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Clinical practice rediscovers social justice: the Power Threat Meaning Framework

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Abstract. – The publication of the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5) in 2013 was met with mixed reactions: some hailed it as a fundamental innovation in the field of diagnosis, while others denounced its underlying assumptions as basically unchanged from the problematic previous editions. In the same year, the British Psychological Society published a position statement calling for a paradigm shift in the classification of behaviors and experiences in relation to psychiatric diagnoses. Five years later, in 2018, shortly before the release of the *International Classification of Diseases*, 11th Revision (ICD-11), the British Psychological Society published the Power Threat Meaning Framework (PTMF, hereafter PTM) in both full and summary form. Over the following seven years, the model gained considerable international dissemination: translations have multiplied, and the summary version is now freely available in Spanish, Norwegian, Swedish, and Italian. At the same time, the PTM has generated lively debate: training initiatives have been launched, some services have experimented with its adoption across different sectors, and it has become a key reference text for part of the critical movement in the United Kingdom and beyond. After outlining its origins and aims, this article examines the nature and method of the PTM, highlighting its epistemological and political positioning. The article then analyses the framework's core ideas and their innovative aspects, outlines its areas of application and the criticisms it has attracted, and concludes by reflecting on its potential as an instrument for reconnecting clinical practice and social justice.

Key words: Power Threat Meaning Framework, clinical psychology, diagnostic classifications, social justice.

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What is it (not)?

The Power Threat Meaning Framework (PTM) is a conceptual framework designed to understand and work with distress and with what the authors describe as “troubled or troubling” behavior. However, contrary to what might appear at first glance, it is not a diagnostic or clinical model in the strict sense. The PTM does not limit itself to classifying experiences or behaviors or to defining diagnostic clusters; rather, it is more broadly oriented toward understanding human experiences in terms of power, threat, meaning, and survival responses.

The intention and the scope of the model are simultaneously theoretical, methodological, practical, political, and cultural. The PTM was not primarily created to replace existing diagnostic manuals, but to question practices and frameworks of meaning that establish clinical approaches as the privileged tool for recognizing and intervening in citizens’ distress. Such practices, the authors suggest, transform experiences and behaviors into objects of diagnosis (clinical objects) and those who experience them into “patients” (clinical subjects). The PTM thus emerged to problematize the institution of the clinic as the privileged knowledge-power apparatus (Foucault, 1969) for the care of suffering. Mental health care systems are defined by the PTM as mechanisms that risk reproducing social inequalities (Johnston *et al.*, 2018), offering a passivizing reading of suffering and subjectivity through the use of pathologizing and individualizing diagnostic categories.

By contrast, mental health is here understood as a phenomenon that emerges from the structural aspects of the context in which individuals and groups move, and is situated within dynamic interactions in concrete, collective, and social space. The awareness, already embraced by other disciplines, for example, epidemiology and medical anthropology, but generally a minority position in psychology, permeates the PTM in all its parts and, in our view, makes its vocation profoundly transformative at both the cultural and policy levels. It is rooted in the need to interrogate the power relations that traverse the clinical field, as well as the structure and the social, cultural, and political processes that define the forms of citizenship, subjectivity, suffering, and care.

The method: participation and co-production

Similarly to what occurs with the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), whose drafting has attracted criticism regarding the processes, the actors involved, and conflicts of interest that have substantially influenced its contents, for the PTM as well (available online free of charge in all versions), the process cannot be separated from the product. There is a radical structural coherence between form and content: the principles on which the model is based are the same ones that inform its process and drafting method.

The process through which the PTM was produced is therefore not a methodological detail but an epistemological element. The *method* adopted by the authors reflects a specific position on what it means to *produce knowledge*, *who produces* this knowledge, and *for whose benefit* it is produced. The PTM adopts the epistemological perspective of critical realism (Pilgrim, 2022), starting from the assumption that knowledge is neither neutral nor natural nor the exclusive domain of experts, but is always produced within relations of power, lived experience, and social contexts. Suffering, like the theories about it, is a historical and social product. Knowledge is not decontextualized truth: "Theories and judgments about identifying, explaining, and intervening in mental distress and troubled behavior are not interest or value-free" (Johnston *et al.*, 2018, p. 73).

