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PERSPECTIVE ARTICLE

# Mental illness: a source of injustice with an impact on relationships

Catherine Ducommun-Nagy

[1]College of Nursing and Health Professions, Drexel University, Philadelphia, PA 19104
[2]Institute for Contextual Growth, Inc. Ambler PA 19038

catherine.ducommun.nagy@gmail.com

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## ABSTRACT

This article aims to present a view of mental illnesses that is rarely considered by professionals, which is that suffering from a mental illness constitutes a form of injustice, often leading to relational damage. They affect the balance of giving and receiving between the people who are ill and seek some form of redress for this injustice and the people they relate to who are expected to compensate them. This view is based on the ideas of Ivan Boszormenyi-Nagy (1920-2007), a Hungarian American psychiatrist who was a pioneer of family therapy and the founder of contextual therapy, an approach that centers on relational ethics as the main determinant of close relationships. The article starts with a presentation of Boszormenyi-Nagy's ideas and a comparison of his view of relational ethics with the view of relational ethics found in the broader field of health and social sciences. The author then continues by presenting mental illnesses both as a form of injustice and as a source of injustices, which is a theme that does not appear in the literature on mental illnesses. This is followed by a discussion of the therapeutic resources offered by contextual therapy to decrease the detrimental consequences of this injustice on relationships.

This article concludes with two short case illustrations based on the clinical work of the author, who is a contextual therapist and developer of the approach and a child and adult psychiatrist with years of experience in observing the relational consequences of mental illnesses. The empirical findings proposed here should serve as a source of inspiration for professionals working with clients suffering from mental illness or any severe or chronic illness.

**Keywords:** Contextual therapy, relational ethics, retributive injustices, relational injustices, distributive injustices, situational injustices, destructive entitlement, parentification, constructive entitlement, multidirected partiality, mental illnesses as injustice.

## Introduction

In the fields of medicine and psychiatry, mental illnesses are discussed from an individual perspective in terms of diagnosis and treatment. Here, the focus is on the relational implications of mental illness. It is obvious that mental illnesses affect relationships in ways that vary according to the diagnosis and symptoms involved. Parents suffering from major depressive disorder may lose hope that they can engage in effective parenting. A person suffering from a delusional disorder may accuse others of having ill intentions. Here, the postulate is that suffering from any kind of mental illness, especially if severe or chronic, constitutes an injustice. The next postulate is that, as such, exposure to injustice leads not only to individual psychological or psychosomatic symptoms but also to detrimental relational consequences, especially in the parent-child relationship. The uncommon perspective proposed here is based on the work of Ivan Boszormenyi-Nagy (1920-2007) a Hungarian American psychiatrist, one of the pioneers of family therapy, and the founder of contextual therapy[1,2,3].

The pioneers of family therapy introduced the idea that health and illness do not depend solely on individual biological and psychological determinants but are also influenced by systemic determinants. More specifically, they proposed that families should be viewed as open systems that possess mechanisms to maintain homeostasis, as defined by von Bertalanffy in his general systems theory[4]. Consequently, they postulated that the emergence of symptoms in one family member serves to prevent changes in the family system. For instance, they considered that the onset of psychotic symptoms preventing a youth from leaving home for college serves to maintain family homeostasis[5]. This led these pioneers to dismiss the biological determinants of mental illnesses as irrelevant. This was not the position of Boszormenyi-Nagy, who did not question that mental illnesses had a neurobiological, if not a genetic, basis. His view on the organic origins of mental illness played a role in seeing mental illnesses as an injustice: they affect only certain individuals, while most people are spared from this experience.

While Boszormenyi-Nagy saw limits in the systemic model proposed by his early colleagues, he agreed with their idea that individual and relational health depended on supra-individual factors. His original contribution was to postulate that individual health and healthy relationships depend on the mutual commitment of family members or relating partners to care about each other's needs, their willingness to maintain a fair balance of giving and receiving between them, and their ability to engage in trustworthy parenting in the next generation. This led him to introduce the notion of *relational ethics* as a major determinant of relationships decades before the term was introduced in the health and social sciences.

Relevant to relational ethics is the notion that exposure to injustice, including the injustice of suffering from a mental disorder, leads to detrimental relational consequences because people who have experienced injustices are often pushed to seek redress in ways that become exploitative to others and create new injustices. Contextual therapy offers therapeutic resources to limit the negative impact of these injustices on relationships, which will be discussed in detail. In short, they are based on a unique strategy, multidirected partiality, meaning an offer of fair attention to all the participants in the relationship and a unique definition of the therapeutic moment. It is defined as a double gain. Individuals who have been victims of injustice are helped to discover that generous giving may lead to more personal gains than insisting on redress.

