

**DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM):  
TO BE OR NOT TO BE**

**Author:**

Ferenc Zoltán Simó (Dr. Jur.)  
(Hungary)

Author's email address:

[simofredz@gmail.com](mailto:simofredz@gmail.com)

**Reviewers:**

Katalin Mező (PhD)  
University of Debrecen (Hungary)

Ferenc Mező (PhD)  
Eszterházy Károly Catholic University  
(Hungary)

...and two anonymous reviewers

Simó, Ferenc Zoltán (2022): Diagnostic and Statistical Manual of Mental Disorders (DSM): To Be or Not to Be. *Különleges Bánásmód*, 8. (4). 95-103. DOI [10.18458/KB.2022.4.95](https://doi.org/10.18458/KB.2022.4.95)

**Abstract**

Although the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be one of the best diagnostic guides of all times, there are some voices that question its practicality, functionality, and flexibility as well. Even if it has never claimed it to be perfect, it is only stated/portrayed as an organized guide or guidance for information. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the most widely used and acknowledged, and as well as time honoured (with successive editions over 70 years) system for diagnosing mental disorders in the United States and all over the world. Since 1952, the first edition (DSM-I) and its successive time honoured editions over 70 years. This study is focussing on debates, issues and concerns related to DSM-5, which has had in effect since 2013.

**Keywords:** DSM, diagnosis, psychiatry, psychology, mental disorders

**Disciplines:** medical sciences, psychology

**Absztrakt**

MENTÁLIS ZAVAROK DIAGNOSZTIKAI ÉS STATISZTIKAI KÉZIKÖNYVE (DSM): LENNI VAGY NEM LENNI

Habár a *Mentális zavarok diagnosztikai és statisztikai kézikönyv*-et (angolul: Diagnostic and Statistical Manual of Mental Disorders - továbbiakban DSM) mindenidők egyik legjobb diagnosztikai útmutatójának tartják, azonban vannak vélemények, melyek megkérdőjelezzik a gyakorlati, funkcionális hasznát és rugalmasságát is. Még akkor is ez a helyzet áll fenn, ha a könyv sohasem hirdette tökéletességét, inkább egyfajta útmutatóként szolgált. A DSM a legszélesebb körben elfogadott és használt rendszer, melyet a mentális zavarok diagnosztizálására használnak az Egyesült Államokban és világszerte az 1952-ben megjelent első (DSM-I) verzió óta, s amely az elmúlt 70 évben kiállta az idők próbáját az egymást követő verzióival. Jelen

tanulmány a 2013-óta, napjainkban is érvényben lévő DSM-5-tel kapcsolatos elemzések, viták bemutatására koncentrálnak.

**Kulcsszavak:** DSM, diagnózis, pszichiátria, mentális zavarok, pszichológia

**Diszciplínák:** orvostudomány, pszichológia

The reason, why the study focuses on DSM-5 and consequently DSM-V-TR is the fact that many scholars and practitioners consider it to be a kind of breakthrough, for example, Betty Garcia and Anne Petrovich argue that „[t]he *DSM-5* signifies a major change in the diagnostic framework. The multiaxial system, introduced in the *DSM-III* and continued through the *DSM-IV-TR*, has been eliminated. The *DSM-III* was an important step forward because its multiaxial format promoted a view of individuals in the context of their lived experience and encouraged the exploration of important non-diagnostic factors relevant to effective treatment. A major challenge with the utilization of the *DSM-5* is to introduce diagnostic protocols that focus on what has been lost with the elimination of the multiaxial system. In addition, the challenge for the clinician or educator is to find assessment formulations that address the whole person in her real-life contexts, which offer diverse sources of strength and resiliency to counterbalance sources of stress” (Garcia and Petrovich, 2016, 10.).

In addition to the latest development on DSM “Bible”, we also highlight some remarkable pros and cons related to this “not-so-easy-to-use manual”. First of all, it is important to note that the preface of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders 5* (DSM-5) describes its objective by stating that “[s]ince a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed

