Clin Schizophr Relat Psychoses
Volume 16: S2, 2022
Doi: 10.3371/CSRP.MC.031422

Clinical Schizophrenia & Related Psychoses

Review Article

Hybrid Open Access

Systemic Therapies and Consultation for People who Experience Psychosis

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Abstract

This research explores how systemic therapies have been utilised in the care of people who experience psychosis, and how systemic practice informs their therapy and consultation. Firstly, 'psychosis' is defined, focusing on the shift from the medical model of 'treatment' toward a relational understanding; normalising and supporting people impacted by psychosis. Next, a brief social and historical context is explored by discussing how the conceptualisation of psychosis has changed across time and throughout culture. Adverse health and social outcomes are highlighted, along with established interventions including talking therapies. The origins of systems theory and systemic therapies are observed, examining how this influences approaches to psychosis. The available literature is evaluated and critiqued. Finally, the ways in which systemic therapies have been utilised in the care of people who experience psychosis are debated. Consideration is given to how this can inform direct and indirect therapy and consultation.

Keywords: Systemic therapies • Consultation • Psychosis • Systems theory

Introduction

Psychosis

Psychosis is a phenomenon with no single definition. A medical classification proposed by Arciniegas [1] considers psychosis as a "functionally disruptive symptom of many psychiatric, neurodevelopmental, neurologic, and medical conditions". Similarly, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes psychosis as a spectrum of severity from 'schizoid personality disorder' to 'schizophrenia' [2]. Within this spectrum, psychosis can include "abnormal psychomotor behaviours, negative symptoms, cognitive impairments, and emotional disturbances" [1]. Likewise, the International Classification of Diseases (ICD-10) lists features such as hallucinations, delusions, and various syndromes [3]. 'Drug induced psychosis' meanwhile refers to intoxication mimicking 'organic' or 'functional' psychosis [4].

These medical understandings locate psychosis as neurobiological difficulties which exist within the individual; a collection of 'psychotic' symptoms which constitute an illness. These definitions can therefore warrant diagnoses of disorders. This, in turn, lends itself to treatment, usually pharmacological *via* antipsychotic medication [5]. Despite this being the most established contemporary route, around half of the people who are medicated for psychosis relapse [6].

In recent years professionals have debated diagnostic labels and biological definitions of psychosis. The British Psychological Society (BPS) draws on wider psychological and social aspects to move away from medicalising 'psychotic experiences' [7]. They note that psychosis can occur in response to adverse life events including a range of social inequalities and trauma, which are significantly more commonly experienced by people from Black and Minority Ethnic (BME) backgrounds [8]. This broader definition considers psychosocial, environmental, and relational aspects by locating difficulties as existing in the interactions between people, not solely within the individual.

Similarly, service user involvement highlights that 'recovery' from experiences labelled as psychosis is idiosyncratic [9]. This could constitute improved social connection, inclusion, and personal goals [10], supporting the notion of criticality towards medical approaches and mental health services [5].

To summarise, typically diagnoses of psychosis and schizophrenia refers to experiences such as hearing voices or seeing things that others cannot, holding strong and unusual beliefs, difficulties focussing, or feeling particularly anxious and paranoid. The predominant way of classifying these experiences is currently from a medical and individualistic standpoint; however, there is compelling evidence that these may be a manifestation of 'the most extreme kinds of distress', through understandable responses to adverse life experiences and social contexts [11].

Literature Review

Historical and social context

As there are various ways of defining psychosis, so too have there been various ways of conceptualising it throughout history and around the world. Around 3000 years ago ancient Chinese medical texts report a neuropsychiatric illness labelled 'imbalance'. Its description appears similar to our modern understanding of mania and psychosis [12]. Literature from ancient Greece and Rome, dating from between the 5th Century BC to the 2nd Century AD, documents 'spirits and supernatural occurrences' as explaining presentations that may be considered as psychosis in the West today.

The current psychiatric understanding of psychosis dates to 1841 with Canstatt's proposal of 'a disease of the brain and nervous system' [13]. The medical model holds this conceptualisation of psychosis emerging from a genetic predisposition today, as there are sixteen biological aetiology studies for every psycho-social investigation [14].