During the drafting of the model, this epistemology was translated into a participatory approach, involving a plurality of actors, based on the paradigm of co-production (Rose, 2017; Rose & Kalathil, 2019; Soklaridis *et al.*, 2024). This paradigm is based on the distribution of knowledge-power. It places particular value on the contribution of service-users, the so-called "experts by experience": individuals who, having directly lived through a condition of psychological distress, have transformed their personal experience into expertise, offering empathic and practical support to others in similar situations. According to the authors, it is important to "take the meaning, the narrative and subjective experience seriously", making it clear that this implies "a central place for the narratives of experts by experience (Experts by Experience)" (Johnstone & Boyle, 2018, p. 73). This represents a concrete attempt to overcome what is termed "epistemic injustice" (Bortolotti, 2025; Fricker, 2007) in the production of knowledge: the systematic exclusion of the experiences and knowledge of people living with distress, in favor of the hegemony of technical perspectives that occupy a dominant position in the hierarchy of knowledge. Beyond considerations of equity, there are strong practical reasons for integrating "emic" forms of knowledge and practice – those developed within groups and communities based on their own experience, culture, and worldview – into "official" knowledge. Such forms of knowledge are essential to guide research and intervention in directions that are genuinely useful to their intended beneficiaries, generating outcomes in a non-extractive manner (Smith, 2021).

The collective process underlying the PTM was thus developed through a dialogue among diverse voices, roles, and experiences in which the professionals relinquished their monopoly over knowledge-power. The working group was composed of psychologists and activists with direct experience in mental health services, such as Jacqui Dillon and Eleanor Longden, together with a researcher, Kate Allsopp, an advisory group of service users and family members, a critical reading group with particular attention to issues of diversity, and numerous other contributors. Incorporating a plurality of perspectives and experiences, the PTM is probably the first attempt to develop a conceptual framework of this scope through a co-produced approach, involving people who experience psychological distress both as members of the core team and as consultants, while systematically integrating their testimonies and the literature emerging from the user and *survivor* movement.

Subsequent developments have followed the same democratic and participatory momentum. In 2019, the *PTMF Committee* was launched – made up of both professionals and experts by experience – to develop resources, training materials, and dissemination initiatives consistent with the principles of co-production and participation that underpin the framework. Finally, the Italian translation of the PTM deliberately adhered to these same principles and was carried out collectively with the active involvement of users and people with experience of psychiatric services.

A diagnosis of context and epistemology

To understand the nature of the PTM and its principles, it is necessary to situate it within the historical and socio-cultural context from which it emerges and to which it seeks to respond in a transformative way. For decades, the medicalization of human experience, of which the DSM is one of the key symbols and instruments, has constructed suffering as an object of clinical classification (Foucault, 1969), isolating it from its social (WHO, 2014), economic, political and cultural determinants. The prevailing tendency is to address distress primarily as an individual problem grounded in organic causes. At the same time, the development and dissemination of psychological approaches that emphasize subjectivity and intrapsychic dynamics have reinforced a conception of distress as detached from its context, contributing to forms of psychologization (De Vos, 2012). These conceptions are closely linked to the individualistic worldview typical of neoliberalist Western culture. By decontextualizing distress, clinical practice risks, rather than supporting emancipatory relationships and processes aimed at social justice, becoming a tool of normalization, rendering invisible the conditions of structural oppression, systemic injustice, and socioeconomic inequality (Johnston *et al.*, 2018).

Starting from this contextual diagnosis (Batstra & Frances, 2025), the epistemological positioning and practical proposal of the PTM can be understood. Diagnostic systems such as the DSM and the *International Classification of Diseases* (ICD) derive from a positivist tradition which, through the application of the biomedical model, interprets distress as an internal property of the individual, organizing it into categories presented as neutral, natural, and universal: the so-called mental disorders. However, the diagnostic act is also a political and social act, as it defines through a "theory of disorder" what constitutes an illness, who becomes a patient, and which forms of suffering merit clinical attention (Kleinman, 2019). The PTM was developed to avoid the risk that the medicalization of phenomena and experiences rooted in social dynamics constructs suffering as a private matter, naturalizing the context in which it is produced. Troubled and troubling behaviors that characterize mental disturbance, rather than being interpreted as abnormal – literally, outside the norm – are, within the PTM, understood as normal responses, endowed with meaning that needs to be reconstructed, to abnormal structural conditions, that is, conditions that are inadequate to meet individuals' needs.

