

Split-Domain Cognition in Psychiatric Diagnosis and the DSM

Canonical variant. Version 1.0, April 2026.

Preface

About this document. This is a domain-specific variant of Split-Domain Cognition, addressed to psychiatric diagnosis and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR). It works out the collapse of three distinct cognitive operations — observation of presentation, criterion-matching against a public rubric, and institutional verdict carrying clinical, legal, and insurance consequences — into a single utterance that the diagnosed person cannot audit. The variant asks what diagnosis would have to look like if the three operations were held apart. Its philosophical grounding draws on Gabor Maté (biopsychosocial approach, Compassionate Inquiry, trauma-as-context), R. D. Laing (existential psychiatry), and Michel Foucault (category imposition as political act).

Where this sits in the corpus. The canon home is splitdomaincognition.org. The variants index is at [/variants/](#); this variant in particular at [/variants/psychiatric-diagnosis-and-the-dsm/v1/](#). The principle this variant interprets is articulated long-form in *Split-Domain Cognition* and short-form in *A Principle, Not a Pattern*. The protocol by which this variant was derived is at [/derivation-protocol-v1/](#).

Authority and version. Canonical, v1.0. April 2026. The website is the source of record. If this PDF and the website disagree, follow the website.

Use. Openly citable. See [Governance](#) for the one-person canon and how variants are admitted.

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Opening

Psychiatric diagnosis is a clinical practice that sits between a person's observable distress and a set of institutional responses — medication, psychotherapy, hospitalisation, disability status, insurance authorisation, school or workplace accommodation, social recognition of a condition as a condition. Its public self-image is medical — a clinician observes, recognises a pattern, names the pattern, and treats what the name indicates. Its actual practice is the collapse of three distinct cognitive operations into a single utterance that the person being diagnosed cannot audit.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) — now in its fifth edition with text revision (DSM-5-TR, 2022) — is an unusually explicit rubric. It specifies criteria for each disorder, with specific symptom counts, durations, and exclusions. On paper, the DSM is one of the most formalised judgement frameworks in medicine. A clinician using the DSM is supposed to assess whether the observed presentation meets the specified criteria. The rubric exists; the criteria are public; the procedure is legible.

The collapse is not in the DSM as written. It is in how the DSM is applied inside clinical practice. A 15-minute psychiatric intake does not afford the separation the DSM's structure implies. The clinician observes, categorises, and prescribes inside a single encounter, often in a single utterance. "I think you have depression. I'd recommend starting an SSRI and coming back in two weeks." The sentence fuses observation, rubric-application, and treatment verdict — three different cognitive operations bundled so tightly that the person receiving the diagnosis cannot locate where one ends and the next begins. The fusion is the SDC failure mode appearing inside the most formalised judgement framework contemporary medicine has produced.

This variant is written from an intellectual stake, not a clinical one. Prayas is not a clinician. The variant draws on Gabor Maté's published work — the research archive in [~/Dropbox/personal_projects/gabor.mate/](https://www.dropbox.com/sh/1234567890/AAABBBCCCDDDEEE?dl=1), including *When the Body Says No*, *In the Realm of Hungry Ghosts*, and *The Myth of Normal* — as its primary clinical reference. It also extends the worth argument from [worth-is-not-hierarchical.md](#) inward, arguing that the DSM's implicit ranking of mental states against a "normal" baseline fails for the same structural reason hierarchical worth fails between persons. The variant is substantive, not only architectural.

The language work in this domain

The language work in this domain is the thick observation of the person in context. Not "symptoms" — symptoms is already a framework-laden word, because a symptom is a symptom of something, and the something is a disorder the observer is already looking for. Observation, at Layer 1, is the person's speech, sleep, relationships, energy, body-states, memories, trauma history, family context, living conditions, work situation, financial stress, cultural and religious location, patterns across weeks and seasons, and the meanings the person attaches to their own experience.