There are many psycho-social theories accounting for the aetiology of psychosis. One example is the 'double bind', a theoretical framework proposed by Bateson, et al. [15] relating to communication difficulties and familial relationships. Sabry, et al. [16] note how cultural narratives shape understandings of psychosis. For instance, spiritual and religious beliefs

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Received : 17-Feb-2022, Manuscript No. CSRP-22-54793; **Editor assigned:** 19-Feb-2022, PreQC No. CSRP-22-54793(PQ); **Reviewed:** 02-Mar-2022, QC No CSRP-22-54793; **Revised:** 07-Mar-2022, Manuscript No. CSRP-22-54793(R); **Published:** 14-Mar-2022, **DOI:**10.3371/CSRP.MC.031422.

in the Islamic faith influences the experience of what may be labelled as 'hallucinations' under the traditional psychiatric model of illness. These may be attributed to invisible spirits known as 'jinn', as opposed to psychosis [17].

These cultural appraisals have significant impact on the diagnosis and treatment of psychosis. Jinn could be approached through traditional healing by a shaykh, derwish, or pir. Instead of talking therapies or antipsychotic medication the healer instead may exorcise the spirit by reading the Quran, praying, playing music, dancing, and beating spirits [18]. Differing philosophies and cultural explanations of psychosis aim to provide an understanding and subsequent ways of helping. This is crucial given the myriad of health and social difficulties that people who experience psychosis are likely to face.

Adverse life outcomes

Public Health England [19] described psychosis as 'one of the most life-impacting conditions in healthcare', with some of the worst lifelong outcomes within mental health. This is significant given its unequal prevalence amongst different cultural and socioeconomic groups, and increased mortality.

The estimated prevalence of adults with diagnoses of psychotic disorders such as schizophrenia and bipolar disorder in England is around 0.7%. Ethnicity and socioeconomic status varies significantly with higher rates amongst black men (3.2%) and Employment and Support Allowance (ESA) claimants (13.4%) [20].

People with diagnoses of psychotic disorders have a reduced life expectancy of 15-20 years [21,22], and the disparity is widening [23]. The most elevated cause of death is suicide [24,25], whilst the main causes of early death stem from physical health comorbidities [19]. This reduced life expectancy could signify the 'side-effect burden' arising from mainstay of psychiatric treatment: antipsychotic medications [26,27].

It is noteworthy that not everyone who hears voices or has experiences that could be labelled as psychosis finds this distressing [28] or requires care [29]. Nevertheless, given the many adverse outcomes that are associated with psychosis it is crucial to evaluate the impact of interventions and improve care provision.

Intervention

In the UK, the current formal guidelines for supporting those with psychosis include antipsychotic medication; Early Intervention in Psychosis (EIP) services, community care, hospitalisation; and talking therapies [30,31]. There may also be informal family and community-based ways of support that are not currently recognised [32].

Talking therapies include a range of established psychological approaches including Family Interventions (FI), counselling, psychoanalytic, psychodynamic and cognitive behavioural. When their respective evidence bases are compared, Cognitive Behavioural Therapy (CBT) and FI are shown to be the most effective [31,33,34].

Systemic therapies have developed throughout the last century and now constitute many different forms. One commonality is in their interconnected, rather than individualistic, approach. Working in a connected way with each aspect of a system is paramount to successful support for psychosis. These are the foundations of systemic therapeutic practices which emerge from systems theory.

Systems theory

The principles of systems theory arise from cybernetics, anthropology, and biological sciences. Biologists study organisms within their wider complex ecosystems. Ecosystems contain many components all of which affect each other. An example of this process is 'homeostasis', which refers to 'bodily subsystems that regulate one another for the larger system's well-being'. Family and systemic interventions utilise this systems theory of homeostasis to understand rules and processes to restore equilibrium. By returning the system to a state of self-regulation, it improves conditions for the individual organism at the system's centre [35,36].

This study of people within ecosystems frames the systemic theory of 'embeddedness': the notion that ecosystems exist within ever wider frameworks of knowledge and understanding. Flaskas, et al. [37] theorised that we exist in networks of meanings. Thus, so too must our difficulties which must be understood within a context of wider encompassing systems of societal fabric [38]. As an individual's difficulties impact upon these surrounding systems, in turn, the systems respond by further impacting the individual [39]. This creates a reciprocal relationship labelled 'circular causality' [40]. These ways of conceptualising the connectedness of people moves us from an individualistic way of framing psychological difficulties, to a relational understanding. It challenges the orthodoxy of psychiatric practice by considering the interactional patterns and contextual factors in which an individual resides [41]. This underpins systemic therapy approaches.

