Climate change-related distress within the dominant mental health paradigm: Problems, pitfalls, and a possible way forward

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With the increased acceptance of climate change as a current reality, the notion of climate change-related distress (CCRD) has entered dominant mental health discourse. As climate activist and organiser Daniel Sherrell (2021) expressed in his book *Warmth: Coming of age at the end of the world:*

The full feeling of [climate change] can only ever be public, located in the gaps and sinews between things, perceptible only in constellation. Not something any of us can "have", but a truth wrought together through hunches and glancing blows. (p. 175)

However, as with any form of distress, broad cultural understandings of mental distress and CCRD will shape the description, categorisation and development of support, interventions, and resources. For this reason, this paper will describe the dominant mental health epistemology, and discuss the impact of this way of knowing on how the experience of CCRD is conceptualised and approached. In addition to highlighting the disadvantages of the dominant understandings of mental distress and CCRD, this paper presents the Power Threat Meaning Framework (PTMF) as an epistemologically appropriate model for understanding and responding to CCRD.

Positioning Statement

In light of the social constructivist underpinnings presented in this paper, it is salient to highlight my own ways of being, knowing, and doing (Bainbridge et al., 2013). I am a light-skinned, non-Indigenous, genderqueer, able-bodied bisexual young person with an experience of bicultural upbringing of Turkish and Australian understandings of the world. I strive to discuss and engage with notions of cultural democracy, justice-doing, and decolonising practice in the way I practise as a neurodivergent-identifying and affirming psychotherapist, activist, and ally. I have, throughout my life, had the privilege of housing, indoor plumbing, and electricity access, as well as food security and urban-based privilege as it relates to climate and the ecological crisis. First Nations Peoples' ongoing connections to culture, lands, sky, water, and community wisdom can be held as powerful and resilient ways of knowing and doing that contribute to rich descriptions of important

collective stories and knowledges. I write this on the unceded lands of the Kaurna people. I pay my respects to Elders past and present, and acknowledge that Aboriginal and Torres Strait Islander Peoples' sovereignty was never ceded.

A Brief History of Mental Health Paradigms

Mental health paradigms provide culture-bound, nonuniversal definitions and scaled conceptions of "normality" (Sweet & Decoteau, 2018), and may therefore explicitly or implicitly reflect and promote values and norms that inform what society deems acceptable (Rogers & Pilgrim, 2014). The history and current landscape of mental health paradigms impact dominant understandings of distress, as well as the allocation and provision of services, and are therefore worthy of revision prior to discussion of the popular discourse around CCRD.

Eurocentric Biomedical Paradigm

The Eurocentric biomedical paradigm widely used in both medical and nonmedical settings involves adopting an illness framework that defines emotional distress as a form of mental disorder and providing treatment of the illness once it is diagnosed (Rogers & Pilgrim, 2014). This way of understanding mental distress emerged in the United Kingdom during the European Enlightenment period (Carron & Saad, 2012), and has maintained dominance within many capitalist, neoliberal societies (Esposito & Perez, 2014). This model is disseminated through ongoing colonisation in the Aboriginal lands colonially known as Australia (Rhodes, 2019) and across the globe (Mills, 2017; Taitimu et al., 2018). This framework is dominant as psychiatrists trained in the biomedical paradigm are usually the most dominant role within mental health services (Rogers & Pilgrim, 2014), and hold decision-making power (*Mental Health Act 2007* (NSW); *Mental Health Act 2009* (SA); *Mental Health Act 2014* (Vic); *Mental Health Act 2016* (Qld); *Mental Health and Related Services Act 1998* (NT)). For example, the statutory role of the Chief Psychiatrist in so-called South Australia entails upholding mental health legislation in that state (*Mental Health Act 2009* (SA)).

