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# The *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision: through tradition and change. Critical analysis and clinical implications

*Fabio Di Fabio*,* *Antonella Moschillo***

Abstract. – Today, the *Diagnostic and Statistical Manual of Mental Disorders, fifth edition, text revision* (DSM-5) is a central point of reference in contemporary psychiatry, not only as a diagnostic manual but also as a device that structures access to care, clinical language, and patient understanding. This article takes a critical look at the main changes, highlighting the continuity with previous editions and the conceptual transformations that have been introduced. The history of the DSM shows that there is tension between the search for diagnostic reliability, the simplification of observable symptoms, and the complexity of the subjective experience. The DSM-5-TR introduces significant updates: the inclusion of prolonged grief disorder, the revision of race and gender language, the expansion of unspecified mood disorders, and the redefinition of intellectual disability and functional neurological symptom disorders, as well as the self-coding of suicidal and self-harming behavior. These changes reflect an orientation toward a psychiatry that is more sensitive to cultural and social contexts, while maintaining priority over standardization and diagnostic replicability. The manual, while not revolutionizing the paradigm, continuously calibrates the boundary between normality and pathology; the text is analyzed with a critical eye, highlighting its limitations and potential, and encouraging a more contemplative use in clinical practice and patient care.

*Key words*: DSM-5, psychiatry, psychiatric nosography, diagnosis.

## Premise

In recent decades, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has become an almost mandatory reference for clinical practice, research, and organization of mental health services. Even for

*Policlinico Umberto I, Rome; Department of Neurosciences and Mental Health, Sapienza University of Rome, Italy. E-mail: fabio.difabio@uniroma1.it

**ASL Roma 5, Tivoli (RM); Department of Dynamic and Clinical Psychology, and Health Studies, Sapienza University of Rome, Italy.
E-mail: antonella.moschillo@uniroma1.it

those working in a psychoanalytic context, the DSM is today an inescapable interlocutor: indeed, its categories structure access to care, institutional language, and, increasingly, the very way in which patients are able to name their suffering, which adheres to the official nosography.

The publication of the DSM-5-TR (APA, 2022) is not a mere editorial revision of the manual but a moment of adjustment of this classification device in a deeply changed clinical, cultural, and scientific context. The changes introduced, even when they appear technically minor, reflect theoretical orientations, social evolutions, and institutional objectives that directly affect the way in which psychological distress is recognized, defined, and treated.

The purpose of this article is to provide a critical and technically informed reading of the main innovations of the DSM-5-TR (APA, 2022), with particular attention paid to their clinical and epistemological implications. We will try to understand what is changing, how it is changing, and in what direction psychiatric nosography is moving today. For the psychoanalytic community, this work of clarification is all the more necessary since the DSM, although foreign to its theoretical tradition, continues to exert a concrete influence on the clinical field in which it operates. Neglecting the DSM means increasing the risk of losing a fundamental interpretative lens on the contemporary forms of suffering and the devices that organize them.

## Historical landscape of the DSM

In the debate about the modern evolution of subjectivity and mental pathology, the American Psychiatric Association (APA) has played a central role. Through the various editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the APA has not only provided a technical diagnosis directory but has also helped to define the way in which psychiatry has thought about mental suffering, its scientific status, and its implicit conception of the human being. The DSM has functioned, in this sense, as a true conceptual infrastructure: a grid that organizes what is recognized as disturbance, what is normal, and what remains in an area of ambiguity between adaptation and pathology.

Since its inception, the DSM project has been driven by the aspiration of making mental suffering the object of ordered, standardized, and cumulative knowledge, modelled on other medical disciplines. This aspiration, however, has never been neutral. Each classification implies theoretical, anthropological, and regulatory choices that profoundly affect how mental illness is described, treated, and ultimately experienced by patients. In this regard, the DSM should be interpreted as a historical device located at the

intersection of clinical needs, dominant scientific models, institutional interests, and cultural transformations.

