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Psychiatry Is Bereft—It Lacks a Workable Philosophy for Consciousness—Herewith a Three Pronged Escape Plan

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PHILOSOPHY and PSYCHIATRY are unusual bedfellows. Medical students, already hard pressed for time, are generally thrust into the melee of mental disorders, having spent years focussing on first dissecting and then prodding human bodies, which too often leaves little room for evaluating theories about human nature, especially with respect to “Intent” or Free Will. The present writer was unusual in that having spent two years in pre-clinical medical training, he devoted a full university year to pursuing philosophical studies in up to 20 different university departments. Thus he entered his teaching hospital with a working knowledge of Hume, Kant, Sartre, Wittgenstein, Buber and others.

This is not a clinical paper—it focuses on the reasoning behind psychiatric precepts—so it is perhaps inevitable that today’s prevailing ideology is shown to be grievously wanting—a case of decidedly unphilosophical, even anti-philosophical, medical practice. The notion of there ever being a “scientific” theory of psychiatry has already been discounted in a series of earlier papers—which leaves us with the responsibility for choosing the best possible option, from an infinite number of theoretical models available.

The paper provides a whistle-stop tour of how mental disease looks if you start with a confident and consistent look at that pinnacle of human attributes—consciousness. It doesn’t presume to say what consciousness is, but it does assume that it has a function, like every other human asset. Indeed by cutting corners, evaluating what has worked over 60 years in psychiatry, the result is as straightforward a picture of sanity as one can reasonably expect. As such, it leaves the reader with little wriggle room—there is enough clarity here, for you to accept or reject the main proposition. However, since the flaws described tend to be lethal, acceptance entails action. Now read on.

Keywords: the link between consciousness and sanity, the link between consciousness and insanity, the therapeutic importance of smiles, psychosocial dwarfism of the mind, the need for urgent action to combat DSM-psychiatry

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Introduction

“ARE YOU AWAKE?” This is the one and only question to which the answer can never, ever be “NO”. It is therefore unique throughout all philosophy. It’s like asking someone to say “I’m asleep”—not possible, given the way human beings are. We humans say “no” all too often—well, here is an instance where no one can. Consciousness is endlessly complex—but here, at its heart is this utter simplicity. To answer any question, indeed to think at all, you need to be awake. Quite what happens before and after is permanently and inextricably beyond us. It is therefore wise to start as simply as possible, in order to begin to cope with something that is essentially interminably unknowable. What is most remarkable about consciousness is that if you do break things down into small enough bites, so as to be able to grasp the fundamentals as you go along, then it can take you, sensibly, to heights you could scarcely dream of. In the present context, that means illuminating both insanity itself, i.e. all mental illhealth, and thereafter its cure.

“NO, I’M NOT AWAKE”—no one in their right minds can say this. Or if they do, then it means that their consciousness has gone awry. Which, at heart, is what psychiatry is all about. Consciousness is ineffable—but it can also go wrong. And, since it is virtually impossible to pin consciousness down, then if we do find one example of a flaw, as here, then it makes most sense to capitalise on it, follow it as far as it will go, and see just how far it can take us. Two other examples follow later in this paper, one illuminating serial killers, the other climate change deniers. Psychiatrists who fudge the whole idea of consciousness, thereby cut themselves off at the knee. Even a grossly over-simplified version of consciousness, like the one offered here, is vastly better than none. Only a clear and self-evident philosophy for consciousness can keep psychiatry healthy.

This paper picks a delicate pathway through the interminable thicket surrounding consciousness. And since thinking about the very process of thought, tends to lose itself in contortions, let’s begin by picturing an imaginary scenario which might help. For this we need to examine a part of the human being which does share some of the characteristics of consciousness, but which can shed more light than otherwise.

The human organ which comes readily to mind in this context, is the mouth. Now, everyone knows what this is. Everyone has one. Look in a mirror, and you can see your own, as clear as day. No problem there. And at first, you might think you can describe it, even define it, easily enough. Try it. “The mouth is the opening in the lower part of the face”. Who could disagree?

Well, if all observers were blindfolded, or otherwise so disabled that they could only see the mouth as indistinctly as we all do consciousness—then this would transform even such an everyday organ into something quite mysterious. It would become both as intangible, and as unscientifically “subjective”, as being awake. Once direct observation was obscured, then cantankerous minds would jump in immediately, and disagree about mouths, with a vigour, even a venom, that would surprise you.

A school of thought would spring into existence which would focus on what the edges of the mouth did—commonly known as “lips”. Some would suppose that they could move all over the place—going up for smiles, and curled down for sneers. In this Einstein-style thought experiment, where nothing can be visualised with clarity, a contrary school would immediately vigorously oppose this, saying the very idea that lips moved at all, was preposterous, and as for expressing “emotion”, whatever that might be, well that was for the birds.