This biomedical paradigm is pervasive in that people in distress are often given treatment in hospitals and diagnosed using the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*). People who are under resourced and desiring less acute subsidised mental health support are still required to visit medical centres to see a doctor to acquire a mental health care plan (Love, 2018). The psychiatric model dominant in Australia requires diagnosis using the *DSM-5*, which is only one of many psychological assessment and classification systems in use worldwide. The *DSM-5* denotes treatment using manualised protocols, including psychological therapies, prescription drugs, or other biologically based mechanisms such as electroconvulsive therapy (Stone et al., 2020). Much time, effort, and money is spent determining how the nature of people's distress lives within their brains, and how their supposedly abnormal brains are defective and require fixing (Deacon, 2013; Love, 2018). However, the *DSM-5* has been widely criticised as lacking an evidence base (Allsopp et al., 2019), and being rooted in racist

and sexist ideology (Karter & Kamens, 2019). Despite extensive evidence that most mental illnesses have no well-established or credible biological aetiology, some people are understood to be mentally sick, and others mentally well. Those who are sick are deemed abnormal and presumed to require intervention (Allsopp et al., 2019; Johnstone et al., 2018; Rogers & Pilgrim, 2014).

Mental health services currently operate under mental health legislation that requires ultimate decision-making power be held by medical doctors (psychiatrists). Consequently, the biomedical model of psychiatry is legally inculcated in systems, policies, procedures, and staff behaviours around people in distress across Australia (*Mental Health Act 2007* (NSW); *Mental Health Act 2009* (SA); *Mental Health Act 2014* (Vic); *Mental Health Act 2016* (Qld); *Mental Health and Related Services Act 1998* (NT)). Indeed, Fennig and Denov (2019) explain how this biomedical paradigm perseveres as an "expression of power relations*"* (p. 305)*,* and therefore produces a medicalised pathway of diagnosis and treatment, even when these are culturally inappropriate. Within the discipline of psychology and allied mental health professions, this pathologising stance extends to the dominant concept of trauma, a popular term that can contribute to the promotion of individualist and colonially driven descriptions of suffering that obscure the systemic and structural violence that produced it (Reynolds, 2020).

Biopsychosocial Model

The biopsychosocial model extends from the aforementioned biomedical paradigm in that it aims to also consider the psychosocial factors (such as environmental, social, political, and cultural contexts) that may impact and perpetuate an individual's level of mental distress (Borrell-Carrió et al., 2004). Rogers and Pilgrim (2014) note that as the power of the biomedical paradigm is still at large, the biopsychosocial model has modified, rather than replaced, the paradigmatic dominance of biomedical explanations of distress. Indeed, the same authors who proposed contemporary alterations of George Engel's original model state that the biopsychosocial model itself is not a new paradigm (Borrell-Carrió et al., 2004). Although the biopsychosocial model may challenge the reductionist aetiological theory of the biomedical paradigm, the systemic prevalence of the biomedical paradigm leads the biopsychosocial model to still privilege biological factors and explanations (John, 2005; Johnstone et al., 2018; Pilgrim, 2013; Read & Harper, 2020). Consequently, the biomedical paradigm is understood to be the current dominant mental health paradigm.

Understandings of Climate Change-Related Distress Within the Biomedical Paradigm: Problems and Pitfalls

In light of Morton's (2018) assertion of the challenge of coming into contact with climate "factoids", this paper will not include variable statistics of stark temperature changes, grim predictions, and imminent risks, but rather affirm the known and well-documented existence and ongoing ecological impacts of climate change. In their research on the psychological impacts of climate change on First Nations and farming communities,

Cunsolo and Ellis (2018) popularised the notion of “ecological grief” (p. 275), which they define as experienced or anticipated ecological loss of species, ecosystems, and meaningful landscapes due to acute or chronic environmental change. Although this term requires refining to delineate it from other notions of grief and other climate-related distress (Comtesse et al., 2021; Cunsolo & Ellis, 2018), research and activist communities typically advocate for a response to CCRD (Wu et al., 2020). Indeed, young people are increasingly engaging in climate activism (BBC Future, 2019), and “climate emotions” is now a common theme in news reporting (BBC Future, 2021).

The diverse impacts of climate change can lead to CCRD in a number of complex, yet evident ways: ecological destruction; displacement; material, food, and water scarcity and inequality; conflicts and violence; physical impacts of extreme weather events; and other impacts such as infectious vector-borne disease (Watts et al., 2018) could all likely contribute to experiences of distress. Across the globe, the notion of CCRD has gained attention within academia and psychological organisations (Burke, 2017; Swim et al., 2009), with most authors urging for further research into CCRD (Cunsolo & Ellis, 2018; Gibson et al., 2019), including intervention and policy development (Charlson et al., 2021).