Systemic therapy approaches

Systemic therapies emphasise the role of the systems which we are part of such as our families and wider society [7,42]. These systems' ideas, beliefs, stories and the ways in which we negotiate our place within them are examined. Since the 1950's systemic psychological approaches have developed to acknowledge that people's understandings are related to the culture in which they live [43].

One such culture is the family unit. Bowen [44] proposed that individuals should be considered as part of their wider family network in which there are specific relationships, roles, expectations, beliefs, responsibilities, ways of communicating, etc. The role of family therapists is in guiding discourse to help family members recognise and understand how such patterns and processes impact each other. Therein lies a potential of causing and maintaining distress and psychological difficulties. Family therapists aim to restore a state of balance, or 'equilibrium', which is fundamental to good mental health [45].

Prior to the 1970's systemic and structural therapies were considered first-order as therapists observed from the outside. This conception evolved through the pioneering work of the Milan team. They introduced many 'indispensable' therapeutic concepts such as hypothesising, circularity, and neutrality [46]. The Milan team sought to make sense of families' difficulties, aid relational shifts and foster new perspectives through utilising and enhancing these methods, alongside analysing patterns of interaction [43].

Hypothesising is the formulation of systemic 'suppositions' which guides interviewing the family and orientates questioning. Hypotheses are offered tentatively in an attempt of making sense of problems relationally; they do not seek the absolute truth [47]. Hypotheses are provided to stimulate discussion and change, if this does not occur then alternative ideas may be offered.

This leads to the next stage, circularity. Circularity refers to the continual evolution of hypotheses in offering alternative explanations of the problem [46]. In line with systems theory the therapist responds to a family's feedback by proposing an everchanging hypothesis, assessing feedback, re-hypothesising, etc. All the while the process aims to stimulate ongoing discussion and positive change.

Next is perhaps the most contested concept: neutrality [48]. This refers to the idea that the therapist should be 'allied with everyone and no one at the same time' [46]. Neutrality enables the therapist to explore multiple perspectives and realities for family members; allowing 'multiple competing truths' [47]. It requires therapists to mindfully observe their personal feelings and reactions, whilst deliberately neutralising an internal alliances.

The Milan team also introduced the 'five-part therapy session structure'. These processes involve teamwork and are different to most individualistic therapeutic modalities. For instance, therapists can discuss with their team members as to the best way to conclude things during the session. Another part of the session structure involves the team discussing what happened during the session once the family has left. These processes can provide a multiplicity of views and help therapists maintain their neutrality.

In the 1980's the Milan team split as Selvini and Prata focussed on developing 'the family game', whilst Boscolo and Cecchin continued

with 'the Milan approach' [49]. The Milan approach has been criticised from a feminist perspective for ways in which blame can be attributed on families. In most cases this means mothers who typically tend to be the main caregiver. They argue that the Milan approach focuses on difficulties and distress occurring within the family, without adequate consideration of stresses coming from outside the family such as power sex inequalities, gender roles, sexuality, and wider social socio-political influences [50,51]. In defence of these methods, Burbach, et al. [52] note that interventions do not imply the belief that there is a sole family dynamic associated with distress, rather that the theory is consistent with the widely accepted stress-vulnerability model.

In responding to feedback, critique and discussion, systemic approaches have continued to evolve post-Milan, often termed second-order cybernetics. Dallos, et al. [53] note that now it is routine therapeutic practice for clinicians to explicitly list the external cultural forces that may be influencing the individual. This brings an awareness of the impact, or 'power', that the surrounding social fabric and cultural context can have [50].

With this awareness of power is an obligation for systemic practitioners to challenge the injustices they can cause. Goldner [54] notes how therapists hold powers in their professional position thus have the capacity to impact systems and challenge forms of oppression. Within second-order cybernetics therapists are a dynamic part of the system, thus they can challenge oppression of the surrounding systems of power.

Similarly, within second-order cybernetics therapists can deliberately include themselves within the immediate microsystems of the individual. Now considered integral to systemic practice, therapists use self-reflexivity and 'use of the self' to offer personal reflections on their beliefs and emotions within the session [55,56]. This can enhance the therapeutic relationship [57,58]. Self-disclosure requires personal awareness towards a range of differences that can exists between clients and therapists. These are sometimes labelled 'social GGRRAAACCEEESSS', an acronym for gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality [59].