Models that are formally distinct from the biomedical model often operate, in practice, in similar ways. Approaches that value experience and subjectivity, such as psychoanalysis, or diagnostic systems, such as the PDM-3, tend, nonetheless, to present an understanding of suffering at the individual level. The PDM-3 introduces important elements (such as the recognition of clinically significant, non-pathological experiences and of vulnerability linked to socio-cultural contexts), offering a more nuanced interpretation of distress. However, much of the psychotherapeutic apparatus and diagnostic tools, such as the PDM-3, focus on intrapsychic or relational processes, devoting little or no attention to structural factors, inequality, and power relations. In this way, they risk obscuring the material and historical conditions underlying suffering and, albeit unintentionally, reinforcing individualistic interpretations of distress, thereby weakening the possibility of personal and collective action on living conditions.

Founded in the epistemology of critical realism, the PTM seeks to acknowledge the reality of suffering without separating it from its contexts. Psychological difficulties are understood as meaningful responses to threats (Threats) experienced within specific power imbalances (Power), to which individuals, groups, or communities attribute meanings (Meaning). This systematic framework is put forward to guide reflection and intervention on the relationships between individuals and structure.

Content and innovation

What, then, are the key components of the PTM, and in what ways do they constitute a substantive innovation compared with culturally hegemonic models? We reproduce in full the "narrative summary of the foundational pattern" that forms the basis of the model:

> "Economic/social inequalities and ideological meanings that support the negative operation of power result in increased levels of insecurity, lack of cohesion, fear, mistrust, violence and conflict, prejudice, discrimination, and social and relational adversities across whole societies. This has implications for everyone, and particularly those with marginalized identities. It limits the ability of caregivers to provide children with secure early relationships, which is not only distressing in itself for the developing child but may compromise their capacity to manage the impact of future adversities. Adversities are correlated, such that their occurrence in a person's past and/or present life increases the likelihood of experiencing subsequent ones. Aspects such as intentional harm, betrayal, powerlessness, entrapment, and unpredictability increase the impact of these adversities, and this impact is not just cumulative but synergistic. Over time, the operation of complex interacting adversities results in a greatly increased likelihood of experiencing emotional distress and troubled or troubling behaviors. The form of these expressions of distress is shaped by available resources, social discourses, bodily capacities, and the cultural environment, and their core function is to promote emotional, physical, and social safety and survival. As adversities accumulate, the number and severity of these responses rise in tandem, along with other undesirable health, behavioral and social outcomes. In the absence of ameliorating factors or interventions, the cycle is then set up to continue through further generations." (Johnstone & Boyle, 2018, p. 195)

It is evident that many of the elements employed and the entities evoked in the analysis differ from currently available models: a central role is attributed to social inequality, sociocultural discourses and meanings, material circumstances and conditions, and social phenomena. The complexity of the perspective increases: it is not possible to understand and act upon mental distress without a deep understanding of the social organization and processes, beginning with the unequal distribution of power, material, and symbolic resources, constraints, and opportunities (Wilkinson & Pickett, 2009, 2020). It is therefore necessary to examine the interaction between individuals, groups, and communities and the contexts in which they are born, grow, develop, and die (Marmot, 2005, 2013). The Foundational Pattern is based on population-level trends (Johnston *et al.*, 2018) informed by epidemiological research, which are difficult to reconcile with the individual clinical level. It places social determinants of health at the center and shows how distress develops from "synergic", "cumulative", "probabilistic" interactions among different factors and experiences. This analysis resonates with the concept of "syndemic" (Singer & Clair, 2003), which describes how dynamic interaction between two or more co-occurring conditions of illness, adversity, or disadvantage contributes to the worsening health of the populations in which these conditions arise. The syndemic approach has, among other things, clarified why some minorities systematically experience poorer average health than the rest of the population. For this reason, the PTM underlines the need for social and political responses to the problems, and it has been proposed as a tool within the public health system (Harper, 2023). The model thus guides us, from a health promotion perspective (WHO, 1986), towards the construction of contexts and policies capable of interrupting or preventing the processes that such adversities may trigger. Particularly significant is the recognition, until now largely absent in mainstream clinical psychology, that oppressive structures constitute a disproportionately greater risk factor for marginalized identities, offering an intersectional understanding (McCall, 2005) of health, suffering, and care. As highlighted by the theory of "structural violence", distress is disseminated unevenly along axes of ethnicity, gender, and class through social structures that harm individuals and groups by constraining their agency and creating unequal access to resources, such as education, healthcare, and housing (Farmer, 1996). From this perspective, violence, illness, and distress are "rarely divorced from the actions of the powerful" (*ibidem*, p. 21).

