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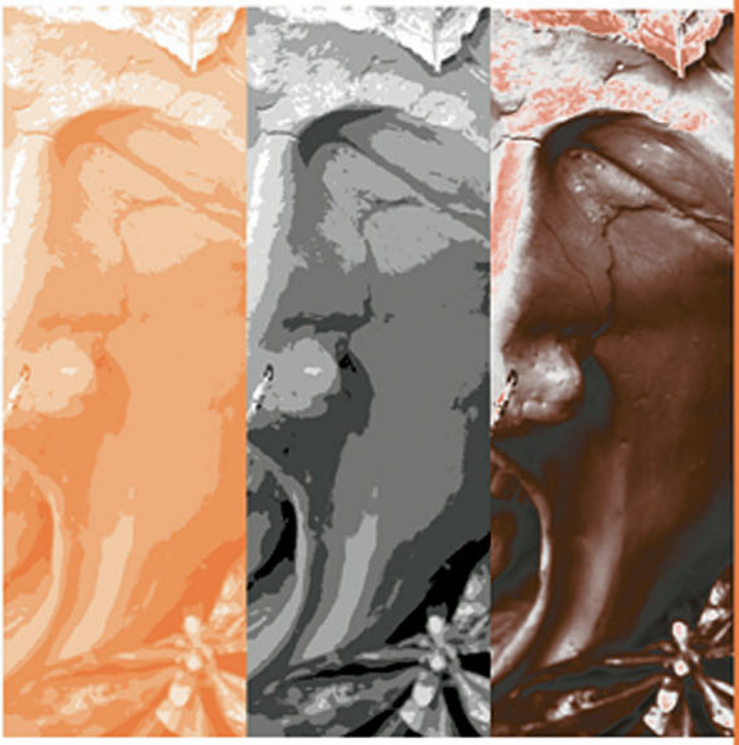
JOHN F.M. GLEESON, EÓIN KILLACKEY
AND HELEN KRSTEV

Psychotherapies for the Psychoses



THEORETICAL, CULTURAL AND CLINICAL INTEGRATION

PUBLISHED FOR isps THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES

Psychotherapies for the Psychoses

Throughout the world, access to psychotherapeutic and psychosocial treatments for the psychoses varies significantly, with many people diagnosed with psychotic disorders receiving only medication as treatment. *Psychotherapies for the Psychoses* considers ways that this gap can be bridged through theoretical, cultural and clinical integration.

The theme of integration offers possibilities for trainees and experienced mental health professionals from diverse orientations and cultural perspectives to strengthen alliances for tackling the gap in availability of treatments. In this volume contributors discuss:

- Theoretical integration across the psychological therapies for psychoses
- Global perspectives on psychosocial approaches for psychoses
- Integrating psychotherapeutic thinking and practice into 'real world' settings.

Psychotherapies for the Psychoses explores different approaches from a variety of theoretical perspectives, providing significant encouragement for mental health practitioners to broaden the range of humane psychotherapeutic possibilities for people suffering from the effects of psychosis.

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Theoretical, cultural and clinical integration

Edited by John F. M. Gleeson, Eóin Killackey and Helen Krstev

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The ISPS (the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses) has a history stretching back some fifty years during which it has witnessed the relentless pursuit of biological explanations for psychosis. The tide is now turning again. There is a welcome international resurgence in interest in a range of psychological factors in psychosis that have considerable explanatory power and also distinct therapeutic possibilities. Governments, professional groups, users and carers are increasingly expecting interventions that involve talking and listening as well as skilled practitioners in the main psychotherapeutic modalities as important components of the care of the seriously mentally ill.

The ISPS is a global society. It is composed of an increasing number of groups of professionals organized at national, regional and more local levels around the world. The society has started a range of activities intended to support professionals, users and carers. Such persons recognize the potential humanitarian and therapeutic potential of skilled psychological understanding and therapy in the field of psychosis. Our members cover a wide spectrum of interests from psychodynamic, systemic, cognitive, and arts therapies to the need-adaptive approaches and to therapeutic institutions. We are most interested in establishing meaningful dialogue with those practitioners and researchers who are more familiar with biological based approaches. Our activities include regular international and national conferences, newsletters and email discussion groups in many countries across the world.

