Chapter 5
Advocating for Integrated Therapy in the Social Environment to Treat Schizophrenia Problems

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Psychological therapy, in its various forms, has been effective improving the lives of people diagnosed with schizophrenia or severe mental disorders. However, the historical tradition treats these problems from a psychiatric and almost exclusively medical, neurological, or pharmacological approach. These pharmacological treatments have eliminated lifelong institutionalisation of these people, but have not really addressed either the causes or the consequences of these problems. Psychology, as a science of behaviour and human relationship, has addressed some of the causes of family and social stress, and it has provided effective treatment systems to address the personal and social consequences of this problem; it has reduced many of the behaviours associated with this category called "psychosis"; and it has improved living conditions, autonomy, and personal life similar to those of other people. In this chapter, we will address some of these solutions, in defence of a psychological and social approach to the problems of schizophrenia. We are not only trying to prevent some of the variables that cause these problems to arise, but also trying to change the professional approach, the family, social, economic, and even political environment that would allow us to improve the resolution of these problems.

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5.1 Problem Definition

The high variability of psychotic spectrum disorders, both in their possible aetiopathogenesis, their course and prognosis, and even their different response to different types of intervention, leads us to believe that there are as many psychoses and psychotic experiences as there are diagnosed individuals. This aspect was already anticipated by Bleuler himself (1911/1993) when he spoke of the "group of schizophrenias". It could be stated, paraphrasing Van Os (2016), that "schizophrenia does not exist", highlighting the need to redefine and reconceptualise what we call psychosis.

The approach to problems that are included under the category of "schizophrenia", "psychosis", or "severe mental disorder" is based on a medical and biological definition of the problem. A "mental illness" is assumed to underlie everything that the person displays to family members or professionals. From this conception, a person who shows several of the symptoms at a given moment (in a "break") will already have that illness permanently and chronically.

Thus, we must start by defining what the personal, psychological, or relational problems that are grouped under the category of "schizophrenia" consist of. We will start from a basis that does not assume a "disease" or "psychopathological disorder" common to all these problems. Giving them a name does not mean that we know what they are, let alone what causes them. Only the scientific method allows us to know the causes of these problems and to be able to predict and change them. But we cannot do this based on names, but only on the basis of variables that are measured and are independent of the phenomenon itself. Thus, explaining that a person tells us that he/she hears voices in his/her head because of schizophrenia is not a scientific explanation. It is circular, tautological reasoning, because we have already defined schizophrenia by a strange behaviour such as hearing voices.

What we may therefore consider common to this diagnostic category are certain behaviours that appear strange, inappropriate, and even dangerous to the social context. However, none of the behaviours ("symptoms") of schizophrenia are different from other behaviours that we consider "normal", which are accepted by the social context. Many people have experiences of "hearing voices"and have beliefs about their environment that they perceive as strange (an estimated 10%), yet they do not find them distressing and do not contact mental health services. In any case, it is parameters such as frequency, intensity, duration, or history of these behaviours that differ from the rest of the population. They are like others, only stronger, more intense, or longer lasting.

This already leads us to a relativistic and external position (social, environmental, contextual), since the definition of schizophrenia problems must start not only from the description of the behaviours included in that set, but also from their parameters and why they are considered abnormal. None of these behaviours can be analysed without the context in which they happen, without the family, work, social, economic, etc., environment that determines that they are strange or unusual. For example, that some of these behaviours arise with massive cannabis ingestion suggests biological or neurological factors. However, in Jamaican and Rastafarian culture, this practice is considered part of the religious context, they are considered normal, and for them there are no mental health problem issues involved. Similarly, in Maori culture (New Zealand), people with these strange experiences are considered special, they would be a gift to that person, and would have a value in the social and religious reality of their culture.

We are not going to go into the classic definitions of psychopathology, nor how they have been formed and modified historically. We will start from the descriptions made by the DSM-5 (APA, 2013) and ICD-11 (WHO, 2019) diagnostic system itself, to show the characteristic behaviours we are referring to, which would be the following:

1. *Delusions*, defined as "fixed beliefs that are not susceptible to change even if there is evidence to the contrary". That is, cognitive-verbal behaviour about oneself or others that the social context considers to be unrealistic, exaggerated, or bizarre. How is this psychopathological behaviour different from believing in aliens, abductions, ghosts, telepathy, conspiracy theories, intelligence surveillance, the rejection of vaccines, or animal food? If we are objective, none. The difference is in the context that determines what is accepted and what is not, in each historical and social moment, and some of them are even applauded by that same social environment.
2. *Hallucinations*, defined as "visual or auditory perceptions that occur without the presence of an external stimulus". That is, also cognitive-verbal behaviours of reporting events that are not seen, heard, or perceived by others. This type of behaviour can be common in any person. Even the DSM makes the distinction that hypnagogic images around sleep would not be considered hallucinations and would even be normal in religious cultural contexts. How are these hallucinations different from the "flying flies" we see if we had an eye problem, or the tinnitus we continually hear as background noise? Nobody sees or hears them from the outside, but they are there. In any case, it could be the way these hallucinations are told, which would be different from other similar behaviours that are socially accepted.
3. *Disorganised speech*, also defined as disorganised thinking, describes the individual's verbal behaviour in a format not understandable to the audience of that speech. Again, how is such language different from the thoughtless and loquacious speech of our neighbour, or the hundreds of pages of some post-modern philosophers that only they understand? In any case, it could be the absence of referential content in such speech that makes the difference, but again it is the audience (social and verbal context) that determines that such speech is unacceptable and strange.
4. *Disorganised motor behaviour*, defined as various types of motor responses that are aimless, repetitive, stereotyped, unpredictable, inappropriate, or bizarre, including "catatonia" such as a near total decrease in movement. There is no need to define much more here, what is the difference with respect to the hyperactivity of many children and young people, or the extravagant behaviours of

many youtubers? Precisely, the difference lies in the context in which these responses are given, because now we are not on the dance floor, or recording a video, but in the everyday context with other family members, who are the ones who will consider these movements to be strange and extravagant, and therefore will have to be changed.

5. *Low probability behaviours*, considered as "negative symptoms", all defined as diminished habitual behaviour, ranging from low expression of emotions, reduced daily activities, reduced speech, reduced social contacts, or lack of experiencing pleasure in activities. The definition here is also very clear, as these are the usual behaviours of daily life that would be characterised by a very low frequency and intensity. Again, how are these behaviours different from the ones we all have on weekends, the many hours a day sitting on the sofa in front of the TV, or the routine and boredom of an unemployed person? In any case, it would be the parameter of intensity that would define them, in addition to the family environment that would consider that "you can't just lie around all day doing nothing".

