Psych Unit Psychiatrists: Ditto – And Profile Recommendations

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Psych unit psychiatrists.

Sometimes they work with deep crisis.

The genuine psych unit psychiatrist wants to solve a problem. They may mis-identify the problem, misunderstand the problem domain, and likely will not consider the field of experience and representation and even the very real, as it actually exists.

They identify routine dynamic behavior as indicating a diagnosis of absolute deficiency.

They identify a-routine dynamic behavior as ditto.

They identify partly routine, partly a-routine dynamic behavior as ditto.

They identify what is not apparently (even if it is so) peaceable, predictable, and ethical as ditto.

They do not ask for or identify the logic of the individual.

They do not ask for or identify the mental, emotive, intentional, and physical states of the individual.

They do not ask for or identify the joy, centeredness, dilemma, questions, perspectives, challenges, and helfpuls and usefuls of the individual.

They do not ask for or identify the standpoint of the individual.

They do not ask for or identify the actual social-relational space of which the individual is a part.

They do not ask for or identify the individual as participant.

They do not ask for or identify partial states of the individual.

They do not identify the individual as say 90% functional, some challenges or dilemma; but rather indicating a diagnosis of absolute deficiency. [And the 90% idea is an entirely useful and realistic category.]

They identify all problems in society that an individual might have, that they encounter as a result of the mind (or decision or emotion or social-relational), as being a disorder. A permanent bio-genetic disorder or malfunction of the brain. But in being of the mind, decision, emotion, or social-relational, they should consider each individual and situation in terms of these – the mind, decision, emotion, and the social-relational. They should be able to describe world-space, and the individual-and-the-world. And they should be able to describe function, exceptions, partial function, and dysfuction alike – explanatory and with a view to models and causes – and not the narrow view of permanent bio-genetic malfunction in the brain, that considers only in terms of diagnoses of absolute deficiency. The physical (brain) informs the mental (mind) and vice-versa; and the mind should be taken into account, and an understanding of the mind, as well as perception, understanding, reason, synthesis, merit, speech, action, standpoint, the breath, the body, diet, exercise, the social-relational, the experiential, meaning, apropos world-space, and the selective use of meds (for certain situations).

They do not factor the domains of life: the mental, the existential, the social, the societal, the experiential, and the physical, in approaching any individual or situation, even if (and they usually would) these domains would apply. Instead, they categorize all dilemma in all domains as a bio-genetic disorder (a bio-genetic malfunction in the brain, no content, no meaning, no world-space, no thought-realm, no description). With the only recourse meds. For a lifetime.

They do factor out behavioral health and mental health, with mental health being a subset of behavioral health. The term ‘behavioral health’ is strong if it points to action. The term ‘behavioral health’ is counter-productive if it denotes micro-management of speech and action (and their patterns, behavior). Mental health is one field of behavioral health, and is its own thing. So this aspect is workable.

Yet – all of this – and they ditto.

Etc.

Any such mistakes on the part of psych unit psychiatry that are indicated here should be corrected. That would be a step to psych unit mvo-psychiatry – a significant step. Then, there is a dimension profile of the individual (and likewise the situation), and part of this is spelled out again as follows. This, then, would be the second step to mvo-psychiatry.

Psych unit psychiatrists

Sometimes encounter mental dilemma.
Sometimes encounter existential dilemma.
Sometimes encounter social dilemma.
Sometimes encounter societal dilemma.
Sometimes encounter experiential dilemma.
Sometimes encounter physical dilemma.

These are in the domains of life

The mental
The existential
The social
The societal
The experiential
The physical

These are the domains of life.
Each can be characterized and described.
Sometimes, maybe often, dilemma is a combination of grades of dilemma, among these domains of life.
Each can be characterized and described.
This sets context and meaning.

Psych unit psychiatrists

Should describe these.
Diagram these.
Apply the noumenal to these.
Apply the phenomenal to these.
Apply the interconnected to these.
For each individual and situation.

The individual can be described in terms of the resilience factors:

Joy
Centeredness
Dilemma
Questions
Perspectives
Challenges
Helpfuls and usefuls.

Psych unit psychiatrists

Should describe these.
Diagram these.
Apply the noumenal to these.

Apply the phenomenal to these.
Apply the interconnected to these.
For each individual and situation.

These can be applied to the domains of life.

Psych unit psychiatrists

Should consider each individual and situation in terms of grades of dilemma:

Crisis dilemma
Significant dilemma
Part dilemma
No dilemma
No-dilemma.

This can unfold over time.
They should acknowledge, describe, address, and explain.
They should tie these into the domains of life and the resilience factors.
They should retain (and perhaps re-formulate the context of) best practices in dealing with crisis dilemma.

If the individual is admitted to the psych unit, the psych unit psychiatrist and psych team, with profile and standpoint in hand, should take up the following:

Philosophy (statements, quotes, reason, view); spirituality and its applied basis; practical and proven psychology; speculation on how we think and why, and act; narrative; open dialogues; the social-relational; diagrams and description by, for, and with the individual; excellent classes; 1 on 1; the participant; dynamic working with the profile of the individual; the selective use of meds; and pointers to state, agency, and organizational resources.

A portfolio would be created with and for the individual. This could be used by the psych unit psychiatrist and psych team, by the individual with the psych unit psychiatrist and psych team, and in his or her own personal life and development, and in followup treatment.

In addition, psych unit psychiatrists

Should consider the mind, the mind that is the individual's, that the individual has before him or her.
Should model theories of the mind, with practical vocabulary, observations, and the experiential.
Should put reason, 'reason on the table', with the individual.

Should have the individual as participant.
Should acknowledge the standpoint of the individual, and his or her logic.
Should acknowledge and work with the world-space of the individual.

This then would be psych unit mvo-psychiatry.

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