# Third-Order Relational Psychotherapy

*Social Means to Therapeutic Ends*

By

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To Esperanza, my mother.

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Don’t give in; don’t tone it down; don’t try to make it more logical; don’t edit your soul according to fashion. Instead, ruthlessly follow your most intense obsessions.

Franz Kafka

# Foreword

Those who know Raúl Medina know that it is not rhetoric when he says that this book is an invitation to readers to converse with him from an open and critical position. This work invites us to rethink psychotherapy and to maintain a genuine, supportive and reflective dialogue.

That is why, as we open the pages of this book, we sit down to talk with Raúl Medina in an honest and profound conversation, in which he shares his ideas about third-order therapy and explains that the therapeutic task must also include culture and structural problems in order to understand individual and collective discomfort.

Critical reflection involves reconsidering the assumptions on which our beliefs and values have developed, as well as psychotherapeutic theory and practice, it is still not easy, because, as Michael Kimmel says, privilege is invisible to those who have it. However, the author has been able to transcend that difficulty and share with us a map that helps us to circumvent those blinders and privileges we have as therapists. More importantly, from this perspective, one can recognise how individualism, classism, machismo, racism and hyper-consumerism permeate our current culture and thus the theory and practice of psychotherapy.

To read these points so explicitly is a breath of fresh air, for while psychotherapy has timidly and quietly acknowledged structural pathologies, for the most part it has remained blind to social injustices and the isomorphism that is replicated in the relationship inequalities.

As the author mentions, addressing and recognising this power imbalance is a necessary clinical skill today, as therapists cannot remain neutral in situations of injustice.

As Desmond Tutu points out, if we do this, we are actually favouring the the oppressor. By our false neutrality we contribute to maintaining relational inequality and social injustice, thus becoming complicit with power.

Understanding and addressing relational power imbalances is not only an ethical issue, but also an issue of good clinical practice and, at the same time, a social intervention. Therapists are not trained to identify and address such imbalances, which tend to be to be challenging to see and therefore to connect to clinical and mental health issues and to relational power and social justice issues.

When we recognise these difficulties and blindnesses, a chasm opens up at our feet and many questions arise: if we cannot be neutral, what is our position as therapists? How do we challenge our patients to grow without breaking the therapeutic alliance? How do we stay on the ground of psychotherapy and avoid falling into indoctrination? How can we be outraged by injustices and inequalities without doing violence to others? How to turn dialogue between people into an encounter of solidarity? How do we accompany and challenge clients in unequal, dishonest and sometimes violent relationships without losing sight of their dignity and their wounds? How to do this without victimizing them or making them unaccountable?

In short, how can we be ethical and loving psychotherapists, but at the same time challenging, provocative and ultimately effective?

At first glance, it seems impossible. Many of us, recognising that psychotherapy must include these principles, have felt stuck for a long time, trying to resolve these apparent dilemmas.

In this work, Raúl Medina has been able to integrate these loose pieces as if they were a jigsaw puzzle, unravelling false dichotomies and presenting a proposal for dialogue that is critical, but also restorative and supportive, a way of living in intelligent resistance, a loving indignation, an emotional intervention, but also a political one. He makes them clear to us not as a simple oxymoron, but with a clear methodology, with cases that illustrate his approach. Raúl proposes clear resources to do so, always recognising the human dignity of people, presenting indignant love and dialogue in solidarity as therapeutic resources, always from the ethics of care, as a collective act of communion and

mutual collaboration that helps to rebuild love and to face mistreatment and exclusion in solidarity.

It is a revolutionary work that gives voice to and includes what until now has remained on the margins, a view that strips away the androcentric, classist, racist and meritocratic privileges of theory and clinical practice. Thus, in this work, we can all feel identified and, at the same time, validated, because the critique is made from solidarity and dignity. We know that social justice and equality is not a zero-sum game, but involves hard work that allows us to identify our privileges, blindnesses and challenges us to renounce them (if this is possible), but it is a step in which we all come out stronger.

