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POWER THREAT MEANING FRAMEWORK – A BRIEF DESCRIPTION OF THE BASIC ASSUMPTIONS AND CONTEXT

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Power Threat Meaning Framework
medicalization
diagnosis

Summary

The article briefly presents the basic principles of a non-categorical approach to diagnosis, the Power Threat Meaning Framework (PTMF), published in 2018 by the British Psychological Society. It discusses Power, Threat, Meaning, and general patterns of threat responses, as they are conceptualized in this framework. The article also provides a brief description of the theoretical foundations and inspirations influencing the content of the PTMF. The PTMF draws from various philosophical, sociological, psychological, psychiatric, and psychotherapeutic traditions, offering a coherent integrating perspective. The PTMF is also presented in the broader context of contemporary controversies regarding the dominant systems of nosological diagnosis and the negative consequences of the reification of diagnostic constructs and the limitations of the biopsychosocial model in psychiatry and psychotherapy, which in practice favours the biological level. In the conclusion, the article also briefly presents criticism of the PTMF. The PTMF offers an approach that can be applied in clinical practice and scientific research, allowing for a broader consideration of economic, social, and cultural issues in the process of supporting people in distress. The PTMF can help prevent the excessive medicalization of individual and social problems.

Introduction

Nosological models of the classification of mental disorders, such as the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), are currently widely criticized from many different theoretical perspectives, both in the context of clinical practice and research [1]. There are several different, although related, levels on which these critiques focus. Karter [2] distinguishes the macro level (epistemological and ontological problems related to the empirical and conceptual status of diagnoses), the exo level (broadly understood structural and socio-cultural aspects of diagnoses, especially in the context of neoliberalism and neo-colonialism), the meso level (specific social and institutional controversies related to the influence of various institutions, e.g. pharmaceutical companies on the construction of diagnoses), micro

(issues concerning historical and scientific details related to, e.g. technical aspects of the process of the development of new versions of the DSM or ICD) and the individual level (potentially harmful impact of diagnoses on the individual, such as issues of stigmatization, self-stigmatization, self-fulfilling prophecy or nocebo effect).

Low reliability of diagnoses, leading to research problems (e.g. in the context of searching for biological correlates or determining the effectiveness of interventions) is also being highlighted [1]. Another significant problem is the high heterogeneity of diagnoses and the overlapping of individual categories containing many similar symptoms, which may also be related to the so-called co-occurrence [3].

There are various proposals to overcome the impasse and lack of research and clinical progress that result from relying on the ICD or DSM categories [4]. Beyond attempts to further develop a categorical approach and create more and more increasingly detailed categories, which, it is assumed, would ultimately address actually existing separate biological conditions, there is also discussion of the dimensional approach (it is, however, associated, among other things, with the challenge of determining the boundary between normal variation and a level that could be said to indicate a disorder; this approach may also lead to the potential pathologization of an increasingly wide range of behaviours as being on a "spectrum" [5, 6]).

In addition, we should mention (1) the Research Domain Criteria (RDoC) project promoted by the National Institute of Mental Health, which is essentially an attempt to build new categories, although starting from biological data, instead of looking for correlates of previously arbitrarily created diagnoses; (2) Hierarchical Taxonomy of Psychopathology (HiToP), in which a new model would be built on the basis of data of a primarily behavioural nature, subsequently arranged hierarchically (from the most general categories to increasingly specific ones) and dimensionally, in accordance with observable relationships between various types of problems; (3) or psychodynamic proposals such as Psychodynamic Diagnostic Manual (PDM) and Operationalized Psychodynamic Diagnosis (OPD) [7].

Kendler [5], a prominent psychiatrist, also mentions as one of the main proposals an approach that he associates with the British psychologist Richard Bentall. This approach would focus on specific patient complaints, i.e. on people, instead of on diagnoses. The first-person perspective and individual senses, meanings and stories would become more important. It would also involve going beyond categorical or dimensional models that do not necessarily correspond to the problems of specific people.