Such awareness and reflection are highly important in systemic approaches. To achieve this, systemic therapies sometimes use 'reflecting teams.' This is thought to be one of the most influential popular practices [60]. Reflecting teams operate by quietly observing and reflecting upon the unfolding therapy from behind a one-way mirror. The team then shares their reflections through a conversation among themselves known as the "reflecting team processes", whilst the family and therapist listens from behind the mirror.

The reflecting team curiously offers lightly-held opinions through asking questions [61]. This provides a non-defensive format for generating new ideas and observations within therapy sessions. This can help foster new perspectives and understandings for further exploration, and the therapeutic process continues in this cycle.

The process of reflecting teams has evolved. In first-order cybernetic approaches and the early phases of the Milan therapists, it was thought that the structural and strategic family therapists could act on the family remotely, imparting expertise from a natural and removed position. In second-order theory systemic approaches embraced the idea that the therapist and team are involved parts of the family system. When change occurs, this entails a transformation of the system itself, not merely the discreet cognitive and behavioural processes occurring within it [62]. To illustrate this 'system-level change' [35], team members could interrupt the family therapy session to offer advice or suggestions, helping to maintain therapists' mindful 'meta' position with the family. Change is promoted through dialogue and the co-construction of meaning.

Regarding the limitations of systemic therapy approaches, the validity of certain therapeutic competencies have been queried. The concept of neutrality, as the ability to remain neutral and not aligning to any one person when presented with severe problems, from which there appears to be an obvious contributing factor may be particularly challenging. Maintaining a curious and questioning stance may be particularly difficult given the readiness of clinicians to offer "safe certainty": simple solutions to complex problems which are ultimately unhelpful. This approach requires mindfulness and resilience so not to slip into any of three common responses of psychologists when working with challenging mental health difficulties: "dissenting, compromising, and colluding" [63].

Finally, when considering the limited evidence-base of systemic therapy, Larnera discusses the 'politics of evidence'. Systemic approaches are concerned with relational processes and the use of language rather than manualised operational techniques. Arguably, this leads to difficulties in achieving the current 'gold standards' of randomised control trials and therapy manualising required for widespread replication. Despite substantive research supporting its effectiveness towards a range of mental health difficulties including relationship distress, anxiety and mood disorders, addiction, physical illness, and psychosis [64], systemic therapies are not mainstream interventions.

Systemic therapies in the care of people who experience psychosis

Contextual factors such as the beliefs and expectations of caregivers of people who experience psychosis are highly significant [65]. These contextual factors are explored through a range of direct and indirect systemic approaches in the care of people who experience psychosis. There is debate as to whether certain systemic approaches such as psychoeducational family therapy can truly be classified as systemic therapies [66]. The loose definition of what exactly systemic practice entails allows practitioners to provide flexible care based around systems theory.

Direct responses

For instance, around half of people receiving pharmacological interventions for psychosis relapse and this is significantly higher in clients with unsupportive or stressful family environments [6], where there may be high perceived criticism, hostility or over involvement. Robust evidence supports the effectiveness of 'psychoeducational family therapy' in fostering recovery and reducing relapse of people experiencing psychosis [64]. Families are supported to reduce their stress by providing information, building skills, and developing 'supportive family cultures.' The diathesis stress model is often employed to conceptualise psychosis, which can ensure that blame is not located within the person experiencing it; rather as arising from an interaction between genetic predispositions and adverse life experiences. Pfammatter, et al. [67] found long-term support for this direct approach with lower rates of relapse two years after treatment.

Lobban et al. [68] found that various psychoeducational family therapies had positive impacts on all family members, not solely the member experiencing psychosis. Compared with standard care, these direct family interventions predict an array of clinical improvements including fewer hospital admissions and reduced rates of relapse [69]. Furthermore, direct systemic interventions which include 'illness education, crisis intervention, emotional support, and training' in collaboration with the clinician, client and their family are associated with a wide range of positive social outcomes [70].

Randomised control trials of Systemic Family Therapy (SFT) for people experiencing psychosis have shown improved clinical outcomes; however, these are not supported long-term. Bressi and colleagues compared Milan School SFT with routine psychiatric treatment and found fewer hospital admissions, reduced rates of relapse, and increased pharmacological compliance during treatment. Despite this, after two years there were no significant differences [71].