Thus, this is a profoundly ethical and political work that, as the author has repeatedly pointed out, invites us to do third order psychotherapy as a way of "changing society, family by family", and "until dignity becomes customary".

Lidia Karina Macías-Esparza.

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at the Tzapopan Institute in Mexico.

# Introduction

This book is an exploration of the psychological world from a socio-emotional perspective. In each clinical case, I am confronted by several recurring questions: why does a family or a community break the dialogue of solidarity that has led it to mutual care and respect? Why do some people mistreat and abuse each other, especially in the family context, where individuals should find the affection and respect necessary for their development and well-being? More interestingly, why do some people justify a poor life and even the violence and marginalization they experience and inflict on others? What lies behind domestic violence and the multiple justifications or self-submission? The answer, in very general terms, to which this publication refers and supports, is that there is a cultural symbolism and an organized socio-emotional framework within which a person finds the meaning of his or her existence, and the explanation of its symptoms. This leads to another premise: from the point of view of third-order relational critical psychotherapy, psychopathology, as a biological and psychic expression, is a resistance, in a socio-political sense, to the violence and exclusion that the person experiences and sometimes even imposes upon himself or herself.

Third-order relational psychotherapy deliberately expands the clinical dialogue with families about the impact of other social systems on them and their distress. Together with families, injustices and cultural symbolism related to psychopathology are explored. Third-order change occurs when individuals critically understand and relate to socio-cultural systems as part of the reality to which they belong, rather than as something beyond their reach or power.

This publication presents an innovative psychotherapeutic model with a systemic-social perspective. It outlines the clinical critical proposal step by step, from the first session to the final session where the results are evaluated.

## The ghost of the anti-psychiatry movement returns

The old micro-macro dichotomy is back, this time in the clinical field. Putting psychological symptoms at the centre of our gaze as structural pathologies implies a major paradigmatic challenge, not only where such a link is recognised, but above all to work clinically with this awareness of systems of systems.

In principle, it must be recognised that there are antecedents to psychotherapy which show that personal discomfort is structural: the anti-psychiatric movement of the 1960s, promoted by Basaglia (1980), Laing (1992), Laing and Cooper (1973), Laing and Esterson (1980), Szasz (1982), Berlinguer (1977), Bastide (2005) and many others.

These not only pointed to a structural responsibility for personal discomfort, but also denounced it, especially in the way biological psychiatry treated symptomatology. For example, Basaglia (1980) mentioned that behind every mental illness there is a social conflict. Bastide, in a 1965 text, notes that 'the madman' is the expression of the bad conscience of a society that has denied certain values and fundamental needs of its people.

Berlinguer (1977) points out that

> ... you can't separate the body from the psyche and the psyche from the socio-emotional conditions in which it interacts. It is violence between men and women that causes damage to the body – the brain – and the psyche, which are located within a socio-economic and political frame of reference that classifies and imposes the rules of relationships. The neurosis of the individual is the paroxysm of a collective conflict [...] the neurosis of an individual is always [...] the symptom of a disease of society. (p. 24)

He concludes that any psychic discomfort that is treated as a biological disease, where magic drugs and psychotherapies appear that blame the

body and the individual, will never allow us to see the ethical, moral and social dimensions of personal discomfort.

Today, the spectre of the anti-psychiatric movement confirms their conjectures about madness. Botwin (2019) notes that most mental suffering comes from the socio-economic system. This creates a problem where we believe that our personalities are flawed and need to be corrected and replaced with more adaptive mechanisms to function within the system.

The treatment of discomfort, the result of the rhythms of life, of economic precariousness, ends up being pathologised and medicalised. The number of users of psychotropic drugs is on the increase, and massive drug use seems to be an epidemic. The laboratories are rubbing their hands with glee, as are those who make the most of suffering, such as self-help. There are drugs for everything: to sleep after the stress of redundancy or the uncertainty of life, and drugs to endure endless days. Antidepressants to get out of bed and anxiolytics to get back into bed. (Botwin, 2019)

One of the great historical mistakes was to locate psychological discomfort ontologically and epistemologically in the biology of the individual, as if it were a medical pathology, something natural, outside the social sphere. This is why public health policies focus on intervening in the body and the psyche as variables independent of the context in which they coexist (Foucault, 1986).