With these definitions, at least we now know what to focus, what to look for, what to study, and what parameters to measure to know if we are able to change these problems. Thus, with this category we are basically referring to those five behaviours, which are also common to most people, but when applied to a specific individual, they are considered to have an illness called "psychosis"or "schizophrenia". However, they are just behaviours like any others, but with altered parameters in their frequency, intensity or duration, and the social environment determines that they are strange, rare, inappropriate, etc., so they must be changed or suppressed. If the social environment does not manage to do so, professional help is sought to do so, or even to do so by force, against the individual's own will.

5.2 Searching for Causes

There are no innocent questions and answers in the contexts of so-called mental health problems. All questions and answers have *implications and consequences*, not only for the people treated in these systems, but also for the professionals who apply them. Moreover, any questions and answers about the problems of psychosis and how to treat them are connected to certain *scientific, theoretical, and philosophical conceptions*, and also within historical and socio-cultural frameworks. Any interpretation that is made will always be within supposedly scientific frameworks, although these criteria are in turn determined by a cultural and historical context.

Interestingly, Coll-Florit et al. (2019) used discourse analysis to record the opinions and statements that both professionals and affected people made about schizophrenia and their situation. Broadly speaking, they found that psychiatrists were the ones who presented more metaphors about illness, separating the individual from the illness and presenting it as a battle or a fight against something independent from the person; on the other hand, both the users themselves and psychologists and other professionals used more metaphors about mental experiences, the mind and emotions, as well as their fears; and only psychologists also considered social life, the family environment, communication, as metaphors for this problem. The use of one type of metaphor or another implies a lot about how these problems are seen from different points of view, and how that also determines the way of approaching and treating them.

As professionals, we propose that it is not the same to place ourselves in a *closed knowledge*, with rigid rules and norms of categorisation and treatment, which is supposed to be independent of the time, moment, and place in which both clinicians and those who have these psychotic experiences live, as it is to place ourselves in an *open, evolutionary, adaptive knowledge*, integrated in the cultural, social, economic, and historical context that each person with these experiences and also professionals live in. It is not the same to consider *the psychotic experience as an illness* (whether neurological, genetic, psychological, or mental), as it is to consider it *as a subjective phenomenological experience* (also with its personal and historical causes). The latter would be interpreted according to the cultural narrative of the moment, and the mission of professionals would be to help the person to be the protagonist of his/her own life.

Thus, it is not the same to consider these experiences as *a failure that springs from within the person*, from their brain or their mental activity, as it is to consider it as *the result of multiple dysfunctional exchanges* throughout their lives, including the biological changes that this entail. It is not the same to conceive of psychosis problems as *a disorder of the brain*, which is the usual psychiatric conception, as it is to conceive of it alternatively as *a socially acquired identity disorder*.

5.2.1 Searching for Biological Causes

In the history of psychotic spectrum disorders, many biologically based alterations have been proposed as possible causes of these problems. This suggests that we know nothing certain about the necessary and sufficient biological causes for these disorders to appear. As Díaz-Garrido et al. (2021) and Fonseca-Pedrero and Lemos-Giráldez (2019) state, today we cannot affirm that there are etiopathogenic markers of functional and/or structural alterations of a cerebral or genetic nature that are the cause of psychosis problems. At most, we can consider them as working hypotheses that many researchers continue to explore every day. The fact that so many biological causes are found may imply that these causes are not being looked for where they may actually be. They are looking inside the brain, but the brain is only a necessary element for behaviour to occur, it is not the cause of behaviour. To find the causes of any psychological phenomenon, as in other sciences, we have to find the *necessary-and-sufficient variable* for that phenomenon to happen. The brain is a necessary variable: without neurons, without neurotransmitters, without the prefrontal cortex, etc., we could hardly behave; but *the sufficient variable* is the interaction of the organism with its environment (physical and social). Without that interaction, no behaviour would develop. Even some people with severe neuronal deterioration manage to have certain interactions with their environment (e.g. moving their fingers or gazing), but without these minimal interactions we would say that they are in a coma or clinically dead.

The above does not imply that we deny that some kind of brain damage, neural function, or brain structure may underlie, as *a necessary but not the only cause* of the various psychotic problems. *The social context would also be a necessary cause* for the development of psychotic problems. Early models already spoke of an integration of factors, such as that of Zubin and Spring (1977), on the confluence of genetic factors, life events, and interpersonal conflicts in a person's life, together with a certain susceptibility or vulnerability as personality characteristics. This integration theory has sought explanations in specific aetiological factors for each type of behaviour (Gleeson et al., 2007) and is the basis of the traumatogenic model (Read et al., 2001) and other approaches that integrate genetic and environmental variables (Freeman and Garety, 2003; Petrones, 2004).

We could consider these interactions and experiences as *necessary causes* (certain contexts and crises must be present for the characteristic behaviours to appear), but *they are not sufficient causes either*. There are people who go through similar traumatic or stressful interactions and do not necessarily develop these problems, although they may develop different mental health problems.

In this logic, then, we are arguing for a multi-causal origin of psychosis problems, where *the brain and its malfunctioning may be a necessary cause*, but also *interaction with the social environment would be another necessary cause*. The latter is usually not considered in research, as it tends to always follow the medical model of physical illness, thus discarding a large part of the "causality" of these problems. It remains to be found *which would be sufficient causes*, i.e. those which, if they appear in the individual's history, can be proven to produce these problems with certainty.

5.2.2 Covariations and Biological Correlates

A large part of the difficulty in finding these causes lies in the research methodology, as correlational and epidemiological studies are mainly used, which allow us to glimpse hundreds of "causes" (as many correlations as we wish to obtain), or *post-hoc* studies that draw conclusions *a posteriori*, when the problem has already been created and causes are assumed, and that sometimes the treatments themselves have contributed to create.

Unfortunately, all studies on possible causes of psychosis problems are correlational, and correlation does not imply finding causation. Many biomedical studies are based on studying some neural variable, including the coloured pixels of the *functional magnetic resonance images (fMRI)* and their correlation with some characteristics of people diagnosed with schizophrenia, in any case comparing with normative populations without such a diagnosis. But these illuminated pixels only indicate the activation of certain neuronal groups or areas, which are previously indicated by the experimenter, and how they relate to the motor or cognitive activity that the individual is doing precisely at that moment. We see that, even in this type of highly technological research, interaction is essential as *a necessary variable*, the *f* of *f*RMI precisely indicates *the functionality* of the behaviour.