From the base of the Foundational Pattern, the main body of the PTM framework, which encompasses its core, emerges: the Basic Framework (BF). The BF outlines the four constitutive elements of the model and their interconnections: Power, Threat, Meaning, and Threat Response (Johnstone, 2022). Each of these corresponds to key questions in the interview proposed by the authors. The aim is to provide a framework capable of reconstructing the link between the meanings attributed to threats and adversity and individuals' responses. What are generally interpreted as symptoms, in the authors' language referred to as "troubled and troubling" behaviors, are understood here as responses to experiences of threat, culturally determined, mediated by symbolic and biological processes, influenced by factors that may either exacerbate or mitigate them; their value is therefore functional rather than pathological. From a formal perspective, the articulation of the BF reflects a certain schematic quality linked to the pragmatism of Anglo-Saxon culture, which also constitutes a strength in terms of clarity of presentation, enabling a clear outline of the components of the model and the relationship between them to be delineated clearly (Figure 1).

Power is defined (Boyle, 2020) in both its positive and negative meanings. The aim of care is the restoration of personal and social power, the activation of resources, and the development of a sense of control over one's life trajectory. Emphasis is placed on the operation of power, which, drawing on the analyses of social determinants of health, is divided into distal and proximal factors. It is highlighted that power operates through bodies, relationships, institutions, organizations, and everyday interactions. The PTM proposes a taxonomy of power: coercive, biological/embedded, legal, economic, material, and symbolic, linked to cultural, interpersonal, and ideological capital. This classification, explicitly non-exhaustive, suggests some of the domains through which power operates in people's lives. For example, economic power concerns the effects of unequal access to material resources on health experiences, while symbolic power describes how certain sociocultural constraints can influence opportunities and well-being (such as pressures related to sexuality and gender roles). Corresponding to the dimension of power are the questions: *What has happened to you? How has Power operated in your life?*

The next element, Threat, comprises the set of risks and dangers that negative operations of power pose to the survival, safety, and well-being of individuals or groups. Threats are seen as obstacles to human needs. They are divided into relational, emotional, community, economic and material, environmental, physical, and identity-related, and those associated with knowledge, construction of meanings, and basic values. Thanks to the use of colloquial and accessible language, the description of these threats is relatively straightforward. In the clinical interview, this dimension is reflected in the question: *How did it affect you?*

To emphasize the agency of individuals, the model states that the threats posed by the operations of power must be understood in relation to the meanings attributed to them by individuals and social groups. Meaning (Cromby,