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Dedicated to the memory of
Wayne Fenton
24 March 1953 – 3 September 2006

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Foreword

This new book springs out of the Fourteenth International Society for Psychotherapy in Schizophrenia (ISPS) Conference, held in Melbourne, Australia in September 2003. The theme of the conference was different perspectives in 'understanding' and 'treating' psychosis. Even the use of these two terms is arguably contentious and will no doubt land me in hot water!

The book represents a broad church with contributions from those with a cognitive-behavioural perspective, those adopting a more narrative approach and those operating from a psychodynamic approach. There are frequently tensions between proponents of these various approaches. The book attempts to bring together these different theoretical perspectives in a meaningful way. Material is examined from a theoretical perspective, a global perspective and an integrative perspective. The last specifically deals with integrating psychological interventions into 'real life' settings.

In the third section, the various approaches appear to take their beginnings from the patients themselves, recognizing the different needs of the first-episode patient group and their unique characteristics including developmental phase. The importance of the treatment alliance and collaboration is pivotal to working with this patient group; if one cannot engage these individuals, obtain some shared understanding, then there can be no therapeutic progress. One of the lessons learned from psychodynamic approaches has been the primacy of the therapeutic alliance – something to my mind traditionally denied by behaviourists and given some but insufficient attention by the first generation of cognitivists. In psychotherapy the patient is an 'active' collaborator rather than being the recipient of action initiated by an external referent, the therapist. 'Experience', 'Understanding' and 'Collaboration' are key constructs.

It is pleasing to see that there is a major focus on families in this book. The family has traditionally been vilified, excoriated or neglected since the 1950s. There is a renewed focus on working with families to better understand their problems including their need for support and assistance in living with and 'assisting' the client. Equally importantly, there is a need to prevent

morbidity in family members and isolation of families from their own social network.

Another line of work concerns individuals in the pre-psychotic or 'at high risk' phase. This work is perceived differently by some clinicians: is it damaging and unethical to treat such people – only a percentage of whom will go on to develop psychosis of any type – or is it neglectful and unethical not to treat them? There are different views on this issue and we need to accept the merits of the arguments mounted by proponents of both sides of the debate.

A clear strength of this book is a willingness to entertain different perspectives and to examine the similarities and commonalities in approaches or at least commonalities in aspects of the various theoretical approaches, i.e., the focus on the individual or the family; on attempting to engage and form alliances with them; to understand the client's story – how do they perceive themselves and their 'mental illness'; the developmental tasks and challenges they face. Conciliation and tolerance are words that I would argue come through in this book but also a commitment to evidence of different kinds.

The book includes contributions from researchers and clinicians from various countries and this reflects a real strength of ISPS – it is a truly international organization. Two international contributions – one from New Zealand and one from India – provide descriptions of the cultural context for understanding psychosis and the delivery of psychotherapy for individuals with psychosis.

Two important figures, Professor Ian Falloon and Dr Wayne Fenton, died in 2006 and both had been involved in ISPS at different times. Born in New Zealand, Ian Falloon held a number of academic-clinical positions in the United Kingdom, USA, New Zealand and Italy. Ian was a seminal figure in developing psychoeducational family programmes to assist patients and families alike, in developing behavioural interventions for clients in the community and for his work in examining pre-psychosis clients. Often controversial, and sometimes confrontational in professional fora, Ian did believe passionately in helping clients and families to the best of his ability.

Wayne Fenton was at the time of his death involved as a senior figure in the National Institute of Mental Health in the USA and was a wonderful advocate for sufferers of schizophrenia and their families. I first became aware of Wayne's work in academic psychiatry when he emerged as a collaborator of Professor Tom McGlashan at Yale University and Chestnut Lodge. It is tragic that Wayne seemingly died at the hands of one of his clients and this dreadful event made the news world-wide. This is something that Wayne would have deeply regretted. He was concerned about improving patient outcomes and decreasing the community stigma that patients faced, so the manner of his death is ironic.

So how do we move forward from here? First, this book indicates that psychosocial approaches to understanding and treatment are alive and well. We are addressing significant issues in our collective work, e.g., relapse

prevention, the subjective experience of clients, maintaining integrity of the self, stigma, vocational recovery, complex comorbidity and early detection. Our approaches form an important counterbalance to the prevailing biological perspective fuelled by significant funding opportunities and the financial rewards to be made in pharmacotherapy treatments, notwithstanding their efficacy. We have a harder row to hoe, though we must be equally careful in the claims we make for our therapies and not appear to be overly zealous or dogmatic in proselytizing our psychosocial approaches. We need to continue to show a strong commitment not only to the plight of our clients and their family members but also to the science of our approaches and the significance of our empirical findings. Both Wayne and Ian would have seen these two aspects as absolutely core (essential) to their own practice and advocacy.