and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.” (American Psychiatric Association, 2013, preface). Its claim seems precise enough not to be undermined by any doubts, though it still gives room to further progress as well. Though interestingly the preface of DSM 5 can be found in DSM 5 text revision as well, this must be a reminder for all. With the publication of DSM 5, the so-called progress has not stopped at all, and a better understanding of mental disorders provided by research has paved the way to DSM-5-TR. The advancement is still on its way, as it is explained by the preface of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders 5-TR* (DSM 5-TR): “[t]he clinical and research understanding of mental disorders continues to advance. As a result, most of the DSM-5-TR disorder texts have had at least some revision since the 9 (or even 10) years from original publication in DSM-5, with the overwhelming majority having had significant revisions. Sections of the text that were most extensively updated were Prevalence, Risk and Prognostic Factors, Culture-Related Diagnostic Issues, Sex- and Gender-Related Diagnostic Issues, Association With Suicidal Thoughts or Behavior, and Comorbidity. Also, for the first time ever, the entire DSM text has been reviewed and revised by a Work Group on Ethnoracial Equity and Inclusion to ensure

appropriate attention to risk factors such as the experience of racism and discrimination, as well as to the use of non-stigmatizing language” (American Psychiatric Association, 2022, preface). The impact of both DSM 5 and DSM-5-TR cannot be denied, and it has helped to open up more discussions and research on, for example, forensic science, but it may not be enough to calm down nay-sayers and doubters, such as Allen Frances (2013), Gary Greenberg (2013), Steven C. Hayes and Stefan G. Hofmann (2020), C. Raymond Lake (2012) and Stijn Vanheule (2014) (and the list might go on).

Still, the progress offered by DSM 5 has brought to life more challenges, best described by Charles Scott, in his book: *DSM-5® and the Law: Changes and Challenges*. He gives his readers an excellent summary of the DSM-5 diagnostic alteration (or transformation) and the implication/repercussions of these changes in a variety of types of criminal and civil legal actions. In addition, he intends to provide practical guidelines on how to correctly use the DSM-5 diagnostic process to record diagnoses in a forensic report. Moreover, special features include a summary of relevant diagnostic changes to each chapter topic and an application of the DSM-5 to a great variety of civil and criminal forensic evaluations. Thus, it is vital to note that his book is the first to present how the DSM-5 changes may be able to have an impact on specific forensic evaluations with practical guidance on how to face new challenges posed (Scott, 2015).

*The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* was published in 2022. To acknowledge the gigantic effort to provide the latest version of DSM, we need to see that more than 200 experts worked on it, and the majority were involved in the development of *DSM-5* as well. Additionally, four review groups (Culture, Sex and Gender, Suicide, and Forensic) re-examined and re-evaluated all the chapters, putting emphasis on material relating to their specific expertise. A Work Group on Ethnoracial Equity and Inclusion guarantee that

appropriate attention is paid to risk factors like racism and discrimination and the use of non-stigmatizing, non-victimizing language. *DSM-5-TR* comprises a novel diagnosis, prolonged grief disorder, and new symptom codes that permit clinicians to indicate the presence or history of suicidal behaviour and non-suicidal self-injury. Some essential clarifications to certain diagnostic criteria were re-examined and approved by the DSM Steering Committee, as well as the APA Assembly and Board of Trustees. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)* was the creation of more than 10 years of effort by hundreds of international experts, mental health professionals in every aspect of mental health.

Their commitment and hard work have resulted in an authoritative volume that identifies and categorizes (and catalogues) mental disorders to assist the possible progress, including diagnoses, treatment, and research. (to get to know more about this topic, visit: I1.) Mostly, it can be said that the novel manual can be an important resource for psychiatrists, other physicians, and health professionals, including psychologists, psychotherapists, counselors, nurses, and occupational and rehabilitation therapists, as well as social workers and forensic and legal specialists and researchers to diagnose and categorize mental disorders with brief and explicit criteria intended to assist a (hopefully) objective evaluation of symptom presentations in a selection of clinical settings, for example, inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care. There are novel characteristics and improvements make *DSM-5-TR* easier to apply across all settings. *DSM* has three key components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text. The diagnostic classification is the official list of mental disorders recognized in the *DSM*. Each and every diagnosis consists of a diagnostic code, which is usually used by individual providers, institutions,

and agencies for data collection and purposes related to billing. These diagnostic codes come from the coding system used by all U.S. healthcare professionals, known as the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*. The second area is the diagnostic criteria sets. For each disorder integrated in *DSM*, a set of diagnostic criteria specifies symptoms that must be present (and for how long) as well as a list of other symptoms, disorders, and conditions that must first be ruled out to meet the criteria for a particular diagnosis. While these criteria help increase diagnostic reliability, it is essential to remember that these criteria are supposed and intended to be used by trained professionals using clinical opinion/conclusion; as a consequence, they are not suggested being applied by the general public. The third area of *DSM* is the descriptive text that sums up each and every disorder. The text of *DSM-5-TR* presents information on each disorder under the following titles: Recording Procedures Specifiers, Diagnostic Features, Associated Features, Prevalence, Development and Course, Risk and Prognostic Factors, Culture-Related Diagnostic Issues, Sex and Gender-Related Diagnostic Issues, Association with Suicidal Thoughts or Behaviour, Functional Consequences, Differential Diagnosis, Co-morbidity. (see, for I1).

