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Review Article

Vol. 2, Issue 2, July-December 2026 | ISSN: 3107-9024

Journal of Psychiatry and Psychological Sciences

Rethinking the Boundaries of Psychiatry: A Critical Review of Overmedicalization and the DSM Paradigm

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Received: June 17, 2026; **Manuscript No:** JPPC-26-2721; **Editor Assigned:** June 20, 2026; **PreQc No:** JPPC-26-2721 (PQ); **Reviewed:** July 16, 2026; **Revised:** July 21, 2026; **Manuscript No:** JPPC-26-2721 (R); **Published:** August 13, 2026, **DOI:** 10.67238/jppc.2026.v2.18

Citation: Shishodia A (2026). Rethinking the Boundaries of Psychiatry: A Critical Review of Overmedicalization and the DSM Paradigm. J. Psychiatr. Psychol. Sci. Vol.2 Iss.2, August (2026), pp:197-209.

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ABSTRACT

Psychiatry is undergoing a period of critical self-examination as concerns grow regarding diagnostic inflation, the medicalization of ordinary human experiences, and the limitations of categorical diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM). While the DSM has provided a shared language for clinicians, critics argue that its expansion has contributed to overmedicalization, pathologizing normative variations in emotion and behavior. This narrative review synthesizes historical, empirical, sociocultural, and philosophical critiques of psychiatric overmedicalization, with particular attention to diagnostic expansion, pharmaceutical influence, and the growing evidence supporting dimensional models of mental distress. We examine the evolution of psychiatric nosology, the drivers and consequences of diagnostic inflation, and the implications for global mental health. The review concludes by proposing a paradigm shift toward contextual, dimensional, and culturally grounded approaches that embrace epistemic humility and resist reductionist tendencies.

Keywords: Overmedicalization; DSM; Psychiatric Diagnosis; Dimensional Models; Diagnostic Inflation; Pharmaceutical Influence; Epistemic Humility; Global Mental Health

INTRODUCTION

Psychiatry is undergoing a period of profound self-reflection as concerns intensify regarding diagnostic inflation, overmedicalization, and the limitations of categorical diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) [1]. While the DSM has provided a shared language for clinicians and facilitated research standardization, critics argue that its expansion has contributed to the pathologization of ordinary human experiences, reframing normative variations in emotion, behavior, and personality as symptoms of mental disorder [2,3]. This tension between clinical utility and conceptual validity lies at the heart of contemporary debates about the future of psychiatric diagnosis.

The DSM's evolution reflects shifting scientific paradigms, cultural norms, and institutional pressures. Early editions were grounded in psychodynamic theory, whereas later versions embraced operationalized criteria and a biomedical orientation [1]. However, despite these changes, the DSM continues to rely on symptom-based categories that lack objective biomarkers and often fail to capture the complexity of mental distress [4]. As a result, the boundary between normality and pathology has become increasingly porous, raising concerns about diagnostic inflation and the medicalization of everyday life [5].

Overmedicalization refers to the process by which non pathological experiences are reframed as medical problems requiring diagnosis and treatment. In psychiatry, this phenomenon is particularly pronounced due to the subjective nature of symptom reporting, the cultural authority of psychiatric expertise, and the influence of pharmaceutical marketing [2,6]. For example, sadness may be diagnosed as major depression, shyness as social anxiety disorder, and childhood exuberance as attention deficit/hyperactivity disorder (ADHD). These trends reflect broader societal expectations for emotional regulation, productivity, and rapid solutions to distress.

At the same time, emerging dimensional and network-based models challenge the validity of categorical diagnoses. Dimensional frameworks conceptualize mental disorders as variations along continua rather than discrete entities, aligning more closely with genetic, neurobiological, and psychological evidence [4]. Network models propose that symptoms interact dynamically rather than reflecting underlying disease categories. These approaches offer promising alternatives to traditional nosology, though they also present challenges for clinical implementation.

Cultural psychiatry further complicates the diagnostic landscape by highlighting the role of cultural norms, social

context, and meaning in shaping the experience and expression of distress. Anthropological research demonstrates that psychiatric categories are not universal but culturally constructed, raising concerns about the global exportation of Western diagnostic frameworks [3]. For example, somatic expressions of distress in South Asia, spirit related idioms in Africa, and phenomena such as hikikomori in Japan illustrate the diversity of cultural expressions of suffering. Applying Western diagnostic categories without cultural adaptation risks misdiagnosis, cultural mismatch, and the erosion of indigenous healing traditions.

Pharmaceutical influence represents another critical dimension of diagnostic expansion. The rise of modern psychopharmacology coincided with the operationalization of DSM criteria, creating incentives for aligning diagnostic categories with medication markets [2]. Industry funded research, disease awareness campaigns, and direct to consumer advertising have shaped public and professional perceptions of mental illness, contributing to diagnostic inflation and the overuse of medication [6]. These dynamics raise ethical concerns about conflicts of interest, bias in research, and the prioritization of pharmacological interventions over psychosocial approaches.

Despite these challenges, psychiatric diagnosis remains essential for clinical communication, treatment planning, and access to care. The goal is not to abandon diagnosis but to refine it. A reimagined diagnostic framework would integrate dimensional science, cultural context, and social determinants of mental health. It would embrace epistemic humility, recognizing the provisional nature of diagnostic constructs and the limitations of current knowledge. It would also prioritize patient narratives, lived experience, and relational understanding alongside biological and psychological evidence.

This review synthesizes historical, empirical, sociocultural, and philosophical critiques of psychiatric overmedicalization, with particular attention to diagnostic expansion, pharmaceutical influence, and emerging alternatives to categorical diagnosis. It argues for a paradigm shift toward contextual, dimensional, and culturally grounded approaches that resist reductionist tendencies and promote ethical, patient centered care. Such a shift is essential for restoring public trust, improving clinical outcomes, and ensuring that psychiatry remains responsive to the diverse ways in which humans experience suffering and seek healing.

REVIEW CONTENT

This review employs a narrative review methodology, which is the most appropriate approach for synthesizing historical, sociocultural, philosophical, and empirical critiques of psychiatric diagnosis. Unlike systematic reviews which are optimized for narrowly defined clinical questions narrative reviews allow for the integration of heterogeneous sources, including conceptual analyses, epidemiological data, anthropological studies, and critiques of psychiatric nosology [7]. Given that overmedicalization is a multidimensional phenomenon shaped by cultural, institutional, and commercial forces, a narrative approach enables a more comprehensive and theoretically grounded synthesis.