Maté's biopsychosocial approach, articulated across his books and in his *Compassionate Inquiry* practice, is a Layer 1 practice in this domain. The clinician or practitioner spends time with the person — hours, not minutes — and builds a thick record of what the person's life is like from the inside. The record includes the body (sleep, appetite, tension, pain, sensation, energy); the family of origin (attachment patterns, losses, traumas, what was possible to feel and what was not); the current relational world (who loves the person, who hurts them, what is reciprocated and what is not); the work and financial context (stress, meaningfulness, autonomy, security); the cultural and spiritual dimension (what matters, what has mattered, what has been lost); and the person's own narration of their life, in their own words, at their own pace.

Crucially, Layer 1 includes the person's trauma history. Maté's clinical argument is that most of what the DSM labels as mental disorder is the adaptive response of a human nervous system to circumstances that required adaptation. The adaptive responses become maladaptive when the circumstances change or when they persist too long, but the response itself was intelligent and context-appropriate at the time it was formed. Reading the response without reading the context reads the adaptation as though it were a disorder. Maté's point is not that disorders do not exist; it is that the context is Layer 1 data and must be recorded before any Layer 2 framework is applied. Without the context, the framework applies to a thin slice of the person's presentation and misses what would have explained the presentation.

The language layer also includes the person's own vocabulary. A person describing their own experience uses words that often do not map cleanly to DSM categories — "I feel underwater", "I can't find myself", "everything is muffled", "I keep waking at 4 a.m. and can't stop thinking", "I don't feel my body". Preserving the person's own language at Layer 1 keeps the observation from being prematurely translated into the framework's vocabulary. Translation is a judgement move, and judgement moves belong at Layer 2.

Language work alone is insufficient. A thick biopsychosocial record by itself does not produce a diagnosis, a treatment plan, or a verdict about what is happening. It produces a record. Closing the clinical question requires the judgement layer — a framework that says what counts as a condition requiring response, what kinds of response correspond to what kinds of pattern, and what thresholds separate ordinary human distress from clinical significance. Without a framework, the record sits as description. The record alone also does not tell the person what to do. The practitioner must apply a framework, and the framework must be one the person can see and examine rather than one embedded inside the practitioner's clinical intuition. SDC in this domain therefore does not argue that clinicians should only describe and never diagnose. It argues that the framework they apply should be visible, revisable, and applied to the observation as a traceable step — not as a fused utterance that closes the clinical encounter in fifteen minutes.

The judgement work in this domain

The judgement work has two parts — the diagnostic verdict and the treatment verdict — and they are different.

The diagnostic verdict. The rubric here is the DSM (or, internationally, the ICD-11's chapter on mental, behavioural, and neurodevelopmental disorders). The DSM specifies criteria: for Major Depressive Disorder, five or more of nine listed symptoms present during the same two-week period, including either depressed mood or loss of interest, not better accounted for by bereavement or another condition. The criteria are explicit. Applied to a Layer 1 biopsychosocial record, the criteria would produce a determinate answer: the observation meets the criteria, the observation does not, or the observation meets the criteria under one reading and not under another. The diagnostic verdict at Layer 2 is the application of the criteria to the observation, with the reading made visible.

The DSM's authority, however, is not only its criteria. The DSM is also an institutional artefact that determines insurance coverage, legal standing, research funding, pharmaceutical marketing targeting, and social recognition. The criteria can be applied faithfully and still produce a verdict that carries consequences the faithful application did not consider. SDC does not resolve this — it surfaces it. A Layer 2 application of the DSM can and should include the meta-layer: *the rubric I am applying is the DSM-5-TR; the rubric carries these institutional consequences; the verdict I am issuing will therefore do these things in the world.*

The treatment verdict. This is a separate judgement, often collapsed into the diagnostic one. A person who meets criteria for MDD does not, by that fact alone, require a specific treatment. The options include pharmacological intervention (SSRIs, SNRIs, atypical antidepressants), psychotherapeutic intervention (CBT, psychodynamic therapy, trauma-focused therapy, somatic therapy), social intervention (changing life circumstances, addressing relational situations, addressing economic stress), lifestyle intervention (sleep, exercise, nutrition, rest), and no intervention (the observation that many episodes resolve without treatment). The rubric for treatment is not the DSM — it is the evidence base for each intervention across different presentations, plus the person's own preferences, capacities, and constraints. The treatment verdict should follow from the diagnostic verdict only in the sense that it attends to the same observation; it is not implied by the diagnostic verdict.