### Concerns, doubts and challenges

Although its achievement and status are rarely questioned fully by the debates led by different scholars involved in various disciplines, one can identify problematic areas, concerns, and challenges as well. Some scholars, for instance, Betty Garcia and Anne Petrovich, have already identified and summed up major limitations of *DSM*: “[t]he *DSM-5* continues to have significant weaknesses in its failure to address in a substantial way the vital client contexts of diversity and resiliency. As a result, these contexts are ignored or minimized in the diagnostic process, despite the

fact that these factors help link diagnosis to treatment planning and predict successful treatment outcomes. The institutionalized racism, cultural biases, and the marginalization of culture, evident in former versions of the *DSM* (Kutchins and Kirk, 1997), were not taken seriously by the authors of the *DSM-5*. Problems with reliability and validity of *DSM* diagnostic labels continue, along with the proliferation of mental illness diagnoses in the *DSM-5*. The medicalization of ordinary human suffering may be exacerbated while the environmental contexts of the seriously mentally ill continue to be minimized or ignored” (Garcia and Petrovich, 2016, 343-345). (Also, see: Horwitz, Wakefield and Spitzer, 2007). The loss of sadness: how psychiatry transformed normal sorrow into depressive disorder) Also, as we have mentioned above, the progress of a *DSM* focused on symptoms and determined by committees including primarily of psychiatrists has resulted in a dubious alliance between the pharmaceutical industry and medicine. As a result of this dynamic is that the training of psychiatrists has mostly been limited to the prescribing of psychoactive medications in order to reduce symptoms. Engagement and intervention skills, which deal with the complex causes of mental and emotional problems through interactive, relationship processes, have mainly been given up in the training of psychiatrists (Carlat, 2010). Garcia Betty and Anne Petrovich also argue that “[t]he client has too often been reduced to an assortment of symptoms, for which a label is sought to find the right medication. This then changes the definition of psychiatric practice to the prescription of psychotropic drugs to wider and wider segments of society, including young children. The exclusive focus on psychopharmacology has been emphasized to the point that psychiatry has come to be defined as a profession in crisis (Carlat, 2010). Mental health professionals -such as nurses, counselors, psychologists, and clinical social workers- who are trained to provide psychotherapy

but have less power and prestige than psychiatrists are largely left out of the diagnostic decision-making process despite their greater in-depth understanding of the consumers of mental health services as unique whole persons living in an ecological matrix of interacting internal and external contexts. Despite a stated commitment to do so, peer support specialists were not consulted in the development of the DSM-5 and are also invisible in the diagnostic assessment process” (Garcia and Petrovich, 2016, 343-345). (Also see the book of Edward Shorter, Joel Paris and James Phillips (2013): *Making the DSM-5: Concepts and Controversies*). Other concerns may include the increased number of mental disorders. Thus, it can be stated that the number of mental disorders classified in the DSM has multiplied over the years, with the result that the recent diagnostic classification/categorization debatably medicalizes and pathologizes existential problems in human living (Gambrell, 2005). In spite of the dominance of biological psychiatry in research institutes, the neglect of the patients whose diseases they research seems to persist.

### **The voices of discontent**

Although one can consider DSM-5 and DSM-5-TR as progresses in the field of statistics and diagnosis, one may need to spend some time on dealing with those voices raised from the depth of disillusionment created by both the former versions of DSM and the recent versions of it. More and more authors, scientists and scholars, such as Lake (2012), Frances (2013), Greenberg (2013), Vanheule (2014) and Hayes and Hofmann (2020) have already decided to pay attention to and to focus on controversies surrounding the latest versions of DSM in order to either to debunk the myth of it or to attempt to search for alternatives. For example, Gary Greenberg (author and psychotherapist) has entrenched himself for a couple of years in the conflict that broke out over

