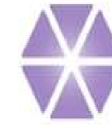
The British Psychological Society

Promoting excellence in psychology



Division of Clinical Psychology

The Power Threat Meaning Framework

An alternative to psychiatric diagnosis

Belfast 2024

@PTMFramework

Slides© Mary Boyle & Lucy Johnstone

The key issue:

People's distress is very real....... They may be extremely low in mood, have disabling panic attacks, be tormented by hostile voices, or have terrifying mood swings.

But are they suffering from *medical illnesses which need diagnosing?* Or do we need completely different ways of understanding distress, which are not based on diagnosis?

Few people can afford to give up diagnosis entirely – it is needed for access to benefits, services etc. BUT *they may decide they do not wish to define themselves and their problems in this way...*

....and professionals should be offering that choice.

‘More of the same’ is part of the problem.

In 2023, a study in JAMA Psychiatry found that over 80% of the Danish population will be treated for ‘mental illness’ at some point in their life, and that subsequently they were ‘more *likely to become unemployed or receive a disability benefit, to earn lower income, to be living alone, and to be unmarried.’*

What can we say about societies which seem to be driving everyone mad – and keeping them that way?

https://www.madinamerica.com/2023/10/eighty-percent-of-the-population-will-get-treated-for-mental-illness-in-their-lifetime-and-theyre-worse-off-afterward

Mental Health, Human Rights and Legislation

‘A fundamental shift is required within the field of mental health’

Stigma, discrimination, and other human rights violations continue in mental health care settings. There is an overreliance on biomedical approaches to treatment options, inpatient services and care, and little attention given to social determinants and community-based, person-centred interventions. Legislation can help ensure that human rights underpin all actions in the field of mental health…

Mental health and well-being are strongly associated with social, economic, and physical environments, as well as poverty, violence, and discrimination. However, most mental health systems focus on diagnosis, medication, and symptom reduction, neglecting the social determinants that affect people’s mental health.

World Health Organisation and United Nations 2023

https://www.who.int/publications/i/item/9789240080737

The PTMF Framework: Narratives not diagnoses

'We are all story-tellers and meaning-makers'

The PTMF supports the use of all kinds of narratives or personal stories instead of diagnostic labels. This can help people to create new, non-medical, hopeful narratives about their lives and circumstances, instead of seeing themselves as 'mentally ill' or 'disordered.'

'Instead of asking what's wrong with me, ask what happened to me.'

The PTMF is about all of us

The PTMF Framework: Narratives not diagnoses

- Developed by a group of psychologists and service users with a wider reference group
- Funded by the British Psychological Society's Division of Clinical Psychology but not an official DCP or BPS model
- An optional set of ideas and resources for anyone to draw on
- ….not a manual of 'how to do it'
- Supporting, not replacing, current non-diagnostic approaches including trauma-informed practice….