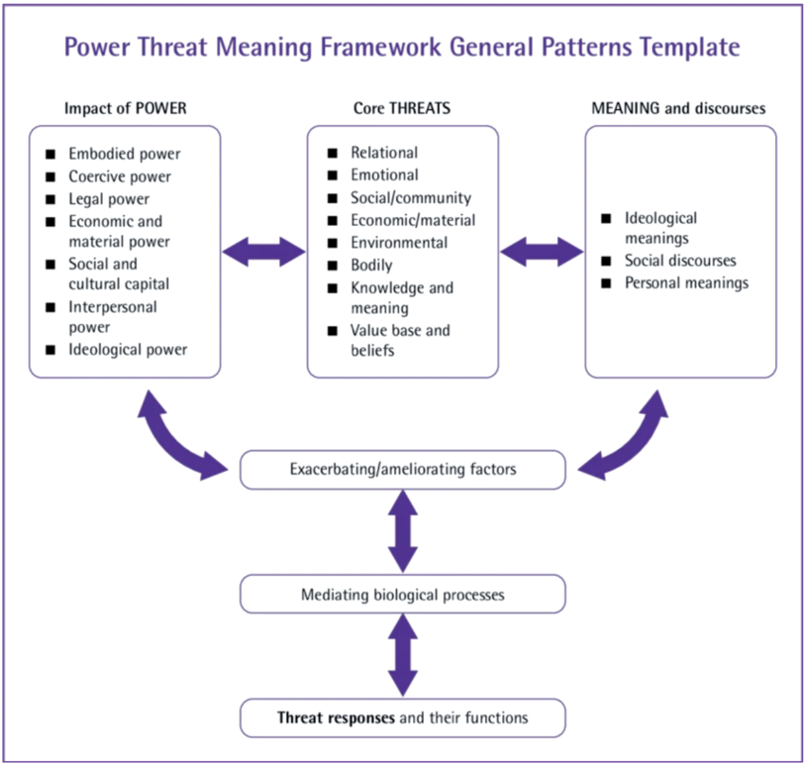

Figure 1. Principle schema within the PTM model (Johnstone L, Boyle M, Cromby J, *et al.*, 2018).

2022) may represent the element most similar to the clinical models familiar to us. The PTM emphasizes, however, that such meaning emerges "within dominant social and cultural discourses and primed by evolved and acquired bodily responses" (Johnstone & Boyle, 2018, p. 9). This dimension includes ideological meanings (dominant ideologies), social discourses, and cultural and personal meanings. The central role of meaning is recognized in its function of mediating "in shaping the operation, experience and expression of power, threat, and our responses to threat" (*ibidem*, p. 9). It is linked to the question: *What sense did you make of it?*

Finally, the Threat Responses refer to the actions that people take to "ensure their emotional, physical, relational, and social survival in order to cope with the negative impact of power" (*ibidem*, p. 9). These responses, based on the meaning attributed to threats exercised by power, are presented as learned or innate (physiological) survival strategies – activities endowed with sense and meaning, rather than as symptoms. These responses are listed without any claim to completeness and are positioned along a continuum, ranging from more to less reflexive, conscious, or the result of choice. Their experience, like that of meaning-making, is shaped by the biological and psychophysiological constraints of our species, as well as by the tools provided by one's cultural background. The question used to explore them is: *What did you have to do to survive?*

In addition to the questions related to the four components of the model, and in order to emphasize the dimension of agency and the importance of personal narrative, the interview also provides an exploration of the resources available to individuals (What strengths do you have?) and a broader view of their life history (What has happened to you?). From the application of the BF to the concrete experiences of individuals and groups, seven Provisional General Patterns are identified,[1] which will not be discussed here in detail. These constitute "survival strategies" rather than "symptoms": threat responses that transcend diagnostic categories, medical specializations, and the boundaries within which "normality" and "abnormality" are usually understood and that characterize, to some degree and at certain moments, the everyday life of every one of us (Johnston *et al.*, 2018, p. 192).

Although the Provisional General Patterns represent groupings of similar experiences and display partial correspondence with existing diagnostic categories, they are not discrete entities. In an attempt to overturn the essentializing logic of classic diagnoses, the patterns of experience are framed in

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[1] 1. Identity; 2. Surviving rejection, feeling trapped, and invalidation; 3. Surviving attachment deprivation and adversity experienced as a child/young person; 4. Surviving separation and identity confusion; 5. Surviving defeat, feeling trapped, disconnection, and loss; 6. Surviving social exclusion, shame, and coercive power; 7. Surviving single threats.

a *verbal* form as active strategies for survival in the face of unfavorable power dynamics. Rather than functioning as diagnostic labels, the Provisional General Patterns resemble a guide that enables certain salient aspects of personal history to emerge – those experiences that were decisive in adopting resilience strategies and in the structuring of distress, in relation to the available resources and contextual constraints. For example, the Provisional General Patterns may concern "Being identified/identifying as a member of a minority ethnic group" (p. 324), or "Surviving witnessing domestic violence as a child/young person" (p. 334), or "Coping with childbirth and childrearing" (p. 235). The aim is to use these patterns to create personal, group, and social narratives that help restore meaning and agency, subject to the relevant cultural assumptions, with the potential to generate hope, rebuild relationships, and promote social engagement. The objective thus combines the promotion of individual and collective health with, at the same time, the advancement of social justice.

