

ARTICLES

The Power Threat Meaning Framework and Self-Discrepancy Theory: Complementary Perspectives

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The efficacy of psychotherapy is now well-established, and research has provided strong evidence for several change factors, such as the therapeutic relationship, insight, corrective experiences, and reality testing (Goldfried, 2019). Increased understanding of the therapeutic change process has been a notable advance in psychotherapy, but an agreed view of the nature and causality of psychological problems has eluded the psychotherapeutic professions. The dominant medical paradigm within psychiatry and psychology asserts a predominantly neurobiological basis for psychological problems while humanist and relational paradigms prefer a broader and meaning-oriented basis for understanding such problems. This paper provides a review of one alternative conceptual framework, the Power Threat Meaning Framework (PTMF) developed by the British Psychological Society. While the PTMF offers a comprehensive alternative method for conceptualising mental health, it does not provide a specific practice roadmap. The framework's authors encourage therapists to apply the PTMF in conjunction with their own theoretical preferences. In this paper, I have two aims: the first, to outline and examine the principles inherent within the PTMF, and the second, to provide an example of how the PTMF might be operationalised using an existing theoretical model, self-discrepancy theory (SDT). While the principles of the PTMF can be integrated with a host of theories of psychotherapy, SDT is utilised here as an heuristic to demonstrate the utility of the PTMF.

When we speak of mental health or mental illness, we can do so from several perspectives. The first is what might be called a normative cultural understanding. By this is meant that people within their respective societies and cultures have a common-sense view of what constitutes “normal behaviour”. This common-sense view is underpinned by a shared intuition of what is considered acceptable social behaviour. Evidence for this normative view suggests that when an individual is referred to mental health professionals, such as counsellors, psychotherapists, psychologists, and psychiatrists, it is generally because relatives, friends, and the general practitioner have all assessed the individual's thoughts and behaviours as atypical. Once a person has been referred to a psychiatrist, a second perspective on mental health and illness tends to come into play. At this point, patterns of behaviours and thoughts that are often deemed non-normative are then codified, that is, they are labelled.

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While lay persons and mental health professionals might all agree that a particular individual's thoughts and behaviours do not conform to socially agreed norms, diagnosing an individual's behaviours and subjective experiences fundamentally alters the category from that of description and exploration of meaning to a determination that the individual possesses an illness.

How we make sense of atypical social behaviour reveals something of our philosophical commitments, whether we are consciously aware of them or not. It is one thing to observe or intuit certain behaviour as non-standard, it is quite another to assert that someone *has*, that is, is in possession of, a mental illness. In the first instance we are observing a particular view of reality, in the second we are assigning a reality. These are quite different processes. The first observation attempts to make sense of what is observed from an open-minded perspective, the second from a closed perspective. It is true that both observers are attempting to make sense of what they see; however, the assumptions upon which they determine their understanding are quite different. Now, if this were an abstract philosophical discussion, its relevance to mental health practice might be limited. However, when we involve societal structures such as state mental health systems with associated legal and economic powers, the bearing of such a discussion on the individual is significant.

Backgrounding a Non-Disease Model of Care

Psychotherapy, like all disciplines, is situated within a wider social and cultural context and system that orientates how people think about life and consequently organise society. Our social and cultural worldview to a large degree informs our values, priorities, and understandings. While worldviews are always in a state of flux, at different times in history certain worldviews and philosophies tend to dominate, influencing personal and social perceptions and priorities. The 20th century was dominated, in large part, by positivism, which holds that there are fixed unchanging universal laws that are measurable and verifiable and, as such, provide the only knowledge of real significance (Bird, 2012; Kuhn, 1970). The implication of this view is that metaphysical ideas that are not measurable in scientific terms are of lesser value and significance. While the philosophical legitimacy of positivism has largely been disavowed in the academy, its influence is still evident in societal perspectives, structures, and organisation (Karupiah, 2022; Mazur, 2020). The tension between a positivist orientation—well expressed by the “evidence-based” maxim in medicine and psychology—and the more emergent (not fixed) subtleties of human communication, relationships, and attachment within the practice of psychotherapy highlights governments' struggles to understand how best to prioritise funding for various allied health disciplines and, through them, support for community health.