A partially similar approach, focused on individual stories embedded in a social context and going beyond categorical thinking, although partially building on psychological formulation [8] and departing from a medical perspective to a greater extent, is offered by the Power Threat Meaning Framework [9] (PTMF). As far as we know, there is no widely accepted translation in Polish literature, we will use the following terms: *władza*, *zagrożenie*, *znaczenie*, *rama*. The main goal of this article is to provide a brief presentation of the basic assumptions and solutions of this proposal.

Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) was developed by a working group of psychologists and patients, with financial support from the Division of Clinical Psychology of the British Psychological Society (BPS), and published by the BPS in 2018, although it is not an official model used by the Society [10]. In principle, the PTMF is primarily an attempt to move beyond the perception of diagnostic constructs as reified entities (which is a common consequence of relying in research and clinical practice on categories from DSM or ICD), which may lead to a number of negative cultural and social consequences for patients and the therapeutic process [1, 4], and to creatively transcend the biopsychosocial model, which seems to favour the biological level of conceptualization and pharmacological interventions [9].

The PTMF can be described as an attempt to answer the question of how to address "problems in living" (in the terminology of Harry Stack Sullivan's interpersonal psychiatry) in another way than by using psychiatric diagnostic systems [11]. How can we best conceptualize behaviours and experiences that may involve suffering and distress for the individual or be distressing to others? The basic assumption here is that what can be called a psychiatric symptom is an understandable response to often very unfavourable circumstances. These responses, both evolutionarily and socially conditioned, have protective functions and demonstrate human agency and creativity; however, on occasion, they may lead to the deepening and perpetuation of suffering [9].

Johnstone and Boyle [12], the lead authors of PTMF, describe the basic problems of the dominant approach, which they call the *"everythings" problem*. Namely, 1. "everything causes everything": there is growing evidence of the negative impact of a range of social and relational phenomena on mental health, while attempts to find primary and specific biological factors continue to fail; 2. "everyone has experienced everything": moreover, it is impossible to isolate specific "risk factors" for particular disorders, people are subject to many of them at the same time, and the occurrence of unfavourable circumstances significantly increases the risk of further negative factors, e.g. poverty contributes to the occurrence of many other threats; 3. "everyone suffers from everything": in the context of nosological diagnoses, this can be described as "co-occurrence" or "co-morbidity" — in practice, diagnostic "ideal types" are very rare, people struggle with many problems at the same time, such as anxiety, a sense of helplessness or lack of hope, low self-esteem, relationship problems, unusual beliefs, self-harm, or related to control of eating; the clinical picture often changes during treatment, which causes people to receive subsequent diagnoses; 4. "everything is a 'treatment' for everything": neither drugs, despite the names suggesting specificity of action (such as antidepressants, which can be used, among others, in personality disorders or obsessive-compulsive disorder, or antipsychotic drugs, which are also recommended for depression, bipolar disorder, anxiety disorders, insomnia, etc.), nor therapies, have a specific effect on distinct "disease entities"; similarly, different psychotherapies have generally comparable effectiveness, regardless of diagnosis and specific techniques.

Johnstone and Boyle conclude: "In summary, all types of adverse events and circumstances appear to raise the risk for all types of mental health presentations (as well as for

criminal behaviour and physical health problems). This appears to be mediated, for better or worse, by all types of attachment relationships, all kinds of social support, all kinds of biological mechanisms, and all varieties of emotional and cognitive styles" [12, p. 6].

Within a medical approach focusing on diagnoses, this is a significant problem that calls into question the basic assumptions of such a system.

In response to these briefly outlined challenges and other problems, the PTMF proposes a radically different approach, integrating a number of, even seemingly very distant, theoretical approaches. These include: radical behaviourism, cognitive, interpretive and hermeneutic approaches, constructivist approach, social constructionism, critical realism, process philosophy, systemic approach, perspectives referring to spirituality, social justice perspectives and liberation/emancipation, New Social Movements (e.g. *psychiatric survivors*), feminist, indigenous psychology and narrative approaches. Together they create a rich set of ideas, theories and solutions that can be applied in a practice which would not obscure the social, cultural and even political context of the problems that people face [11].