…..as well as suggesting new ways forward

The Power Threat Meaning Framework

Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis

January 2018

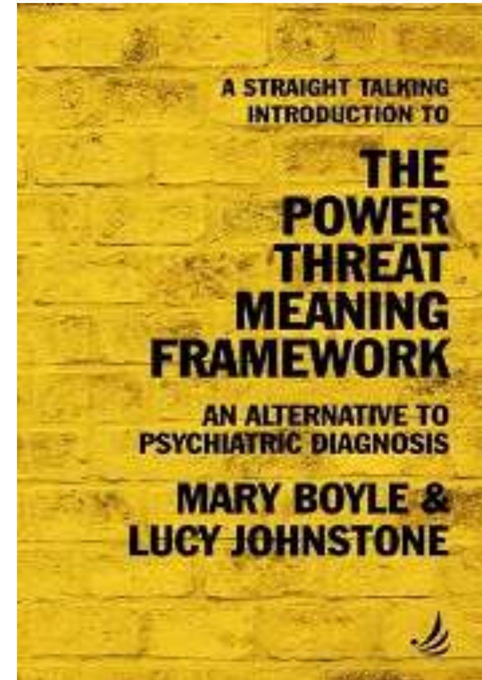
Main Document

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

The Power Threat Meaning Framework

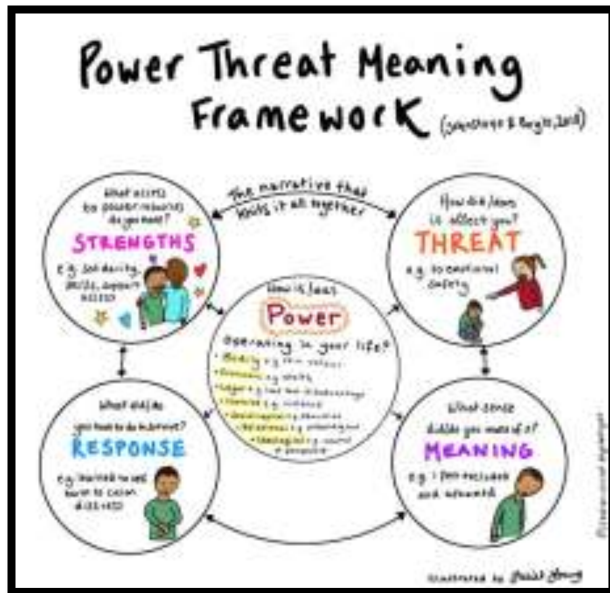
Overview

January 2018



https://www.pccs-books.co.uk/products/a-straight-talking-introduction-to-the-power-threat-meaning-framework-an-alternative-to-psychiatric-diagnosis

The PTM Framework poses these core 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 experiences to you?)

- *'What did you have to do to survive?'*

(What kinds of **Threat Response** are you using?)

‘WHAT ARE YOUR STRENGTHS?’

(What access to **Power Resources** do you have?)

Supportive friends, partners, family, professionals, teachers, officials, communities, material resources, social capital, health, positive identities, education, skills and access to knowledge

….. and to pull everything together -

‘WHAT IS YOUR STORY?’

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

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

Why is Power so central in the PTMF?

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

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

…..all arise from power differences between:

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

The importance of ideological power – power over language, meaning and perspective

- Probably the least obvious form of power. It is when our thoughts, beliefs and feelings are ignored, discounted or disbelieved, often by more powerful groups, and alternative meanings may be imposed instead.

- For example: rape (‘She asked for it’); poverty (‘They’re welfare scroungers’); the consequences of trauma (‘They are psychotic/personality disordered/mentally ill.’)

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

Ideological power is often shaped by gender role stereotypes

In the UK, women are over-represented in MH services, and are more likely to be trapped in violent relationships, to have low paid jobs, and to carry the main responsibility for childcare.

'One of the reasons I felt so down was because I had to admit to myself that I was not a perfect mother... and my feeling deep down was that I was failing as a mother if I couldn't cope with being at home.'

Men are over-represented in the criminal justice system, in drug and alcohol services, and among the homeless. They are at higher risk of suicide, and are less likely to ask for help.

'I am the man in this relationship. I am meant to be the man…to take care of the missus and my kids. And I don't, and I hate feeling like I do with myself because of it.'

Pressures on young people

'Why are so many clever, privileged teenage girls on antidepressants?'

Ella is slim, attractive and a gifted dancer with hopes of studying drama at university. She comes from a secure, loving family with professional parents and two siblings with equally rosy prospects. But following an attempt to end her life last spring, she has been on medication for depression for more than a year. It came after six months of therapy which, ultimately, failed to halt the intrusive thoughts that plagued her. That she'd never be pretty enough, or popular enough, or clever enough... "The pressure of trying to keep up with everyone else never stops. I never feel good enough. I go on to Instagram and see my friends meeting up together and think: why aren't I there too?...I see boys commenting on pictures of girls at school, saying how hot they look, so I think I have to look like that too...Girls lies about their exam marks, because everyone's in competition with each other." (Ella's mother said) "Ella said she hated herself and I don't know why. There's nothing wrong with her – she's beautiful and wonderful"'.

