Reimagining best practices in psychotherapy and mental health treatment

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I have experienced heartache, grief, hallucinations, and the chaos of my mismanaged altered state on my personal and academic life as a student. I think all too often people forget that those living with a mental health disorder, diagnosis, or issue with their health are unique and singular in the expression and needs as individuals, and people ingratiated into a large system of care. We all require different forms of treatment, support, and often help. This is why I will never understand why there are so many niches and cliques out there championing mental health reform yet disabling the voices of people with different sets of needs, opinions, and ideas on how to advance the discourse further. Our voices are diverse and should be diverse. Our voices should reflect our needs as professionals and consumers.

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Only when needs are truly articulated will professionals, and peers alike, reform the system progressively. It is up to all of us, to be clear about our needs, and throw our support to ongoing research to drive the discourse of mental health for all people needing understanding forward (Speed, 2006). This is why I believe, and still do, in bridging the gaps not only in academia, but among the prosumer, peer, and professional community of all people interested in improving the mental health system, with or without a diagnosis, requiring medication or just a supportive friend. Our voices must be as diverse as possible, instead focused on the agents which limit and marginalise us further away from our goals and dreams of tomorrow (Relojo, 2018).

As a psychotherapist, one of the most troubling aspects of providing safe, patient-focused, effective therapy for patients in radically altered states is balancing the benefits of continuing with ongoing treatment due to increasing concerns of risk of harm from their compromised or shifting mental status. Let me be perfectly clear here: I truly believe some people have spiritual emergencies which can be treated with psychotherapy without medication and even with the support of a peer who has similar lived experience in the community without forced treatment. I am also a seasoned mental health

therapist who knows when someone is an acute psychiatric crisis running the risk of self-harm or exacting harm to others as a direct or indirect result of their weakened mental status (Mangnall & Yurkovich, 2008). There must be a decisive change in their treatment pathway and course of therapy. This course of action takes place when we continue the same treatment and wait for progress or halt care in favour of a more restricted treatment setting e.g., in patient or more intense treatment milieu, continues to a big source of conflict in the mental health community (Form, 2012). Practitioners are plagued with patient complaints, family petitions, and court orders which further complicate the provision of psychotherapy. In the end, most patients want the least restrictive and intrusive course of treatment available and rightfully so.

The line I am referring to has been and continues to be outlined by the letter of the law and mental health laws in the US. These laws, for better or worse, make it as clear as day when someone is at immediate risk of serious harm to himself or others. Upon crossing this metaphysical line in the clinical realm, these folks at risk of immediate harm need to be hospitalised and or assessed for further risk of harm. There really is no grey area here. To do otherwise is negligence. Of course, sometimes someone can be at risk of harming themselves, having a spiritual emergency, and still not require in-patient hospitalisation or a psychiatric evaluation and observation. It doesn't matter, though. When the risk is this high, we simply shouldn't be gambling with life. Self-harm is the act of deliberately inflicting pain and damage to your own body. Think about it: as therapists, we assess risk all the time. If we are doing our jobs right and are truly person-centred, we should be using every technique in our toolkit to treat our patients where they are at regardless of how society views mental health diagnosis. Again, it doesn't matter what the world believes a psychiatric label means in the context of providing therapy, what works and is the right fit for our clients in the context of their disorder and circumstance. However, somewhere along the way these new hot emerging trends in psychotherapy and peer work are being thrown around. They are the 'in' therapies, the hot new miracle modalities which are going to bring about better outcomes and are more humane.

Debunking the myth of the miracle modality in psychotherapy

I have made no secret about my scepticism in the clinical value of new research in mental health in the last decade. I am just not certain we are targeting the right areas or bodies of underdeveloped research and moving forward in the important or needed areas to truly impact mental health as a discourse or field of enquiry. ACT (acceptance and commitment therapy) and other hot interventions like dialogical therapies, while sharing some commonalities, also share what has truly become a cancer in mental health research. This cancer, located at the metaphysical polarities of the clinical spectrum for accepted, empirical, and 'evidence-based' research, continues to eat away, and carve out the discourse of mental health treatment from within. Therapists are all talking about ACT, a 'third wave' behaviour therapy approach with a supposedly 'expanded perspective on how to guide clients to skilfully self-regulate emotional distress and conflicting states of mind', or at least, that is what all the literature suggests this new so-called approach to same age-old problematic experiences therapists encounter when treating their patients.