Basic principles and assumptions

The fundamental assumption of the PTMF is a focus on people understood as embodied subjects in social and relational contexts. It is assumed that "abnormal" behaviours and experiences exist on a continuum with "normal" behaviours and can be explained and interpreted similarly. Unless there is strong evidence to contradict such an approach, behaviour should be understood as an understandable response to situations, even though the connections between a person's current circumstances, life history, belief systems, bodily capabilities and behaviour are not always simple and obvious. Therefore, the approach would be more about thinking in terms of difficult situations that people find themselves in, rather than disorders that they allegedly "possess" [9, 14].

In the PTMF, causality in the context of human behaviour and experience is approached probabilistically. Causal influences operate in a conditional and synergistic way, i.e. we cannot talk about simple causality such as: A (e.g. serotonin level) causes B (e.g. depression). In fact, many different factors of different kinds influence each other, strengthening, weakening or even reversing the direction of relationships that could be thought of as cause and effect. It is therefore assumed that although the experience and expression of suffering are enabled and mediated by biological factors, they cannot be said to be simply caused by biological factors, especially since these biological factors are also conditioned by economic, social and cultural factors (in a sort of a feedback loop). Treating and explaining "disorders" as existing independently of this broader context (even though this context constructs them) and solely "caused" or "triggered" by one or other external factor (as is often the case in the biopsychosocial model) is therefore impossible [15]. Such discrete and reified disorders that could be directly influenced or caused by some factor do not exist — or at least they have not been identified at the biological level, and there is little indication that this will be achieved in the future based on DSM or ICD categories [1, 16].

Although various approaches trying to construct and explain human suffering are unable to realize the positivist vision of science detached from values, this does not mean that

useful knowledge is completely unattainable — however, one must be aware that separating "facts" from "values" in this context is problematic. This is particularly visible in relation to intercultural issues, where we may be dealing with the unauthorized imposition of Western conceptualizations of "disorders" (treated as global, as if they corresponded to objective reality) on other cultures. In the area of mental health, it is necessary to take into account a wide range of different research methods (e.g. qualitative) that can reveal these phenomena and enable taking into account the processes of constructing meanings and their specificity within different cultures [17].

Power

The central concept in the proposed approach is power. Among the theoretical inspirations influencing the understanding of this term, one could mention, alongside Foucault, authors such as Bourdieu, Lukes, and Smail [15]. This is, however, not radical social constructionism; the PTMF is rather closer to critical realism in the approach of, for example, Bhaskar [18].

Therefore, power concerns, among others, control of meanings, language, stereotypes, policies, or specific practical solutions that, through various institutions (such as schools, media, corporations, professional guilds, etc.), influence the perception of reality and create subjectivity (e.g. in accordance with requirements of neoliberal economics [19]). Power, as conceptualized here, also determines acceptable ways of manifesting subjectivity and excludes others. Ideological power, of which discourses (along with material institutions) of psychiatry, psychology, and psychotherapy are a part, may also ultimately translate into very direct manifestations of violence and behavioural control (such as in the case of the use of coercion and treatment without consent), which, according to the PTMF would belong to the realm of power by force or power by coercion. [15].

Other forms, levels, kinds or manifestations of power are: biological and embodied power (e.g. related to the possession or lack of socially highly valued features), legal power (concerning specific legal solutions regulating various aspects of life and behaviour), economic and material power (related to, for example, access to various types of services, goods, shelter, etc.), interpersonal power (an example may be the threat of withdrawal of emotional support in close relationships), as well as power related to social and cultural capital.

These various manifestations of power are therefore recognized in the PTMF as closely related and overlapping. For example, economic and material power, together with social and cultural capital, may translate into the possibility to create meanings within ideological power and specific legal solutions within legal power. Therefore, power exerts influence through social and professional structures and organizations, the media, education, science, and social and family relationships.