The turning point came in 1980 with the publication of the DSM-III (APA, 1980), which marked a significant discontinuity from previous editions. As documented by Hanna Decker in *The Making of DSM-III* (Decker, 2013), this edition marked the abandonment of the great psychodynamic and phenomenological models in favor of an overtly descriptive and "atheoretic" approach. Mental disorders were no longer defined on the basis of etiological hypotheses or deep psychopathological structures, but by sets of observable and operational criteria.

This reform was chiefly led by Eli Robins and Robert L. Spitzer, exponents of the Neo-Kraepelinian tradition. Their design was based on three pillars. The first was the need to increase diagnostic reliability, which emerged strongly after the scandal brought up by the US-UK Diagnostic Project (Kendell *et al.*, 1971), which showed systematic divergences between American and British psychiatrists in diagnosing the same clinical cases. The second pillar was the introduction of operational criteria based on lists of symptoms, inspired by the Feighner criteria (Feighner *et al.*, 1972) and then formalized in the *Research Diagnostic Criteria* (Spitzer *et al.*, 1978), with the aim of making diagnoses replicable and comparable. The third was an attempt to overcome the nosographic chaos produced by the different theoretical schools by adopting an admittedly agnostic approach to etiology.

This approach found an explicit formulation in the work by Woodruff, Goodwin, and Guze, *Psychiatric Diagnosis* (Goodwin & Guze, 1979; Woodruff *et al.*, 1974), which argued for the need to suspend all explanatory pretenses in the absence of solid empirical bases. Indeed, these authors wrote in the preface to the first edition:

> "In this book there are few explanations. This is because, for most psychiatric conditions, there is no explanation. 'Unknown etiology' is the hallmark of psychiatry, and its curse. Historically, once the etiology is known, a disease stops being psychiatric. […] people naturally continue to speculate on the etiology, and this is good if it produces verifiable assumptions, and bad if speculation is mistaken for truth. In this book speculation is largely avoided, as it is available elsewhere in abundance. […] One last word on this approach to psychiatry. It is sometimes referred to as 'biological' [organic]. This is a misleading term. A better term, perhaps, is agnostic."

The DSM-III translated this project into a classification system based on explicit criteria, clinical course, and prognosis. This made psychiatry more compatible with epidemiological and pharmacological research by providing a common language and fostering large-scale data collection and integration into health systems.

But this very success introduced background tension. The "atheoreticity" of the DSM is only illusory: deciding which symptoms matter, how to group them, and where to set diagnostic thresholds always implies an implicit theory of mind and deviance. By reducing a disorder to a set of symptomatological criteria, the DSM has prioritized what is measurable and comparable, leaving the subjective history, context, and overall structure of the experience in the background.

Subsequent editions, from the DSM-IV (APA, 1994) to the DSM-IV-TR (APA, 2000), refined the clinical descriptions, including course, prevalence, and co-morbidity data, but without modifying this framework. Classification is still based on operational nominalism: disorders are defined by consensus, not as entities with their own structure. As noted by Steven Hyman, in an enlightening review (Hyman 2010), this facilitated the reification of diagnoses, treated as if they were natural objects, with the clinical risk of reducing the singularity of patients to the available categories.

Over time, this nominalism has been supplemented by a growing push toward the neuroscientific naturalization of diagnoses. An emblematic moment was Thomas Insel's editorial, *Psychiatry as a Clinical Neuroscience Discipline*, published in the *Journal of the American Medical Association* (Insel & Quiron, 2005), which proposed understanding mental disorders as brain disorders, thereby redefining the basic education and sciences of psychiatry.

> "In this comment, we argue that the impact of psychiatry on public health will require that mental disorders be understood and treated as brain disorders. […] if mental disorders are brain disorders, then the basic sciences of psychiatry must include neuroscience and genomics, and the training of psychiatrists in the future must be profoundly different from that of the past."

