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Crossing Cultures with the Power Threat Meaning Framework

The Power Threat Meaning Framework (PTMF) is an ambitious attempt to outline a conceptual alternative to psychiatric diagnosis and the medicalisation of distress. It was developed over a period of five years by a core group of clinical psychologists and service users, funded by the Division of Clinical Psychology of the British Psychological Society, and launched in London in January 2018 (Johnstone et al., 2018a; Johnstone et al., 2018b; see also https://www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework for relevant documents, videos and other resources). It has already attracted interest within and beyond services in the UK, Europe, New Zealand and Australia.

The Framework applies not just to people who have been in contact with the mental health systems, but to all of us. A central aspect is its focus on the way power operates in our lives. It highlights the links between distress and social factors such as poverty, discrimination, social exclusion and inequality, along with traumas such as abuse, neglect and violence. It also looks at power at wider levels—for example the pressure to live up to certain unquestioned standards and ideals. The role of ideological power—that is, the power to shape language, meanings and agendas—is less often recognised, but is central to all other aspects. The imposition of psychiatric labels, which are recognised to lack reliability and validity, can be seen as one example of the operation of ideological power.

The PTM Framework integrates a great deal of evidence about the impact of these various forms of power in people's lives; the kinds of threat that misuses of power pose to us; and the ways we have learned as human beings to respond to threat. In traditional mental health practice, these threat responses are sometimes called "symptoms."

The main aspects of the Framework are summarised in these expanded versions of the survivor slogan, "Instead of asking 'What's wrong with you?' ask 'What has happened to you?'"

- What has happened to you? (How is *Power* operating in your life?)
- How did it affect you? (What kinds of *Threat* 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 Response* are you using?)

In addition, these two questions help us to think about what skills and resources individuals, families or social groups might have, and how to put these ideas and responses together into a personal narrative or story:

- What are your strengths? (What access to *Power Resources* do you have?)
- What is your story? (How does all this fit together?)

The Power Threat Meaning Framework can be used to help people to create more hopeful narratives or stories about their lives and their past and current difficulties, instead of seeing themselves as blameworthy, weak, flawed, or "mentally ill". It also shows why those of us without an obvious history of trauma or adversity can still struggle to find a sense of self-worth, meaning and identity. For some, therapy or other standard interventions may be helpful. For others, the main needs will be for practical help and resources, perhaps along with peer support, art, music, exercise, nutrition, community activism and so on.

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A central aspect of the Framework is the attempt to outline common or typical patterns in the ways people respond to the negative impacts of power—in other words, patterns of embodied, meaning-based responses to threat, as an alternative to diagnostic patterns. The evidence suggests that there are common ways in which people are likely to respond to certain kinds of threat such as being excluded, rejected, trapped, coerced or shamed. It may be useful to draw on these patterns to inform people's personal stories, and to convey a message of acceptance and validation.

Given the widespread adoption of diagnostic thinking, the Framework also discusses possible non-diagnostic approaches to service design and commissioning, training, research, service user involvement, access to welfare and benefits, and public information. There are also important implications for social policy and the wider role of equality and social justice. Lucy Johnstone will now describe the workshop and later on Diana Kopua will now offer her reflections.

1 | THE POWER THREAT MEANING FRAMEWORK IN AOTEAROA NEW ZEALAND

In February 2019 I was invited by ISPS (the International Society for Psychological approaches to Psychosis) to run a two-day workshop in Auckland (along with other workshops in New Zealand and Australia, the latter hosted by the Blue Knot Foundation). The event offered an invaluable and unique opportunity to compare and contrast different cultural experiences and expressions of distress. It also allowed exploration of one of our hopes for the PTMF: that, in contrast to the imposition of the Western diagnostic model across the globe, the PTMF respects and validates other worldviews, in part because it draws on shared core principles. As we phrased it in the document:

> *The PTM Framework predicts and allows for the existence of widely varying cultural experiences and expressions of distress without positioning them as bizarre, primitive, less valid, or as exotic variations of the dominant diagnostic or other Western paradigms. . . . Viewed as a metaframework that is based on universal evolved human capabilities and threat responses, the basic principles of the PTM Framework apply across time and across cultures. Within this, open-ended lists of threat responses and functions . . . allow for an indefinite number of locally and historically specific expressions of distress, all shaped by prevailing cultural meanings. (Johnstone et al., 2018a, p. 22)*

Consultant clinical psychologist Ingo Lambrecht organised the event with support from other members of the ISPS NZ committee.