It should be said that the influence of positivism has not been all bad since it has given rise to numerous scientific breakthroughs, of which we are all beneficiaries. However, it has left lingering negative effects, such as how we assign social values and therefore prioritise government funding—an example witnessed in the difference between funding allocated for the sciences and the

arts (Davies, 2013; Pennington & Eltham, 2021). More particularly for this readership, the effects of positivism are seen in the relative social positioning between psychiatry and psychotherapy (Enache-Tonoiu, 2013; Tavakoli, 2014). It is clear from the structure of the health care budget in Australia that psychiatry is valued as the pinnacle of mental health care, certainly for those service users understood to be at the more complex end of the mental health continuum. By way of illustration, in 2013 the direct health expenditure on psychiatry was \$277 million, while the direct spend on the combined allied health professions was \$16 million (Medibank Private Limited & Nous Group, 2013). This fact raises the question, “On what basis is psychiatry so positioned within the health care sector?” I suggest that there is one overriding reason for the dominance of psychiatry: “diagnosis”. Diagnosis is an interesting term because it has within it several root connotations. The everyday meaning is “the identification of an illness” (“Diagnosis,” 2015). This definition places diagnosis squarely within the medical domain since illness implies organic disease or dysfunction. However, diagnosis also contains in its etiological roots the meaning “the characterization in precise terms of a genus, species, or phenomenon” (“Diagnosis,” 2015). This alternative definition emphasises how we describe or characterise a phenomenon and, in itself, has nothing directly to do with disease (Pickersgill, 2014).

I labour this point of definition because within the current zeitgeist, health care professionals and society at large automatically default to diagnosis as a process of uncovering illness and disease; yet, if we favoured the alternative meaning, “the process of making sense of a phenomenon”, this would potentially shift assumptions about human suffering away from a disease model towards an organismic process-experiential one. Unfortunately, under the influence of a positivist lens many therapists are principally disease detectives. This unfortunate state of affairs reflects a fundamental positivist mistake, wherein it is held that we observe the world objectively or directly without any intervening processes. In other words, if we can observe it and measure it, it must be true. This *naïve realism* is best exemplified in the mental health field by the assumption of professionals that what they diagnose or call reality *is* reality (Pilgrim, 2020). The particularly disturbing aspect of this orientation is that it tends to colour our professional lens, so that instead of regarding clients as *people in distress* we see *disease processes*.

While we counsellors and psychotherapists have long advocated for a humanising phenomenological perspective of human struggle and distress, in our everyday practice we have had to deal with a system committed to a disease model. The difficulties of advocacy and influencing the dominant medical model evidence Kuhn’s (1970) argument of the incommensurability of paradigms wherein there appears to be little capacity for an integration of paradigmatic ideas, which inevitably renders one paradigm dominant at any given time. That said, paradigms and worldviews are not static, and there is evidence of a shift towards a more humanistic and integrated understanding within the health sector, albeit a slow, incremental one (Bru-Luna et al., 2022).

The Power Threat Meaning Framework

One notable marker of a shift in system thinking within the health care sector was the publishing of a statement by the Division of Clinical Psychology (DCP) of the British Psychological Society (BPS) in 2013 about the then newly published *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013):

The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD [International Classification of Diseases], in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a “disease” model. (Division of Clinical Psychology, 2013, p. 1)

Advocates of a non-disease model within the BPS took the challenge seriously and developed the beginnings of an alternative mental health framework known as the Power Threat Meaning Framework (PTMF; Johnstone, 2020; Johnstone & Boyle, 2018b). This framework has been described by the developers as “an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour as an alternative to psychiatric diagnosis and classification” (Johnstone & Boyle, 2018b, p. 5). Rather than regarding human beings as objects acted upon by causal forces, these authors view people as agents who have reasons for their actions. They also note that while alternative paradigms have always existed, the field has lacked “a supporting conceptual framework which works at a broader clustering and pattern-identification level” (Johnstone & Boyle, 2018b, p. 13).

Pattern identification, otherwise conceptualised as diagnosis within a mental health framework, is important because it serves several essential social purposes, namely identifying causal factors and grouping similar types of experiences together, recommending interventions, and providing a basis for administrative decisions and commissioning services. The point made by the creators of the PTMF is that diagnosis serves these functions extremely poorly and that “there are more effective, non-diagnostic ways of fulfilling these purposes” (Johnstone, 2020, p. 4). The approach to pattern identification advocated by the PTMF should not be perceived as simply an alternative approach to diagnosis but as a fundamentally different way to understand human behaviour and distress. Any viable framework must account for the influence of biological, relational, social, cultural, and material factors of distress. The PTMF seeks to integrate these various factors, emphasising that distress is a response to a person’s psychosocial development and history, is linked to social injustice, and is fundamentally about meaning-making.