Henry Jackson
May 2007

Preface

This book began in September 2003 when the Fourteenth International ISPS symposium was held in Melbourne, Australia. In the months following the meeting, Brian Martindale, the editor-in-chief of the ISPS book series, quietly, but persistently, urged the Melbourne-based group at ORYGEN Youth Health, via Patrick McGorry, to take responsibility for gathering key papers from the meeting into this volume.

Initially we were somewhat overawed by the challenge of capturing the volume and diversity of papers into a coherent book and, although our backgrounds include both the psychoanalytic and cognitive behavioural perspectives, we knew that many of the papers were beyond the scope of our range of theoretical orientations, which made the task of adequately representing the meeting seem near impossible. In our early editorial discussions, we found ourselves returning to the topic of the debate at the meeting which was entitled: 'Can biological and psychological interventions be integrated in the treatment of psychosis?' All three of us were somewhat surprised and challenged by the avid defence by some of the negative position. We shared an experience of working in a public sector mental health context where psychosocial interventions were strongly supported and we knew that our clinical and research colleagues at ORYGEN Youth Health shared our aspiration of integrated treatments. I believe we also shared with many delegates at the meeting a sense of dissatisfaction and frustration with the narrow terms of the debate, and we found ourselves motivated to expand upon the theme of integration.

We started to recognize that the debate, or more specifically the issue of integration, could serve us well as an organizing theme for this volume. With Brian Martindale's encouragement we steered away from attempting to record a belated set of conference proceedings, and set about the task of thinking more broadly about integration. In reviewing the conference abstracts we mapped out three aspects to this theme. So, the end result is that by using the narrow question of the debate as our starting point, this volume progresses through other critical themes, including theoretical integration across the psychotherapies in psychoses, cross-cultural perspectives in

psychotherapies for psychoses, and integrating psychotherapies into public sector practice.

In addition to integration, another theme, or perhaps tension, is apparent throughout this volume – that between optimism and pessimism. On the one hand we see that the theme of integration, in its broadest sense, offers hope to the sufferer with psychosis and their family, because their experience is often characterized by fear, confusion, suffering and *disintegration*. On the other hand, one cannot help but feel overwhelmed by the gaps in the availability of psychosocial interventions in real world settings, and by the scarcity of integrative theoretical discussions in the field of psychosis. To write about and to reflect upon the efforts of others in addressing these gaps has been in many ways both a labour and a privilege which has had the transforming effect of heightening our awareness of the need for more effective and responsible advocacy across the globe for the availability of psychosocial treatment and related research.

We hope that this collection offers possibilities for experienced psychotherapists and for trainees from diverse orientations and cultural perspectives to strengthen alliances for tackling this gap. It is our belief that the process of striving for integration promotes constructive theoretical dialogue and stimulates the development of sustainable innovations in practice within contemporary public mental health settings. Our aim is that this text will stimulate the reader, and assist them to encourage colleagues, to creatively integrate psychotherapeutic thinking and practice into specific treatment settings.

John F. M. Gleeson, Eóin Killackey and Helen Krstev
Melbourne

Chapter 1

Integration and the psychotherapies for schizophrenia and psychosis

Where has the 'new view' of schizophrenia taken us?

John F. M. Gleeson, Helen Krstev and Eóin Killackey

Chapter overview

In this introductory chapter we have undertaken a selective review of contemporary integrated aetiological accounts of psychosis. We include a detailed description and critical analysis of the stress vulnerability models (SVM) of psychosis. We acknowledge their limitations, but argue that these models have provided a valuable theoretical platform for the development of integrated treatments in psychosis and for multidisciplinary research efforts which could expand our understanding of psychosis beyond classical linear models of aetiology. However, we lament the gap between the vision, offered in the 1970s, via the so-called 'new view' of schizophrenia and its translation into both practice and research. We conclude that more needs to be done, especially by the leaders of psychosocial research, to actualize the vision of integration.