Other terms have been developed to describe CCRD, such as “solastalgia” (Albrecht et al., 2007), “climate trauma” (Woodbury, 2019), and “eco-anxiety” (Coffey et al., 2021). This paper will address these and other conceptualisations of distress related to climate change collectively as CCRD. Although these terms can be meaningful for some people, and their development contributes to important social discourse around the topic of climate change, this article attempts to speak to the experience of distress more broadly by using accessible language that avoids value-laden terms provided in the *DSM-5* (e.g., “anxiety”) and jargon (e.g., “solastalgia”) that is disproportionately accessible to those with academic, educational, or social privilege (Morgan et al., 2022).

Over-Simplification

It is widely accepted that climate change is a real threat that has devastating individual and community impacts: It is perceived as a problem *out there* that people are facing (Flynn et al., 2021). As concern about climate change reaches worldwide discussion, resources discussing the topic of CCRD that utilise dominant biomedical understandings of distress often mention how human brains are “wired” to ignore the perilous facts about climate change (Gifford, 2011; Marshall, 2014). Framing responses to climate change as an internal problem of biological or brain functioning exemplifies the central tenet of this biomedical paradigm (Deacon, 2013; Deacon & McKay, 2015; Rogers & Pilgrim, 2014). Indeed, in their call to action, Wu et al. (2020) shared concerns of how climate anxiety may lead to “permanent alterations in brain structure and the emergence of psychopathologies later in life” (p. e435). However, this approach seems reductive when considering the substantiated complex interrelated social, material, and political structures related to climate change (Adams, 2021a). Schmitt (2020) argues that within the dominant contemporary psychology paradigm, “psychological processes that deter

climate action are too frequently abstracted from the larger social context, giving the impression that inaction is due to immutable aspects of human psychology and obscuring the potential for transformative social change" (pp. 124–125). Dissemination of this biomedical stance that blames an innate element of the human brain for difficulties coping with climate change and CCRD may lead to oversimplification of notions of climate change, CCRD, and climate inaction (Adams, 2021a; Kent, 2009; Morgan et al., 2022; Schmitt et al., 2020). This over-simplified explanation of CCRD, produced as a result of the biomedical paradigm, leads to obscuring of the inextricable and complex social and political structures implicated in such problems (Adams, 2021a; Kent, 2009; Morgan et al., 2022; Schmitt et al., 2020).

Obscured Power Discourses and Collective Action

The perpetuation of the individualistic stance of the biomedical paradigm shifts the focus away from complex interrelations of individuals, communities, and cultures interacting with climate change as a "hyper-object" (Morton, 2018, p. 22). This stance also obscures important human rights-based actions, such as amplifying the voices of those with lived experience of climate-induced weather events, anti-oppression work, liberation, solidarity, and accountability practices (Ali & Lees, 2013; Toporek, 2018; World Health Organization, 2021). Such processes are necessary to incite and maintain collective action that leads to social and political change (Randall, 2020; Selvanathan & Jetten, 2020; Whyte, 2014).

Associated power relations, as well as extant community-based understandings of distress (Riemer & Reich, 2011), are often hidden or obscured when climate change is discussed with the narrow, individualistic focus inherent to the biomedical paradigm (Adams, 2016, 2021a; Schmitt et al., 2020). The narrow focus propagated within individualistic discourses of mental distress, including CCRD, renders invisible systemic power injustices that increase the risk of experiencing CCRD: experiences of poverty, houselessness, racism, and economic or political oppression (Watts et al., 2018). In contrast, contemporary resources speak to the responsibility of individuals to access resources for coping (Burke, 2017) and advocate for individual behavioural change (Adams, 2021a). This approach omits corporate and governmental responsibility (Wetts, 2020), and is regularly criticised because it places blame on individuals for harm done by powerful institutions (Kent, 2009).

Dominant voices within the mental health industry, such as the Australian Psychological Society (APS), exemplify this stance. On its website, the APS (n.d.) states that maladaptive strategies to CCRD include wishful thinking, diversionary tactics, unrealistic optimism, and resignation. Coping strategies include a problem-solving attitude, cognitive restructuring, and expressive coping. Drawing on Foucault's *Madness and civilisation*, Fennig and Denov (2019) describe how such categories are socially and culturally created over time, and are a part of a larger "discourse" (p. 304) influenced by power and the hegemonic control of the biomedical paradigm that exists within widespread ideologies such as neoliberalism (Sweet & Decoteau, 2018). The use of such behaviours as the benchmark to describe CCRD supports the development of a pathologising lens in

which, for example, participating in collectivised climate activism in a way that leads to arrest or criminal conviction could be classed as maladaptive behaviour, or a symptom of a mental health disorder. This pathologising lens obscures that these behaviours are important, adaptive responses (Verplanken & Roy, 2013) that can create cultural and political influence (Fisher & Nasrin, 2021).

