RADICAL PSYCHOTHERAPY AND SUPERVISION IN THE 21ST CENTURY: POWER, CONTEXT, AND MENTAL HEALTH, PART I

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Abstract: *This conceptual article clarifies radical psychotherapy as a family of clinically grounded, ethically explicit approaches that treat psychological distress as simultaneously intrapsychic and socio-structural. In response to contemporary mental health pressures, precarity, polarization, violence, burnout, and persistent inequality, we argue that strictly individualistic models can unintentionally pathologize adaptive responses to unsafe environments. We propose an "inside + world" model in which symptoms are understood as functional strategies shaped by internal dynamics and external power relations, and we outline five comparative axes that distinguish radical psychotherapy from decontextualized practice: explanatory frameworks, targets of change, therapist positioning, clinical language, and technique framing. A set of clinical postulates is advanced to guide practice: contextualization without erasing personal responsibility, explicit attention to power in the consulting room, shame as socially produced and relationally maintained, an anti-blame stance that avoids both culpabilization and romanticization of suffering, and the primacy of safety and dignity over therapeutic performance. We then translate these principles into practical strategies, including contextual case formulation, power mapping, depathologizing reframes, work with shame and internalized oppression, agency-building micro-interventions, ethical transparency, resource-oriented/community linkage, and evidence-based techniques (CBT/ACT/DBT) deployed within a radical frame. Finally, we address dilemmas concerning politicization, biological and trauma-informed balance, therapist competencies, and multidimensional evaluation. We conclude that radical psychotherapy does not replace established therapies; it recontextualizes them toward root causes power, context, and dignity so that healing is defined as symptom reduction alongside increased agency, protection, and socially recognized personhood.*

Keywords: *radical psychotherapy; power; social determinants of mental health; contextual formulation; depathologization; dignity; agency; internalized oppression; shame; radical healing; critical psychotherapy; radical relationality*

1. INTRODUCTION: WHY "RADICAL" NOW?

Across the past decades, psychotherapy has become simultaneously more culturally visible and more clinically challenged. It is more visible because therapeutic language now permeates public discourse, self-help cultures, and institutional wellbeing agendas. Yet it is more challenged because the dominant clinical imagination often organized around the individual psyche as the primary site of suffering and change faces mounting pressure in a world where distress is increasingly shaped by precarity, polarization, violence (symbolic and material), burnout, and entrenched inequities. In this context, the return of the word *radical* is not a rhetorical flourish. It signals a renewed effort to move toward roots: to examine not only intrapsychic conflicts and developmental histories, but also the lived structures of power, oppression, alienation, and cultural normativity that pattern psychic pain and constrain psychic agency.

"Radical psychotherapy" should be understood, from the start, not as a single school with a unified manual, but as a family of orientations that converge on a shared clinical claim: many symptoms are not merely signs of internal dysfunction; they are also intelligible responses to external realities that repeatedly injure the self, regulate belonging, and distribute safety unevenly. This family includes radical traditions in behavior therapy, humanistic and experiential theory, radical and relational psychoanalytic sensibilities, and oppression-attentive frameworks within contemporary psychotherapy. Importantly, these lines do not agree on everything. They do, however, share an ethical and epistemic insistence that psychological healing cannot be fully conceptualized without attention to context, power, and the relational field both inside the consulting room and beyond it.

1.1 CONTEMPORARY MENTAL HEALTH CRISES: PRECARITY, POLARIZATION, VIOLENCE, BURNOUT, AND INEQUALITY

The contemporary landscape of mental health is frequently described in crisis terms, but the specificity of this "crisis" matters clinically. Precarity, economic, occupational, housing-related, and existential does more than add stress; it alters temporal experience, narrows future-oriented imagination, and increases survival-based cognition. Polarization intensifies the sense that social spaces are unsafe, unpredictable, and morally charged, while everyday forms of violence overt or ambient strain the nervous system and reshape interpersonal trust. Burnout, particularly within caring professions and institutional settings, often emerges not merely from workload but from chronic moral injury, constrained autonomy, and the felt impossibility of doing "good enough" work within systems organized around performance and scarcity. Inequalities (racialized, gendered, class-based, disability-related) function as continuous psychosocial exposures that reorganize shame, fear, vigilance, and self-concept.

A radical lens insists that these are not "background variables" to be politely acknowledged before returning to the individual's cognitions or attachment style. They are constitutive. This emphasis is sharply articulated in contemporary work on radical healing in psychotherapy addressing racism-related stress and trauma, which frames distress as a wound produced by systemic forces and internalized through repeated relational exposures [1]. Here, the clinical question becomes: how does the psyche metabolize injury when the

injuring conditions are chronic, normalized, and often institutionally reproduced? And what does "recovery" mean when the client must keep living inside the same ecology of threat?