(Daily Mail, 8.10.20)

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

- Relationships eg rejection, abandonment, isolation
- Emotional – eg overwhelming emotions, loss of control
- Social/community – eg social roles and status, community links
- Economic/material – eg financial security, housing, basic material needs
- Environmental – eg safety and security, links with the natural world –
- Bodily – e.g. violence, physical ill health
- Value base – eg threats to your beliefs and basic values
- Meaning making – eg about important aspects of your life/imposition of others’ meanings

‘What sense did you make of it?’
(What is the **Meaning** of these experiences to you?)

Human beings actively make sense of their world, and their behaviour is purposeful and meaningful

But what do we mean by ‘meaning’?

Instead, personal meaning is both ‘made and found’. It is shaped by:

- Common understandings about what it means to be ‘mentally ill’, a ‘good mother’, a ‘happy family’, a refugee, and so on (‘discourses’)
- Ideological meanings – deeply embedded assumptions and values about the world that serve certain interests (for example, in most Western societies, competition and personal achievement is valued more highly than co-operation and the good of the community)

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

We have all evolved to be able to respond to threats, by reducing or avoiding them, adapting to or surviving them, and trying to keep safe. In psychiatric terms, they are ‘symptoms.’

These threat responses are biologically-based but are also influenced by our past experiences, by cultural norms, and by what we can actually do in any given circumstances.

They are on a spectrum from automatic (more biologically-based) to more personally and culturally-shaped.

Some examples of threat responses

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

Restoring the link between Threats and Threat Responses

Or- restoring the link between personal distress and social injustice

Psychiatric practice and diagnostic thinking in general, obscures the links between threats and threat responses by imposing a diagnosis and then 'treating' an 'illness.'.

At one level this is common sense. We all know that people living in poverty are more likely to feel miserable and desperate ('depression') and research shows that abuse and trauma makes it more likely that people will hear voices ('psychosis' or 'schizophrenia.')

But a number of factors combine to conceal these links – from the person and from society as a whole.

Disconnecting threats from threat responses

Covid-19: Mental health services must be boosted to deal with 'tsunami' of cases after lockdown BMJ 16.5.20

'Those most at risk: Children and adolescents; Older people; People at risk of domestic abuse; People from lower socioeconomic groups and others who are hit hard financially; Frontline healthcare workers who have faced heavy workloads, life or death decisions, and risk of infection; Women, particularly those juggling home schooling with working from home and household tasks; people with previous mental health problems whose usual support is not available.'

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

….or to put it another way…..

‘*In ordinary language, people with more to be exhausted, depressed and anxious about are feeling more exhausted, depressed and anxious. However, the general picture is... of a population that is “largely resilient”......It is not a pandemic of “mental health” problems that we need to fear, but a pandemic of “mental health” thinking.’*

Johnstone 2020

https://www.cambridge.org/core/journals/bjpsych-bulletin/article/does-covid19-pose-a-challenge-to-the-diagnoses-of-anxiety-and-depression-a-psychologists-view/8DA1C1589B34DD753A50B803B33DCFA4#

Disconnecting threat responses from threats

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

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

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

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

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

NHS Digital

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

Examples from Straight Talking Introduction to the PTMF

Danny Whittaker's breakdown was triggered by the collapse of his nightclub. He had shown extraordinary levels of determination in setting it up at the age of 23, renovating the building almost singlehandedly and working round the clock for months. But it was around the time of the economic crash in 2008 , and everything conspired against him. When his credit was withdrawn, he was unable to save the club. This was the start of a descent into incapacitating anxiety that led to being virtually housebound and nearly destroyed his relationship with his partner. These circumstances would have been hard for anyone, but for Danny, who saw himself as a fairly traditional man, there was an extra layer of torment. He had taken on the belief that 'If you try hard enough you will be rewarded', and in his own words, 'I could not forgive myself' for what he perceived as a humiliating personal failure.

