Fundamental Psychiatric Theory: The Biogenetic (No. 1)

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Draft 1.09
2020 April 4 – 2020 April 12

I feel, again, that so much has been overlooked, in mainstream psychiatry, as to be ridiculous. Here's one point.

In some of my papers I use the term the neurobiogenetic view, or reference the view of permanent neurobiogenetic malfunction as the view of mainstream psychiatry and the psych unit psychiatry. It was generous to do so. Neuroscience references cognitive maps, spatial maps, social maps, the temporal, learning, decision structures, and so forth. Psychiatry says that these do not exist. So we're down to the theory of (properly termed) permanent biogenetic malfunction (sans neuro). So: the claim in psychiatry would be that biogenetic function and malfunction (limited to the serial transfer of molecules across gap junctions, sans the relational and relationship and the unfolding or neurons, sans other functions, and sans a deep mode to meaning-awareness-function) explains all of the above neuroscience terms, setting aside the meta-view, language, processes, and observations of neuroscience, and in addition explains all of the following: perception, standpoint, point of view, understanding, reason; the domains of life (the mental, the existential, the social, the societal, the experiential, the physical); the mental, the emotive, the intentional, the physical; the social-relational, thought-relational; awareness, discipline, training, study; a calm approach or dynamic approach, perplexity, tranquility, energy states, focus, subject matter, context, world-space, the combinatorial, reformulation, 'combinatorial unfolding interconnected relational action-memes' (my term, see Minsky); matter, feeling, thinking, enaction, consciousness, the immaterial (see Dogen), Mind itself (see The Lankavatara Sutra); that the manifestation of form in response to the material world is like the moon in the midst of the water (see The Golden Light Sutra); architecture of the being (see Minsky), mathematical expression, language; philosophy, the spiritual, and religion; ethics and ethics philosophy; discipline; orientation, disorientation, and/or re-orientation; the grades of dilemma in the domains of life: crisis, significant, part, no, and no-dilemma; etc. More, over time.

Just thoughts. Could edit and revise.

But none of 'all of the above' is ever discussed with the individual by the psych unit psychiatrist or followup. Neither is the segment of alleged behavior reported by a third party: the items on the 302 petition are never discussed with the individual, at all.

All that is prescribed – and this is proscribed – is meds; and this is often enforced, mandated, and coerced, sans all dialogue and basic communication with the individual; and this is often along with isolation (in the psych unit), the pejorative, and the view of absolute deficiency, in all ways one can conjure about the individual, including the diagnosis. This permanent biogenetic malfunction and so forth theory and praxis is the (unspoken) basis for the representation of the individual to the family, the state, society, and the individual, by the psych unit psychiatrist – and the psych unit psychiatrist is *the* driver of the representation of the individual. The theory and praxis derived from that theory, nor the

diagnosis, the diagnostic term, its meaning, its theoretical basis, and its practical basis are never discussed by anyone with the individual in a psych unit, at all. Nor is any of 'all of the above' (with infrequent exception, with an outstanding psychiatrist (who nevertheless needs a redefined framework); but never in diagnostic or treatment or legal effect): such is contradicted, set aside, or refuted, by the psych unit psychiatrist (and almost always entirely, in a psych unit and followup) – and the psych unit psychiatrist is the driver of the representation of the individual.

The individual is given no opportunity to correct, explain, reason about, or justify a thought or action. The individual is never given the opportunity to describe, work with, or resolve dilemma (in the domains of life) or to discuss the nature of or merit of the grades of dilemma in each of the domains of life, or other ways. The individual is given no opportunity to discuss the domains of life: the mental, the existential, the social, the societal, the experiential, and the physical; nor to discuss the mental, the emotive, the intentional, and the physical. The individual is given no opportunity to discuss the merit of the items on the complaint, or the facts of and meaning to the situation, and its context and persons. The individual is given no opportunity to be taught about (with few exceptions), discuss the merits of, debate on equal footing, and reason about the theory and praxis of psych unit psychiatry.

There may be problematics. There may be at-ease. There may be part, significant, or full merit. And part, significant, or full merit – and points and grades of demerit – on the part of the individual, person A, and/or person C. These are not well-described nor are they well-addressed, by the psych unit psychiatrist. Nor are difficulties identified in a tractable way, possibilites acknowledged, and paths found that would otherwise be found.