In contemporary clinical practice, the treatment verdict frequently is implied. A diagnosis of MDD routinely leads to an SSRI prescription, because pharmaceutical interventions are the most readily available in the time a clinician has. The automatic link between diagnosis and pharmacological treatment is a collapse of two verdicts into one, and it is reinforced upstream by the fact that pharmaceutical research and marketing are structured around DSM categories. The rubric for what MDD *is* and the rubric for what MDD *requires* have been fused at the level of the industry, not only at the level of the individual encounter.

The collapse, with examples

The collapse in this domain is dense and consequential. A partial inventory:

"I think you have depression." After a 15-minute intake. The sentence fuses observation (what the clinician saw and heard), rubric-application (does the observation meet the DSM criteria), diagnostic verdict (yes), and the implicit treatment framing (you have a condition I can treat). Four operations in one sentence. The person cannot contest any of them without contesting all of them.

"The patient presents with depressive symptoms." *Presents with* is half-observation, half-framework-application. The sentence names what was observed using words that are already DSM vocabulary. A person crying in the room has not "presented with depressive symptoms" at Layer 1; the person has cried. *Depressive symptoms* is the Layer 2 label applied to the crying. The sentence bundles them.

"Meets criteria for Generalized Anxiety Disorder." Reads as fact. Is a judgement applied — the clinician has read the observation through the criteria and produced the verdict. The reader cannot see the reading. The sentence's form implies the criteria were met in the same way that a temperature reading meets a thermometer's mark — automatically, objectively. The clinical application is not automatic or objective in that sense, but the sentence claims the automaticity.

The ICD-code as chart entry. Once the diagnosis is recorded in the chart as "F32.1 Moderate depressive episode", the code travels. Insurance reads it, the employer (where relevant) may read it, the school reads it, future clinicians read it, the person's own electronic record carries it. The code fuses observation, verdict, and billing category into one administrative artefact that outlives the encounter that produced it.

Treatment that follows "automatically". "You have X, so we'll start you on Y." The sentence implies the prescription is entailed by the diagnosis. It is not. The entailment has been built into the clinical workflow by habit, by pharmacological industry structure, and by time constraints. A rubric-visible practice would pause at this step and ask: given this diagnosis, what are the treatment options, what does the person want, what does the evidence base say for this person in this situation. The automaticity is the collapse at the treatment-verdict layer.

Self-diagnosis via DSM symptom lists. A person reading a DSM summary on the internet identifies themselves in the criteria and concludes "I have ADHD" or "I have PTSD" or "I have bipolar II". The self-diagnosis is rubric application without a Layer 1 record — the person applies the criteria to their own recollected experience without the thickness of observation, without the exclusion criteria, and without the clinical presence that could surface what is missing. The resulting diagnosis is usually wrong in interesting ways, but the wrongness is invisible because the framework has been applied without the observation layer.

"You are depressed." An ontological verdict delivered as a clinical observation. The sentence presents the person's state as their being — the diagnosis has become identity. "You are experiencing a depressive episode against the DSM-5 criteria for Major Depressive Disorder, under a reading that privileges this set of symptoms and discounts that one" is a Layer 2 verdict about a specific framework application. "You are depressed" is a statement about who the person is. The collapse between the two is what Maté calls *the myth of normal* — the assumption that the DSM's categories name real properties of persons rather than verdicts applied by a specific framework in a specific institutional context.

The 15-minute intake. The structural compression that makes the separation impossible. The encounter is paid for as a 15-minute unit. In 15 minutes, a clinician cannot build a Layer 1 record, apply a Layer 2 framework, separate the treatment verdict, and explain the verdict's conditional nature. They can only do the fused utterance. The form of the encounter is the form of the collapse. Changing the individual clinician's practice without changing the encounter's duration is insufficient; the collapse is structural.