Other theorisers would go even further and insist that lips can be pursed, and jaws clenched—thereby pouring cold water on the very idea of there being any sort of opening there in the first place. You might think this farfetched—prepare to be surprised.

This mini-thought experiment requires only that all observers be prevented from focusing clearly, and "objectively", on the item in question, namely the mouth. In this imaginary scenario, the field would immediately be filled with multiple and contradictory theories of what that remarkable opening really was. Hostile and contending "schools" would flourish, and peace-of-mind with respect to this vital human organ, go out of the window. The parallel with what actually happens to theories of consciousness, itself indelibly and inextricably fuzzy, is too painful to contemplate.

Cutting through all theories of the "mind" and of consciousness alike, while freely admitting that what follows is a rough and ready approach that is unlikely to satisfy everyone, I here offer three rules-of-thumb, as follows. (1) —Consciousness defies any and all verbal descriptions, which knocks anything remotely resembling a definition off course—so it's best to experience it, with as little verbal interference as possible. (2) —It moves, it changes, it shape-shifts faster and more consistently than anything else in the entire cosmos. Accept this as a fundamental feature. It is its chief asset, not something you need to tie down before you begin. "First-define-your-terms" cripples consciousness. Finally, (3) —The only theory of mind you need, is that each and every one of us does actually have one, whatever it is. We all use ours every waking moment. Our "mind" is something over which we have greater or less control—better some days than others. It is here that consciousness goes wrong. Which is precisely what psychiatry is for.

This paper deploys these three rules-of-thumb with respect to consciousness. In short, they are: (1) —wordfulness; (2) —fluidity; (3) —the mind. Its sections follow the traditional medical paper configuration, viz—background, method, results, discussion and conclusion.

As a qualified doctor, I am entirely confident that many well experienced doctors will find little or nothing in this paper, to surprise them. They will likely want to express these points in their own terms, but if pressed, would, I like to think, support my side of the argument—though some will undoubtedly quail at the ferocity of the current opposing ideology. I half-expect them to be mildly amused that I have the temerity to even begin to tackle such a huge topic, equipped only with a tissue of flimsy words. After all, this is something that is intrinsically mobile, growing, and alive, something which is also the pinnacle of our biosphere—human consciousness.

Background

There may be some readers who regard the opening question of this paper ("Are you awake?") as being so self-evident, so obvious as to be trivial. Everyone, so they suppose, knows what consciousness is. It's so much part of everyday life, that it barely raises an eyebrow. So the idea that psychiatry should concern itself principally with where consciousness goes wrong, simply doesn't arise. Unfortunately this myopic view has been powerfully encouraged, since 1980, by the American Psychiatric Association (the APA), the leading professional psychiatric authority in the United States. In 1952, the APA published its first edition of a Diagnostic and Statistical Manual of Mental Disorders (DSM-I). This was followed in 1964 by a second edition (DSM-II). These were fairly straightforward attempts to bring some order to the ever-shifting field of psychiatry—they are humble enough to be of some merit. They were not best-sellers, nor expected to be.

Unhappily, in 1980 with DSM-III, all this changed. The Board of the American Psychiatric Association is reported by one expert (Breggin, 1993), to have deliberately decided in 1978, to switch its policy from exploring how talking things through can assist with mental pains, to which of a growing number of drug-treatments could be justified, medically. If, as has been suggested, the prime motive for this policy change

was financial, then it is pertinent to note, as Robert Whitaker does (Whitaker, 2015), that the income of the APA rose from $10 million a year, to $65 million, 20 or so years later. Using illness to gain more money is to misperceive both.

These medical points are considered in more detail in an earlier paper (Johnson, 2021a). Here we need to focus on applying our three rules-of-thumb, namely (1) —wordfulness; (2) —fluidity; (3) —the mind.

So to (1) wordfulness—consciousness is too fluid, too changeable to be defined, or even confined by words—experienced, yes; described verbally, no. What DSM-III did (as DSM-IV, p. 10, 1994, confirms), was to replace "consciousness" with "brain". More extensive verbatim quotes are given in the earlier paper. Here we need to emphasise that far from giving consciousness its due, as the acme of human capabilities—various obscure parts of the brain are awarded this accolade instead. So the APA by-passes the problems of words and consciousness altogether, by talking exclusively about "brains".

Next (2) fluidity. From an evolutionary point of view, our consciousness is there to anticipate danger, so as to avoid it, and enhance our chances of surviving in a generally hostile and ever changing world. The essential feature of this is to change plans as threats change. It's called reaction. And as such it is explicitly excluded by DSM-III. "DSM-II was similar to DSM-I but eliminated the term reaction" (DSM-IV p. xvii). This of course, is contrary to what happens with every other living species, where the Iron Law of Evolution applies—react, respond or perish.