Examples from Straight Talking Introduction to the PTMF

There is nothing wrong with working hard to achieve, but when this message chimes so closely with wider neoliberal messages about resilience, aspiration and pulling yourself up by your own bootstraps, and when the odds are stacked against you, you are set up to fall into self-punishment and self-blame. When Danny read the PTMF several years later, he was finally able to take on a different perspective. As he puts it:

'The PTMF forced me to take seriously the possibility that what I considered wholesale personal failures that I'd brought on myself due to incompetence were probably better understood as circumstances forced upon me over which I had zero control. I discovered that my guilt struggled to persist under proper scrutiny' (chapter 6.)

General Patterns in the Power Threat Meaning Framework

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

These patterns are based on meaning not biology

The patterns will always reflect and be shaped by specific social, historical, political and cultural contexts and meanings.

There can therefore be no universal classification of 'disorders' or simple cause-effect links. The patterns always overlap and evolve

They describe what people DO in order to survive threat, not what 'condition' they HAVE

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

They help to avoid pathologisation, relieve guilt, and give a sense of not being alone

‘Surviving Poverty’

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

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

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

Threat Responses e.g. use of alcohol and drugs; insomnia, anxiety, attention and concentration disruption, distrust

See the main PTMF website for more examples

Consequences of diagnostic approaches for minority ethnic groups and non-Western cultures

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

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

In contrast, the PTMF encourages us to respect and learn from local and indigenous ways of expressing and healing distress – which are often narrative-based and community-based.

The PTMF and the importance of acknowledging….:

- Histories of colonisation, collective/transgenerational trauma and loss of identity, culture, heritage and land
- Culture-specific meanings, beliefs and forms of expression
- Culturally-supported practices, rituals and ceremonies
- Community narratives, values, faiths and spiritual beliefs, to support the healing and integration of the social group
- Connections to the natural world

(Main, p.216-217; Overview, p 77-79.)

The PTM Framework and trauma-informed approaches

- Draws on this research (ACEs, neurobiology of stress etc) but also on a much wider range of philosophical, sociological and psychological literature
- Doesn't used diagnostic language ('PTSD') etc..)
- Talks about 'adversity' (less risk of ignoring wider contexts)
- Additional emphasis on background factors eg inequality, social exclusion, racism, discrimination, socioeconomic structures
- Focus on ideological power helps to understand patterns of distress that are not related to obvious 'trauma'
- Suggests non-diagnostic alternatives for welfare access, commissioning, legal work, research….etc..

We need a different narrative about 'mental health/illness/distress/disorder'

Story-telling and meaning-making are universal human capacities.

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

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

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

'Liberation is always in part a storytelling process: breaking stories breaking silences, making new stories. A free person tells her own story. A valued person lives in a society in which her story has a place' (Emma, chapter 6, STI PTMF)

PTMF developments since 2018

Interest across the UK and also from Ireland, Denmark, Spain, Italy, Greece, Cyprus, Norway, Sweden, Iceland, Lithuania, Japan, India, South Korea, the US, the Yukon, Kenya, Australia, and New Zealand.

Spanish, Italian, Japanese and Norwegian translations are out, Danish and Swedish are on the way

Interest from MH services (child, adult, older adult, ID); criminal justice system (prisons, probation staff, parole reports); peer groups; MH charities; professional training (SW, clin psych, nursing); education (schools, teacher training); therapies of all brands; public health; etc..)

There has also been controversy!

Twitter @PTMFramework

The Power Threat Meaning Framework

A video clip from the launch in January 2018 in London, featuring all the main authors

Lucy Johnstone, Mary Boyle, John Cromby, Jacqui Dillon, Dave Harper, Peter Kinderman, Eleanor Longden, David Pilgrim, John Read, and research support from Kate Allsopp.