Narrative reviews are particularly suited to examining the evolution of diagnostic systems such as the DSM, whose categories reflect shifting scientific paradigms and sociopolitical influences rather than discrete biological entities [8]. This methodology also allows for the incorporation of perspectives from philosophy of psychiatry, cultural psychiatry, and critical social science, which are essential for understanding the broader implications of diagnostic expansion.

Search Strategy

A broad search strategy was used to identify relevant literature across multiple disciplines. Databases searched included PubMed, PsycINFO, Scopus, and Google Scholar. Search terms included:

- “Overmedicalization Psychiatry”
- “Diagnostic Inflation Dsm”
- “Psychiatric Nosology Criticism”
- “Pharmaceutical Influence Mental Health”
- “Dimensional Models Psychopathology”
- “Rdoc Critique”
- “Hitop Model”
- “Cultural Psychiatry Diagnostic Validity”

Searches were supplemented by backward citation tracking, review of seminal monographs in philosophy and anthropology of psychiatry and examination of policy documents from the World Health Organization and National Institute of Mental Health [9,10].

Inclusion Criteria

Sources were included if they:

- Were PeerReviewed Articles, Academic Books, Or Authoritative Policy Documents
- Were Published Between 1980 And 2025
- Addressed Psychiatric Diagnosis, DSM Evolution, Medicalization, Or Dimensional Models
- Contributed Conceptual, Empirical, Or Historical Insights Relevant to The Review’s Aims

This timeframe captures the period of greatest diagnostic expansion, beginning with DSM III in 1980 and continuing through DSM 5 and contemporary dimensional frameworks.

Exclusion Criteria

Sources were excluded if they:

- were case reports or singlepatient studies
- focused exclusively on treatment efficacy without addressing diagnosis
- were nonEnglish publications
- lacked relevance to diagnostic frameworks or medicalization

Limitations

Narrative reviews are inherently subject to selection bias, as they rely on the author’s judgment in selecting and interpreting sources [7]. However, this methodology is justified given the conceptual nature of the topic and the need to integrate insights across disciplines. The aim is not to provide an exhaustive catalog of all literature but to synthesize key

arguments that illuminate the dynamics of overmedicalization and diagnostic expansion.

Historical Evolution of Psychiatric Diagnosis

Understanding contemporary concerns about overmedicalization requires examining the historical development of psychiatric diagnosis. The DSM did not emerge in isolation; it reflects evolving scientific paradigms, cultural assumptions, and institutional pressures [1,8]. Each edition represents a negotiation between competing visions of what constitutes mental disorder.

DSM I and DSM II: Psychodynamic and Descriptive Foundations

The first two editions of the DSM (1952 and 1968) were heavily influenced by psychodynamic and psychobiological theories. Diagnoses were descriptive and narrative rather than operationalized, reflecting the dominance of psychoanalytic thinking in mid-20th century American psychiatry [11]. Terms such as "neurosis," "reaction," and "psychogenic" reflected the assumption that mental disorders were rooted in unconscious conflict or maladaptive personality patterns.

Key characteristics included:

- Lack of operational criteria
- Low inter rater reliability
- Strong cultural influence (e.g., homosexuality classified as a disorder until 1973)
- Institutional variability in diagnostic practices

These early editions were criticized for their subjectivity and lack of scientific rigor [12]. However, they also reflected a more holistic understanding of distress, acknowledging the role of personality, relationships, and life events.

DSM III: The Neo Kraepelinian Revolution

The publication of DSM III in 1980 marked a paradigm shift. Often described as the "Neo Kraepelinian revolution," DSM III introduced:

- operationalized diagnostic criteria
- symptom checklists
- a categorical disease model
- an atheoretical stance (in theory)
- improved interrater reliability

This shift was driven by scientific, institutional, and political pressures [13]. Psychiatry faced criticism for lacking reliability and scientific legitimacy, and operational criteria were seen as a way to align the field with general medicine.

DSM III dramatically expanded the number of disorders and lowered thresholds for diagnosis. While reliability improved, validity remained uncertain [14]. Critics argued that the manual reified constructs that lacked empirical grounding.

DSMIV and DSM5: Expansion, Controversy, and Diagnostic Inflation

DSM IV (1994) and DSM 5 (2013) continued the trend of diagnostic expansion. DSM 5, in particular, generated controversy for:

- Removing the bereavement exclusion
- Expanding Adhd Criteria
- Introducing new disorders (e.g., disruptive mood dysregulation disorder)
- Collapsing autism subtypes

Field trials revealed low inter-rater reliability for several major diagnoses, including Major Depressive Disorder and Generalized Anxiety Disorder [15]. Critics argue that DSM 5 reflects:

- Pharmaceutical Influence [2]
- Cultural Intolerance of Distress [5]
- Administrative Needs (Insurance, Disability Claims)
- A Reductionist Biomedical Paradigm [16]

The result is a diagnostic system that is reliable enough for administrative purposes but insufficiently valid for scientific or clinical precision.

Overmedicalization and Diagnostic Inflation

Overmedicalization has become one of the most widely discussed challenges in contemporary psychiatry. It refers to the process by which ordinary human experiences, social problems, and culturally normative behaviors are reframed as medical conditions requiring diagnosis and treatment. Diagnostic inflation the steady expansion of diagnostic categories and the lowering of thresholds for existing disorders has accelerated over the past four decades, particularly since the publication of DSM III in 1980 [13]. This section examines the structural, cultural, and institutional forces driving overmedicalization, as well as its clinical and societal consequences.

The DSM's categorical framework, while intended to improve reliability, has contributed to the pathologization of normal emotional and behavioral variation. Critics argue that the manual's expansion reflects not only scientific developments but also cultural expectations, administrative pressures, and commercial interests [14]. As a result, the boundary between normality and pathology has become increasingly blurred, with significant implications for clinical practice and public perceptions of mental health.

Medicalization of Normal Emotions

One of the most visible manifestations of diagnostic inflation is the reclassification of normal emotional states as psychiatric disorders. Human beings experience sadness, fear, grief, anger, and worry as part of the natural spectrum of emotional life. These emotions serve adaptive functions: grief facilitates mourning and social support; anxiety alerts individuals to potential threats; shyness reflects temperamental variation rather than pathology [15].

Yet in contemporary psychiatric practice, these experiences are increasingly interpreted through a biomedical lens. Several examples illustrate this shift:

Grief as Major Depressive Disorder

The removal of the bereavement exclusion in DSM 5 allows grief to be diagnosed as Major Depressive Disorder after only two weeks of symptoms. Critics argue that this pathologizes a

universal human experience and risks medicalizing the normal process of mourning [16].