In the context of mental suffering and disturbing behaviour, power also operates by creating cultural narratives about them (such as diagnostic systems), which become norms to which people submit, and creates socially acceptable ways of responding to suffering. It should also be noted that power may have both positive, socially beneficial, and negative,

oppressive and harmful aspects. These negative aspects of power may manifest primarily in the context of threats it creates to the fulfilment of human needs [15].

Threat and needs

The negative impact of threat, largely stemming from various direct and indirect manifestations of power, is in the PTMF primarily associated with hindering the fulfilment of core human needs. In the PTMF it is assumed that these, among others, include: safety and security, close attachment to caregivers (in the case of children), positive relationships within partnerships, families, friendships and communities, having influence on important aspects of life, including the body and emotions, meeting basic physical and material needs for oneself and dependants, a sense of justice or fairness, feeling valued and effective in various social roles, engaging in meaningful activities, feeling hope, meaning and purpose in life [9].

The echoes of many different concepts regarding needs can be seen here, e.g. humanistic ones [20]. Satisfaction of needs is recognized as a condition for providing offspring with appropriate conditions for physical, emotional and social development. Threats to the fulfilment of parents' needs can impact children, hindering their development that would allow them to meet their own needs and leading to transgenerational trauma (often further exacerbated by ineffective support systems) [9].

Threats may be therefore associated with broadly defined adverse childhood experiences, such as physical or sexual violence or neglect, they may concern gender (e.g. in the context of power imbalance between women and men), "race", ethnicity, and finally social class and poverty [15]. So, they pertain to the environment, body, values, meanings, relationships, emotions, as well as social, economic and material issues. The PTMF emphasizes that understanding the impact of these phenomena on individuals is impossible without embedding them in a broader cultural context — the context of individual and cultural meanings [21].

Meaning

Meaning is the third fundamental element of the PTMF and a thread that runs through all the others. The very concept of "meaning" can be understood in many different ways. There is a rich philosophical and linguistic tradition grappling with this problem. In the fields of psychology, cognitive science and neuroscience, attempts are also made to conduct research and construct theories regarding the problem of language and how people attribute meaning, in traditions as diverse as radical behaviourism or Lacanian psychoanalysis.

Medlock [22] distinguishes at least several main ways of approaching the "meaning of meaning", stemming from various epistemological and ontological or even spiritual positions (e.g. Buddhism). Cromby [23], in the context of the PTMF, organizes them according to basic threads and content: 1. individual significance (related to self-expression, values, goals), 2. higher values and spiritual relevance (existential and spiritual issues, good lives, mystery, transcendence and self-transcendence, lack of absolute and objective meaning),

3. connection, community, interdependence (with self, identity, environment, colleagues, friends, etc.), 4. multidimensionality (biological, individual, relational, sociolinguistic, cultural in the context of meanings emerging from various dimensions and levels).

Generally, one could then talk about "meaning" understood more as the "meaning of life" (which are closer to points 1 and 2) and about meanings understood more in the context of everyday activities and interactions, emerging also in basic mundane situations (closer to points 3 and 4). The PTMF is interested in both of these levels.

The influences of process philosophy, constructionism, and phenomenology can be seen here. As in Merleau-Ponty's work, meaning is embodied and, according to Shotter's constructionism, it may even go beyond abstract sign systems, such as language, and is embedded in concrete practices, activities and material, institutional and cultural contexts. As an ever-present background, they co-create the meaning of specific acts of speaking, listening or other gestures and behaviours. The emphasis shifts from language itself to meaning in the activities of speaking and listening in situations also shaped by Power [23].

The focus on meaning must also bring to mind the concept of narrative. Narratives, in a simplified way, can be understood at various levels: 1. personal (narratives created by people about themselves, including those regarding their distress and problematic behaviour), 2. cultural (narratives shaping values and meanings influencing the perception and experience of the world and themselves, e.g. regarding social norms and "mental health" norms), 3. meta-theoretical (of which the PTMF may be one of the examples, concerning e.g. structural conditions that influence the shape of cultural narratives) [11].

