Integrating approaches to psychotherapy in psychosis*

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Objective: The evidence base for specific psychological treatments for psychosis is now well established, but many practitioners see themselves as integrationist in approach. The basic tenets of integration are explored with an emphasis on understanding how different levels of need can be conceptualized and then used to 'adapt' a treatment to meet those needs in an individual. The needs are then incorporated into an integrated treatment formulation.
Method: The evidence base is strongest for cognitive behavioural and family approaches, but the present paper summarizes concepts from two specific models of therapy that are intrinsically integrational in their approach: cognitive analytic therapy and psychodynamic interpersonal therapy.
Results: Both approaches show aspects of integration. However, following this approach to integration to its limit would ultimately lead to one undifferentiated therapy.
Conclusions: Both approaches share a common set of values of developing specific ways of increasing collaboration and working together, and these values are shown to underpin adaptive ways of working with psychosis, but further critical analysis of the development of integrative models is needed.
Key words: integration, psychological treatment, psychosis, psychotherapy, schizophrenia.

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Basics of integration

The Scandinavian experience has been paramount in developing integration between social, psychological and physical treatments into a coherent whole. Alanen *et al*. [1] have described the Finnish integrated model for treating psychosis and, as will be described later, they developed the need-adapted approach to the treatment of psychosis. Cullberg *et al*. in Sweden [2] have followed up programs involving the integration of psychosocial treatments with low-dose neuroleptics, and Johannessen *et al*. [3] carried out a multicentre study of early intervention, which relied on an integrated approach to treatment.

These Scandinavian developments in treatment integration have been mirrored internationally with significant developments in Melbourne [4]. The present paper deals with a specific aspect of treatment integration: the integration within a psychological treatment of different models, but the overall context still concerns the integration of a whole treatment system.

The tendency towards integration within psychotherapy is in constant opposition to the drive to diversify psychotherapy models and make them into distinct 'brand names'. The huge growth in these brand names for psychotherapy has been balanced by attempts to bring together diverse approaches [5,6].

The spectrum of integration includes several steps [5,7] as summarized in Table 1. For schizophrenia and other

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Table 1. The spectrum of integration

Integration theme	Description
Rapprochement	Increasingly cordial relations between protagonists of each school
Accommodation	Incorporating favoured parts of other models
Convergence	Increased common-ground
Common factors	Different terminology increasingly seen as describing the same key themes
Eclecticism	A pragmatic approach drawing on elements of any therapy which might help
Assimilation	Full integration of outside concepts into the mainstream beliefs of a model
Integration of methods	As seen in therapies that explicitly combine distinct models
Full integration	The distinctions between original models become unimportant as a new fully integrated approach becomes distinct

psychoses, psychological treatments are at a relatively early stage in development; at least as empirically based treatments, and so the tendency to separate into distinct 'schools' is still evident [8, pp.7–8]. Bachmann *et al.* [9] provided an overview of many of the distinct approaches to psychological treatment for psychosis. They also stressed the need for pragmatic, cost-effective and easy-to-teach methods of psychotherapy to deal with the enormous potential demand for psychological treatments.

There has been relatively little attention to integration of research models of therapy. Fenton [10] has developed a method akin to integration that is described as 'flexible psychotherapy'. His approach relies on an intrinsic hierarchy of tasks and the therapist draws on various therapeutic strategies to assist the patient to achieve particular sequential tasks. The tasks include diagnosis, safety, symptom reduction, mobilization of social support, assessment of social care needs, encouragement of acceptance of illness, promotion of strengths, teaching of stress management techniques, relapse prevention, promotion of the highest adaptive functioning and of activities that promote self-esteem and quality of life and finally, integration of the psychotic experience into the self.

One of the strengths of this approach is that integration is seen almost as project planning in that the therapist holds in mind a potential for the person to achieve wholeness by addressing specific areas of difficulty. This is an important meaning of integration, but the integration within the therapy itself has much in common with the model of case management in that different approaches are brought in at appropriate times when the patient is ready. Fenton and Schooler [11] summarize this approach and its evidence base:

> . . . current evidence-based recommendations and guidelines support a comprehensive, individualised treatment approach that integrates advances in psychopharmacology, practical oriented case management and individual psychotherapy, family psychoeducation, and community support and rehabilitation.

