

## Limitations to the DSM-5

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Accurate psychiatric diagnosis is essential for effective treatment among patients; the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is intended to provide a standardized framework for identifying mental disorders. While the DSM-5 has served as a gold standard for diagnosis of mental disorders, there remain notable limitations in the reliability and validity of its diagnostic value. Some concerns include that the diagnostic checklist structure of the DSM often produces overlapping clinical profiles, fails to account for cultural context of symptom presentation, and relies on rigid categorical classifications that do not reflect symptom severity or progression within individuals.

One major limitation of DSM-based diagnosis is the significant overlap in symptom checklists across disorders, which severely complicates differential diagnosis. Newson and Hunter, in *Poor separation of clinical symptom profiles by DSM-5*, demonstrate that DSM-5 criteria often fail to clearly separate clinical symptom profiles, resulting in individuals meeting criteria for multiple disorders simultaneously; which is inherently not accurate and representative of their situation<sup>1</sup>. This issue is especially evident in trauma-related conditions, as discussed by Ford and Courtois, in *Complex PTSD and Borderline Personality Disorder*, due to shared symptoms such as emotional dysregulation and interpersonal instability, as the two closely intertwined disorders can often complicate<sup>2</sup>. Wakefield in *Diagnostic Issues and Controversies in DSM-5: Return of the False Positives Problem* further critiques this overlap by identifying a “false positives” problem in DSM-5, where broad criteria risk labeling normal or contextually appropriate distress as pathology<sup>3</sup>. Collectively, these studies suggest that checklist-driven diagnosis prioritizes symptom presence over symptom meaning, increasing the likelihood of misdiagnosis largely. They cause overlap within one another in the sense that they share largely the same symptoms which is cause for confusion (mainly emphasized in BPD and complex PTSD), while Wakefield takes this issue one step further and creates a false-positive argument.

Another significant weakness of the DSM framework is its limited incorporation of cultural context in defining and interpreting psychiatric symptoms. Peters’ *Perspectives of Psychiatry* approach emphasizes that understanding a patient’s cultural background is essential for interpreting behavior, distress, and symptom expression<sup>4</sup>. Without this appropriate context of patients, clinicians may incorrectly pathologize culturally normative experiences; as is often not implied in the DSM. Lewis Fernández and colleagues, in *Culture and the Anxiety Disorders: recommendations for DSM-V*, expand on this concern in their analysis of anxiety disorders, arguing that DSM criteria insufficiently address how culture shapes symptom presentation, help-seeking behaviors, and explanatory models of illness<sup>5</sup>. Two prime examples of cultural anxiety syndromes presented in individuals include “Atque de nervios” and “Dhat Syndrome.” Atque de nervios is most commonly reported in Caribbean Latino communities, a disorder that is culturally understood as a response to overwhelming emotional stress rather than simply an anxiety disorder. Dhat syndrome is observed in South Asian cultures where individuals

experience severe anxiety and fatigue related to beliefs that semen loss weakens the body. The distress is interlinked with ideas to cultural beliefs about health and masculinity. These syndromes specifically argue that DSM criteria proves to be insufficient because the DSM was historically developed largely from Western perspectives on mental illness. If clinicians rely only on standard DSM categories without considering cultural context, they may misdiagnose patients and overlook important symptoms—ultimately resulting in ruptures in the provider-patient relationship and suboptimal treatment recommendations. Another example is *Tajin Kyofusho*, a culture-related syndrome largely associated with East Asian cultures where individuals with the diagnosis possess an intense fear of offending, embarrassing, or making others uncomfortable through either their appearance or behavior. The symptoms of this disorder overlap largely with a lot of anxiety disorders because both have the factor of intense fear in social situations but *Tajin Kyofusho* is more particularly centered on the perceived impact oneself has on others, reflecting a lot of their cultural values. Even though they have largely similar symptoms, it goes to show how drastically different each disorder can be with cultural context taken into account. Identification of these cultural nuances could hugely benefit psychotherapy interventions, namely evidence-based approaches like cognitive behavioral therapy which could target the rigidity of certain cultural-laden thoughts tied to anxiety symptoms. Without the cultural nuance context in DSM-based diagnosis, we risk reinforcing bias and reducing diagnostic validity, especially for patients from marginalized or non-Western backgrounds.

The DSM's categorical structure further limits diagnostic precision by treating mental disorders as discrete entities rather than existing along spectrums of severity. Meehl's taxometric research, in *Categorical versus dimensional models of mental disorder: the taxometric evidence*, challenges the assumption that mental disorders are categorically distinct, presenting evidence that many psychological conditions may be better understood on a spectrum<sup>6</sup>. This can be seen in disorders related to psychosis, examples include: Schizoid Personality Disorder, Schizophreniform Disorder, and Schizophrenia. Rather than functioning as entirely separate conditions, these disorders can be interpreted as existing along a spectrum of social withdrawal and psychotic symptoms. Individuals with schizoid personality disorder may display mild attachment and limited emotional expression without full psychosis. Schizophreniform disorder encompasses more acute psychotic symptoms of shorter duration, while schizophrenia represents more persistent and severe psychotic impairment. The overall symptoms and progress between these diagnoses imply that rigid categorical boundaries oversimplify the complexity of psychopathology and fail to adequately capture gradual differences in severity and functioning. Helzer and colleagues support this critique in *Dimensional versus categorical classification: comment on special section*, arguing that categorical classification fails to capture symptom progression, comorbidity, and subthreshold presentations<sup>7</sup>. As a result, individuals who do not neatly meet diagnostic thresholds may be excluded from care, while others may receive labels that do not entirely reflect the complexity of

their experiences and individual symptoms. This rigidity undermines both clinical decision-making and longitudinal understanding of mental health. In addition, a similar issue can be seen with depressive disorders where symptoms fluctuate from mild subthreshold depressive experiences to persistent depressive disorder and major depressive disorder. Someone may experience significant changes in mood but not reach the threshold numbers required to be diagnosed for a major depressive disorder diagnosis. Rather than setting a clearcut divider between “disordered” and “not disordered,” these experiences can still exist along a continuum of severity and impairment. Further going on to show how categorical thresholds overlook individuals even though they experience significant distress just because they fall below the diagnostic cutoff.

While the DSM-5 provides a common language and foundation for psychiatry diagnosis, its checklist-based, categorical framework prevents significant limitations. Overlapping symptom profiles blur diagnostic boundaries, insufficient cultural consideration risks misinterpretation, and categorical classification fails to capture symptom severity and progression. Together, these issues highlight the need for diagnostic models that are more dimensional, culturally responsive, and clinically flexible. Moving beyond rigid diagnostic categories may improve accuracy, reduce misdiagnosis, and better reflect the lived experiences of patients, ultimately advancing both psychiatric research and clinical practice.

## References

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