## Relational Ethics in Contextual Therapy and in Health Sciences

One of Boszormenyi-Nagy's earliest mentions of relational ethics appeared in a 1976 article, "Behavioral Changes through Family Changes." His main point was to show that in family therapy, the treatment goals and the implementation of desirable changes need to be determined by the needs and interests of all the participants in the relationship.

"At this point, it is important to recall that the concept of ethics underlying our further explorations is by no means synonymous with any particular system of moral regulation. On the contrary, the broad humanistic base of a genuine relational ethics will inevitably challenge and test the priority schemes of particular traditional moral codes. In my view, dogmatic concepts of good or bad will have to be replaced by the dialectic notion of the consideration of both sides of any relationship" [3 (p.173-174)].

The element that stands out here is that relational ethics, as defined by Boszormenyi-Nagy and contextual therapists, are not based on preset moral or religious values or moral codes but on an actual dialogue between the participants in the relationship. They should show a willingness to hear how each of them views the degree of fairness or exploitation of their relationships, what they expect from the others, and then adjust their actions in accordance with what they have learned from this dialogue, aiming to treat others as they would like to be treated themselves. Here, the notion of relational ethics corresponds to what Buber[6] described as an I-Thou relationship in which both partners meet in their full humanity, in contrast to an I-It relationship in which one instrumentalizes the other as a mean to achieve a goal.

The notion of relational ethics appeared later in the general field of health and social sciences with a notable absence of reference to Boszormenyi-Nagy or contextual therapy. Within the field of psychology, Gergen[7], a psychologist and leading figure in the development of social constructionism, introduced the notion of relational ethics as a form of second-order ethics, in which individual responsibility is replaced by relational responsibility and the cocreation of meaning. Professionals who introduced relational ethics in the field of care professions, such as Bergum[8] in the nursing profession, discussed it in the context of professional-client relationships. They were combating the idea that professionals could make care decisions based on principles that did not consider their clients' human reality. Instead, they proposed that decisions should be made based on dialogue with clients, enabling them to contextualize their needs and respond accordingly. Feminist scholars introduced the notion of ethics of care in the 1980s. Gilligan[9] proposed that men view ethics in relation to fairness and rights, whereas women approach ethics from the perspective of responsibility within relationships. Nodding[10] proposed a form of ethics that is based on a response to others' needs.

The main difference between the authors who use the notion of relational ethics in healthcare contextual therapists is that, in general, contextual therapists focus on relational ethics within the relationships in which their clients are engaged (close relationships, couple, family relationships, parent-child), not so much on the therapist-client relationship. Nonetheless, as professionals, contextual therapists strive to meet their clients as people embedded in a unique societal and relational context and with unique needs.

## Injustices and their Relational Consequences

### RELATIONAL AND SITUATIONAL INJUSTICES

Classical literature on contextual therapy refers to two types of injustices: retributive and distributive. An updated terminology proposed by Ducommun-Nagy[11] refers to retributive injustices as relational injustices and distributive injustices as situational ones. *Relational injustices* refer to injustices in the balance of giving and receiving between people, extending to the actual exploitation and infringement of people's basic rights. These injustices should be repaired by those who commit them. In couples and family relationships, the most typical injustice of this kind is the unilateral exploitation of one member by another.

*Situational injustices* result from exposure to various kinds of misfortunes that others do not experience. These injustices could also be understood as injustices in the distribution of chances, hence the early notion of *distributive injustice*. This may include the early loss of a parent, exposure to a natural catastrophe, living with a chronic mental or physical illness, or a disability. Here, one cannot pinpoint a wrongdoer who can be held responsible for repairing these injustices. This remains true in the case of exposure to prejudices and discrimination. Specific groups may be responsible for the mistreatment of other groups. They should be held accountable for the damage they cause. At the same time, the misfortune of being part of a group that experiences hardships or attacks is an injustice that is not the result of someone's personal actions.

Individuals who are victims of any kind of injustice are entitled to redress; however, this does not always occur. People who have caused relational injustices may not accept responsibility for their deeds, or, for various reasons, they may be unable to offer redress to the people they have hurt. Hence, many relational injustices remain unrepaired. Situational injustices remain unrepaired for another reason: since no one can be held responsible for

causing these injustices, no one can be held accountable to repair them. Some people manage to live with injustices. Others do not, and they begin to seek redress in ways that are destructive; hence, the notion of *destructive entitlement*.