the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), the American Psychiatric Association’s compendium of mental illnesses and what Gary Greenberg calls “*the book of woe*.” Since its first appearance in 1952, the book has been “habitually” revised, and with each and every revision, the “official” view on which psychological problems constitute/amount to mental illness. One of the well-known examples, homosexuality, for instance, was “diagnosed” as a mental illness until 1973, and Asperger’s was recognized in 1994 only to witness its status challenged almost twenty years later. There is no doubt that virtually each and every version and text revision has created controversy and turmoil, but the DSM-5 has traumatized psychiatry to its foundations. The theatre of war has been brought to the doorsteps of APA that has had to suffer blows from patients/clients, mental health practitioners, and ex-members for expanding the reach of psychiatry into daily life by encouraging (and supporting) doctors to diagnose more illnesses and prescribe more therapies, and very often even medications whose effectiveness (and usefulness) is less known or unknown and whose side effects are severe. Many critics, including Greenberg, argue that the APA is not supposed to have the naming rights to psychological pain or to the hundreds of millions of dollars the organization earns, particularly, when even the DSM’s defenders admit and recognize that the disorders listed in the book are not (always) real illnesses. Gary Greenberg attempts to provide us with the history behind the DSM, which has grown from mini-pamphlet-sized to encyclopaedic since it was the first debut. He seems to relate the recent war to the flawed process by which the DSM-5 has been revised. Greenberg Gary, for instance, in his book, *The Book of Woe: The DSM and the Unmaking of Psychiatry* attempts to map and register the fallacies of DSM 5, in detail specific changes; for example, the elimination of bereavement exclusion and inclusion of a host of novel diagnoses which are yet to be tested and

validated. He also details the removal of bereavement exclusion from diagnostic criteria of depression, and states his concern over the possibility of classification/categorization of normal/common human emotions and consequent medicalization. His scepticism can also be related to the dimensional assessments and cross-cutting measures incorporated in DSM 5 (and in DSM-5-TR). Greenberg demonstrates the connection between various stakeholders in psychiatry, (primarily “the Big Pharma” and the insurance companies) APA, and how their “investments” could form and reform the policies and actions of the APA. (Greenberg, 2013) (See: Shorter Edward Shorter: (2015). *What Psychiatry Left Out of the DSM-5: Historical Mental Disorders Today*)

Another critic of DSM, C. Raymond Lake, argues that schizophrenia is a misdiagnosis and the primary objective of his book, *Schizophrenia Is a Misdiagnosis: Implications for the DSM-5 and the ICD-11*, is to improve the lives of patients with primary/ functional psychoses. The key to progress is effective treatment, and the key to correct treatment is a precise diagnosis. The clinical literature affirms that psychotic patients are regularly misdiagnosed as suffering from schizophrenia when, in fact, they suffer from a psychotic mood disorder or a subtle secondary/organic disease presenting with psychosis. Such (misdiagnosed) patients, their families, and their caretakers suffer major disadvantages from the misdiagnosis of schizophrenia. He also states that psychotic mood-disordered patients misdiagnosed with schizophrenia receive substandard care regarding their medications, as a result, allowing their mood conditions to deteriorate. (Lake, 2012)

Other mental health professionals, such as Joel Paris, claim that there has been a massive over-diagnosis in psychiatry. Joel Paris's *Overdiagnosis in Psychiatry* (2015) examines the hazardous epidemic of superfluous or inaccurate treatments. The last 30 years of psychiatry have seen the advance of a

system of categorization intended to create (or institute) greater scientific credibility. Regrettably, the existing/recent nomenclatures are based exclusively on signs and symptoms rather than on causes, which remain hidden/unknown. This has unavoidably led to inaccurate, vague diagnosis and uncertain. Joel Paris argues that the result of this concern can manifest when mental health professionals can have problems separating psychopathology from normality, and can ultimately wind up prescribing treatments that do more harm than good (Paris, 2015). He also states that “[m]odern psychiatry has rejected its long-standing psychosocial perspective, and has adopted a narrow version of the medical model. From the National Institute of Mental Health (NIMH) to the National Association for the Mentally Ill (NAMI), the motto has been adopted that mental disorders are brain diseases. This dogma is half-true and half-untrue. Yes, everything we observe clinically also happens in the brain. But you cannot understand the mind on that basis alone. A landmark event occurred in 1980, when the American Psychiatric Association adopted the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), a system that became standard all over the world. Over the next several decades, the DSM, including its 1994 revision as DSM-IV, was the primary tool used by psychiatrists to classify mental illness, both in the United States and around the world. The DSM system is now in its fifth edition (DSM-5), and while there have been a few changes, it remains essentially the same. It describes almost any type of psychological symptom using hundreds of categories that include everything from distress and disappointment to disabling illness. The DSM makes many of life’s misfortunes diagnosable, and implicitly offers psychiatry as a cure for unhappiness.”(Paris, 2015, 12.) Other “loud voices” come as far as to promote distrust in the system as well, for instance, Stewart Justman argues “[...] that medicalization promotes harm under the