Shyness as Social Anxiety Disorder

Shyness, introversion, and social reticence are common personality traits. However, the expansion of Social Anxiety Disorder criteria has blurred the distinction between temperament and pathology, contributing to rising diagnosis rates [17].

Childhood energy as ADHD

High activity levels, impulsivity, and distractibility are common in childhood, particularly in boys. Yet educational pressures, reduced tolerance for behavioral variation, and broadened diagnostic criteria have contributed to dramatic increases in ADHD diagnoses and stimulant prescriptions [18].

Worry as Generalized Anxiety Disorder

Worry is a universal cognitive process. When diagnostic thresholds are lowered, everyday concerns about work, relationships, or health can be reframed as symptoms of Generalized Anxiety Disorder [14].

These examples illustrate how diagnostic expansion can transform normal emotional variation into medical pathology, often with significant clinical and social consequences.

Structural Drivers of Diagnostic Inflation

Diagnostic inflation does not occur in isolation. It is driven by a complex interplay of structural, cultural, economic, and institutional forces. Several key drivers are particularly influential:

Insurance and Reimbursement Systems

In many healthcare systems, reimbursement requires a formal diagnosis. Clinicians may feel pressured to assign diagnoses even when symptoms fall within the range of normal variation to ensure patients receive care [13]. This creates a structural incentive for diagnostic expansion.

Pharmaceutical Marketing

The pharmaceutical industry has played a major role in shaping diagnostic categories. Direct to consumer advertising, disease awareness campaigns, and the promotion of "chemical imbalance" narratives have contributed to public demand for diagnosis and medication [14]. Conditions such as social anxiety, adult ADHD, and bipolar spectrum disorders have been heavily marketed.

Cultural Expectations of Rapid Solutions

Modern societies increasingly view distress as a problem to be eliminated rather than a natural part of life. The expectation of quick fixes often in the form of medication creates demand for diagnostic labels that justify treatment [15].

Educational and Occupational Pressures

Schools and workplaces often rely on psychiatric diagnoses to access accommodations or justify performance issues. This can lead to increased diagnosis of ADHD, learning disorders, and anxiety disorders [18].

Expansion of "Risk" Categories

The DSM has increasingly included prodromal or subthreshold conditions (e.g., attenuated psychosis syndrome), which broaden the scope of pathology and increase the number of individuals eligible for diagnosis [16].

Administrative and Legal Pressures

Diagnostic labels are used in disability claims, forensic evaluations, and educational planning. This administrative reliance on diagnosis reinforces diagnostic inflation [17].

These structural drivers create a feedback loop in which diagnostic expansion becomes self perpetuating.

Clinical Consequences of Overmedicalization

The consequences of overmedicalization extend far beyond diagnostic labels. They shape treatment decisions, patient identity, public perceptions of mental health, and the allocation of healthcare resources.

Overdiagnosis and Overtreatment

When diagnostic thresholds are lowered, individuals with mild or transient symptoms may receive psychiatric diagnoses and pharmacological treatment unnecessarily. This can expose patients to medication side effects without clear benefit [14].

Stigma and Identity Foreclosure

Receiving a psychiatric diagnosis can shape self-perception and identity. For some individuals, labels such as "depressed," "anxious," or "ADHD" become central to their sense of self, potentially limiting their perceived agency and resilience [15].

Neglect of Psychosocial Interventions

Overmedicalization often leads to an overreliance on pharmacotherapy at the expense of psychosocial interventions. Social determinants of mental health poverty, trauma, discrimination, loneliness may be overlooked when distress is framed primarily as a medical problem [17].

Erosion of Public Trust

When diagnostic categories appear overly broad or influenced by commercial interests, public trust in psychiatry may decline. Controversies surrounding DSM 5, pharmaceutical conflicts of interest, and rising diagnosis rates have contributed to skepticism [16].

Increased Polypharmacy

Diagnostic inflation often leads to polypharmacy, particularly in complex cases where multiple overlapping diagnoses are assigned. This increases the risk of drug interactions, side effects, and long term health consequences [18].

Diversion of Resources

When mild or subclinical cases receive disproportionate attention, resources may be diverted away from individuals with severe mental illness who require intensive support [13].

Summary Table: Examples of Diagnostic Inflation

Condition	Normal Variation	DSM Diagnosis	Drivers of Inflation
Grief	Bereavement	Major Depressive Disorder	Removal of exclusion; cultural intolerance of sadness (16)
Shyness	Introversion	Social Anxiety Disorder	Lower thresholds; pharmaceutical marketing (17)
Childhood energy	Temperament	ADHD	Educational pressures; broadened criteria (18)
Worry	Stress response	Generalized Anxiety Disorder	Broad criteria; cultural expectations (14)
Temper outbursts	Developmental behavior	Disruptive Mood Dysregulation Disorder	DSM5 expansion; school pressures (15)

Table 1: Comparison of Normal Human Experiences and Corresponding DSM Diagnoses

Pharmaceutical Influence and Conflicts of Interest

The relationship between psychiatry and the pharmaceutical industry has been one of the most influential and controversial forces shaping modern diagnostic practice. While psychopharmacology has improved the lives of millions, the commercial imperatives of the pharmaceutical industry have also contributed to diagnostic expansion, shifting treatment priorities, and the medicalization of normal human experience. The rise of modern psychopharmacology coincided with the operationalization of DSM III criteria, creating a mutually reinforcing relationship between diagnostic categories and medication markets [19].

Pharmaceutical companies operate within a profit driven model that depends on expanding markets for psychotropic medications. Because psychiatric diagnoses lack objective biomarkers and rely heavily on subjective symptom reports, diagnostic boundaries are particularly malleable. This creates fertile ground for commercial influence. As diagnostic categories broaden, the potential market for medications grows accordingly [20].

Industry Influence on Diagnostic Expansion

The publication of DSM III in 1980 marked a turning point in the relationship between psychiatry and the pharmaceutical industry. The introduction of operationalized criteria created clearer diagnostic categories that aligned with drug indications, facilitating clinical trials, regulatory approval, and marketing strategies [21]. Several diagnostic trends illustrate the interplay between pharmaceutical interests and diagnostic expansion:

The Antidepressant Boom

The introduction of selective serotonin reuptake inhibitors (SSRIs) in the late 1980s and early 1990s transformed the treatment landscape for depression and anxiety. Marketing campaigns emphasized the idea of a "chemical imbalance," despite limited scientific evidence supporting this model [22]. Depression was reframed as a common, chronic, and biologically based condition requiring long term pharmacotherapy. This narrative contributed to rising diagnosis rates and widespread SSRI use.