Consultancy group of service users/carers

Critical reader group to advise on diversity

Other expert contributions

https://www.youtube.com/watch?v=qCMCzAy6wOs

NHS
Central and
North West London
NHS Foundation Trust

Context

Setting

- Northwick Park Mental Health Centre, North West London
- Two adult mixed acute wards (22/23 beds)

In 2017

- Medical model
- Focus on diagnosis
- Context not seen as relevant
- Limited psychological interventions
- Low staff morale
- Medicating and policing culture
- High rates of violent incidents on the ward

NHS
Central and North West London
NHS Foundation Trust

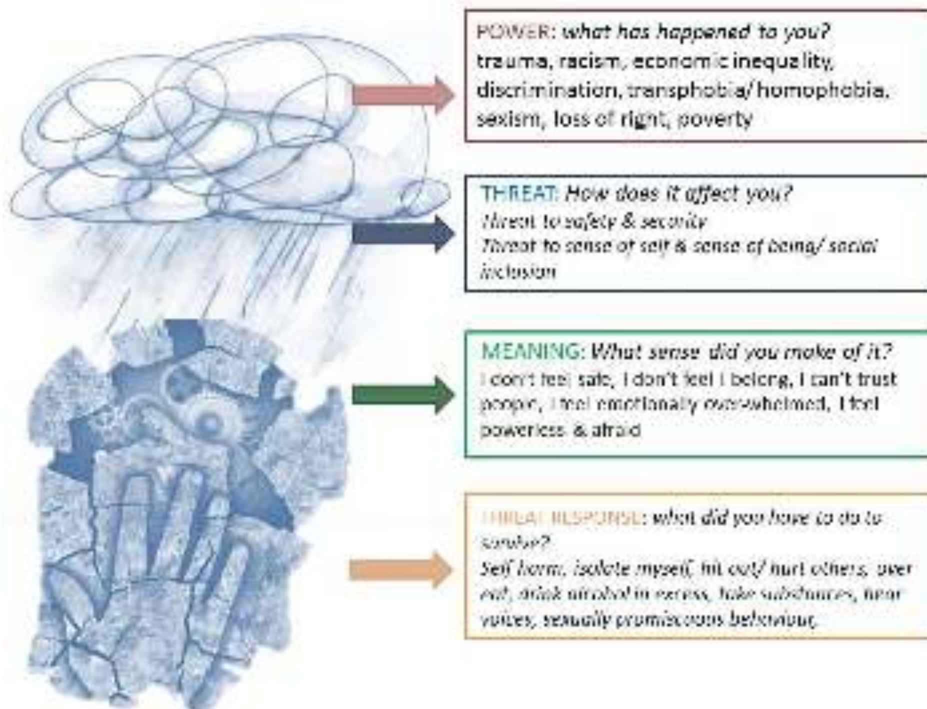
The Stabilisation Manual: Supporting internal safety

Introductory information pack plus 10 stabilisation skills workbooks

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

NHS
Central and North West London
NHS Foundation Trust

Structure of the Meeting



- Review background
- Feelings
- Stuck
- **Power resources**
- **Power imbalances**
- **Threats**
- **Meaning**
- **Threat responses**
- Feelings
- Ways forward

Inpatient wards in Central and North West London, UK

After 4 years, the changes are…

- **Self-harm:** Over 90% reduction in self-harm incidents
- **Restrictive interventions:** Statistically significant reduction in use of restraint and seclusion
- **Staff:** Increased understanding, compassion, and skills. Most satisfied staff in acute adult wards across the Trust
- **Service users**: 100% of inpatients interviewed agreed or strongly agreed that the approach has supported them to learn new and helpful ways of better managing their mental health (including difficult thoughts, feelings, and unusual experiences such as paranoia and voices).

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

Staff interviews

Theme: Increased understanding of the relationship between trauma and distress

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

"[…] to make you realise, to remind you that there's always a story behind the presentation."