## Third-order thinking in relational psychotherapy

This perspective is related to what some call "third-generation psychotherapies" (Pérez, 2014). It is a clinical movement that has promoted the integration of the contextual variable in the diagnoses and clinical interventions of all psychotherapies.

The third-order model presented in this work is founded on two theorical perspectives. Firstly, it draws from the ecological paradigm espoused by Bateson (1991, 1993), who adeptly integrates cybernetics

and the general theory of systems. Secondly, it aligns with poststructuralist research in the social sciences, which, akin to the systemic, offers a contextual understanding of human behaviour.

This publication shows that third-order thinking, transformed into an ecological and psychosocial epistemology, is a psychotherapeutic resource that allows individuals, families and their community to return to dialogue in solidarity. By jointly confronting the symbolism and structural conditions that limit their freedom and affect their health (poverty, patriarchy, classism, individualism, racism, hyper-consumerism, job insecurity, etc.). Therefore, third-order relational psychotherapy focuses on raising awareness of the systems that organise lifestyles that interfere with health. (McDowell, Knudson-Martin, & Bermudez, 2019)

Two dimensions are analysed, structural problems related to public policies – poverty and cultural mythologies: the former is present through the injustice caused by the lack of universal rights, poverty, precarious welfare and employment, health policies and institutional abuse, structural aspects external to the individual and the family that have led to marginalisation and social exclusion. In short, the structural zone of daily family concerns overshadows any personal needs and dreams.

On the other hand, socio-cultural structural factors are not external to identity, family and community. They are embedded in their relational patterns – probably for generations – so they have enormous power in constructing micro-realities. They are unspoken narratives of truth that are practised daily, such as parenting, family roles and rules, etc. They are normative, non-negotiable and taken for granted. In other words, systems of systems are rooted in intersubjective recognition and generate their own identities. For example, within the patriarchal culture, it is assumed that the needs of men take precedence over the needs of women, developing a lifestyle where roles, hierarchies, power relations, feelings, morals and identity mandates are assumed. It could be said that there is a structural disconfirmation of gender; 'disconfirmation' is the perception of one's non-existence in relational terms" (Linares,

2012, p.62). In this case, an entire community does not take into account the needs of women; they are denied by patriarchal mythology.

In summary, this publication delves into a socio-cultural theory of human biology, the identity, power, emotions and the family, a set of concepts from which indignant love, dialogue in solidarity, critical honesty and the family of choice are derived as the axes from which the warp of this clinical proposal is woven.

## An integrative proposal: Systemic-Socio-Symbolic

This book proposes the integration of two explanatory models of human behaviour. The systemic-socio-symbolic approach, which examines the patterns that emerge between people and between systems, focuses on identifying the consequences of this interaction rather than its causes. In contrast, psychosocial poststructural theory focuses on the causes of this interaction, in particular the social structure and the meaning that people construct and give to their behaviour. The two models are complementary because they agree that it is in the contexts where both guidelines and meaning are constituted. We agree with Corsi (2006) who invites us to build a multidimensional integrative psychotherapy, where he emphasises the overcoming of false dichotomies of traditional thinking and proposes to adopt an open, flexible and creative position. From these positions, an integrative model is presented. The third order, as mentioned above, refers to a social epistemology that explores the psychological dimension from a critical reflexivity. In other words, we integrate self-reference and ecological reflexivity with key psychosocial research that demonstrates the structural conditions of individuality; to further support Batenson's core belief: The ecological unity of nature and culture.

In the light of the above, this publication is organised around the following conceptual categories.