The model seeks to account for the different components of experiences of distress, articulating them dynamically in relation to context and avoiding reductionism. The biological level, in that it provides the constraints within which the experience can occur, is considered crucial. At the same time, however, the social dimension is recognized as central in shaping, experiencing, and expressing distress. Similar to the attempt to move beyond both biological reductionism and subjective idealism within the epigenetic approach (Bottaccioli & Bottaccioli, 2024), the PTM integrates the body, material constraints, and physiological responses with social and cultural contexts, showing how responses to threats are at once biologically embodied and symbolic, probabilistic and situated. This dynamic and, in a sense, "holistic" approach makes it possible to address some of the limitations of current clinical models. On the one hand, it allows for the inclusion and interpretation of the cultural dimension of distress as a dynamic process of negotiation between experience and context. In a way similar to the concept of "idioms of distress" (Nichter, 1981), this makes it possible to move beyond problematic labels such as "culture bound" syndromes, implicitly essentializing in relation to Western standards: in this perspective, every expression of distress is dynamically "context bound", linked to a specific historical, material, and symbolic context. On the other hand, this approach makes it possible to move beyond the long-standing distinction between severe patients, often considered exclusively for psychiatric/pharmacological intervention, and other patients, possible candidates for psychotherapy. By acknowledging that there are different ways in which distress is experienced and expressed, and by avoiding labeling such variations as bizarre, primitive, or "more severe", it becomes possible to reduce the stigma that produces exclusion, systematically relegating the most vulnerable individuals to psychiatric services. Finally, the PTM is equally useful for individual interventions, as well as for work with families, groups, and communities. The emphasis on the context allows for a transformation of the setting, both by extending it to include significant others in the person's environment – not only family members – who may constitute a resource,[2] and by identifying action at the community, social, and policy level, aimed at modifying contexts and living conditions, thereby restoring power, sense of control, agency, and trust.

Dissemination and use

Having outlined the features of the model, we describe, through a non-systematic review of the literature, its areas of application, the subjects who use it, and some criticisms it has received.

Evidence from the literature indicates that its use extends beyond the clinical and healthcare sector, where it is primarily employed for case formulation by both individual practitioners and multidisciplinary teams (Nikopaschos *et al.*, 2023). Indeed, it has been adopted within psychological practices in the correctional settings to support individuals in custody in understanding the origins and functions of violence, thereby deconstructing a criminal identity (Gallagher *et al.*, 2025; Reis *et al.*, 2019). It is also used in educational and school contexts to analyze the distress of students and teachers, shifting focus from individual deficits to contextual pressures (Devenney, 2021). In these settings, it is employed by school psychologists, teachers, and educators, including as a tool for reflecting on their own practice and professional identity (Brett *et al.*, 2024), as well as an analytical framework for the British educational system as a whole (Bodfield & Culshaw, 2024). There is also evidence documenting the use of the PTM in informal support contexts, outside professional settings. This includes its use by carers of people with mental health difficulties to address their own challenges (Paradiso & Quinlan, 2021), as well as by mutual aid groups, such as the SHIFT Recovery Community, to make sense of their experiences of stress and foster a sense of agency, collective empowerment, trust, and validation (Community, 2022).

The systematic review by Gallagher and colleagues (2024) synthesizes the empirical evidence that has emerged and the main areas of application of the PTM five years after its publication. The study included 17 studies, and the narrative synthesis identifies four main areas. The first comprises studies in which the PTM was used to inform both data collection and analysis, guiding interviews, focus groups, and thematic analyses in line

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[2] In a manner similar to the *Open Dialogue*, to which a final section is dedicated.