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

Service user interviews

Theme: Learning skills to support internal safety

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

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

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

‘ Trauma-Informed Care on mental health wards’ 2023

https://www.frontiersin.org/articles/10.3389/fpsyg.2023.1145100/full?utm_source=F-NTF&utm_medium=EMLX&utm_campaign=PRD_FEOPS_20170000_ARTICLE

Both the CNWL project and the PTMF are recommended as an example of good practice in NHS England’s guidance on Acute Inpatient Care for Adults and Older Adults (September 2023)

https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/

Jigsaw, a national Irish organisation working with young people age 12-25

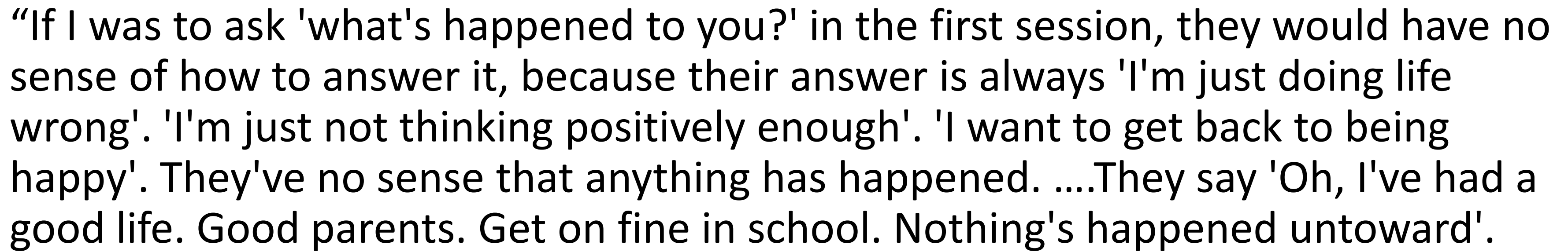
PTMF supports its aims to:

- Promote a community perspective on distress
- Make links with social contexts
- Offer options other than therapy
- Bring about strategic change towards non-diagnostic perspectives

PTMF is also being used to:

- Offer ideas about language use, eg in workshops
- Develop simple versions of PTMF ideas along with the young people
- Use PTMF terms to structure referral information (‘threat responses’ etc)
- Use the PTMF to structure individual therapy and case discussions
- Use the PTMF to develop collaborative formulations
- Incorporate PTMF into outcome measures
- Apply the PTMF to themselves

Versions of the core questions developed with young people



“If I was to ask 'what's happened to you?' in the first session, they would have no sense of how to answer it, because their answer is always 'I'm just doing life wrong'. 'I'm just not thinking positively enough'. 'I want to get back to being happy'. They've no sense that anything has happened. ….They say 'Oh, I've had a good life. Good parents. Get on fine in school. Nothing's happened untoward'.

So that's why I take two or three sessions to get to know someone, so that there's enough information to say….do you think any of the things that you've mentioned might have had an effect on how you've been feeling? That's just another way of phrasing 'what's happened to you?’ And sometimes they've been able to acknowledge, maybe, exam stress. Maybe bullying. Maybe a relationship. Maybe the way their parents talk to them….But sometimes it takes a deeper unpacking, of 'Okay. So you're still not seeing anything that's had an effect. What's it like being in a school where you know there's a high emphasis on academic achievement? Or, what's it like when your parents let you know that they've been disappointed that you only got 70 instead of 80 in an exam?’ And then they start to access their feelings around that, and are able to sense that 'oh, maybe there is something more here actually'.”

Copies of the worksheets: (see Professional Practice: Jigsaw)

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

An interview about using the PTMF with young people:

https://thinkful.ie/articles/cian-aherne-ptmf-1

‘The power of the unveiling of some of these truths in the room with people. It’s just so palpable. I can feel it in a way that I could never feel with imparting a diagnosis or engaging with a CBT programme...You’re not telling them the answers, you’re uncovering the answers together.’