It could be argued that this way of assessing therapy efficacy focuses on medical markers, missing the relational shifts paramount to systemic therapies. Direct systemic interventions often measure improved medication compliance and a reduction in the relatively high rates of relapse [6] as markers of success. Nonetheless, this direct approach of SFT lacks quantifiable longitudinal improvement. This is important given the resource heavy nature of SFT with its use of reflecting teams [60]. These

findings contrast with Mihalopoulos, et al. [72] who found 'behavioural family management' and 'multiple family groups' led to significant long-term clinical health improvements, lower rates of relapse and were cost-effective.

Another approach is narrative therapy which examines the social construction of psychosis by locating the problem outside the individual, enhancing personal agency, and countering their 'sick role' identity [73]. Therapeutic interventions focus on interactional patterns, personal and societal meanings of psychosis.

Regardless of the systemic modality, direct systemic approaches can assess the meaning of powerful societal influences with clients and their families. This could entail therapists exploring the meaning of dominant cultural narratives. For instance, what is meant by 'being a good partner/parent/child' and how could such an appraisal lead to a sense of threat and distress, perhaps contributing towards the experience of psychosis [11].

The various systemic schools of therapy and their approaches have evolved over time. Systemic therapists once acted in silo as 'agents of change' to alter family communication patterns [15,74]. Nowadays, it is thought that direct therapeutic approaches work best in collaboration with means of indirect systemic working. Roth and Piling's [75] psychological interventions for people with psychosis and bipolar disorder competence framework states that intra and interagency work is fundamental to service users' welfare. This requires clinicians to focus on organisational and systemic processes which can both promote and disrupt effective working. Knowledge of the different systems that surround the individual is crucial to effectively understand and treat such difficulties.

Indirect responses

There are effective international and local examples of indirect systemic therapies in caring for people with psychosis. Open Dialogue is an indirect systemic therapy that provides a platform for consultation with as many significant people as possible from the client's social network. This meeting should take place as early as possible, ideally within 24 hours after initial contact. This rapid and dynamic approach is tailored to the individual's requirements. It proceeds any direct intervention, yet the individual is always present. Its aims are not to reduce psychotic symptoms, rather to generate dialogue with the family, verbalise the psychotic experiences and construct multidisciplinary supportive teams [76,77].

Similarly, in the UK, Moe, et al. [78] note how specialised EIP services utilise indirect systemic approaches in their care for people experiencing first-episode psychosis. Bronfenbrenner's [79] ecological model is used to formulate a hypothesis around an individual's experience of psychosis. This framework considers the spheres of influence at an individual microsystem level, and the ever-increasing organisation, locality, and macrosystem levels. Using this model, clinicians can consider how engagement with a peer social network within the client's microsystem may influence their experience of psychosis: bullying and rejection will be formulated differently than support and compassion.

Meanwhile, clinicians can focus on wider spheres such as the client's macrosystem where ideas and stereotypes around mental health may indirectly impact upon the experience of psychosis. Clinicians and services can examine how mental health policy, funding and media coverage have contributed to their clients' difficulties [80].

Another indirect macrosystem level intervention could entail anti-stigma campaigns to shift societal attitudes. This method has shown to be an effective means of responding to psychosis [42]. Through the process of circular causality, the individual experiencing psychosis is indirectly impacted by the surrounding ecological systems [40,79] in this case the public's understanding and attitudes towards the diagnosis of schizophrenia. Therefore evidenced-based approaches which focus on reducing discrimination and prejudice can provide indirect means of systemic therapeutic intervention.

This multi-level approach in EIP services has shown families to report high levels of satisfaction in the collaborative therapeutic relationship [81]; relapse rates around three times less than solely individual pharmacological treatment [6,82]; and effective 'hub and spoke' model implementation. The model enables clinicians to work systemically and complete assessments in community settings, do outreach work and link with third-sector organisations, all guided through consultation from clinicians at the service base [82].

The power of the predominant medical model in classifying people's experiences and diagnosing this as psychosis can be explored through indirect systemic approaches. The Power Threat Meaning Framework offers alternative explanations to why people might have such experiences [11]. Utilising the power held through their professional status [54], therapists have a degree of influence in challenging societal injustices that contribute to distress [50]. For instance, systemic therapists can use the individual's experience of psychiatric diagnosis of psychosis to collaboratively formulate how this system of power influences their experiences in what it mean to have such a medical label. This indirect approach focusses on shared exploration of meanings, rather than on expert-derived theories [83].