In the context of psychotherapy, depending on the theoretical background and specific approach, narratives are understood in different ways. The framing of narrative in the PTMF seems to be closer to the concepts of, for example, Hermans or White than, for example, Adams. Therefore, it seems that narratives are treated here as decentred, plastic and flexible, and their evaluation is avoided (e.g. as pathological vs. non-pathological ones). Narratives can be expressed using various means, so they do not concern language only and may be non-chronological and non-linear [24].

Narratives created in the therapy process are not treated as privileged. Therapeutic (in terms of function) narratives can emerge in many different social, interpersonal and relational contexts, including poetry, songs, music, art and culturally-specific legends and beliefs. The PTMF emphasizes people's agency when it comes to creating their own narratives, but on the other hand, it tries to avoid the "magical voluntarism" described by the previously mentioned Smail [25], i.e. the simplified belief that "all you need to do is change your thinking". Narratives, like meanings, do not exist in a vacuum detached from economic, material and corporeal reality. As Johnston [26, p. 68] puts it, identity is "what you can say you are, according to what they say you can be". This may, for example, mean that a person who has been diagnosed with schizophrenia, thus being "a person with schizophrenia", can no longer become "a person without schizophrenia", if we adopt the narrative about the lifelong and chronic nature of such a diagnosis — not everything then can be "thought", said, and especially embodied in life.

Threat responses

Problematic behaviours, or in psychiatric terms, "symptoms", may serve a variety of functions, such as regulating overwhelming feelings, seeking attachment, maintaining a sense of control, avoiding threat, maintaining a sense of identity and self-esteem, or enabling belonging to a social or peer group. They may reflect both the influence of pre-reflective (unconscious, unconditioned, or minimally linguistically or culturally shaped, but also subject to the influence of learning) reactions (e.g. fight, flight, freeze or heightened vigilance reactions) as well as behaviours subject to reflective influences [15].

Threat responses may serve many different functions (e.g. unusual beliefs may not only give meaning to life, but also be related to self-esteem), and individual functions may be fulfilled by various behaviours (ritual behaviours or the use of violence may both serve the purpose of achieving a sense of control). Starving yourself may be related to the need for control. Lack of trust may protect against abandonment and loss of attachment, and the function of insomnia may be to protect against danger [21].

The influence of power manifests itself in this context both at the level of creating threats to the fulfilment of needs (e.g. due to working conditions or the activities of various types of institutions) and at the level of shaping possible responses to these threats (e.g. advertisements may encourage people to regulate tension using substances), creating a culturally determined "pool of symptoms". This may, for example, partly explain why certain expressions of suffering become more or less common over time. For example, "disorder awareness campaigns" may simultaneously increase the cognitive accessibility of specific problematic behaviours. Significant historical and cross-cultural differences in the occurrence of specific problems may result from a changing "symptom pool" [15].

General patterns in the PTMF

In the PTMF, instead of "disorders" that people are supposed to "have", certain *general patterns* are proposed consisting of broad regularities of meaning-based responses to Power, that people adopt, consciously or otherwise, in relation to specific threats to needs. These regularities and responses are shaped by meanings, not biology, so they may change over time and across cultures [21].

They may manifest differently in different people, so the proposed patterns should be treated as preliminary guidelines enabling joint construction of an individual narrative with the patient, rather than ready-made solutions. As they are based on empirical observations, they can also constitute the basis for further scientific research [9].

Practice and the PTMF

To put it simply, the PTMF proposes replacing the key question for medicalization: "what's wrong with you?" (i.e. "what disorder do you have?"), with: "what happened to you?". This should not, of course, be taken literally. It does not follow that such a specific

statement should be necessarily used by a clinician — it only illustrates a certain ontological and epistemological shift that is supposed to be involved [27].

"What happened to you?" thus refers to the necessity of taking into account the level of analysis related to Power, of framing the patient's problems both in terms of their individual history, possible important and/or unfavourable events that may have influenced them, as well as placing them in a broader social and cultural context.