This is where radical perspectives become clinically urgent: they offer conceptual and relational tools for acknowledging that much distress is *rational* in irrational conditions, and that the "symptom" may be a survival adaptation with moral and social meaning, not only a malfunction to be corrected. Even when the client's suffering includes intrapsychic conflict, dissociation, or self-destructive patterns, radical approaches ask whether therapeutic change must include not only inner insight but also the restoration of agency, dignity, and relational power in the client's actual world.

1.2 THE LIMITS OF STRICTLY INDIVIDUALISTIC MODELS: WHEN SYMPTOMS BECOME "PERSONAL DEFECTS"

Many mainstream models of psychotherapy (even when compassionate) can drift into an implicit individualism: the symptom is treated as primarily rooted in cognitive distortions, faulty schemas, dysregulated affect, maladaptive learning histories, or unresolved internal conflicts. These frames can be profoundly effective, and radical psychotherapy does not reject the value of intrapsychic work. The problem arises when the explanatory map becomes too narrow, producing a subtle but consequential moral effect: the client begins to experience suffering as evidence of personal defect, weakness, or failure. In such cases, therapy risks becoming a sophisticated form of adaptation training to unjust realities, helping the person tolerate what is intolerable without naming why it is intolerable.

A radical orientation challenges this drift by re-centering dialectics: the psyche is shaped by its environment, and the environment is mediated through meaning, embodiment, and relational experience. Classic discussions of dialectics and method in reconstructing radical therapy highlight precisely this: clinical work must hold contradictions, avoid simplistic causal narratives, and treat personal suffering as embedded in social relations and power arrangements [2]. The dialectical sensibility is also present in radical empiricism approaches that attempt to reconcile conflicting theories in psychotherapy by returning to lived experience as the decisive ground of meaning [3]. In other words, "radical" here is epistemological: it refuses to reduce experience to one privileged explanatory register, whether biological, cognitive, behavioral, or intrapsychic.

From a psychoanalytic and psychotherapist-scientist standpoint, the critique becomes even sharper: the unconscious is never purely private. It is socially formed. The superego speaks with borrowed voices; shame is often socially installed; desire is shaped by permission structures; and symptoms frequently function as compromises between inner conflict and external constraint. Radical psychoanalytic thinking, in this sense, is less a departure from depth psychology than a return to its sociogenic implications, what it means to become a subject under conditions of power. Contemporary reflections on "becoming a (radical) psychoanalyst" emphasize that psychoanalysis itself can be radical when it resists professional domestication and remains attentive to ethics, institutional power, and the social production of psychic life [4].

Radical-relational perspectives in transactional analysis psychotherapy offer a related argument: oppression and alienation are not merely "stressors"; they are relational realities that structure identity, agency, and the possibility of recognition. Therapeutic work,

then, involves reclamation of voice, belonging, and self-definition, within and against oppressive relational fields [5]. This is a crucial shift: it repositions therapy as a site where the client's suffering can be understood not only through the lens of pathology but also through the lens of social injury and relational deprivation.

1.3 AIM OF THE ARTICLE: DEFINITION, DIFFERENTIATION, PRINCIPLES, AND CLINICAL STRATEGIES

This article proceeds from a central thesis: radical psychotherapy has re-emerged as a response to the widening gap between intrapsychic explanations of distress and the socio-structural realities that generate and sustain that distress. The aim is therefore fourfold.

First, we clarify what radical psychotherapy *is*: not a unified school, but a family of approaches linked by a commitment to contextualized suffering, power-awareness, and ethically oriented healing. This includes traditions that have explicitly used "radical" to describe behavioral approaches, such as radical behavioral psychotherapy and its contemporary examples [6], along with functional analytic psychotherapy, which frames change through the analysis of behavior-in-relationship and integration across therapeutic models [7]. Radical behaviorism has also been explored as a conceptual lens that can widen psychotherapy's explanatory power beyond mentalistic reductionism, emphasizing observable functions of behavior without erasing meaning [8]. These traditions matter here because they demonstrate that "radical" is not synonymous with "political": it can also mean methodologically foundational, returning to first principles about how change occurs.

Second, we differentiate radical psychotherapy from strictly individualistic clinical models. The differentiation is not an attack on established therapies, but a reframing: many standard techniques (e.g., exposure, cognitive restructuring, mindfulness, relational repair) can be deployed either in a decontextualized manner or within a radical frame that explicitly acknowledges power, oppression, and the moral ecology of suffering. The difference often lies less in the technique than in the interpretive and ethical container.