These are patients, according to the literature on ACT (e.g., Hayes et al., 2006), who experience affective dysregulation from a new or existing anxiety, posttraumatic stress disorder (PTSD), depression diagnosis and/or deep interpersonal conflict (Boltivets & Relojo, 2019). The theory behind ACT is a framework which posits through the application of a traditional mindfulness exercises and intensive psychotherapy targeting specific cognitive processes, the patient will experience relief through acceptance of private experiences; active cognitive diffusion; being present; and self as context. When all of these targeted modalities are mobilised in the course of psychotherapy, patients supposedly become more flexible in their interpersonal kinship networks and other interactions in their professional work and personal lives. Building upon the assumption that firstly, a positive increase in prosocial interactions will result in the cultivation of value-based behaviours (Caleb et al., 2019). ACT theoretical underpinnings go a layer deeper. The literature suggests this algorithm for conducting therapy will yield further patient insight into their own personal set of values, developing a stronger commitment to

positive action and behaviour (Schoendorff & Steinwachs, 2012). This chain reaction yield, what ACT terms, the behavioural and cognitive activation which contributes to the success of patients experiencing therapeutic gains in the course of their treatment.

The framework of ACT builds upon basic mindfulness. While I doubt many therapists would minimise the importance of patients understanding basic mindfulness or even a nuanced deep and complex awareness of self-awareness tools, the use and validity of research confirming this existing modality is already widely accepted and utilised across the board by therapists in mental health. So, what's really new then? Self-acceptance? I haven't met a social worker, psychologist or psychiatrist that hasn't, in the course of treating anxiety, depression, and PTSD, forgotten to teach self-acceptance strategies when the opportunity presented itself in the course of their patients' treatment (Gagani et al., 2016). The next wheel I like to suggest isn't so inventive is active cognitive diffusion (Dobrev, 2001). Even more problematic, cognitive diffusion, which has patients confront or raise problematic areas of their dysfunction or conflict without affective state escalation or agitation isn't even accepted as completely effective in treating the symptoms of these disorders.

I have seen first-hand, both experienced and inexperienced therapists clumsily use this technique, and sessions collapse shortly after as their patients unravel, become irritated, and begin to flood with emotion and negative sense memory. So, if this technique is so delicate and difficult to apply in practice, why incorporate it into this already complex and overly technical so-called ACT paradigm. I am assuming, much of this has to do with the assumption that ACT-trained therapists will go through rigorous training and attend every webinar possible throughout their careers and tenure or practicing ACT. The final two underpinnings are in my opinion, the basic skills taught in social work 101. Maybe I am missing something here? Or, just maybe, contextualising the self in more meaningful and meaning-laden terms is what we are already doing as therapists (Kuha et al., 2018). So many of these so called new and exciting modalities we chit-chat about at the water cooler and gloat about to our colleagues should already be in our tool kit for practicing psychotherapy.

Owning our craft

I seem to be unclear as to what's new here in terms of practicing person-centred therapy. Clinicians like myself are finding themselves sitting at the same round table discussing the same techniques and theories from graduate school. Maybe I am a brilliant clinician, or just maybe, I've taken the time to truly be person-centred, read a diagnosis for what it is, and apply my existing and ever broadening skill set to my patients and experience good outcomes without calling upon the buzz of a new acronym or miracle modality. I get it, we all do it, and want to talk about our skills in broad colourful strokes of positive regard, but we therapists should also be a little humbler and learn our craft from the moment we commit to the helping process. Instead, we blame our shortcomings and inability to successfully treat our patients on our incomplete education of new terminology and the next, 'in' therapy (Bautista et al., 2018).