This is a theme of the mvo-p psych idea, and its critique of the present-day mainstream psych unit. The mvo-p psych unit would be illuminative, realistic, not able to solve or resolve all dilemma, but able to point to so much that is currently set aside and a-priori and without discussion either contradicted, refuted, or ignored. Mvo-p psych would suggest ways, in psychiatry, the psych unit, and followup, toward equable consideration of the individual and situation, acknowledgment of the domains of life, acknowledgment and discussion of dilemma and no dilemma in the various domains of life, discussion in terms of 'all of the above' including standpoint and merit, deeper modes of approach and treatment, and just outcomes; and toward seeing the individual as an individual (as a person, in dimension), part of an unfolding, dimension world.

It can be difficult, this dimension world. It can be at-ease. And it can be points and shades in between, states, and unfolding partial states. From the Zen standpoint, it is all-functions[1]. This should be acknowledged, in society, and in the psych unit. Then, it would be realistic, in that way.

United States
2020

Footnotes

1. See the essay Zenkei by Dogen, in Shobogenzo by Dogen translated by Nishijima and Cross.

Related Papers

[Introduction To Mvo-p And My MVO: 2019 Thesis]

Resources

In Search Of The Brain's Social Road Maps
Scientific American
2020 Febuary 1
https://www.scientificamerican.com/article/in-search-of-the-brains-social-road-maps/

Endnote – Analysis: False Imagination

Here is an example of my logic:

> Mahamati, there are two kinds of the view of an individual personality; that is, (1) the inborn one and (2) the one due to the false imagination; it is like [the relation between] the relativity view and the false imagination [of the three] Svabhavas. (118) For instance, Mahamati, depending on the relativity view of things there arise varieties of attachments to the false imagination. But this [existence] is neither a being, nor a non-being, nor a being-and-non-being; it is not a reality because of the false imagination, and, being discriminated by the ignorant, assumes varieties of individual signs to which they are strongly attached just as the deer does to a mirage. Mahamati, this is the view of an individual personality falsely imagined by the Stream-entered, which has been accumulated for a long time by their ignorance and attachment. This is destroyed when the egolessness of a person is attained by which the clinging ceases.
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> – The Buddha, The Lankavatara Sutra ch. XLIX (translated by D. T. Suzuki).

Assassin: "The significance of MLK is that he was shot, and that was the end of him and all he could do."

Citizen: "No. The significance of MLK is in his life, teaching, and action; and his enduring legacy; and in MLK day. It is also in what each of those who pick up his words do with it, in the ongoing."

Psychiatrist: "Well, the significance of MLK is in the biogenetics that gave rise to his words and action. Since MLK is esteemed, we can analyze his brain for significance. And, did MLK need meds or not?

Likely not, since his social action would not fit into the disorders schema of the DSM. He did not suffer either delusions or depression. Although he may have been a bit of 'delusional grandiosity'. Still, society accepted that, so perhaps…."

In light of the above quote: "The view of the Citizen holds. And, consistent with this, the very reality of MLK is in just his very life-action in the unfolding fabric of present-moment reality, this actual life – this occurs in each of our minds and lived experience who so picks it up, and this is the non-discriminated space. In his "I Have A Dream" speech, he spoke on both the experiential, the practical, the ideal, and the merit of idea. It is natural to let MLK live; and he continues to do so."

I actually have to know more about MLK. I know just a scattering of things. Satyagraha and an initial watching of the entire "I have a dream…" speech (which point to, respectively, quiet-form yet active presence, and merit and freedom, a claim on 'all men are created equal').

"One man come in the name of Love. One man come and go. One man come he's a justifier. One man to overthrow." – U2, the song "Pride (In The Name Of Love)".

Thesis point: I'm beginning to develop an idea that there is an image of 'the mentally ill' conjured by this or that person in society, carried through to and reinforced by psychiatry, that attaches to various individual marks-as-signs of the conjured image as much as the individual, thoughts, speech, action, situation, context, etc. are ignored, or caricatured. The entire tractable domain, resolvable or not, dilemma or not, merit or not, is set aside. This point of mine might be a significant step, and it's based upon some ideas from the past month.

Endnote – Juxtaposition: MLK And NIMH

MLK: "I have a dream that one day my four little girls will be judged not by the color of their skin but by the content of their character." – Martin Luther King, Jr's "I Have A Dream" speech, https://www.youtube.com/watch?v=I47Y6VHc3Ms.

NIMH: "I have a dream that one day we'll be able to judge each person in advance not on the basis of their character but rather on their genetic makeup at birth and brain structure. And ideas and cultural merit and content and training matter not, nor the person's own applied efforts, realization, insight, studies, nor spiritual, religious, or philosophical practice, nor literature." – https://www.governing.com/topics/health-human-services/the-big-change-coming-to-mental-health.html.