With the DSM-5 (APA, 2013) and the DSM-5-TR (APA, 2022), these tensions became even more apparent. Alongside attempts to introduce dimensional and transdiagnostic approaches, there has been a further expansion of the pathological field from prolonged grief disorder to a marked increase in autism and attention deficit hyperactivity disorder (ADHD) diagnoses in developmental age. Allen Frances, already in charge of the DSM-IV, has interpreted this direction as a growing medicalization of everyday life, mainly benefiting the pharmaceutical industry: a dynamic that, as he writes in *Saving Normal* (Frances 2013), risks transforming society into a community of chronic patients. Frances writes:

> "The stakes were too high to turn a blind eye – high for both wrongly labeled future 'patients' and society as a whole. Diagnostic inflation has led too many people to depend on antidepressants, antipsychotics, anxiolytics, sleeping pills, and painkillers. We are turning into a pill-swallowing society."

In this context, the DSM-5-TR presents itself as a recent crystallization of tensions that have long been going through psychiatric nosography. Rather than merely updating the wording, it represents a point of reorganization of conceptual, clinical, and institutional structures that are already in place. In order to assess its scope, it is therefore necessary to move from the level of general criticism to that of its operational choices, made up of definitions, criteria, specifiers, and vocabulary.

It is in these technical devices that the conceptual framework of the DSM takes its operational form and produces its clinical effects. It is on this level that the analysis of the DSM-5-TR that follows is contextualized.

## Critical and technical analysis of the DSM-5-TR

In light of this historical and theoretical course, the analysis of the changes introduced in the DSM-5-TR acquires a meaning that goes beyond mere technical updating. Although most revisions consist of relatively minor interventions, error corrections, terminology clarifications, or resolution of inconsistencies between diagnostic criteria, some changes are sufficiently important to affect clinical practice and the conceptual setup of the manual, as aforementioned (First *et al.*, 2022).

Some of these changes concern the formulation of the *specifiers*, often with a predominantly clarifying function and without substantial implications for the overall philosophy of the DSM; these interventions will not be considered here. Instead, we will focus on nine profiles of change, which, in our opinion, more clearly reflect the adaptation of the manual to the "spirit of the times". For each profile, a summary outline has been prepared, followed by a brief analytical comment. These will then be followed by a summarizing discussion, addressing not only the most recent revisions but also the overall logic governing the entire DSM framework.

### *1. General setting changes*

The DSM-5-TR introduces a new section entitled *Introduction and Use of the Manual*, which establishes stricter protocols for the application of the criteria.

The fundamental change is to move from a "discontinuous" revision model (large editions every 15-20 years) to an iterative, continuous model. The APA has established standing working groups to monitor scientific literature and propose changes in real time, which will be published online before being added to future editions. This transforms the manual from a static text to a dynamic "epistemic maintenance" device. In this way, the APA breaks with the tradition of drastic changes between editions (as hap-

pened between the DSM-III and DSM-IV), preferring a more fluid and adaptable “continuous” revision (First, 2016).

This new vision is emblematic of the context in which the manual was published, that of a rapidly evolving world characterized by technological acceleration and growing social uncertainty. The “iterative” approach implies that diagnostic categories are no longer defined definitively but can be reviewed and corrected as new evidence builds. Thus, psychiatry is seen to be constantly evolving, reflecting the reality of an increasingly “liquid” world, as described by Zygmunt Bauman (2000), where institutions and truths are modeled on the needs immediately perceived.

## *2. Prolonged grief*

Inclusion of prolonged grief disorder (PGD) in Section II (Official Diagnosis).