## The ecological nature of biology and identity

Integrative psychotherapy involves a complexity that needs to be woven clearly and carefully. It requires not only a logical relationship of learning or change, as proposed by Bateson (1991, 1993) and Watzlawick, Weakland and Fish (1976), but also a social theory of biology and 'mind' that provides a scientific basis for the relationship between identity, psychopathology and structural conditions. In narrative family therapy, White and Epston (1993), Anderson (1999), Andersen (1994), Seikkula and Olson (2003), Seikkula and Arnkil (2016), Ramos (2001a), and others have successfully integrated symbolism into their patterns through narrative, dialogue, and conversation. However, none of them propose a social theory of biology and psychism that substantiates this quality and connection, because they take it for granted. They have replaced the object of study, the triangular relational pattern, with language. Here we present the foundations of a social theory of biology and identity that allows us to move towards a social relational psychotherapy that recognises, without separation, the ecological nature of the individual and the body.

## Emotions and power, the axes of personal discomfort or well-being

Every encounter is traversed by power and affection. This means that emotion and power are two essential axes that are implicit in human behaviour and that connect systems. This belief is based on the assumption that some form of power and emotion is implicit in all manifestations of personal discomfort or well-being. This publication examines it in depth in order to redefine emotion and power as collective rather than individual variables.

## Dignity as a social conscience and attitude for therapeutic dialogue

If counsellors are not to see themselves as victims of fate or misfortune, they must experience discomfort not as something natural or private,

but as a problem of a socio-cultural order. This third-order awareness leads to indignation, a feeling that activates the person to do something to confront the injustice that family members are likely to produce every day (Santiago, 2018). After becoming aware of the third order that affects health, the first therapeutic objective is for the client to transform the psychopathology expressed in depression, anxiety, anger, etc., into indignation, from which he or she will confront his or her discomfort from a more active position, politically and socially speaking. Dignity therefore becomes a psychotherapeutic resource.

From this approach, the client is treated as a person and not as a repository of an atypical symptom or behaviour; the therapeutic team treats the client as a worthy and legitimate person. The therapist who adopts this perspective will allow an open therapeutic dialogue without prejudice and emotional interference. All these components of the therapeutic relationship will lead to a genuine therapeutic alliance.

## Indignant love as a resource for family reorganisation

After the symbolic contextualisation of personal discomfort and family violence, the clinical work appeals to indignant love to uproot the resistance expressed by the symptom. Recognising in the other that they are also trapped and suffering allows for an emotional bond, with a shared recognition of each other as people worthy of respect and dignity. This shared feeling reopens the possibility of dialogue. It is about moving from sadness, fear, despair, anger, pain, struggles, complaints, mistreatment and the desire for revenge – symptoms – to solidarity, respect and love for the other and for oneself, and thus moving together to resistance.

Indignant love' is an emotional-political category that stimulates a dialogue of solidarity between family members. It implies a communion between people in which they recognise each other's needs. The aim is to face together, through critical reflection, the difficulties and external structural challenges, both self-imposed and shared. It is from here that we defend other crucial issues of psychotherapy: the dialogue of solidarity and its critical condition.

## Dialogue as an object of study

Dialogue is an object of study and intervention for third-order relational psychotherapy. From this point of view, dialogue is considered transversal because it permeates all bio-psycho-social activity, not only of the person but also of others and the particular contexts in which it takes place. In other words, it is not a purely linguistic act, but a matrix in which power, emotions, the senses, corporeality, the biographies of those who dialogue, their imaginations, illusions and hopes are inserted. For this reason, dialogue is conceptualised as a complex psychosocial symbolic scenario that makes visible the intersectionality of discomfort.

## The dialogue of solidarity

For dialogue to have restorative power, it must be supportive. One of the aims of third-order relational therapy is to work for the restoration of a dialogue of solidarity between family members, which will support and accompany an honest and critical position. Once the solidarity dialogue is re-established, counsellors will generate new agreements and resources to move forward. Solidarity dialogue is what Bateson (1999) calls, from an ecological perspective, "sacred unity": the ongoing desire to find a place with others, to make life an effort and a shared joy, to experience awe in our connections with others and the planet that sustains us.