The acuity and esoteric nature of these hot, miracle modalities continue to overshadow what we practitioners are setting out to do. Instead of practitioners learning a vast, eclectic and broad skill set to treat all diagnosable or treatable conditions, the task at hand has become estranged from healing and the helping process. Alas, clinicians are boxed into a small physiological space for learning new research and identifying gaps in current mental health trends and community-based needs. In a sense, these mental health clinician-crats (and those that decide what techniques are in, and which are out) are ruling out and marginalizing hope and healing for a segment of the population which could benefit and stand to profit from advancing research forward across the board and not limiting future data collection to the in treatments and those practiced by those with more influence in the field than intellectual credence.

Interdisciplinary parity: Which is the right clinical pathway forward?

As a social worker, I sit on a vast, layered, and profoundly broader body of knowledge, theoretical understanding and foundation of information than some other more narrow-focused disciplines out there in mental health. This is why I believe it is up to social workers, prosumers (people with lived experience and professional training) and other more ornate backgrounds and experiences to jettison research into the next era. In order to truly help people, the mental health community needs to better define what 'help' means for people with a mental health disorder. We work in a multidisciplinary field rife with different approaches and different languages all targeting the same issue, treating mental illness or mitigating the impact of the disorder by providing a service to people in the public mental health system. Maybe this is the problem. By in large, practitioners are working in isolation at the micro level within a larger system of care. This is a bit counterintuitive to reform an already mixed up way of managing the entire way we do things in mental health (Jayakody et al., 2000)

In the end, there are so many different perspectives on what constitutes best practice in mental health treatment. So, what is and is not best practice will continue to be hotly contested until the structure of the system is changed as well as what the system defines as common indicators of progress and what a good outcome is and is not. Thinking about progress is critical for both consumers and practitioners, as well as researchers and those with a vested interest in creating space in the field for creative pathways to empowering people with a diagnosis to be motivated in their recovery and truly track in their own terms, their success in treatment.

In therapeutic settings, therapists monitor the progress of their patients. This is done in several ways, depending on the type of therapy (for example, the modality, setting and treatment milieu) and needs to also be taught to consumers of treatment, so both practitioner and patient can work more closely and in greater clinical harmony. For most therapists, in private practice, or in the public mental health system, there are already methods of tracking progress, without using complex, cumbersome, and expensive treatment modalities to implement and train staff. But, ultimately, these measures, are clumsy and at times, disorganised approach to tracking recovery, and its converse, the over-intellectualized, ornate, and highly prescribed new, hip, modalities, which are so difficult to train with enough latitude to reach the mass base of practitioners, that identifying a common language to measure client and collateral reporting during interdisciplinary meetings, or even indiscipline collaboration becomes impossible and presents yet another impasse to treatment.

The DSM-5, and other manuals, research, can only provide generic research for diagnosis, Meaning, research and prognosis is measured in broad strokes, and is based on studies, populations, circumstances, but is limited in its ability to truly put numbers and language around a person-centred prognosis for people with a mental health disorder. This is a problem for people who want to know what's ahead, plan for it, and what to expect, in their own terms, while living out their life with a diagnosis. Underneath diagnosis, and even less researched, is rate-of-recovery, and the speed (duration of illness and the symptoms) of a person to experience progress and relief from their symptoms. I recommend, without further delay, immediate research and studies charged with the measurement of recovery, in very real terms, that truly allows patients and practitioners to know what to expect, when to expect it, and plan so problems can be addressed before they occur.

Ethical considerations for taking back the academy and research

I am very serious about the set of propositions I am laying out here. This is part of a restatement of claims I have made before, but this article needs to signal a giant tectonic shift in how we do things in our field. So, who really is charged with appraising the clinical value of our research these days? Who is really validating the claims researchers are making? Scholarly work, studies, published papers – all these outlets and mediums for disseminating good information in our field have bias. We must accept and own these biases. Peer-reviewed work, blinded, however we tell ourselves our work is pure, intellectually and ethically solvent, needs to be overhauled if not torn down at the very ground floor we built the discourse on before we can call ourselves truly unbiased, and platonic in our commitment to unassailable research in mental health. Let's be totally honest here.