with the dimensions of the SB. In the second, the PTM was used exclusively for data analysis, without structuring data collection. The third area includes studies exploring professionals' responses to the PTM, their perspectives, and the challenges of its application. Finally, the authors identify studies describing PTM-informed psychological practices, such as interventions and case formulations, across different settings. This important body of work must be situated within a lively debate surrounding the PTM. In addition to the criticisms reported by the authors concerning the robustness of the evidence underpinning the model, doubts as to whether the SB meaningfully differs from diagnostic labels, and the charge that it entails ableist assumptions (Gallagher *et al.*, 2024), the most substantial area of critique is philosophical. For example, it has been argued that, despite presenting itself as an emancipatory alternative to traditional diagnostic models, the PTM risks becoming a further "master narrative", imposing a totalizing interpretative framework on the experience of distress (Rashed, 2023). In this vein, some contend that, notwithstanding the PTM rejects the disease model, it implicitly reproduces its structure by adopting a reductive and inconsistent notion of meaning, reducing power to threat and offering a linear account of distress (Morgan, 2023). This critique, however, is challenged by a close reading of the model, which, rather than proposing linear pathways (biological, environmental, or psychological), integrates these components within a complexity-oriented perspective: without granting primacy to contextual dimensions, it reincorporates them alongside biological and psychological ones, restoring their value and visibility. In support of this, the foundational document itself states that "all human experiences are mediated by our biology" (Johnstone *et al.*, 2018, p. 5): responses to distress are described as both biologically embodied and symbolically mediated, thereby ruling out, at least in the authors' intentions, any reduction of distress to the contextual or threat dimension alone.

While, from a theoretical perspective, many of the critiques directed at the model present shareable nuances, the PTM conserves, in our view, the merit of offering concrete, practical, and constructive alternatives for moving beyond the purely deconstructive critique of traditional diagnostic paradigms and can be applied across a wide range of contexts, settings, and disciplines (Atkinson *et al.*, 2025; Gallagher *et al.*, 2024). Beyond the philosophical dimension, an unresolved issue concerns the clinical and practical applicability of PTM within healthcare settings that are strongly oriented towards diagnosis, not only in clinical terms but also at an organizational and bureaucratic level – and within training pathways centered on the transmission of a classificatory *forma mentis* through specific psychopathological languages. The PTM itself, despite explicitly proposing to become an alternative capable of fulfilling the functions that diagnosis currently claims to serve – such as indicating interventions, making decisions about access to services, or guiding legal rulings – acknowledges that “diagnostic thinking is deeply embedded in administrative systems for services and in society as a whole” (Johnstone *et al.*, 2018, p. 31) and admits that “in the short and medium term, psychiatric diagnoses will still be required for people to access services, benefits, and so on” (*ibidem*, p. 18). It seems, therefore, that the applicability of the PTM, while positioned in a dialectical relationship with the cultural and power hegemony exercised by the DSM, does not lie in replacing it as a new dominant nosological system. Rather, it lies in balancing diagnostic activity with an increased emphasis on resources, engaging with the context, the inclusion of a plurality of actors, and a tendency towards *empowerment*. Furthermore, by calling clinicians to account for a specific ethical, political, and value-based positioning, the PTM appears to redefine, in our view, a certain degree of agency that characterizes the role of the health professional. Rather than acting as the mere expression of an overarching system, the clinician adopts a dialectical stance with health-related knowledge and practices, co-constructing, together with the patient, strategies aimed at regaining power over their own life. In this sense, it involves adopting an active role in relation to diagnosis, which becomes one among many elements that can be flexibly mobilized within a shared process: deconstructed and abandoned when necessary, or strategically adopted when useful for meaning-making or for accessing certain rights linked to receiving a psychiatric diagnosis (for example, concessions at work or school). Making explicit the dimension of power exercises through clinical practice thus enables therapists to assume responsibility not only at the level of psychological change but also by engaging in collaborative, dialectical, or even conflictual exchanges with the actors and structures present in both their own and their patients’ life contexts. In this way, their scope of action expands beyond the clinical field to include interventions at the level of services and policies (Read & Harper, 2022), as well as social participation and cultural production. The PTM devotes considerable space to the possible practical applications of the model beyond the clinical settings, articulating them across areas such as service programming, legal practice, research, and health policy. Getting involved in health policy by seeking to contribute through campaigns or advocacy actions, or the production of position and policy papers, or by opening to the public through meetings aimed at co-constructing non-pathologizing narratives of mental health – these represent just some of the ways one can take up the challenge.