> [Time criterion: Death must have occurred at least 12 months earlier for adults and at least 6 months earlier for children and adolescents.
> Symptomatological criteria: Presence of intense yearning/longing for the deceased person or preoccupation with thoughts or memories of the deceased person, accompanied by at least 3 of 8 symptoms (identity disruption, disbelief, avoidance of reminders, intense emotional pain, difficulty reintegrating, emotional numbness, feeling life is meaningless, and intense loneliness) present almost every day for at least the last month.
> Exclusion: The disorder is not better explained by major depressive disorder or post-traumatic stress disorder and must clearly exceed cultural and religious norms.]

The introduction of prolonged grief disorder has given rise to extensive sociological and cultural reflections, first and foremost the one carried out by a group of scholars (Breen *et al.*, 2015), which, through an international online survey (in only Western countries) on public attitudes, revealed that about 25% of respondents did not share the view that mourning could be considered a mental disorder. This is even more evident in public opinion in non-Western countries. For example, a similar survey in China (Tang *et al.*, 2020) found that as many as 40% of respondents considered grief to not be attributable under any circumstances to mental illness, even when it involved suicide.

However, the DSM Committee eventually voted for inclusion in the Manual due to the significant statistical analyses showing that the prolonged grief disorder construct contains a high level of internal consistency (Cronbach’s alpha greater than 0.80 in all samples tested). It is statistically distinct from other disorders with similar symptoms, such as major depressive disorder, post-traumatic stress disorder, and generalized anxiety (Prigerson *et al.*, 2021; Szuhany *et al.*, 2021). All of this has allowed for the

inclusion in the DSM of an *ad hoc* category for the complications of grief, and indeed, this has resulted in the creation of a clear clinical boundary for an experience that has historically been treated as a natural process anchored in culture and religion. In fact, contemporary psychiatry intervenes to "normalize" mourning, setting time limits beyond which pain is no longer tolerated.

In a social context strongly geared toward performance and functional continuity, emotional suffering tends to be conceived as a state that must be contained and resolved within a predictable time frame. The setting of a twelve-month time limit for persistent mourning implicitly introduces a criterion of "appropriate duration" of pain. From a phenomenological perspective, however, grief is not a mere constellation of symptoms, but a break in the horizon of meaning and continuity of experience. In this context, its diagnostic codification risks operating as a normalization device, which legitimizes pain only to the extent that it falls within socially acceptable time and statistical parameters.

### *3. The "decolonization" of psychiatry*

The DSM-5-TR implemented a massive text revision to eliminate discriminatory language.

> [The term "race" has been removed where it was used as an intrinsic biological variable, such as in the category: V62.4 (Z60.5) "Subject to (perceived) discrimination or persecution", in which the term "race" was used.
> The text explicitly recognizes that disparities in diagnosis are often due to external factors such as structural racism and socio-economic inequalities.
> The term "minority" has been largely replaced with more specific descriptions (*e.g.*, "ethnoracial groups") to avoid implying a hierarchy of importance or power. Generalizations about genetic differences in response to psychotropic drugs have been removed, now attributed to individual enzymatic variations and not racial affiliations.]

This review puts an end to the use of "race" as a biological category, recognizing that structural racism is a factor of collective stress. It represents an important step in the deconstruction of a psychiatry that has historically contributed to perpetuating inequalities (Garb, 2021). If overdiagnosis of schizophrenia, alcohol dependence, personality disorders, etc., among Black people was a documented practice, the DSM-5-TR attempts to break down these barriers.

The change is not just about terminology but involves broader reflection on the implications of systemic racism. The challenge now is to translate these principles into clinical practices that do not consider the subject as an abstract individual, but as a being immersed in a sociopolitical context that

determines mental health. The feeling is, however, that although Western societies introduce more politically and socially appropriate terminology, attitudes are still not equally inclusive and egalitarian.

## *4. Gender and identity*

The changes in the chapter on gender dysphoria are radical in their semantic impact.

