Jack, Jill, And The Baseball Bat

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Draft 1.03
2019 April 5

Here's the formation to a new paper. It’s a story:

Jill: Jack! Mike is misbehaving! He said to himself, "I am hitting the ball right." while imagining that he's a professional baseball player! Hit him with a baseball bat!
Jack: Right!
Jack: There, that should do it!
Jill: At least you stopped his errant mind.
Jack: Right. When he comes to, I'll give him some neuroleptics. I'm a psychiatrist-type.
Jill: Right! Wonderful idea! Just don't say anything about his mind.
Jack: Right. I never do. That is something I know nothing about.
Jill: Right! Neither functionality nor perception, no nothing. We can't talk to him about anything meaningful.
Jack: Right. Nor 'right behavior'.
Jill: I wonder if he thought, "I shouldn't talk to myself."
Jack: He should have. It's the neurobiogenetics should take care of that.
Jill: Right.
Jill: He's coming to.
Jack: There. I've injected him with a neuroleptic. That should keep him for 30 days.
Jill: Then we'll administer another dose?
Jack: Yup!
Jill: Oh wonderful wonderful! Just don't say anything, remember, about the mind.
Jack: Oh, that. Right. Of course. Wouldn't think of it, in any case.
Jill: Oh wonderful, wonderful!
Jill: And neither say anything about perception, the mental and the physical worlds, world-space, mental states, emotive states, intentional states, physical states.
Jack: Never do.
Jill: Maybe we should commit him to a psych unit.
Jack: Right. He's delusional.
Jill: Right! And don't say anything about joy, centeredness, dilemma or no dilemma, questions, perspectives, challenges, and helpfuls and usefuls.
Jack: Never do!
Jill: Nor thought space, energy states, perception, speech and action, and patterns of speech and action.
Jack: Nope!
Jill: And do not, I suggest, introduce the idea of the domains of life: the mental, the existential, the social, the societal, the experiential, and the physical; and how these might interplay and be variously active in one way or in another.
Jack: Nope, no worries. Everything’s either a mental disorder or a behavioral disorder. We don’t try to explain these too much. Nor any of this, really.

Jill: Bravo! Bravo!
Jill: And please oh please don't introduce the idea that there may be grades to dilemma: crisis dilemma, significant dilemma, part dilemma, no dilemma, and no-dilemma; and sometimes with mixed, in different domains or other categories, or even in the same domain or category!
Jack: Nope, again: no worries! In a psych unit, everything is a crisis. All events are categorized that way.
Jill: And don't mention philosophy, spirituality, psychology, speculation on how we think and why, and act, the dialogical, etc., and their interpretations. That might be seen as applying too much, or as key drivers for behavior and action.
Jack: Nope! It's all the neurobiogenetics.
Jill: And definitely not that any of this – any of 'all of the above' – might be considered from a noumenal and phenomenal perspective, or that any of this might be interconnected or dependent arising.
Jack: No way! Of course not! That's much too in-depth.
Jill: Nor a discussion of the event, or situation, or its context.
Jack: Nope! Omitted.
Jill: No explanation permitted?
Jack: Nope. And even if the individual is perfectly low-key and cooperative, we usually inject him with a sedative that renders him unconscious for 12 hours or so. And the selective use of meds is never considered, much less in open dialogues with the individual. It's meds, and always meds. And just about only meds, if we can help it, that is relevant. We rarely have sufficient classes and definitely rarely if ever 1 on 1. We certainly don't consult with the individual, or invite them or permit them to be participant.
Jill: Well done! Key insight and praxis!
Jill: Nor anything of his own standpoint, or discussion of merit?
Jack: Of course not! And they'll take care of that at the psych unit. Omitted, contradicted, and refuted.
Jill: Nice! Nice to know! A free day in America! The free market at work!
Jack: I know! One more person found and helped to center and avoid danger to self and other!
Jill: Right! The power of delusion. Just don't discuss centering with him. Nor that disorientation, re-orientation, and orientation all might be discussed. All right?
Jack: Of course not! The meds took care of that. It's all in the meds-neurobiogenetic combination! All of 'all of the above is'! That's why we keep 'all of the above' hidden, and off-the-table!
Jill: What a success story!
Jack: Anything else before I phone this in?
Jill: Yes! Yes there is Jack! Just also please oh please don't let him bring reason to the table.
Jack: Nope! Standard practice! And at the psych unit, if he tries, he's termed more seriously mentally ill, and further treatment required! For being unable to see into his own condition! It's impenetrable, and judges buy it!
Jill: No kidding! How wonderful, wonderful! Another free day in America! I just love the logic!
Jack: Standard operating procedure. We'll just give him a term like shizophrenic bipolar I manic. These other terms are too obscure. Wouldn't be comprehensible.
Jill: Right! Just one more thing. Don't ever tell him that we can change our own minds. We can do a switch! And that sometimes that happens, and oftentimes is useful! It's just what we do! But don't tell him that, OK? Please?
Jack: Never in a million years! He's already talked to himself and has delusional ideas about being a professional baseball player when he's just 10 years old. He already clearly has demonstrated