The next core issue, directly related to the previous one: "how did it affect you?", denotes reflection on the level of Threats. The question "how do you understand it?" or "what sense did you make of it?" would refer to analysis at the level of Meanings. "What did you have to do to survive?" would mean referring to the threat responses, i.e. specific behaviours, thoughts and feelings, e.g. coping strategies [9].

The questions "what are your strengths?" (i.e. an attempt to refer to the resources of power that the patient could use to improve her situation and condition, such as skills, social support, knowledge) and "what is your story?" (i.e. the level of personal narrative and trying to connect all the threads) can be particularly helpful in a clinical context. However, it should be emphasized here that these levels of analysis apply to all people, not only to those seeking professional support [21].

In the pursuit of creating a more favourable narrative, there are points of convergence, for example, with the Open Dialogue approach. Still, the PTMF draws on many approaches and traditions, which is why very different therapeutic modalities, from those closer to radical behaviourism (such as Acceptance and Commitment Therapy) through psychoanalytic and psychodynamic to existential or phenomenological and humanistic therapies, can successfully use such a non-categorical approach approach to diagnosis [28].

The case of Ewa, presented by Rostworowska and Opoczyńska [29, 30], can serve as a short example of a practical approach similar to the PTMF. The patient's behaviour, initially described as simply "symptoms of schizophrenia" (according to the diagnosis, which would correspond to thinking along the "what is wrong with you?" question), initially appeared to be meaningless and exclusively "psychopathological". Taking into account the young woman's personal history in the context of the family system, and her reaction to her brother's suicide death (the question "what happened to you?" and other issues, i.e. referring to the levels of power, threat, meanings, threat reactions and their functions) allowed the problematic behaviours and experiences to be framed as adequate, normal, and sensible responses to tragic events. During the therapy, it was also possible to draw attention to the patient's strengths (power resources), enabling her to use them to take beneficial, real actions and create a narrative that is more conducive to development and recovery. As Rostworowska and Opoczyńska write: "The therapist's conversations with her stopped being about the symptoms, their differentiation and insight into them. Instead, they became conversations about their function, aim and sense in the context of family history. […] When the patient's understanding of herself changed she was able to think, together with her therapist, about her plans for the future. She began to think that her parents might perhaps need her, that she should perhaps move back home and continue her studies somewhere closer to her home, to support her parents with her presence. Finally, as a consequence of her therapy, the patient decided to go back home and study nearby. Perhaps this decision was possible because Ewa did not think of herself in terms

of a person ill with schizophrenia but in terms of a person who is faced with the issues of life and death, with loss, bereavement, loneliness and fear for her family." [30, p. 30].

Thanks to this way of reformulating of the problem, the patient graduated from school, found a job and has not been hospitalized since [29, 30]. Within the framework of the PTMF, however, the initial conceptualization of her problems as arising from the reified construct of schizophrenia could be completely omitted, or even viewed as introducing an unnecessary obstacle that would then need to be overcome.

A similar description can be found in the case described on the website of the Polish Institute of Open Dialogue Foundation: "I saw how a >psychotic< who is listened to, whose words are not >delusions< but have a specific meaning for his family, specific because related to his and their history, can recover from this illness, can understand it, get to know it, and accept it as another experience, and not as a >disease<, stigmatizing him for life and turning him into a chronic" [31].

The cited examples do not mean, of course, that the PTMF applies only to problems diagnosed as psychosis or schizophrenia and called diseases, or to people classified as "mentally ill". They illustrate, however, one of the assumptions of the PTMF, according to which seemingly "abnormal" and incomprehensible experiences and behaviours are framed as understandable responses to circumstances, life history and their sense/meaning, and that such conceptualization and the corresponding interventions can be helpful and effective.