Here we have a powerful medical authority arguing fiercely against the very possibility that we, as living human beings, should or even could, **react** to anything. Not a healthy view. Put this in concrete terms, and think of yourself in a crowded room—we all need oxygen—no mammal can live without it—and if you fail to **react** to shortages of this vital gas, you will suffer the consequences, which, if unrelieved, are 100% guaranteed to be fatal—not because I say so, but because this is our unrelenting human reality. Fluidity (2), here, is life-saving.

I have to confess that what astonishes me most about the APA is that it breaks rule-of-thumb (3). Here we have a psychiatric text of global significance, backed by substantial finances, and yet instead of psychiatry being there to treat the mind, the very concept of this ineffable part of every human being, is here obfuscated into non-existence. How else could you interpret the following? "The problem raised by the term 'mental' disorders has been much clearer than its solution, and, *unfortunately*, the term persists in the title of DSM-IV because we have not found an appropriate substitute…" (DSM-IV, p. xxi, emphasis added). If this doesn't explicitly eviscerate "mind", what would?

To everyone's surprise, DSM-III was a roaring best-seller. Millions of copies were sold. Criticisms of it were rife, but failed to impact. DSM-5 (2013), elicited a condemning review in *The Economist*, but conspicuously little from eminent mental health journals, who much prefer the status quo (The Economist, 2013).

As a pre-clinical medical student, I had a ravenous hunger for philosophy. I well recall one Professor Wisdom, the curiously named head of the University Philosophy Department, asking in one of his lectures—"Do other minds exist?" I remember he held his hands up to his temples to imitate ears twitching, so giving grounds for assuming that they did. In reality, if you have to ask, you are already lost.

Method

CONSCIOUSNESS is unique in the entire cosmos. Nothing even approaches it with respect to flexibility, speed of switching from one item to another, or the almost unlimited range of items which can fall within its

compass. It is also the only source of talk. Without consciousness, talk doesn't exist—this is what lies behind the opening question above. So let's assume that words come from consciousness—indeed, in an earlier paper thought and speech were linked together so tightly, they were judged, for practical purposes, to be inseparable (Johnson, 2021b). But here we are more concerned with the philosophy of consciousness—in other words, how is it possible to talk about the part of you which does the talking? Or, as in rule-of-thumb (1)—how can you communicate or even describe the very apparatus which itself does the communicating and the describing? It's like a single hand trying to grasp itself.

It is important to stress this point. Earlier attempts to define consciousness follow the examples set by either Pavlov or Freud. Both hoped to somehow mechanise the process—the objective being to find out what made it tick, so as to predict confidently what it would do next. This of course, is precisely the opposite of what consciousness is there for. Its very essence is to NOT follow precedence. Unless it comes up with a new plan to escape new threats, then it is failing in its fundamental biospheric task, namely to adapt to changes in the environment, so as to avert illhealth, death or ultimately, species-extinction.

This paper accepts that consciousness exists, at least it does when you are awake—but avers that verbal constructs to define or delineate it, are contra-indicated. This is rule-of-thumb (1). "Wordfulness" is intended to convey a glimpse into the awesome ability of consciousness to generate new words, new talk, new sentences, out of the blue as it were, i.e. *sui generis* on steroids—to say nothing of new music, new art and other delights anew. If it did run to "rule" or did follow predictable mechanical equations (or, heaven forbid, algorithms), then it would thereby automatically fail to cope with the incessant changes in our everyday reality—which don't.

It's not only the weather that is never the same one day or one year to the next, but so are supplies of food, shelter and companionship—all need constantly to be brought up to date. Every day, sometimes every minute, they present ever new problems, which need thinking through, if we are to flourish or even survive. And the process by which they are thought through, is best labelled consciousness. So don't waste valuable thinking time in trying to define what consciousness is, or is not. As with the central tenet of all clinical practice, check out what works, improve it where you can, and then build on it, as if nothing were amiss. Do-what-you-can-with-what-you've-got.

Inexpressible is the first (1), and fluidity the second (2), rule-of-thumb. Just sit back and take a look at what consciousness actually does. And the first thing you note is that it changes—it can turn on the proverbial sixpence. When you look at it from this point of view, it is the only entity in the entire cosmos which can switch from looking in one direction, to gazing solidly in another, *within split-seconds*. All right, wasps sting fast, but only in one direction—thought can veer 180 degrees within seconds, even microseconds—going one way one minute, and diametrically in the opposite, the next. You are trundling along on a well worn thought path, when suddenly a new idea pops into your mind, and your thought pattern is totally transformed. It becomes utterly unlike whatever you were thinking before. We take this in our stride, indeed we need to—in fact it's the hall mark of an excellent clinician that when a new avenue opens, you jump at it, discarding whatever reasonings you were doing before, without demur. This is rule-of-thumb (2)—fluidity.

