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NOTES ON PSYCHOLOGIES OF VULNERABILITY

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Introduction

Years ago, the psychoanalyst Roger Money-Kyrle (1971) drew attention to three uncomfortable basic facts of life: (1) we are all dependent on other people for our survival, (2) we are not the centre of the universe and consequently our exclusion is inevitable, and (3) the passage of time and ultimately death are inevitable. Such facts about human dependency and vulnerability in ourselves and others can evoke strong feelings, ranging for example from shame, fear, hatred, contempt, derision, depression and pity to concern, empathy and fellow-understanding. Behavioural responses may be similarly variegated, from the hostile and potentially lethal to the protective.

Vulnerability can thus be a very uncomfortable reality, particularly when it is our own. One common way of dealing with such psychological discomfort is to utilise processes of psychological splitting in order to disown or disavow it in ourselves and to then defensively localise it by projecting it into others (Segal, 1986). Such externalisation, when extreme, can lead to the dehumanisation and stereotyping of others and the concomitant impoverishment of the self (due to losing touch with core elements of our humanity). Such projective processes occur not only on an individual level but also in groups of all sizes: families, organisations, communities and nations.

It is important to emphasise these dynamic processes at the outset because in studying vulnerability it can be all too easy to identify individuals or populations that are supposedly at risk while overlooking our own inescapable individual human vulnerability. Thus, for example, people from ethnic minority groups, or who are very young, elderly, poor, homeless, female, or have disabilities or mental health problems are commonly clustered together as vulnerable or potentially vulnerable groups. They are seen as vulnerable *to* something, typically

some negative health, social, economic or moral risk. Seeking to define the characteristics of such groups based on their relative risk of harm, while relevant for policy making and service planning, potentially entails an unhelpful deficit model that stereotypes and essentialises such groups under that banner (Liamputtong, 2007). Strengths and experiential qualities of those identified as vulnerable may be overlooked, as may dynamic and wider systemic social factors, and the baseline fact that – for any and all of us – to be alive is to be vulnerable. We all face distress and ultimately death.

With this as an important caution, the present chapter outlines several classic contributions to the biopsychosocial approach to vulnerability, to psychopathology (and to a lesser extent to the wider experience of distress), offers a conceptualisation of these factors in relation to development and help-seeking, and outlines associated vulnerability-stress models.

In considering different types of psychopathology (e.g. depression, anxiety, personality disorder, schizophrenia, etc), key vulnerability factors are typically seen as a necessary though not sufficient precursor to the emergence of a particular disorder, the emergence itself being triggered by other factors such as stress (for a review of the latter concept see Grant and McMahon, 2005). *Vulnerabilities are thus typically regarded as predispositional causal factors that may together with other factors catalyse distress and disorder.* These factors may be observed on many different though potentially interrelated levels: genetic, biological, cognitive, affective, interpersonal, attachment, etc (Hankin and Abela, 2005).

Working definitions of vulnerability as a concept frequently suggest it is a relatively stable, latent trait within individuals that confers a relative susceptibility to a disorder (Zubin and Spring, 1977; Ingram and Luxton, 2005). Where relatively immutable factors (such as genetic or other constitutional variables) are less significant as sources of vulnerability, other factors – such as psycho-social vulnerabilities – may be more plastic and thus more amenable to fluctuation within and between individuals over the life course, as well as more auspicious targets for intervention.

Notions of vulnerability or *diathesis* (the terms are interchangeable) have a long history dating back to ancient Graeco-Roman medicine, where the latter term related to the doctrine of the humours expounded by Hippocrates (*c.*460–*c.*370 BC) and Galen (AD 129–*c.*201). By the nineteenth century, the concept was part of the emergent psychiatric nosology and theories of aetiology. During the twentieth century, notions of vulnerability *and* stress were increasingly prominent in emerging conceptualisations of schizophrenia (Bleuler, 1963), as well as other forms of psychopathology. It is to a consideration of these concepts that we now turn.

Vulnerability, distress and help-seeking

The precipitants of human distress are many and varied, as are the factors that prompt individuals to seek help. In the health services, the demand for care is

often said to be elastic and to constantly outstrip whatever provision is made (O'Donnell *et al.*, 1992). Given finite resources, difficult political and managerial decisions are required in their allocation. Some people become patients and some do not in this process. Some needs go unmet. This situation causes further distress for those untreated, guilt in some of those treated, anxiety for the health service workers and agendas for planners and politicians. It is well established, however, that those people who succeed in being considered potential patients are only a small proportion of those who at any one time have similar needs. This phenomenon, the clinical iceberg (Scambler and Scambler, 1984; Elliott *et al.*, 2011), posits that the majority of symptoms do not result in demands on the health services, instead being self or informally treated or untreated. This pattern exits for all symptoms and all levels of pathology (Wadsworth *et al.*, 1971; Wilkinson, 2007).