1.1 | The Aotearoa New Zealand Background

The context will be familiar to New Zealanders but is spelled out here for those to whom it is new.

Ingo Lambrecht was able to secure the use of a *marae*, a communal Māori meeting place or sacred space, for the two days. The marae was set in the grounds of a mental health service which offers Māori interventions alongside more conventional ones. This is a common service structure in New Zealand, and Pākehā (non-Māori) are also able to access these approaches if they wish. There is no single model, but a well-known one which is widely integrated into practice is Te Whare Tapa Wha (Durie, 1994). This is based on the four interconnected cornerstones of Māori wellbeing: mind, spirit, physical health, and the family (*whānau*). This has been expanded into the Meihana model by a group of clinicians who wanted to develop a framework that actively engaged with Māori beliefs, values and experiences (Pitama, Huria, & Lacey, 2014). Meihana added the dimensions of *taiao* (physical environment) and *iwi katoa* (societal context). If any of these elements are out of balance, there will be a threat to well-being. A number of variations on these models are described by McNeill (2009). For example, Te Pae Mahutonga (Durie, 1999) explicitly included the impacts of colonisation on Maori lives, experiences and concepts, as did the most recent version of the Meihana model, which also emphasised the roles of racism and migration away from traditional *iwi* (tribal) land.

All of these are holistic perspectives, but differing from most Western ones in several aspects, including the emphasis on spirituality. The concept of whānau is much more expansive than the equivalent word in English, and includes the extended family of aunts, uncles, grandparents and so on, both living and dead. Several whānau make up a *hapū*, and several hapū make up an iwi or tribe. These identities are strongly connected to the natural world. Thus a traditional Māori introduction will include "my river is . . ." and "my mountain is . . ." , as well as "my whānau is . . ." , "my hapū is . . ." and "my iwi is . . .".

The wider context is in some ways very different from the UK. Briefly, Aotearoa New Zealand (Aotearoa is the Māori name for the country, roughly translatable as "land of the long white cloud") was settled by Europeans from around 1800 onwards. Aotearoa New Zealand became a British colony in 1840 through the landmark Treaty of Waitangi, signed by representatives of the British Crown and Māori chiefs. This enshrined Māori legal ownership of their lands and possessions and gave them equal rights to British citizens. The principles of the Treaty were very imperfectly realised and did not prevent subsequent annexing of Māori land. To this day, Māori and Pacific Island peoples are greatly overrepresented in the statistics on poverty, unemployment, mental health and addictions. Nevertheless, the Treaty stands as a statement of principle and has, arguably, contributed to a commitment to recognising and respecting Māori and Pacific Island worldviews and to acknowledging and reducing the ongoing inequalities and health disparities in these populations.

New Zealand is in the middle of a major government inquiry into mental health and addiction services, which are seen as failing the population as a whole; suicide rates are high, as are addictions. A long period of consultation has resulted in 40 recommendations, which are currently being considered. The summary document reads well—some extracts are given below (He Ara Oranga, 2018):