> [“Experienced gender” replaces “desired gender”. The term “desire” suggested a whim or an unfulfilled aspiration; “experienced/expressed” recognizes identity as a present and ontologically valid fact.
> Gender assigned at birth: the term “born” (*e.g.*, “male born individual”/“female born individual”) disappears in favor of “assigned at birth” for the male/female gender. This change recognizes that gender is a medical category assigned by external observers at birth, which may not match the identity of the person.
> “Gender affirmation” procedures replace the terms “reassignment” or “cross-sex”. “Affirmation” implies that medical intervention (hormonal or surgical) is used to validate and align the body with an existing identity, rather than changing it.]

“Gender dysphoria” was already a new diagnostic class included in the DSM-5 (it replaced “gender identity disorder” of the DSM-IV) and reflected a change in the conceptualization of the characteristics that defined the disorder by emphasizing the phenomenon of “gender incongruence” rather than identification with the opposite sex, which was how gender identity disorder was conceptualized in the DSM-IV. In explaining the criteria, “the opposite sex” had been replaced by “the opposite gender” (or “an alternative gender”), and the term “gender” was systematically used instead of “sex” because the concept of “sex” was deemed inappropriate when referring to individuals with a sexual development disorder.

After the DSM-5 was published, the debate continued (Zucker, 2013) and some changes were made in the revision of the text, which seem to only concern terminology, but which are also very significant in philosophical terms. For example, the transition from the concept of “desire” to that of “expressed” (but note that the most phenomenologically meaningful term “experienced” is not used) marks an important discontinuity: it is no longer an unrealized aspiration, but an experience that concerns the already present identity of the subject.

Abandonment of the term “born”, in favor of “assigned at birth”, promotes a more fluid and less binary view, recognizing the self-determination of transgender people. These changes reflect a profound change in the way psychiatry relates to gender identities, assuming a role of identity facilitator rather than regulatory judge. Terminology becomes a tool for empowering and respecting diversity.

## *5. Mood disorders review and new operational categories*

The manual clarifies and expands the diagnosis of "unspecified mood disorder".

> [This category is used to describe clinical pictures with a mixed mood that does not fully meet the criteria for duration or number of symptoms for mania and hypomania episodes or major depressive disorder. For example, a person with persistent depressive symptoms who has sudden thought accelerations or irritability for only two days (below the four-day threshold required for hypomania) can now be accurately categorized, avoiding being misdiagnosed with bipolar I or II disorder.]

Traditionally, psychiatry has divided mood disorders into rigid categories. However, many patients have "hybrid" symptoms that do not fit easily into these binaries. The DSM-5-TR finally corrected a problem introduced by the DSM-5: the lack of diagnostic space for those patients who have mood disorders, but for whom it is not yet (or will never be) possible to determine whether the clinical picture will evolve into a bipolar or depressive form.

The unspecified mood disorder category effectively restores the concept already present in the DSM-IV under the name of unspecified mood disorder. This solution has always been welcomed with relief by clinicians, as the chapter structure of the DSM-5 had often forced premature and clinically unclear choices. Updating is crucial to avoid inappropriate drug treatments, such as excessive use of mood stabilizers or antipsychotics in cases where more nuanced approaches are required.

## *6. Intellectual developmental disorder*

The term "intellectual disability" is officially replaced with "intellectual developmental disorder". Although the term "intellectual disability" remains in parentheses to facilitate the transition, the new wording fully aligns with the World Health Organization (WHO) International Classification of Diseases - 11$^{th}$ Revision (ICD-11). Diagnosis is no longer based on IQ test scores, but on adaptive functioning of the subject in conceptual, social, and practical domains.

The use of the term "disorder" instead of "disability" (in this specific evolutionary context) emphasizes the need for continuous support during the development phases. It stresses that the condition is not a static and immutable deficit, but a mode of operation that requires environmental adaptations.

The currents of thought that support neurodiversity find institutional acknowledgement in the DSM-5-TR. People with intellectual developmen-

tal disorders are no longer regarded as “deficient”, but as belonging to a human dimension that deserves respect and personalized support, shifting the focus from what the subject “cannot do” to how he/she can “function more appropriately” in specific contexts.