The work by Goldberg and Huxley (1992; Goldberg, 1995; Goldberg and Goodyer, 2005), looking more specifically at psychological and emotional disorders, has recapitulated this pattern. They found a one year community prevalence rate of between 26 and 31 per cent for such disorders. Only a proportion of these people are identified in primary care as having conspicuous psychiatric morbidity and fewer still are referred on to specialist mental health services (10 per cent and 3 per cent of the general population respectively). Their epidemiological work on pathways to psychiatric care predicted an average rate of 20.8 adults per 1,000 of the population would utilise specialist mental health services per year. More recent studies in Edinburgh found referral rates of between 23 and 24.6 per 1,000 (O'Sullivan *et al.*, 2005, 2007). For people with 'severe mental disorders', such as schizophrenia and bi-polar affective disorder, health service utilisation is markedly higher than those with 'common' varieties (Goldberg and Huxley, 1980, 1992). This distinction Goldberg and Huxley relate to the very marked social disability produced by the 'severe' disorders and their much lower spontaneous remission rates. A similar pattern pertains with somatic medical conditions. However, the general trend with 'common mental disorders' is clearly towards non-consultation with the appropriate health services. This is in spite of many of the disorders' being debilitating, chronic and sources of marked suffering. It is also in spite of their being responsive to treatment.

Considered from a naïve realist perspective, this picture might be regarded as counter-intuitive: people who are distressed would be expected (from utilitarian assumptions) to seek to minimise this. An alternative reading of the picture, however, might suggest that people who are distressed or who have an increased vulnerability to distress and disorder (where these are seen as points on a dimensional construct, moving from less to more severe) are also impaired in seeking help, and that perhaps the two phenomena have some common aetiological factors.

In considering this speculation in more depth, it is important to do so in the light of existing studies in two major areas: (a) common vulnerability and stress factors predisposing individuals to psychological distress and disorder, and (b) factors associated with health service help-seeking. The review will be largely limited to

what Goldberg and Huxley (1992) term 'common mental disorders', particularly less severe depression and anxiety disorders. The plausibility of there being certain common factors will then be reconsidered.

Common vulnerability factors to psychological distress and disorder

When people encounter psycho-social adversity (variously termed as stressors, problems, life events, etc) they respond differently. For some the encounter is the precipitant of psychological disorder, others continue to function in a healthy manner and some grow or develop as persons, depending on their relative underlying levels of vulnerability. This section considers three specimen potential sources of such different levels of vulnerability: inherited genetic factors, recent interpersonal factors and remote interpersonal factors.

Genetic factors

With severe mental disorders, such as bi-polar affective disorder, there is persuasive evidence for a significant specific genetic contribution (e.g. McGuffin and Katz, 1989; Hankin and Abela, 2005). The same, however, cannot be said for common mental disorders. Considering less severe (or 'non-endogenous') forms of depression, McGuffin and Katz (1989) conclude that, although heritability appears to be a factor, non-genetic influences seem to be more important. Kendler *et al.* (1987), in a large twin study, showed that, while genetic factors influenced the propensity to both depression and anxiety, the effect was not specific. It was non-genetic (environmental) factors that appeared to have more specific effects in determining a person's vulnerability to develop one or other variety of distress or disorder. Given the high incidence of such disorders (e.g. nearly 60 per cent of adults by the age of 65 will have had one or more episodes of clinically significant depression: Bebbington *et al.*, 1989), and the lack of specificity between genetic factors and particular disorders, it appears that such factors (while clearly contributory) are less relevant explanatory variables.

Recent interpersonal factors

Epidemiological studies have highlighted a number of factors that increase a person's vulnerability to stressors. The classic work of George Brown and his team has been of seminal importance in this area. Brown and Harris (1978) pointed to the centrality of social support in mediating the impact of stressful life events on working-class women, a group with a particularly high incidence of depression. Their emphasis on the lack of a close confiding relationship, the presence of three or more children under 14 and unemployment as vulnerability factors can each be seen as contributing to impaired support. The other vulnerability factor, death of one's mother before the age of 11, will be further discussed in the next section. The most crucial and subsequently most replicated element within this social

support matrix has been the importance of a positive confiding relationship, a core tie (e.g. Campbell *et al.*, 1983; Bebbington *et al.*, 1984; and Harris, 1988). The lack of such a relationship conferred a markedly higher vulnerability to depression on people when experiencing stressful life events.

Brown *et al.* (1986) elaborated the earlier vulnerability picture. They found that in order to be protective against depression a confiding relationship needed to be associated with active unambivalent emotional support, i.e. without a negative response from the core tie. The quality of these central relationships was highly correlated with self-esteem. Being 'let down' by the core tie in the face of adversity increased the risk of depression, whilst crisis support for those with markedly low self-esteem was found to be very helpful. This susceptibility to the behaviour of the core tie supports Brown *et al.*'s (1986, 1990a) contention that people have few, and frequently only one, such core relationship.