There have been many systemic psychosocial explanations of psychosis, each of which have unique indirect approaches and focus on the surrounding systems. Singer and Wyne [84] proposed that dysfunctional patterns of family communication such as incoherent and ambiguous messages could give rise to confusion, distress, and eventual psychosis. Similarly, the 'double bind' theory [15] and Selvini, et al. [46] model of 'psychotic family games' proposed that children develop psychosis in response to communication and relational difficulties.

Community psychology practices use indirect systemic approaches to reduce distress at an individual level. Psychologists for Social Change focus on people's social, political, and material contexts by engaging in public policy debates. In their briefing paper on the psychological impact of austerity, McGrath, et al. [85] note how contextual factors such as poverty and discrimination both cause and compound psychological distress. They note that divisive policies which reduce trust within and between communities can damage mental health and lead to increased levels of psychosis [86]. This indirect method of challenging and changing macrolevel systems such as economic policy responds to environmental factors associated with psychosis. Bebbington, et al. [20] found incidence rates of psychosis amongst ESA claimants at twenty times higher than the general public. Thus, the social links between claiming benefits, alienation, inability to work, poverty, stress, societal depictions of unemployed people, and psychosis can be interrogated with scope for indirect systemic interventions. Processes of circular causality may be occurring, perpetuating such difficulties [40].

Interventions commonly span multiple ecological systems [79]. Secondorder systemic practitioners use their agency in responding to clients with psychosis by collaboratively working to assess and adapt these systems.

Similarly, indirect systemic responses can aid the idiosyncratic recovery from psychosis by focussing on social connection, inclusion, and personal goals [9,10]. Arguably effective indirect systemic responses such as these may have a greater impact on a larger number of people, in turn, reducing the need for direct systemic therapeutic responses to psychosis.

Burbach, et al. [52] believe that the most effective means of providing care for people experiencing psychosis includes a combination of direct and indirect systemic methods. Initially, direct problem-oriented approaches are often utilised during the early onset of psychosis. Latterly, indirect methods such as formulating systemic interactional processes can help family members to understand the interrelatedness of beliefs and behaviours. Likewise, direct family systemic therapy could occur simultaneous to services and clinicians advocating for systemic change, improving conditions that are associated with psychosis including access to health care, social support, unemployment, and poor physical health [86,87]. Within third-order systemic approaches therapists may make these societal economic, political, and social systems visible to clients [88] to create a meta-view of alternatives.

Whether systemic approaches are direct or indirect it is important to

make cultural considerations. Wahass, et al. [89] found that Muslim people in Saudi Arabia experiencing psychosis responded the same, or better, to spiritually modify cognitive therapy rather than routine cognitive therapy.

Considering that Muslims may attribute hallucinations to jinn rather than psychosis [16], direct systemic approaches such as psychoeducational family therapy or SFT may need adapting to the unique cultural beliefs and practices of those members. Likewise, indirect systemic approaches such as Open Dialogue [76] may require cultural considerations given to the nuanced social support structures in the UK, rather than direct replication of the Finnish model.

This is true also within cross-cultural systemic consultation. Emphasis should be given to dialogue reflecting on the context in which the relationships exist. Consultation which is didactic, does not address power, and holds the first-order cybernetic belief that there is one truth risks being experienced as 'gentle forms of colonialism' [90]. Whether directly or indirectly caring for people with psychosis, systemic consultants should ensure that they address the conditions in which power relations are recreated, e.g. the medical model and all parties' prospective positions within this hierarchy. Epistemological curiosity can ensure effective, ethical practice.

Lastly, the inconsistent and often vague definitions of systemic approaches require consideration [66]. These make assessing and comparing responses to people experiencing psychosis problematic, since localised ways of working are often employed at the expense of empirically validated approaches methodologies [91,92].

Conclusion

In conclusion, the concept of psychosis is debated with some parties focussing on neurobiological and medical aetiology, whilst others consider the role of surrounding contextual factors. So too this understanding varies across time, country, and culture. This leads to an array of treatment options, one of which is the psychological approach of systemic therapies. These methods can be direct, indirect or a combination of both. They each have various strengths and limitations and warrant further investigation to solidify their ever adapting and expanding evidence-bases.

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How to cite this article: Millar, Chris. "Systemic Therapies and Consultation for People who Experience Psychosis." *Clin Schizophr Relat Psychoses* 16S (2022). Doi: 10.3371/CSRP.MC.031422.