permanent neurobiogenetic malfunction. Sad to say, can't be straightened out, except on maintenance and corrective, by a lifetime of meds!
Jill: Oh, wonderful wonderful!
Jack: And then we can put him on disability income, from the federal government!
Jill: Oh, nice! How wonderful wonderful! You mean the meds don't absolutely bring back a fully functional state? How wonderful, wonderful!
Jack: Well, there's sedation, and, no, sadly, he'll be inwardly delusional for the rest of his life, except for the compensating factor of meds.
Jill: How sedating are they?
Jack: Well, he may calm down from his hyper-excited state. Then he may sleep a lot.
Jill: And are there side-effects?
Jack: Yes! There are! Drowsiness, significant increase in sleep, and unable to work fulltime, lack of alertness, weight gain, likely less brain mass, inability to truly, deeply challenge the diagnosis.
Jill: Why, that's right where we want him! Too bad about the drowsiness, but probably keeps him from his delusions. But the others sound great!
Jack: I'm glad you think so! Psychiatrist-types have thought of everything!
Jill: Oh, hallelujah! Wonderful, wonderful! So he's now going to be fine?
Jack: Yes, he'll be just fine.
Jill: Just remember, and seal this in your precious oh so brilliant mind: don't ever say anything about the meaningful content that I stated not to.
Jack: Never. Never in a million years.
Jill: And he won't have the opportunity to explain or justify himself to the psych unit psychiatrist?
Jack: Nope! He won't have a chance to! He won’t have a chance!
Jill: Oh wonderful wonderful! Joy indeed! Glory to us all, we psych types!
Jack: I know, isn't it brilliant?
Jill: How much do you psychiatrist types get paid for your brilliant minds and theory to exclude everything except the neurobiogenetically relevant?
Jack: About $200,000 per year, median, 1 standard deviation $160,000-240,000! Is that justified, in your humble view?
Jill: Oh, justified indeed! Very fair!
Jill: Well! We've solved it for another outlier from the standard deviation in society! I'll bet he won't do that again!
Jack: Yup! And the wonderful thing is, we don't announce the rules up front, or work with a philosophy of life perspective. That way they have to figure out the rules as they go along.
Jill: Yup! Got to keep them on their meds. It's neurobiogenetically necessary!
Jack: That's the wonderful part!
Jill: And you’ve already covered the ground with the crazy ones, the misfits, the rebels, the round pegs in square holes, the ones who see things different, the ones who drive the human race forward?
Jack: Yup! Done in the late 1990s with the free-for-psychiatry Apple Think Different ad series!
Jill: Wonderful, wonderful! How delightful to have inverted that one!
Jack: Yes, quite! Steve Jobs never met the psychiatry and psych unit psychiatry system!
Jill: As opposed to the Mind-system of the Lankavatara Sutra!
Jack: Indeed! Indeed!
Jack: Well, here are the police and the ambulance. He should be just fine.
Jill: Hand off the paperwork and we can be on our way!
Jill: Want to meet tomorrow to discuss more about biological pathways from the brain to the brain?

Jack: Yup! And I'm getting your pattern. We won't discuss decision-making at the structure-of-the-mind-layer-to-speech connection! Nor awareness, nor understanding, thought, speech, and action; nor effort! That's too much of the Buddha!
Jill: Yes, yes, that's it!
Jack: Nor the nondual and the mind-body-breath connection! Nor nondiscriminating mind!
Jill: Precisely! Brilliant, brilliant! You haven't been studying Zen Buddhism for nothing! That's how sharp you are!
Jack: Thanks Jill! I really appreciate that!
Jill: Have you gotten to the part where Master Mumon says, "The Buddha-mind is the basis, and gateless is the Dharma gate." Or, anything like that?
Jack: That precise statement! It's in Shibayama's "The Gateless Barrier"!
Jill: Oh, how significant, how wonderful! I can't wait to introduce you to Marvin Minsky and Wittgenstein!
Jack: I'm looking forward to it! We should be able to invert that, too! What about Aristotle? And Edward Tufte!
Jill: Yes, indeed! Wonderful, wonderful! A glorious day in free America!

Kevin

Endnote (Experience)

I don't know what psych unit psychiatrists say to someone who has attempted suicide. Perhaps that person finds relief, or not. Outcomes from the standpoint of the individual, in practical terms, should be studied; and best practices re-inforced.

Psychosis and depression should be taken seriously (and also grades in between), in the same manner as all of life – but with 'all of the above' it gives context, proportion, and the mvo framework – which should be taken equally seriously, as should the dimension to all of life, yielding work and play, the esoteric and the everyday. The experiential is key. This yields a dimension, vocabulary, logic, reason, realism, descrption, participant, explanation standpoint, for the psych unit psychiatrist and those they touch.

Perspectives should be sought that cover all those who have been committed to a psych unit in the United States: Do you feel more isolated from the world or more connected to the world (a) as a result of the psych unit; (b) as a result of other personal effort; (c) as a result of philosophy; (d) as a result of spirituality; (e) as a result of psychology; (f) as a result of speculation on how we think and why, and act; (g) as a result of narrative; (h) as a result of the dialogical or open dialogues; (i) as a result of other resources; (j) as a result of everyday effort; (k) connection with other people and the social-relational. More than one answer is just fine. Please feel free to answer what, why, who, where, or how, or other description.

And the question: Was any of 'all of the above' presented? Even the selective use of meds? Or was it always meds, only meds, a diagnosis of absolute deficiency, and very little explanation – including none of 'all of the above'?

Endnote (Feynman)

I recommend the book “Surely You’re Joking, Mr. Feynman” by Richard Feynman. Feynman was a physicist from the 20th century who was creative, reasonable, expert, and accessible – and the anecdotes he tells in this book include one on his encounter with psychiatry. He was found deficient, and his account is hilarious and cutting. Then one could read “No Ordinary Genius” by Christopher Sykes, a fascinating record of Feynman with insight and elucidation.