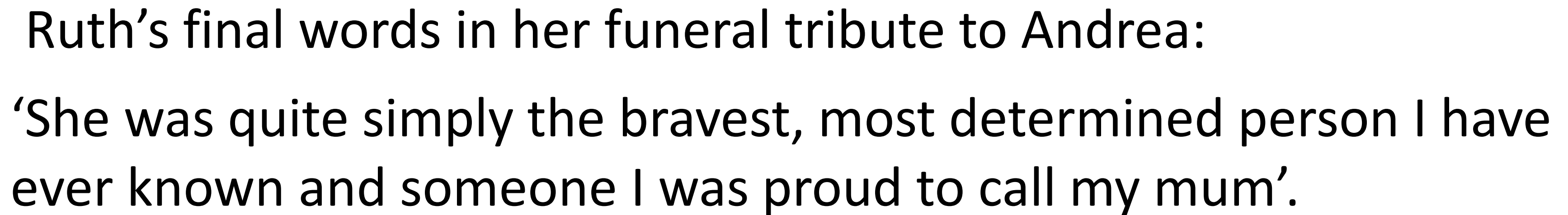


'I had the opportunity to work through mum's story posthumously, through the Power Threat Meaning Framework… (and create) a much more hopeful narrative about Andrea's life instead of the blameworthy and deficient one portrayed in her medical notes:

'Andrea was intelligent, creative and outgoing with a great sense of humour. These strengths would have been areas to build on and together with other aspects, could have provided an opportunity to see her not as a "chronic mental patient" but as a survivor of extremely difficult circumstances.'

It was incredibly healing for me to feel that, through me, Andrea had finally been heard…..and that through all her suffering her strengths shone through

https://www.madintheuk.com/2022/11/healing-from-transgenerational-trauma-my-mum-my-daughter-me/



Ruth’s final words in her funeral tribute to Andrea:

‘She was quite simply the bravest, most determined person I have ever known and someone I was proud to call my mum’.

‘It feels immensely powerful for me to share something of the loving woman my mother was.’

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