Self-esteem was seen as a crucial intermediary in this research. Brown *et al.* (1986) argue that self-esteem is at least 'in part the internal representation of social support' (p. 827). Brown *et al.* (1990a) discuss this latter point in relation to their finding that a high correlation existed between 'objective' and 'subjective' ratings of the core tie, i.e. between the actual and the perceived support. They concluded that this correlation is due to the external environment having been internalised and so rendered potent.

The specific findings relating to core ties are supported by a number of studies looking at the prophylactic effect of more general social support (e.g. Power, 1988; Cramer, 1991; and Cresswell *et al.*, 1992). Cramer's (1990, 2001, 2006) studies of the utility of a close personal relationship for a person's psychological adjustment offers a similar conclusion. Nils Cochrane (1990) has lent further empirical support by showing a strong association between depression and unsatisfactory physical contact experience. He also demonstrates an independent association between depression and the experience of not being loved. He argues positively that good physical contact importantly contributes to a person's inner resources for coping with adversity. This echoes Brown *et al.*'s (1986; and see Brown, 2002) assertion that, when facing a crisis, it is the derivatives of the person's history of support, the subjective sense of having received 'unconditional love [that prevents] the subject from despairing of a better future' (p. 826).

These studies highlight the vital significance of current relationships in people's lives (Crocker, 2002; Tew, 2011). Such relationships confer meaning and purpose. In seeking to understand vulnerability and distress, this area has clear explanatory potential, which will be considered further below.

Remote interpersonal factors

The influence of early childhood experience on the later adult mind in general and on coping resources in particular (self-esteem, in Brown and Harris's [1978] terminology) has been the subject of an increasing number of studies from a variety of theoretical perspectives. A certain consensus appears to be emerging from these

studies. The epidemiological studies by Brown and Harris (1978, 1989) indicated a correlation between loss of one's mother through death (before age 11) or long-term separation and adult depression. Bebbington *et al.* (1991) found that separation (particularly between age five and ten) was the one significant predictor of subsequent psychiatric difficulties. Brown *et al.* (1990a) reported that it was the lack of care consequent to such early experiences that increased later vulnerability, and that even without maternal loss, lack of early care was a significant predictor of increased adult vulnerability (via low self-esteem) to depression (Bifulco *et al.*, 1987). While this effect was independent of poorer quality adult core ties in accounting for part of the variance in vulnerability, it increased people's risk of such adult core ties. The combined effect of both poor adult and child relationships was unsurprisingly the severest, participants with both being five times more likely to have low self-esteem than those with neither (Brown *et al.*, 1990 a, b). Nils Cochrane (1990), in investigating childhood and adult physical contact and feeling loved, found a similar pattern: unsatisfactory early experience of these phenomena (particularly physical contact) increased later vulnerability to depression; however, adult experience was again the more powerful predictor.

Subsequently, Brown and his colleagues (Brown and Harris, 1993; Brown *et al.*, 1993; Brown, 2002; Oatley, 2007) expanded their earlier investigations into early experiences as precursors of adult depression, this time also considering adult anxiety disorders. They reconfirmed the role of both early and recent adversity (particularly lack of parental care, and abuse) in increasing the risk of adult depression. The experiences of loss and lack of hope were here the main differential influences in the development of depression. Adult anxiety disorders (excepting mild agoraphobia and simple phobias) were only found to be related to childhood adversity as a vulnerability factor. Danger and lack of security were the differential influences for such anxiety disorders. Given the high likelihood of negative life events producing apprehension of both danger and loss, the significant co-morbidity of the two conditions is unsurprising.

Developmental psychologists have also proposed that early experience has a significant influence on a person's later self. Taking one example from the extensive literature with this area, Newson (1978) argued that it is the infant's experience of 'unreasonable care', the sense the infant has that her parent (or special caregiver) considers her *especially* valuable, that is important to the child's development of a positive sense of self. Newson thus argued that 'partiality' is a necessary characteristic of the caregiving role for the child, an important point to emphasise, particularly in the context of social care services.

Attachment theorists, drawing frequently on Bowlby's (e.g. 1969, 1973, 1980, 1988; and see Davila *et al.*, 2005; Pearce, 2009) work, are paying increasing attention to links between insecure childhood attachment and later adult vulnerability to depression and distress. Healthy child and adult functioning, according to the theory, follows early parenting that is both supportive when necessary and encouraging of autonomy (Bretherton, 1992; Kennedy and Kennedy, 2004). This

fosters the development of reciprocally influenced 'internal working models' of both self and others. A healthy working model would be one internalised or derived from an attachment figure experienced as accessible, trustworthy and ready to help if called on. The mother is usually the most significant and earliest attachment figure, although infants do form attachments to a hierarchy of other figures (Bretherton, 1992; Van der Horst, 2011).