On the other hand, psychological studies attempting to find personality traits or specific characteristics in their history, life episodes, family characteristics, susceptibility to stress, etc., are always correlational. They are generally based only on questionnaires, on verbal information given by the individual and/or his/her family, to which are added the diagnoses and assessments of clinical professionals. They cannot really offer many efficient causes for schizophrenia problems either, and they are always based on *post-hoc* studies, when the problem has already presented itself in clinics or health centres. From the very first moment, it is usual that people start to be medicated, and from then on their whole life. It is quite difficult to separate "causes" when medical treatment becomes exclusive and compulsory, with its own iatrogenic effects, and therefore indistinguishable from the very problems it is trying to solve. The toxic effect of the antipsychotics (or neuroleptics) themselves in the long term, producing cognitive impairment, structural alterations, shorter life expectancy, or lower recovery rate, is not without criticism (Harrow et al., 2012; Omachi & Sumiyoski, 2018; Wunderink et al., 2013).

5.3 Rethinking the Causes

In this knowledge open to other alternatives in the search for causes, we can start from the approach of Pérez-Álvarez (2003), and Pérez-Álvarez and García-Montes (2006), on the causes of psychological disorders in general. These authors speak of the four causes of psychological disorders, which in this case we could also extend to the four causes of psychotic disorders.

1. *The efficient cause.* It tries to answer the question of what, who or whose causes psychotic experiences to appear. In this sense, the efficient cause would be found in the relationships between people and the circumstances of life, generally bad or adverse for the person. The individual has these experiences that he or she does not know how to interpret, which makes him or her confront his/her immediate family and social environment, and to which he/she reacts in an exaggerated or inadequate manner. Further to this reasoning, Guerin (2020a, b) proposes that psychotic experiences are an adaptive resource that people use in the face of bad life experiences, after having tried other alternative resources and having failed. For example, Ordoñez et al. (2012) found that, among those admitted to psychiatric units, at least 75% of people reported traumatic experiences, and 69% of women and 59% of men had suffered sexual or physical abuse in childhood. Clearly, there are multiple efficient causes, ranging from childhood abuse

and neglect, poor prenatal health, maternal stress, experiences in war situations, poverty, cannabis use, etc. (Cantor-Graae, 2007).

2. *The material cause.* It tries to find the entity or matter of these psychotic experiences. From a contextual and phenomenological perspective, the contents of these experiences would be based on intense suffering, so that the individual gives answers to cope with this suffering, which changes the experience of the self as an entity from which one acts (the voices heard are those of others) and as the director of one's own life (and these others order what to do). The person does not manage to verbally relate their subjective experiences in an adequate and articulate way to others, with expressions or discourse that others understand. His experiences are his/her own, no one else has them, and no one else has taught him how to name them, how to integrate them into his/her personal self, or how to describe them in words that others understand. From this perspective, then, psychosis problems are presented as disorders of personal identity, where hyperreflexibility (Pérez-Álvarez, 2008), depersonalisation of one's own experiences, and the loss of common sense with the social environment, would be the matter or entities that compose them, regardless of the symptoms or forms that appear in each person thus diagnosed.
3. *The formal cause.* This responds to the form, configuration, or topography of the different behaviours ("symptoms") of these psychotic experiences. In this case, the DSM and the ICD diagnostic systems capture these forms very descriptively. The experiences are lived subjectively by the individual with their personal history and current interactions, but when they describe them, or are described by family members, they begin to be classified, ordered, and categorised. It would be a "secondary elaboration" (Pérez-Álvarez, 2003, 2019) where professionals ask questions and obtain information, based on questionnaires that are confirmed with themselves, so as to delimit the different behaviours presented by that person, always within the categories and parameters defined by those same systems. However, we must not limit ourselves to these categories or "symptoms", because we must also consider the culture and the historical and social moment in which the problem arises. Historical studies have already shown how these "symptoms" can change throughout history, and how they are closely related to the social and cultural environment (religion, political system, technology, media). Possibly, the fact that more importance is given to the so-called "positive symptoms" than to the "negative symptoms" is due to the fact that the drug is listened to more than the individual (González-Pardo and Pérez-Álvarez, 2007). But what we have in our hands, and what we have to treat, is not an illness, nor a disorder, nor a set of symptoms, but *a person with alterations in their way of being in the world*. Alterations involve suffering for these people (and their relatives in many cases), and which would be the formal causes that the professional has to find out and remedy.
4. *The final cause.* This responds to the function, the results, the purpose, or what the psychotic experiences are for, both for the individual and for those close to them and the professionals who care for them. It is about finding out what these psychotic behaviours are for, what consequences they have, what happens to the

> individual when he/she suffers, and what actions the social environment takes with regard to them. As we will see below, the social and contextual perspectives that are emerging look for these whys and wherefores in the individual's need to adapt to the social environment that exerts its power and stress; in short, the social function of the dominant power to eliminate any source of dissidence or alteration of the established order. We could even analyse a function of maintaining the problem as a chronic illness that obtains a high economic return and a justification for the social power to have "something" to deal with.

In this situation, professionals trained in contextual and social analysis should approach psychotic experiences in a functional way, addressing these final causes. Their clinical exchanges should aim at shifting the focus of people with these experiences from fighting against these experiences (their thoughts, voices, hallucinations, hyper-reflexivity), to fighting to open up a horizon towards a valuable life. The aim is for the person to direct his/her life and to be the protagonist of positive social interactions, valuable for his/her life, even if and in spite of these psychotic experiences are still present. In each person, it will be necessary to look for the "causes", which will not always be the same in those who receive this diagnosis, to try to change them or in any case to offer alternative ways, to confront this environment that is hostile to them.

In addition, a professional who deals with mental health problems must question his/her own work in depth, must have a broad knowledge of the social relations and movements, both in their history and in their economy, which condition many of the problems classified as "disorders". If professionals do not take a critical look, detached in time and space from the present problem, it is difficult to even realise those four ultimate causes that could account for the emergence and maintenance of mental health problems. However, if this more relativistic, more philosophical, and phenomenological perspective is adopted, perhaps professionals will find other ways of approaching and helping people suffering from psychotic problems.

5.4 The Medical and Pharmacological Approach

The emergence of medications, and especially the appearance of chlorpromazine in 1952, developed a biological model according to which "something is wrong in the psychotic brain", be it neurotransmitters, structural changes, or any other issue. Symptoms associated with these malfunctions emerge and are organised into different disorders. As new drugs emerged, new pathologies were created to be treated with these drugs. All with four fundamental objectives in the case of schizophrenia: symptom control, reducing the frequency and severity of psychotic episodes, improving quality of life, and facilitating the social, occupational and family integration of the person with this diagnosis (SEP, 2000).