Third, we articulate core principles: depathologizing language; reflexivity about power in the consulting room; the integration of social determinants into case formulation; and the repair of agency and dignity as therapeutic outcomes. Experiential and person-centered traditions contribute an important dimension here. The "radical impact of experiencing" on psychotherapy theory underscores that transformative change often occurs through crossings, moments where experience disrupts rigid theoretical boundaries and reorganizes what is possible for the self [9]. This resonates with radical therapy's historical emphasis on affect, embodiment, and liberation from internalized oppression [10].

Fourth, we propose a set of clinical strategies consistent with a psychotherapist-scientist stance: strategies that are conceptually coherent, ethically defendable, and practically implementable. This includes power mapping, contextual case formulation, shame and internalized oppression work, and relational interventions that strengthen agency without collapsing therapy into activism. We also address typical objections, especially the worry that "radical" becomes ideological, by emphasizing that radical psychotherapy is, at its best, client-centered in an expanded sense: it centers not only the client's inner world but also the reality of the client's world.

Finally, to avoid caricature, we will also specify what radical psychotherapy is *not*. It is not propaganda; it does not require the therapist to impose political conclusions; and it does not deny biology, temperament, or intrapsychic complexity. Rather, it insists that psychological healing becomes more truthful, and often more humane, when therapy names the conditions under which the psyche was forced to adapt.

1.4. CLINICAL SUPERVISION AS ETHICAL CONTAINMENT AND REFLEXIVE PRACTICE IN RADICAL PSYCHOTHERAPY

If radical psychotherapy in the 21st century calls for an explicit engagement with power, context, and dignity, then clinical supervision becomes not an auxiliary professional requirement, but a structural necessity. A radical orientation expands the aims of psychotherapy beyond symptom reduction toward agency restoration and contextual truth. Yet precisely because it addresses power, oppression, and socio-structural determinants, radical practice carries distinctive risks: ideological enactment, therapist over-identification, savior dynamics, moral polarization, and countertransference driven by unexamined social positioning. In this sense, supervision functions as an ethical container, a reflexive space in which the therapist's authority, assumptions, and relational impact can be examined rather than unconsciously enacted.

Contemporary supervision theory increasingly conceptualizes supervision not merely as technical oversight, but as a structured developmental and relational process. The Supervision Pyramid model articulates supervision as operating across multiple interrelated layers, from technical skill acquisition to deeper reflective and relational processes that shape professional identity [12]. This layered conceptualization resonates strongly with radical psychotherapy's inside + world model. Just as radical clinical formulation integrates intrapsychic and socio-structural dimensions, supervision must integrate technique, relational process, ethical stance, and contextual awareness. A purely technical supervision that evaluates adherence to interventions without examining power, shame, and social context would risk reproducing the same reductionism radical psychotherapy critiques.

Within radical psychotherapy, supervision fulfills at least four interlocking functions: (1) reflexive containment of power, (2) competence development, (3) protection against ideological drift, and (4) institutional navigation.

1.4.1 Supervision as reflexive containment of power

Radical psychotherapy explicitly acknowledges that power operates both in the client's world and in the consulting room. However, the therapist's own social positioning, class, gender, ethnicity, professional status, institutional affiliation, theoretical commitments, inevitably shapes interpretation, intervention, and silence. Supervision provides a structured relational field in which these influences can be made visible and metabolized rather than denied.

The Supervision Pyramid model emphasizes that effective supervision moves beyond case discussion toward reflective integration, supporting the supervisee in recognizing personal reactions, implicit biases, and developmental needs [12]. This is particularly crucial in radical work, where the therapist may feel strong affective responses to injustice, discrimination, or institutional harm described by the client. Without

supervision, such responses can shift subtly from ethical alignment to enactment, for example, colluding with the client's avoidance, reinforcing polarization, or prematurely endorsing confrontation strategies that exceed the client's safety constraints.

Supervision thus becomes a site where power can be examined at two levels: the therapist–client dyad and the supervisee–supervisor dyad. In both relationships, asymmetry exists. Radical psychotherapy insists that such asymmetry must be named and ethically negotiated; supervision operationalizes this insistence by modeling transparency, collaborative formulation, and attention to relational impact.

1.4.2 Competency-based supervision and radical clinical responsibility

Radical psychotherapy cannot rely on moral passion alone. It must remain clinically disciplined, methodologically grounded, and ethically accountable. Competency-based training for clinical supervisors provides a framework for articulating observable skills, developmental benchmarks, and evaluative standards that protect both clients and therapists [24]. A competency framework clarifies that radical orientation does not exempt the clinician from core therapeutic proficiencies: case formulation, alliance building, risk assessment, boundary maintenance, and evidence-informed intervention.

Indeed, radical psychotherapy arguably requires an expanded competence set. In addition to standard clinical skills, the therapist must demonstrate competence in contextual formulation, power mapping, depathologizing language, and culturally responsive practice. Competency-based supervision allows these dimensions to be articulated explicitly rather than assumed. It supports the development of supervisors who can evaluate not only technical performance but also ethical reflexivity, cultural humility, and the ability to differentiate validation from collusion.