Various researchers (e.g. Heard, 1987; Kennedy and Kennedy, 2004; Davila *et al.*, 2005), in reviewing a number of attachment studies, have emphasised the correspondence between parent and child attachment classifications and that less secure infant attachment predicted adjustment difficulties in primary school. Further research by Fonagy (2001; Fonagy *et al.*, 1991) using the Adult Attachment Interview (George *et al.*, 1985) demonstrated a significant intergenerational correlation in attachment security: for example, early insecure attachment was thus associated with subsequent adult vulnerability. Adult psychopathology is not, however, the inevitable consequence of an insecure childhood attachment. Later experience, such as a good marriage, can powerfully mitigate the effects of early difficulties (Fonagy *et al.*, 1991; Quinton and Rutter, 1988; Shaver, 2011). Pound (1987) corroborates these finding in her discussion of the NEWPIN project, a befriending project for vulnerable women. She highlights the self-perpetuating tendency for those with early childhood histories of adversity and related insecure attachment to have poorer adult relationships, which 'manifested themselves in a generalised withdrawal from or ambivalent attitude to people at large' (Pound, 1987, p. 10).

The development by Parker and his colleagues of the Parental Bonding Instrument (hereafter PBI) (Parker *et al.*, 1979) provided one example of a straightforward measure of recalled parental behaviour, conceptualised here as a potential vulnerability factor. Research (e.g. Parker, 1981, 1989; Mackinnon *et al.*, 1991) suggested the PBI was also a reliable and valid measure of actual parental characteristics. The measure incorporated two dimensions, care and overprotection, which were thought to be important components of such attachment experience. The poles of each dimension were caring and empathic versus rejecting or indifferent behaviour and behaviour that was overprotective, intrusive and fostering dependency versus encouraging independence and autonomy respectively. Parker's original research (Parker *et al.*, 1979) found an association between a perceived lack of care and overprotection. This pattern appeared connected with adult distress in a number of subsequent studies with both psychiatric outpatients and non-patient groups. It characterised the early experience of those with neurotic disorders (e.g. Alnaes and Torgersen, 1990; Parker, 1983a, 1984) in general and non-endogenous depression (e.g. Birtchnell, 1988; Parker, 1983b, 1984; Parker *et al.*, 1987; Plantes *et al.*, 1988; Davila *et al.*, 2005) in particular.

Gotlib *et al.* (1988), with a clinical sample, argued for the primacy of PBI care scores as the major predictor of distress (subsequently supported by Mackinnon *et al.*, 1993) but suggested from their study that overprotection as a vulnerability factor was linked with more chronic distress. Richman and Flaherty (1986)

concluded that early overprotection was linked with more chronic distress and may be linked to adult depression through it fostering a dependent and fatalistic personality style. Congruent with this, Plantes *et al.* (1988) conclude that low care may be of prime aetiological significance in failure to develop 'good enough' self-esteem, thus leaving the person vulnerable to adversity and potential psychological distress. Overprotection they argue may impair normal socialisation and independence, thus depriving the person of potential resources useful when facing difficult life events. Flaherty and Richman (1986), using a broad measure of adult social support, failed to find a relationship with parental overprotection. Positive relationships were however found between childhood parental and particularly maternal care and adult social support levels, a finding subsequently replicated by Parker and Barnett (1988).

As argued above with regard to current relationships, people's early relationships also seem of considerable importance in trying to understand their current states, including their levels of vulnerability. The general trend of the studies quoted makes it clear that early adversity can become a lived experience, predisposing people to vulnerability and continued distress as adults. This will be discussed further below.

Vulnerability and health service use

A number of studies have sought to delineate those patient factors that determine who does and does not make use of health services; factors that are important in both identifying vulnerability and remediating it. Numerous factors have emerged from these studies (and some with particular consistency) that relate to such 'illness behaviour' (Mechanic, 1992).

The most significant finding is that the severity, duration and number of a person's current symptoms all positively predict their likelihood of seeking professional help (e.g. Barker *et al.*, 1990; Bebbington *et al.*, 1991; Fylkesnes *et al.*, 1992; Hannay, 1986; Olfson and Klerman, 1992; Verhaak and Tijhuis, 1992). This was found when distress was both self-rated and professionally diagnosed. Looking at depression in a large white-collar cohort, Dew *et al.* (1991) reconfirmed this finding, but noted soberingly that only 32 per cent of those with depression at clinical levels actually sought help (a phenomenon known as the illness 'iceberg').

A person's past history of service utilisation is also predictive of current use (Dew *et al.*, 1991; Hannay, 1986). Having obtained some satisfaction from past service use appears important. Murray and Corney (1990) found that among GP low attenders experiencing marked psychosocial difficulties the main stated reason for not attending was past unsatisfactory or disappointing consulting experience. Apart from those who might be regarded as disillusioned, Murray and Corney (1990) note a smaller group of low attenders with marked psychosocial difficulties who seemed to have extreme difficulty in confiding in anybody.