What was happening a few years before this "psychopharmacological revolution"? It is interesting to remember that the DSM was developed in the midst of a real battle with the democratic intention (but the science is not democratic) of reaching consensus. With the support of the pharmacological industry, what was really intended was to restore psychiatric prestige in the medical world, which was at a low ebb after the criticisms of the 1970s. Suffice it to recall Hobson's (2003) "... the development of drugs that interact with brain chemical systems is the most important advance in the history of modern psychiatry". No doubt it is, but the psychiatry is among the most powerful sections in the medical world, and it is thanks to the enormous amounts that the psychopharmaceutical industries pour into this section of medicine. The reality at this point in the twenty-first century is that the supposed biological cause of any *mental disorder* has not been found. One of the reasons for this is that we would need to know the brain model of "normal functioning", and this does not exist either, so it is difficult to compare to find the differences. Indeed, a recent meta-analysis of 40 studies (McCutheon et al., 2021) comparing neuronal activity in people at high risk of schizophrenia and others without problems has shown the absence of such differences.

It all seems relatively simple and even consistent with the accepted social model. We attribute the origin of so-called "psychotic" behaviours to a place in a "damaged brain", a problem with neurotransmitters, genes, or some other cause over which we seem to have no choice. We then look for substances that appear to be able to repair these "defects". So, once we have the "symptoms" and the chemical treatments to compensate for them, we act medically. No one is responsible, it is a "chemical condemnation" and as such we can only accept it and live to reduce the symptoms that are considered the problem, and not so much the situations that are experienced in the context. Thus, the family already knows that the cause is a brain problem, and the only thing to do is to pity and treat the person "as if he/she were mad". The individual, for his/her part, does not have much to decide either, only to take the pharmacological treatment even if the short, medium, and long-term side effects make him feel worse and worse, with less and less energy, with movements that he/she does not seem to be able to control, with his/her attention completely scattered, without energy. This is what he/she has to do, to "stabilise" him/herself, and not to be a nuisance.

The professionals of the *Rethinking* project (Crespo-Facorro et al., 2016) produced a consensus document on the efficacy, effectiveness, and efficiency of treatments applied to the problem of schizophrenia. In these conclusions, they state that first- and second-generation antipsychotics are effective, provided there is good compliance, for the so-called "positive symptoms", while cognitive-behavioural interventions have also been shown to be useful, albeit with a moderate effect size. However, they state that there are no drugs that have shown efficacy for "negative symptoms" (primary or secondary), and some of them may even produce negative symptomatology in people who do not have problems (Arango et al., 2013). It also appears that injectable, long-acting, second-generation antipsychotics have advantages in reducing problems and facilitating the coexistence of the individual and his/her family. However, there are also studies that do not show improvements over traditional treatments in symptom reduction, cognitive and social functioning, or relapse prevention (Kishimoto et al., 2014; Lemos et al., 2010). On the other hand, other types of drugs (antidepressants, benzodiazepines, anticonvulsants) that have also been used seem to show little efficacy (Buchanan et al., 2010).

The great shortcoming of this type of pharmacological studies, however, is that they fail to evaluate the social functioning and quality of life of these people, since efficacy studies generally only evaluate the "symptoms" and their changes. They do not consider the individual as a whole, as a human being in his/her social context, so the social functioning of that person, his/her family, social and work interactions, etc., are not assessed. Nor is the person's own opinion taken into account. If we consider the importance of the subjective experience of schizophrenia, and how the individual is able to adapt to it, the assessment of that experience and the person's own opinion about his/her recovery, inclusion in the social environment, or quality of life, are also fundamental aspects to consider in the effectiveness of a treatment. In this sense, recent research has been incorporating more subjective element of the concept of "recovery" (Disky et al., 2015), where the person expresses their satisfaction, their feelings about their current situation, and evaluates both the service received, and their progress and quality of life in the present.

The difficulties in carrying out this type of studies and assessments undoubtedly result from the pressure of care, the scarcity of resources, and medicalisation as an exclusive health resource. If it is an *illness*, as it is socially understood, then it must be *cured* with drugs. In this way, the patient is stripped of his or her own ability to cope.

A further reason for the necessary change in the field of mental health is the iatrogenic nature of the treatments. "Antipsychotic"drugs have had a geometric increase, so that it seems hardly credible that they have solved anything beyond the profit results of the pharmaceutical companies, and all the "contracted" science that has moved in around them. The more drugs patented, the more everyday realities become illnesses, resulting in an increasing number of supposed illnesses that are coupled with the emergence of new psychotropic drugs (Goldarcre, 2019; Gotzsche, 2020).

In short, the biocommercial paradigm has not proved useful for treating mental illness, although we must recognise that the use of drugs can contribute at specific times to allowing the person to be in a better position to solve the problems that lead to suffering. However, a sensible, controlled, and time-limited consumption that alters the person's coping conditions as little as possible; and that is also explained as what it is for: to reduce physical discomfort, but not to treat a problem that has its social roots. It is precisely at this level, the way the person relates to and is in his/her various social contexts, that will be the key to intervention.

5.5 The Psychological Treatments

Traditionally, psychological treatments for schizophrenia problems have really been seen as adjuncts or complements to pharmacological therapy. Since the latter does not achieve optimal results, especially not in the long term, and has high side effects and poor adherence to treatment, there has been a need to include other forms of intervention to help improve the situation. In this case, the psychological treatments with the greatest experimental support that appear in the NICE guidelines (2014), those of the APA (2019), the RANZ-CP of Australia (2016), the CPA of Canada (2017), of other professional associations on the subject, and also in Spain the *Guide of the Ministry of Health and Consumer Affairs* (GPC, 2009) are usually the following: cognitive-behavioural therapy, social skills training, cognitive-social training, assertive-community treatment and employment support, family intervention, and psychoeducation.

These are being incorporated with other forms of intervention based on meta-cognitive rehabilitation, or therapies based on acceptance and mindfulness. Although they differ from one guide to another, they tend to have common elements, albeit with varying degrees of effectiveness. An extensive description of these reviews can be found in these same international guidelines and in various writings (Fonseca-Pedrero, 2019; Fonseca-Pedrero et al., 2021; McDonagh et al., 2018; Ridenour et al., 2019; Shirivastava, 2020).