Viscu and colleagues emphasize that supervisor training must be structured, intentional, and grounded in clearly defined competencies rather than informal transmission of style or ideology [24]. This emphasis aligns directly with radical psychotherapy's anti-dogmatic stance. A radical therapist is not one who adopts a political posture, but one who demonstrates disciplined contextual thinking, relational sensitivity, and the capacity to integrate intrapsychic and socio-structural formulations without collapsing into reductionism.

1.4.3 Preventing ideological enactment: supervision as epistemic safeguard

One of the most frequent criticisms directed toward radical psychotherapy is the risk of politicization. This risk is real when therapists unconsciously substitute personal ideology for collaborative clinical inquiry. Supervision operates as an epistemic safeguard, ensuring that contextual interpretations are grounded in the client's narrative rather than imposed upon it.

The dialectical tradition in radical therapy reminds us that method must hold contradictions rather than resolve them prematurely [2]. Similarly, supervision must tolerate complexity: the client may be both structurally constrained and personally avoidant; the therapist may be ethically aligned and emotionally reactive; systemic injustice may coexist with intrapsychic repetition. Supervision offers the relational distance necessary to examine these tensions without collapsing into certainty.

In practice, this means asking in supervision:

- Is the contextual explanation emerging from the client's experience, or from my theoretical commitments?
- Am I minimizing intrapsychic conflict by overemphasizing social determinants?
- Have I adequately assessed risk, safety, and the client's real-world constraints before supporting assertive or confrontational interventions?

Such questions prevent radical psychotherapy from becoming reactive or missionary. They preserve its scientific credibility and relational integrity.

1.4.4 Supervision as professional and institutional navigation

Radical psychotherapy unfolds within professional systems that are themselves shaped by regulation, documentation requirements, funding structures, and institutional norms. As Murphy observes, contemporary professionalization and state regulation profoundly shape how psychotherapy is practiced, evaluated, and constrained [11]. Radical therapists must navigate these systems without abandoning contextual truth or ethical commitments.

Supervision provides a forum for negotiating these tensions. How does one document contextual formulations within diagnostic frameworks? How does one advocate for clients while maintaining professional boundaries? How does one integrate social determinants into case notes without triggering institutional defensiveness? These are not merely bureaucratic concerns; they shape the feasibility of radical practice.

Supervisors trained within competency-based frameworks are better positioned to guide supervisees through these institutional complexities while maintaining ethical coherence [11]. In this sense, supervision extends the radical project beyond the therapy room: it supports sustainable practice within real systems rather than idealized contexts.

1.4.5 The parallel process: supervision modeling radical relationality

Finally, supervision itself can embody radical relationality. If radical psychotherapy treats dignity, agency, and negotiated power as clinical values, supervision must model these principles. The supervisor who invites collaborative reflection, names evaluative power explicitly, and supports the supervisee's developing professional voice enacts the very stance radical psychotherapy seeks to cultivate with clients.

The Supervision Pyramid framework underscores that supervision contributes not only to skill acquisition but to professional identity formation [12]. When supervision integrates contextual awareness and ethical reflexivity, it shapes clinicians who can hold complexity without polarization. It teaches therapists to tolerate ambiguity, to differentiate validation from endorsement, and to sustain both compassion and accountability.

In this way, supervision becomes a recursive structure within radical psychotherapy: it contains the therapist so that the therapist can contain the client. It introduces a third space where power can be examined safely, shame can be processed, and agency can be strengthened at the professional level. Without such a structure, radical psychotherapy risks fragmentation, burnout, or ideological rigidity.

1.4.6 Synthesis

Clinical supervision is therefore not peripheral to radical psychotherapy; it is constitutive of its ethical viability. By integrating layered reflective processes [12],

competency-based standards [11], dialectical thinking [2], and awareness of institutional contexts [22], supervision safeguards radical psychotherapy from both reductionism and dogmatism.

If radical psychotherapy aims to restore agency and dignity in clients living within complex power structures, supervision ensures that therapists do not unconsciously reproduce those structures. It provides a disciplined space for examining authority, countertransference, ideology, and institutional pressure. In doing so, supervision transforms radical psychotherapy from a rhetorical commitment into a sustainable, accountable clinical orientation suited for the ethical demands of 21st-century mental health practice.

