New Paradigm Person-Centred Therapy: The reason for practitioners of Person-Centred Therapy to hold onto hope in the face of the toxic abominations of '*Person-Centred Pluralistic Therapy'*, *SCoPEd*, and *Psychiatry (contd.)*

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In the previous edition of PCQ I discussed the toxic nature of 'Person-Centred Pluralistic Therapy' and ScoPEd from a 'New Paradigm Person-Centred' viewpoint. As a continuation of that discussion, this article aims to shed light on the toxic nature of psychiatry from the same viewpoint.

Originally, I had intended to confine my explication of the toxic nature of psychiatry to a single article, but I soon realised there was so much to cover that this was being far too ambitious. Accordingly, I'm endeavouring to deal with matters in more than one: the present article in which I mainly focus on the Power Threat Meaning Framework and the ideas it presents apropos psychiatrists needing to join the dole queue; and an additional article, or articles, in which I look to employ New Paradigm Person-Centred theorising as a means of augmenting the PTMF's attempt to wave psychiatry goodbye and develop a truly scientific alternative.

Part IIA: Psychiatry and the Power Threat Meaning Framework

Neither fish nor fowl, so what do psychiatrists do?

When I worked for a secondary mental health-care psychology team in an NHS trust someone in the team mentioned that the trust's psychiatrists had threatened to go on strike. Likely it was a joke, because we tended to like a joke. But who knows?—our psychiatrists weren't known for their grip on sanity.

In any case, our general reaction to the thought that these top earners in our mental health teams were unhappy with their work conditions was hardly sympathetic. 'Bring it on!', summed it up. 'What difference would it make—because what do psychiatrists do?…No really! What do they do?'

Now I'm not sure whether my colleagues were simply not impressed by the net zero contribution of our psychiatrists to the meaningful work of the trust, or, like me, were also entertaining the rider: 'And besides what psychiatrists do contribute could just as well be performed by someone of inferior rank and lower pay grade'. Dishing out the MT's (major tranquilisers) and lithium isn't rocket science and could just as well be done by nurse practitioners, even psychologists—as it is in South Africa and some US states; while zapping patients with ECT would seem to fit better with a neurologist's job specs.

Unfortunately, as things turned out, our psychiatrists didn't go on strike. But I'm keeping my fingers crossed and hoping that with the current wave of NHS strikes psychiatrists might follow suit and so give the general public the opportunity to realise that my psychology colleagues and I weren't mad to envisage a mental health service devoid of the services of its current top dogs.

Believing in the Bibles

But while psychiatrists' nerves have been caused to jangle somewhat at the prospect of being replaced by cheaper alternatives or differently specialised doctors, this is not what has caused psychiatrists to get really jittery.

No, what has caused even greater nerve jangling is the heartening prospect that the whole way of being of the psychiatrist might get junked: that, like the Monty Python parrot, psychiatry might 'cease to be', thanks mainly to the doomsday scenario involving psychiatry's Bibles: namely, the DSM (the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*) and the ICD (the World Health Association's *International Classification of Diseases*), the manuals on which psychiatrists around the world base their profession-defining expertise in diagnosing psychiatric problems as 'medical diseases' and thereby dispensing appropriate 'medical treatments'.

The doomsday scenario? That the 100 years plus 'medical' knowledge contained in the pages of the DSM and ICD might prove to be a load of phlogistonated hot air.

And what's made such an Armageddon a more likely prospect and heightened psychiatric jitteriness has been the uppityness of the number twos in the mental health world, the clinical psychologists: their questioning the wisdom of the 'wisdom' contained in these sacred texts—especially in the UK, I'm pleased to say.

In connection with which, a publication of real note has been the ground shaking publication in 2018 of the Power Threat Meaning Framework. Published under the auspices of the British Psychological Society's Division of Clinical Psychology (BPS DCP), this work is essentially a replacement document for both the DSM and ICD: a 'non-believers' Bible, as it were: 'a framework' that 'can serve as a conceptual alternative to psychiatric classification in relation to emotional distress and troubled or troubling behaviour' (OV, p. 5)—one written in response to a 2013 position statement by the DCP entitled *Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift.*

But just why was/is there the need for such a paradigm shift in the classification system regarding 'functional' diagnoses, i.e. those 'severe mental disorder[s] for which no specific neurological or other physical pathology has been demonstrated' (American Psychological Association Dictionary of Psychology)? Why, to pose the question in traditional everyday language, why was/is there a need for a new paradigm by which to define the nature of 'madness'?