DESTRUCTIVE ENTITLEMENT.

Destructive entitlement refers to a valid entitlement to fairness that results in expectations that are destructive to relationships. Furthermore, victims of injustices are likely to be blind to the relational injustices they may cause because, from their own perspective, they are simply asking for fairness and consideration. They often expect special understanding and support from partners, friends, colleagues, or event therapists, which is an imposition on them. Many professionals complain that some of their clients "behave entitled." They see these clients as people who are very difficult to work with, understanding that their arrogant attitude and claim for special treatment is a personality trait that may never change. This is not the perspective of contextual therapists, who see this kind of attitude as the result of destructive entitlement, meaning that these clients may have a valid claim to compensation coming from past injustices resulting in unrealistic demands. Once these injustices are recognized, attitudes often change.

Concerning children, destructively entitled parents often turn toward them for reassurance or ask them to take on adult responsibilities. Contextual therapists talk about *parentification*, meaning that there is a reversal in the order of giving and receiving between the parent and the child, in which the child is expected to behave like a caring parent, while in structural family therapy, it is considered a mere change in the family hierarchy[12]. Adults can set limits on unfair demands, but children cannot. Consequently, parentified children are likely to accumulate destructive entitlement and seek redress by parentifying the next generation.

MENTAL ILLNESSES AS INJUSTICE

Boszormenyi-Nagy reported on many occasions in this teaching and personal communications that his determination to become a psychiatry came from a personal experience. As a teenager, he witnessed a man with schizophrenia being mocked and ostracized because of his bizarre behavior and incoherent babbling. This experience deeply affected him. Wanting to help people like him, he decided to become a psychiatrist and later trained as a biochemist, engaging in research on the biological markers of schizophrenia. Returning to clinical work and becoming a pioneer of family therapy, he maintained the position that mental illnesses have neurobiological and possibly also genetic determinants, which, as already discussed, was not the view of many of the pioneers of family therapy.

While Boszormenyi-Nagy understood early on that people suffering from mental disorders experience situational injustices based on prejudice and discrimination of various kinds, his belief that mental illnesses have organic determinants played an additional role in his understanding of mental illnesses as a situational (distributive) injustice. Unfortunately, he never published anything on this very specific point, and this article constitutes an original contribution to the field of psychiatry and mental health sciences. This also explains why it does not contain references to other authors who may have addressed this issue.

MENTAL ILLNESSES AS A SOURCE OF INJUSTICES

Several contextual therapists have researched the connection between the degree of fairness and exploitation in close relationships and the emergence of individual symptoms or relational difficulties. This is exemplified in articles such as the one on the correlation between marital the quality of the marital relationship and depression[13]. Most publications on this subject use the relational ethics scale developed by Hargrave and his colleagues[14]. Their work confirms Boszormenyi-Nagy's hypothesis regarding the importance of fairness and trustworthiness for healthy individual functioning and healthy relationships. Here, the proposition is to take the reverse approach, looking at mental illness not as the result of imbalances in relational ethic but as a source of injustices. Unfortunately, this aspect of mental illness has not been included in their research.

Mental disorders can cause unfairness in relationships simply because people may not be able to reciprocate due to their limitations; for example, people with a neurocognitive disorder may not remember what they received from others. Individuals with social anxiety disorder may not be able to participate in activities their partners would enjoy. As a result, mental disorders may cause injustices in relationships that are not due to a lack of goodwill but to decreased abilities.

MENTAL ILLNESSES AND PARENTIFICATION

A common consequence of mental illness is the parentification of children. This occurs when parents with mental disorders (or physical illnesses) are unable to function in their daily activities or parental roles. As a result, they ask their children to assume responsibilities beyond their age, such as house chores or the care of younger siblings. Children may gain practical experience from these tasks or feel pride in being able to help the family. However, it is important that other adults who live with them and professionals working with these parents and families ensure that these children's emotional and developmental needs are met. This is even more important when children are exposed to traumatic situations, for instance the episodes of intrafamilial violence that may occur in the context of their parents' addictive disorders.

Fortunately, when they recover, many of these parents are able to recognize the help they receive from their children, and this restores a measure of fairness in their relationship. However, when parents are blinded by their own destructive entitlement, this acknowledgment does not occur. This is where therapy is needed to avoid relational damage that may span more than one generation when the children who had been parentified become destructively entitled adults who turn to their own children for redress.