You might think consciousness was difficult enough in itself, philosophically speaking—but there's worse. Let's suppose, for the purposes of argument, that consciousness occurs in a place, a location—and being bold, we'll call this spot "the mind"— rule-of-thumb (3).

This boils down to something extremely simple—I cannot tell you what is going through your mind at the moment. I keep trying to insert new ideas into it, but who can tell how successful I am being? Yet this is

precisely what consciousness is all about—thinking things through, blending in different and new "ideas", whatever they are, however they arrive or indeed however "valid" or "vital"—and "vital" here is not a metaphor, as we noted with respect to oxygen supplies above.

So here again are the three rules-of-thumb—(1) Wordfulness—don't tie consciousness down verbally, because that destroys its very essence. (2) Fluidity—consciousness can move, can alter, can amend faster than anything else that ever was or is. (3) Minds are real, they matter, they play a more significant role in healthcare than almost anything else.

You may have a better method of approaching this singularly difficult, but utterly adsorbing aspect of humanity—and if you do, I wish you well. But in all cases, make sure you allow enough breathing space in your philosophy for this most awesome, this quasi-miraculous accomplishment—one that is freely available to every human being that ever was—everytime we are awake.

Results

The results of the American Psychiatric Association's radical innovation in 1980, should by now, have been equally spectacular. Where are they? Roughly two generations of psychiatrists have now come and gone, having been fed a diet based exclusively on its drastic reappraisal of psychiatry. The hope was that the robust amputation of what it means to be human, would massively improve our understanding of mental disease, and so ease the damage which this inflicts on so many. The world should have become mentally healthier, with better mental harmony not only within families and at work, but also in wider social and international relations. Mental frictions and abuses should have been rendered obsolete by a more realistic appraisal of human capabilities. Otherwise, it would be hard to justify degrading consciousness, formerly known as the acme of human accomplishments.

So who would you now believe? Established psychiatry, nowadays labelled DSM-psychiatry, carries on, unsullied. As before, even a gross and very public calumny by the nearest thing we have to a global newspaper, *The Economist*, passes without comment. "The American Psychiatric Association's latest diagnostic manual remains a flawed attempt to categorise mental illness. DSM-5 is a monster" (The Economist, 2013). Nearer home, solid, "scientific" evidence shows that conventional medical drug treatment, far from helping psychotic symptoms, actually prolongs them over a 20 year period, not by a trivial amount, but up to tenfold (Harrow 2014).

Any other medical specialty whose very heart had been so comprehensively pierced, would at least pause for thought. Not so here. Circling the waggons would be nearer the mark. Medical journals ditch my contributions, within hours. More—in my own personal career, I have been expelled from half a dozen consultant psychiatrist posts, on one occasion with the active connivance of the then UK Prime minster—not because I played golf, but because what I did, made a noticeable (and bitterly resented) difference. My evidence at a recent inquest was ruled out of court by the coroner, solely because I was deemed not to have complied with "orthodox" psychiatry (which is precisely what had rendered the treating psychiatrist so terminally impotent). Even the UK Medical Licencing Authority (the GMC) came within an inch of striking me off, because my report on a single prisoner contravened DSM philosophy. The DSM has been labelled the psychiatrist's Bible—certainly those who question it, are given a first hand taste of what the Spanish Inquisition must have been like. Is there now enough public interest and understanding to launch a reformation?

But let's get more realistic here. Consciousness is notoriously hard to pin down—we need to turn to something more concrete, such as dying and causes of death. Globally, by far the leading cause of death is

cardiovascular disease, commonly known as heart attacks or strokes (Ourworldindata, 2017). What has this got to do with psychiatry and its woes? Well, you don't have to work as a family doctor for 20 years to know that dying of a broken heart is not merely an empty phrase. After some 10 years as a general practitioner, I found myself saying "stress is a killer". The coronary arteries are not only a vital part of the human organism—they are also peculiarly susceptible to emotional strife.

So what is emotional strife? Where does stress come from? And in which part of the human being does it occur? You do not have to be a qualified doctor to know that it occurs solely in the mind. Serenity, peace-of-mind, calmness, the ability to relax—all are beneficial in coping with heart disease. Ask any cardiologist. And where do these desirable attributes occur? No prizes for this one—it's in consciousness. And only there. Stress occurs when your consciousness faces challenges which it cannot resolve. It works best, and well, when it can sort things out—when it can't, and when these are close to its "heart", then that's stress. And, as the global statistics show—stress kills.