Amongst a conceptually congruent backdrop, the subject of the individual has a place in engendering ecological restoration and transformation (Adams, 2021a). However, the pervasive biomedical paradigm leads to a significant emphasis on pathologising individual behaviours for coping with CCRD, thus obscuring the public episteme of the systemic power injustices that contribute to climate change and CCRD (Clayton, 2020, p. 3). Indeed, individualistic discourse is rife in neoliberal societies where mental distress becomes a mechanism for maintaining capitalistic aims (Cohen, 2016; Zeira, 2021). As Schmitt et al. (2020), citing Fuchs et al. (2016), notes, individualistic, pathologising constructions of responses to climate change "[neglect] to raise questions about the failure of democratic institutions, how power is distributed, and why people in positions of power choose to use that power in particular ways" (p. 128). The current focus on individual behaviour change, and the subsequent shift of accountability away from contributing corporations and governmental and systemic factors, and the resultant undermining of the impact of collective action (Kent, 2009; Schmitt et al., 2020) is unlikely to produce scaled structural and social transformation necessary to mitigate ongoing ecological destruction (Adams, 2021a).

Social and Cultural Incongruence

There is a credible risk that individualistic discourses around CCRD can serve to absolve powerful corporations of their share of responsibility and thus serve their interests. Some companies have been found to purposefully misinform policymakers and the general public about the causes of climate change (Supran & Oreskes, 2017, 2020). Furthermore, 70% of contributing emissions are emitted by only 100 such companies worldwide (Griffin, 2017), whose capitalistic and consumerist structures contribute to climate change and global suffering (Flynn, 2021).

It has been suggested that individualistic discourses can invalidate community struggles, especially for marginalised people who experience epistemic injustice (Byskov, 2021) against their communities by powerful conglomerates and institutions (e.g., people of colour and First Nations People; Barnwell et al., 2020). These same communities are disproportionately affected by climate change and CCRD (Hayes et al., 2018), compounding other forms of oppression and injustice (Morgan et al., 2022; Woodbury, 2019). Indeed, Watts et al. (2018) note that mental health impacts "are often products of long and complex causal pathways, many of which can be traced back to distal but potent root causes, such as famine, war, and poverty, of which climate change is an accelerator" (p. 594). Consequently, the individualistic framing of distress within the biomedical

paradigm may displace vital justice-focused community perspectives (Fernandes-Jesus et al., 2020) with incongruous conceptual understandings and subsequent ineffective methods for addressing CCRD (Lebowitz & Appelbaum, 2019).

Importantly, individualistic Anglocentric constructions of mental distress in the biomedical paradigm are known to not be useful, and are harmful for First Nations Peoples (Coe, 2021; Dudgeon & Walker, 2015), who are at high risk of experiencing CCRD (Hayes et al., 2018; Middleton et al., 2020). Furthermore, collective justice-seeking action and decolonising methods around climate change and CCRD used by these communities are often underfunded (Cuffe, 2021), silenced (Lakhani, 2021), and even criminalised (Bell, 2020; Taylor, 2021). One investigation of culturally relevant idioms related to CCRD in Tuvalu included a contextual sociopolitical discussion, but nonetheless concluded with a recommendation for these culturally held terms to be described as corresponding to disorders within the *DSM-5* (Gibson et al., 2019). This rewriting of culturally relevant wisdom imposed an Anglocentric, individualistic, biomedical conception of diagnosis and treatment for those experiencing CCRD (Gibson et al., 2019). This exemplifies the influence of present-day colonisation (Coe, 2021) and the need for fostering cultural democracy (Akinyela, 2014), decolonising practices (Eatock et al., 2021), and congruent engagement with Indigenous and relational ontologies (Adams, 2021b) within the unfolding academic concepts and public descriptions of CCRD.

