A Fundamental Description: Several Fundamental Problems In Psychiatry, And Potential Resolution, A Redefined Framework

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One of the fundamental problems in psychiatry (and this is exemplified in the psych unit) is that it sets aside and omits ‘all of the above’ – and then replaces it with an interpretation, for each individual, only in terms of a diagnosis of absolute deficiency pointing to (so the theory goes) permanent neurobiogenetic malfunction. But it sets aside all of ‘all of the above’. A second fundamental problem is that it reifies a median of behavior, itself an abstract thing, as the reality, seeing deviation from the median as psychiatrically deficient; whereas the data are naturally variant (human thought, feeling, and experience – the domains of life – are vast and varied). A median can be useful, but it is only an abstract singular way to interpret data, or to be a statistical referent, with some meaning. But it is not the actual thought, feeling, and experience, and does not reflect the variance or distribution, and to set it forth as the actual ideal state with variance as deficient rather than explanatory is a key mistake. A third fundamental problem is that it considers neither mind nor truth; and these should be set in the context of the domains of life. These should be recognized in the individual, and various degrees and types of inquiry and perspective noted, and perhaps initiated. We have access to these, our very selves, and this should be respected. Then things can be taken up on merit. A fourth fundamental problem is that it does not recognize the value of language, and of dialogue between the psychiatrist and the individual; and it pre-empts this with its diagnosis of absolute deficiency and its neurobiogenetic theory, ‘a-priori decisis’.

So what psychiatry, and especially psych unit psychiatry, needs to do is to replace its current disorders paradigm with an mvo-p paradigm and an ‘all of the above’ framework; and this framework includes a realistic description of problems and for some of these the selective use of meds – but with the actual world and human experience as the framework, and potential ground for resolution. If that were what was encountered in a psych unit, or the psychiatrist’s office, or with the psych team and dialogue with family, friends, and colleagues, then the psych unit would be a different place. Not a place of ‘to isolate’ and ‘to pin on alleged failure’ and ‘penalty’ and ‘a-priori decisis’, but a place of dimension, vocabulary, logic, reason, realism, description, the participant, and explanation. Where reason and merit of the individual and others and merit of this or that are on the table. Significantly, the domains of life (the mental, the existential, the social, the societal, the experiential, the physical) would be considered, and the grades of dilemma (crisis, significant, part, no, and no-) would be factored out for each of the domains of life. And the rest of ‘all of the above’ – thru to body-breath-mind-world-space. This would lead I suspect to deeper paths for treatment, equable approaches, and just outcomes.

There are situations. There are problems. There are joys. There is merit. There is explanation. There are various degrees and types of orientation, dis-orientation, and re-orientation. These should, along with the many things, be acknowledged and more profoundly dealt with.

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