Solving difficulties is what consciousness does—when these become insoluble then it flounders and gets lost in the ensuring mental turmoil. What should follow smoothly and rationally, suddenly becomes insuperable, and dangerous to health. Calmness of mind is life-saving. Check out those you know who have suffered coronary artery attacks—are they stress free? Do they know how to become stress free? A workable philosophy for consciousness, and where it goes wrong, can indeed save lives.

But let's be very clear—any who suffer stress, would dearly love not to. Never blame the sufferer—it's the healthcare team, abetted by overbearing DSM-psychiatry, which deflects the origins, and the solutions of stress. Only when consciousness is placed centre-stage can we focus on where quasi-lethal stress arises. In the next section, emotional blindspots are described, and it is here that the real (generally hidden) roots of stress are to be found.

As I was completing this paper, Dr Cathy Wield, a fellow member of the Critical Psychiatric Network (an emailing group of some 300 psychiatrists), described the medical treatment she had received from the prevailing orthodox psychiatric system (Wield, 2021). She listed the 33 named drugs she had been prescribed (see Note One below). She was assaulted by 100 electro shocks. And was even subjected to ham-fisted brain surgery—pursuant to the purblind ideology innovated by DSM-III in 1980. This is a clear, compelling and medically reliable account of DSM-psychiatry, in the raw. But look at what those 33 drugs were supposed to do. There are 10 different varieties (see Note Two below), none of which is consistent, rationally based or, as this case shows, efficacious. Where's a workable philosophy of consciousness when you need one? This is medical practice, run by headless chickens. It's a medical disgrace. Isn't it time you came to its rescue? I commend Dr Wield for her courage in surviving this DSM-psychiatry onslaught, and thank her for communicating to us all, in this way. I trust her invaluable contribution will add weight to the need for psychiatric reform.

As if this were not bad enough, worse is to come. Misjudging stress is one thing, disgraceful scatter-gun polypharmacy another, both of which are direct consequences of trashing consciousness. But what of the future? What if the wishful thinking element built into DSM-psychiatry impacted on public health still to come? Diverting medical attention away from the mind, and from talking things through, might have seemed a good idea in 1980. But prioritising drugs has a yet more sinister long-term side-effect. What happens to those in their late 50s and 60s, who were prescribed psychodrugs as teenagers? A little noticed follow up study in Sweden gives us a horrifying statistic (Nordstrom et al., 2013).

DEMENTIA, currently the fifth cause of death globally (see global data cited), is already set to rise to become our next, even costlier pandemic. What this long-term Swedish study shows is that teenagers are especially susceptible to psychodrugs—ingesting them doubles the risk of succumbing to early onset dementia, some 50 years later. This is also a public health disgrace. Knowing this (which you now do), how much longer are you prepared to tolerate DSM-psychiatry?

Discussion

"PLEASE SMILE AT ME, DAD and/or MUM". Did you feel a pang when you first read these few words? I hope so. They are the acid test for why consciousness goes wrong. Read them again, put them in the mouth of a two-year-old or younger—an unspoken plea from a forlorn infant to a nearby adult. Now play them through your mind, your imagination, once more—"PLEASE SMILE AT ME, MUM and/or DAD" (infants are gender neutral). If after the initial gasp, you find yourself turning away, immediately thinking something other, or dismissing it as unnecessarily soft, even sloppy—then you are experiencing where, why and how, consciousness goes wrong. This is the key to unlocking all and every insanity, from eating disorders, through violence and psychotic symptoms, to the most idiotic political lunacies you can think of. Simple, obvious, born out by vast amounts of objective, scientific and irrefutable medical evidence—but routinely ignored, and discounted, for exactly this reason—it's all too painfully simple.

INSANITY IS A DEFICIENCY DISEASE. Now before we get too excited, too carried away, let's review the most obvious deficiency disease of them all—scurvy. If you set out on a long sea journey, far from land, then after a month or two, your teeth will start to bleed and then fall out. Your joints will become filled with blood, and you will likely die. Medically speaking, your connective tissue is falling apart—it doesn't work any more. This happened regularly to mariners, until some brave soul started eating lemons. Or with UK sailors, limes—whence "Limeys". But you don't have to take my word for it—just eat nothing but dried food for months on end (vitamin C is water soluble), with never a fresh fruit or vegetable in sight, and your gums will bleed, and your life become endangered. I don't know how vitamin C works—but I do know how and why smiles do.

Suppose as a doctor, you were tasked with saving a bunch of children who were behaving bizarrely. They were described to you as having "unusual eating and drinking behavior… such as eating from a garbage can and drinking from a toilet bowl, stealing food, alleged picky eating and rejecting food at the table, polydipsia and polyphagia, possibly alternating with gorging and vomiting and with selfstarvation" (Rogol, 2020). Madness.