## Critical dialogue in solidarity

From the perspective we advocate here, dialogue must always be critical in order to have a reflective component and to enable innovation and change. That is, the critical position towards oneself and others implies an epistemic meta-gaze in which we are the object of analysis and evaluation. This means recognising ourselves as people in relation to those with whom we interact in order to perceive, act and feel ecology out of reverence and commitment. Being critical of ourselves and our family members allows us to take nothing for granted and to constantly rethink the beliefs and rules we impose on ourselves, moving towards consen-

sus and open negotiation as a way of life. It also creates the possibility of prioritising unity and mutual care in the face of diverse dilemmas and challenges.

## Critical honesty for deep psychotherapy

The third order as a psychotherapeutic model inevitably leads to a self-critical position: for the client and for the psychotherapist. After visualising the systems of systems, critically acknowledging what has led them to divide, separate, argue and be collectively outraged, psychotherapy needs to confront the person by inviting an honest and critical dialogue with oneself. Therapeutic dialogue at this stage focuses on the client's honest reflection on his or her involvement in the experience of abuse. This confrontation with oneself will make it easier for the family dialogue to be more genuine, honest and emotionally close. It is necessary to invoke it in therapy in order to do deep clinical work. Deepening self-reflection through critical honesty is a painful process, but with liberating therapeutic results you will see yourself in co-responsibility and consequence. Critical honesty leads to self-rebellion. By rebelling against ourselves to accept who we are, we can see the structural influence of existence and the power brokers that remind us daily of how we should be.

The penultimate chapter explores the theme of the family in depth, rethinking it and making it a third-order psychotherapeutic resource.

## Invoking the family of choice as a provocation of the patriarchal structure

This section examines the family as an object of study in the social sciences, particularly the historical constitution of the heterosexual nuclear family, legitimised by functionalist sociology, and its implications in the construction of patriarchal culture, individualism and the privatisation of emotions. Post-structuralist research analyses and recognises the various non-traditional family forms resulting from the women's revolution. Special importance is attached to family forms

that emerge in the context of structural poverty, in order to learn from them. Finally, a form of family claimed by the homosexual community is analysed, which they call the "family of choice", which we take as a psychotherapeutic resource that rethinks the family beyond the bonds of kinship, expanding the world of intimacy, care, recognition, accompaniment and affection.

This clinical proposal has been integrated from texts published in scientific journals and other unpublished texts, enriched with clinical cases and biographical history. The basis of this publication is the product of collaborative work, fostered by sustained critical reflection. Several of them are in recurring quotations that have inspired the weaving of this model of psychotherapy. Bateson (1991, 1993) continues to be a source of inspiration, as his texts depict what is now called relational psychotherapy with third order thinking. Ackerman (1982), Minuchin, Colapinto and Minuchin (2000), Ramos (2015) and Linares and Colapinto (20–21) warn of structural causes such as poverty and institutional abuse that affect families and create discomfort. Haley (1985) explains that it is necessary to locate the problem in the social unit in which it is manifested and invites the therapist to reflect critically on his or her role in society. The Milan School (Selvini, Boscolo, Cecchin, Prata, 1980) introduced circular questions as a powerful method that allows the family to see itself in context and as part of the problem and the solution. It is worth mentioning the work of Walters, Carter, Papp and Silverstein (1991), who were the first to critically incorporate the gender perspective into systemic family therapy, leading to a rethinking of the traditional heterosexual family and especially of systemic psychotherapeutic practice with patriarchal biases. White and Epston (1993) introduce the socio-political and narrative dimensions to take the problem beyond the individual. Anderson and Goolishian (1990) give fundamental importance to the therapeutic relationship to treat clients as wise people who can actively participate in psychotherapy. With the help of Andersen (1994) and later, such as Seikula and Arnkil (2016), the Nordic School focuses on restoring the support network together with health services through an open dialogue so that the person with the symptom is authentically heard. Andolfi (2022,2023) proposes ther-