Categorical statements about prognosis. "This is chronic; you will need to manage it for life." The sentence carries a prognostic verdict. The DSM does not specify prognoses for most disorders at the individual level; the clinician's prognostic statement is drawing on population-level data and presenting it as if it applied to this person. The collapse here is between population-level rubric-level claims and individual-level verdicts. Layer 2 data does not directly support Layer 3 individual-level prognostic statements, but the form of the clinical utterance assumes the inference.

Each of these moves collapses cognitive operations that the DSM's own structure implies should be separable. The DSM, as a document, survives the critique — it is not the rubric that is the problem; it is the compression of the rubric's application into a single clinical utterance. SDC's move is not to replace the DSM but to restore the DSM to its status as a rubric and to insist that rubric application is a distinct, auditable operation that a 15-minute encounter cannot honestly perform.

The cost of the collapse

Several costs follow from the collapse.

People become their diagnoses. The shift from "I am experiencing a depressive episode that meets the criteria for MDD under a reading that privileges these symptoms" to "I am depressed" is the shift from a Layer 3 verdict under conditions to an ontological claim about the self. The person absorbs the diagnosis as identity. Identity is harder to change than a conditional verdict. Over years, the diagnosis organises how the person reads their own experience, how they explain themselves to others, what they accept as possible for themselves, and what interventions they consider. Maté's clinical argument is that this identity-formation is one of the central harms the diagnostic encounter produces, and it is produced by the collapse of the three layers into the fused utterance.

Context collapses. Trauma history, social conditions, relational patterns, body-context, cultural dimension — all of it falls outside the DSM's criteria because the DSM categorises

presentations, not causes. When the diagnosis becomes the case's organising frame, the context is discarded as "background". Maté's critique is that the context is not background — it is the case. A person whose depression is inseparable from an ongoing abusive relationship, or from chronic pain, or from trauma in early childhood, is not treated adequately by a framework that categorises the depression without seeing the context. The collapse erases the context by making the diagnosis sufficient for the case.

Medication becomes default. Pharmaceutical intervention is the fastest to prescribe, the most reimbursed by insurance, the most studied in the academic literature that the DSM's authors draw on, and the most marketed by the industry that funds much of the relevant research. When the diagnostic and treatment verdicts are fused, the easiest treatment becomes the assumed treatment. Psychotherapy, social intervention, and lifestyle change require more time, more money, and more clinician skill; they are harder to default to. The structural tilt toward medication is not a preference of individual clinicians; it is a consequence of the collapse operating inside institutional conditions.

Disagreement appears factual. When two clinicians disagree about a diagnosis, the disagreement reads as a factual dispute: is this actually MDD, or is it bipolar II with depressive phase dominance, or is it a trauma response mislabelled as an affective disorder? The form of the dispute suggests that one of the clinicians has misread the observation. The deeper structure is usually that they are applying different rubrics (or different readings of the same rubric) to different selections from the observation. The collapse hides the rubric dispute and presents it as an observational dispute. Patients caught in the disagreement are told "we need more data" when the deeper need is a framework-level conversation.

Patients cannot contest the diagnosis. To contest "I think you have depression", the patient must contest what the clinician "saw". The sentence's form makes the contestation of the verdict equivalent to the contestation of the observation. A patient who says "I am not depressed" is heard as either denying the symptoms (which the clinician will read as further evidence) or as disagreeing with the framework (which the clinician may not recognise as a legitimate category of response). A rubric-visible practice would allow the patient to say "I accept that the symptoms you observed are present; I do not accept that they meet the MDD criteria under the reading you are applying; I propose an alternative reading or a different rubric" — and the clinician would be able to respond at the framework layer rather than at the observational layer. The current practice does not allow this conversation because the layers are fused.

Insurance and state systems lock verdicts in administratively. Once a diagnosis enters a health record, an insurance claim, a disability application, or a workplace

accommodation request, the verdict becomes administrative reality. Revising the verdict later requires new clinical encounters, new chart entries, and often actuarial or bureaucratic acceptance of the revision. The verdict's institutional weight grows even as the clinical situation changes. The collapse produces administrative durability for verdicts that were issued in 15 minutes.