The ADHD Explosion

The expansion of ADHD criteria in DSM IV and DSM 5 coincided with aggressive marketing of stimulant medications. Direct to consumer advertising (in countries where permitted), school based awareness campaigns, and the promotion of adult ADHD contributed to dramatic increases in diagnosis and prescription rates [23]. In some regions, stimulant use has increased more than tenfold over two decades.

The Bipolar Spectrum Movement

The rebranding of bipolar disorder from a rare, severe condition to a broad spectrum encompassing mood instability, irritability, and subthreshold symptoms aligned with the marketing of atypical antipsychotics and mood stabilizers. Pharmaceutical companies funded research, sponsored educational programs, and promoted the concept of "bipolar spectrum disorder," contributing to rising diagnosis rates [20].

Anxiety Disorders and the Rise of Anxiolytics

The expansion of anxiety disorder categories, including Social Anxiety Disorder and Generalized Anxiety Disorder, coincided with the marketing of SSRIs and SNRIs for anxiety. Disease awareness campaigns framed shyness and worry as treatable medical conditions [22].

These examples illustrate how diagnostic expansion can create new markets for medications, while pharmaceutical marketing can shape public and professional perceptions of mental illness.

Mechanisms of Pharmaceutical Influence

Pharmaceutical influence operates through multiple channels, many of which are subtle and deeply embedded within academic and clinical structures. Key mechanisms include:

Sponsored Research

Pharmaceutical companies fund a substantial proportion of psychiatric research. Industry funded studies are more likely to report positive outcomes, favorable comparisons, and minimized side effects [19]. Selective publication, ghostwriting, and suppression of negative findings have been documented in multiple cases.

Key Opinion Leaders (KOLs)

Prominent psychiatrists often serve as consultants, speakers, or advisory board members for pharmaceutical companies. These individuals influence clinical guidelines, DSM committees, and continuing medical education (CME) programs. Their dual roles create potential conflicts of interest [20].

Ghostwritten Articles

Academic articles, review papers, and even clinical guidelines have sometimes been ghostwritten by pharmaceutical companies and attributed to academic authors. This practice shapes the scientific literature and influences clinical practice [21].

Industry Funded CME Programs

Continuing medical education is a major channel for disseminating information about psychiatric disorders and treatments. When funded by industry, CME programs may emphasize pharmacological interventions over psychosocial approaches [22].

Disease Awareness Campaigns

Pharmaceutical companies often sponsor public campaigns that raise awareness of specific disorders. While these campaigns can reduce stigma, they may also broaden diagnostic boundaries and increase demand for medication [23].

Direct to Consumer Advertising

In countries such as the United States, direct to consumer advertising promotes medications directly to the public. Advertisements often frame normal emotions as symptoms of treatable disorders, encouraging individuals to seek diagnosis and medication [24].

Influence on DSM Committees

Concerns have been raised about financial ties between DSM panel members and pharmaceutical companies. A widely cited analysis found that a significant proportion of DSM 5 committee members had industry affiliations, raising questions about potential conflicts of interest [20].

These mechanisms illustrate how pharmaceutical influence permeates multiple levels of psychiatric practice, from research and education to diagnosis and treatment.

Ethical Implications

The entanglement between psychiatry and the pharmaceutical industry raises profound ethical concerns. These concerns extend beyond individual conflicts of interest to encompass broader questions about the integrity of psychiatric knowledge, the medicalization of human experience, and the prioritization of pharmacological interventions.

Bias in Diagnostic Thresholds

When diagnostic criteria are influenced by commercial interests, thresholds may be lowered to expand the market for medications. This risks pathologizing normal variation and promoting unnecessary treatment [19].

Overreliance on Pharmacotherapy

Pharmaceutical marketing often emphasizes medication as the primary or sole treatment for mental disorders. This can overshadow psychosocial interventions, lifestyle factors, and social determinants of mental health [22].

Distortion of Research Agendas

Industry funding shapes research priorities, often favoring studies that support medication use over those that explore psychosocial or structural interventions [21].

Undermining of Public Trust

When the public perceives psychiatry as overly influenced by pharmaceutical interests, trust in the profession may decline. Controversies surrounding antidepressants, antipsychotics, and DSM 5 have contributed to skepticism [24].

Impact on Vulnerable Populations

Children, adolescents, and marginalized communities are particularly vulnerable to overdiagnosis and overtreatment. Pharmaceutical influence may exacerbate existing inequalities in mental health care [23].

Toward Ethical and Transparent Practice

Addressing pharmaceutical influence requires systemic reforms, including:

- Stricter Conflict of Interest Policies
- Transparency In Research Funding
- Independent Cme Programs
- Greater Emphasis on Psychosocial Interventions
- Public Education About the Limits of Pharmacotherapy
- Inclusion Of Diverse Perspectives in Diagnostic Committees

A more balanced approach would recognize the value of medications while resisting the overmedicalization of human experience.

Categorical vs. Dimensional Models

The limitations of categorical diagnosis have become increasingly apparent over the past several decades. While the DSM's categorical framework has improved reliability and facilitated research standardization, it has also produced a diagnostic landscape characterized by high comorbidity, arbitrary thresholds, and limited predictive validity [25]. These limitations have prompted the development of dimensional and networkbased alternatives that aim to provide a more accurate and scientifically grounded understanding of mental distress.

Categorical models assume that mental disorders are discrete entities analogous to infectious diseases with clear boundaries, distinct etiologies, and consistent symptom profiles. However, empirical evidence challenges this assumption across multiple domains, including genetics, neuroscience, and clinical epidemiology [26].

Limitations of Categorical Models

High Comorbidity

One of the most striking features of DSM diagnoses is the high rate of comorbidity. Individuals diagnosed with one disorder frequently meet criteria for multiple others. For example, depression and anxiety disorders overlap extensively, suggesting shared underlying dimensions rather than distinct disease entities [27-28]. High comorbidity undermines the assumption that DSM categories represent discrete conditions.

Arbitrary Cutoffs

DSM diagnoses often rely on symptom counts (e.g., "five out of nine symptoms") that lack empirical justification. Small differences in symptom number can determine whether an individual receives a diagnosis, despite minimal differences in clinical presentation [25].