Sex differences are commonly reported in professional help-seeking, with women consulting more frequently than men (Scambler and Scambler, 1984; Briscoe, 1987; Fylkesnes *et al.*, 1992; Wilkinson, 2007; Elliott *et al.*, 2011). Looking

specifically at GP consultations, Briscoe (1987) found women consulted nearly twice as often as men, although more recent research has failed to note any significant sex difference when just considering professional help-seeking (Barker *et al.*, 1990; Elliott *et al.*, 2011).

Findings on age differences are variable. Barker *et al.* (1990) found older adults were more likely to seek professional help, as did Fylkesnes *et al.* (1992). The latter noted however that, while younger people were less likely to seek initial professional help, they were more likely to be referred on to specialist services. In their large study on help-seeking for emotional problems, Tijhuis *et al.* (1990) found younger adults more willing to seek help.

Higher socio-economic status, Mechanic (1992) argues, increases people's likelihood of consultation, as people with this status are more able to accurately appraise their symptoms. Tijhuis *et al.*'s (1990) finding that higher income levels and more education are both associated with a higher willingness to consult supports this. Fylkesnes *et al.* (1992) found those with more education were less likely to visit their GP, although more likely to be referred on to specialist services. Bebbington *et al.* (1991) confirmed psychiatric referral was associated with a higher educational level.

Dew *et al.* (1991), in her white-collar group, found that both poor support from one's spouse and encouragement to consult from family and friends were linked with an increased likelihood of service use. The latter finding has been widely supported and is seen as an important 'trigger' for seeking help (Zola, 1973; Scambler and Scambler, 1984). This form of 'peer encouragement' can be seen as influencing pre-patients' perception of the controllability or treatability of their distress. When this perception is raised, people engage in more active problem-related coping (Schussler, 1992), which could reasonably be thought to include health service help-seeking.

Illness behaviour would seem to be in a constant state of change, being influenced by both the availability of and wider politico-cultural attitudes towards health care and prevailing social attitudes about illness and distress. Bearing this in mind and given that the studies outlined in this section were carried out in several countries, some variation is to be expected. Sociological models have largely influenced the investigation of help-seeking (see, for example, Gallagher, 1980; Sørgaard, *et al.*, 1999; Tuckett, 1976; and Zola, 1973). While these have been productive insofar as they go, they have largely failed to connect with the psychological studies of distress and its aetiology (as detailed in previous sections, for example). Thus, a holistic conceptualisation is still needed. The next section offers a sketch of one possible dynamic model to incorporate the origins of vulnerability, distress and help-seeking.

A conceptual model of vulnerability, distress and help-seeking

Balint (1957) was one of the first to suggest a holistic approach when he advised doctors that in addition to (a) considering the symptoms they ought to understand

(b) why the patient presents these particular symptoms (c) at this particular time and (d) what they seek from the consultation. He suggests this is a process of negotiation within a relationship, and it is this that appears to be a major common thread to vulnerability, distress and help-seeking.

Given a certain inherited genetic endowment, constitution and temperament (Rutter, 1987), humans develop within an interactive social context. Through the caregiver–infant relationship, infants gradually elaborate a model of themselves and of the caregiver that becomes incorporated into the mind. The interpersonal becomes intrapsychic (e.g. Brown *et al.*, 1990a). This might be regarded variously as a type of early cognitive-affective schema, a working model of attachment relationship or an internal object relationship.

In Western culture, a single caregiver, typically the mother, has been the prime model. Other significant relationships developmentally come after this and are usually of somewhat lesser importance, particularly when the infant is disturbed and seeks care or comfort. Given a 'good enough' early relationship, the infant can develop a sense of herself as good, lovable, worthwhile, creative, giving and autonomous. Simultaneously, she will form a model of the caregiver as a 'good object': someone who is trustworthy, accessible, loving and helpful. Where the early experience is less than might be averagely expected – through, for example, a difficult temperament in the infant or psychological disturbance in the caregiver – the results impact on the infant's nascent sense of self and other. The infant might thus come to view herself as bad, naughty, harmful or unlovable and the caregiver as unloving, withholding, rejecting, seductive, hostile, incompetent, vulnerable, fragile or erratic. Object relations theorists (see, for example, Rayner, 1990) argue that it is the relationship that is internalised as dynamic process. Thus, some reciprocity would be expected between the internal sense of self and other (or 'object', in psychodynamic terminology). Apart from the prime attachment figure, others undoubtedly influence the child's development (Shaver, 2011). These other attachments or object relaionships, if good, could mitigate some of the negative effects of a poorer-quality one. If bad, the reverse is likely, as later experiences reinforce and compound earlier ones. Self-esteem (Brown and Harris, 1978, 1989; though see Baumeister, 2005) appears clearly to be an aspect of these internal object relationships.