apeutic dialogue from the voice of children and adolescents. Perrone (2012,2014) clinically situates violence and abuse in the socio-political context in which interpersonal family interaction takes place. Boscolo and Bertrando (1996) masterfully combine systems thinking with socio-constructionism to welcome a panoptic vision. In particular, the work of Sluzki (1998) has been of enormous importance and inspiration: it extends the analysis of individual malaise beyond the family to include the social network. Linares (1996) invites us to observe relational nourishment within family triangular games, with a clinical method as the axis from which discomfort or well-being is shown and can be seen. Currently, Pakman -for whom I am deeply grateful for his critical feedback- (2020a) is exploring singularities, that they happen all the time but are not recognised or validated as useful for clients. He mentions that poetics, as a therapeutic resource, is a conceptual network that includes the concepts of image, appearance, singularity, event, around the concept of meaning. This network that the client has received in his or her experience helps to make relevant changes.

Laso (2015, 2018) and Laso and Canevaro (2022) propose a powerful model called 'deep experiential therapy', it focuses on working on the basic relational needs of respect and recognition so that they are honoured. And in doing so, working on the differentiation and maturation of the counsellor. Finally, Cyrulnik (2016) places the scope of care and attachment beyond the family and the child's history to discover a universe of socio-emotional resources that deal more successfully with individual and biological emotional wounds or traumas. Other clinical writers who have influenced the main arguments of this book are discussed.

Various philosophers and social theorists have also nourished the therapy proposed here. In particular, Bakunin (1900), Bourdieu (1991, 1999, 2006), Foucault (1991), Habermas (1990), Bauman (2016), Freire (1971), Maturana (1997), Martín-Baró (1998), Gergen (1997, 2005), Ahmed (2012), Han (2016, 2017), Vygotsky (1987, 1989, 1991), Mead (1972), Harré (1982), Goffman (1981, 1995), Sennett (2012) and Bajtín (1979a, 1979b) have influenced this work.

The proposals of these authors are not taken literally, but are only the conceptual starting point for structuring a solid object of study that allows us to investigate and intervene in psychological distress, a purpose, it should be emphasised, that has not been easy. Psychotherapy is proposed here to make visible the structural power implicit in patterns of violence and even in people's identities. Third-order consciousness will lead to finding a way to gradually exorcise individual discomfort and encounter ecology. A clinical epistemic resource that will allow us to build change for well-being together.

Part 1

# THE CONTEXT

## Critiques of Individualistic and Neurocentric Models

Chapter 1

# The Global Diagnosis of Mental Health in Neoliberal Society

The figures of the World Health Organisation (Web Editorial, 2019) – before the great pandemic of the twenty-first century – are conclusive: 970 million people worldwide suffer from a mental disorder. Depression and anxiety are widespread and have increased by more than 40 percent in the last 30 years. These are two symptoms of neoliberal society.

## Critique of Biologically Oriented Public Mental Health Policy and Disjointed Individualism

Today, and for more than a hundred years, mental health policy has opted for medication for mental distress. At present, the psychiatric model represented by the DSM 5 considers psychological distress as a medical illness, not only reserved for insanity, but applied to any behaviour that breaks the rules of 'good living'. The recurrent tantrums of a girl who doesn't feel cared for or seen by her parents; the inability of a child to sit still for hours at a desk in a classroom without exploring; the rebellion of an adolescent against the rigid authority of his parents; the screams and despair of a woman in a context where her husband constantly abuses her; the depression of a young person who doesn't live up to his parents' expectations; the feeling of failure in a woman's life because she doesn't have children, doesn't marry or gets divorced, and so on. All this and much more is 'scientifically typified as a neural, genetic or individual problem, and the diagnosis implicitly entails the prescription of drugs to be taken'.

