A Critique Of Psychiatric Theory As Described On The American Psychiatric Association Website – What Is Psychiatry? (No. 1)

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Here I'd like to cite the website of the American Psychiatric Association, and then offer observations.

American Psychiatric Association: What Is Psychiatry?
https://www.psychiatry.org/patients-families/what-is-psychiatry-menu

On this web page, there is the following statement:

> Diagnosing Patients
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> Because they are physicians, psychiatrists can order or perform a full range of medical laboratory and psychological tests which, combined with discussions with patients, help provide a picture of a patient's physical and mental state. Their education and clinical training equip them to understand the complex relationship between emotional and other medical illnesses and the relationships with genetics and family history, to evaluate medical and psychological data, to make a diagnosis, and to work with patients to develop treatment plans.
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> Specific diagnoses are based on criteria established in APA's Diagnostic and Statistical Manual of Mental Disorders(DSM-5), which contains descriptions, symptoms and other criteria for diagnosing mental disorders.

In a psych unit, the psychiatrist, with exception (for an exceptional psychiatrist: this is, I found, in psych units and followup, 3/17 psychiatrists), never discuss anything material – "discussions with patients" – to determine anything. The psych unit psychiatrist never discusses the "patient's physical and mental state". They never discuss the situation, the various states (mental states, emotive states, intentional states, physical states). In most psych units (9/9) the treatment is unilateral (the one exception, in part, was 1 psychiatrist of 3, at one psych unit, and up to that point at that psych unit, the treatment was unilateral, and dismissed discussion). In the same ratio, the psych unit psychiatrist never does this, from the above: "work with patients to develop treatment plans". They never, in fact, at all, tell the patient the diagnostic term(s), what the diagnostic terms mean, the basis for the diagnosis; much less discuss the situation or various states or merit/demerit or domains of life, or dilemma and no-dilemma. They never discuss one's thinking, feelings, much less understanding, thought, speech, and action.

I'd like to note the following statement from the above quote from the website: "…the complex relationship between *emotional and other medical illnesses* and *the relationships with genetics and family history*…". So this is the theory: an emotional state that is an illness is a *medical* illness. This is astonishing. We can work with the emotional in mind and the interpersonal, even body-breath-mind-world-space. We can work with the emotional in mind, via reflection, changing our minds, investigation and inquiry, and so forth. Mind drugs such as street drugs or psychiatric drugs can affect the emotional and other mental states. This does not mean that other things such as our own minds and others' inputs (resources) can't also affect, work with, emphasize, use, or change emotions and other mental states, and even our perception and reasoning about them.

And Minsky proposes that emotions are just another type of mental states, resources we use and are, in the brain, manifest and worked with in the mind – in tandem with other of our Ways To Think and the external world. He postulates that there is so much that we work with, *in mind*, in many ways and in many domains. He postulates that we think and reason about things, including other ideas in mind and the external world. See his books *The Society Of Mind* and *The Emotion Machine*. Psychiatry, it seems, and certainly psych unit psychiatry, from my experience, omits all of this. It is astonishing. No wonder the domain, from the standpoint of the experiential, various states, and domains of life, in context of psych unit psychiatric theory and praxis, is a bleak landscape, desultory, devoid of meaning. One needs to pull and draw from other resources – and happily these are available, in just this world, including the so much resource available in what humans have put forth and worked with from the Buddha to Aristotle to the Indigenous to Minsky to the religions – and so much more. Things can take time, and they may be either etched or unfold over time; and require diligence.

Note that the quote mentions that psychiatric theory looks to genetics and family history.

But they never look to the individual, situation from all points of view or as it might actually exist, standpoint, reason itself, a discussion of the domains of life (the mental, the existential, the social, the societal, the experiential, the physical), the nature of various people in the individual's life, the interpersonal, one's actual expression, and so forth – 'all of the above'. They never look to ethics and context. Nor do they discuss the mind and truth; they do not bring these to the table, have theories on them, note their practical effects, or their integration with this world – and omit all consideration of them.

And all of this with the given that the individual has a diagnosis from the DSM – given a-priori decisis with respect to 'all of the above' – and given with psychiatric theory itself. And the individual in a psych unit is never participant in the discussion.

Remember that the worldview of the psychiatrist – particularly the psych unit psychiatrist – is in terms of disorders and the biogenetic theory (the DSM; all emotional illnesses are medical illnesses, genetics, and family history). It is not: the four reliable facts from Nagarjuna: reason (reason itself), the external world, the present moment, and reality – this world – seemingly similar to God. Nor is it: the various states and the domains of life. Nor is it: philosophy, spirituality, religion, narrative, the dialogic, mediation, the everyday, or problem-solving. The APA mentions on their web page the psychosocial, but these have never been brought to the table with me by any psych unit psychiatrist or followup. So the individual is a-priori decisis rendered in terms of only disorders (in terms of absolute deficiency),

and the view of the individual is that it is a permanent biogenetic malfunction. But the psychiatrist – in particular in a psych unit and followup – hasn't considered the real world. The individual is never participant.

What an idiot theory. Cruel, for all its omissions to the individual in a psych unit – the very nature of the individual, the various states, the domains of life, available resources, and world-space. In addition, note that the psychiatrist as described above – and psychiatric theory – never works with nor talks in terms of *the mind*.

Further on, the web page says:

> What Treatments Do Psychiatrists Use?
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> Psychiatrists use a variety of treatments – including various forms of psychotherapy, medications, psychosocial interventions and other treatments (such as electroconvulsive therapy or ECT), depending on the needs of each patient.
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> …

In a psych unit, neither psychotherapy nor psychosocial interventions are ever used; nor are they referenced. Only medications are used.

And as I've stated elsewhere, only medications are used, sans all else. Meds can sometimes be apropos, appropriate, helpful, and useful; and they should be set in a framework and context of mvo-p psych and 'all of the above'.

With one private-practice, independent, intelligent, aware, genuine psychiatrist I worked with for a short time in NYC, meds were not the rule and he gave excellent advice; in addition, we had some excellent dialogue. He was perceptive and realistic. I was participant. Notable! This was long before my encounter with psych units. This psychiatrist should be modeled. He actually did use psychosocial theory – and he talked about and recognized *the mind*. Significant! This psychiatrist was consistent with mvo-p psych and 'all of the above'. (Then, it should be my mvo-p concise term, as an update to psychobiosocial. See related papers below.) He should be emulated.

I introduce a redefined model for the psych unit psychiatrist. See related papers below for an Introduction to this and to mvo-p. Start there. See my MVO: 2019 Thesis for more on this topic.

There are going to be problematics, problematic situations, at-ease nature, at-ease situations and aspects, and points in the grades of dilemma and no-dilemma within the domains of life and situations. These should be seen as to their true nature, and worked with in realistic ways, grounded in sound and multi-disciplinary theory, ideas, approaches, and praxis. They should draw from thought and practice both ancient and modern.

Resources

The Society Of Mind by Marvin Minsky.
The Emotion Machine: Artificial Intelligence, Common Sense Reasoning, And The Future Of The Human Mind by Marvin Minsky.
Inventive Minds: Marvin Minsky On Education by Marvin Minsky.
Zen Training: Methods And Philosophy by Katsuki Sekida.
Fundamental Wisdom Of The Middle Way by Nagarjuna translated by Nishijima.

Related Papers

Introduction To Mvo-p And My MVO: 2019 Thesis
The Concise Term (Again!) As One Way To View The Domain (Mvo-p Psych)
I Know Exactly What I Did To End Up In Psychiatryville. They Had To Do With The *Mind*.