Such factors contribute to the everyday experience of psychological states, identity, social relationships and mental health. The specifics of lived experience in these areas are clearly important to consider for both indivuals and groups. Certain phenomena, such as childhood abuse (e.g. Chu *et al.*, 2011) and racialised life events (Brugra and Ayonrinde, 2001), can be readily seen to assume prominence in conceptualising this area.

The studies outlined above strongly suggest that early experience influences adult states. Early object relations, whilst changeable and not inevitably predisposing to vulnerability to adult psychopathology (Quinton and Rutter, 1988; Tew, 2011), are models that filter and influence adult perceptions of people (both self and other) and events. They can affect the quality of core ties and wider social

support (e.g. Flaherty and Richman, 1986; Richman and Flaherty, 1986). While the early internalised childhood relationships seem to predispose people to the repetition of similar quality ones in adulthood, the adult relationships (core ties) can be viewed as independent (or at least semi-independent) of them. The relationship between the quality of adult core ties and vulnerability seems clear from the previous discussion of the literature.

Poor early child combined with poor later adult relationships are likely to confer a significant adult vulnerability to distress, particularly in the face of adverse life events. Poor early combined with good adult and good early combined with poor adult relationships all generally raise a person's vulnerability level, with the latter constellation appearing to confer the higher probabilistic risk. By contrast, good early and good adult (internal) relationships will generally be a protective pattern, promoting resilience (Seery *et al.*, 2010). It seems to be the quality of the internalised current adult experience (i.e. that which is more contemporaneous) that is most associated with one's level of vulnerability.

While poor object relations are a vulnerability factor and raise one's risk of disorder even in the absence of life events, when in conjunction with difficult life events a compound effect occurs. Such life events act as a multiplier, increasing the risk of psychological disorder. Goldberg and his colleagues (Goldberg and Huxley, 1992; Goldberg, 1995; Goldberg and Goodyer, 2005) have pointed out that vulnerability factors increase both the rate and impact of life events, thus further raising the prospects of distress.

Weiss (1986) has offered a typology of adult bonds as derived versions of early childhood attachment relations and include within this 'help-obtaining' bonds. He argues that these are 'transferences' as they 'often contain the security-seeking motivations that children bring to relationships of attachment' (Weiss, 1986, p. 108). From an object-relations perspective, Bollas (1987) has elegantly discussed people's search for transformation through a 'transformational object' as a search for the lost infantile experience of rapid change, development, satisfaction or 'transformation' by the prime object (the mother or main caregiver). Help-seeking would clearly be a species of this transformational quest. It (like other adult relationships) would however not be fully immune from the effects of the first internal working model, or object relation, and we might expect, for instance, that those with a lack of trust in their early caregiver would on that basis be more likely to be ambivalent about seeking help as adults.

In summary, a dynamic model of development is here highlighted in which identity is formed in and through human relationships (and their internalisation and consequent incorporation into mental structure). The results of this contribute to our level of vulnerability to psychological disorder, particularly when faced with difficult life events, and to our ability to seek or utilise help. The basic dynamic model is outlined in Figure 2.1 and we can now turn to consider vulnerability models at a micro level.