Well, it was/is because—and here is the crunch reason—it was/is because of '***widespread acknowledgement that current classification systems such as DSM and ICD are fundamentally flawed'*** (OV, p. 5). In other words, phlogistinated hot air. Or, as Campbell Purton picturesquely expresses matters *a la* the DSM. 'It is because the DSM is like a library that classifies books by their colour, height, and number of pages' (Purton, 2014, p. 156). Which is why in 2013 the DCP called for 'a paradigm shift in relation to the experiences these diagnoses refer to, towards a conceptual system not based on a 'disease' model' (ST, p.29).

The *Power Threat Meaning Framework*

This, then, is the backdrop to the publication by a group of leading British clinical psychologists along with certain ‘experts by experiences’, of the document entitled The Power Threat Meaning Framework (PTMF), a work that begins by elaborating the reasons the existing medical paradigm of conceptualising and ‘treating’ mental distress is fundamentally flawed; and thereafter outlines a potential *new* paradigm based upon the key concepts of ‘power’, ‘threat’ and ‘meaning’—concepts which are employed to provide (a) a non-medical, non-diagnostic understanding of mental distress, (b) the rationale for a programme or programmes for helping those suffering such distress.

Okay, so let’s first look at some of the things the PTMF has to say about the flawed nature of the existing medical paradigm.

A sick model

(i) The view that there is a need for medical diagnosis apropos the various forms of mental distress involves the exclusionary assumption that the individual person has a disease, i.e that there is something wrong with their body. The profession of psychiatry has, in the words of the PTMF, ‘taken it for granted that the methods and assumptions used by medical researchers in identifying patterns in bodily problems can be applied to finding similar patterns—of symptoms and signs—in our ‘abnormal’ thoughts, feelings and behaviours’ (ST, p. 27).

This, as the PTMF authors point up, represents a tunnel vision mindset in which there is little or no rationale for considering that factors outside the person’s physical organism—such as horrible things happening to them—might be the essential cause of a person’s distress: horrible things which if addressed could lead to the relief of that distress. Why this point is important is because so many of those who have recovered from mental ‘illness’ have testified that they have found relief by coming to terms with horrible past events (that their distress is a meaningful reaction to those events), not by thinking in terms of what was wrong with them in bodily terms.

(ii) The PTMF highlights the fact that psychiatry’s bio-medical model approach treats the person as if they are an island, i.e. as a lone individual suffering from a disease confined to their person. Such a conception, points up the PTMF, is a fundamentally flawed paradigm when the personhood of persons and its construction is very much a societal, cultural, and historical affair—as is the mental distress persons suffer from.

(iii) For over 100 years now psychiatry has searched in vain for ‘bio-markers’, physical/organismic characteristics of some kind (such as abnormalities of brain or gene) which serve as distinguishing features of the different types of mental stress. Bio-markers of this kind have yet to be found.

(iv) With no ‘bio-markers’ available, mental ‘illnesses’ are diagnosed on the basis of ‘people’s beliefs, feeling, and actions’, ‘subjective complaints made by the person themselves or others’ (M, p. 22). The individual’s own conception (and that of others) on whether they have a mental ‘illness’ or not is highly subjective in nature and thus varies according to the culture and period of history individuals are living, e.g. if voice hearing is prized in your culture at a particular time in history, it is not going to be viewed as a sign or symptom of ‘madness. And not only that but it is to be noted that psychiatrists make judgements on that subjective basis also.

(iv) Different doctors frequently give different diagnoses for the same client's presenting mental distress, a phenomenon which has led to a person being told they suffer from a different mental 'illness' at different times in their life.

(v) The psychiatric 'illness' categories are not clear-cut and discrete with the same 'symptoms' being part and parcel of different 'illnesses'.

(vi) Psychiatric diagnoses don't provide an explanation of a person's mental distress, but rather a circular argument, viz. ''Why does she hear voices?' 'Because she suffers from schizophrenia.' 'How do you know she suffers from schizophrenia?' 'Because she hears voices'' (ST, p. 24).

(vii) What have been taken to be signs or 'symptoms' of 'madness' has varied across different cultures, and different historical time periods, not least in the historical development of the different editions of the DSM.

(viii) Within a society, different classes, different genders and different ethnic groups are more or less likely than one another to be diagnosed as suffering from a particular mental disease.