5.5.1 Psychological Treatment with Empirical Support

Cognitive-Behavioural Therapy In general, this type of therapy is an extension of cognitive-behavioural techniques applied to other problems, but now adapted to the specific characteristics of these people. In this case, a diversity of behavioural techniques include not only contingency management (e.g. token economy in institutions), but also teaching self-management and self-control, coping skills training, controlling anxiety dealing with others, changing depressive and ruminative thoughts, etc. Particular emphasis is placed on reducing the distress and disability associated with psychotic behaviours, reducing emotional disturbance and achieving greater involvement of the individual in relapse prevention and social adaptation. The review and meta-analysis by Wood et al. (2020), based on 23 randomised cognitive studies, showed positive effects after therapy and at follow-up, not on "positive" behaviours but on "negative" behaviours, daily functioning, and readmissions.

Fundamentally, cognitive-behavioural strategies focus on people's beliefs, trying to change these schemas, to confront reality, or to modify automatic thoughts. In our view, however, what they can achieve is the strengthening of these delusions. Focusing on the content by insisting on it is a form of positive reinforcement, which paradoxically increases them by trying to change them. Hence, from the most recent therapies, the central objective is changed towards the acceptance of these thoughts, the description, and vision of these hallucinations as true, although in the background, giving priority to vital objectives, personal values, and relations with the environment, in spite of continuing to have these strange experiences that the individual does not know how to handle.

Social Skills Training This type of intervention, which is common to the previous one, focuses on improving social competences, adequate processing of social information, and social cognition about their environment. In addition, interactive skills, emotional skills, instrumental roles, and social norms are taught to facilitate the individual's social inclusion. On this basis, neuropsychological rehabilitation therapies ("cognitive rehabilitation techniques") have also been proposed that focus on cognitive skills training, learning new supervised skills for managing the everyday or work environment. A meta-analysis of 27 studies (Turner et al., 2018) of randomised group comparisons has shown that social skills training has better results than controls and standardised treatment groups on "negative symptoms", and also on other problem behaviours, especially on measures of social integration and functioning. This effectiveness was also maintained in long-term follow-ups.

Cognitive-Social Training This perspective that adds the word "social" to the cognitive refers to the degree to which people integrate that social information or have social and emotional processing skills, empathy, knowledge of social norms, involvement in social settings, etc. (Baez et al., 2013). This theory goes so far as to determine its components in emotional processing, social perception, theory of mind and attributional style and even ventures to identify in which brain areas these "social mental processes" could be located (Pinkham, 2014). From our perspective, this psychological and cognitive theory has little "social" element. It implies looking again for causes *within* the individual, rather than in the interactions he/she makes with his/her environment. Problems of social relations, social malfunctioning, or maladjustment are attributed to a certain "social cognition". From this cognitive approach, we are back to having to deal with the "mind" and something supposedly altered within the individual.

Assertive-Community Treatment This is an intervention model aimed at organising the health system around the problem, rather than a treatment technique. It consists of a multidisciplinary team that tries to implement most of the available services (treatment, rehabilitation, health, social and economic support). The aim is to maintain a comprehensive service for people with severe and complex mental disorders, of a chronic nature, and with severe effects on their daily functioning. In many cases, these people have only received uncoordinated, piecemeal treatment, wandering from professional to professional, without receiving comprehensive care in all the aspects. The ultimate goals of this form of intervention are not so much to refer problems, but to keep the individual in contact with health and care services, reduce the incidence and duration of hospitalisations, improve adherence to treatment and therapeutic guidelines, and thereby improve the social functioning and quality of life of these individuals (Vanderlip et al., 2017). In fact, it is the programme recommended as public health policy by the WHO (2008) and has been implemented in many European countries.

Family Intervention Since the deinstitutionalisation of people with psychosis in the last century, families have been at the forefront of all forms of intervention. They are important not only as a possible source of conflicts and stress (remember the "expressed emotion"), which have to be addressed in joint sessions and therapeutic indications for day-to-day life, but also as a "family burden" since they are the ones who have to face all the episodes, conflicts, discomfort, stigma, and difficulties of all kinds. Thus, professional support for the family, attending to their emotional and relational needs, avoiding blaming, and the creation of a good therapeutic alliance are crucial for the maximum benefit of any programme. Systematic reviews (McFarlane, 2016; Sin et al., 2017) indicate a 50–60% reduction in problems compared to treatment as usual, especially when such family intervention is applied in the first episodes or early phase of the psychosis problem and is also combined with some of the other evidence-based therapies.

Whatever the theoretical basis for intervention in the family, it is also combined with "psychoeducation" and problem solving that arise throughout the therapeutic process. However, from our point of view, these interventions are very much influenced by the medical-psychiatric model, where family members are usually asked to help with pharmacological adherence, monitoring of the person, or day-to-day care. In addition, if the basis of an "illness" model is assumed by the relatives, then they adopt more roles of "caregivers" than "problem-solvers". Generally, these programmes increase the information available to family members, and they improve interactions within the family, as well as adherence to treatment, and overall family satisfaction, but do not show improvements in behaviours characteristic of "psychosis“.

Psychoeducation This is practically a type of intervention that is present in all other forms of treatment, since an element of information and education is always included in all programmes, especially for the family. The aim is to provide relevant information about the problem and the planned form of treatment, as well as strategies for the management of their environment regarding the difficulties that arise in day-to-day life, medication intake, reactions to episodes, emotional treatment, etc. In many cases, this information is also included in the form of readings and even online support programmes. The inclusion of this element aimed at family members and caregivers within rehabilitation programmes has shown better final results (Sin et al., 2017). A meta-analysis study (Alhadidi et al., 2020) of 11 randomised studies shows that adding psychoeducation to the programme results in fewer relapses and lower readmission rates, while increasing the sense of well-being and control by the family environment, than groups that did not include this component in the intervention.

5.5.2 Psychological Treatment as Support

One of the arguments most often put forward for the need for psychology to collaborate in interventions on psychosis is the need for adherence to pharmacological treatment. It is preached that the individual must be "aware of the illness", i.e. he/

she must accept and assume the role he/she is forced to play, recognise that he/she has an “illness”, and that the only possible treatment that will benefit him/her is pharmacological treatment. This “recognition” is an essential factor for the initiation of pharmacological or psychological therapy. Without it, the success of any voluntary intervention by the individual is difficult, and it is a predictor of subsequent pharmacological success (Ayesa-Arriola et al., 2011). However, it focuses the entire problem on the individual and not on the relationship with the social context. It is logical that if the person accepts that he/she “has” an illness and that there is nothing he/she can do to change but take medication, then he/she will adjust to this demand. In this way, psychologists also contribute to the psychopathologisation of problems, making the individual the only one to be blamed, and the person’s life is decontextualised.