Other developments in integrated approaches include that of Arieti [12]. He brought together the interpersonal domain through his principle of 'establishing relatedness', treatment of overt symptoms (often using precursors of cognitive behavioural strategies), understanding and analysis of conflict and an attempt to increase participation in the patient's life. This can be seen again as integration at the level of goals with only passing attention to the integration of theory.

A third example of an integrative model is that of Hogarty's personal therapy [13]. This approach is planned over 3 years and focuses variously on cognitive and emotional responses to stress with the intention of strengthening the individual by increasing the capacity to 'buffer' stress and enhance coping strategies. As with Fenton's approach, progress follows preset stages around goals specific for the individual. Therefore, the first phase concentrates on internal coping and social skills training; the second adds relaxation and reframing; and the third brings in vocational and social activities with criticism management.

All three of these approaches have much in common with the 'recovery model', now widely accepted as a less stigmatizing and more individually focused approach than earlier models.

Threats to integration

Integration can be seen at four different levels of the care system, each or all of which can be compromised and reduce the effectiveness of the system as a whole. The four key factors are the healthy *individual, carer and family*; the healthy mental health *team*; the healthy *organization*; and the healthy mental health *system*.

Each of these levels needs attention if work on psychosis is to be effective. The first level is evidently crucial in that integration within the individual's own psychological functions affects the family members, carers and others in the immediate network of the individual. Of equal importance are pressures towards disintegration

of family function. The extensive work on the high levels of critical expressed emotion from family members can be seen as an effect of this level of integration breaking down [14].

Less commonly discussed are the effects of integration or otherwise within the mental health team and its parent organization. Individual team members are subject to intense pressures and dysfunctional forces within the organization may amplify the individual's defences. Davenport [15] drawing on the work of Menzies Lyth [16] described how these disintegrative forces lead to attempts of team members to use defences characteristic of organizations under stress: detachment, denial, ritualized task performance and avoidance of change. These defensive processes can interact in an unhelpful way with the fragmentation and splitting that underpins many psychotic illnesses. Incidentally, Davenport points out the triple effect when the psychosis coexists with a history of abuse when the characteristic dynamics of abusive relationship history are added: boundary difficulties, revictimization and difficulties with power relationships.

The final level of required integration is within the wider mental health system and social context. Although there are significant differences and social contexts in different states, a common pattern is to separate responsibilities of commissioners from those of providers of care. Even when the other threats to integration are managed skilfully, a failure at this level of organization can have a damaging effect on the care of psychosis.

Theoretical integration

There are influential models that integrate different aspects of the causal chain leading to a psychosis. At one level these are attempts to successfully integrate biological factors, psychological factors and the wider social environment. Indeed, the dominant model in mental health is probably the 'biopsychosocial' approach. As McGorry has pointed out [4, pp.279–280], the biopsychosocial approach does at least deal with the potential for reductionism in some biophysical explanations. Potentially, biopsychosocial models provide rich sources of interaction between early predisposing factors (such as genetic predisposition, early exposure to pathogens, birth order, birth experience, date of birth, early physical trauma, neurodevelopmental delays, delays in neuronal maturation, psychological trauma and a myriad of other factors) and later precipitating and adult vulnerability factors.

At one level, mental health has the biopsychosocial concept as a talisman to avoid rivalry and conflict between professional and research groups, but day-to-day observation of professional interaction shows that the rapprochement is often at a very superficial level, as witnessed by polarized views on the role of medication. True, in many areas of the world, there is a consensus that medication (perhaps at lower doses than conventionally used in some countries [2]) is a necessary but not sufficient aspect of treatment. But, in practice, non-physical treatments are often seen as 'adjuncts' to the main protagonist in the treatment plan; the 'silver bullet' of a precision drug that affects precisely the right neuronal pathways. There is an element of parody in this description, and many practitioners assimilate drug treatment with highly sophisticated psychosocial interventions. But the key point is that care systems do not put equal weight on the three legs of the tripod and differential investment in research leaves non-drug treatments in a disadvantaged position.