(ix) The major form of 'treatment' available to psychiatrists is the meting out of certain drugs, viz., 'antidepressants', 'antipsychotics', 'anxiolytics', and 'mood stabilisers' . However, as Mary Boyle and Lucy Johnstone point out, unlike drugs for physical conditions, no evidence exists that these drugs are 'treatments for specific disorders' or that they 'target an underlying process' (ST, p. 25).

Indeed, 'the same drug may be recommended for several different 'disorders', a state of affairs, Boyle and Johnstone relate, that supports Joanna Moncrieff's contention that such drugs 'are not specific 'treatments' but have a much more general brain altering effects' some that 'help people cope', others 'even damaging' (p. 25). In other words, such drugs are on a par with alcohol and street drugs.

An alternative approach

For such reasons, the PTMF authors consider psychiatry to have failed in its endeavour to generate a scientific paradigm vis-a-vis the phenomena of mental distress: failed, that is to say, to identify and conceptually characterise a coherent pattern in those phenomena, one whereby the investigator is able to construe and make sense of them as constituents of a greater whole—and so know how to deal with them.

Where psychiatry has failed, though, the authors of the PTMF have taken it upon themselves to step into the breach, primarily by formulating a conceptual alternative to the psychiatric bio-medical classification system apropos 'emotional distress and troubled and troubled behaviour' (OV, p. 5).

Deeming a revolutionary paradigm shift to be required, what the authors of the PTMF propound is the abandonment of psychiatry's disease model in favour of an 'overarching' 'meta-framework' of ideas that 'draws upon a variety of models, practices, and philosophical traditions but is broader than and not reliant on any particular theoretical orientation' (CPF, p. 2; OV, p. 8)—broader, too, in terms of taking into account factors beyond the biological: factors that the

psychiatric manuals treat with disdain but which nevertheless play an important part in the expression and experiencing of emotional distress by the individual; factors that are psychological, social, cultural, political and historical in nature.

In other words, a conceptual framework that takes account of all the multifarious factors that can combine to bring about a person's experiencing of mental distress, one that, as with paradigm theories, employs a few key concepts to delineate an **orderly pattern** in a profusion of phenomena.

Evidenced by the framework's eponymous title, for the PTMF these key concepts are the concepts of *power, threat,* and *meaning.* They are the fundamental notions by which the PTMF's authors determine an orderly sense-making pattern in an individual's distressed experiencing. Together they form 'the foundational pattern' (ST, p. 102) which serves as the alternative to psychiatry's 'disease' paradigm. And, as with the psychiatrist's 'medical' prescriptions, they serve to provide the foundation on which the authors ground a remedial therapeutic programme, a programme that includes the additional conceptual elements of 'threat responses', 'power resources', and 'story telling'/'narrative'.

Grounded upon these six elements, the PTMF therapeutic programme consists in individuals (alone and in families and larger groups) pondering answers to the following six questions:

- 'What has happened to you? (How is *power* operating in your life?)
- 'How did it affect you? (What kind of *threats* did it pose?)
- What sense did you make of it? (What is the *meaning* of these situations and experiences to you?)
- What did you do to survive? (What kinds of *threat response* are you using?)
- What are your strengths? (What access to *power resources* do you have?)
- …and to integrate all the above: '*What is your story?* (ST, p. 30)

Below I give an account of each of these conceptual elements in turn.

Power

As employed in the PTMF, the concept of power represents the Framework's core concept—the authors putting it 'first and foremost in this way'… 'because power, in both its positive and negative senses, is a central aspect of all our lives' (ST, p. 37). For, as a concept deriving from the domains of political theory and sociology, not only is power construed as 'a key factor in linking … [an individual's emotional and psychological] distress difficulties to wider social processes' (ST, p. 41), but thanks to the influence of the thought of Michel Foucault we are able to 'think about the less obvious aspects of power and how these relate to our feelings and behaviour' (ST, pp. 41-2).

Accordingly, confess the PTMF authors, defining power is difficult in that the term 'refers to a complex set of processes, abstract and concrete, more and less visible' (ST, p. 41). Thus, in their view, there is 'no one definition' of power. However, the authors do feel able to narrow things down somewhat by positing that:

> Power can have several meanings. Generally it means being able to gain advantages or privileges, to arrange things to meet your own interests; or being able to gain advantages or privileges for others, to arrange things to meet their interests.