2. WHAT IS RADICAL PSYCHOTHERAPY? DEFINING A "FAMILY" OF PRACTICES

Radical psychotherapy is best approached as an orientation rather than a bounded school. It is a *family resemblance concept*: different traditions, methods, and theoretical languages converge around a shared commitment to treat psychological suffering as inseparable from the conditions in which subjectivity is formed, conditions shaped by power, culture, institutions, and material realities. The term *radical* is often misunderstood as "extreme," yet historically and philosophically it points to something more precise: a return to roots (*radix*), to the generative sources of distress, meaning, and constraint. Radical psychotherapy is therefore not a call for ideological purity, but an invitation to clinical depth, depth that includes intrapsychic complexity and socio-structural determinants.

This chapter consolidates that idea in three moves. First, it provides an operational definition that clarifies why "radical" is not a technique but a stance. Second, it traces conceptual lineages, critical, feminist, anti-oppressive, community-based, trauma-informed, narrative, existential, and radical-relational strands, that make the field legible as a coherent family rather than a scattered set of political claims. Third, it articulates three foundational premises that unify radical practice across differences: (a) distress has psychological *and* socio-structural causes, (b) healing includes agency and dignity, and (c) the therapeutic relationship becomes a site where power can be made visible, named, and ethically negotiated.

2.1 OPERATIONAL DEFINITION: AN ORIENTATION, NOT A SINGLE SCHOOL

A useful operational definition must do two things at once: preserve conceptual clarity and avoid reducing radical psychotherapy to a partisan slogan. Early efforts to articulate "the status and tasks of radical therapy" emphasized that radical approaches aim not merely to relieve symptoms but to clarify how personal suffering is intertwined with social arrangements, and to translate that insight into a method of intervention and consciousness [13]. This remains a core clinical intuition: many forms of suffering become chronic because the client is repeatedly required to adapt to conditions that constrain agency, recognition, safety, and belonging.

From this standpoint, radical psychotherapy can be defined as:

A clinically integrative, ethically explicit orientation that interprets distress through the joint lens of intrapsychic life and socio-structural power, and that treats healing as involving both symptom relief and the restoration of agency, dignity, and relational freedom.

This definition deliberately avoids privileging one technique. Radical practice can occur in individual therapy, group therapy, family and community contexts, and across modalities. Indeed, when radical clinicians speak of "psychotherapy for the 21st century," they often highlight that the radical task is not simply to refine techniques, but to redesign the *therapeutic project*, its aims, its language, and its understanding of what counts as change [14]. In a similar spirit, existential accounts argue that radical psychotherapy is less about adopting an "activist" identity and more about confronting the ethical demand to treat suffering in its full context, without collapsing complexity into personal defect [15].

Importantly, the orientation-level definition protects radical psychotherapy from two common distortions. The first distortion is to reduce it to a political critique that abandons clinical rigor. The second is to domesticate it into a superficial "context statement" appended to otherwise decontextualized symptom work. Radical psychotherapy, in its most defensible form, is neither propaganda nor ornament. It is a method of clinical *seeing*, a way of formulating problems and guiding interventions so that the client's lived reality is not psychologized away.

A psychoanalytic and psychotherapist-scientist lens is particularly useful here. Psychoanalysis already assumes that psychic life is structured by forces that are not immediately conscious; radical psychotherapy extends the question: what social and institutional forces become internalized as shame, fear, compulsive self-monitoring, or resignation? Where is the superego borrowing its language from? Which relational injuries are culturally normalized? In this sense, radical psychotherapy is not anti-depth; it is depth expanded.

2.2 CONCEPTUAL LINEAGES: CRITICAL, FEMINIST, ANTI-OPPRESSIVE, COMMUNITY, TRAUMA-INFORMED, NARRATIVE, AND RADICAL-RELATIONAL TRADITIONS

The "family" character of radical psychotherapy becomes clearer when we examine its lineages. These traditions do not merely add sociological commentary; they reshape clinical concepts such as authenticity, autonomy, relationality, and therapeutic action.

Feminist and phenomenological lineages have long argued that subjectivity is not formed in a vacuum. Authenticity is not simply an internal congruence; it is constrained by gendered and social expectations that allocate legitimacy and voice unevenly. Feminist accounts explicitly connect authenticity to power and embodied experience, offering radical psychotherapy as a practice of reclaiming agency against internalized norms [16]. What looks like "low self-esteem," for example, may also be a coherent response to long-term disconfirmation within a patriarchal or coercive relational ecology. A feminist-radical stance therefore reframes therapy from "fixing" the self to supporting a more truthful self-relation under conditions that often punish truth.

Critical theory lineages bring an analytic vocabulary for ideology, normalization, and institutional power, concepts that help clinicians name what clients often feel but cannot articulate: that distress sometimes functions as a rational response to irrational systems. Critical theory in psychotherapy highlights how clinical work can inadvertently reinforce dominant norms by individualizing structural injury [17]. When therapy treats burnout as a personal failure of resilience without addressing moral injury, exploitation, or constrained autonomy, it becomes complicit in maintaining the conditions that produce burnout.