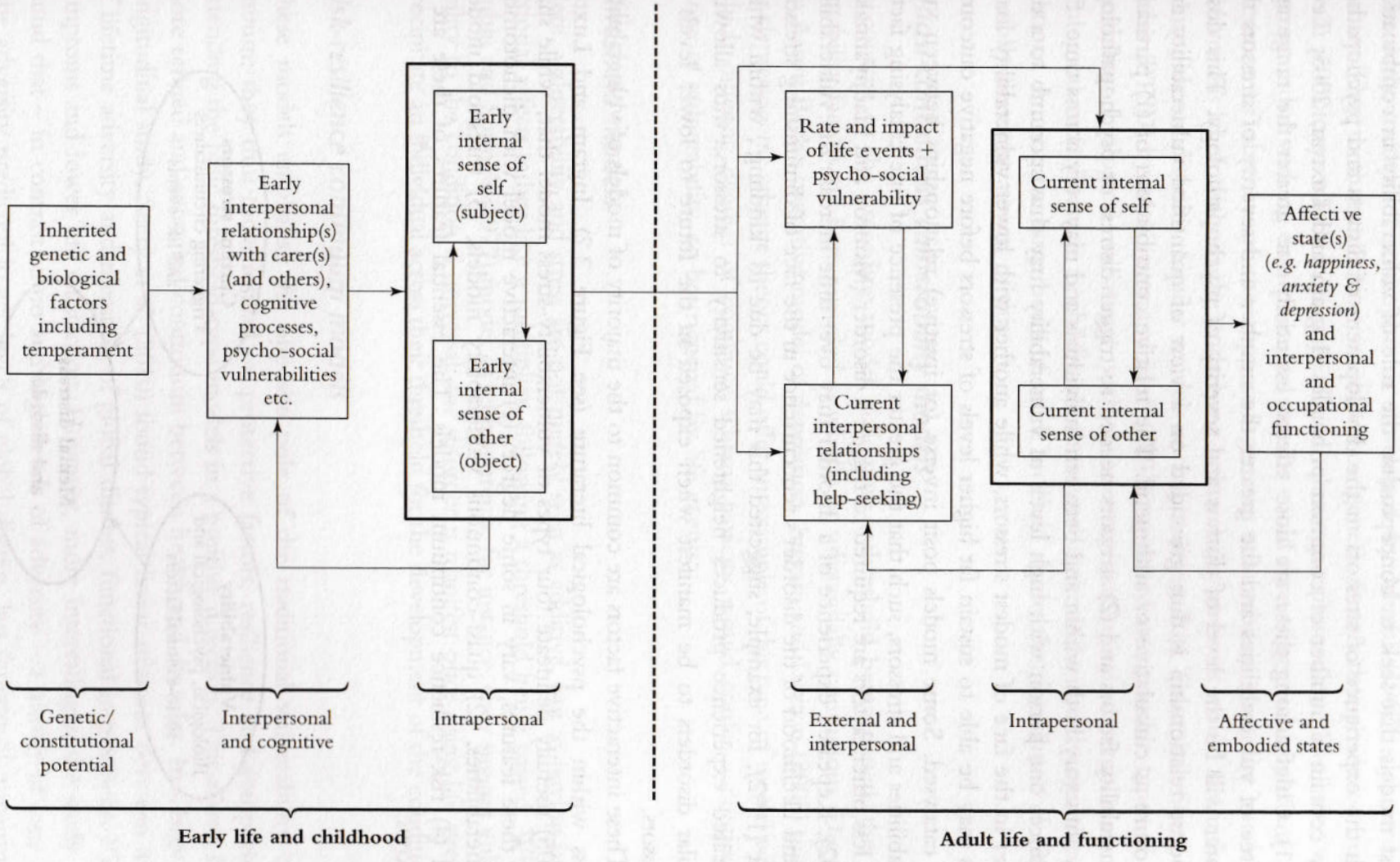

FIGURE 2.1 Schematic representation of development through a process of reciprocal external in internal relationships

Vulnerability-stress models

Most models that seek to conceptualise the role of vulnerability in combination with the experience of stressors in the development of distress and psychopathology contain a number of common principles (Ingram and Luxton, 2005; Tew, 2011). Chief among these are dose effects: essentially the greater the range and degree of vulnerabilities and the greater the number and severity of stressors the greater will be the level of distress and severity of psychopathology. This dose-response relationship is thus grounded on a view of quantified vulnerability and exposure as cumulative or arithmetic. The relative contributions of (1) particular vulnerability factors and (2) stressors needed to trigger distress or psychopathology may thus vary both within and between individuals and may vary across time. For instance, one person with high levels of vulnerability may thus succumb to a disorder in the face of modest stressors, while another with lower vulnerability loadings may be able to sustain far higher levels of stressors before negative outcomes are catalysed. Some models posit inverse (or ipsative) relationships between vulnerabilities and stressors, such that the greater the presence of one catalysing factor the less other factors are required to trigger a disorder (Monroe and Hadjiyannakis, 2002). Repeated experience of a disorder may over time increase the vulnerability to and likelihood of the disorder's reoccurrence in the face of diminishing stressors. Post (1992), for example, suggested this may be due to 'kindling', within which repeated experience produces heightened sensitivity to stressors, thus allowing similar disorders to be manifest when exposed in the future to lower levels of stressors.

These interactive factors are common to the majority of models of vulnerability-stress within the psychological literature (see Figure 2.2). Ingram and Luxton (2005) usefully delineate four types of vulnerability-stress model that, while sharing these features, vary in some degree: (1) interactive model with dichotomous vulnerabilities, (2) quasi-continuous vulnerability models, (3) threshold models, and (4) risk-resilience continuum models. The essential features of these are as follows:

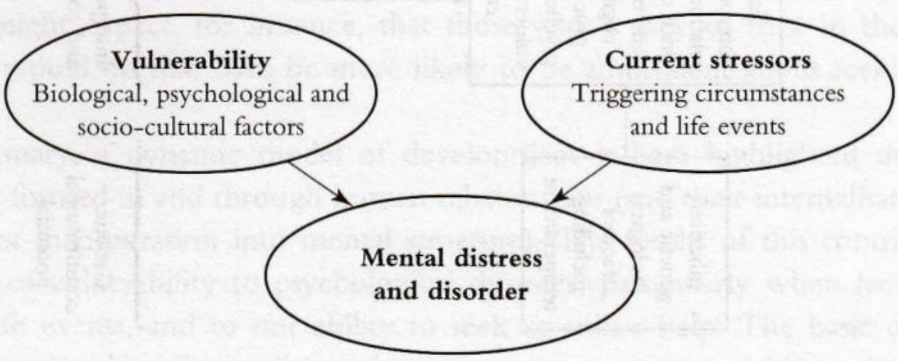

FIGURE 2.2 Basic Stress-Vulnerability model (adapted from Tew, 2011)

