Psych Unit Psychiatry Contradicts And Refutes ‘All Of The Above’

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‘All Of The Above’

When I refer to ‘all of the above’ I’m referring to the following, in considering an individual, those he or she touches, and the situation, in a psych unit scenario; and note that many of these things apply as routine descriptors of everyday life, just one way to view things.

The states: mental states, emotive states, intentional states, and physical states. The resilience factors: joy, centeredness, dilemma or no dilemma, questions, perspectives, challenges, and helpfuls and usefuls. The domains of life: the mental, the existential, the social, the societal, the experiential, and the physical. The basic descriptors: thought space, energy states, perception, speech and action, and patterns of speech and action. The grades of dilemma: crisis dilemma, significant dilemma, part dilemma, no dilemma, and no-dilemma; and how these would apply overall and to the domains of life and to the basic descriptors.

Then there is the following, that applies: philosophy; spirituality; psychology; speculation on how we think and why, and act; narrative; diagrams and description by, for, and with the individual; open dialogues and the dialogic; mediation; the relational, including thought-relational, social-relational, and unfolding world-space; excellent classes with discussion; 1 on 1; fundamental resources; pointers to state, agency, organizational, and private resources; and, in the psych unit setting, the selective use of meds.

Then also there is: standpoint (of all those involved or not directly involved); the participant (including that of the individual); merit; reason – reason ‘on the table’; discussion and dialogues; factoring in; the situation, as described from various standpoints; and world-space and unfolding world-spaces, encountering each other.

This results in deeper insight and just outcomes. This should apply in the psych unit, and psychiatrists should be trained in such. It has to happen at the psych unit psychiatrist’s level – as well as the psych team. It would mean dimension, vocabulary, logic, realism, the participant, description, and explanation – and would be either a delight or a comparative opportunity to unfold, for each of those involved. There will remain difficult situations, and there will appear not so difficult situations, perhaps each more further resolvable, as a different approach is taken up.

This would be what I term ‘mvo-psychiatry’, for mental view and orientation psychiatry. Mvo-psychiatry would be multi-disciplinary.

Psych Unit Psychiatry And Refutes 'All Of The Above' – And A Way To A Dynamic Path

It's tough to find one's way, through the psych unit system. At least, one needs Dogen's statement, "Some go to the river to catch fish, some to catch the Way, some to catch themselves, some to catch catching."[1] This statement also indicates 'all of the above', and is a really nice statement.

It's tough to find one's way, through the psych unit system, when the psych unit psychiatry[2] proactively sets aside 'all of the above' as being relevant or meaningful. It denies the applicability of the philosophical, the spiritual, the psychological, the speculative on how we think and why, open dialogues, and other like resources for the individual. It contradicts the idea that there are domains to our being here: mental, existential, social, societal, experiential, and physical (and joy, centeredness, and dilemma or no dilemma within each of these, that may apply; and that each of these and each of the domains is a noumenon, at the same time interconnected with the rest). It does not consider in terms of mental states, emotive states, intentional states, and physical states, or their expression. It does not consider thought space, energy states, perception, speech and action, and patterns of speech and action – the relational and merit, and the noumenal, phenomenal, and interconnected of these. It does not consider the individual standpoint, nor the unfolding interplay of the subjective and the objective. It does not consider things in the realistic terms of crisis dilemma, significant dilemma, part dilemma, no dilemma, and no-dilemma. It proactively refutes and denies right to 'reason on the table', with the individual. It contradicts the idea, 'the individual as participant'. It contradicts and refutes the idea, 'representation of the individual, by the individual'.

It refutes and sets aside that this is the individual's world, is the individual, along with his or her relational to others, to things, and to space; is the situation, is the world-space before it. It does not consider that this is a mutually co-arising world-space, that the psychiatrist, the psych team, the individual, others, and the situation are standpoints in, with various views.

And it refutes and sets aside the idea that the individual can describe and work with 'all of the above', in a realistic and applied manner.

It often does not consider in terms of actual facts, much less Wittgenstein's 'the world is all that is the case'. But actual facts are included in 'all of the above' – and so is context.

It does not consider, at all, in the first place, 'the mind, the mind that is before one.', much less any truth body like Nagarjuna's four reliable facts: reason, the present moment, the external world, and reality. Or St. Paul's admonition, "Be transformed by the renewing of your mind."[3]

It does not consider the real, and what might be actually the case, for the individual and those he or she touches.

Thus, it's difficult to find one's way, in a psych unit and having gone through a psych unit, where the individual is now stated only in terms of absolute deficiency, deficient in an irrecoverable sense, on meds for lifetime, as the sole resource. Yet – and this is significant! – the dilemma or not facing the individual and those he or she touches, and their worlds, may be described in terms of 'all of the above'

– but this is contradicted and refuted, by the psych unit psychiatry. And during a psych unit stay, and having gone through one, psych unit psychiatry – the psychiatry itself – presents none of 'all of the above'. Yet – again – this is or could be the individual's world, and those of those he or she is in contact with, it is reality.[4] And the individual's world could actually be one of ethics, strength, and no-dilemma: yet, the result is a diagnosis of absolute deficiency. The individual is given no right or opportunity to explain, or represent himself or herself, or his or her world and life state.