> *We recognised from the start that this Inquiry represented a "once in a generation" opportunity for change. All over the country, people told us they wanted this report to lead to real and enduring change—a "paradigm shift." (p. 7)*
>
> *People said that unless New Zealand tackles the social and economic determinants of health, we will never stem the tide of mental health and addiction problems. . . . A call for wellbeing and community solutions—for help through the storms of life, to be seen as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self. (p. 9)*
>
> *For Māori health and wellbeing, recognition of the impact of cultural alienation and generational deprivation, affirmation of indigeneity, and the importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and Iwi. (p. 9)*
>
> *For Pacific peoples, the adoption of "Pacific ways" to enable Pacific health and wellbeing—a holistic approach incorporating Pacific languages, identity, connectedness, spirituality, nutrition, physical activity and healthy relationships. (p. 9)*
>
> *We can't medicate or treat our way out of the epidemic of mental distress and addiction affecting all layers of our society. (p. 10)*
>
> *We believe that many dimensions of the aspirations of Māori and Pacific peoples, especially the call for a holistic approach, point the way for all New Zealanders. (p. 11)*

1.2 | The Workshop

We registered under a tree on a beautiful hot day—a mixed Pākehā and Māori audience of clinicians (including several psychiatrists), voluntary and family workers, students, service users and peer supporters. The process of welcoming a visitor to a marae is called a *pōwhiri*, and can take various forms. In this case, the *tangata whenua* (hosts) performed a

haka pōwhiri (a welcome dance and chant) as I and other attendees approached the *wharenui* (meeting house). Once inside, and after a moment of respect for the ancestors whose pictures were on the far wall, a *kaumatua* (elder) led songs and *karakia* (prayers). The hosts greeted the visitors with a kiss on the cheek or *hongi* (touching nose and forehead). We then moved to another room to share tea and fruit (food and drink are not permitted in the wharenui).

Wishing to echo Māori introductions by placing myself a bit more precisely than "I am a clinical psychologist", I described my home city of Bristol, UK, my family, and my Scottish heritage of Johnstones, Grahams, McKays and Frasers. I also told the attendees that two of my great-grandparents had been missionaries in Ghana and Sri Lanka (known to Britons then as the Gold Coast and Ceylon). I said that it felt important to recognise that we all have a relationship to colonialism. I also posed the deliberately provocative questions: "Is the Western diagnostic paradigm simply another form of colonialism, perhaps more subtle than earlier versions, but equally damaging in its impacts? Will the Inquiry go far enough in achieving the longed-for "paradigm shift"? Or will we simply end up with better-resourced versions of what we already have? Is it legitimate to offer the failed Western diagnostic model alongside indigenous ones, or does it need to be abandoned altogether?"

The first day consisted of introducing the PTM Framework and illustrating it through the personal story of Debra Lampshire, current ISPS NZ chair, which made for a powerful exercise. We ended with a karakia.

After a briefer welcoming ceremony, the second day started with a reflection on Māori perspectives by Pikihuia Pomare, a Māori clinical psychologist and Jason Haitana, a Māori consumer adviser. Pikihuia started with a *waiata* (song) and then linked back to the previous day's discussion about power in its many guises, including colonialism and white privilege, and the consequent need to reclaim the Māori knowledge that has been silenced. Jason picked up this theme by recounting some Māori creation stories or *pūrākau*. As he said, they are more than just stories, because, while not literally true, they do express important truths handed down from ancestors. His first story was about Ranginui and Papatūānuku, the sky father and earth mother of the world, living in darkness. Their children decided that they needed to be pushed apart in order to bring light into the world, and they did this, but not without effort and pain. He invited the audience to share resonances with their own lives, such as the need for children to create the space to become themselves. The attendees, both Māori and Pākehā, responded with a range of personal reflections.

I was left with several thoughts. First, the notion of stories, myths and legends as a vehicle for truths is very much supported by the PTMF. That is why it argues for narrative in general, not just the particular type of narrative called formulation. If we go beyond conventional evidence-based practice and historical truth and also consider "narrative truth" (Spence, 1982, cited in Johnstone et al., 2018a, p. 83), we can value stories according to whether they seem to "fit" in a way that "makes change conceivable and attainable" (Schafer, 1980, cited in Johnstone et al., 2018a, p. 82). Second, as one of the attendees commented to me, the Māori stories displayed clear themes that could be described as power, threat and meaning. I am not suggesting that they need translating into those terms, simply noting commonalities between the two perspectives of Māori pūrākau and the PTMF core themes. Third, the audience's reactions gave me a sense of how these pūrākau could be used to reflect on, explore and heal human dilemmas and struggles. This too echoes the PTMF, which refers to narrative competence as "the capacity for human beings to deeply absorb, interpret and appropriately respond to the stories of others" (Grant, 2015, cited in Johnstone et al., 2018a, p. 78) and recovery as "reclaiming our experience in order to take back authorship of our own stories" (Dillon and May, 2003, cited in Johnstone et al., 2018a, p. 75).