> Power can operate through our partners, families, friends, communities, schools, work, health services, the police, government and the media. Power can be used negatively; for example, when people are hurt, excluded or silenced by others. It also can be used positively such as when others protect and care for us. (OV, p. 92)

This being the case, the PTMF authors identify the following forms of power as 'potentially relevant to many forms of distress and troubling behaviour' (ST, p. 43):

- biological or embodied power, where particular physical attributes are valued or not
- interpersonal power, where power operates through relationships
- coercive or power by force, where violence is used for positive or negative purposes
- legal power, where the law is used to promote or eliminate behaviours
- economic and material power, where financial wellbeing or its lack determine things
- Social/cultural capital power, which provides access to benefits in society
- Ideological power, where our meaning, thoughts and feelings are influenced by the language we use.

So understood, '**Power is everywhere'** (ST41)**.** It is ubiquitous. The workings of power are behind everything that happens to us.

Threat

According to the PTMF authors, 'the negative operation of power can affect people by creating threats ['threats to safety, survival or wellbeing'] in all aspects of their lives' (ST, p. 59). Which is to say, threats can be engendered by 'aversive life circumstances where we are likely to struggle rather then flourish' (p. 61)—not only those 'very unusual extreme or life-threatening events from outside' that we term 'traumas', but also those 'continuous or repeated very negative experiences' that are 'embedded in people's lives and relationships' (CPF, p. 51).

The PTMF itemises these aspects of people's lives where such threats can occur:

- Bodily - involving illness and physical harm
- Emotional - to do with difficult feelings
- Economic/material - pertaining to the security of sufficient money and safe housing
- Social/community - related to one's standing in society
- Environmental - linked with living in an unsafe or undesirable residential setting
- Knowledge and meaning construction - lacking the opportunity to make sense of one's world for oneself
- Identity - not being supported in developing or maintaining one's personal identity
- Value based - 'loss of purpose, values, beliefs and meanings' (ST, p. 63)

Meaning

In contrast to the psychiatric paradigm of mental distress that 'sees people as bodies that need fixing', 'the PTMF views human beings as primarily meaning-making creatures who actively try to make sense of their worlds' (ST, p. 70).

In relation to which, the importance of 'meaning' for the PTMF authors is the phenomenological issue that it is not the objective 'events or situations' in themselves that leads to our experiencing of mental distress but 'the meanings we create about [those] events or situations' (p. 71). This is a reason why 'we can't make simple cause-effect links between the events and circumstances of people's lives and the consequences in terms of distress and 'mental health problems'' (ST, p. 71).

For it is meanings that 'shape distress', with the meanings we employ having arisen from our development from birth and 'from many sources, including our emotions and physical senses and the language we hear and learn', inclusive of 'the discourses of the society around us and the ideological interests that underpin those discourses' (ST, pp. 73, 74).

Threat Responses

The PTMF's conception of 'threat responses' is largely based upon 'the trauma-informed approach (TIA)', an approach which 'integrates research about the importance of early relationships (attachment theory), the effects of traumatic events on the mind and body and the wider social environment' (ST, p. 86).

And here what the PTMF authors found particularly useful apropos the TIA is 'the way it reframes psychiatric 'symptoms' as threat responses and survival strategies used by our minds and bodies to protect us from the impact of adversities' (p. 87). Although, as previously mentioned, an essential difference between the TIA and the PTMF approach is that in place of the term 'trauma', a term usually linked with 'specific abusive events', the PTMF prefers to use the more general term 'adversity'. This it does in order to shed light on just how wide are the workings of negative power, specifically its 'links to the wider context of economic inequality and social injustice', i.e., 'the more subtle pressures and expectations of modern industrial societies' (p. 88).

The PTMF mentions these subtle pressures because this may be one factor in obscuring the fact that particular threat responses, particular 'psychiatric symptoms'—of which the authors mention a whole host —are 'necessary and creative ['protective'] strategies' in the face of past and present threatening situations, strategies that serve certain 'functions and purposes' (pp. 91, 94).

As to other obscuring factors, besides such subtlety and the fundamental gaslighting medical 'illness' supposition, the PTMF highlights the following:

- The storing of feelings and memories of events 'in a different way in the brain, where they may be lost to our conscious minds' (p. 89)
- Adopting 'socially disruptive strategies' because of having less access to 'conventional or approved forms of power' (p. 92)
- Adopting a socially approved way of behaving in order 'to avoid emotional conflict and pain' (p. 92)
- The varying across historical time periods in how distress is expressed, viz. the 'hysteria' of Victorian women which is not seen today.
- '[C]ultural differences in the way distress is expressed' (p. 93).
- A failure to realise that the unusual behaviours and experiences of mental distress are extreme expressions of and on a continuum with so-called 'normal' behaviours and experiences.