Consequently, the development of practices to support people experiencing CCRD must navigate the tension between dominant biomedical frameworks of understanding and a realisation of the social, cultural, and political contexts and meanings of CCRD. An epistemologically appropriate framework to describe CCRD is necessary to understand CCRD and the context surrounding this experience, so that societal resources and public policy can shift to address this urgent need (Cunsolo & Ellis, 2018; Morgan et al., 2022).

An Alternative Framework for Understanding and Responding to Climate Change-Related Distress: The Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) was developed by the British Psychological Association as a conceptual alternative to psychiatric diagnosis and the medicalisation of distress, coproduced by people with lived experience (Johnstone et al., 2018). The PTMF can be summarised in the following questions, which can apply to individuals, groups, or communities: “What has happened to you?” (How is power operating in your life?), “How did it affect you?” (What kind of threats does it pose?), “What sense did you make of it?” (What is the meaning of these situations and experiences to you?), “What did you have to do to survive?” (What kind of threat responses are you using?), “What are your strengths?” (What access to power resources do you have?) and “What is your story?” (How does it all fit together?; Johnstone et al., 2018, pp. 190–191).

The PTMF gives a detailed description of why the current biomedical paradigm is not epistemologically appropriate in describing the complexities of the human experience, and how this has failed people who seek support for their distress.[1] The PTMF offers a vastly different way of conceptualising distress when compared with the biomedical paradigm. In the PTMF model, distress is recognised as an understandable, skilled response to negative uses of power that lead to adversity and injustice (Johnstone et al., 2018). Use of this de-individualised framework therefore mitigates risk of centring CCRD around an individual's pathology or personal failings (Chamberlain et al., 2021). The framework also challenges professionals to shift away from the biomedical paradigm and instead turn toward prioritising understandings of the cultural, political, and systemic power injustices that impact people and communities (Whitaker et al., 2021). Use of the PTMF has been reported by some people with lived experience of distress to instil hope, reduce stigma, provide empowerment, and create a better experience when compared to the current mental health system (SHIFT Recovery Community, 2020). Working towards the intersection of community and individual narratives is transformative within climate activism spaces (Kluttz & Walter, 2018), and the PTMF places specific emphasis on collective narratives (Llewellyn-Beardsley et al., 2019).

Barnwell et al. (2020) investigated use of the PTMF in community-level distress around climate change-related environmental events in South Africa. In their qualitative investigation, community members spoke about mining-related environmental threats, such as water scarcity and contamination, which have been worsened by climate change. Extant unequal power distribution and racial environmental injustice led to psychological distress, which was framed not as a vacuous occurrence, but as part of cumulative community-level psychological adversities (Barnwell et al., 2020). The authors concluded that the "PTMF therefore assists practitioners in moving beyond an individualistic or medicalised conceptualisation of climate-related distress to one that is social ecological" (Barnwell et al., 2020, p.13). Use of the PTMF in response to CCRD may include using questions to identify operations of power, threats, the meaning of these experiences to the person or community, threat responses, and strengths (Johnstone et al., 2018; Morgan et al., 2022). These are used to construct a larger narrative which combines all of these elements into a meaningful story (Rajendra, 2019). This process can enable a reclamation of a CCRD-related story that captures the dominant role of power and privilege in this narrative (Johnstone et al., 2018; Morgan et al., 2022). Indeed, climate change disproportionately affects those already marginalised by other negative misuses of power such as poverty, racism, houselessness, and displacement (Hayes et al., 2018; Page et al., 2012). Recently, Morgan et al. (2022) introduced "ecological power" as a form of power operations described in the PTMF and provided examples of ecological power, threats, threat responses and strengths that speak to an experience of "responding to climate breakdown" (p. 96). This process attempts to render power relations and dynamics visible, and thereby validate distress responses as intelligible considering the systemic and epistemic injustices (Byskov, 2021) that have led to and perpetuated climate change and CCRD (Johnstone et al., 2018; Morgan et al., 2022).

The PTMF recognises that ongoing colonisation shapes distress responses and that anti-oppressive and decolonising processes are vital in developing rich community narratives using the PTMF (Johnstone et al., 2018). Concurrently, the PTMF also acknowledges the challenging task for professionals to strive toward this non-expert stance while working amongst powerful systems, institutions, and policies that still operate within a biomedical paradigm (Johnstone et al., 2018). Morgan et al. (2022) condone the PTMF as one non-universalised alternative to understanding CCRD, existing despite and counter to dominant, entrenched ways of being, knowing, and doing within mental health settings (Cooke et al., 2019). In the emerging space of exploring notions of CCRD lies opportunity for effective research and practice that is informed by the PTMF, prioritising the social, political, and cultural nuances and complexities of diverse communities impacted by climate change (Morgan et al., 2022).