Praxis-oriented lineages intensify this critique. Praxis here is not simply "practice" as applied technique; it is ethically oriented action that integrates reflection and transformation. A praxis framework has been proposed as a radical alternative to strictly scientific paradigms when those paradigms reduce lived experience to variables and thereby miss what matters ethically and existentially in suffering [18]. This is not a rejection of evidence, but a critique of narrow evidentialism. In praxis terms, the question becomes: *evidence for what ends, and under what assumptions about the person and the world?*

Existential and psychoanalytic crossings contribute another strand: radical psychotherapy can mean refusing the cultural pressure to treat mental health as a productivity tool. Existentially influenced psychoanalytic psychotherapy, for instance, emphasizes that distress is often a signal of rupture in meaning, freedom, and relational truth, and that such ruptures are frequently intensified by social fragmentation and coercive normativity [19]. This helps radical psychotherapy retain a central psychoanalytic insight: the psyche is not only wounded by events, but also by the loss of symbolization, recognition, and narrative continuity.

Radical relationality has become an increasingly explicit philosophical foundation for psychotherapy. If the self is fundamentally relational, then power is not an "external factor" but a structural dimension of relations, inside and outside therapy. Philosophical accounts of radical relationality argue that therapeutic change involves reworking the relational conditions of being, including those shaped by history, culture, and exclusion [20]. Clinical implications follow: therapy must attend to how recognition is distributed; how safety is constructed; and how the client's identity is negotiated within relational fields that may be oppressive.

Developmental and population-specific applications also demonstrate the breadth of the family. Radical relational approaches to adolescent psychotherapy, for example, emphasize that adolescent distress is often amplified by social regulation, institutional surveillance, and identity-based marginalization, making the therapeutic project as much about reclaiming relational space as about symptom management [21]. Radical psychotherapy thus becomes a way to articulate how development unfolds within social constraints, not merely within a dyad or family system.

Finally, professional and institutional critiques show why the radical question is inseparable from how psychotherapy is regulated and professionalized. Contemporary analyses of professionalization and state regulation raise concerns about how institutional frameworks can standardize psychotherapy in ways that prioritize compliance, risk-management, and credentialed legitimacy over relational depth, ethical reflexivity, and contextual truth [22]. In this view, radical psychotherapy also includes a critique of the profession's own power: who is authorized to heal, under what rules, and whose suffering becomes legible in official terms?

These lineages together show why radical psychotherapy is not a niche ideology but an integrative conceptual field. Its shared premise is that psychotherapy cannot be clinically adequate if it ignores how power organizes experience.

2.3 THREE FOUNDATIONAL PREMISES OF RADICAL PSYCHOTHERAPY

Despite theoretical diversity, radical psychotherapy is held together by several premises that can guide formulation, technique selection, and ethical stance (Figure 1).

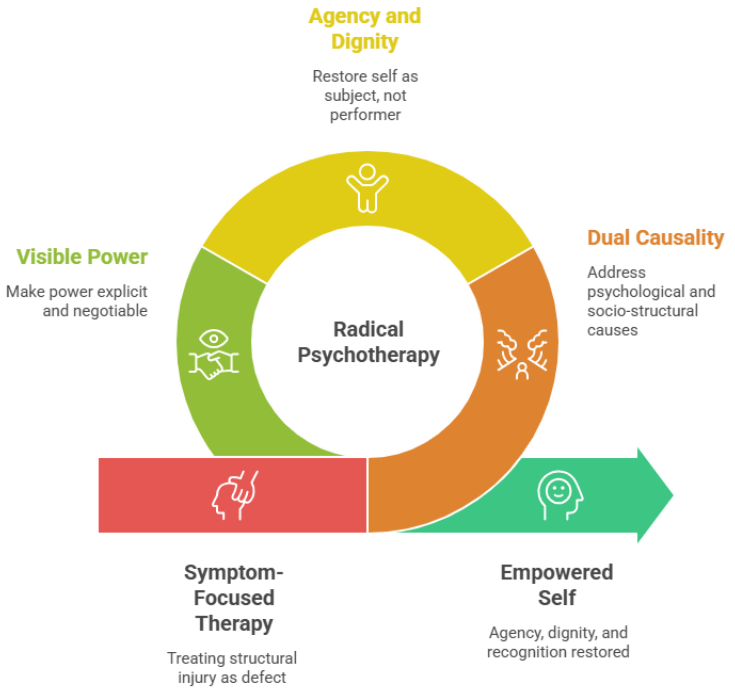

Figure 1. Foundational premises of radical psychotherapy

(a) Distress has psychological and socio-structural causes

Radical psychotherapy insists on dual causality without reductionism. The symptom is not only a product of cognition, affect regulation, or unconscious conflict; it is also shaped by structural exposures, racism, sexism, poverty, labor exploitation, institutional betrayal, and social marginalization. This premise prevents a therapeutic error that is both clinical and moral: treating structural injury as an individual defect.