Heterogeneous Symptom Clusters

Many DSM disorders encompass highly heterogeneous symptom profiles. Two individuals with the same diagnosis may share few or no symptoms. This heterogeneity challenges the validity of categorical constructs and complicates treatment planning [26].

Lack of Biomarkers

Despite decades of research, no DSM disorder has been validated by a specific biomarker. This undermines the disease entity model and suggests that psychiatric categories may not map onto discrete biological conditions [29].

Poor Predictive Validity

DSM diagnoses often fail to predict treatment response, course of illness, or functional outcomes. This limits their utility in personalized care and highlights the need for more precise diagnostic frameworks [30].

These limitations have motivated the search for alternative models that better capture the complexity of mental phenomena.

Dimensional Alternatives

Dimensional models conceptualize mental disorders as variations along continuous spectra rather than discrete categories. These models align more closely with genetic, neurobiological, and psychological evidence, which consistently demonstrates that mental traits and symptoms exist on continua [27]. Three major dimensional frameworks have gained prominence: RDoC, HiTOP, and network theory.

Research Domain Criteria (RDoC)

The Research Domain Criteria (RDoC) initiative, launched by the U.S. National Institute of Mental Health, represents a radical departure from traditional diagnostic systems. Rather than organizing mental disorders into categories, RDoC focuses on underlying psychological and biological systems (29).

Core Principles of RDoC

- Dimensionality: Constructs exist on continua from normal to abnormal.
- Multilevel analysis: Constructs are studied across genes, molecules, circuits, behavior, and self report.
- Transdiagnostic focus: Symptoms are not tied to specific DSM categories.
- Neuroscience integration: Emphasis on brain circuits and biological mechanisms.

Strengths

- Aligns with neuroscience and genetics
- Avoids arbitrary diagnostic boundaries
- Encourages mechanistic research

Critiques

- Overemphasis on biology
- Limited clinical applicability
- Risk of reductionism
- Neglect of subjective experience

RDoC represents an important scientific shift but remains primarily a research framework rather than a clinical tool.

Hierarchical Taxonomy of Psychopathology (HiTOP)

The Hierarchical Taxonomy of Psychopathology (HiTOP) is a dimensional model developed to address the limitations of DSM categories. Unlike RDoC, HiTOP is grounded in clinical data and aims to improve diagnostic validity and utility (28).

Structure of HiTOP

HiTOP organizes psychopathology into a hierarchical structure:

- Super spectra (e.g., internalizing, externalizing, thought disorder)
- Spectra (e.g., fear, distress, antagonism)
- Subfactors (e.g., panic, social anxiety)
- Symptoms and traits

This structure reflects empirical patterns of symptom co occurrence.

Advantages

- Reduces comorbidity
- Provides more precise assessment
- Aligns with genetic and neurobiological evidence
- Offers a clinically intuitive framework

Limitations

- Still under development
- Requires new assessment tools
- May be complex for routine clinical use

HiTOP represents one of the most promising alternatives to categorical diagnosis.

Network Theory of Mental Disorders

Network theory conceptualizes mental disorders not as latent diseases but as networks of interacting symptoms. For example, insomnia may lead to fatigue, which leads to concentration problems, which leads to anxiety creating a self-reinforcing network [27].

Key Features

- Symptoms cause each other
- Disorders emerge from network dynamics
- No underlying disease entity is required

Strengths

- Explains heterogeneity
- Accounts for symptom interactions
- Offers novel treatment targets

Limitations

- Limited longitudinal data
- Complex modeling requirements
- Unclear clinical implementation

Network theory challenges the very notion of psychiatric disorders as discrete entities.

Clinical Implications of Dimensional Models

Dimensional and network-based frameworks have profound implications for clinical practice.

More Personalized Assessment

Dimensional models allow clinicians to assess symptom severity, trait profiles, and functional impairment more precisely than categorical diagnoses [28].

Better Alignment with Neuroscience

Neurobiological findings map more naturally onto dimensions (e.g., anxiety sensitivity, reward responsiveness) than onto DSM categories [29].

Reduced Stigma

Dimensional models emphasize continuity between normal and abnormal functioning, reducing the "us vs. them" dichotomy inherent in categorical diagnosis [30].

Improved Treatment Matching

Dimensional assessments can guide treatment selection more effectively. For example:

- High negative affect may respond to CBT or SSRIs
- Anhedonia may respond to behavioral activation
- Emotional dysregulation may respond to DBT

Transdiagnostic Interventions

Approaches such as the Unified Protocol target underlying processes (e.g., avoidance, rumination) rather than specific diagnoses [27].

Challenges for Implementation

- Requires new training and assessment tools
- Insurance systems rely on categorical codes
- Clinicians may resist paradigm shifts

Despite these challenges, dimensional models offer a more nuanced and scientifically grounded approach to understanding mental distress.

Cultural and Social Considerations

Psychiatric diagnosis does not occur in a cultural vacuum. Every symptom, every expression of distress, and every interpretation of behavior is shaped by cultural norms, social structures, and shared meanings. While the DSM aspires to universality, its categories reflect Western assumptions about the mind, the self, and the nature of suffering [11,12]. As psychiatry globalizes, these assumptions increasingly collide with diverse cultural frameworks, raising concerns about misdiagnosis, cultural mismatch, and the erosion of indigenous healing traditions.

Anthropological and transcultural research demonstrates that psychiatric categories are not universal but culturally constructed [11]. The DSM's symptom-based approach often fails to capture culturally specific idioms of distress, explanatory models, and healing practices. This section examines cultural variability in distress, the risks of diagnostic imperialism, and the importance of culturally grounded approaches in global mental health.

Cultural Variability in Distress

Cultures differ profoundly in how they conceptualize the self, emotion, illness, and healing. These differences shape not only the content of distress but also its form, meaning, and social response [12].

Somatization in South Asia

In many South Asian contexts, emotional distress is expressed through bodily symptoms such as fatigue, headaches, or gastrointestinal discomfort. Western psychiatry often labels this pattern as somatization, but within these cultural contexts, somatic expression is normative and socially sanctioned [11]. Diagnosing such presentations as Major Depressive Disorder without considering cultural context risks misunderstanding the patient's experience.

Spirit related idioms in Africa

In parts of sub-Saharan Africa, distress may be interpreted through spiritual or relational frameworks, such as ancestral displeasure or disrupted communal harmony. These explanatory models are not simply "beliefs" but deeply embedded cultural systems that guide help seeking behavior [12].