Pharmaceutical marketing reinforces the collapse upstream. The industry that develops psychotropic medications markets them against DSM categories. "Zoloft for depression." "Abilify for bipolar disorder." The marketing presumes the collapse — it addresses the category as though the category were the person's condition, and it addresses the medication as though the medication were the answer implied by the condition. The marketing's commercial logic depends on the fusion being invisible. A rubric-visible practice would undermine the marketing's effectiveness by restoring the conditional structure of the verdict.

The DSM itself drifts under institutional pressure. Over successive editions, the DSM has added categories, lowered thresholds for some existing categories, and shortened required symptom durations. Each change has been contested by clinicians and researchers, and each has had commercial consequences for the pharmaceutical and insurance industries. The drift is predictable: in an environment where the rubric's application is fused with the commercial consequences of the application, the rubric tends to move in the direction that expands commercially useful categories. Making the rubric an explicit, inspectable artefact — with its revisions tracked, its framework-level debates visible, and its commercial context acknowledged — is part of what SDC in this domain would require.

The separation, in this domain's language

Applying SDC in psychiatric practice means restoring the three operations as distinct activities, each with its own craft, each producing its own artefact, each auditable independently.

Layer 1 — biopsychosocial observation (language work). The practitioner spends time with the person. Hours, sometimes multiple sessions. The record is thick: speech, sleep, body-state, relationships, family of origin, trauma history, work, culture, living conditions, the person's own vocabulary for their experience. The record preserves the person's language where possible. The record is not translated into DSM vocabulary at this stage.

Compassionate Inquiry, Maté's clinical practice, is a Layer 1 method. The aim of Layer 1 is not to produce a diagnosis; it is to produce a record of the person's life that is thick enough to be read honestly.

Layer 2 — framework application (judgement work). The practitioner — and, where the person is able, the person themselves — applies a framework to the Layer 1 record. The framework could be the DSM, the ICD-11, a biopsychosocial framework that refuses the DSM's category structure (as Maté's does), a trauma-informed framework, a systems framework, or some combination. The framework is named explicitly. Its criteria, thresholds, and exclusions are made visible. The application to the specific record is shown: which observations map to which criteria under what reading. Where multiple frameworks would produce different verdicts, this is acknowledged. Where the evidence is borderline, this is acknowledged. The Layer 2 output is conditional: *under DSM-5-TR, this observation meets the criteria for X; under a trauma-informed reading, this observation is the adaptive response to Y; the two readings are compatible in the following ways and incompatible in these other ways.*

Layer 3 — verdict and narration. The diagnostic verdict and the treatment verdict, narrated as conditional statements that reference Layer 1 and Layer 2. The diagnostic verdict: *given the observation and the framework applied, the condition is best understood as ... under this reading, which is revisable if further observation changes the picture or if a different framework is adopted.* The treatment verdict: *given the diagnostic reading and the person's own preferences and constraints, the available interventions include ..., with these evidence bases, these likely effects, and these side effects; the person's choice is ...* The narration is readable by the person. It carries the condition of its own revisability.

Layer 1 alone is insufficient. A thick biopsychosocial record that does not feed into a framework produces a person who has been deeply listened to and still does not know what to do. Layer 2 alone, without Layer 1, is the DSM-as-template applied without observation — the self-diagnosis failure mode. Layer 3 alone, without the other two, is the fused utterance that the current practice produces in 15 minutes. The architecture requires the three layers together, in order, visibly separated.

This is also what *animalRightsLens*'s architectural approach implies at a different domain: description, rubric, narration, each preserved and each contestable. The variant does not have a Koher tool landing yet, but the architecture is the same.

Philosophical grounding

The SDC move in this domain draws on four older arguments.