## Assessment, Diagnosis and Treatment Goals in Contextual therapy

THE FIVE DIMENSIONS OF RELATIONAL DYNAMICS

Boszormenyi-Nagy presented his approach as a multidimensional integrative model that takes into account all the possible determinants of relational reality or relational dynamics regrouped in five clusters or dimensions. Three of these dimensions correspond to Engel's biopsychosocial model, which was based on a holistic view of patients, their symptoms, and their care[15] The dimensions paralleling Engel's model are the dimension of facts (dimension I) entailing the biological determinants of mental illnesses, the dimension of individual psychology (dimension II) entailing the psychological manifestations of mental disorders and the dimension of transaction (dimension III) entailing the systemic determinants of mental disorders and the effects of mental illnesses on communication. The two dimensions specific to contextual therapy are the dimension of relational ethics (dimension IV) and the ontic dimension (dimension V). The dimension of relational ethics groups the determinants of behavior that are related to people's expectations of justice, fairness, and loyalty. It is based on the idea that the quality of human relationships depends on fair reciprocity and reciprocal loyalty, and that the degree of fairness or exploitation that people experience determines, to a large extent, how they treat others. It entails the effect of mental disorders on giving and receiving in close relationships. The ontic dimension (dimension V) is an addition to an earlier four-dimensional model made in 2000 by Boszormenyi-Nagy[16] in connection with a relational definition of the Self that he had proposed decades before as part of his dialectical theory of the personality and relational definition of the self, meaning that the Self can be established in contraposition to a Not-Self, an other[17]. This can be understood as no Self without another. Mental disorders affect the way in which this contraposition occurs. An example of this is people with narcissistic personality disorder. Instead of establishing an I-You relationship with others, they engage in an I-It relationship when instrumentalizing them.

ASSESSMENT

Contextual therapists use their multidimensional framework to identify the possible sources of individual and relational pathologies and the possible therapeutic resources that could be mobilized in any of the five dimensions of relational reality to address their clients presenting problems. Based on their initial training, some contextual therapists may be able to implement various forms of treatment that are not based on contextual therapy, such as psychiatric interventions or individual therapy.

However, in general, contextual therapists focus on the dimension of relational ethics both in terms of the origins of the presenting problems (lack of reciprocity, injustices of various kinds, and detrimental expressions of loyalty) and in terms of therapeutic resources. Considering the DMS Classification system[18], one could say that, as such, contextual therapists do not focus on the diagnosis or treatment of specific mental disorders and more on "other conditions that may be the focus of clinical attention." Simultaneously, their interventions

 

often lead to an improvement in individual symptoms, such as decreased anxiety resulting from increased trustworthiness.

THERAPEUTIC GOALS

In contextual therapy, the main therapeutic resource should come from the restoration of fair relating but as already discussed, this is not always possible especially when people are blinded by their destructive entitlement. This has led to the proposal of another therapeutic goal: the earning of constructive entitlement. Here, the healing moment is defined as the moment when one person is willing to make a gesture toward the other party. Regardless of how small this gesture may be, the person who acts in a giving manner makes a gain in the form of self-validation, understood as a gain in self-esteem and inner freedom, described as *constructive entitlement*. At the same time, the person who benefits from this gesture makes a direct gain by receiving what the first person was willing to offer, something as small as a little more attention or a small acknowledgment or something more significant.

Here, earning constructive entitlement becomes an antidote to destructive entitlement. As parents discover that they can experience inner gains from even small gestures, they will be more ready to pay attention to their children and try to meet their children's needs. This is the path to deparentification and the restoration of the proper direction of giving and receiving between parents and children, meaning that parents should be able to give to their children more than they ask from them.

Furthermore, for people suffering from mental illnesses, giving can be a source of healing because constructive entitlement leads to self-validation, resulting in an increase in inner freedom and self-confidence, which they often lack. Moreover, the act of giving establishes a contraposition between the giver as a self and the other as a beneficiary, leading to an increase in the self-definition of the giver, which is an added therapeutic resource[19].

Another therapeutic resource comes from helping adults who have been parentified in their youth due to the mental illness of their parents realize that the relational injustice created by their parents did not result from malice but from their hope to be compensated for the injustice of their predicament. From this perspective, both parents and children can be understood as equal victims of the situational injustice created by the original injustice, here the mental illness (Ducommun-Nagy[20]). Adults who can see this often feel entirely liberated from their grudge against their parents. This, in turn, decreases the risk of parentifying their own children.