At the same time, radical psychotherapy does not romanticize context as if it explains everything. Psychoanalytic insight remains essential: individuals metabolize social forces differently, depending on temperament, early attachment, trauma histories, and internal object relations. The radical move is to hold both: the inner world and the world as it presses into the inner world.

(b) Healing includes agency and dignity

A second premise is teleological: it concerns what therapy is *for*. In many mainstream frames, "improvement" is measured via symptom reduction and functioning. Radical psychotherapy expands the outcome space to include agency and dignity, capacity to choose, to set limits, to claim voice, to negotiate recognition, and to remain connected to oneself without collapsing into shame.

This does not mean that symptom relief is irrelevant; rather, radical psychotherapy asks what symptom relief costs when it is achieved through adaptation to dehumanizing conditions. Healing, in a radical frame, includes the restoration of the self as a subject, not merely as a performer of coping skills. This is why radical approaches often use the language of liberation, reclamation, authenticity, and resistance, not as political branding but as clinical descriptors of agency regained.

This premise also clarifies a central misunderstanding: radical psychotherapy is not "less psychological" because it considers social factors. It is, arguably, *more* psychological because it treats agency, dignity, and recognition as core psychological needs rather than optional moral add-ons.

(c) The therapeutic relationship is a space where power becomes visible and negotiable

A third premise is relational and ethical: the therapy room is not outside power. It is an institutionalized relationship with asymmetries (expertise, authority, payment, diagnosis, documentation). Radical psychotherapy therefore treats the therapeutic relationship as a site where power must be made explicit, at least enough to prevent reenactments of silencing, invalidation, or epistemic injustice [23-25].

This premise does not require constant political discussion; it requires clinical reflexivity. It asks: whose interpretation dominates? What is permitted to be said? What is named as "resistance" versus recognized as protest? What does the therapist assume is "healthy" and whose norms define it? The radical task is to render these questions speakable and negotiable, so that the client's subjectivity is not subordinated to therapeutic ideology.

Research from educational and relational contexts similarly emphasizes that communication processes and supportive relationships between actors (teachers, parents, and students) can significantly influence psychological development, resilience, and behavioral outcomes [26-29]. Studies also highlight the role of participatory and emotionally informed educational environments in shaping social competencies, emotional development, and motivation for learning [27,30,31]. Such findings reinforce the broader principle that relational dynamics—whether in educational or therapeutic contexts—function as key environments where meaning, agency, and behavioral change are negotiated.

In group psychotherapy, the relevance of this premise becomes even more pronounced. Group-based processes are particularly sensitive to relational hierarchies, collective norms, and communication patterns. Educational and mentoring research demonstrates that collaborative environments, mentorship structures, and digitally mediated interaction spaces can shape participants' engagement, identity formation, and collective learning processes [28,32]. Even when the future of group therapy is imagined in terms of "radical changes," those changes often center on how groups can address social fragmentation, isolation, and institutional forces that shape belonging [23].

Recent research also suggests that the interplay between contextual environments, meaning-making processes, and intrinsic motivation can influence broader well-being outcomes, including life satisfaction and adaptive functioning [33]. The radical principle therefore remains consistent: relationships are where distress is produced and where change becomes possible, but relationships always operate within power arrangements.

REFERENCES

1. Adames, H. Y., Chavez-Dueñas, N. Y., Lewis, J. A., Neville, H. A., French, B. H., Chen, G. A., & Mosley, D. V. (2023). Radical healing in psychotherapy: Addressing the wounds of racism-related stress and trauma. *Psychotherapy*, *60*(1), 39.
2. Sipe, R. B. (1986). Dialectics and method: Reconstructing radical therapy. Journal of Humanistic Psychology, 26(2), 52-79.