A specific version of a biopsychosocial approach is widely accepted, the 'stress vulnerability' models [17]. Essentially, this proposes an interaction between underlying vulnerability and the expression of that vulnerability depending on social, psychological and environmental factors. Although this is not intrinsic to the stress-vulnerability model, the theory is widely seen as similar to the relationship between a genotype and a phenotype, that is, the root cause is at a molecular biological level and the basic picture can then be 'coloured in' by environmental factors. The original hypothesis simply states that there is a lawful interaction between the two with the product of vulnerability and later stress determining the probability of breakdown into illness.

The analogy with tuberculosis is telling: group treatment, as originally developed by Pratt, was shown to be an effective treatment, at least according to the research standards of the day [18, p.479], but these findings were effectively jettisoned when the role of mycobacteria in causation was shown. By analogy, psychosocial influences are seen as minor league when compared to the assumed precision of biological markers.

Despite all of the above, there are some widely shared assumptions that drive treatment developments. Whatever the arguments about causal direction, it is clear that neuronal activity at least coexists with emotional experience, including that of psychosis. Second, these interactions occur within a social system and are modified by the social system.

Psychologically, we relive past experiences in the present in some form. This can be interpreted from a wide range of psychological theories, but theories underpinning treatment development all share a common assumption that these early patterns are 'sticky' and, by default, will tend to recur. At the very least, these recurrent patterns of interaction and attachment style will influence the content of a psychotic illness and may determine its course and outcome.

Table 2. What promotes mental health?

Safety and security	Physical health	Good, secure relationships	Sense of community	Occupation	Identity and self-esteem
Food	Overcoming disability	Attachments	Sense of belonging	Fulfillment	Valued role
Shelter	Freedom from pain	Friendships	Social support	Purpose	Ethnic and cultural identity secure
Physical security	Attention to basic health	Family ties	Access to community resources	Security	Lifestyle choices
Access to resources	Positive health and wellbeing	Sexual relationships	Religious and cultural needs embedded in the local community	Reward	Feelings of mastery and success
Freedom from exploitation and abuse		Connectedness	Access to community resources	Being valued	
Freedom from threat			Someone to advocate on your behalf	Being recognized for your role	

Some of these principles have been incorporated into the concept of a *need assessment*, which will produce a profile of actions needed to maintain (or restore) mental health. The model described in Table 2 has six main categories, each of which are broken down into more specific areas. To some extent, this model draws on an implicit hierarchy of needs, as the later goals are jeopardized if the simpler needs are not met.

From a purely psychosocial model of need, it might be assumed that remedying any deficits in need would automatically restore the person to full social functioning. This is not necessarily true, as, according to the stress vulnerability model, these psychological and social needs can also be understood as 'buffers' against the neurocognitive changes brought about by stress. More buffering is needed if stress is unduly high, or if the individual's intrinsic vulnerability is high. The intrinsic vulnerability can be conceptualized at a neurocognitive level, the origin of which is still open to wide speculation.

Some theories of causation merge vulnerability factors with likelihood of stress. For example, in considering the strong association of urbanization with incidence of schizophrenia, van Os [19] concedes that even a powerful and replicable effect such as 'urbanization' does not lead to a good explanation of what constitutes the 'toxin', although many theories abound, including the association with social deprivation, increased availability of illicit drugs, and increased levels of traumatic stress through crime. Other factors, however, such as social drift have been shown not to account adequately for the phenomenon [20].

Given the imprecision of our causal hypotheses in individual cases, we are pushed to increasing reliance on generic models of how needs relate to underlying causes. The pioneers in this field in Scandinavia [1] suggested the phrase 'need-adapted care'.

Alanen states that:

> Need-adapted care comprises:
>
> (a) Therapeutic treatments planned individually to meet the needs of patients and of the people nearest them.
>
> (b) The psychotherapeutic attitude, with efforts to try to understand what has happened and happens to the patient and those nearest them, characterizes the treatment.
>
> (c) Different therapeutic activities should support, not counteract, one another.
>
> (d) The treatments are all part of a developmental and interactive process.
>
> (Alanen [21], cited in Pylkkanen [22])

These principles have been described in detail in the well-established work in Finland, but they can be applied in other settings. In the next section, the application of the underlying principles of need-adapted care is shown in the context of two recent treatment developments: the applications of cognitive analytic therapy (CAT) and psychodynamic interpersonal therapy (PIT) in the treatment of schizophrenia. The care systems are quite different in the context of the UK, but the humane principles of care embedded in the Finnish model translate very effectively across care settings.