Hikikomori in Japan

The phenomenon of Hikikomori extreme social withdrawal illustrates how culture shapes the boundaries of pathology. While often compared to depression or social anxiety, hikikomori reflects unique sociocultural pressures in Japan, including rigid educational expectations and intergenerational dynamics [21].

Neurasthenia in China

Although removed from the DSM decades ago, Neurasthenia remains a common diagnosis in China. It captures fatigue, irritability, and somatic complaints in ways that align with cultural norms and avoid the stigma associated with psychiatric labels [11].

These examples demonstrate that distress is not a universal biological signal but a culturally mediated phenomenon.

Risks of Western Diagnostic Imperialism

As Western psychiatric frameworks spread globally, concerns have emerged about diagnostic imperialism the imposition of Western categories onto nonWestern populations [12,21].

Misdiagnosis

Symptoms that are normative within a cultural context may be misinterpreted as pathological. For example, spirit possession experiences may be labeled psychosis, or somatic expressions of distress may be misdiagnosed as anxiety disorders [11].

Loss of Indigenous Healing Traditions

Western psychiatric models may displace traditional healing systems that are culturally congruent and effective. This can undermine communitybased support structures and erode cultural identity [12].

Overreliance on Medication

Western biomedical models emphasize pharmacological treatment, which may not align with cultural understandings of illness or patient preferences [20].

Cultural Mismatch in Treatment

Therapeutic approaches developed in Western contexts may not translate effectively across cultures. For example, cognitivebehavioral therapy assumes an individualistic model of the self that may not resonate in collectivist societies [11].

Pathologizing Cultural Norms

Behaviors considered normal or even valued in one culture may be pathologized in another. For example, deference to authority may be misinterpreted as dependent personality traits [12].

Diagnostic imperialism reflects a broader tension within global mental health: the desire to provide universal care versus the need to respect cultural diversity [21].

Social Determinants of Mental Health

Mental distress is profoundly shaped by social conditions. Poverty, discrimination, violence, migration, and inequality are powerful determinants of mental health [20]. Yet categorical diagnostic systems often obscure these structural factors by framing distress as an individual pathology.

Poverty and Inequality

Economic hardship increases the risk of depression, anxiety, substance use, and traumarelated disorders. However, DSM diagnoses rarely account for socioeconomic context [14].

Migration and Displacement

Refugees and migrants face unique stressors loss, trauma, cultural dislocation that may not fit neatly into DSM categories. Overdiagnosis of PTSD in refugee populations is a welldocumented concern [21].

Genderbased Violence

Women experiencing domestic violence may present with symptoms of depression or anxiety, but the root cause is relational and structural, not biological [12].

Racism and Discrimination

Chronic exposure to discrimination contributes to psychological distress, yet diagnostic frameworks often ignore these systemic factors [20].

A culturally grounded psychiatry must integrate social determinants into assessment and treatment.

Toward Culturally Grounded Psychiatry

A more culturally responsive psychiatry requires tools, frameworks, and practices that honor cultural diversity and contextualize distress.

The Cultural Formulation Interview (CFI)

The DSM5 introduced the Cultural Formulation Interview to help clinicians explore cultural identity, explanatory models, social context, and patientclinician dynamics [1]. While underutilized, the CFI represents an important step toward culturally informed assessment.

Community Based Models

Communitybased mental health programs such as taskshifting initiatives, peer support networks, and culturally adapted therapies have shown promise in diverse settings [21].

Integration of Traditional Healing Systems

In many cultures, traditional healers play central roles in addressing distress. Collaborations between biomedical and traditional systems can enhance cultural congruence and improve outcomes [12].

Culturally Adapted Psychotherapies

Evidencebased therapies can be adapted to align with cultural values, communication styles, and explanatory models [11].

Epistemic Humility

Culturally grounded psychiatry requires epistemic humility the recognition that Western psychiatric knowledge is not universally applicable and that other systems of understanding may offer valuable insights [25].

Global Mental Health: Promise and Controversy

The global mental health movement aims to reduce the treatment gap in low and middleincome countries. While this goal is laudable, critics argue that global mental health initiatives often export Western diagnostic categories and treatment models without adequate cultural adaptation [21].

Strengths

- Expands access to care
- Reduces stigma
- Promotes human rights
- Supports taskshifting and community care

Critiques

- Risk of diagnostic imperialism
- Overemphasis on medication
- Neglect of social determinants
- Insufficient engagement with local knowledge

A balanced approach requires integrating global evidence with local cultural wisdom.

The Future: A Contextual, Culturally Responsive Psychiatry

A reimagined psychiatry would:

- Recognize cultural diversity in distress
- Integrate social determinants into diagnosis
- Collaborate with traditional healing systems
- Use dimensional and contextual models
- Prioritize patient narratives
- Embrace epistemic humility

Such an approach would move psychiatry beyond reductionism and toward a more humanistic, culturally grounded practice.

DISCUSSION

The preceding sections have traced the historical evolution of psychiatric diagnosis, examined the forces driving overmedicalization, analyzed the influence of pharmaceutical industries, and explored emerging dimensional and culturally grounded alternatives. This discussion synthesizes these threads to illuminate the broader implications for psychiatric theory, clinical practice, and global mental health. Psychiatry stands at a crossroads: it must reconcile its scientific aspirations with the complexity of human experience, its diagnostic systems with cultural diversity, and its therapeutic tools with ethical responsibility [3,11,20].

At the heart of this debate lies a fundamental tension between categorical and dimensional understandings of mental distress. Categorical models, exemplified by the DSM, offer administrative clarity and facilitate communication, but they risk oversimplifying the fluid and context dependent nature of psychological suffering [1,25]. Dimensional models, such as HiTOP and RDoC, provide greater scientific nuance but remain challenging to implement in clinical and administrative settings [28,29]. This tension reflects a deeper epistemological divide: whether mental disorders are discrete disease entities or complex, emergent phenomena shaped by biological, psychological, and social forces.

Overmedicalization as a Systemic Phenomenon

Overmedicalization is not merely the result of diagnostic criteria expanding in isolation. It is a systemic phenomenon arising from the interplay of cultural expectations, institutional incentives, scientific paradigms, and commercial interests [2,14]. The DSM's expansion over successive editions reflects not only scientific developments but also broader societal trends:

- Cultural intolerance of distress has reframed normal emotions as symptoms requiring intervention [5].
- Insurance and reimbursement structures incentivize diagnosis [13].
- Pharmaceutical marketing promotes biomedical narratives and expands markets [20,22].
- Educational pressures encourage labeling of childhood behaviors [18].
- Administrative systems rely on diagnostic codes for resource allocation [17].