If you'd been trained in DSM-psychiatry, and who isn't these days, you'd presume this was a brain disorder, and despite the apparently incompatible range of positive and negative symptoms, you'd look for a brain or genetic abnormality, and would reach for the nearest available drug. And you'd be 100% wrong, and people will die as a result. The tragedy is compounded by the fact that neither you nor your institution have, so far, been able to resist the dire flaws in DSM-psychiatry.

Indeed DSM-psychiatry has written itself into a corner—a corrupt corner according to Whitaker (2015). I've come to the view that it is a self-perpetuating disaster. It cannot now escape without outside help, either from the general public, and/or from within the wider profession. If you're not medically trained, any critique that you care to raise can easily be dismissed as old wives' tales. If you actually claim to be a psychiatrist yourself, then if you don't toe the line, your medical licence can be revoked with ease.

So what is really going wrong with the gruesome eating disorders just listed? And what could possibly be done to assist, even to cure them? How simple do you want to be? How about prescribing “smiles”. Or coaxing them to smile, and then to blossom. Or is this just too simple to be believable? Let’s carry out a brutal experiment—let’s deliberately starve a whole nationful of children for 4 or 5 years. You’d have to be pretty mad to do this – but since it’s already been done to German children, during the First World War, the least we can do is learn from it, and use whatever wisdom we can gain from that, to prevent further irrational political pandemics.

> Based on original observations of earlier studies of large group refeeding of children after the war—whether raised in intact families of all social strata (18, 19), orphaned by the war, or from underprivileged families (20), **the authors noted that children from underprivileged families had growth outcomes very different from the former two, *despite* adequate caloric replenishment**. Children from underprivileged families continued to show subnormal growth in height and weight gain, whereas the vast majority of children in the former two groups showed rapid catch-up growth, reaching 3 to 5 cm within 4 to 6 weeks (17). (Rogal, op cit)

Look more closely to the sentence highlighted—“underprivileged families had growth outcomes very different from the former two, *despite* adequate caloric replenishment”. We all know starved children fail to thrive—but what this tells us is that even if you increase the calories without at the same time, decreasing emotional instability and uncertainty, you gain nothing. This is repeated so often in healthcare, it has acquired its own label—“psychosocial dwarfism”. Starve growing children of emotional support, and they never grow as big and as healthy as identical children with plenty to smile about. You might not want to know this, or even believe it, however often it is told—but what goes into the mouth to build the body, is on a par with what goes into consciousness to build the mind, always assuming, which I do, that we’ve got one to build.

Here the cause of grossly abnormal, and self-defeating behaviour is obvious—insanity in infants. It is also, and has been frequently proved to be, entirely remediable. You simply have to improve the emotional environment. Simple, not always easy. All I’ve had the temerity to do is extrapolate from these obvious, objective, scientifically proven facts well known in child development—to adult psychiatric morbidity. Psychosocial dwarfism first of body, then of mind, or consciousness—a logical progression, a propostion that is difficult to propagate in a stifling psychiatric ethos.

Let’s recap. Consciousness exists. Its function is to model our ever changing reality. And, when this modelling goes awry, and fails to keep in touch with that reality, then the correct label for this, is INSANITY. And the most obvious reason for that, is faulty input. You may think there’s enough oxygen in the room—and if you’re right, all is well. If you’re wrong, and it doesn’t matter *why* you’re wrong, your health, indeed your life will suffer—again not because I say so, not because its morally degenerate or ideologically improper—it’s just that humans without oxygen, cease. The closer the model within our consciousness reflects our contemporaneous reality, the saner (and safer) we are.

THE SIMPLICITY OF INSANITY comes from the obvious fact that consciousness has a crucial flaw—its input channel is unbelievably narrow, it’s minute. But this seems to be an integral part of how it works. It’s like the focal point of vision—fix your eye on a single word on this page, and all the others become blurred—they’re still there, but indistinct. This enables you to focus, to think clearly, to piece together the bits that do connect, and discard those that don’t. Not easy, but doable.

In addition to the three rules-of-thumb with respect to consciousness, we now need to ponder the implications of this restricted input channel. Also, the ability to focus. Few doubt that you can look at different

words on this page, at will. You might want to start at the top, or reread the sentence you just read—your choice. People do deny you this right, especially those who fervently support DSM-psychiatry—but we can take it as read, that reading is your choice, you can choose, and I recommend that you do.

This question of choice impinges on insanity. What if, instead of roaming freely, at will, you were obliged to look away, to ignore certain unpalatable facts and features that everyone else thinks are obvious, but to you are simply not there. This is a blindspot, an emotional blindspot—the retinal blindspot was demonstrated in an earlier paper (Johnson, 2021b), and if you are sceptic about just how invisible things can be, perhaps a gentle review of that "experiment" might assist.