Both of these models have developed in the last two decades, specifically to integrate best aspects of practice

and yet retain a theoretical coherence and set of personal values that delineate them from eclecticism.

Cognitive analytic therapy

Ryle [23] developed this model of therapy. Cognitive analytic therapy is an integrative, interpersonal model of therapy predicated on a radically social concept of self-developed over recent years in the UK by Anthony Ryle and recently developed into a generic model for a variety of disorders using a range of 'tools' to strengthen collaboration and to explicate complex recurring patterns [24]. A CAT-based model of psychotic disorder has been developed much more recently based on encouraging early experience in this area [25]. The model describes and accounts for many psychotic experiences and symptoms in terms of distorted, amplified or muddled enactments of normal or neurotic reciprocal role procedures (RRPs) and of damage to the self.

Cognitive analytic therapy has been highlighted in the present paper because of its strength in developing a collaborative relationship through the medium of shared 'tools' such as a reformulation letter, and a diagram representing the main conflictual areas. In its early form, the CAT was primarily focused on simple 'procedural sequences' that reinforced 'neurotic' ways of coping. More recently, there has been an emphasis on state shifts as a fundamental concept for understanding complex experiences such as dissociation and psychosis.

Case example

Tanya is a 24-year-old woman with a long history of relationship problems, following an abusive relationship with an older friend who mocked Tanya and goaded her into behaving in extreme ways to deal with unwanted attention. As a young adult, she had underperformed at school and university and had dropped out from university following an acute psychosis characterized by mocking, persecutory voices that told her she was a 'witch'. Without much prompting, she acknowledged that she had always found double-edged phrases like 'wicked' difficult as she was never sure which way the phrase was meant, even though at times she could see that it might be complimentary.

She was not keen to be followed up after her psychosis as she thought that this would stigmatize her as a 'weirdo', but she was willing to do some work making a map of the 'traps' she kept finding herself in. 'Traps', 'snags' and 'dilemmas' are three classes of problematic reaction which are examined in CAT. She could see that her exaggerated fear that she might be thought to be sexually interested if she ever spoke to a woman was linked to her experience of being exploited by her older classmate at school, and that the voices in her head when she felt stressed were like an anticipatory warning of something happening that she dreaded; particularly, being mocked for her feelings of wanting to be close. After considerable further exploration of some key relationships, her dilemma was summarized as:

> *Either* being bullied and alone *or* being protected but suffocated and trapped.

This also linked to a powerful 'snag' that if she tried to speak to anyone to make contact, 'they would think I fancy them or something' and that this would be catastrophic, as she feared people would spread the word like wildfire. The discussion focused on her belief and separated a realistic level of anxiety (based on the observable 'tale-telling' of her acquaintances) from the extreme panic about her life being the subject of a tabloid newspaper expose. This belief was difficult to tackle: she knew journalists and she assumed that I, as a therapist, did not. She had seen reputations ruined, but she could also see what people meant about 'no publicity being bad publicity' and began to acknowledge that sometimes she longed to be noticed as she had been as a 'star pupil' in her early schooldays.

This allowed a better account of another aspect of her story. Sometimes she responded to voices by smashing windows in the street. As she worked on a homework task of writing down even minor versions of these experiences, it was possible to piece together a tentative view of her 'target problem procedure': we spent some time making it as brief and memorable as possible (so she could use it as part of her self-monitoring) and came up with a personal formulation as follows:

> I'm like a light bulb; I attract everyone to me, so I'm noticeable
>
> *and then*
>
> I feel 'paranoid' and think everyone is talking about me
>
> *and then*
>
> I want to get even so when I'm walking home I hear their smug voices laughing at me so I smash their windows (to stop them looking at me).

This is a simplified version of the formulation to illustrate the way in which her concepts are linked through

the snags, traps and dilemmas into something she can own as a sequence. The next stage is to draw a 'sequential diagrammatic reformulation' (SDR) which puts all of the above into a diagram with different self-states, the unwanted feelings that trigger changes and the repetitive cycles followed to keep at least a semblance of control. The diagram uses her words as far as possible, although the structure relies on joint effort. The SDR becomes a relatively safe way to talk about extreme fears and a way of recalling complex concepts in subsequent sessions by referring to the states in the diagram.