Levels of integration

Before providing an account of the history of recent integrated perspectives of psychosis, it is worthwhile to consider the possible levels at which integration can occur in relation to treatment. One conceptual framework was provided by Norcross and Goldfried (2005) in the second edition of their edited volume on integration in the psychotherapies. They suggested that integration can be achieved, first, at the micro-level of technique (i.e., technical eclecticism); second, by considering the interactions and synergies between separate treatment approaches (e.g., psychotherapy *and* psychopharmacology); or third, by blending theoretically diverse approaches into integrated models of therapy (e.g., cognitive analytic therapy or dialectic behaviour therapy). An integrative 'perspective' in the psychotherapies has also been described, which has been characterized as a flexibility and inclusiveness in attitude to treatment approaches. Additionally, the term 'integrated approaches' has been used as a collective description for all of these efforts (Greben, 2004).

Integration in schizophrenia and the psychoses

Attempts to integrate aetiological explanations and treatments in schizophrenia have an extensive history. These efforts appear to be underpinned by a belief that interdisciplinary research endeavours provide the best hope for furthering the understanding of psychoses, and, that patients and their families will achieve substantial benefits from integrated treatments. We believe that these efforts can be broadly described as consistent with the 'integrative perspective'. Additionally, we can point to some examples of technical eclecticism contained in individual psychotherapeutic interventions described in the research literature (Hogarty et al., 1995). However, it is noteworthy that so little consideration has been given in the psychosis literature as to *how* to integrate across treatment approaches (Gabbard, 2006), and that examples of coherent, theoretically blended models of psychotherapy in psychosis are so rare (Kerr et al., 2003). As an illustration of this state of affairs, it is noteworthy that Norcross and Goldfried's (2005) extensive volume does not contain a single reference to the application of integrated psychotherapy to psychosis or schizophrenia.

The Melbourne ISPS debate: our starting point for a focus upon integration

At the Fourteenth International ISPS symposium in Melbourne in 2003, a panel of psychiatrists and psychologists, including Professor Henry Jackson, Dr Brian Martindale, Dr John Read, Professor Richard Bentall, Dr Wayne Fenton and Dr Ann-Louise Silver debated the question: 'Can biological and psychological interventions be integrated in the treatment of psychosis?' This discussion provided a starting point for this chapter, and the volume. Arguing for the affirmative Dr Brian Martindale argued:

> the simple answer to the debate is that they can be integrated. However the most important point is that psychological therapies are very rarely offered to any substantial degree and are usually done in such a skewed fashion dominated by biology.

Although on the opposing team Dr John Read opened his address also arguing that integration was desirable but that political and economic realities actively worked against it. He went on to argue that:

> The claim that we already have integration is frequently made, with reference to the 'stress-vulnerability' or 'stress-diathesis' paradigm. This is often equated with the so-called 'bio-psycho-social' model. This model, as currently applied, is actually a colonization of the psychological and the social by the biological.

These arguments lead us to an examination of the history of the 'stress-diathesis' paradigm in psychosis – specifically to reconsider its appropriateness as an integrative theoretical perspective, and to a consideration of the 'application' of the 'new view' of psychosis.

The 'new view'

The thirtieth anniversary of Zubin and Spring's (1977) 'new view of schizophrenia' is an appropriate vantage point from which to reflect upon its impact. Having emerged contemporaneously with Engel's (1977) broader critique of reductionistic biomedicine and his alternative 'biopsychosocial' model, Zubin and Spring's (1977) model remains the most influential example of an integrated model of the aetiology of schizophrenia – nearly 700 citations of their article at the time of writing is indicative of its popularity within the international research community.

Few contemporary leading researchers in the field of psychosis would argue for a unifactorial account for the aetiology of schizophrenia. Unfortunately, this consensus and enthusiasm for integrated aetiological explanations has not been translated into access to integrated treatments – we would concur with Brian Martindale and John Read that even across wealthy industrialized nations treatments are too often narrowed to biological options, or psychosocial interventions are adjunctive afterthoughts to antipsychotic medication. Data from our own country, Australia, provides a case in point. A national prevalence survey of people diagnosed with psychotic disorders revealed that less than 40 per cent of individuals with psychotic disorders reported receiving counselling or any form of psychotherapy over the previous year (Jablensky et al., 2000). Not surprisingly, this evidence provided a basis for cogent arguments for a redistribution in Australia of mental health resources for the treatment of psychosis towards psychosocial treatments and community supports (Neil et al., 2003). As also pointed out by Brian Martindale in the ISPS debate, there is compelling evidence that, despite the empirical support for their effectiveness (Pilling et al., 2002), family based interventions are rarely implemented into routine care (Fadden, 2006). From the perspective of the patient and carer, it has to be concluded that much of Zubin and Spring's (1977) vision remains unfulfilled.

