In Other Words, Psychiatry Does Not See – Even Claims That All Such Does Not – That The So Much In Real Life Applies

By Kevin A. Sensenig
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Thesis Point

In other words, psychiatry does not see – even claims that all such does not – that the so much in real life applies: it claims that the individual cannot work with this so much in real life.

Item

Aristotle's philosophy of virtue can be taken up, or Kant's moral normatives and reason, even Bentham-Mill's consequential utilitarianism. Christian, Muslim, Hindu, Indigenous, or Buddhist ethics can be taken up.

These change the brain-as-mind; or the brain intersecting mind in a mutually conditioning, nondual way; or the mind, reason, perception, and action – the actual domain of psychiatry having nothing to do with a biogenetic condition. Unless the biogenetic condition necessarily compromises this in totality up front – rendering such change impossible. I would argue that this is unproven, in fact that its opposite can be proven, and that psychiatry has not scrutinized the individual or situation in these terms in the first place, at all. In fact, it does not consider them relevant. Yet it makes its theory-in-praxis claim that all such effort is irrelevent and immaterial.

But by excluding these – and the standpoint of the individual – in the first place, it does not acknowledge what is actually there – and so creates an unreal, specious space, and erroneous conclusions. And it provides no tractable material for the individual to step to.

See attached PDF for some interesting comments on philosophy – which should be introduced in high school. This would, given the right approach, allow a path for the high school student to be participant in society; and to ascertain, challenge, or work with some of the fundamentals of our culture, from a Western standpoint. The student can bring his or her own thinking, and material from-diverse-cultural-views, to the table. (See Quora comment on Aristotle, Kant, Bentham-Mill.) I feel to treat the high school student as capable of probing and mature thought can address some of the malaise and dislocation – and vacuous experience – of some of the American high school experience. This makes it experiential, in this way, along with superb classes in other topics, extracurriculars, and the student's own life, family, friends, mentors, and colleagues – and societal participation, even perhaps including

studied and reflective solitude (even reading literature is reflective and solitude! We should make philosophy another such topic, and it should be participant.).

Item

Psychiatry sees in terms of deficiency, biogenetic malfunction, and the disorders paradigm; and it uses an idea of the median of behavior as an existent fact and reality, the thing of referent itself (and this is never discussed; nor is the possibility of the combinatorial-and-principle-and-view-and-experiential-and-perception-and-reasoning (I wonder if there's a Sanskrit word for this, but for now the English catenation will have to do; it would have to be defined anyway) ever realized, acknowledged, or discussed, at all). That is their world-view, and theory/praxis. They cannot see any of what I mention – nor that this, too, resides in the very being of the person – in conjunction with the world-space. They never discuss the actual with the individual, in a psych unit or followup. The psychiatrist discusses neither standpoint, understanding, thought, speech, action, awareness, effort, the domains of life (the mental, the existential, the social, the societal, the experiential, and the physical), the various states (mental states, emotive states, intentional states, physical states), nor thought space, energy states, perception. The psychiatrist in fact never discusses the situation, facts, the complaint, the basis for the diagnosis, the diagnosis itself, or the psychiatric biogenetic theory pointing (so the theory goes) to permanent neurobiogenetic malfunction. The psychiatrist never discusses the mind, truth, and the body-breath-mind-world-space. The psychiatrist takes an adversarial stance to the individual, oftentimes in person (that is the standard praxis) during "treatment meetings", and always in court testimony.

So, psych unit psychiatry omits, contradicts, and refutes all of this as being applicable, relevant, material, or possible – then (and this is a given in society's psychiatric practice) without explanation or elucidation of its own theory and praxis, takes the adversarial stance with respect to the individual, and is the society-approved provider of the representation of the individual (always in terms of absolute deficiency, and setting aside 'all of the above') to the family, the state, society, and the individual.

It's pretty bleak, a desultory landscape devoid of meaning or, ultimately, reality and actuality.

Psych unit psychiatry's treatment in terms of isolation in a psych unit – usually with very little to do – needs to be turned to the idea of resource, solitude, the social, and excellent, practical classes and one-on-one. It needs a review period so that situations can be factored out and seen for what they really are, in an equable and just manner. Its other treatment – meds – may work for some, but meds should be used selectively and in a framework and context of mvo-p psych and 'all of the above'.