Is it important to note that the nondiagnostic approach of the PTMF has faced criticism from neurodivergent communities (AADD-UK, 2018), as they advocate for a politic of diversity and neurodivergent-affirming practice, in which diagnosable neurological differences are not inherently bad (Krcek, 2013). This exclusionary rhetoric counters essential tenets of the PTMF itself: mainly, that varied responses and ways of being or identifying are meaningful contributions to individual and community narratives. Indeed, the social model of disability challenges the individualism of the medical model of disability, advocating for a shift in focus towards extant power injustices and social, political, and cultural inequalities (Berghs et al., 2016), including those which operate within the climate crisis specifically (Barker et al., 2022; Office of the United Nations High Commissioner for Human Rights, 2020). Such ableism has been noted to occur within climate-activist spaces, where variable sensory or feeding needs are individualised and critiqued, rather than recognised as the failure of social systems and structures to provide climate-safe practices (Jenks & Obringer, 2019; King & Gregg, 2022).

Neurodivergent communities offer diverse ways of responding to CCRD that also challenge the dominant biomedical paradigm. Indeed, Greta Thunberg has named her neurodivergence a “gift” (Thunberg, 2019, p. 193) that is vital to perseverance in climate activism (Moriarty, 2021). The central tenet of acceptance and recognition of difference in the Neurodiversity Movement (Runswick-Cole, 2014) could aid in validating a diverse range of CCRD responses which can then be meaningfully captured to make sense of the climate crisis. The intersectional identities of marginalised people, usually most affected by CCRD, warrant validation and consultation as to the ethical congruency of the PTMF. Indeed, a critical approach should advocate for alternatives, seek consultation from neurodivergent lived-experience communities, and also turn such analyses towards held privilege and power, and unchecked ableism.

Conclusion

The dominance of the biomedical paradigm has led to widespread mischaracterisation of distress responses to climate change as unintelligible and pathological. This mischaracterisation functions as an epistemic injustice that obscures issues of systemic

injustice and oppression. The emerging notion of CCRD has begun to be viewed, researched, and approached through the lens of the dominant biomedical paradigm in mental health contexts. Subsequent individualistic discourses within dominant systems of mental health research and practice, perpetuated through ongoing colonisation and neoliberal capitalism, obscure manifest operations of power and systemic injustices that contribute to climate change and CCRD. Such discourses have led to popularised dissemination of individualistic research and resources for CCRD, shifting focus away from collective-centred initiatives that are more culturally relevant for people whom the literature shows disproportionately experience CCRD (Hayes et al., 2018; Middleton et al., 2020), such as First Nations communities. The collectivised political and social activism within these communities is also frequently criminalised and invalidated, rather than promoted as impactful and necessary, stifling efforts to shift the looming trajectory of climate change and obscuring the current reality of ecological destruction.

One example of an epistemologically appropriate framework for the description and exploration of CCRD is the PTMF, which acknowledges colonisation and systemic injustice as important factors in climate-related distress. With the inclusion of critical and congruent engagement with marginalised populations, including neurodivergent communities, understanding CCRD as an intelligible and mentally adaptive response to climate change through use of the PTMF can make way for opportunities to understand collective action as an important cultural, social, and political force. The PTMF offers opportunities to validate liberating strategies in the face of ongoing environmental injustice and, with care, to centre decolonising and anti-oppressive processes within the helping professions and research communities to address the needs of diverse communities affected by anthropogenic climate change.

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Footnotes

[1] Some examples include: that researching for causes of mental disorders such as “schizophrenia” is not useful as such categories lack validifying evidence, that such research obscures the well-established link between social and interpersonal factors with distress, and that diagnoses remove intelligibility from thoughts, emotions, and actions, leading to shame, invalidation and disempowerment. See Chapter 1 in Johnstone et al. (2018) for a detailed explanation.

Rana Rose Kökçinar *(they/she) is a passionate climate activist and is interested in the theoretical, philosophical, and practical discourses around climate change-related distress. They currently work as senior psychotherapist at Expressive Therapy SA on unceded Kaurna land.*

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