These forces create a feedback loop in which diagnostic expansion becomes self-reinforcing. As more individuals receive diagnoses, public awareness increases, expectations shift, and diagnostic categories become embedded in cultural discourse [15]. This process can lead to what some scholars describe as diagnostic creep, where the boundaries of pathology gradually expand to encompass ever broader segments of the population [14,16].

The Limits of the Biomedical Paradigm

The biomedical model has been enormously influential in shaping contemporary psychiatry. It has facilitated the development of psychopharmacology, advanced neuroscientific research, and provided a framework for understanding severe mental illness [19,29]. However, its limitations have become increasingly apparent.

Lack of Biomarkers

Despite decades of research, no psychiatric disorder has been validated by a specific biomarker (29). This challenges the assumption that mental disorders are discrete biological entities analogous to infectious diseases.

Heterogeneity and Comorbidity

The high degree of symptom heterogeneity and comorbidity within DSM categories suggests that these categories may not reflect underlying biological realities [25,27]. Instead, they may represent clusters of symptoms that co occur due to shared risk factors or social determinants.

Reductionism

The biomedical model often reduces complex experiences to neurochemical imbalances or brain dysfunctions. This reductionism can obscure the role of trauma, relationships, culture, and social context in shaping distress [11,12].

Pharmaceutical Influence

As discussed in Section 4, pharmaceutical marketing has reinforced biomedical narratives, sometimes at the expense of psychosocial approaches [20,22].

These limitations underscore the need for a more integrative framework that incorporates biological, psychological, social, and cultural dimensions.

The Promise and Challenges of Dimensional Models

Dimensional models offer a compelling alternative to categorical diagnosis. They align more closely with genetic and neurobiological evidence, reduce comorbidity, and provide more nuanced assessments [27,28]. However, they also present significant challenges.

Scientific Promise

Dimensional models capture the continuous nature of traits such as anxiety, impulsivity, and mood instability. They allow for more precise measurement and may improve treatment matching [28].

Clinical Challenges

Implementing dimensional models in clinical practice requires new assessment tools, clinician training, and changes to administrative systems. Insurance reimbursement, disability evaluations, and legal frameworks rely on categorical diagnoses [17].

Philosophical Questions

Dimensional models challenge the very notion of mental disorders as discrete entities. This raises philosophical questions about the nature of psychopathology, the purpose of diagnosis, and the boundaries of normality [3,25].

Risk of Overcomplexity

While dimensional models offer nuance, they may be perceived as overly complex or impractical for routine clinical use [26].

Despite these challenges, dimensional models represent an important step toward a more scientifically grounded and clinically useful diagnostic framework.

Cultural Context and the Limits of Universality

As Section 6 demonstrated, psychiatric diagnosis is deeply influenced by cultural norms. The DSM's claim to universality is undermined by the diversity of cultural expressions of distress [11,12]. Western diagnostic categories may not capture the lived experiences of individuals in non Western contexts, leading to misdiagnosis, cultural mismatch, and the erosion of indigenous healing traditions.

Cultural Variability

Distress is expressed differently across cultures through somatic symptoms, spiritual idioms, relational metaphors, or behavioral patterns [11].

Global Mental Health Debates

The global mental health movement has expanded access to care but has also been criticized for exporting Western diagnostic frameworks [21].

Epistemic Humility

Psychiatry must acknowledge the limits of its knowledge and the validity of alternative explanatory models. Epistemic humility is essential for culturally responsive practice [25].

Toward an Integrative, Contextual Psychiatry

The future of psychiatric diagnosis lies not in choosing between categorical and dimensional models but in integrating multiple perspectives. A more holistic approach would:

- Recognize the value of categorical diagnoses for communication and administration [1].
- Incorporate dimensional assessments for precision and personalization [28].
- Integrate cultural and social context into diagnostic formulation [11,12].
- Prioritize patient narratives and lived experience [3].
- Address social determinants of mental health [20].
- Resist reductionist explanations [29].
- Promote ethical, transparent relationships with industry [19,22].

Such an approach aligns with the movement toward contextual psychiatry, which views mental distress as an emergent phenomenon shaped by biological vulnerability, psychological processes, social relationships, and cultural meaning.

Reimagining the Purpose of Diagnosis

Ultimately, the purpose of diagnosis is not to categorize individuals but to support understanding, communication, and treatment. A reimagined diagnostic system would:

- Support clinical decision making
- Facilitate access to care
- Respect cultural diversity
- Avoid pathologizing normal variation
- Promote recovery and resilience
- Enhance scientific understanding

CONCLUSION

Psychiatry stands at a defining moment in its intellectual and ethical evolution. Over the past century, the field has oscillated between competing paradigms psychodynamic, biomedical, sociocultural, and now dimensional and network-based frameworks. Each paradigm has contributed valuable insights, yet none has fully captured the complexity of human distress [3,11]. The contemporary landscape is marked by unprecedented diagnostic expansion, rising rates of psychiatric labeling, and growing concerns about the medicalization of ordinary life [2,5,14]. At the same time, emerging scientific models and culturally grounded approaches offer promising pathways toward a more nuanced and humane psychiatry.

This review has demonstrated that overmedicalization is not a simple by product of diagnostic error but a systemic phenomenon shaped by cultural expectations, institutional incentives, and commercial forces [13,20]. The DSM, while providing a shared language for clinicians and facilitating research standardization, has expanded in ways that blur the boundaries between normality and pathology [1,14]. As noted earlier, diagnostic thresholds have been lowered across multiple domains, contributing to diagnostic inflation and the risk of pathologizing normative emotional experiences such as grief, shyness, and childhood exuberance [15–18].

Pharmaceutical influence has further complicated this landscape. The alignment of diagnostic categories with medication markets has created incentives for broadening diagnostic boundaries and promoting biomedical narratives [19–22]. While medications play an essential role in treating severe mental illness, their dominance in contemporary practice reflects structural and commercial pressures rather than purely scientific considerations. The ethical implications of this entanglement bias in research, overreliance on pharmacotherapy, and erosion of public trust underscore the need for greater transparency and epistemic humility [20,24].

At the same time, advances in psychopathology research challenge the validity of categorical diagnoses. Dimensional frameworks such as HiTOP and RDoC offer more empirically grounded models that align with genetic, neurobiological, and psychological evidence [27–29]. Network theory provides an alternative conceptualization in which symptoms interact dynamically rather than reflecting latent disease entities [27]. These models highlight the limitations of categorical diagnosis and point toward a future in which mental distress is understood along continua rather than through rigid categories [25,26,30].