In psych unit pychiatry, 'all of the above' – and even meaning, itself – is set aside and proactively rejected as relevant (and this is enforced). Again, none of 'all the above' is rendered meaningful for the individual, or that it applies. In fact, psych unit psychiatry refutes and sets aside the entire world, except the record of a few, which may or may not be accurate, and which may be very biased – and is certainly not 'all that is the case' – and except for the strict rule of meds, for a lifetime, as the only resource.

But meds are not the only apropos medicine – 'all of the above' is apropos – and only when psych unit psychiatry begins to take up such a language, and a study of the mind and what one perceives, and its interdependence with the physical, and the existential, social, societal, experiential, and physical, and mutual co-arising with it and of these, and this very world itself, will it begin to tap into a state of dimension, vocabulary, logic, reason, realism, description, the participant, and explanation. This is a redefined framework. It might include the selective use of meds, but only selective – and certainly would introduce ideas of 'all of the above' to the actual psychiatric practice, and psych team awareness – toward a deeper sense of addressing dilemma, or justification, and determining just outcomes. The description 'all of the above' is powerful, and has a complete feel to it. It is also extensible.

When it introduces such theory and praxis, psych unit psychiatry will then and only then begin to have the means to discuss the matters that come before it in a manner that is dimension, vocabulary, logic, reason, realism, description, the participant, and explanation. This is what the world-space is.

This redefined theory and praxis will have outcomes for just results, and for the benefit of the individual, and those he or she touches, and society and the state. In addition, we will have a deeper sense of 'truth' to pass around, and consider. This is consistent with Rawls' sense of justice,[5] and is simply a way that we consider the Way, or this or that truth-body.

Psych unit psychiatry must include the idea 'worlds within worlds, coming into contact with and mutually co-arising with each other'. This is what life is, it is the very world before us, and as Nagarjuna states, it is when we consider the fusion of the abstract and the concrete that we see the real world, before us.[6]

Not all crisis will be resolved. But the questions and answers will go much deeper – in fact, for the first time, they will be of depth at all, and not inverted, from reality and 'what is the case'.

Endnote 1

This paper is an excellent exposition of a significant part of my thesis that I've developed since 2014, especially since 2017. It is that so much is relevant, and psych unit psychiatry inverts the entire world, to its own vacuous ends, only occasionally introducing helpful treatment; but its theory/praxis is less than helpful, and contradicts and refutes 'all of the above'. Psych unit psychiatry is consistent with one of the problems in today's society in America: an amount (for some) of experience that is desultory, vacuous existence, devoid of meaning and engagement, or filled with disorientation and a lack of intellectual, spiritual, spirited, dynamic, etched, philosophical, common sense, literary, artistic, reasoning and so forth resource – that the individual might want – to make one's own 'class'-type. There is a lot of this, and there is a lot that is dynamic, in society; but the dynamic is locked up, inaccessible due to financial, interpersonal, awareness, class, and so forth factors. Psych unit psychiatry is part of the problem, and is 100% consistent with it. Where it works is where meds are, in fact, apropos, appropriate, and useful – and this happens. But the rest are trapped in an unjust, resource-lacking system, and psych unit psychiatry is unprepared to meet need or any sense of justice, or 'to factor out'.

My efforts began as part of my efforts in Zen and Minsky and Nabokov in the year 2000; that turned in part to careful preparation. Then it was varying degrees of significant dilemma, part dilemma, no dilemma, and no-dilemma, sometimes calm, sometimes dynamic. Psych unit psychiatry has had 'none of the above' that would have truly applied. It is an inverted system.

There was the occasional conversation with a genuine psychiatrist, but this did not affect just outcomes, and it was not part of the framework. There was only one place that had enough classes, and these were quality, intelligent, and participatory. The psych unit psychiatry at that place was dismal and disingenuous. So: no way out. And the framework does not allow for anything other, in any case.

Art classes and discussion groups were at times presented at other psych units, but there was not enough of this. There was too much down time during the day and evening, where all one had to do was rest in one's bed, bored, unless one took a journal. At one psych commitment hearing I was thus cited by the treating psychiatrist for 'hyper-grafia', meaning I wrote too much. All for a normal journal.

And if you debate points – and cite reasonable explanation – one is found *more* deficient, for not recognizing one's own alleged deficiency, the diagnosis, as the psychiatrist unilaterally renders, this seen as 'the objective view'. (However, it fails to take into account any of 'all of the above' and is neither objective nor realistic; and it is never discussed with the individual, in the first place, this diagnosis or what it means, etc.) Thus, due to this, and because reason is kept off the table during routine conversation with the psychiatrist, it is just not covered, it is set against – reason is kept 'off the table'. And none of 'all of the above' is considered relevant, to the framework.