3. Hanna, F. J. (1994). A dialectic of experience: A radical empiricist approach to conflicting theories in psychotherapy. Psychotherapy: Theory, Research, Practice, Training, 31(1), 124.
4. Barratt, B. B. (2019). Beyond psychotherapy: On becoming a (radical) psychoanalyst. Routledge.
5. Minikin, K. (2024). Radical-relational perspectives in transactional analysis psychotherapy: Oppression, alienation, reclamation. Routledge.
6. Kohlenberg, R. J., Hayes, S. C., & Tsai, M. (1993). Radical behavioral psychotherapy: Two contemporary examples. Clinical Psychology Review, 13(6), 579-592.
7. Kohlenberg, R. J., & Tsai, M. (1994). Functional analytic psychotherapy: A radical behavioral approach to treatment and integration. Journal of psychotherapy integration, 4(3), 175.
8. Mellon, R. (1998). Outsight: Radical behaviorism and psychotherapy. Journal of Psychotherapy Integration, 8(3), 123-146.
9. Ikemi, A. (2017). The radical impact of experiencing on psychotherapy theory: an examination of two kinds of crossings. Person-Centered & Experiential Psychotherapies, 16(2), 159-172.
10. Althöfer, L. G., & Riesenfeld, V. (2020). Radical therapy: The fifth decade. In *Claude Steiner, Emotional Activist* (pp. 131-144). Routledge.
11. Viscu, L. I., Cădariu, I. E., & Watkins Jr, C. E. (2023). Competency based training for clinical supervisors. Elsevier.
12. Viscu, L. I., & Watkins Jr, C. E. (2021). A guide to clinical supervision: The supervision pyramid. Academic Press.
13. Hurvitz, N. (1977). The status and tasks of radical therapy. Psychotherapy: Theory, Research & Practice, 14(1), 65.
14. Chaplin, J. (2006). 13 The Bridge Project: radical psychotherapy for the 21st century. EBOOK: The Politics of Psychotherapy: New Perspectives, 159.
15. Pearce, R. (2017). Towards a Radical Psychotherapy. Existential Analysis: Journal of the Society for Existential Analysis, 28(1), 31-44.
16. Leland, D. (2000). Authenticity, feminism, and radical psychotherapy. In Feminist phenomenology (pp. 237-248). Dordrecht: Springer Netherlands.
17. Gaitanidis, A. (2015). Critical theory and psychotherapy. In Critical psychotherapy, psychoanalysis and counselling: Implications for practice (pp. 95-107). London: Palgrave Macmillan UK.
18. Berger, L. S. (2000). Praxis as a radical alternative to scientific frameworks for psychotherapy. *American journal of psychotherapy*, *54*(1), 43-54.
19. Montgomery, M. R. (2020). Radical existentialism is manuski: Existentially influenced psychoanalytic psychotherapy. In Re-Visioning Existential Therapy (pp. 107-117). Routledge.
20. Costello, J. (2024). *Philosophical Foundations of Psychotherapy: Radical Relationality*. Routledge.
21. Starrs, B. (2018). Adolescent psychotherapy: A radical relational approach. Routledge.
22. Murphy, D. (2011). Unprecedented times in the professionalisation and state regulation of counselling and psychotherapy: the role of the Higher Education Institute. British Journal of guidance & counselling, 39(3), 227-237.

23. Mackenzie, K. R. (2001). An expectation of radical changes in the future of group psychotherapy. International journal of group psychotherapy, 51(2), 175-180.
24. Hook, J. (2025). To Arms! Psychotherapy as Class Warfare. In *The Revolutionary Psychologist's Guide to Radical Therapy* (pp. 309-332). Cham: Springer Nature Switzerland.
25. Malan, D. H. (2013). *A study of brief psychotherapy*. Routledge.
26. Dughi, D., Torkos, H., Coșarbă, E. M., & Redeș, A. D. (2024). Parents' perceptions about improving student's behavior through participation in non-formal activities. A qualitative analysis. *Journal Plus Education/Educația Plus*, 35(1), 155-170.
27. Dughi, D. E., Cosarba, E. M., & Torkos, H. (2024). The role of dramatic padagogy in developing transversal competence on students. *Journal Plus Education*, 35(1), 237-246.
28. Dughi, D., Cosarba, E., & Petcut, D. (2024). Digital platforms and applications used in romanian language and literature classes at the high school level. *Journal Plus Education*, 36(2), 331-339.
29. Dughi, D., & Cosarba, E. M. (2025). Education and resilience: how teacher–parent communication can shape children's futures. *Journal Plus Education*, 38(Special Issue), 276-284.
30. Dughi, D., Paul, B. P., & Grindeanu, B. (2025). Innovative approaches to stimulating interest in reading. *Journal Plus Education*, 37(1), 531-543.
31. Dughi, D., & Bold, I. (2022). Language teaching and emotional intelligence developing at preschool age, through fairy tales and stories. *Journal Plus Education*, 31(2), 83-96.
32. Dughi, D. (2020). Mentoring in lifelong learning for teachers-example of good practice. *Educația Plus*, 26(1), 247-253.
33. Dughi, T., Rad, D., Roman, A., Dughi, D., Stoian, C. D., Stoian, N. R., ... & Rad, G. (2025). When Home Helps or Hurts: A Moderated Mediation Analysis of Work Meaning, Intrinsic Motivation, and Life Satisfaction Across Family Flexibility Profiles. *Behavioral Sciences*, 15(11), 1451.