MULTIDIRECTED PARTIALITY, THE MAIN STRATEGY OF CONTEXTUAL THERAPISTS

The restoration of fair relating between partners and family members requires a restoration of a dialogue in which each person regains the ability to hear the others and to try to take their interests into account, an ability lost in the case of destructive entitlement. To help people re-engage in this form of dialogue, contextual therapists rely on a specific strategy, *multidirected partiality,* also understood as multilateral fairness. It is based on the idea that all participants in the relationship should be given the same opportunity to present their side in their own terms and to express their own view on the degree of fairness or exploitation of the relationship. The hope is that once they have received the full attention of the therapist, they will be more willing to listen to others. While multidirected partiality is based on people's right to fairness and on helping them to present their claims, it is also based on people's right to give and on helping them to give and earn constructive entitlement. Here, it is crucial that people suffering from mental illnesses or any kind of disability are not dismissed as givers.

## Clinical Applications Concerning the Injustices Caused by Mental illnesses

The two examples used below should not be considered case studies in the strict sense of the medical literature, but they should have clinical relevance as case examples for medical and other professionals who work with people suffering from mental illnesses. In this section, the diagnoses will follow the DSM-V classification of mental disorders[19]. The first example involves a mother who was blocking her daughters' chance to establish contact with peers due to a delusional disorder of the persecutory type (397.1) and how this related to her eldest daughter's diagnosis of severe major depressive disorder (296.23). The second example concerns a teen who was attending a specialized residential treatment

center with an individual diagnosis of Other Neurodevelopmental Disorder (315.8) and Specific Learning Disorder (315.1) with impairment in mathematics, severe and a secondary diagnosis of sibling relational problem (V61.8) and problem related to living in a residential institution (V60.)

FIRST CASE

The initial contact with a mother with a diagnosis of delusional disorder of persecutory type (397.1) occurred at the time of the hospitalization of her elder daughter Lea, a 15-year-old girl who was hospitalized due to suicidal ideation with a diagnosis of major depressive disorder, severe (296.23). Part of her hospital treatment included contextual family therapy. The first session included the patient, Lea, the parent and her younger sister Emma. In the first family therapy session, it became obvious that Lea's mother was suspicious and anxious, but nothing was mentioned about her diagnosis. When asked about a possible family history of mental illness, she and her husband were vague.

Shortly after the first family therapy session, the mother requested an individual session. In this session, she revealed that when she was a young adult, she had been taunted by people who played all sorts of tricks on her. No one could see them except her. She had been advised that she was suffering from a delusional disorder and should take medication, but she did not accept this diagnosis: these people were real and would not stop bothering her just because she was taking some pills. By the time she got married and had her daughters, they had disappeared from her life, and the subject was never discussed with the family. Unfortunately, these people returned to her life. They started calling her when she was alone at home. The phone would ring, she would pick it up, hear laughter, and then nothing. She was so upset that she decided to disconnect the phone. Initially, her husband and daughters fought with her. They wanted to know why she had disconnected the phone and why they could not use it. However, she was so adamant about not responding to their questions and refusing to reconnect it that, in the end, they gave up. Her husband accepted the situation because he could reach people from work, but her daughters, especially Lea, remained very unhappy. She was worried that Lea's depression was aggravated by the fact that she could not reach her friends. She did not want to bring up this issue in family therapy because she did not want her husband and daughters to think that she was crazy.

The therapist began by acknowledging the injustice of the mother's predicament. Whether these people existed or not, the experience of being taunted by mean people was an injustice. It was also unfair to know what Lea needed and not be able to help her. The mother was touched by the therapist's comment. This led to a more precise discussion of the phone situation. The family had limited means and could not afford to buy a cell phone for Lea. The therapist asked about voicemail. Lea's mother had never thought about it but felt that this was a good solution: the bad people would not want to leave messages for fear of being discovered, and Lea and her sister could get messages from their friends and call them back later.

In the next family therapy session, she was helped to communicate to the family that she was ready to connect the phone to an answering machine. Her offer surprised the family, but they agreed not to ask for an explanation. Lea mentioned that this gave her hope that her life would change after she returned home.

This example shows that parents suffering from mental disorders, even severe ones, often still care about the needs of their children and should not be dismissed as givers. However, they may need support to discover how they can help their children within the boundaries of their own limitations. This example also illustrates the use of multidirected partiality. The therapist recognized the mother's interest to remain silent about what was happening to her because she did not want to be labelled as crazy, but her willingness to address her daughters' needs earned her constructive entitlement. Both the daughters and the husband earned entitlement by accepting to refrain from asking questions, which was a form of giving since it was a response to the mother's request. Furthermore, this intervention contributed to renewed hope for Lea, with a direct impact on her recovery from depression.