Endorsement of peer work in academia is as rife with political intrigue and back door funnelling of money and funding as the White House. The difference with academia is that we refuse to talk about it. And there are no television dramas depicting our ethical and moral battles in the wings of institutions and library halls. Similar to the perseverance of our patients, we must redirect the very meaning-making and re-target the areas of research which aren't talked about: the missing or underdeveloped areas of research which continue to confound and contest the very bodies of knowledge we hold as truly incontestable (Lacasse, 2014). Well, if we are really being honest about what we do in mental health, we would do just that. No modality, no study, no manuscript for submission is truly above reproach. There are taboo areas of how we do things as researchers that are problematic (Mohr et al., 2017)

If we do not overhaul and turn academia, pedagogy and practice on its head sooner rather than later we are headed for disaster. I would hazard to say the destruction of this field as we know it as an accepted discourse of intellectual enquiry. So, before it is too late, ask questions, continue to go against the current, until the very armamentarium of new research moves with us towards a brighter, healthier vistas of tomorrow.

The extended metaphor of the war time therapist

I am not gesturing to being clairvoyant or the most versatile and experienced practitioner overnight. I am going to suggest though that we should begin to put together the basic rubric for what can best considered best practices for psychotherapy despite the varied, and micro nature of the provision of care in some cases. For each micro interaction, each session, group, and generally, way of handling the practice of mental health treatment shares indisputable commonalities based on the principles of balancing the protection of life with the risk of failing, experiencing relief and progress in the wake of distress and the possibility of relapse. In this vein, and a few things come to mind, we can begin to think of best practice of micro and patient-centred approaches through a very macro, sociological, and human rights perspective for carrying out the provision of mental health treatment. Let's break it down, psychotherapy crosses several intersections in society when it comes to governance, ethics, plight, human rights, and the need for all people to live a life buoyant with self-determination and good health. All of these intersections mark the medium for measuring good practice. For the purposes of this discussion, let us think of the office of the president, when it comes evaluating the indicators, we are all familiar with to measure the success of the president and the nature of his role as a leader, protector, and model for health among the citizenry. In times of war, or extreme peril. When the nation state is altered radically and requires guidance, repair, and stabilisation, we term our leaders war time war time presidents.

These are presidents described as strong, persevering, and able to lead during times of extreme national distress or even division. These presidents unify the populace around them. If you've never struggled with a major mental health disorder, or issue in your life, you might not liken disorder to war, but I do. Every day for me is a war against my illness, and I am in it to win it or else suffer the tragic unfortunate process of florid psychosis in full bloom (Addington et al., 2003). As a practicing social worker (really, the reader need only think of a mental health clinician), it is my duty, my responsibility to teach the people I work with to carry on despite their plight. My clients suffer from a full range of mental health disorders, all complicating their lives to the point where the best route to health may be too obfuscated to identify at first glance. This is where I come in, and this where I thrive. I am a war time social worker. Yes, this is a thing, if a president can lead the nation to peace and victory. I can lead my clients to health and wellness out of the annals of disaster, grief, or any of the endless symptoms people can become stricken with under the terror of mental illnesses (Pilao et al., 2017). This is serious, this is also very important. War time social work is the micro level counterpart of the war time leaders in our nation's long history of challenging *wrongers* throughout the world. Instead, I challenge my clients to confront their evils, inside and many times in their interpersonal landscapes when their social world gets out of hand. I am now challenging all social workers, psychologists, and clinicians in mental health to take on a new acronym and designation as a war time clinician. Like the point person who owns their case (Guttman, 2019). The war time social worker is you're go to clinician when the odds are pitted against

the client to recover. There is a reason why you bring on the war time social worker into the clinical picture. Because; serious harm was done, endured, and must be righted if the client is to survive or return to their baseline. The war time social worker has a job, a great task ahead.