auspices of healing, both by marketing disorders (“fostering the same pathologies intended to be healed”) and distorting the calculation of harms and benefits” (Justman, 2015, 11.). Also, Stijn Vanheule, in his work, *Diagnosis and the DSM: A Critical Review*, concludes that “[...] the DSM (from the DSM-III until the DSM-5) uses a naive medical semiotic model: symptoms are signs of underlying conditions that can be studied independently from their context. In this view, context variables only play a moderating role that might alter the shape of mental symptoms, but don’t determine the core characteristics of the symptom. Associated with this point of view, the DSM starts from the assumption that, essentially, mental disorders are neurobiological natural kinds. This viewpoint makes up a rhetoric discursive position that feeds the credibility of psychiatric diagnosis, yet this position remains unproven: unambiguous non-overlapping biological validators have never been successfully connected to any of the DSM categories” (Vanheule, 2014, 84.). Offering a critical reading of DSM is not the only goal of his book, he also presents us with some vital assumptions as well (ones that might have been of assistance in the creation of DSM-5-TR, too) Stijn Vanheule states that “[i]n contrast with the decontextualizing DSM approach, I believe that mental symptoms should above all be studied within relevant contexts. Obviously, the biology of the body is an important context within which symptoms arise. Yet there are many other contexts that cannot be neglected and should be taken into account in making a diagnosis. Humans should not only be seen as objects that are suitable for naturalistic examination, but also as signifier-using subjects that keep track of their own lives and have memories and experiences in which symptoms are embedded. What is more, human subjects relate to one another, live in social contexts, and thrive on cultural determinants.” (Vanheule, 2014, 84-85.). (Also see the book of Steven C. Hayes, Stefan G. Hofmann. (2020). *Beyond the DSM: Toward a Process-*

*Based Alternative for Diagnosis and Mental Health Treatment* or the book of Demazeux, Steeves & Singy, Patrick (Eds.) (2015). *The DSM-5 in perspective: philosophical reflections on the psychiatric Babel.*) Obviously, the concerns and issues have been heard and noted by the “creators” of the “psychiatric Bible” as well, since, as we have already discussed, a considerable amount of work has been done by the Work Group on Ethnoracial Equity and Inclusion in order to assure that appropriate attention is paid to (high) risk factors like racism and discrimination and the use of non-stigmatizing, non-victimizing language as well. Other concerns are connected to social factors, since Allan V. Horwitz assumes that the social embeddedness of DSM contributes to the turmoil it has created, he states that “[t]he history of the DSM indicates the manual’s deep entrenchment in the intra-professional and general sociocultural forces that impact the psychiatric profession. Some of these influences arise from within the field. Between the mid-twentieth century and the present, psychiatric practice relocated from mental institutions to offices and clinics. At the same time, the profession’s political center of gravity moved from the psychodynamic clinicians who dominated the initial DSM period to researchers, who held a very different diagnostic agenda. As well, changing medical norms forced the profession to adopt a more scientific seeming classification system. Other forces came from outside the field. Once psychiatry moved from the hospital to the community, patients and their families were less likely to view diagnoses as imposed and unwanted labels than as valued sources of treatment and other resources. Federal agencies, schools, and insurance companies all made DSM conditions requirements for service provision. Drug advertisements became major channels for suggesting which diagnosis described a consumer’s problems. All of these factors changed dramatically from the manual’s emergence in 1952 through its most recent version in 2013”. (Horwitz, 2021)

(Also see Horwitz Allan V. PhD, Jerome C. Wakefield, DSW (2012). *All We Have to Fear: Psychiatry's Transformation of Natural Anxieties into Mental Disorders*).