SECOND CASE

This is the case of a teen living in a residential treatment center because his treatment and educational needs could not be met locally. He was

presenting with an Other Neurodevelopmental Disorder (315.8) and a Specific Learning Disorder (315.1) with impairment in mathematics, severe. His individual treatment focused on helping him manage his functional limitations, and he received special education to address his learning disorder.

The reason for the family therapy consultation came from his behavior during home visits, during which he was aggressive toward his younger brother and was damaging property at his parents home. Since he never acted in a similar manner in the institution, he did not meet the criteria for a diagnosis of disruptive, oppositional, or conduct disorder. Based on what came out of the contextual family therapy session, he also met the criteria for a Sibling Relational Problem (V61.8) and a problem related to living in a residential institution (V60.)

For the most part, the family history of this family of four was uneventful and did not contribute to the understanding of the general clinical presentation of this youth. However, something was striking: his father worked in finance, dealing with numbers daily, and his younger brother was very talented in math. This became the source of a clinical hypothesis: was the teen's aggressive and destructive behavior a response to the injustice of experiencing severe difficulties in an area where his father and brother excelled? This hypothesis was tested in the family session attended by the two parents, the younger brother, the teen, and his life counselor, who was there to offer support since he had difficulties expressing himself.

Using multidirected partiality, the session started by asking the parents to describe what was happening at home and their concerns. The teen was then told that it might be hard for him to see his little brother doing well in math while he had to struggle so much. What it unfair? While in general he was slow to respond, here he immediately turned toward his mother: "Why did you make my brother right and not me?" The mother fell into tears, stating that, of course, she was very sorry for his difficulties and that, of course, she would have been much happier if they did not exist, but that she had no ability to change things. The father was also touched by this. The brother added that he understood that things were easier for him, but also that he should not be attacked for that.

Here came a change. It seems that now that the unfairness of his disabilities had been acknowledged, the teen sounded ready to leave his brother alone and also to stop breaking things at his parents' home as a way to show his anger for not being able to live with the family. This was confirmed by a clear improvement in his behavior during subsequent visits home.

Professionals faced with such situations may be hesitant to qualify a mental disorder as an injustice. They may fear that pointing out the limitations experienced by their clients would further stigmatize them. However, from the vantage point of contextual therapy, pointing out a deficit or a handicap and labelling it as a form of injustice has often had liberating effects on people who view their situation as unfair, as was the case here. In this case, the acknowledgement offered by the therapist, and even more so by family members, allows them to become less revengeful and less inclined to seek compensation within their close relationships. This may not change the course of their illness in general but may contribute indirectly to a clinical improvement. For instance, knowing that people understood the unfairness of his situation this teen became more open to the intervention of his special-education teachers, while before that, he was often too frustrated to accept their help.

## Conclusions

This article opens with a presentation of the work of Boszormenyi-Nagy, the founder of contextual therapy and a presentation of the aspect of contextual therapy that are relevant to the exploration of mental illness as a situational injustice and as a source of relational injustices. This part of the article should be new to most readers in the field of medicine, since the approach has not been presented in medical publications, but only in publications on marriage and family therapy. Simultaneously, because of its humanistic perspective on relationships, it may resonate with the personal experiences of many professionals. The part of the article that focuses on mental illness as injustice should serve as a source of inspiration not just to readers who are child and adult psychiatrists or professional who work in other capacities in the field of mental health. Readers who are physicians, nurses, and other professionals

who meet with people affected by severe or chronic illnesses and various forms of disabilities could also use this article as a resource when they encounter clients who behave entitled or when they are parentified by clients who refuse to assume their part of responsibility in their treatment.

The part of the article that focuses on diagnosis, assessment and interventions is based on the empirical knowledge accumulated by the author during decades of clinical work but it is during its redaction that some new ideas emerged for instance, the idea of connecting the notion of "behaving entitled" with the notion of destructive entitlement. The work on this article also allowed for a more precise definition of the nature of the injustices that occur in the parent-child relationship when parents experience the injustice of suffering from a mental illness, which is that children too are victim of the situational injustice affecting their parents.

At the same time, more research is needed, and the author hopes that the next generation of contextual therapists actively engages in research that could confirm her empirical findings on the detrimental relational consequences of injustices connected to mental illnesses. The author also wishes that the results of the therapeutic interventions proposed in this article could be validated as a form of evidence-based therapy.

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