As is evident, we envisage a profound shift not only in professional instruments, but in the very conception of the psychotherapist’s role. This can only occur through a substantial investment in dialogue, discussion, training, and supervision within the settings that address mental health, whether educational or practice-based. To this end, interdisciplinary dialogue is an essential tool, stripped free from those forms of sectarianism that fuel instrumental divisions, as well as the inclusion of a plurality of voices ranging from practitioners to service users, from family members to teachers, and from younger to older generations. We are aware that adequate levels of available training and organizational support may be difficult to secure in high-pressure institutional contexts. However, in keeping with the ethos of the PTM, we believe that this process can start from the bottom up, through forms of self-organization and at the level of individual services, and then spread more widely through dialogue and collaboration.

Conclusions

With its complex perspective on social dynamics and by offering flexible lenses through which to grasp the articulation of distress within lived contexts, the PTM can be a valuable resource. Beyond providing a framework for understanding and intervention that foregrounds issues of power and adaptation, the PTM enables us to move beyond the illusion of clinical neutrality. The widespread assumption that clinical *dispositifs* can enjoy a "state of sociological weightlessness" has long been challenged, for example, by Castel with his concept of "*Psychanalisme*" (Castel *et al.*, 1975), more recently extended more broadly to psychotherapy thanks to the construct of "Psychotherapism" (Bessone, 2023; Bessone *et al.*, 2022), or by the psychopolitical and critical psychology perspectives (Bessone *et al.*, 2024; Prilleltensky, 2008). In practice, this presumed neutrality obscures social inequalities and their role in the production of distress, amplifying the ways in which clinical *dispositifs* may reproduce inequitable aspects of the social order, thereby contributing to iatrogenic processes. In this sense, the PTM does not merely introduce a political perspective *into* clinical practice itself, but suggests the inherently political nature *of* clinical practice, understood as a knowledge-power *dispositif*. This is recognized as a *dispositif* endowed with a constitutive relationship to the social organization from which it derives and which it reproduces. Thus, the set of clinical practices and theories can never be separated from their *social function*. The PTM introduces a tension aimed precisely at transforming the social function of the clinic, denouncing its tendency to be conservative and oppressive, and calling for its dialectical subversion, in a manner analogous to the Basaglian overturning. If the prevailing prescription for clinical settings is to separate psychology from politics, the personal from the political, the PTM operates in the opposite direction by structurally reconnecting these two dimensions, emphasizing their intrinsic relationship. The PTM reconstitutes the political dimension of clinical action, understood as its potential to reinforce or transform some aspects of the social structure within which it operates and of which it is both a part and its expression. Moreover, Freud had already stressed the need to recognize the role of the oppressive aspects of society in shaping psychic suffering, and called for their transformation, as illustrated, for example, by the anecdote of the horse at the end of the *Five Lectures* (Freud & Staude, 2007).

In this perspective, the PTM represents a practical tool for organizations working in the field of health that are grounded in clear political coordinates and aware of their social role, seeking to integrate health promotion with social justice (Labonté & Laverack, 2008; Powers & Faden, 2006). Such organizations may struggle to find clinical models that are consistent with their ethical vision. In this sense, although open to further refinement, the PTM provides a concrete alternative: by overcoming the classic dichotomies of body-mind, individual-society, private-public, it offers a conceptual and methodological framework to address not so much chemical imbalances and instinctual conflicts as power imbalances and social conflicts. The proposed adoption outlined here highlights its benefits primarily in terms of a greater alignment between the clinical component and the organizational level with their underlying political coordinates, of which the clinical dimension is only one part, thus serving as a bridge between theory, practice, and mission.

This may apply, for example, to social outpatient clinics or "*Social Clinics*" (Da Mosto *et al.*, 2023), as well as to organizations that seek to embody a "*socially inspired psychotherapy*" (D'Elia, 2024) and are attentive to context, such as the *Rete di Psicoterapia Sociale*.[3] These innovative practices embody in the current context the legacy of earlier experiences, such as the *Free Clinics* (Danto, 2005), in which individual and collective change were regarded, as we believe they should be, as mutually inseparable and part of a broader commitment to the common good.

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[3] See the proposal by Fabio Vanni: https://progettosum.org/wp-content/uploads/2025/06/Relazione-Vanni-24.5.25.pdf

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