Structural Flaws To The DSM

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This concerns psychiatry's book Diagnostic And Statistical Manual (DSM). It is standard practice to use this book as the primary referent, in psychiatry and psych unit psychiatry. Let us scrutinize it, from several angles.

I wonder if the DSM doesn't commit several overall, structural, design errors:

1. A failed use of qualifying and qualified ('qualifying and qualified' were pointed to by the Buddha as one instance of false reasoning, in the Lankavatara Sutra, and I need to work with this more. Perhaps he was just pointing away from discrimination, and also to a fault in the reasoning).

2. A false use of categories (see Aristotle's "Categories").

3. A false use of statistics, the DSM's statistical approach being actually pseudo-statistics, and really just a way to bin or relate things – and is this useful? – to invent 'disorders'. Just because they use numbers and can count-and-bin doesn't make it truly 'statistical'. And significantly, as juxtaposition: the combinatorical combination must mean something, and this must be built in to the relationships and their content. See Marvin Minsky's "The Society Of Mind" for the truly combinatorical (the triangle diagrams and idea – what I term 'combinatorical unfolding interconnected relational action-memes', involving both time and the at-once, and meaning-structure-and-content).

4. And actually, it's the inversion of uniframes! (each disorder and its bin-and-count "statistics"). See Minsky's book "The Society Of Mind" for a description of uniframes. (From my own r&d/engaged activity, based on his work, the inversion of uniframes is dysfunctional. See my endnote "Category 4: The DSM, The Inversion Of Uniframes, Its Invalidity, And What It Means".[1])

I suspect that while some of the symptoms may be real and problematic for some individuals, the entire layer of 'disorders' is false, a made up and useless and mis-used layer of falsity. I think quite firmly that it is these symptoms that should be related and used to come up with an actual description of the problem-domain, per individual – a description of the states mental states, emotive states, intentional states, and physical states; and then a description of the domains the mental, existential, social, societal, experiential, and physical; and for these the resilience factors joy, centeredness, dilemma, questions, perspectives, challenges, and helpfuls and usefuls; and then the grades of dilemma: crisis dilemma, significant dilemma, part dilemma, no dilemma, and no-dilemma. That way there's 1) reality; 2) a map. See my papers "'All Of The Above'" and "A Dimension Profile Of The Individual".

I also think the DSM lends itself to false diagnosis of problems, and ignores entire domains of actual function, that explain this or that. It further – and significantly – does not form any sort of representational picture of the individual – except to describe in terms of disorders. But 'disorders'

(from the DSM) form the entire universe of the psych unit psychiatrist (and certainly none of ‘all of the above’ is included in this, or indicated by it). Thus, each individual the psych unit psychiatrist (or psychiatrist) encounters is rendered in terms of disorders.

Footnotes

1. It is stunning to realize that both this applies – the inversion of uniframes – and the fact that I did r&d/engaged activity on another thing (in addition to my own mental work on the inversion of uniframes): advancing the point of perception to precede its natural state, directing prematurely (before the actual perception had had time to fully develop, in the sequence of nen, sensation → perception → synthesis (see “Zen Training” by Sekida)) to quick-response and shallow synthesis, unconnected to anything else that would lead to careful reasoning or apertainment – *and that these 2 elements of my r&d/engaged activity precisely model what goes on within the psych unit psychiatrist’s mind, means, theory, and praxis – except that I was indeed attempting also a just outcome* (which psych unit psychiatry does not, is not even aware of it at the framework level, or may be, and always thwarts this, any sense of or actual fact of justice). You have to know how the psych unit psychiatrist takes in insufficient evidence, and a biased statement of facts, omits and rejects reason, ‘reason on the table’ with the individual, omits and rejects the individual as participant, omits and rejects explanation from the individual and others, contradicts and rejects all of ‘all of the above’ as relevant or material, and then quickly surmises a disorder, rendering for the individual, the family, work, the state, and society, someone who is absolutely deficient, in need of meds for a lifetime. It end up omitting the entire world, at its basis – if you include the *selective* use of meds – but with this it omits all else. Pysch unit psychiatrists do not penetrate the matter, at all, much less with ‘all of the above’ (see my papers “Psych Unit Psychiatry Contradicts And Refutes ‘All Of The Above’” and “A Dimension Profile Of The Individual”). The psych unit psychiatrist might be helpful sometimes – when meds are in fact apropos. But in all cases, apropos or not, they omit ‘all of the above’, and fall into these errors.

Work To Do

I have significant work to do, to validate and explain my take on the 3 or 4 flaws to the DSM, here. Others should, in the meantime, feel free to probe and see for themselves.

Category 4: The DSM, The Inversion Of Uniframes, Its Invalidity, And What It Means

For instance, I need a dimension description of what uniframes are. (That is, I’ll have to consult Minsky’s TSOM again.) I’m pretty sure it’s stored away in subconscious memory (something like, “see if this attribute fits a given (constant) description, and add its element to the collection if it does”) as is its inversion (something like, “try to explain an element first by lining it up with a potential description-term or category, that element then becoming the description itself, and seeing if one can force it in the collection, that is defined of itself and other elements [the existence of the elements, as

the purported proof of the description-term, and the description at the same time, of the alleged category], in any way”). It’s noticeable, once one has a clear grasp of this!