The history of the stress vulnerability frameworks: an integrative perspective on psychosis

During the twentieth century a range of theoretical orientations strongly influenced explanations of the development and course of psychosis, including psychoanalytic theory, family systems theory, learning theory, and a range of biological models (Perris, 1989). Elsewhere, these have been classified in terms of theories focusing on environmental factors, learning and

development theories, and biological models. The problem, according to Zubin and Spring (1977), was that none of these met the criterion for an adequate aetiological explanation for the onset and course of schizophrenia (Zubin and Steinhauser, 1984). This was the starting point for their macrotheory or 'heuristic framework' for psychosis.

The original model offered the promise of providing an integrated aetiological account of schizophrenia which could break the empirical logjam attributed to the competing unifactorial explanations, and was promoted as a theoretical framework for integrating psychotherapeutic and biological treatments.

The popularity of the SVM can also, in our view, be understood as a reaction to the pessimism of the Kraepelinian disease concept of schizophrenia, which others have argued was underpinned by nineteenth century ideas of *degeneration* and *disintegration* with implicit assumptions of inevitable deterioration (Barrett, 1998a, 1998b). This pessimism was countered by a series of long-term follow-up studies conducted in the 1970s and 1980s, which highlighted the prevalence of an episodic course amongst the population diagnosed with schizophrenia – at odds with Kraepelin's assumptions regarding prognosis. Although not entirely new, these data provided important grist for the SVM mill (Zubin et al., 1992).

The basic assumption of stress vulnerability models

The shared assumption of SVMs is that psychotic episodes result from an interaction between stable or *distal* factors (e.g., genetics *or* personality variables) and transient or proximal factors (e.g., life events, interpersonal conflict). The proponents of the stress vulnerability models agreed that interactions amongst these factors can result in acute psychotic psychopathology via the activation of latent vulnerability (Ciompi, 1989; Nuechterlein et al., 1992; Perris, 1989; Strauss et al., 1985; Zubin and Spring, 1977). Furthermore, as far as we know, all proponents subscribed to the notion that acute symptoms can be prevented or ameliorated by some combination of the individual's personal resources, the emotional support of close others, and by biological treatments. However, further analysis reveals that a diversity of models emerged with varying fundamental assumptions. Some examples of these variations are outlined next, followed by a description of their evolution.

An overview: from 'triggers' to 'integrated developmental perspectives'

According to Perris, the SVMs inherited older conceptualizations of *individual vulnerability* conveyed in the ancient Greek *diathesis* and in psychoanalytic accounts of the neuroses dating from the time of Freud (Perris,

1989). Perris also suggested that stress vulnerability proponents are indebted to Jaspers for linking hereditary predisposition (*Anlage*) and environment in his theory of the genesis of psychopathology (Jaspers, 1913, cited in Perris, 1989).

Paul Meehl's (1962, 1989, 1992) theory of *schizotaxia* was perhaps one of the first aetiological arguments for an interaction between an underlying latent propensity for schizophrenia and environmental contingencies based upon empirical research. Citing findings on neurological soft signs, Meehl (1989) argued that *schizotypes* inherit an integrative defect of the central nervous system (CNS) which he labelled *schizotaxia*: 'it is something wrong with every single nerve cell at all levels from the sacral cord to the frontal lobes' (Meehl, 1989, p. 936). He conjectured that schizotaxia, with the addition of variable social reinforcement schedules, led to the development of schizotypal personality organization, characterized by anhedonia, cognitive slippage, ambivalence, and interpersonal alienation. Meehl hypothesized that approximately 10 per cent of so-called *schizophrenes* developed schizophrenia via a range of potentiators, including invalidating social relationships.

Zubin and Spring's stress vulnerability model

The stress vulnerability nomenclature was introduced by Zubin and Spring (1977). They emphasized the episodic course of schizophrenia, as opposed to a continual disease process, arguing that individual episodes were triggered by endogenous and exogenous *challenging events* which exceeded the patient's vulnerability threshold. Zubin and Spring conceptualized vulnerability as either a genetically *or* environmentally acquired level of risk for developing the disorder, which could be offset by coping capacities, and by an ability to learn from previous episodes.