Psychology and psychiatry have adopted the medical model of diagnosis and treatment, conceiving of mental disorder as "a picture of symptoms that correspond to a supposedly dysfunctional internal psycho-

logical mechanism, equivalent to the biological condition assumed by the medical model of disease" (González & Pérez, 2007, p. 128).

There is no denying that the existence of human suffering is expressed through psychological and biological symptoms. However, the medical bases that govern biological psychiatry and the accurate diagnosis and labelling of psychopathologies are being challenged. They emphasise that neuro and genetic conditions are dependent, not independent, variables. Pérez (2012) points out that although the brain is involved in providing the neurophysiological substrates and correlates of all human activity, insofar as it involves a living organism that performs it, this does not mean that such activity is inscribed, caused or produced by the brain, by a supposedly creative brain. (Pérez, 2012, p.91) Al respect, Wakefield (1992) warns that the danger of focusing on the biological level is that environmental, behavioural and social factors often go unnoticed.

## A Frightening Suspicion

In 1971, Tomas Kuhn voiced concerns that the refutation of a scientific theory was not sufficient to engender a change in associated views. He contended that scientific progress encompasses not only logical reasoning and methodologically testing evidence against reality, but also the validation of findings and results by power groups in communities and different sectors of society, particularly those who fund research. In essence, a paradigm shift, or a change in a scientific model, is primarily driven by group and economic interests.

There has been a notable increase in the number of reported conflicts of interest between pharmaceutical groups, neuropsychiatric research, and government institutions. These groups provide the majority of funding for research, with a focus on identifying disorders that can be treated with medication. The issue, therefore, lies not with the drug companies but with scientific communities that fail to adhere to scientific ethical guidelines. This issue has been exemplified by the case of the development of the DSM5 (Davis, et al., 2024).

González and Pérez (2007) observe that the credibility of biologistic psychiatry is contingent on the commercialisation of psychopharmaceuticals, which necessitate the definition of specific disorders to which they can be prescribed (p. 324). The underlying rationale for this practice, as articulated by the authors, is as follows:

> The pharmaceutical industry and a significant segment of the medical community adhere to various iterations of the neurochemical imbalance hypothesis, which posits that an underlying cause of mental illness is an imbalance of neurochemicals in the brain […]. This hypothesis is espoused despite a paucity of compelling evidence substantiating a neurological origin, and there is a complete disregard for physiological considerations. (p. 324) González and Pérez (2007) further posit that "the psychiatric system sponsored by the pharmaceutical industry is […] a research mechanism that has stalled and does no more than mere evaluation of drugs" (p. 325).

It has been asserted by several researchers (González & Pérez, 2007; Frances, 2014) that the establishment of an excessive number of diagnostic categories for mental disorders, encompassing adults, children and adolescents, is not only unethical but also a collusive arrangement with pharmaceutical companies. The most substantial criticism is attributed to the findings of two decades of longitudinal research into the utilisation of antipsychotic medications. The findings reveal that these medications possess no therapeutic efficacy, merely exert a controlling influence, thereby inducing numerous secondary complications, including drug dependence and biological impairment in various bodily organs (Harrow, Jobea & Faulla, 2014). In a similar vein, other researchers have cautioned that antidepressants, akin to most pharmaceuticals, are not merely ineffectual but detrimental. Andrews, Anderson, Amstadter and Neale (2012) argue that antidepressants are not only non-psychotherapeutic, but also cause serious health damage. Consequently, psychiatric or neurological practice has shifted towards a focus on medication rather than on the individual and the context (Wakefield, 1992).

## Will a New Public Mental Health Policy be Announced?

This has led to public organisations openly criticising the neurocentric and individualistic model. The WHO, for example, states that mental health systems focused on biomedical and individualistic diagnosis and treatment have not been effective, adding that the factors that cause psychological distress are inequality, poverty, injustice and social discrimination. They recommend that these factors be included in a new public mental health policy (Redacción web, 2019).