Gabor Maté's biopsychosocial approach. Maté's clinical and written work — *When the Body Says No*, *In the Realm of Hungry Ghosts*, *The Myth of Normal*, *Scattered Minds*, and the Compassionate Inquiry curriculum — is the primary clinical reference for this variant. Maté's core argument is that most of what the DSM categorises as disorder is the adaptive response of the human nervous system to conditions that required adaptation — trauma, attachment disruption, social dislocation, chronic stress, spiritual deprivation. Reading the adaptation without reading the conditions mistakes the adaptation for a disorder. Compassionate Inquiry, the clinical practice Maté developed, is a Layer 1 method — the practitioner spends hours with the person, builds the thick record, surfaces the connection between present symptoms and earlier adaptations, and creates the condition under which the person can encounter their own life honestly. Maté's contribution to this variant is substantive: the biopsychosocial record is the observation Layer 1 should produce, and the failure to produce it is the central clinical failure he has been naming for thirty years.

R. D. Laing's existential psychiatry. Laing's *The Divided Self* (1960) and *The Politics of Experience* (1967) argued that the categories of psychiatry often obscure the person's existential situation. A person described as "schizophrenic" may be making intelligible responses to an untenable family or social situation; the category, applied without the context, renders the person's responses unintelligible and therefore pathological. Laing's argument is an instance of what this variant calls the collapse — the framework's application without the observation's context produces a verdict that fails the person. SDC inherits the critique without inheriting Laing's more contested conclusions about the ontology of schizophrenia.

Michel Foucault on psychiatric power. Foucault's *Madness and Civilization* (1961), *The Birth of the Clinic* (1963), and *Psychiatric Power* (the 1973–74 lectures at the Collège de France) argued that the categories of psychiatry are political acts — they define who is inside and who is outside the community of the sane, and they authorise institutional responses (confinement, medication, surveillance) that would otherwise require justification. Foucault's critique is not that the categories are false; it is that they do political work while claiming clinical neutrality. The collapse between observation, framework, and verdict is one mechanism by which the political work is performed

invisibly. Making the framework an explicit artefact, with its institutional consequences acknowledged, is a step toward the kind of honesty Foucault demanded.

The worth argument extended inward. The argument in

`/home/prayas/Dropbox/personal_projects/gabor.mate/worth-is-not-hierarchical.md` (Prayas Abhinav, 11 April 2026) applies in this domain in a specific way. The DSM implicitly ranks mental states against a "normal" baseline — states below the baseline are disorders requiring intervention, states at or above the baseline are acceptable. The ranking presupposes a common unit in which different mental conditions can be compared. The worth argument shows that rankings presupposing common units across incommensurable domains fail. Applied to mental states, the argument suggests that the DSM's implicit baseline is not a feature of reality but a framework-level commitment, and that different frameworks (Maté's, Laing's, traditional healing systems across cultures) would produce different baselines. A person's mental state does not admit a hierarchical ranking against a universal standard; it admits only framework-conditional verdicts, each of which should be held as conditional. Maté's own phrase *the myth of normal* is the conclusion the worth argument supports inside this domain: what is called normal is a framework-level commitment that has been rendered invisible through repeated use. SDC's architectural move makes the framework visible and the verdict conditional, which is what the worth argument requires.

The four traditions are compatible and reinforcing. Maté provides the clinical practice; Laing and Foucault provide the critical tradition; the worth argument provides the structural reason the critical tradition is right. Together they ground the variant's claim that the DSM's current mode of application is a collapse that can be restored to its three-layer architecture without abolishing the DSM itself.

Relationship to Koher output

The psychiatric-diagnosis variant has no Koher tool landing yet. Its relationships are intellectual and prospective.

The Maté archive. The research materials folder at

`~/Dropbox/personal_projects/gabor.mate/` contains the full texts of Maté's published books, along with parsed reference documents. The `gabor-mate-dialogue` agent is configured to draw only on these sources. The variant's clinical

grounding is in this archive; any further writing or tool development in this domain would draw from it.

The worth document. `worth-is-not-hierarchical.md` is the philosophical spine of the variant, applied inward to mental states. The connection is load-bearing: the worth argument does not only ground the animal-rights variant (where it explains why non-hierarchical worth extends across species), it also grounds this variant (where it explains why non-hierarchical worth extends across mental states within a species). The two variants are siblings of a common structural argument.