Zubin and Steinhauser (1984) added the concept of *etiotypes* to the model, i.e., heterogeneous pathways leading to the development of schizophrenic vulnerability with equivalent behavioural and symptom outcomes. It was argued that *aetiological life events* could produce various etiotypes through genetic, biochemical, neurophysiological, developmental, or learning mechanisms. In other words, many pathways potentially led to vulnerability and ultimately psychosis. We would argue that these theorists foreshadowed the trauma-vulnerability pathway highlighted more recently by Read and colleagues in their traumatogenic model (Read et al., 2001).

These early versions of the SVM model were criticized on several fronts. The main concerns were that they failed to stipulate schizophrenia-specific aetiological pathways to vulnerability and that the conceptualization of stress within the model overlooked subjective appraisal of life events (Nicholson and Neufeld, 1992). Others criticized the model for its characterization of remission from positive symptoms as a state of equilibrium, because it failed to account for deterioration in other symptom domains, such as negative

symptoms (Carpenter, 1981). For some, this formed the basis for a rejection of the SVM in favour of a synergetic account of the psychosocial ecosystem (Dauwalder and Hoffman, 1992).

The UCLA model

Nuechterlein and Dawson (1984) incorporated Zubin and Spring's model into their *heuristic conceptual framework*. Drawing tentatively upon putative vulnerability factors, they attempted to outline the processes leading from stable, trait-like vulnerability to transient intermediate states (i.e., prodromal psychosis), and eventually to psychotic behaviours. They proposed that deficits in information processing were central to enduring vulnerability. They described interactions between these deficits and autonomic hyperactivity, and social competence and coping skills. When this interplay between enduring vulnerabilities became engaged in a vicious feedback loop with the social stressors and unsupportive social networks, transient intermediate states purportedly resulted. They argued that these states were marked by processing capacity overload, hyperarousal and deficient processing of social stimuli. In accordance with Zubin and Spring's (1977) model, unless the cycle was broken, psychosis resulted. Zubin and Spring's (1977) concept of a *threshold* for psychosis was also incorporated into the UCLA model of relapse, which entailed the hypothesis that maintenance medication raises 'the threshold for the appearance of psychotic symptoms' (Nuechterlein et al., 1994, p. 63). Nuechterlein and Dawson's (1984) initial working model evolved to later incorporate the concept of personal and environmental protective factors which buffered the individual from personal vulnerability factors and *environmental potentiators* (Nuechterlein et al., 1992).

Systemic stress vulnerability models

The paradox of the SVM discourse, in our view, is that in attempting to provide a macro-level, humanistic explanation of psychosis, the language is often sterile, with explanations built upon metaphors which seem to disallow the actual human experience of psychosis to be conveyed, in the way, for example, that seems more permissible in the consumer recovery literature (Corrigan, 2006). If Kraepelin's *dementia praecox* was underpinned by language and concepts belonging to degenerative infectious disease processes (e.g., general paresis), then perhaps the concepts underlying stress vulnerability models were influenced by physiology, reflected in the discourse of *thresholds, feedback loops, triggers* and *equilibrium*.

The metaphor was made explicit in Claridge's (1990) argument for a *systemic disease model* of schizophrenia. Claridge proposed, like Eysenck (see Eysenck and Eysenck, 1976), that there was a continuity of schizotypal personality variables, which was implicated in vulnerability, from the normal

population to the identified patient population, although the clinical population was situated at the extreme end of the distribution. This was compared to the diagnosis of hypertension because blood pressure levels are continuous from the healthy to the clinical population. This argument is maintained of course by contemporary researchers (Myin-Germeys et al., 2003).

A second example of a systemic illness model was provided by Ciompi (1989). Like Zubin and Spring (1977), Ciompi (1989) was concerned with the competing unifactorial conceptualizations of schizophrenia which he believed were analogous to multiple perspectives of the same mountain peak. His theory aimed to bridge explanations from biological and psychosocial perspectives. Ciompi, consistent with the UCLA group, argued that information processing deficits, associated with hyperarousal and increased sensitivity to stress, were implicated in premorbid vulnerability. However, he emphasized more strongly the interplay of biological and psychosocial processes over three stages, including the evolution of vulnerability, the onset of active psychosis (which he termed *psychotic decompensation*), and beyond (i.e., chronic states, remission or residual symptoms).