Oh, brother – NIMH looking at genes and brain imaging to predict mental illness and treat, in advance of full-blown clinical symptoms.

A book from F&M's library that I happened to pick up when I attended: "We can see that blacks' skulls are on average smaller in size than whites', and therefore blacks can't be as intelligent." The book was from the 1800s, as I recall. Of course, skull size is predicted, the theory goes, by genetics.

And so, NIMH must think, is one’s entire thought content, and thought, action, and acts, throughout one’s life.

Instead, I would *talk* to the individual or person, in real world terms, just this actual life.

Life can be difficult. It can be at-ease. It can be points in between. It is often significance and meaning. Sometimes surprising paths can be found. Explanation, a description of dilemma and no dilemma, and dialogue would go far. Sometimes discipline, and sometimes strong action, but often, I think, even illumination and straightforward clarification on the part of the psych team, the individual, person A, person B, person C, and an acknowledgment of the dimension to the situation, its context, and consideration of just this world, and relief from circumstantial pressures, or a re-interpretation of them, etc. … even a discussion of the interpersonal and what was meant – all this can go far. But these types of things never happen, in a psych unit. Instead, it’s the biogenetic theory and a-priori decisis praxis.

Endnote – Three Ways To View The Cause, In Psychiatric Theory

It seems to me that with the biogenetic model, psychiatry has to explain it:

1) Is it a permanent biogenetic malfunction that interrupts the normal function of the ego?

2) Is it a permanent biogenetic malfunction, that permanently alters the ego, giving it certain features -- 'ego-color', that is 'mentally ill'? And that, again, the ego cannot reverse? That is, once this marker ‘mentally ill’ has been established as the permanent ego-color, no amount of effort, realization, mental change, or explanation can yield a further different color – and this color is a mark for a lifetime of coerced treatment.[1][2]

Corollary: In line with the research that I cited being done at NIMH, is this 'ego-color' (now permanent), that is, the state 'mentally ill', established genetically and in brain structures that can be measured?

3) Is it an introduction of permanent biogenetic malfunction features to an otherwise normally functioning mind?

My own positive experience with Zen Buddhism, and a deleterious experience with psychology: the mind is mutable. It is one space, thing, and no-thing with the world-space.

If the mind is in a state of 'ice' or 'fixed', then it might be difficult to work with this mutability. This mutability can become very tangible, a working fact, with sudden insight or dedicated effort and proper guidance -- and time.

This should be fruitful!

Footnotes

1. This is, given a fact of the ego. If it's not ego, then one might notice all sorts of dimension to the individual, person A, person B, person C, the situation, context, and world-space. See my MVO: 2019 Thesis. See The Diamond Sutra in *The Diamond Sutra And The Sutra Of Hui-neng* translated by A. F. Price and Wong Mou-lam. It is worth attention, reflection, zazen (or other meditation), and considered in the actual world, this world.
2. The psychiatrist might say, once we've established this ego-color as being 'mentally ill', without really considering the nature of 'color' (except that the individual has a 'disorder', in DSM terms – and no more, no less, no different, at all – biogenetic), then we no longer have to discuss the person's content (of character, standpoint, projection, and interpretation) and world-space; and never in any case consider these at all (except for the inherited "correctness" of the complainant's statement and its absolute merit), in these terms and actualities, before, during, and after. And since we never in any case consider these, we can a-priori decisis decide that the individual is mentally ill, has this ego-color (again, sans all actual totality description), that it's in DSM (disorders pardigm) terms, and that it's permanent – and coerce treatment. No alternate path is suggested, and potential, the material, and possibilities are denied as relevant or potential. Furthermore, the individual has no say in the matter, and reason – reason itself – is kept off the table, as are the items of the complaint, a description of the situation, the merit of anything that can be discussed, and the biogenetic theory itself, and so forth. And if we can trace this ego-color (mental illness, and all that any person ever is) back to genes and brain imaging, then we've solved it again, in this fashion, in a strictly one-sided materialistic way. The psychiatrist holds the objective view. The individual is never participant, and a-priori decisis the psychiatrist determines that the individual cannot reason, at all, nor present his or her own standpoint, nor discuss merit, ethics, action, and belief, nor explain, nor justify, nor switch in mind or action, nor learn, nor change. In addition, the psychiatrist neither thinks nor talks in terms of neuroscience: cognitive maps the individual might have (a part of what I term standpoint), social maps, an appreciation of the temporal-spatial, decision and why, switching in mind, learning, feedback, and training.