To aid pattern identification, the PTMF highlights several general principles:

1. Patterns of human functioning are organised by meaning, not biology.

2. Since meaning is the core element, the natural science notion of causality does not apply because meaning is contingent on multiple factors, each potentially influencing the other, rendering prediction unreliable. Patterns that may be observed should be understood as imprecise and overlapping.
3. General patterns of human behaviour and responses represent what people “do”, not what people “have” (Johnstone, 2020).

In appreciating these general principles, it is important to recognise that meaning does not exclude biology. However, rather than placing biology (disease/dysfunction) as the principal explanatory factor, biology is placed in the service of meaning-making. For example, the fight, flight, freeze response has clear biological drivers, but instead of seeking to moderate neurochemical pathways through medication, knowledge of biology and neuroscience is used to inform meaning-making and consequent adaptive responses. The same example illustrates the second general pattern in that neurological responses are not understood to be causal mechanisms of human distress alone, rather it is our response to the activation of neurological mechanisms, in the above examples, or to social or psychological mechanisms, that are central to meaning-making and therefore to healthy adaptation. The reality is that two people under similar levels of duress respond differently at every level of their being. To generalise causal explanations largely on the basis of biology or any other single factor is highly reductionistic.

In contrast to psychiatry’s approach to understanding distress and its maintenance by asking, “What is wrong with you?”, the PTMF asks four different questions:

- *What has happened to you? (How is power operating in your life?)*
- *How did it affect you? (What kind of threats does this pose?)*
- *What sense did you make of it? (What is the meaning of these situations and experiences to you?)*
- *What did you have to do to survive? (What kinds of threat responses are you using?)* (Johnstone & Boyle, 2018a, p. 8).

The assumption underpinning these questions is that emotional distress and problematic behaviour are understandable responses to life circumstances and adversities and not markers of disease or biological dysfunction. The first question assumes that the individual, family or group have had experiences that have affected them negatively and in which they were disempowered. This may have resulted from a series of negative developmental experiences, relational conflicts, or explicitly traumatic experiences, such as sexual abuse. The principal result of the misuse of power is an experience by the individual,

family or group of a threat to wellbeing, that is, a threat to the meeting of a person's core needs. Johnstone and Boyle (2018a) have provided a general list of core needs which comprise:

needs for safety and security; as infants and children, close attachments to caregivers; positive relationships within partnerships, families, friendships, and communities; to have some control over important aspects of our lives, including our bodies and emotions; to meet basic physical and material needs for ourselves and our dependents; to experience some sense of justice or fairness about our circumstances; to feel valued by others and be effective, in our social roles; to engage in meaningful activity and, more generally, to have a sense of hope, meaning, and purpose in our lives (p. 9).

When an individual has negative experiences owing to the misuse of power of any kind, they experience a threat to which they will attempt to assign meaning. The problem is that the meaning assigned to such experiences is often confused, defaulting towards self-blame and devaluation. It should be noted that meaning incorporates a whole-of-person experience. As Johnstone and Boyle (2018a) explain, "Meaning is understood here as being constituted through both beliefs and feelings, as well as through bodily reactions, and symbols" (p. 9). The meaning of the question "What has happened to you?" is a collective product of cognition, feelings, bodily potentialities, and social discourses, a complex combination of felt sense, social messages, and cognitive constructs.

Case Formulation

One of the applications of the PTMF is case formulation outside of a diagnostic mindset. Formulation from a PTMF perspective can draw on different theories of change, that is, theories of psychotherapy, as long as formulations are non-pathologising. Formulation in PTMF draws together and identifies patterns, described in a narrative fashion and constructed jointly between the therapist and client. Johnstone (2017) describes formulation "as the process of co-constructing a hypothesis or 'best guess' about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them" (p. 3). Formulation from this perspective is also not a product, but rather a process of two people making sense of experience, which may change and develop over time.