Ciompi's links between environmental processes and biological substratum were constructed from four theoretical components. The first was stress theory, which for Ciompi was important in linking environmental adversity (overburdening the vulnerable information processing channels) to hyperarousal resulting from secretion of adrenaline and noradrenaline, which, he pointed out, produced modifications in the central nervous system (Ciompi, 1989). This enabled Ciompi to hypothesize about the impact of a conflictual family environment upon the development of the *vulnerable premorbid terrain* and course of illness.

The second mediator described by Ciompi was neural plasticity, i.e., the finding that neurons react to repeated stimuli both functionally and anatomically, consolidating the organization within neural networks. For Ciompi this system of *privileged pathways* constituted the psyche (Ciompi, 1989, p. 17). Plasticity, affected by environmental *and* biological processes, enabled him to link neural functioning and structure to affective and cognitive patterns which could be implicated in schizophrenic vulnerability.

Third, Ciompi referred to theoretical models of dopamine pathways, which he argued associated basic arousal and attentional processes with higher order executive functioning. Ciompi argued that excessive dopamine levels resulted in a disturbance in the interaction between emotions and cognitions in patients with a premorbid vulnerability. Finally, he drew upon the theory of dynamics of complex systems, which originated from thermodynamics, to account for shifts between equilibrium and active psychosis. This theory postulates that catastrophic structural changes (called *dissipative structures*) can result from a rapid redistribution of excess energy within a system, producing a *cascade effect* when the point of no return is reached. Ciompi pondered the

utility of this theory for the development of mathematical models of the course of schizophrenia. We would argue that Ciompi's set of theories provided an enriched view of the genesis of vulnerability and the connections between stress and vulnerability, incorporating both biological and psychosocial factors.

Brenner and collagues also attempted to close the explanatory gap between vulnerability and specific phenomenology (Brenner et al., 1994). Consistent with the UCLA group, Brenner's model emphasized an interaction between biological processes, cognition, and psychosocial stress. Drawing upon findings from a range of neurobiological methodologies (i.e., computerized tomography (CT), magnetic resonance imaging (MRI) and neuropathological studies) Brenner's group argued that deficits in information processing stemmed from premorbid damage to the paralimbic structures. They posited that early damage to these structures, when followed by psychosocial stress and/or spontaneous physiological processes, lead to a breakdown in critical integrative functions, producing the phenomenology of psychosis. This theory formed a basis for Brenner's Integrated Psychological Therapy (IPT) with a focus upon compensatory improvements in information processing.

Interactional-developmental models

Carlo Perris' *constructivistic and interactionistic developmental perspective* on vulnerability (Perris, 1998, p. 29) entailed a broad conceptualization of vulnerability (Perris, 1989, 1998). Like other stress vulnerability proponents, Perris assumed that schizophrenia subsumes a group of heterogeneous syndromes which have heterogenous aetiological pathways.

Perris' model of vulnerability differed from other SVMs in a variety of ways. His first point of departure was his conceptualization of vulnerability. Perris assumed that information processing deficits reflected largely unconscious dysfunctional working models (or schemas) of the self and the environment. Perhaps more radically, Perris assumed that vulnerability was generic in nature, becoming differentiated and expressed in specific psychopathological form – thus psychosis was only one possible manifestation. Reframing Zubin and Spring's (1977) thesis, he wrote: 'Each of us is endowed with a degree of vulnerability that under suitable circumstances can express itself in a psychopathological disorder. Such a disorder may assume the characteristics of a schizophrenic syndrome' (Perris, 1998, p. 27). This conceptualization of a *generic* vulnerability is consistent with the *dynamic vulnerability formulation* proposed by Nicholson and Neufeld (1992).

The trajectory of Perris' vulnerability also differed from the earlier models. Although others also emphasized the interplay between vulnerability and stress (see Nicholson and Neufeld, 1992), Perris proposed that vulnerability evolved across the lifespan through dialectical transactions between the person and the environment. These commenced with inherited genetic propensities,

then incorporated child–parent interactions from an attachment perspective, and allowed for a continuing effect of the environment, as well as traumatic life experiences. For Perris, the individual was not a passive incubator of vulnerability, but was perceived in line with Bandura's (1978) notion of *reciprocal determinism*. This overlapped with Strauss and colleagues' *interactive developmental model* of schizophrenia (Strauss and Carpenter, 1981), which emphasized both the development of vulnerability and the individual's strengths, 'frequently in the direction of human development' (Strauss et al., 1985, p. 290).