Summary

Like other proposals, the PTMF received both favourable and negative comments and opinions. On the one hand, it has been widely welcomed across the UK, including in a number of inpatient wards in London, and has been translated into several European languages including Spanish, Italian, and Norwegian. On the other hand, part of the psychiatric community calls the PTMF an "ideological attack on psychiatry" — although this accusation itself seems to be ideological and not of a scientific nature. Some researchers and practitioners also claim that the PTMF does not bring much new or that it is even worse and less practical than DSM and ICD diagnoses. Some people accuse the PTMF of replacing one dominant narrative with another [32], but it is difficult to believe that this is a sufficient argument for maintaining the current one.

Some patients talk about the relief that a nosological diagnosis can bring. However, it seems that a sense of recognition of their suffering, attention, sympathy, or some kind of explanation and naming of problems, hope for effective help, and awareness that other people may be facing similar challenges, which likely account for this effect, can also be provided in a different way, for example relying specifically on the PTMF. McWilliams asserts that nosological diagnoses are maps that can be helpful for novice therapists; however, reifying these maps obscures the actual territory, and as a result, they may do more harm than good [33].

Some people point out that ICD or DSM diagnoses are necessary due to their purely administrative and bureaucratic functions, e.g. related to the financing of services. However, this is only a feature of the organization of the financing system, which can be designed

differently, and not a matter of theory and clinical practice itself. Moreover, diagnoses are neither a sufficient nor a necessary condition for receiving psychiatric help [34]. A similar situation occurs, for example, in the case of social benefits — nosological diagnosis is only a preliminary step to a deeper analysis of the case and decisions relying on issues far beyond the diagnosis itself.

The PTMF is also accused of forcing thinking in terms of trauma, which is supposed to result from the question "what happened to you?", or even that such a question itself may be retraumatizing. In fact, the PTMF aligns exceptionally well with trauma-informed approaches [35], but, as we have already mentioned, these sample questions should not be asked or taken literally. Rather, they are about redirecting attention from the search for a broken "thing" (diagnosis) that we should "fix" to dynamic, multi-conditioned processes that in various ways influence personal suffering manifesting itself in an individual way; to bring to light history, narrative, meanings and their specific circumstances. This may or may not apply to experiences typically seen as "traumas".

Although the practice described above may seem common in psychotherapy and counselling (though its prevalence may also depend on the specific modality), it differs significantly from the practice of psychiatric diagnosis. In psychiatric diagnosis, even if in an ideal situation there is consideration of a broader context and such questions, ultimately they are intended to isolate "symptoms" from a list and match them to the reified construct of a disorder, for which they then serve at most as triggering or maintaining factors. The PTMF proposes certain preliminary patterns or regularities in different responses to threat, but it is more of a hermeneutic hint that can assist in narrative creation, rather than a latent variable factor determining behaviour, as is the case with nosological diagnoses [4]. It is also worth noting that, as research indicates, many psychotherapists are critical of DSM and ICD diagnoses — which may raise questions about the ethics of using categories (tools) in therapeutic practice, while not being convinced of their validity [36]. Knowledge about existing alternatives to such diagnoses is usually associated with support for their application and development [7].

The PTMF is also compatible with the *"drug-centred" model of drug action,* proposed by Moncrieff, as opposed to the *"disease-centred" model of drug action*. This first approach recognizes that the psychoactive properties of some substances may be helpful in certain circumstances (e.g. by causing sedation, arousal, blunting of emotions), but this is not, however, associated with diagnoses and the purported biological abnormalities linked to them, that drugs are supposed to act upon. Instead, it arises from the nature of the drugs themselves [37, 38].

Unlike the biopsychosocial model, the PTMF does not assume pathology and does not favour the biological level. The three-part model may be a useful heuristic, but in reality the distinction between biological, psychological, and social levels is arbitrary. The PTMF puts more emphasis on agency and the ability to create and express meanings which give a unique character to individual experience. Despite the fact that most interventions in health care systems are aimed at the individual, the PTMF places much greater emphasis on the social and relational context of human problems. The idea is to approach the patient's situation in relation to the concepts of Power, Meaning and Threat as a prism that provides a framework for interpreting reported complaints and

developing solutions for them. The PTMF is rather about "people with problems" than "patients with diseases".

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