Here I want to bring two men into this discussion, I'll call the first one "Alec" and the second "Donald". Both had horrendous blackholes in their consciousness—flaws which were perfectly obvious to everyone else, but entirely non-existent to each of them. The reason insanity is so simple, is that the explanation for why they had these serious, damaging flaws in consciousness is so obvious, so clear and so inevitable, one wonders why it isn't more widely accepted. In a nutshell, children are impressionable.

Alec was a prisoner I worked with for several years in a maximum security prison. He was a serial killer. He calmly planned to kill every two years. His consciousness was dedicated to this, and he set about putting it into practice. You might say this was the essence of evil. "Part of me wants to kill, and as long as it does, I will let it". My task was to persuade him to stop letting it. And I did this by giving him reliable, trustworthy, emotional support, something he had never had in his entire life. In an earlier paper I made four points, as follows. (1) Was Alec's father wrong to throw his mother down stairs (when Alec was aged 4)? YES. (2) Can he tell his father this (aged 24)? NO. (3) Should he be able to? YES. And (4), did he know that all his symptoms of serial-killing came from his inability to tell him? NO. But when he did, they went.

Alec was too small at the time to take revenge on his father's evil—and even aged 24 was still too terrified of him, so had to direct his murderous rage at parent-substitutes. His consciousness was continuing to misinform him, persuading him that he lived in a world in which super powerful men could destroy, whatever he did. This world was obsolete—but to bring him up to date, he needed to have his terror abate—he needed stability, reliability, certainty, so that he could abate it himself, which happily for all concerned, he did. The motto I used was Truth, Trust and Consent. More details are given elsewhere (Johnson, 2018).

Broken thinking is not confined to violent men. Look around you today at the political sphere, and wishful thinking and Fake-News prevail—with no self-evident rhyme or reason to them. However, all such aberrant behaviour falls into place, once you see the perpetrator as emotionally infantile. Then they are scouring the world for parental approval which they were never given, and can no longer find in the adult world. They work desperately, trying to solve yesterday's (kindergarten) problem in today's (adult) world. If you want a diagnostic label, you could try "Kindergartenitis"—not pretty, but self-explanatory.

This is evidence that they had a grim, smile-deprived, childhood. And yet, because of the narrow input channel, clouded with the paralysing effect of terror, they find they can never leave it behind. They go through adult life weighed down by a broken consciousness which keeps insisting, as Alec's did, that nursery-rules still prevail, that powerful people provide only sneers, and there is no point in thinking a way out of the torture, because you can never trust anyone enough to see it. Childhood tortures persist because they seem unchallengeable—insanity in a nutshell.

As for words, so with emotions. If your parents were happy and taught you smiles, then that's what will come naturally to you. If they didn't, then you might have learnt sneers instead, and they can be rather more

difficult to amend. The reality is that all parents make mistakes, we all do. The key is to get enough trustworthy support, either then or later, so as to be able to see these, and then discard them—or else be brought up in a village.

So to Donald. Here we have a man, who, as an infant was taught the language spoken by the adults around him. Unhappily those same adults also taught him that powerful people will always sneer at you—they would also hoax you at the drop of a hat. Sadly for us all, climate change fell into the "hoax" category. No amount of today's "evidence" could change the "hoax" position—to do that you would need to go right back to square one, and review and redraft his earlier vocabulary input—not always easy, and out of the question without Donald's fully informed consent. Meanwhile, he continued to battle hoaxers, as if there were no tomorrow, just as he had been taught there wasn't, in his kindergarten years. He didn't make much progress in this, since it was now the wrong battle, being several decades out of date. Incidentally, neither "cherish" nor "delight" were in his original vocabulary either.

The beauty of this simplicity is that it points up the obvious cure for insanity. Stability. Certainty. Reliability. Smiles. Insight. Confidence. These are the necessary ingredients for eliminating insanity. Easy to say—and not nearly as difficult as they sound. Once you accept that consciousness is part of everyday life, then that's where we need to look for how to repair it. What you need is some trustworthy, non-Fake-News person to hold your hand mentally, while you rearrange your mental furniture—a rearrangement others cannot do for you, but they can certainly expedite things, so that you can. Think back to the time when things went well, when they were going more right than wrong, and you'll find that it was trustworthy human relations that were at the heart of it. People listened to what you wanted to say, took your point of view into account, and helped. They liked helping, because that's the way they too gained stability, and sanity. We need other people to be there for us. We cannot be sane without them. When they smile, so can we.