Item

Further followup.

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Further note.

If it is a conflict between a person A and person B, and person B faults person A, then psychiatry – many times, perhaps, and in all cases in a psych unit – identifies person A as the individual with absolute deficiency, total fault, and a disorder indicating biogenetic malfunction – and never penetrates or identifies the actual nature of things, nor the merits of person A, person B; especially if a totality-view is seen in the first place, by an observer, as the framework and basis (mvo-p psych, for instance). It might note a fact. It might get facts wrong; and it never has a totality, equable view. It omits so much.

It does not identify 'conflict' or 'the substance to a particular conflict'; and never seeks or permits the individual's standpoint, explanation, description of dilemma or no dilemma in the domains of life, the domains of life themselves, or reason – reason 'on the table'.

If there are particular types of mental events, these are not well characterized or described, as per the individual experience, but typed to a disorder, based upon a third-party account. This account may or may not be accurate in the first place, and the mental event is in any case not penetrated as to its actual experiential reality, spiritual or religious significance, meaning, useful descriptions, and tangible working-space. Logic and reason, and the working-through of things is not acknowledged nor is it seen as possible to do so. (I'm here thinking of certain types of "psychotic" thought. But there may be antecedent to this: the Buddha refuted Mara and an army of demons at the time of his enlightenment; the story goes that arrows the demons shot at him turned to flowers in mid-air. Rajava's experience in *The Lankavatara Sutra* (translated by D. T. Suzuki) is relevant. Jesus Christ was tempted by the devil. There may be entire domains of spirituality and the mind that should be considered – and looked to for insight: not to penalize entire groups of individuals who may or may not encounter disorientation at such a landscape. Accurate perception, an able stance, and wisdom could be looked to. On other things, thought-space and thought-points might carry their own nature that sometimes is interpreted to be psychotic; yet the reasoning-points may be sound, or they can be penetrated, and the expressions may be fine or not, understood or simply out-of-context, from the standpoint of another. If for another individual, it is a depressing or troubling thought, then the individual can note that thought and let it go, perhaps introducing though C to thoughts A and B. Perhaps mindfulness or meditation, or a scripture verse or a prayer, or a new philosophical expression, or a strategy gotten from narrative, can be undertaken. This all should be acknowledged. Psychiatry is at least 2,600 years, 2,000 years, and possibly much longer, out of sync with the human experience. (Its only recourse is confinement, isolation, and meds or ect. Another tool it used to use until it was banned by law – not voluntarily, but by an act of the United States Congress – another tool it used to use was surgical removal of parts of the brain.) Perhaps indigenous experience could be looked to, as well – don't know. Inasmuch as they haven't been already, throughout history, been "surgically removed" by the same colonialist a-priori

decisis, stare decisis attitude, themselves. We should look to the indigenous for insight and wisdom – they only flourished for 10s of millenia, in sustainable ways, on this planet. They worked out themselves-and-this-planet, themselves-and-the-world-space. Obviously, I include the American Indian in this.) And we have some mental events in response to the external world; and other mental events in response to yet other mental events, or as synthesis and reason. Perception plays a role in this – and it is body-breath-mind-world-space, arising at-once, dependent arising (pratityasamutpada), and in the present moment.

I have a significant statistical sample, for the psych unit and followup. Multiple psych unit commitments have yielded this. The benefit of r&d and the experiential-observational. And the Zen Buddhist material. And the various influences such as college, physics, philosophy-logic, Marvin Minsky, Edward Tufte, Ludwig Wittgenstein, Karen Lebacqz, and everyday experience. I can go further, as with the philosophy on virtue, etc, to get other perspective, and to enhance my own perspective. If I was going to be treated the way psych units and followup do, then anyone would be treated so. I was willing to be participant, explanatory, and to resolve things, in every case. None of my thought, speech, or action contradicted basic ethics, and now I've taken ethics deeper, and continue to do so. My cases were: inliers of behavior (penalized!), outliers of behavior (misinterpreted, and their logic not sought out but denied a-priori), significant merit (not acknowledge; set aside and ignored, seen as not relevant), and some mistakes (misunderstood and set outside of context; no explanation or switch was permitted). In all cases I needed to retain a clear mind, without the sedation and part- or significant-disabling features of meds, to present myself and situation, and explanation, context, and discussion of merit and demerit, or switch in thought, speech, or action.