## *7. Functional neurological symptom disorder*

The term “conversion disorder” has been completely replaced with “functional neurological symptom disorder”.

> [The diagnostic criteria have been simplified to no longer require the presence of an identifiable psychological stress factor. The diagnosis is now based on clinical evidence of incompatibility between the symptom and known neurological conditions (*e.g.*, Hoover’s sign in the case of limb weakness), shifting the focus from “psychic cause” to “clinical presentation”.]

This is a particularly important change, as it involves abandoning terminology that is historically linked to the 19th-century psychiatric tradition, which subsequently became psychoanalytical too. Conversion hysteria had already been described in detail by Freud in his writings with Josef Breuer, collected in his book *Studies on Hysteria* (Breuer & Freud, 1895). The term “conversion” recalled the mechanism by which an intolerable affection, linked to a removed representation, was diverted from the psychic plane to that of the body. The presence of severe bodily symptoms – paralysis, anesthesia, aphonia, visual disturbances, seizures – in the absence of any organic injury is, for Freud and for subsequent psychoanalytic tradition, the result of a process of conversion of a psychic conflict into a somatic phenomenon. The conversion thus represented both a disguised expression of unconscious conflict and a form of body language. The emotional energy that could not be processed mentally (due to repression) and that found an outlet in the body, producing a symptom that had a high symbolic value.

The adoption of the term “functional” introduces a more descriptive lexicon that is less loaded with theoretical and moral implications: it does not assume that the symptom results from an unconscious “conversion” of trauma but rather indicates an alteration of the functioning of neuropsychological circuits in the presence of structurally intact brain architecture (Stone *et al.*, 2016). This terminology shift is consistent with an orientation that aims to reduce patient stigmatization, avoiding interpretations that can be perceived as guilt-inducing or reductively psychologizing. At the same time, it reflects the current tendency to interpret these disorders as expressions of neural network dysfunction, marking a progressive realignment of nosography toward integrative models between neuroscience and clinical practice, rather than toward explanations that are broad and inclusive of intrapsychic conflict.

### *8. Disappearance of the term "neuroleptic"*

The DSM-5-TR systematically removed the term "neuroleptic" throughout the manual. Instead, terms such as "antipsychotic drugs" or, in more technical contexts, "dopamine antagonist drugs" are used. The term was considered obsolete because it emphasized the "motility-reducing" (tranquillizing) effect of first-generation drugs, neglecting the more complex mechanisms of action of modern drugs.

The substitution of "neuroleptic" with "antipsychotic" therefore signals an attempt to realign the pharmacological lexicon to a psychiatry that is increasingly defined in terms of targeted intervention on psychopathological processes, rather than simply controlling behavioral symptoms. In this sense, the terminology change should contribute to a less stigmatizing representation of drug treatments and to an image of clinical practice geared not only at containment, but at the modification of pathogenetic processes involved in psychotic disorders.

### *9. Suicide and self-harm*

The DSM-5-TR introduces new Z-codes for recording suicidal behavior and non-suicidal self-harm. These codes allow clinicians to record other conditions that may be a focus of clinical attention, even in the absence of a diagnosis of concurrent mental disorder (*e.g.*, a person without depression who attempts suicide following financial collapse).

Traditionally, suicidal behavior has been considered primarily as an epiphenomenon of an underlying mental disorder. Its partial autonomy within the DSM-5-TR introduces the recognition that a suicidal crisis can emerge even in the absence of a major psychiatric diagnosis, as a response to conditions of intense existential suffering. This innovation has significant clinical implications, as it allows specific interventions on suicidal risk to be targeted regardless of the presence of mood disorder or other formal psychopathologies.