They are charged with not just a simple intervention (Griner & Smith, 2006). They are charged with major restorative clinical work and progress. If this is not experienced or produced, the client is surely in peril. War time social workers are as savvy in their skills as they are speedy in their writing to produce brilliant outcomes. Their skills outpace the constraints of most people's movements and the speed of societal waves to interfere or complicate the lives of their clients. In fact, the war time social worker mobilises the community and its resources around and for their client. They stretch and use resources in a way that creates new opportunities for their clients. I have been a war time social worker for my clients' time and again. I have had to manipulate billing to justify needed services so my clients would be met with consistently and frequently when they needed it the most (Pinto-Coelho & Relojo, 2017). I have gone to war for my clients to secure housing, bridge connections and natural supports, and create safety plans that are so radical, they transcend the bounds of conventional status changes around the protection of health. I've held meetings across multiple systems until the right person in the government was reached that could bring about the needed oversight across systems to ensure my clients would not fall through the cracks of treatment when they need it the most. So, I ask you: what kind of therapist are you? Are you willing to escape the confinement of conventional clinical wisdom and depart from the textbook? Or are you going to sit idly by while your client falls apart, when the minimum work just doesn't cut it? I am encouraging you all, with every breath I can spare, to expel out of your lungs the disease of inactivity and traditionalist thinking when it comes to clinical practice. Understand the intersections that guide our lives and don't let the lines get blurred when it comes to intervening in the most effective way possible, every time.

CONCLUSION

I believe that research must be wholly beneficial to the public, raising the discourse to new heights. Knowledge must be free and rife with regard for society's welfare. As a prosumer and mental health interventionist researcher, I have sought nothing but a bold new model that works for the masses (Chavez-Valdez et al., 2019). We need therapy and practitioners utilising methods which are both targeted, yet beneficial to all conditions and diagnosable disorders (impairments, both environmental and developmental, and, as this theory unfolds, at the root of it all: biological).

My theory here is that we must adhere to natural laws and revise life within the limits of our biological wherewithal as people. Therefore, I termed Biologic theory as such. Biologic theory is totalising and yet person-centred. Sitting atop a canon of research that suggests empirical-driven, evidence-based treatment must be as dichotomous as it is episodic. I am dispensing a new vast continuum of working knowledge. Both mobilised and charged with the provision of care, treatment, and elaboration of mental health under the auspices of this new theory. I now bring into being a new power: (*novi virtutem*) to revise the discourse further.

In my opinion, there are no limits and no frontier too unmanageable. Only restricted and subsumed by the limit of our imaginations. Biologic theory inserts itself with cautious regard for deterministic philosophy and the real limits imposed by nature and the finality of life itself. This is a prosumer approach to driving treatment forward. This is the age of the rise of the prosumer. There is no question that the best and most effective practitioners must have an internal, real, and first-hand experiential knowledge of how to implement this theory in practice.

The ultimate and proximate implications are thus not process- or content-driven, but rather wholly and inherently biological. Nature sets the quotient for change. Self-directed, internal, spiritual, and external, this is the person in their environment. The limits of our world mark the weak points and the strengths of each person. Our knowledge only drives us to the apex of understanding and is not defined by the process or content of the work. This means that only the therapist's experience practicing and the

breadth of how the work stems from lived experience – as biological, natural, and interconnected people fundamentally are the real and final markers for outcomes and people's journeys in life.

Instead of gesturing to overt or covert limitations, biologic theory makes use of them instead of expelling determinism for its obvious reductionist and ableist underpinnings. Biologic theory has only two basic philosophical assumptions. These assumptions are: (a) human capacity for change is limited by the biological nature of the bodies' medical and psychiatric status and (b) all people are unique in their potential for change.

This dialectical approach satisfies not only deterministic, but categorical, diagnostic uses for treatment and sets the stage for empirical evidence to assemble a legitimate canon of unbiased and differentiated future research. Even self-deterministic views of people are satisfied and incorporated into the grand schema connecting biologic theory.

From the untreatable to the most canonical expressions of mental health disorders, to acute and chronic conditions rooted in trauma, biologic theory nurtures previous research and cultivates the conditions for lasting impact in definable treatment. This means that the limits of our capacity to retract, redirect or (more biologically said) heal are what this theory considers the aim of real mental health treatment. For people to be as successful in their mental hygiene as clinically possible is both reciprocal to the material expression of their very DNA for healing, and, this theory sharply implies, driven by the reigns of the prosumer to enact this theory in practice.

For the prosumer: Operating the therapist's clinical scalpel is as important as their lens and gaze for interpreting the person being treated with biological needs for healing. This is not based on content or process, but value. This value, for better or worse, must never be calculated for state-sponsored selection for rehabilitation and assessment of greater worth to society. Instead, this theory must be applied to society itself and the macro-biological systems existent, ripe for change and urgent reform.

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