This insistence on “illness awareness” also has another side which is called “self-stigmatisation”. That is, as soon as the diagnosis is received, the individual himself assumes the possible discrimination of his/her family, friends, and relatives. This leads to self-isolation and reluctance to seek help, support, or alternative ways to improve their situation. Thus, the person with a diagnosis of schizophrenia is not only confronted with the real fact of stigmatisation by the social environment, which isolates him/her, sees him/her as strange, and does not want to be around him/her, but also a self-assumed role believed to be true by the individual himself/herself, which leads to more isolation and fewer possibilities of interactions with others.

We believe that psychology is in urgent need of a critical revision to question this profoundly iatrogenic model, which views human distress in terms of the “ghost in the machine”, a ghost that also seems to have a broken mechanism. Thus, psychological intervention should not focus on decreasing hallucinatory behaviours (e.g. “focusing” or “reality testing”), since focusing on them may increase them, or at least increase their evocation and verbalisation. The aim would be that the individual would interpret these experiences differently, adapt to them, and that they do not determine his/her actions in everyday life. It is also useful to try to find out their functionality, what triggers them, what behaviours follow, and what happens after these episodes, always trying to focus on the functionality, rather than on the form or content of these experiences.

However, official psychology also plays the role of a social loudspeaker for the biocommercial model, as it accepts without nuance the biological discourse of alterations that need a chemical solution, instead of understanding the profound social and relational component that leads to situations of personal suffering. A change in health policies is needed, with a more social and community orientation in health services, which prioritise this reality of social functioning and quality of life in the success of the treatments that are implemented.

5.6 The Contextual and Social Perspective

It is important to establish from the outset what this contextual and social perspective implies, as they are polysemous terms, and are used with multiple other theoretical conceptions. It is not only psychology that uses the word "social", but also community psychiatry interventions, and even social services. We will consider here as fundamental, both as causes and as objects of change, the immediate context, and the wider social context in which the individual with these problems lives. Context, then, will be the whole set of variables and factors that directly (and also indirectly) affect psychosis problems (van Os, 2010). In other words, we consider variables that are external to the problems to be more important and more addressable. By changing immediate family interactions, social interactions with friends and acquaintances, work environment, personal autonomy, economic independence, living conditions, opportunities, and accessibility to resources, etc., it is more likely that many of the psychotic behaviours, which until now have been addressed from an individual perspective, can be solved.

Programmes Focused on "Community Intervention" They have a behavioural and cognitive-behavioural basis, as they integrate various strategies already endorsed for intervention in other types of clinical problems. In this case, training in daily living skills, social skills, assertiveness, coping, social emotional management, work integration, etc., are used. Controlled studies of this type show the efficacy of such training and employment support to be very effective for the individual's daily life, decreasing substance use, hospitalisations, and decreasing the risk of social exclusion (Liberman and Kopelowicz, 2005; Killackey, 2009). Among the social approaches, experiences started already in the 1980s with the so-called "case management programmes". Here a tutor or manager acts as a guide and coordinator between the different mental health devices and the individual, facilitating different types of programmes, support, social options, etc. In Spain, this type of experience has not been very successful due to a lack of funding and training for the professionals on the team. On the contrary, models of individual intervention and psychosocial reintegration have been devised and implemented, such as the previously mentioned "assertive community treatment", combining individual, psychological, pharmacological, and social approaches (Mesa-Velasco et al., 2021), which have reduced hospitalisations and the severity of the problems (Wilkinson et al., 1995). Although they are minor, self-help groups and social clubs have also other strategies to use the social context to improve the interaction problems of these people. Such services can create a non-clinical context that can benefit communication and the learning of appropriate social skills, as well as providing support and social reinforcement, breaking isolation, and improving the social network for these individuals.

Psychological and Social Interventions Without Drugs Pharmacological management and the "deactivation" of the individual that this involves means that experiences or interventions that do not include pharmacological treatment are rare. Recent research has begun to compare the efficacy of different interventions with and without pharmacological treatment (or with the lowest possible doses). The review by Cooper et al. (2020) has identified 17 non-drug studies, but of these only 9 randomised studies comparing drug and non-drug groups, and mostly with small samples. In these results, interventions with the psychological treatments described above, but without adjunctive medication, achieve the same overall results as those using only medication as the exclusive treatment. Psychotic behaviours decrease at a medium level, but social functioning improves greatly.

Interventions Focused on the Social Function We have already mentioned the social function of the medical-psychiatric model that tries to impose a single form of treatment based on drugs and unique biologistic causes. Actually, from a more contextual and social perspective, we can consider that the dominant powers (from the family to the state) try to impose their social narrative, and the control of social behaviours in established frameworks, so that those who escape (or try to avoid) these frameworks, showing alternative narratives and stories, are forced into a form of treatment that renders them useless for their daily lives and prevents them from coping with these functions of power and social control. This social analysis also emerges from the British mental health movement on the *Power, Threat, and Meaning Framework* (Johnstone et al., 2018), which views mental health experiences as an individual's reaction to a social and political framework of power, which exerts pressure and stress, and to which they rebel, flee, try to adapt, or fight back. In this sense, psychotic behaviours would have a reason as an adaptation and reaction to the suffering of this power, and where the individual reacts and tries to cope as best he/she can with these threats from the social environment. This framework is finally understood from the "meaning" that the individual gives to that power and that threat, that is, from the perception and subjectivity that the person gives to that situation, which makes him/her suffer, react, or remain paralysed in the face of all those interactions that oppress him/her.

Interventions from the Functional Context The maintenance of psychotic problems can also be analysed from the functional analysis of behaviour (Ramnerö and Törneke, 2008) based on the principles of learning, where the direct consequences of a behaviour on the environment are studied. When a behaviour occurs, usually strange to its context, it receives consequences from the social environment, which usually reacts by being surprised, altered, attacked, immobilised, or by moving away, isolating the individual, avoiding his or her social presence, etc. From what we know about the laws of learning, this strange behaviour will be repeated if it receives contingencies. In these cases of "bizarre" or "psychotic" behaviours, they are considered as an attempt at dysfunctional adaptation to adverse life situations (Pankey and Hayes, 2003; García-Montes et al., 2006; Pérez-Álvarez, 2019) and would have a function or purpose of avoiding the aversive emotional experience derived from these situations (e.g. direct escape, avoidance of the aversive situation, experiential avoidance). But in attempting to do so, they encounter new social contingencies that chronically maintain them. If that context does not change (family, lifestyle, and social relationships usually remain stable), then they become chronic, long-lasting behaviours. They would have a maintenance function through their immediate effects, by eliminating responsibilities, confrontations, problems with others, etc., and even maintaining socially reinforced behaviours by attracting a great deal of attention and care. In many cases, the set of variables that follow psychotic behaviours says a lot about their chronic maintenance, including the reactions of professionals, who tend to strengthen these formal causes (by insisting on the "symptoms") and also the final causes (by reinforcing their maintenance). In these cases, the intervention must seek to change these contingencies, not only by teaching family members and relatives, but also by trying to change the moment-to-moment interactions that the individual has in his/her daily life. This also involves social and economic changes, of a more global nature, but which form part of the macro-contingencies that maintain social behaviour, so that they would also be the object of change in these psychotic problems. Interdisciplinary work is therefore essential, not only with the medical professionals that already exist, but also with social workers, employment counsellors, support tutors, etc., who can really do a great deal of work to avoid the chronicity of the problems.