The second half of the morning consisted of an informal panel discussion with seven of us. A relatively long timeslot was allocated for this, and I was struck by the way it unfolded. In keeping with the earlier session, some of the Māori speakers responded to points indirectly by telling a traditional story and, similarly, some of the audience, though Pākehā, began their contributions by telling stories about themselves. The sense was of the unfolding of a flowing conversation that went deeper than the usual academic debate. At several points the day before, when explaining the concept of formulation, I had been rightly reminded that such a process of co-constructing a story is essentially about two people being deeply in contact with each other and touching each other's hearts. This does not, as far as I am aware, feature in any official definitions of formulation, and yet it struck me as absolutely true.

I had suggested that the discussion might want to return to the questions I posed at the start of the first day. There weren't direct answers—it wasn't that kind of conversation, and we don't yet know how the Inquiry's work will turn out. Nevertheless, there was strong endorsement of the PTMF's inclusion of causal factors that are omitted from most psychiatric and psychological models, such as the impact of colonisation, intergenerational trauma, denial and loss of traditional knowledge, and the role of ideological power in all these areas. Some of the attendees were strongly in favour of abandoning the DSM-based model, along with advocating the PTMF as an alternative, albeit imperfect and still developing, way of taking us forward.

One of the panel members was a young Māori woman, a survivor of services who is now training to be a psychiatrist in order to bring about changes in the system. She had come across the PTMF by chance and had read the main document in its entirety. She recognised that it would need adapting for local needs but felt that it had the space to offer this. As a result, she was very enthusiastic about its potential to support indigenous understandings and told us that it is already being used to inform thinking in one Māori mental health service.

The Inquiry includes a summary of specifically Māori responses ("Whakamanawa: Honouring the voices and stories of Māori"). An extract illustrates the similarities to PTMF messages:

> *Māori voice across the Inquiry recognises mental distress as a reasonable response to adverse wider environments. Within a wellbeing paradigm, mental distress is not medicalised, pathologised, or criminalised; pathways to healing are whānau-based, inclusive of spiritual elements and supported by a healthy wider environment . . . . The focal point in a wellbeing paradigm shift assumes that mental health is a dimension of experience relevant to all members of society. (pp. 25–26)*

2 | REFLECTIONS

I found the whole workshop a deeply thought-provoking and enriching experience. Unlike at some training events, I felt I received far more than I gave, both in terms of ideas and challenges but also in terms of warmth, connection and the opportunity to experience a flavour of a very different culture.

I want to avoid making simplistic generalisations about a culture that is unfamiliar to me, and I am aware that there has been much mingling of blood and ideas between Europeans and Māori over the years. As a result, people now live in both worlds, and have varying degrees of identification with traditional practices and perspectives. For example, many Māori converted to Christianity in the 19th century.

Having said this, I agree with the Inquiry that Māori and Pacific Island worldviews have much to offer to all New Zealanders and, I would add, to Western perspectives in general. It is all too evident that, in the UK at least, we have lost the senses of community, spirituality, identity and connection to the natural world that are so highly valued by indigenous New Zealanders, with impacts on wellbeing that are widely documented. We attempted to acknowledge this in the PTMF with references to the impact of colonialism and intergenerational trauma, the inseparability of the individual from the social group, and the need to integrate mind, body, spirit and the natural world. We also included, as possible ways of reclaiming power, identity and agency:

- 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;
- Addressing collective/transgenerational trauma and loss of identity, culture, heritage and land;
- Narrative-making through art, poetry, literature, music; and
- Political action.