Yet scientific innovation alone cannot resolve the challenges facing psychiatry. Cultural and social contexts profoundly shape the experience and expression of distress. As Section 6 illustrated, Western diagnostic frameworks often fail to capture culturally specific idioms of distress, explanatory models, and healing traditions [11,12]. The risk of diagnostic imperialism

the imposition of Western categories onto diverse populations remains a pressing concern in global mental health [21]. A culturally grounded psychiatry must integrate local knowledge, respect indigenous healing systems, and recognize the role of social determinants such as poverty, discrimination, and trauma [20].

Taken together, these insights point toward the need for a paradigm shift in psychiatric diagnosis one that moves beyond reductionism and embraces complexity, context, and cultural diversity. Such a paradigm would not reject the DSM outright but would situate it within a broader, more flexible diagnostic ecosystem. It would incorporate dimensional assessments, contextual formulations, and culturally informed practices [28,29]. It would prioritize patient narratives, lived experience, and relational understanding alongside biological and psychological evidence [3,11].

A reimagined psychiatry would also adopt epistemic humility, acknowledging the limits of current knowledge and the provisional nature of diagnostic constructs [25]. It would recognize that mental disorders are not fixed entities waiting to be discovered but evolving frameworks shaped by scientific, cultural, and historical forces. This humility is essential for avoiding the pitfalls of overmedicalization and for fostering a more ethical and responsive practice.

Ultimately, the goal of psychiatric diagnosis is not to categorize individuals but to support healing, understanding, and human flourishing. A diagnostic system that pathologizes normal variation, ignores cultural context, or prioritizes commercial interests over patient wellbeing cannot fulfill this mission. By contrast, a system that integrates dimensional science, cultural sensitivity, and contextual understanding can guide more compassionate and effective care [11,12,28].

Psychiatry's future lies in embracing this integrative vision. Doing so will require structural reforms, interdisciplinary collaboration, and a willingness to question long held assumptions. It will require clinicians, researchers, policymakers, and communities to work together to develop diagnostic frameworks that reflect the richness and diversity of human experience. Most importantly, it will require a commitment to placing patients not diagnostic categories at the center of psychiatric practice.

In conclusion, psychiatry stands at a crossroads. The field must balance scientific rigor with humanistic understanding, resist reductionist tendencies, and adopt diagnostic frameworks that reflect the complexity of mental distress. A shift toward dimensional, contextual, and culturally informed approaches is essential for restoring trust, improving outcomes, and ensuring ethical practice [3,20,29]. By embracing this shift, psychiatry can move toward a future that honors both the science and the humanity of mental health care.

AUTHOR CONTRIBUTIONS

Dr. Ash Shishodia conceptualized the review, conducted the literature analysis, and wrote the manuscript.

ACKNOWLEDGEMENTS

The author thanks colleagues at Thrive Wellbeing Centre for their insights on diagnostic reform and ethical psychiatry.

CONFLICT OF INTEREST

The author declares no conflicts of interest.

REFERENCES

1. Edition F. Diagnostic and statistical manual of mental disorders. Am Psychiatric Assoc. 2013;21(21):591-643.
2. Angell M. The epidemic of mental illness: Why. The New York Review of Books. 2011;58(11):20-2.
3. Bolton D. What is mental disorder?: an essay in philosophy, science, and values. Oxford University Press; 2008.
4. Cosgrove L, Krimsky S. A Comparison of DSM-IV and DSM-5 Panel Members' Financial. pmed. 1001190. 2012.
5. Frances A. Saving Normal. New York: HarperCollins; 2013.
6. Foucault M. Madness and Civilization. New York: Random House; 1965.
7. Ghaemi SN. The rise and fall of the biopsychosocial model. The British Journal of Psychiatry. 2009;195(1):3-4.
8. Horwitz AV, Wakefield JC. The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder. Oxford University Press; 2007.
9. Insel TR. The NIMH research domain criteria (RDoC) project: precision medicine for psychiatry. American journal of psychiatry. 2014;171(4):395-7.
10. Kendler KS. The phenomenology of major depression and the representativeness and nature of DSM criteria. American Journal of Psychiatry. 2016;173(8):771-80.
11. Kleinman A. Rethinking Psychiatry. New York: Free Press; 1988.
12. Kirmayer LJ. Beyond the 'new cross-cultural psychiatry': Cultural biology, discursive psychology and the ironies of globalization. Transcultural psychiatry. 2006;43(1):126-44.
13. Kutchins H, Kirk SA. Making us crazy. Simon and Schuster; 2003.
14. Lahey BB. Public health significance of neuroticism. American Psychologist. 2009;64(4):241.
15. Potuzak M, Ravichandran C, Lewandowski KE, Ongür D, Cohen BM. Categorical vs dimensional classifications of psychotic disorders. Comprehensive psychiatry. 2012;53(8):1118-29.
16. Moncrieff J. The myth of the chemical cure. InThe myth of the chemical cure: A critique of psychiatric drug treatment 2008. London: Palgrave Macmillan UK.
17. Paris J. The intelligent clinician's guide to the DSM-5®. Oxford University Press; 2015.
18. Zachar P, First MB, Kendler KS. The bereavement exclusion debate in the DSM-5: A history. Clinical Psychological Science. 2017;5(5): 890-906.
19. Regier D. DSM-5 field trials. Am J Psychiatry. 2013.
20. Rose N. Our psychiatric future. John Wiley & Sons; 2018.
21. Summerfield D. How scientifically valid is the knowledge base of global mental health?. Bmj. 2008;336(7651):992-4.
22. Van Os J. The transdiagnostic revolution. World Psychiatry. 2016.
23. Wakefield JC. Misdiagnosing normality. Psychol Sci. 2010.
24. Widiger TA. Dimensional models of personality disorder. World Psychiatry. 2007;6(2):79. J Pers Disord. 2011.

25. Zachar P. A metaphysics of psychopathology. MIT press; 2014.
26. Zimmerman M. Problems with DSM-5. J Clin Psychiatry. 2013.
27. Borsboom D. A network theory of mental disorders. World psychiatry. 2017;16(1):5-13.
28. Clark LA. HiTOP model. J Abnorm Psychol. 2017.
29. Deacon B. The biomedical model crisis. Clin Psychol Rev. 2013.
30. Hyman S. The diagnosis problem. Nat Rev Neurosci. 2010.