Acceptance-Based and Life-Based Interventions These are the new approaches that have emerged from the so-called "third-generation therapies" or also "contextual therapies" (such as *Acceptance and Commitment Therapy*; Hayes et al., 2012) in which the emphasis is on the individual's relationship to his/her environment, including here his/her verbal context. The fundamental idea is that the more the individual struggles with his/her private events (hallucinations, recurrent ideas, and thoughts), the more he/she is increasing them, so that this struggle is the centre of his/her life and becomes the source of all other problems. The therapy, then, basically consists of accepting these events as true, observing them, describing them, and "letting them go", in order to focus on the present life here and now. Psychological flexibility is sought, so that extraneous thoughts and experiences do not become the centre of everything, but rather the personal values, the life goals that a person has.

This view is also shared by phenomenological and experiential theories, which attribute a deficient construction of the self, the way of living intersubjectivity with others, and the lack of relationship with the world (Ayesa-Arriola et al., 2011; Martín-Murcia & Cangas, 2021; Parnas and Handest, 2003). This type of interventions can also include "open dialogue" and "hearing voices" approaches that emphasise personal experience and help to understand them within the social and family context (Ruddle et al., 2011; Valtanen, 2019). The review of Ventura-Martins et al. (2017) and Louise et al. (2018) about these therapies have shown their effectiveness in reducing psychological behaviours, anxiety, and depression, as well as functioning in daily life. More details of these therapies and their effectiveness can be found in other chapters of this book, and in manuals such as Díaz-Garrido et al. (2021) and Fonseca-Pedrero (2019).

Social-Contextual Approach Essentially, here, we advocate the search for causes and solutions to the problems of schizophrenia in the individual's social and experiential environment. Focusing on the "brain" or the "mind" has not led very far to effective long-term solutions. It is necessary to focus on the outside, on the interactions that occurred in that person's life, and those that are happening at the moment. It would be by changing those interactions and that context that better long-term solutions could be found. When the individual has an autonomous, socially positive life, economic independence, and life goals, these problems of "psychosis"can be considered solved.

Our approach is: **contextual, social, and external,** since we assume that the causal variables of the problems are outside the individual, in the interactions that happened in his/her history and in the present. At the moment the first "psychotic break" appears, history can no longer be changed, but the person's future can be changed. Thus, the therapeutic goal should be not so much to change the individual, but to change his/her environment or social context, and the way he/she interacts with these contexts, including the verbal interactions and the explanation of the experiences he/she suffers. If we assume a causality or triggering of psychotic problems from difficult and stressful situations, then we must also look for the remedy in those situations, starting with the family. New crises and readmissions are much more likely if the person lives with very critical family members.

From this social-contextual approach, we also follow the ideas of Guerin (2016, 2017, 2020a, b), the individual's living conditions from childhood and adolescence shape the various behaviours, and some of them will be strangers to their environment. They will not emerge suddenly, but increase or exaggerate from weaker ones, which are socially "spoiled" or "punished", and the individual tends to adapt or try to escape from these new conditions, sometimes exaggerating even more, reacting in an emotional and strong way, which often leads to institutionalisation and medication. In this way, both negative environments and bizarre behaviours feedback, becoming entrenched and chronically maintained.

Therefore, our analysis is that the intervention should not focus on an inner self, but **on the concrete interactions that happen in everyday life** between that person and his/her family. Direct observation in real context is what can indicate the aversive situation that the individual is experiencing. The family should be taught how to interact without punishing, because if the family members do so, it is because they do not know any other repertoire, nor do they know how to deal with the problems. The so-called "psychoeducation" described above, we believe, is not enough; it is only information about the problem from a medical-illness point of view, rather than information about the daily reality of these social interactions. Information has little power to modify behaviours, it has to be a direct training, and if possible in the family environment, to observe and start modifying these interactions in situ. Therapy should be brought into the home, not in an "artificial" or "professional" context, which is not functional to produce the same negative interactions that usually occur in daily life, but should take place at mealtimes, chats, discussions, etc. Family intervention is missing this great opportunity for action. In these cases, social interventions through living with others outside the family, "protected homes", or supervised living may be valid options, although so far there is little research on their effectiveness.

On the other hand, life today pivots around work and money. This is the context that determines a large part of new social behaviours as well. Thus, in a person with these “psychotic” problems, the fact of **being employed and financially independent** are the fundamental factors for a *full functional recovery*. This should be the ultimate goal of therapeutic interventions, where the individual moves from a sufferer’s sick role to a normalised role as an autonomous person. However, discrimination and stigma towards these people greatly hinder these goals. Sheltered workshops and associations of “sheltered work” or “special employment centres” are some options, as long as they do not become a refuge isolated from the real social and working environment and do not become yet another form of abuse of unprotected workers by employers.

The aim should be to ensure that integration into the labour market is real, in a normalised job, alongside other workers without problems, and not to persist in the tendency to “ghettoise” or “overprotect” when trying to deal with employment issues. Logically, the initial difficulties are based on deficits in social and professional skills to develop some work, but experiences with so-called “artistic” jobs show the usefulness of this approach. A person with such problems may not be able to be in construction or in an office, working rigorous hours and under the stress of abusive bosses, and may quickly give up because he/she does not know how to cope with the circumstances. However, he/she may be able to develop a job writing articles, being a blogger, radio scriptwriter, theatre actor, artistic painter, or studio musician (El País, 2004; La Colifata, 2021). As we argued above, psychotic-type behaviours can be presented by anyone, and it is a matter of degree whether they are considered pathological or not. In fact, the line between psychotic and creative behaviour in many artists is a fine one (see the examples of van Gogh, Munch, Martín-Ramírez, Wölfli, Nijinsky, John Nash, Joyce, Hemingway, Virginia Woolf, Philip K. Dick, Kafka, Jack Kerouac, Syd Barret, Peter Green, and a long etcetera).