(Johnstone et al., 2018a, pp. 77–79; Johnstone et al., 2018b, pp. 216–217)

After my brief but direct exposure to a very different culture I realise that this recognition does not go far enough. While it is obviously not appropriate for the PTMF authors themselves to adapt the document for non-Western perspectives, I believe that future editions need to place more emphasis on these universal human needs.

2.1 | And Some Reservations …

I have no wish to idealise the perspectives I learned about. Specifically, I have concerns about the infiltration of medicalised thinking into these non-Western approaches. After describing its Te Whare Tapa Wha approach, one Māori community mental health service added these paragraphs (now amended) which could have come from any standard psychiatric textbook:

> ***What is Mental Illness?***
> *Mental illness is a clinically significant behaviour or psychological disorder that is associated with distress or disability. . . . A mental illness can . . . limit our ability to function as society would normally expect of us and can put us and others at risk. Mental illness is therefore, a broad term that covers problems ranging from minor to severe disorders . . .*
> *Schizophrenia is a serious mental disorder that affects about 1% of the general population. It is a complex illness characterised by "psychosis," a word used to describe disorder of thoughts (e.g. delusions—false beliefs held in spite of evidence that they are not real), perceptions (e.g. hallucinations—seeing, hearing or feeling things which are not there), disorganised speech and grossly disorganised behaviour, which are not experienced by others and which are not seen as abnormal by the sufferer. These four symptoms are often referred to as the "Positive Symptoms" of schizophrenia because they are the result of the disease process.*

Similarly, the Inquiry, along with its progressive "call for wellbeing and community solutions—for help through the storms of life, to be seen as a whole person, not a diagnosis" (He Ara Oranga, 2018, p. 9), includes plenty of phrases implying the very diagnostic model it is criticising, such as "enduring psychiatric illness" and "serious mental illness" (which appear to be conceptualised as something fundamentally different from other forms of distress). Among the welcome recommendations for tackling social determinants of distress are several that merely imply "more of the same" (such as, "Expanding access to services for significantly more people with mild to moderate and moderate to severe mental health and addiction needs" (He Ara Oranga, 2018, p. 17). Having a culturally aware service is not a guarantee against the infiltration of biomedical ideas.

In conclusion, the outcome of New Zealand's Inquiry remains to be seen. I have no doubt that this bold initiative will result in some real improvements, but it seems likely to fall short of a fundamental challenge to the diagnostic approach. Nevertheless, if the PTMF can support a move in that direction, I and the other authors will be delighted. In the meantime, I will always value the lifelong connection that has now been forged with the marae at Manawanui.

3 | COMMENT FROM DIANA KOPUA

The publication of the PTMF was a welcome relief for me at a time when I was the Head of Department for Psychiatry in the Tairawhiti (East Coast of the North Island of New Zealand) where I led a new service, Te Kuwatawata (TKWW) which opened in September 2017. Our attempt was to revolutionise the way in which services were shaped, that is, to centralise meaning, values, culture and relationships; making the biomedical model secondary. The PTMF supported our belief that there was a need to challenge the status quo.

In New Zealand, Māori Health leaders continue to work hard to have Māori knowledge recognised, but it has not been accepted as a real alternative to the interventions of Western psychiatry.

Similarly, Māori *whakapapa* (genealogical ties to the natural environment) and the narratives that describe these connections have for too long been referred to as myths and legends. However, each narrative provides a framework for distress to be considered in a way that is unique and culturally enriching for the indigenous people of New Zealand.

Such approaches can also work on a socio-cultural level to promote a positive identity for indigenous communities by celebrating the power of indigenous deities, narratives and healing practices that were marginalised and sometimes suppressed by the forces of colonisation.

TKWW is a service that was established with the support of the Ministry of Health's innovation funding. This service is the "front door" to the mental health service and was founded on a Kaupapa Māori framework but remained a mainstream service for both Māori and non-Māori.