In addition to the diagram, there are self-monitoring forms and resource sheets which can help to elaborate the possible emotional states that a person might feel. All of these together lead to the writing of a reformulation letter by the therapist: This is written to summarize in prose form the main themes shown diagrammatically, but it is written directly to the person so that the therapist's concerns and shared understanding can be accessed by the patient at any time. Some people use the letter preferentially and some the SDR. In Tanya's case, she had a strong preference for using the diagram and elaborated it and amended it in sessions.

The letter gives a brief summary of past key-life experiences, the nature of the difficulties and the main traps, snags and dilemmas, and ends with an attempt to provide a sentence or two that become the focus of all of the remaining sessions. Typically for someone with such complex issues, we had five sessions to formulate the problem, a further 10 sessions then an extension for a further eight sessions and an ending session (i.e. 24 sessions in the initial therapy) with two follow-up sessions 3 months apart.

The reformulation letter focused on the key themes stated as:

> In the remaining sessions we might focus on these themes:
>
> You tend to feel bullied and controlled in relation to someone who wants to be suffocatingly close and control your thoughts, so you try to keep as separate as you can so you won't be noticed.
>
> At other times you can feel 'wicked' and strong, and you are 'in people's faces' and then, suddenly, you feel they are laughing at you and you feel isolated and alone.
>
> You then feel 'wicked' in the other sense (of having done something terribly bad that you will be punished for). You find it hard to keep a grip then, and you hear people talking about you in a mocking way.

We agreed we would tackle these issues in a systematic way with regular monitoring. There were some setbacks (e.g. an occasion when she took 'ecstacy' and felt so good she considered leaving therapy to get 'quicker results'), but overall, her self-esteem improved and she felt more able to re-enter social circles using our self-monitoring tools. We also looked at practical ways she could return to studying (through a link our department had with the adult education department), and she was able to move into shared, supported accommodation but with considerable autonomy. In these aspects, we were jointly case managing her needs in an explicit way, which supported the therapeutic work we were doing.

In terms of Alanen's principles, CAT offers a way of making an individually adapted therapeutic plan, drawing on all of the therapist's expertise and knowledge. The fundamental approach is collaborative and builds on a shared 'curiosity' about how various explanations can fit together. In the context of psychosis, as with cognitive therapy, the delusions and hallucinations are approached as puzzling and troublesome, but ultimately open to a shared attempt to think through them. Along with the specific CAT treatment strategies, the therapist is encouraged to draw on his/her wider experience and, particularly with psychosis, develop a multifaceted plan to assist recovery. All of the work in trying to reformulate the problem is seen through the prism of the relationship between therapist and patient, although the relationship is not as central to the process as in psychodynamic therapies.

This account of CAT is necessarily simplified, but it highlights the way in which the structure of CAT leads to a shared formulation that can be used as a foundation for further work together.

Conversational model

Robert Hobson, working closely with Russell Meares in the late 1960s tried to formulate an approach to therapy that focused on the minute-to-minute conversation between therapist and patient. For this reason, it is known as the conversational model of psychotherapy [26], although it is also now known, in a research context as PIT [27].

Hobson's work was constantly trying to reconcile a scientific, research-oriented approach with his extensive knowledge of poetics and literature. He was particularly focused on the details of the therapeutic conversation. He followed William Blake's attempt to understand how the whole can only make sense if every detail is also noticed and worked through. He quotes Blake on the need for attention to precise details in a therapeutic conversation: '. . . art and science cannot exist but in minutely organised

particulars' (William Blake, Jerusalem, III, 55:60–68, cited in Hobson [26, p.161]).

Collaboration is fundamental to the conversational model. It literally means, 'to work jointly with, especially in literary, artistic and scientific production' (Oxford English Dictionary). In the context of psychotherapy, it clearly means much more than a literary production, but the analogy holds to the extent that both therapist and patient work together to develop a 'shared feeling language'. Although Hobson acknowledges that the relationship is intrinsically uneven in some senses (not least in that the responsibilities are carried by the therapist), he states that the therapeutic relationship is characterized by 'mutual asymmetry' capturing the important characteristic that both are equally involved and present, but they carry different, asymmetric roles.