Thus, the psychiatrist determines a diagnosis of absolute deficiency, pointing to permanent neurobiogenetic malfunction, meds for life as the only treatment – after all of this, including the rejection of reason, 'reason on the table'; the rejection of any and all discussion of merit; the rejection of any representation of the individual standpoint; the rejection of a dimension representation of the individual at all; and a rejection of the individual's logic; and including only a third-party record of

segments of events that are taken out of context, may be inaccurate, or do not describe the domain. This is all decided a-priori, in terms of what I term ‘a-priori decisis’ – and this is the theory/framework, and actual praxis.

One psych unit psychiatrist did want to inquire about Zen, with others on the team. I declined, a wise move, in spite of his genuine and helpful gesture, since it was premature (I realize now) – I did not have a firm grasp on Zen, nor its realization, to be able to describe it. But that was a kind and actual gesture. At that psych unit – my first one – we needed to have discussed mental states, and thought space and energy space and so forth: logic (and reason, since I worked with these), writing things down, sorting things out – all within routine expression. That was do-able and may have led to a recovery state. Diagrams and description by and for the individual, and applied effort. Not meds.

Thus, my efforts in the mental well-being space. And these 70+ papers, from 2017 to present; and some from before. And a renewed practice of Zen Buddhism, and renewed re-encapsulation and re-formulation of Minsky ideas, for this and for integration with the Zen. So I took the right path.

It’s now striking quite deep. A profound space to work in, and with delight and joy – the participant.

Psych unit psychiatry should focus on solving problems – not on fabrication and not on ‘to set aside “all of the above”’.

It’s stunning, what an inverted system it is. It simply should not be – it is not qualified by any means to be – a referent for the State. And, sadly, too much actual difficulty does happen in society, to not focus on those, and with an ‘all of the above’ approach, including resource. Then, to be more aware of the rest, in society, as provided by explanation and/or dynamic – those happy, centered moments and beings. Maybe even an inversion of the social/societal situation, in some cases!

See my paper “Mvo-Psychiatry – More!” for a different take on a transformation, of psych unit psychiatry, from its present state, and its actual significant potential to answer not only crisis (and this would be re-formulated) with better treatment, deeper insight, and more just outcomes, but on how it could be a broad resource for many in society with questions or inquiry, and their own answers. A much different thing. Psych unit psychiatrists, and those they would be connected with, and then those they lead to, could be our teachers, and resource-aware providers of resource and insight. A real and deep societal domain. ‘All of the above’ – for all of us.

Endnote 2

Again, this points to how common sense, the experiential that many of us have (the everyday, and including what State legislators could intuit or relate to, and their constituents), and the state could serve to review the domain; and the State could possibly re-visit some of psych unit psychiatry’s givens and praxis (and the field psychiatry). It's a really nice statement of a significant point of my overall thesis, which is meant to be constructive and transformational. Many of us work with ‘all of the above’ in our day to day lives. But that’s contradicted and refuted – and one’s rights and opportunity to it are set aside and surrendured – in a psych unit. It should be the opposite! And that’s what I see as the

dynamic outcome to my efforts – that psych units (and psychiatry) become places of ‘all of the above’, and real resource for both crisis and inquiry. This would be a dramatic step.

Footnotes

1. See Dogen’s essay “Guidelines For Studying The Way” in the book “Moon In A Dewdrop”, edited by Tanahashi.
2. Here I’m talking about the psych unit psychiatry – the psychiatry itself. Not the psych team (if any). Not the classes (there may be classes during the day, and this should be the rule, where one can consider quality, meaningful material, discussion, and worksheets, led by capable psych teachers). Not any therapy that may be provided, or spiritual guides. Psych unit psychiatry considers none of these relevant – and none of ‘all of the above’ relevant. It considers meds as the only relevant agent – meds for lifetime, with no other resource provided, that is posed as material. Note also that it’s the psych unit psychiatry, and only the psych unit psychiatry, that is represented of the individual and the situation and so forth to the State, family and friends, and work.
3. See Romans 12:2 in the Bible.
4. This leads to a vacuous state, devoid of meaning; bleak, desultory, without substance. Isolation from the world occurs; a sense of the interconnected is not established, and should be. ‘All of the above’, and to establish a sense of the interconnected, would solve this, in many instances, as much as possible. It’s also up to the individual, dilemma or no-dilemma.
5. See John Rawls. For instance, in “Six Theories Of Justice” by Karen Lebacqz. You have to read into what he’s saying; and Rawls also illuminates Mills’ ideas, in that chapter. Mills can be read to dimension if one establishes ‘many points of contact’ with the lived and the material, and sense of justice – what it means for each individual as well as the collective, and this or that aspect. It can also be taken in an unhelpful, rigid manner, that excludes – by people who already exclude so much. So you must be able to insert into the space – Wittgenstein says, “Logical space is infinite, and you can always insert a new point into logical space” (“Tractatus Logico Philosophicus”) – something of an idea or that is tangible. When dialogue-and-branch, or dialogue-and-the-relational, is possible, then Rawls and Mills become compatible, is my view.
6. See “Fundamental Wisdom Of The Middle Way” translated by Nishijima. There is another translation available.

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