The service prioritises addressing institutional racism by engaging staff in routine workforce training based on a Māori framework, Mahi a Atua (tracing ancestral footsteps). The narratives shared in Mahi a Atua workforce training are important in shifting staff awareness of the need for change. Mahi a Atua, a Māori-rich framework, now has strong community support and is a movement that has liberated the indigenous voice to advocate for Māori equity and empowered non-Māori to embrace critical thinking about their practice.

Mahi a Atua is a process where Māori creation stories, or pūrākau, are explored so that a set of words, ideas, images and narratives can help provide a matrix through which communal, family and individual challenges are understood within a cultural context (Rangihuna, Kopua, & Tipene-Leach, 2018). The idea is to begin to work with Māori individuals, their families (whānau) and their communities (iwi) from a place that is far from the clinical gaze and the clinical mind-set of psychiatry.

As the founder of Mahi a Atua I was able to utilise my position to advocate for this as critical in creating change. Whilst addressing the systemic problems, absolute commitment was given to ensuring every family system was respected and understood as unique, and that their own narratives were embraced as integral to change.

Next year is 2020—as we move into a new decade of social change, it will be a time of planting seeds that shift consciousness and awaken us to the potential of how we deliver change. Mahi a Atua is a solid vehicle for change in New Zealand and TKWW is one potential portal for delivery. TKWW is not a perfect system, but it has challenged the systems that keep us locked in the past and made us accountable to the families we are serving and to ourselves as practitioners.

TKWW is the first service of its kind and, as expected, there have been many challenges. The PTMF has acted as a "distant cousin" with more commonalities than differences and it has been referred to in training to highlight the issues that impact us as practitioners in mental health, locally and globally. There is a need to challenge the status quo and it requires a collective consciousness across the world in order to improve the outcomes for human suffering.

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REFERENCES

Dillon, J., & May, R. (2003). Reclaiming experience. *Open Mind*, *120*, 16–17.

Durie, M. (1994). *Whaiora: Maori health development*. Auckland, New Zealand: Oxford University Press.

Durie, M. (1999). Te Pae Mahutonga: A model for Māori health promotion. *Health Promotion Forum of New Zealand Newsletter*, *49*, 2–5.

Grant, A. (2015). Demedicalising misery. Welcoming the human paradigm in mental health nurse education. *Nurse Education Today*, *35*, 50–53.

He Ara Oranga (2018). *Report of the government inquiry into mental health and addiction*. Retrieved from www.mentalhealth.inquiry.govt.nz/inquiry-report

Johnstone, L., & Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018a). *The Power Threat Meaning Framework: Overview*. Leicester, UK: British Psychological Society. Retrieved from https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/PTM%20Overview.pdf

Johnstone, L., & Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018b). *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*. Leicester, UK: British Psychological Society.

McNeill, H. (2009). Maori models of mental wellness. *Te Kaharoa*, *2*(1), 96–115. https://doi.org/10.24135/tekaharoa.v2i1.127

Pitama, S., Huria, T., & Lacey, C. (2014). Improving Māori health through clinical assessment: *Waikare o te Waka o Meihana*. *Journal of the New Zealand Medical Association*, *127*(1393), 107–119.

Rangihuna, D., Kopua, M., & Tipene-Leach, D. (2018March 9). Mahi a Atua: A pathway forward for Māori mental health. *The New Zealand Medical Journal*, *131*(1471), 79–83. Retrieved from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1471-9-march-2018/7518

Schafer, R. (1980). Narration in the psychoanalytic dialogue. *Critical Inquiry*, *7*(1), 29–53.

Spence, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. London, UK: Norton.

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Dr Diana Kopua is the first Ngati Porou psychiatrist. Diana began her journey in health as a psychiatric nurse where she developed Mahi a Atua as a therapeutic intervention. Diana then studied medicine at Otago University and specialised in psychiatry. Diana graduated as a fellow in 2014 and based herself in the Tairawhiti area. She is now the co-director of Te Kurahuna Ltd where she is pioneering change through Mahi a Atua workforce training.