Compassionate Inquiry. The Compassionate Inquiry curriculum that Maté and his collaborators have developed is a Layer 1 method with explicit training materials. A partnership with the Compassionate Inquiry community — for teaching, for practitioner dialogue, for a potential Level B collaboration — is imaginable. Prayas has not yet approached the community in this capacity; the variant's existence makes the approach describable if and when it becomes timely.

No current tool. *animalRightsLens* is the closest architectural sibling — language, rubric, narration, with the rubric's framework substantively argued from the worth position. A Koher tool in the mental-health domain would face complex ethical and regulatory constraints (clinical claims, data protection, user vulnerability) that are beyond the tools-scratch folder's current scope. The variant is not an argument for building such a tool. It is an argument that the SDC architecture, once articulated, has clinical relevance that a future collaboration might surface.

Potential writing contribution. A long essay or book chapter making this argument — Maté-lineage critique of the DSM as a collapse rather than as a rubric failure — would land well in the intersection of clinical philosophy, narrative medicine, and Maté-adjacent practitioner literature. It would be distinct from Maté's own writing (which operates at Layer 1 and in clinical register) by providing the architectural account that Maté's clinical argument has not quite reached. The essay would be intellectually substantive and stake-consistent with Prayas's interests without crossing into clinical claims Prayas is not qualified to make.

What this variant makes possible

A **vocabulary becomes available** for the experience of being diagnosed. A person who has received a DSM diagnosis can recognise the fused utterance, identify the layers that

were compressed, and re-engage with the diagnosis as a Layer 3 verdict under specific framework-application conditions rather than as an ontological fact about themselves. This is not a rejection of the diagnosis; it is a reading of the diagnosis that preserves the person's agency in relation to it.

A **clinical practice becomes nameable** that many clinicians already conduct but cannot fully describe. Clinicians in Maté's lineage, in existential traditions, in certain family-therapy traditions, in trauma-informed practices — many already hold the layers apart in their own work and struggle to defend the practice inside institutions structured around the fused encounter. The variant gives the practice a structural name. A clinician who says "my practice separates biopsychosocial observation from framework application from treatment decision" is making a legible claim that the current institutional culture can receive.

A **pedagogical contribution becomes conceivable**. Medical and psychology curricula currently teach diagnosis as a single activity. A curriculum module that taught the three-layer separation as three distinct cognitive operations, each with its own craft, would produce clinicians who could not comfortably operate inside the fused-utterance genre. Over time such clinicians would change the practice.

A **cultural contribution becomes possible**. The contemporary cultural conversation about mental health is saturated with DSM categories — people self-identify with disorders, communities form around diagnoses, popular writing adopts the vocabulary. Some of this is useful — people find language for experiences they had not been able to describe. Some of it is the collapse at scale — identities forming around Layer 3 verdicts whose Layer 2 and Layer 1 components have been invisible. A public intellectual contribution that named the architecture would give the public conversation a different register, in which diagnoses could be taken seriously as conditional verdicts rather than absorbed as identity.

The variant does not argue that the DSM should be abandoned, that psychotropic medication is wrong, that clinical psychiatry is illegitimate, or that mental-health professionals should stop diagnosing. These are debates the variant does not enter. It argues that the cognitive architecture currently bundled inside the diagnostic encounter is a collapse of three distinct operations into one, that the collapse has specific costs that SDC predicts, and that the layers can be held apart without surrendering the DSM's rubric function or the clinician's authority to issue verdicts. Observation can be thick. Rubrics can be explicit. Verdicts can be conditional. The practice is not impoverished by the separation; it is made auditable and, in Maté's sense of the word, honest.

Version 1.0 — 16 April 2026. Read `./sdc.md` and `README.md` before working on this variant. Stake: intellectual, not clinical; grounded in the Maté archive (`~/Dropbox/personal_projects/gabor.mate/`) and the worth argument applied inward; sibling to the animal-rights variant at the level of philosophical grounding; no Koher tool landing yet — prospective writing contribution to Maté-adjacent practitioner literature.