The combinatorial, and ‘combinatorial principle unfolding interconnected relational action-memes’ idea (my term as an slight extension to one of Marvin Minsky’s significant ideas in *The Society Of Mind*), might account for much of this that I saw and worked with in mind, speech, and action.

Buddhists have studied the mind deeply and in profound ways, and work with the mind, truth, and this very world, including the interpersonal. Realization occurs – and this is body-breath-mind-world-space. I take my journey deeper, but the past 3 years have been tremendously fruitful. (In Zen, you can mature a practice slowly or more deeply as one goes along – and I did mine a certain way – but in any case it can take some time to penetrate the matter. I have done so, now, to a significant degree – and can take it much deeper and more extensively. It is joy and the fusion of fun and serious.) It is particular, disciplined, detailed, and expansive. It is explanatory; and it describes a path and paths.

Psychiatry – exemplified especially in psych unit psychiatry and followup – has such a narrow view of the biogenetic that it cannot take into account nor explain much. Yet it is a dominant theory and praxis in American society. It is a 250-year-old theory and praxis. It can be scrutinized and reasoned about – as a philosophy that would try to exclude the so much in real life that applies (including all philosophy; spirituality; religion; psychology; speculation on how we think and why, and act; dialogic; discussion of understanding, thought, speech, action, effort, and awareness; the very world and its nature; the domains of life (the mental, the existential, the social, the societal, the experiential, the physical); the mediative; the everyday; language; other viewpoints; the participant; etc.). This is the state of things.

25% of Americans are on psychiatric meds. States support the psychiatric theory and praxis, and support the theory and praxis used in the psych unit, and the psychiatric logic therein. Psychology reference it. It is a dominant theory and praxis in American society.

The State needs to review psychiatric theory and praxis. It needs to look to adept philosophical, spiritual, religious, psychological, dialogic, mediative, descriptive, and everyday reasonable, insightful descriptions, terms, and actualities. It needs to ask questions about givens, and probe psychiatric logic to determine something much more compelling, that acknowledges the dimension and potential of each individual and situation, and to redefine the approach to difficult situations and what is apperceived – and the questions that are asked. It needs to ask questions about the nature of our existence, and what people in society work with, from all angles and points of view and experience, and how that illuminates. Then the State, the profession, and society will be able to work with dimension, vocabulary, logic, reason, realism, description, the participant, and explanation. We then can sort through things much better, noting both at-ease situations and dilemma situations, and shades and grades of these – and know better how to recognize and work with each of these, in realistic, disciplined, structured, dynamic, flexi, responsive, and compassionate ways. There are going to be difficult situations. There are going to be at-ease situations. There are going to be situations with points in between. It's about perceiving, ascertaining, and reasoning about what is actually there, what the actual situation is, what is actually the case, in all reality, from multiple angles, using dimension descriptions, and taking appropriate action.

In many ways, each type of expression is just an expression, the thing itself – but actual and lived in the present moment. The whole world is Suchness – so what is present? And expressions and experiences of many types should be looked to – and, to see the world as it actually is-and-unfolding, the infinite instances-and-occurring of this Suchness – they exist in society, history, and thought and practice, theory and praxis, both ancient and modern.

Mvo-p psych.

That should do for this thread.

United States
2003-2020

Endnote – Resources

And, I rely on third-party analysis also, say on the online magazine Mad In America. And on Ubuntu Linux and LibreOffice Writer to write. Obviously, I now have my partial freedom, although the current 'state of the art' is to keep me on meds, setting aside (as, realistically, the psych unit also would), 'all of the above'. The individual needs an Advocate in a psych unit, an Advocate with a Surface or an iPad, recognized by the State, and trained in mvo-p psych and justice theory. The individual doesn't have a

computer or computer system with archive and records. The psych unit does, and the psychiatrist takes an adversarial stance with respect to the individual – and they also get all the funding – the individual sees no financial support through the process, only financial, freedom, and positional detriment. Usual disclaimer: some individuals may benefit from this or that experience in a psych unit. I never did – except for what I studied of my own resources from my own apartment, during that time, or notes I took.