That is, there is a description ‘schizophrenia’ that is held in mind (or in the DSM); this description is the set of elements in the bin, which are used to prove the existence of the term ‘schizophrenia’ – but these elements are the description they’re purported to prove: and therefore, naturally, any set of symptoms are going to prove the existence of themselves, and the existence of themselves is this bin ‘schizophrenia’ – a term which existence one is trying to prove, by adding things to its bin. Already a flaw, the inversion. But this term ‘schizophrenia’ is then reified when it is a 1) a collection of elements that prove the existence of themselves only, but are represented as proving something tangible and real, ‘schizophrenia’; and 2) an actual disease of the brain, a disorder – when it is nothing more than a snapshot or representation from a certain standpoint, and the bin (some actual thing ‘schizophrenia’ is represented to be thus proven, but it’s merely a bin, which can be proven simply by adding things to it!). The elements are used to prove the term, but they prove only themselves. The logical flaw is that they then are purported to define or declare or instance in mind a disease ‘schizophrenia’ – which is nothing more (as all words are) merely indicative of something. The designers of the DSM put terms there such as ‘schizophrenia’ which they prove the existence of by the binning of symptoms or features – but this is not the assignment and binning by attributes of elements to some definition or supposition – except for the attribute, held in mind, ‘schizophrenia’, which is defined in terms of the elements that are put in the bin! This is the flaw that is the inversion of uniframes. Things (elements) are then newly added to the bin or term ‘schizophrenia’ according to this idea of what ‘schizophrenia’ is, which is nothing more than the bin itself, which the elements are purported to prove, but proving only the existence of themselves. This is the frustration, uselessness, and dysfunction of such a scheme. It is arbitrary, where things are binned according to some ‘pre-fixed’ idea, which is nothing more than the bin itself, trying to prove the existence of the bin or term, and trying to be useful by formulating an idea ‘schizophrenia’, to which one tries to add a new bin or term, via the thought “this is the attribute ‘schizophrenia’”, but which attribute is assigned to the element, which content is then used to define the term ‘schizophrenia’, the term that the element is binned to, according to an attribute ‘schizophrenia’. But its reason is not based on the element itself, just the attribute, which only “proves” the term – but this was determined only because one thought of the element! That is, the proof of the element is not in the element itself, but is represented as being its (newly assigned) attribute ‘schizophrenia’, which then is used to prove the term ‘schizophrenia’, which justifies the binning of the element. Such self-referential thought, in trying to bin according to an attribute that one assigns in trying to prove a bin, and then work with, in the meaning-layer of the element(s), having assigned it to the bin, by assigning the attribute to the element (and not the element revealing an attribute, or not) leads to bass-ackwards conclusions, an inverted worldview, and dysfunctional confusion.

*** Another way to state it (or a further complication) is that you’re applying some definition to the element that includes the term, say because of expectation, then using that term to both describe the element and prove the element’s assignment validity to the bin of the term, trying to have the element prove the term. But this is not valid at all. ***

More thoughts…

One could walk through the DSM and try to find a bio-genetic feature for each of the symptoms or their bins, yet psychiatrists have not walked through the DSM and tried to explain: joys, centeredness, dilemma, questions, and perspectives. They have not studied the mind itself. They have not considered the grades of dilemma crisis dilemma, significant dilemma, part dilemma, no dilemma, and no-dilemma for these, and put them in their book (the DSM); nor have they explained or put in the DSM the domains the mental, the existential, the social, the societal, the experiential, and the physical; they ignore these and represent all experience as neurobiogenetic disorders (permanent neurobiogenetic malfunction). They have not explained the discriminating mind, nor non-duality, with bio-genetic features. They have not explained reason, the external world, the present moment, reality, understanding, thought, speech, and action with bio-genetic features.

Psychiatrists have not, via the DSM, nor via bio-genetic features, explained philosophy, spirituality, psychology, speculation on how we think and why, and act, narrative, resources, worldview, and the power of open dialogues and discourse. Nor have they explained mathematics, the Space Shuttle, or the arrowhead.

Mathematics is part of the universe, and also a constructed-from-axiom field, and our knowledge of it comes from effort and study. The Space Shuttle is a result of proto-specialists in the human mind developed to a refined degree, incorporating mathematical, engineering, and spatial knowledge and insight. Ideas, awareness, and skill. The arrowhead likely is something developed by observation, experiment, spatial knowledge, and insight.

They have not explained very much at all!

Yet psychiatrists purport to decide on the basis for their clients (both voluntary and state-appointed) whether that person has a permanent, intractable DSM-based disorder (and the individual is of mind-breath-body-world-space; that individual has views and standpoint and a logic and the relational and the experiential; but this is another domain psychiatrists haven't considered nor do they have a vocabulary for).