5.7 What Do We Want to Achieve with the Therapy?

Studies of empirically validated therapies and practices always base their conclusions on quantitative changes that are assumed to be the effect of the treatment. Depending on the design used, these changes will be more or less reliable in terms of their conclusions, but always quantitative and based on changes in scores on questionnaires or structured interviews with scales of the “clinical” opinion of professionals. Very few studies base their conclusions on direct observation of the behaviours of the persons to whom these diagnoses are given; at most family members are asked, again with a standardised questionnaire and opinion scales. Even studies on pharmacological efficacy only measure the information that the individual or the professional gives on the frequency and type of drug prescribed; very few studies measure the amount of metabolites of these drugs in the blood, in order to have something objective to go by. Obviously, all these scales and opinions are then converted into numbers, and from there they are used as if continuous variables had been measured. Nothing could be further from the truth, because in essence our studies on therapies are always based on language, on the opinion of the family, the professional, or the individual. Does anyone measure the frequency or duration of clinically relevant behaviours (even if they are called “symptoms”)?

Not only that, but what studies measure the real changes in that person’s life? Certainly, very few. Only a small number measure so-called “quality of life” (again, an opinion), frequency of readmissions, time between visits, months in employment, or some socio-economic variables that might be somewhat more objective. But efficacy studies, and subsequent meta-analysis studies, do not usually capture these variables, but only quantitative changes in the questionnaires.

Obviously, these are necessary data, but it also leads us to a reflection on what is the change (objective) we want to achieve with any therapy, and with any intervention programme, whether in an institution or in the public health system. The objective, we believe, would not only be a quantitative change, but several changes that may reflect the real performance of the intervention on the individual’s daily life. In this sense, **we advocate the use of more direct measures of behaviour, measures in the daily life of the individual** (or within an institution, if that is the case). This would involve measuring the so-called “clinically relevant behaviours”, i.e. those behaviours that mostly lead to a diagnosis. Some of these were described at the beginning of this chapter. This implies focusing on and trying to change specific behaviours rather than “psychopathologies”. But it would not be a matter of “clinically opining”, for example, that hallucinations or delusions have decreased, but of observing and directly measuring the number of such statements a person gives per unit of time; or the amount of time they can remain silent or static in an interview; or recording the frequency of irrational speech; or the speed at which they talk about how their week has gone. That kind of data would be more objective and direct than the opinion of a professional who will, at most, do an interview and a general observation for a few minutes.

Hence, it is necessary to incorporate other data on daily life, social contacts and relationships, time and types of work, habits of independence and personal autonomy, pro-social behaviour in their environment, leisure, and entertainment behaviour, etc., into efficacy research. But, observed directly and not from questionnaires, since they would only represent the opinion (again) of professionals, relatives, or the individual him/herself.

In addition, **any intervention must seek the maximum autonomy and independence of the individual** to function in his/her social environment, in all aspects of family, relationships, friends, work, finances, leisure, etc. We believe that what should be sought is that social functioning, appropriate to the environment, even with (despite having) “symptoms”. If a pharmacological treatment reduces these symptoms but prevents this social functioning, because it cancels out the individual, we are not really on the best path to effective intervention. Many psychological, social, and contextual treatments have shown that such functioning is possible even if the individual continues to maintain some of these behaviours. Precisely, as we said earlier, contextual therapies seek functioning in the here and now life of the individual, even if hallucinatory behaviours are still present. As we said at the beginning, we all hallucinate and we all have our delusions and paranoias, it is a question of degree. It is a continuum, and it is in this balance that we can seek the autonomy and freedom of the individual to develop his/her life as a person.

5.8 Towards the Future

We are not trying to reissue an old confrontation, more mythological than real, between psychiatry and psychology. We are dealing with the urgent need to replace a biocommercial paradigm (García-Valdecasas and Vispe, 2011) dominant in mental health care in general, with one that, without denying the importance of biology, focuses on psychological and social aspects, not by whim but by seeking a real benefit for people.

Tailoring to the needs of the individual involves the use of social, psychological, and biological treatments in a coherent package for each particular person. Experiences from Finland with support systems and community, in team-based treatment units called “open dialogue” (Lakerman, 2014), and prevention experience in Melbourne (Phillips et al., 2007; RANZ-CP, 2016) have been significant. Social interventions seek to reduce the impact of social exclusion. The labelling of the individual and their isolation from the social environment results in significant disadvantage and loss of opportunity and entitlement in relation to others. People so diagnosed tend to have less money, be lonely, very socially disconnected, unemployed, and are possible victims of any abuse or neglect. Also the Norwegian experience (Johannessen et al., 2005; Ulland et al., 2014) integrates pharmacological interventions with psychological ones, where the prevalence of patients with schizophrenia problems is among the lowest in Europe, where they consider that homeless people (usually with this type of problems) are entitled to housing, social support, and psychological and/or social treatment; in addition to a system of care from the first episode, where they receive immediate support and individualised treatment to adapt their situation to the family and social environment.

Rethinking’s multidisciplinary team (Crespo-Facorro et al., 2016) includes a series of recommendations, which we endorse as our own, for the improvement of comprehensive care for people with schizophrenia:

- Provide an integrated, evidence-based package of care that meets physical and mental health needs.
- Provide support for people with schizophrenia to live in their usual environment.
- Develop mechanisms to help them navigate complex employment and social benefit systems.
- Provide specific support, information, and educational programmes for family members and careers.
- Regularly review and improve care procedures.
- Involve all stakeholders: users, professionals, relatives, and organisations.

- Provide support for research and search for new treatments in proportion to their social impact.
- Establish well-funded awareness-raising campaigns as part of ongoing action plans.

Many factors remain to be addressed in this brief proposal for change. There is certainly room for a more social and contextual (political?) analysis of why the factors that contribute to the production of problems of psychological discomfort (poverty undoubtedly has a prominent place here) disappear from the variables taken into account, and we only focus on organic factors. Behind this we consider that there is a whole socio-political construction of reality, where the term illness is something "politically constructed" and for the benefit of the system.

We are undoubtedly advocating those treatments should not be placed in the hands of "pharmaceutical" psychiatry, but in the hands of multidisciplinary teams where factors such as social integration, work, confrontation of discomfort, etc., are also objectives and actors in the treatment formats. In short, therefore, to improve care for people with these problems, the new forms of treatment must include ecological, contextual, and relevant assessments for the quality of life of people with schizophrenia, not only quantitative statistical data, but also the real repercussions that the programmes have on the lives of people, families, and the social environment in general.

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