Let's punch that home. Covid has proved that no-one-is-safe-until-we're-all-safe—if you allow pockets of viral infection to build, then re-infection with a more virulent variant is just a matter of time. Because you have tolerated slums in your country, in your deindustrialised rust belts, or in other neglected and deprived parts of our joined up world—then these are the gaping wounds in your community that the virus will exploit to the full. You ignore your fellow citizens' plight, at your peril. Human Rights are therapeutic. Globally. The virus is no respecter of your brand of politics—unaddressed inequalities allow, even encourage, it to fester.

So what is obvious with virus pandemics, applies also to sanity. Stability in society is an essential ingredient for stability in consciousness. Why should it not be? How could it be otherwise? Consciousness is there to help you prevail against impending chaos—you cannot do this single handed—from which it follows, as day does night—no one is sane until we're all sane.

The priority of all mental healthcare is to empower the sufferer to regain control of their consciousness—enable them to re-establish their ability to cope with the social pressures which afflict them. This means providing them with meaningful things to do, trustworthy friendly emotional support, a way of sorting out their problems so they can sort them out for themselves. A-smile-a-day-keeps-the–doctor-away—it really is as simple as that, though far from easy.

Each and everyone of us has our own share of consciousness. And the irrefutable fact is that I need to borrow access to yours, just as you do to mine. We are all living organisms, and we all need helping out because mutual support is all we have against inimical chaos. The world doesn't owe us a living—without food we starve, without oxygen we suffocate, we're dead. And consciousness is so unwieldy, so unsteady, that we all

need reassurance, which can only come for another's consciousness. Your consciousness is invaluable to me. It pays us all to ensure that this is a sane global world, which currently, it's not (see also Johnson, 2021b). Sane as in "as realistic as we can get". No one is sane until we're all sane.

Conclusion

This paper sets out an entirely rational workable philosophy for irrationality—as follows—

1. Consciousness exists, but describing it verbally is like carrying water in a sieve (1)—you have to rely on verbal integrity, precisely the opposite of Fake-News.

2. Its input channel is not only significantly narrow, but easily blocked by adversity—whence come unseeable emotional blindspots, which are 100% curable by insight and smiles.

3. Accordingly infants taught sneers can suffer a lifetime of nursery nightmares—psychosocial dwarfism of the mind (3).

4. But childhoods are so yesterday. And, with enough trustworthy support, even Verbal Physiotherapy, long term adverse effects can be expunged, as if they'd never been.

5. The real medical catastrophe is that psychodrugs do exactly the opposite of what is required—they **de-focus** consciousness—whereas what is needed to cure all insanity, is more realistic **re-focusing**.

6. From which it follows that empowering "intent" detoxifies psychosis.

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If you find yourself in an airless room with dwindling oxygen, and you choose for ideological reasons, **not to react**—you are first ill, then dead—your choice. To eliminate **reaction (2)** by the stroke of a pen (DSM-IV, p xvii), is to dice with death—this is simply because the mind (3), when diseased, kills. No-one-is-sane-until-we're-all-sane. Are you awake?

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Note One—Dr Wield's Drugs

This is the list of the 33 drugs Dr Cathy Wield was given in lieu of effective psychiatric treatment. This is known medically, as polypharmacy—and is taken as medical proof that you don't really know what you're doing. In the present case, the flaw arises entirely from a deliberate 1980s American Psychiatric Association policy—here denoted as DSM-psychiatry. The drugs are named as—Fluoxetine, Lofepramine, Dothiepin/dosulepin, Lithium, Chlorpromazine, Temazepam, Paroxetine, Thioridazine, Venlafaxine, Flupenthioxol, Imipramine, Clopixol, Olanzapine, Procyclidine, Tryptophan, Depot Depixol, Metochlopramide, Domperidone, Zopiclone, Clomipramine, Tri-iodothyronine, Droperidol, Mirtazapine, Reboxetine, Phenelzine, Clonazepam, Respiridone, Nitrazepam, Amitryptiline, Quetiapine, Valproate, Sertraline, Ketoconazole.

Note Two—Dr Wield's Drug Categories

In all, the 33 drugs Dr Cathy Wield was subjected to, fall into 10 different categories—none of which take consciousness into account, nor, in some cases, her consent. There were—3 types of Selective Serotonin Reuptake Inhibitors (SSRIs); 5 of Tricyclic Antidepressants (TCAs); 2 of Serotonin-Norepinephrine Reuptake Inhibitor (SNSRs); 1 of Monoamine Oxidase Inhibitors (MAOIs); 1 of Other Antidepressants; 2 of Mood stabiliser; 6 of Old antipsychotics; 3 of New antipsychotics; 4 of Benzodiazepam-Zopiclone; 4 of Other.

HEALTH WARNING

MEDICAL NOTE—never stop psychiatric drugs abruptly. Abrupt withdrawal can bring on worse symptoms than the original disease. Expert medical help is needed to undo these devastating toxic effects.

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