Interactive model with dichotomous vulnerabilities

The early models of schizophrenia developed by Meehl (1962) suggested that vulnerability to that condition was based on genetic factors that produced organic brain pathology, which in turn produced schizotypic personality. The latter when compounded with an environmental stressor could then trigger schizophrenia. The presence or absence of the supposed genetic vulnerability gave the model its *dichotomous* label; without the underlying vulnerability stressors would not induce a schizophrenic disorder. Similar models conceptualising Post Traumatic Stress Disorder (PTSD) by McKeever and Huff (2003) suggested two possible types of vulnerability: biological variations such as neurophysiological dysregulation and ecological variables such as childhood abuse and maltreatment and cognitive distortions. Among the large body of work on child abuse, that by Chu *et al.* (2011) usefully develops aspects of this.

Quasi-continuous vulnerability models

In contrast to the preceding model, following a threshold being passed, the vulnerability factors are here regarded as wholly or substantially continuous. Drawing on Aaron Beck's cognitive model of depression, Ingram and Luxton (2005) suggest his depressogenic schema theory could offer an example of this type of model within which differing degrees of cognitive schema toxicity would confer a continuous range of vulnerability, to be triggered by life events.

Threshold models

Here, vulnerability and stress are not merely seen as additive, but as having interactional effects rather like a multiplier, following a threshold being passed. Within Zubin and Spring's (1977) model of schizophrenia, for instance, they suggest vulnerability to the condition is universal: the disorder is manifest once rising life stressors precipitate an individual across their threshold for the development of the condition.

Risk-resilience continuum models

These models emphasise the opposite pole of the traditional vulnerability continuum: they thus focus instead on protective factors, resilience and competence, extending the basic threshold-type models in a positive direction. This allows for a more refined and extended continuum between health and disorder. In a large US longitudinal study, Seery *et al.* (2010) found typical linear relations between levels of lifetime adversity and measures of global distress, functional impairment, PTSD symptoms and lower life satisfaction. However, more interestingly, the study also found that – in contrast to no and high levels of adversity – a history of *some* lifetime adversity predicted lower levels of global distress, less functional impairment, lower PTSD symptomatology and higher life satisfaction scores. Such data suggest that, in moderation, the experience of adversity can have a positive impact on

certain life outcomes, operating perhaps through a type of stress inoculation and the promotion of resilience.

Conclusions

The various models here presented suggest that vulnerability in itself (as a relative and dynamic concept) is a necessary though not sufficient precondition for disorder. Other environmental stressors in dynamic interactions with vulnerabilities are typically regarded as necessary to trigger states of distress and severer levels of disorder or psychopathology (Tew, 2011). Dose-response effects play an important role in this and in the key vulnerability-stress models. Research on and theorisation of vulnerability, however, has often utilised a positivist stance, which – when crudely deployed – can contribute to dominant discourses that essentialise the vulnerable as 'other'.

By contrast, it has been here argued that vulnerabilities exist in every human being as a basic fact of life (Money-Kyrle, 1971). The permeability of our psychological and social lives to the other (and thus to both vulnerability and growth) was earlier emphasised in the object-relations informed model of development (see Figure 2.1). Our own contextual and existential vulnerability is, however, so often concealed from everyday consciousness, with seductive notions of invulnerability (promoted by cultural archetypes such as super-heroes, armour and invulnerability, eternal life and deities, as well as psychological processes such as utopian fantasying, evasion of reality, and wish fulfillment) contributing to individual and collective denial of our own vulnerability. These ideas from psychoanalysis, which have certain commonalities with Foucault's (1974) discussion of dividing practices and the creation of binaries, offer an approach to vulnerability as a concept that eschews a strictly normative understanding in favour of a relational, dynamic and systemic approach.

Vulnerability is essentially being vulnerable *to* something, typically an environmental (whether biological or social) threat and this shift in focus is recognised within the biopsychosocial model. Modest experience of and engagement with adversity appears to confer some psychosocial benefit, impacting positively on quality-of-life scores, probably in part through promoting resilience (Seery *et al.*, 2010). Other modes of help-seeking, as previously discussed, importantly situate people within a dynamic matrix wherein self and other interrelate and these encounters contribute to the development and vicissitudes of mental life and our inner resources. The present psychologically and psychoanalytically informed reading of vulnerability thus situates the concept at the centre of human life, rather than othering it on the periphery.

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