Self-Discrepancy Theory

The PTMF does not prescribe a way of doing therapy but rather argues for a non-pathologising way of thinking about the human organism as a relational, socially situated being with enormous capacity for change. The answers to the four heuristic questions linked to the notions of power, threat, meaning, and response can be conceptualised within different theories of psychotherapy, rendering the PTMF a highly beneficial and inclusive framework. While it

is not possible in this paper to provide a range of exemplars of the PTMF using different theoretical models, it will be helpful to examine a theory that is representative of one major theoretical paradigm, the humanistic/organismic paradigm. There are many complementary theories within the humanistic/organismic cadre of theories, but the one selected here is self-discrepancy theory (SDT) (Higgins, 1987). SDT is an extension of person-centred theory and shares many of its theoretical commitments. Discrepancies are understood to be incongruencies between the *real/genuine self* and the *ideal self*. Rogers (1959, 1961) proposed that the real self represents the attributes that an individual actually possesses, while the ideal self is a self with the attributes that one would ideally like to possess—a self which reflects one’s goals and aspirations.

Rogers (1951, 1959) proposed that introjected conditions of worth from significant others can lead to a high *real-ideal* discrepancy and that such discrepancy predisposes individuals to emotional distress. Higgins (1987) introduced the notion of an additional discrepancy, the *real-ought* discrepancy. Higgins extended the thinking about the effect of discrepancies by theorising that a *real-ought* discrepancy is uniquely related to anxiety and the *real-ideal* discrepancy is uniquely related to depression. Research evidence broadly supports Higgins’ claim, although there remain some inconsistencies in the findings (Higgins, 1987; Mason et al., 2019; Watson et al., 2014). SDT postulates two dimensions underlying the different self-state representations, namely, Domains of the self (Real; Ought; Ideal) and Standpoints on the self (Own; Other).

The *Ought Self* and *Ideal Self* are referred to in SDT as *Self Guides*, which provide respective reference points for the *Real Self*. When the Self Guides and the Real Self are placed in relationship with each other, six basic self-state representations can be identified:

- Real/Own, Real/Other
- Ought/Own, Ought/Other
- Ideal/Own, Ideal/Other.

A key notion within SDT is that different self-representations lead to different affect states. As stated by Mason et al. (2019), “SDT postulates that it is the relationship between these different self-representations that accounts for their motivational and affect significance including their potential role in emotional vulnerability and psychopathology” (p. 373). The greater the discrepancy between the self-states, the greater the resulting affect state. While it is possible to have several self-state discrepancies, the greater the self-state and self-guide mismatch (discrepancy) the greater the emotional valence. At this point, it should be noted that there are many different conceptualisations of the self, which are beyond the scope of this article to explore (Foucault, 1988; Freud, 1923/1961; Heidegger, 1927/1962; James, 1890/1948; Wittgenstein, 1958). However, it is acknowledged that Rogers (1946) tended to refer to

the self in more unitary terms and that current debates in psychology grapple with the concept of a decentred self, that is, the notion that there is no single self, only multiple selves. A middle perspective here is that of a bounded self, constituted of several self-constellations, or different self-states (Barrett-Lennard, 2003). While it is recognised that the notion of the self is complex, for the purposes of this discussion this middle position provides sufficient recognition of the complexity involved in the issue.

To highlight the application of the PTMF within an SDT approach, the four PTMF questions are examined. The first question—“What has happened to you?”—may more usefully be reframed as “What has happened to your ‘self?’” Incorporation of the word “self” in the question draws attention to subjective and introjected experiences while not negating broader external problematic experiences. Usually, external events can be described relatively easily; however, internal experiences of events are typically more difficult to access. From the perspective of SDT, it is understood that negative experiences have the potential to create self-discrepancies, which negatively affect the developmental or self-actualising process.

A key point of interest in exploring any synergies between the PTMF and SDT, apart from more philosophical interests in the nature of the self, is the clinical benefit that their cross-pollination may provide. The question “What has happened to you?” or its derivative “What has happened to your ‘self?’” might be further refined as “What has happened to your *experience* of self?” This is where SDT potentially offers support to therapists by helping them identify and explore self-discrepancies via attending to emotional and somatic states. While some emotions are accessible to obvious expression, affect states are not always available to awareness (Vandekerckhove & Panksepp, 2009). The extent to which we can access salient yet “non-conscious” experience and how we might go about doing so is a subject of keen research interest, especially in the field of trauma therapy (Levine, 2015; van der Kolk, 2014). One of the potential benefits of SDT is that it draws the clinician’s attention to different affect states and their likely link with meaning-based experience.