### Conclusion

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (and DSM-TR as well), used by clinicians and researchers to diagnose and classify mental disorders, is the product of more than 10 years of effort by hundreds of international experts in all aspects of mental health. Their devotion, commitment, and hard work have given way to an authoritative volume that is able to define and classify mental disorders to assist and improve diagnoses, treatment, and research. This extensive manual includes concise and specific criteria intended to assist an objective assessment of symptom presentations in several clinical settings inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care. It seems vital to note that DSM-5 and DSM-5-TR were released with insightful modifications revealed in the required diagnostic process, specific criteria for previously established diagnoses, as well as the addition and deletion of specific mental disorders. One of its greatest assets is the creation of a common language for clinicians concerned with the diagnosis of mental disorders. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition and DSM-5-TR, are the most comprehensive, recent, and critical resources for clinical practice available to today's mental health clinicians and researchers of all orientations. Moreover, the information provided by the manual can also be important to other physicians and health professionals, including researchers, psychiatrists, psychologists, counselors, nurses, and occupational and rehabilitation therapists, as well as social workers and forensic and legal specialists. With all its boundaries, limits, concerns, and

controversies, the DSM is a vital tool that deserves constructive criticism and relevant change for the sake of those who look to it for assistance. The focus on access to web-based information on recent research and evidence-based treatments, promised by the authors of the DSM-5 and DSM-5-TR, may assist the process of increased accessibility, but this would necessitate that all of the mental health professions, along with consumers of treatment and their families, are able to make use of this source and engage in the dialogue, surrounding the latest versions of DSM. DSM-5 and DSM-5-TR can still claim to be the most definitive resource for the diagnosis and classification of mental disorders, even if through its long life, more than 70 years, have already invited doubters and nay-sayers as well.

### References

- American Psychiatric Association (1952). *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Association Mental Hospital Service, Washington.
- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition. Arlington, VA, American Psychiatric Association.
- American Psychiatric Association (2022). *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edition, Text Revision. Washington, DC, American Psychiatric Association.
- Carlat, D. (2010). *Unbinged: The trouble with psychiatry: A doctor's revelations about a profession in crisis*. New York, NY: The Free Press.
- Demazeux, S. & Singy, P. (Eds.) (2015). *The DSM-5 in perspective: philosophical reflections on the psychiatric. Babel*. Springer, Berlin.
- Frances, A. (2013). *Saving normal: an insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life*. HarperCollins, New York.



- Gambrill, E. (2005). *Critical thinking in clinical practice: Improving the quality of judgments and decisions*. Hoboken, NJ: John Wiley and Sons.
- Garcia B. & Petrovich, A. (2016). *Strengthening the DSM: incorporating resilience and cultural competence*. Springer Publishing Company, USA.
- Greenberg, G. (2013). *The Book of Woe: The DSM and the Unmaking of Psychiatry*. Blue Rider Press, USA.
- Horwitz, A. V. (2021). *DSM: A History of Psychiatry's Bible*. Johns Hopkins University Press, USA. 145-146.
- Horwitz, A. V. & Wakefield, J.C. (2012). *All We Have to Fear: Psychiatry's Transformation of Natural Anxieties into Mental Disorders*. Oxford University Press, USA.
- Horwitz, A.V., Wakefield, J.C. & Spitzer, R. (2007). *The loss of sadness: how psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press, Oxford.
- Hayes, S. C. & Hofmann, S. G. (2020). *Beyond the DSM: Toward a Process-Based Alternative for Diagnosis and Mental Health Treatment*. New Harbinger Publications, California.
- Justman, S. (2015). *The Nocebo Effect: Overdiagnosis and Its Costs*. Palgrave Macmillan US.
- Kutchins, H. & Kirk, S. A. (1997). *Making us crazy. DSM: The psychiatric bible and the creation of mental disorders*. New York, NY: The Free Press.
- Lake, C. R. (2012). *Schizophrenia is a misdiagnosis: implications for the DSM-5 and the ICD-11*. Springer, Berlin.
- Paris J. (2015). *Overdiagnosis in Psychiatry: How Modern Psychiatry Lost Its Way While Creating a Diagnosis for Almost All of Life's Misfortunes*. Oxford University Press, Oxford.
- Scott, C. (2015). *DSM-5® and the Law: Changes and Challenges*. Oxford University Press, Oxford.
- Shorter, E. (2015). *What Psychiatry Left Out of the DSM-5: Historical Mental Disorders Today*. Routledge, London.
- Shorter, E., Paris, J. & Phillips, J. (eds.) (2013). *Making the DSM-5: Concepts and Controversies*. Springer-Verlag New York.
- Vanheule, S. (2014). *Diagnosis and the DSM: A Critical Review*. Palgrave Macmillan, UK.
- I1: American Psychiatric Association. About DSM-5-TR. web: [https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm#section\\_2](https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm#section_2) [2022.12.04.]