Conversely, in 2019, the Belgian Supreme Health Council advised against the utilisation of DSM categories, citing not only their ineffectiveness and the exacerbation of discomfort and exclusion experienced by those diagnosed, but also, and more significantly, the perceived manipulation and interference by pharmaceutical companies in the scientific evidence supporting these categories. The Council's report advocates for a more contextualised approach to understanding psychological symptoms, emphasising the need to consider a person's biography, existential challenges, and contextual-interactive functioning. In essence, the report suggests a shift towards a contextualised clinical psychology that places the client at the centre of healthcare services (Superior Health Council, 2019).

Cirillo, Selvini and Sorrentino (2004), González and Pérez (2007) and Pérez (2014) conclude that after 100 years of research on mental health policies, it has been shown that individual, contextualised psychotherapy and interdisciplinary work between psychiatry, family and community psychotherapy are more successful in dealing with severe psychological symptoms than psychopharmacological or individual therapies.

In light of these findings, it can be posited that the pursuit of individual happiness through psychopharmacological interventions and therapies, which are often tailored to meet the needs of neoliberal society, is a manifestation of contemporary trends. This pursuit of happiness, devoid of a holistic approach, has contributed to an unprecedented psychosocial collapse, characterised by pervasive feelings of guilt,

failure, hopelessness, and helplessness, experienced by a significant proportion of the population.

The psychotherapeutic model proposed here is based on the critical argument against neurocentrism and emotional individualism, and the belief that, in human behaviour, although real, 'nothing is natural'. Structural and family violence is a social phenomenon, not a natural one. It is important to note that many of the injustices and systematic abuses endured by humanity have been attributed to 'objective naturalistic scientific' explanations of the human being, including slavery, racism, gender inequality, gender roles, violent and polygamous men, homosexuality, the heterosexual nuclear family, as well as psychosis and depression, all of which have been examined and refuted. Explanations that seek to locate human behaviour within the rhetoric of the 'natural', which translates into a disconnected biology, seek to deny the fundamental role of context and to remove the causes of discomfort from critical and political analysis. This implies, among other things, an ethical review of the role of science in the ad hoc construction of realities, and, of course, the role of public mental health policies and their institutionalised practices.

Part 2

# THE PARADIGM

## First, Second, and Third-Order Thinking: Learning and Change

Chapter 2

# Systemic Family Therapy: Towards Third-Order Relational Critical Psychotherapy

Systemic Family Therapy, a therapeutic approach that emerged in the mid-twentieth century, posits the concept of intersystemic functionality within the human mind. Drawing inspiration from the ecological paradigm espoused by anthropologist Gregory Bateson (1991, 1993), particularly his seminal work "Steps to an Ecology of the Mind," and "A Sacred Unity", this therapy emphasises the interconnected nature of systemic processes.

In this paradigm, the human brain is not viewed as an independent entity, but rather as a component of a larger, interconnected system that is intertwined with its environment. This perspective challenges the conventional notion of a self-contained brain, emphasising instead the dynamic and interconnected nature of cognitive processes. As Bateson (1993) points out, 'what it thinks is a brain that is inside a man, that is part of a system that makes up a context' (p.269). In other words, it is not possible to draw a clear boundary between the body, the self and the environment, as this would result in a misrepresentation of the complex, intertwined circuitry of the human mind. "In the context of a living system, all elements are intricately organised into a dynamic network in which actions and reactions constantly alter the nature of the field, thereby shaping the intricate web of relationships and interactions that define the system as a whole. (Bateson, 1991, p. 53)

The Batesonian paradigm is predicated on the notion that natural and cultural phenomena occur in a systemic manner, and both are considered to be part of the ecological dimension. Units such as the brain, identity, the individual, or the family are systemic in nature. Drawing from this theoretical framework, and the insights gleaned from the profound global pandemic of the twenty-first century (Medina, 2023), contemporary explanations of human behaviour that emphasise attrib-