For example, Higgins (1987) posits that a large *real-ought* discrepancy leads to anxiety-based feelings and a large *real-ideal* discrepancy leads to depressed mood. When the *standpoints on the self* are added, identification of these base feeling states are further nuanced. Hence, a *real-ought* discrepancy can be seen from one’s own standpoint: “I ought to be or do thus-and-so according to my own internal standards ...” or “I ought to be and do what others expect of me”. Each standpoint creates variations in the base emotional response. In the case of *real-ought/own* domain and standpoint, the primary emotional response is fear and threat. When the standpoint of *other* is added, this base response includes the experience of *shame*. Shame is particularly linked to an assessment of oneself as being of diminished value in relation to others. As trauma researchers, Dabovich et al. (2019) noted, “This focus on others may be construed as the over-valuing of them in relation to the self” (p. 269). While it is regrettable that such negative self–other comparisons often have pernicious

impacts on personal wellbeing, the process of negative self-comparisons is not a disease warranting psychiatric diagnosis. A critical issue here is not just the individual client's meaning-making of their experiences but also the clinician's meaning-making. Clinicians sympathetic to both the PTMF and organismically oriented therapies see the effects of shame in the above example as a common and understandable human attempt at meaning construction, albeit, misconstrued. Pronouncing it as a disorder with a diagnostic label changes the fundamental meaning of this human process.

The second question in the PTMF—"How did it affect you?"—focuses on the effects of negative experiences, particularly on the meeting of core needs. As noted earlier, a wide range of needs could be affected, but in the context of self-discrepancies it should be noted that the negative impact on need satisfaction will be related to the type and degree of discrepancy. For example, the relative gap between the *real self* and the *ought self* or *ideal self* will, in many ways, determine outcomes. The question of needs can be examined in several ways and is beyond the scope of this paper; however, drawing on the work of Ryan and Deci (2020) on SDT, the type and degree of self-discrepancies will be expressed in the degree to which the primary needs of *personal agency*, *personal and professional mastery and competency*, and *satisfactory relationships* are met. The place of needs within therapeutic change is a fascinating topic and well worth further research and development.

The third question proposed within the PTMF is "What sense did you make of it?" While it is essential to identify, acknowledge, and appreciate the effects of negative experiences, the implicit meaning derived from these experiences is often a central turning point in the therapy. While meaning-making can be informed from a breadth of theoretical perspectives, organismically oriented therapies tend to highlight the place that attending to experience plays in accessing self-understanding and personal meaning-making. Gendlin (1996), for example, emphasised the significance of attending to the bodily *felt sense* as a means for making the implicit meaning of a situation or experience evident. Neurobiology and somatic therapies have similarly asserted the importance of attending to the bodily experience of self (Payne et al., 2015; van der Kolk, 2014). This has direct resonance with the focus of SDT on linking different emotional states with specific self-discrepancies. Many therapeutic approaches now recognise the importance of working organically from in-the-moment experience, or more specifically, the *felt sense*, to meaning. SDT might be thought of as a form of heuristic support in this process: firstly, for the therapist, to consider where and in what way a self-discrepancy has blocked or confused meaning for the client; and secondly, for the client, by identifying and discarding these self-discrepancies, thereby enabling a reengagement with experience and the genuine (real) self.

The fourth question proffered by the PTMF is "What did you have to do to survive?" This question refers to how we managed the threat imposed by negative experiences. The type and range of threat responses can be expressed across different domains, such as interpersonal, intrapersonal, and biological.

We know, for example, from adverse childhood experiences studies (Bethell et al., 2019; Jones et al., 2019) that traumatic experiences, in particular, can have profound impacts not just on social functioning but also on human biological processes influencing a range of disease states. Intrapsychic and interpersonal responses to negative experiences are commonly thought of in terms of defence mechanisms and coping strategies. Therapists drawing on different theoretical orientations will interpret and work with the impacts of difficult experiences in different ways. SDT does not address such issues specifically, but therapists influenced by SDT would tend to position their practice from within the humanistic/organismic theories of practice.

Conclusion

It is evident that there is growing discontent with the psychiatric worldview. The fact that the clinical division of one of the oldest psychological associations in the world (the British Psychological Society) has raised substantial objections to the psychiatric mindset and its attempts at basing its legitimacy as a scientific discipline in diagnosis hopefully signals the beginnings of a paradigm shift in how we understand mental health. The PTMF, with the support of other advocates, might be regarded as an emerging bulwark against the dominance of psychiatric thinking. What the PTMF does not provide are the specific tools for working with clients. SDT is just one approach that provides further insight into how clients may be supported to move from troubling experiences of living towards a renewed sense of their own value and agency by connecting more deeply with themselves and realigning self-discrepant meaning with more actualised views of self and other.

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