Hobson and colleagues in Manchester [28] developed a carefully defined model from the concepts described by its originator. Initially, these were tested by showing that therapists who had been trained by Hobson behaved in consistent ways, and differently form equally trained therapists who had not worked with Hobson [28]. A training package involving three training videotapes and structured supervision was tested [29]. The package had very powerful effects in changing doctors' behaviour from an interrogative style to a conversational style characterized by negotiation, tentativeness, focus of feelings by use of 'understanding hypotheses', and using a more personal style of language.

Psychodynamic interpersonal therapy can be seen as attending in particular ways to a therapeutic conversation so as to maximize the possibility of change. Conversation is central to the model: 'Conversation is reciprocal . . . . There is a progressive increase of mutual understanding, which involves negotiation and adjustment: the correction of misunderstanding . . .' [26, p.187]. This central idea, developed jointly with Meares, led to a key point in this model of therapy: what a therapist should *not* do. In their paper on the persecutory therapist [30], they spelled out some of the subtle (and not-so-subtle) ways that a therapist can use the power asymmetry of the relationship to 'put down' the patient. This is particularly important with psychosis as: (i) the patient may well be particularly sensitive to criticism; and (ii) the therapist may struggle with powerful countertransference feelings and express these in ways that are out of awareness.

The research on this model of therapy, in Sheffield, Leeds and Manchester, England, has led gradually to the development of a treatment manual [31,32] reflecting these key features, and specifying ways in which the model needs to be altered for specific purposes, such as working with depression, somatizing disorders and thoughts of self-harm. There are particular areas requiring attention in working with psychosis. Therapists need to pay particular attention to regularity and length of sessions, as there is a tendency to be more casual about this with in-patients and those with an active psychosis than with out-patients with less severe illnesses. The therapist may need to spend much longer 'being with' the patient before sufficient trust is built up to work in depth on delusional material. The therapist must avoid the risk of becoming 'persecutory' by knowing too much too quickly, as the patient will tend to fill the session with material before being ready to assimilate or process it. Attention to the mutual asymmetry inherent in the relationship is essential in addressing the inevitable inequalities in the power relationship. Collaborative conversation is crucial to the development of case formulation.

For many therapists these points may seem obvious, but observing therapists closely shows that therapists often abandon the usual format and structure of therapy as though in an attempt to be less pressurizing, whereas the resulting lack of structure has the exact opposite effect.

Role of case formulation as an aid to integration

Case formulation in working with non-psychotic problems has become routine practice, but it is relatively recently that formulation methods have been used systematically with psychosis. The development of a formulation shared between the patient and the in-patient staff team has still not been incorporated into routine practice. Davenport [33] developed such a method using psychodynamic interpersonal principles embedded within a generic formulation that was shared with all team members, patients and often their families. The key features of the team formulation identify the patient's core self-schemas and beliefs, summarize dysfunctional attitudes and behaviours, and then identify likely staff and family responses. The desired therapeutic attitudes, responses and goals could then be built into the formulation. Specifically, the patient's strengths were spelled out to promote self-esteem. The formulation was then shared with staff, patient and family to be used like an interpersonal 'map'.

A key feature of this type of formulation was that it was built around the actual conversations with the patient, using as far as possible the patient's own words. The shared formulation allows patients, staff and carers to quickly identify part of a cycle being enacted at any moment and the strategies to minimize the effects, or even use them beneficially. All involved need to know where they are in such a complex environment, and in stressing coping capacity and how to increase this the patient feels more in control.

