Psychosis In Dimension: A Fundamental Shift

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Psychosis is just mental states, emotive states, intentional states, and physical states. It is various thoughts, perceptions, and views. It is points of thoughts, perceptions, and views. It is a geometry. It is a logic. Thus, with mutual inquiry and dialogue, another person can see, and can simulate in his or her own mind, some of the psychotic individual's psychosis, or represent it. This makes it tactile and real, and description, connection, the relational (thought-relational, social-relational, and world-space), and meaning can be realized. Psychotic thought then becomes just another type of thought, arrangement, trajectory, function, relational-unfolding, ethics, and experience; and to realize this is key. To work with these ideas and expression and reality is key.

This is significant because psychosis then becomes approachable. This is a view that psych unit psychiatry and the psych team – and other people connected with the individual – should pick up, to everyone's benefit, or mutually awakened understanding and awareness, at least.

Right now the individual is rendered hopeless, upon contact, except for a lifetime of meds, and even then can't be connected with, before, during, or after a psych unit commitment, with and without meds. A diagnosis of psychosis may be given where there is none – or where 'psychotic' is just another way to think. (I'm reminded of Minsky's use of that term, in his assessment that emotions are just another Way To Think.)

In my case, psychotic thoughts or not: the psychiatrist could have just asked!, or started an inquiry, with me! It is tactile!

I'm so excited about this. The Minsky material that I studied in the 2000-2003 timeframe is so important for this, for me, as are my other influences, the logic and ethic of Buddhism, and Zen.

This all steps out of the disorders paradigm. And part of this, the first step, is to step to the domains of life as the noumenal, phenomenal, and categories, interconnected, abstract, concrete, and the fusion of the abstract and the concrete (reality): the mental, the existential, the social, the societal, the experiential, and the physical. Then, one incorporates and expresses and dialogues about 'all of the above', including this.

Inquiry And Questions

Questions…

These questions should be asked, and an inquiry started, before any meds are given. It should be the case that meds may or may not be given, later, even in the case of dilemma; and certainly not in the case of no dilemma. Meds subtract a lot, and distort mental processes, mind, perceptions, and mind-form-being in their own way. They shift the sense of time. One needs the wake-state nature of the mind, and the actual mind, perception, and thoughts, to explain, work with, and develop dialogue about. One needs this to re-orient, or to explain, work with merit, and justify.

The psychiatrist and/or psych team can work with the dimension factors above, including the various states, ethics, and goals. They can ask the individual directly, is there some dilemma or not, or disorientation, or orientation, that you feel? This should be stated in just such an open, inquiry-based, equable way! Likewise other questions about thoughts, thought-space, the point-geometry of thoughts, and so forth, that I mentioned. Again, in an open, inquiry-based, equable way!

Endnote – A Redefined Framework And The Genuine Psych Unit Psychiatrist

So this is part of the redefined framework, mvo-p. The genuine psych unit psychiatrist, psych team, and others, should be encouraged that there is, in fact, in this world, and this context, so much to work with.

Endnote – Stages

It may be that the psych team realizes the individual simply has a sophisticated, compelling world-space. In that case, the individual is justified, and reason should be respected, even with various views and opinions. The various dimension features above and dialogues and inquiry with the individual – and discussions of merit and results – should be worked with and expressed.

It may be that the psych team realizes that there is part dilemma, and takes steps to help the individual work through that, in inquiry and as participant. The psych team will want to be aware of merit, context, the situation, and other points of no dilemma. The individual will be involved with unfolding logic and ethic.

It may be that the psych team realizes that there is significant dilemma or disorientation; in that case, again, it may not even be the best option to use meds, but their use should be selective. The psych team should be careful to discuss the mentioned dimension factors, ‘all of the above’, and critical points.

The psych team might recognize crisis dilemma, but remember that this is only one of the grades of dilemma, and must be genuinely factored out: there is crisis dilemma, significant dilemma, part

dilemma, no dilemma, and no-dilemma. Again, there are the domains of life to start with: the mental, the existential, the social, the societal, the experiential, and the physical.

Sometimes perhaps meds may be used.