Peer groups and narrative construction

See articles on website by Griffiths et al (2019) and by the SHIFT Recovery Community (2020)

See chapter 9 'What is your story?' in '*A straight-talking introduction to the PTMF*' (Boyle and Johnstone 2020).

'*What I didn't expect was that the framework would empower me to reclaim my selfhood as I began the life-changing process of transforming from a service user labelled with a pejorative personality disorder to become a strong independent survivor taking control of my life*' Amanda Griffiths

What might this look like in your setting?

What do you already do that is compatible with these principles?

What else might you do in terms of:

•Promoting informed choice about psychiatric diagnoses

•Promoting narrative understandings

•Awareness of Power – in narratives, in clients' lives, in staff/client relationships, etc.. Are some kinds of Power easier/harder to identify?

•Trauma awareness

•Building on strengths (individual and community)

•Promoting non-medical, non-professional ways forward

•Respecting diversity

•Working with wider communities

•Supporting social action

‘We met weekly in a peer-led group to read and discuss sections of the PTMF Overview and applied the ideas to our own lives. We each completed the template diagram from the PTMF Guided Discussion and shared our life stories with each other. We began to develop a new perspective: rather than seeing ourselves as abnormal and disordered – which had left us feeling hopeless and blaming ourselves for our difficulties – we began to see our ‘symptoms’ as understandable reactions to abnormal and threatening life circumstances.

This was a very therapeutic process as we felt our experiences were recognised, validated and understood and we began to feel more hopeful about the future.’

SHIFT Recovery Community, 2020 (see PTMF website under ‘Articles’)

‘The power discussions are some of the most heartbreaking but also exciting to facilitate. Heartbreaking because it can be really hard for people to suddenly experience the realities of how power is negatively operating in their lives. It genuinely is like watching the sunrise over the hills, as they connect the concept to their own lives. In each group there has been at least one person who experiences a fullness of anger over the following week as they come to terms with ‘seeing’ the oppression in their lives….However, it is also exciting in that people start to shift the responsibility from themselves….back to the situations they faced….You see some people literally sit up straighter.’

Hannah Komatsu, Peer Group faciliator

Impact of POWER

I am a survivor of many traumatic experiences. In addition, I am being disempowered by two very powerful systems (statutory mental health services and children's social care). This resulted in two male professionals exploiting their position of trust, power and authority to coerce and sexually abuse me. Subsequently these organisations used their power to deny my autonomy, and pathologize my behaviours as being symptomatic of a 'personality disorder' which is victim blaming. Consequently, I had to form a subservient relationship with a controlling psychiatric system in order access support to try to heal from the effects of these harrowing experiences.

Strengths and Power resources

I have a well-developed insight into the psychology of trauma and human distress. My intelligence and resilience enable me to self-advocate and stand firm against coercion. I am encouraged through the reciprocal relationships I am developing with my peers that motivate me to learn new skills in order to support others facing similar adverse life experiences. Additionally, I am inspired by trauma informed professionals whose ground-breaking work informs me to develop a new understanding of my experiences. Some of whom have helped and supported me in this process. I have a beautiful family who give me the strength and determination to get through each day.

My story

Adverse childhood experiences led to complex trauma throughout my life. Constant repetitive cycles of coercion, powerlessness and multiple forms of abuse have not only had a lasting effect upon my interactions with others, but are also impacting on my physical, emotional and psychological wellbeing. My energy levels are depleted from being consistently broken and distressed by a disempowering, authoritative and controlling mental health system that has been coercive and traumatizing when I needed compassionate trauma informed provision. As a consequence, I am dispirited and struggle to trust others. Even though all of this has deeply hurt and retraumatised me, my relationships with my peers and family are protective factors that motivate me to find the strength to utilise my experiences to self-educate and self-advocate, whilst campaigning for trauma informed services and improved mental health provision for other survivors.