Thus by so making plain that an individual's mental distress and troubled and troubling behaviour constitute 'an understandable and indeed adaptive reaction to threats and difficulties', plus that such reactions are on a *continuum* with 'normal' reactions, the PTMF's aim is to convey a message that is 'normalising and not pathologising (either medically or psychologically' (p. 128).

Power Resources

Beyond clarifying that current forms of mental distress represent meaningful responses to past and present adversity, the PTMF deems it to be therapeutically valuable for a person to identify and focus awareness on their 'power resources' or strengths, i.e., what the individual 'has going' for them.

To aid such reflection the PTMF provides an extensive list of what those strengths and resources might be, viz., 'people who care for you or the person you are working with, aspects of their/your identity that you/they feel good about, skills and values that are important to you/them' (p. 34). Here the 'main aim' of such an exercise is 'to encourage ideas and reflections in order to build a story' (p. 35), a personal story that provides a meaningful alternative to the impersonal diagnostic label imposed upon the person by the medical profession.

Story Telling/Narrative

'Narratives, or stories', say the authors, 'lie at the heart of the PTMF' (p. 124), grounded as it is on the belief that 'creating a different narrative can be a deeply healing process' vis-á-vis mental distress—a 'counter-narrative', that is, to the one of psychiatric diagnosis (pp. 125f, 144).

The basic message of the PTMF is thus that the whole rigmarole of psychiatric diagnosis needs to be abandoned and individuals instead enabled to develop their own 'new narrative', a personal story that is meaningful for them. Here the role of the professional is not only to listen to the person's story without diagnosing, but to work collaboratively with them in facilitating the 'formulation' of that story, a facilitation process that the PTMF's six question programme with its underlying concepts is meant to serve—although in making use of the PTMF an individual or group may choose to do so without employing the six questions approach.

In any case, however their personal story is produced, employment of the PTMF will have ensured that that story has fostered reflection upon the social, cultural, and historical context of the person's life; one whose difference from a psychiatric assessment involves not just the lack of diagnostic psychiatric terms (and maybe simply employing 'straightforward problem descriptions such a ''hearing distressing voices' or 'feeling suicidal' or 'experiencing severe anxiety''), but using different 'forms of sense-making' beyond language, e.g., 'art, poetry, dance, music and so on' (pp. 167, 125).

In no way, though, do the authors of the PTMF view the PTMF as a final word on the nature of a non-diagnostic approach to helping people with mental distress—which is why they draw attention to 13 non-diagnostic approaches currently being employed by other helping programmes. They do this 'with the dual aim of demonstrating that non-diagnostic approaches are already being successfully implemented both within and outside statutory services; and suggesting ways to further integrate the ideas and principles underpinning the PTM Framework' (OV, p. 89).

Of interest to person-centred practitioners is the fact that one of the 13, Leeds Survivor Led Crisis Service, is very much based on the ideas and philosophy of the Person-Centred Approach.

A final word

To my mind, as the authors of the PTMF themselves put it, 'the PTMF poses a major challenge to the dominant diagnostic model' (ST, p. 172)—doing so by adopting a scientific point of view to highlight the flawed nature of 'the DSM mindset': the make-believe that the Bibles of psychiatry—the DSM and ICD—are bona fide medical manuals that 'carve nature at its joints'; the pretence that with only pseudo-scientific hot-air as their guide psychiatrists are practising medicine; the delusion that psychiatry represents a benign endeavour rather than a toxic abomination which needs to be got rid of.

As I see things, therefore, the authors of the PTMF are greatly to be praised for dealing psychiatry a major body blow. However, from a New Paradigm Person-Centred perspective it is still going to be a long hard slog before the enterprise of psychiatry becomes a thing of the past and we possess bona fide scientific understanding of mental distress and how those who suffer from it might best be helped.

What the PTMF has achieved, though, can, in my opinion, be further carried forward by employing New Paradigm Person-Centred ideas to fortify the PTMF's contribution, thereby advancing the realisation of such objectives. On that day we will be hailing the superseding of the present psychiatric paradigm and the birth of its 'organismic' successor.

It is on this fortification process that I intend to focus my efforts in future articles.

References

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