Discussion

These two brief accounts of two models of therapy are indicative of recent developments across theoretical boundaries. The present paper has stressed psychodynamic approaches, but cognitive behavioural therapy (CBT) is probably the dominant approach to psychological approaches now worldwide. In CBT, some of the themes addressed earlier are described in terms adopted from relational approaches. For example, Fowler *et al*. [34], in a chapter summarizing cognitive therapy for delusions, give an example of the importance of *containing* anxiety that is developing between patient and therapist:

> Andrew presented in a fearful state, saying, 'Everyone is against me, I see evil around in people everywhere, they look at me. People are influencing me. I can feel it in my body, they are changing the sensations in my stomach'. Andrew looked suspiciously at the therapist; it was a major task to keep him calm. The challenge in the initial stages of working with Andrew was simply to contain his severe anxiety and prevent spread of fear to the therapist. [34, p.133]

Cognitive behavioural approaches are probably the best researched approaches [35] to psychosis, but advocates of CBT have followed a tactical approach in addressing very specific aspects of problems through pragmatic trials with relatively little attention to underlying mechanisms, although Bentall *et al*. have attempted to develop an overarching theory of delusion formation and paranoid thinking [36].

The integration of these different theoretical strands into a coherent whole is beyond the scope of the present paper, but it is noticeable that there has been a rapprochement between practitioners who are identifying similar phenomena and ways of addressing the consequential distress from related perspectives.

However, the underlying question of integration has not been resolved. Both models described in the present paper, though having distinctive features, have much in common, and even these common properties are incorporated to a degree in cognitive behavioural approaches and systemic approaches. If this logic is followed through to its conclusions, we would end up with one model constituted of 'common therapeutic factors' [37]. This approach has much to commend it, and there probably are some principles that can and should be applied across all models of therapy. But, in practice, these approaches are extremely difficult to research because some of the common factors, such as maintaining a positive therapeutic alliance can be seen as 'micro-outcomes' rather than processes. In other words, a good alliance may be a marker of a good therapy but not necessarily a *cause* of a good outcome. The risk of moving too far towards an integrationist approach is that there is a loss of figure and ground. Some therapies see the relationship as the foreground and behaviour as the practice that embeds the learning from the therapy. The opposite view is equally compelling: changing behaviour is the primary outcome, but attention to the relationship may overcome blocks to progress.

There are still pragmatic questions to ask: would the benefits of combining the features of PIT and CAT outweigh the difficulty in maintaining coherence and focus. These questions are rarely asked. The nearest is when a particular model incorporates a specific element and the addition of this component is evaluated, but even this is rarely seen.

In the examples given, the two therapies can be seen as bases from which the biopsychosocial model can be examined from somewhat different, though overlapping, perspectives. In doing so, a more fundamental issue is raised about the optimal extent of eclecticism. This tension between the pressure to take the best aspects of several therapies and the need to delineate a new, differentiated approach runs through any discussion of integration in psychotherapy.

For psychosis, there is the additional complication that any integration needs also to take into account the different needs of the patient at different stages of the psychosis.

Conclusions

A common theme runs through the paper of integration of treatments through addressing the needs of the patient and adapting the theoretical approach to fit. The analysis of needs, as summarized by Alanen, introduces a personal perspective to the work of the therapist and the experience of the patient. The two therapies considered here are exemplars of integration in psychotherapeutic work with psychosis, but the principles can be applied to any therapeutic modality.

The theoretical weakness of integration is also exemplified in the present paper. It is never clear when the optimal balance between integration and differentiation is reached. The point of balance may also be different at different stages in the trajectory of illness and recovery. Pragmatic research may help us to know whether the addition of a particular component makes a treatment more effective, but the complexity of carrying through research on all combinations is daunting.

Also, different types of research tend to favour different degrees of integration. Efficacy research tends to favour discrete, carefully defined and theoretically coherent approaches; whereas, effectiveness research tends to adopt the ways therapies are delivered in practice, and will therefore include a degree of eclecticism. This bias acts in favour of higher effect sizes for discrete treatments as these are the ones exposed to the research methods with the highest internal validity. However, effectiveness studies with their greater tolerance for 'real world' conditions allow greater variation in treatment delivery and hence approximate to the 'noisiness' of actual therapy, but with somewhat lower effect sizes reflecting the greater imprecision of measurement.

In routine practice, it seems appropriate to allow therapists to integrate different areas of skilled intervention, but the risk is in allowing eclecticism to mask imprecise case formulation. Possibly, using inherently integrative approaches, such as CAT and PIT, which follow their own internal logic, gives a good balance in practice by allowing some therapists to use appropriate quality control when working with complex patients. The weaker evidence base offsets this benefit for the newer, integrative approaches compared to established unimodal approaches.

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