Perris also reflected on the transition from vulnerability to active psychosis. Critical of the threshold concept, because of its inelegant fit with a multidimensional view of vulnerability, Perris, like Ciompi (1989) and Dauwalder and Hoffman (1992), believed *catastrophe theory* (Thom, 1975) could be applied to understanding onset and relapse. Perris argued that catastrophe theory's account of dramatic change following a slow build-up of disparate but interacting forces, offered a useful heuristic account of the emergence of psychopathology.

Finally, Perris' discussion of stress shifted the emphasis from *triggering* events to an ongoing interactional process of subjective appraisal of the environment and subsequent action. This could in turn precipitate certain events which may be more or less stressful, and which can also be *buffered* by protective factors. For Perris, the importance of stress lay in its potential for activating automatic dysfunctional thoughts, which serve to sustain core dysfunctional cognitive schemas, thus completing the transaction between stress and vulnerability. Perris' model remained a macro-theory which fell short of explaining how generic vulnerability becomes manifest in specific psychotic phenomenology, such as hallucinations and delusions.

The contemporary stress vulnerability models

Since the mid 1990s, a shift away from the development of macro-level theories of psychosis and schizophrenia has occurred, with greater emphasis upon micro-level aetiological accounts of individual symptoms. However, the SVM framework has been maintained as a basis for psychoeducation within cognitive behaviour therapy for psychosis.

In addition, the influence of the SVM models can be seen in what we consider to be the recent 'rediscovery' of social factors in the development of vulnerability within recent epidemiological research which has been focused upon social adversity, and the role of developmental trauma and abuse (van Os and McGuffin, 2003). This has taken fullest manifestation of course in the traumatogenic model of John Read and colleagues (Read et al., 2001). The influence of Perris' model is clearly discernible in more contemporary macro-level explanations – especially Freeman and Garety and colleagues who have strongly emphasized the role of early adversity, schema, and the

role of emotions in mediating and maintaining psychotic symptoms (Freeman and Garety, 2003).

Toward the actualization of the vision splendid of the stress vulnerability models

The period from the 1970s to the mid 1990s witnessed the development of a rich theoretical discourse, which provided a platform for the development of integrated approaches to treatment and research in the psychoses. However, we would argue that this vision has failed to be realized.

There are of course many reasons why integration has not been implemented in practice. Some of these were covered by proponents in the Melbourne ISPS debate. Richard Bentall, for example, pointed to the fundamental differences in aetiological assumptions held by pharmacological practitioners and psychotherapists, John Read pointed to the political and economic forces of 'Big Pharma', which he argued have minimized the research and understanding of social and psychological factors within the stress vulnerability framework.

We would assert that there are other factors which maintain this state of affairs, which are more within the control of psychosocial researchers and practitioners. As argued by Fadden (2006), many clinicians working in contemporary mental health services may lack the training in fundamental counselling skills let alone skills in psychotherapy or family work specific for psychosis. We would also assert that the frequently large case loads in public community mental health settings are often not conducive for psychotherapeutic interventions, and that funding systems are overly focused upon expediting 'throughput' – i.e., early discharge to the primary health system. Where specific training has been accessed, ongoing supervision structures are often not in place to allow for wider dissemination. Managers of public mental health services may perceive these interventions as adjunctive or add-on options which mean that the structure of roles within public mental health facilities do not allow for it. In research endeavours, funding cycles and research benchmarking require rapid turn-around of publications – the testing of linear models of aetiology and evaluation of pharmacological interventions are arguably much easier routes to building a research track record than devising, funding and evaluating psychosocial interventions.

However, for those of us interested in pursuing Wayne Fenton's assertion at the 2001 debate that 'biological and psychological treatments must be integrated if we are to properly discharge our responsibilities as clinicians and psychotherapists', it is important to redress the pessimism, and consider what might sustain efforts and move us closer towards actualizing the vision of SVM proponents.

First, we would argue that further theoretical discourses are required around integration. Dialogues which focus upon theoretical integration and