One could invent an entire library of 1,200 page books on various features to human existence in this way, by making up terms and then binning the very elements seen according to a pre-supposed idea of the world, first assigned as an attribute to elements – terms that are bins of things according to some worldview, the worldview expressed in the elements themselves – attributes-and-elements that bin to some element-description that includes the term, assigned to the element as a term that is then binned to the description (represented by the term) – and this is purported to be by such but that can't be reasonably or axiomatically or scientifically or observationally proven (that the attribute would map to). One could come up with any worldview that has the quality 'arbitrary' this way, likely problematic and unrealistic! The DSM is a hopeless collection of the elements.

As I indicated above, it would be entirely feasible to design a replacement for the DSM that acknowledges symptoms – and really joy, centeredness, dilemma, questions, perspectives, challenges, and helpfuls and usefuls, and degrees of dilemma (crisis dilemma, significant dilemma, part dilemma, no dilemma, and no-dilemma) for several realistic categores that stand up to noumenal scrutiny – and mental states, emotive states, intentional states, and physical states, and so forth, including certainly a useful grid from 'all of the above', and puts them in terms that indicate the actual individual domain the

individual finds himself or herself with, as well as things, view, others, and this world. Entirely dimensional, vocabulary, logical, reasonable, realistic, dialogue-oriented, participant, explanatory – and 'a representational picture'.

Symptoms or dilemma may be actual. Joy, centeredness, dilemma, questions, and perspectives may be actual. Grades of dilemma may be actual, including no dilemma. These should be sought out, and in the context of 'all of the above'. They are the human experience.

From a DSM replacement, 'all of the above' would be profiles of the individual, eminently realistic and useful.

More On Uniframes

It goes even further, with uniframes. To bin according to some attribute (that is part of the things) is only the simplest interpretation. What Minsky really means in chapter 12 of "The Society Of Mind" is that one has created an entire structure-function representation in one's mind – a unified frame – of something (he uses the example of a child learning for himself or herself what an arch is). Then one deals with a tactile, tractable place of recognition and cognition, perception and action, from structure-and-function, the frame, as one encounters and creates the world.

This means that to bin-and-count, according to a label ascribed after the fact to a collection based on some theoretical idea, when that idea has neither structure nor function to it, and that idea is the bin itself, that the bin points to as being the attribute, is not this.

In fact, Minsky says,

> But one can't learn what something means merely by tying things to names. Each word-idea must also be invested with some causes, actions, purposes, and explanations.
>
> – "The Society Of Mind", Section 12.4, p. 122.

I might suggest that mvo-p (the redefined framework for psychiatry) would instead of trying to construct entire theoretical definitions out of bin-and-count of items binned only according to the a-priori theoretical idea which is itself just the bin-and-count with a label, the label being the attrbute for the bin in the first place (which the 'statistical' bin-and-count is trying to prove), it would concern itself with the mind, how we use it, how we perceive things and work with perceptions and the perceptual, how we orient, with ourselves and within the world, how we work with understanding, thought, speech, action, livelihood, effort, awareness, the social-relational, thought-relational, and the very philosophical, spiritual or religious, psychological, speculative, and everyday basis we have for and along with these. This would be akin to understanding, on the part of the mvo-p professional, some structure to a bone and how to set a fracture, in the case of the physician – with for the mvo-p professional, due diligence to learning in very material, noumenal, phenomenal, and practical ways about the mind, body-breath-mind-world-space, mind-body-spirit, and/or the relational, including the unfolding world-space, mutually co-arising – and 'all of the above'.

In “The Society Of Mind” Minsky does masterful work in bringing any number of observations and theories to the table, on how minds function, what they do, and how they might be arranged. One of my favorites is his (my term) ‘combinatorical unfolding interconnected relational action-memes’ – the triangles-diagrams of interconnected hierarchies (agents and agencies). Seeing these as the mindless stuff that interoperable make up minds is one theory – Minsky’s; in Zen Buddhism one might suggest that what one perceives is just Mind-only (my question for the reader: is the relational mind? – which ties beautifully to Minsky’s wonderful description; see the Lankavatara Sutra, translated by D. T. Suzuki, which I have enjoyed so much with diligent contemplation and the everyday, and have yet to finish!).

Related Papers

“‘All Of The Above’”
“Psych Unit Psychiatrists Make A Mistake”
“Psych Unit Psychiatry Contradicts And Refutes ‘All Of The Above’”
“Structural Patterns To DNA Yielding Proto-specialists, And The Mapping Of Ideas”
“Psych Unit Psychiatry, The DSM, And False Mappings”
“A Dimension Profile Of The Individual”

References

“The Society Of Mind” by Marvin Minsky.
“The Emotion Machine” by Marvin Minsky.
“Categories” by Aristotle.

Articles

The DSM: “Scientifically Meaningless” Diagnoses by Peter Simons, Mad In America (https://www.madinamerica.com/2019/07/dsm-scientifically-meaningless-diagnoses/). Here the authors of a study note in their way the means and results of the inverted view and logic found in the DSM.