At the same time, this diagnostic reorganization is not unambiguous. While it broadens the gaze on human suffering, it can be used to trace all forms of suicidal or self-harming behavior within a psychopathological context. In this way, psychiatry risks extending its jurisdiction to forms of discomfort that, as in the case of anomic suicide described by sociological tradition since Durkheim (1897), and already described by Marx (Plaut & Anderson, 1999), are rooted in fractures of social connections, in the loss of regulatory references, and in the processes of disintegration of the collective fabric, rather than strictly in an individual pathology.

Taken together, the changes examined do not constitute a simple technical review but rather outline a recognizable trajectory. Through terminolog-

ical adjustments, redefinition of criteria, and new category articulations, the DSM-5-TR continues to reorient the way suffering is made visible, defined, and treated. What emerges is not so much a paradigm shift but a gradual recalibration of the balance between clinical description, neuroscientific models, and contemporary cultural sensitivities. These shifts, though sometimes subtle, have real effects on clinical practice and patient experience: they change pathological thresholds, redefine what counts as a symptom, and transform the relationship between crisis, diagnosis, and treatment. It is therefore from these operational choices that it becomes possible to question more deeply the conceptual structure of the DSM. The following chapter, therefore, proposes to conclude by offering suggestions with which to try to place these transformations in a wider framework, examining the historical, epistemological, and institutional assumptions that have made the DSM what it is today.

## Conclusions

As mentioned, this last chapter proposes placing the DSM-5-TR within the broader genealogy of the DSM project, questioning its implicit assumptions, scientific alliances, and systemic constraints that guide its evolution.

A critical reflection on the DSM must therefore question the type of subject that the manual assumes: an abstract, de-contextualized individual, observable from the outside, whose inner experience can be broken down into symptoms and traced back to standard categories. In this process, the meaning and sense of experience tend to fade away. Phenomenological and psychodynamic traditions have highlighted the limitations of this approach, showing that psychopathology cannot be reduced to a sum of signs, but must be understood as a global transformation of the way of being-in-the-world. Psychic suffering, therefore, is not an isolated object but an experience that affects the entire existence of the subject.

The DSM should therefore be interpreted as a historically situated device, influenced by implicit philosophical choices, whose effects go beyond the clinician and enter professional training, health systems, insurance policies, and the pharmaceutical industry. This function also extends outside of the clinical context. The DSM categories enter into common language, shape the self-understanding of subjects, and define interpretive frameworks for suffering, consolidating the perception of disorders as objective and natural realities, rather than as historical and cultural constructions.

From a technical point of view, the manual gives priority to the reproducibility of the diagnosis (inter-rater reliability) over its clinical validity. Concordance between observers ensures standardization but does not

ensure that what is diagnosed really corresponds to a meaningful clinical structure. The proliferation of diagnostic categories responds to the need to recognize previously neglected forms of suffering, but may further fragment the psychopathological field, multiplying labels without clarifying the structural relationships between them. It risks "hyper-nominating" suffering: every discomfort has a name, but not always a meaning.

In fact, the DSM reduces the psychopathological experience to measurable symptoms, neglecting the central question for those experiencing it: Why these symptoms, at this time, in this context? Phenomenological perspectives recall that psychic suffering cannot be understood without considering the way the world shows itself to the subject. Loss of natural evidence, alteration of temporality, delusional experiences: these are not signs among others, but transformations that redefine the whole experience. What lends itself to discrete coding is marginalized, reflecting a conception of science that favors the measurable and struggles to confront complex, qualitative, and ambiguous phenomena.

Finally, the link between diagnosis and treatment shows the practical impact of the manual: categories guide access to treatment, prescriptions, treatment duration, and assessment of outcomes. When diagnosis becomes an ontological reality, clinical identity risks overlapping with personal identity, compressing the complexity of experience and contributing to the stigmatization and medicalization of problems that have existential, social, or relational roots.

To bring these tensions to light means returning a reflective dimension to psychiatry: no classification can exhaust the sense of suffering, but, if taken critically, it can become an instrument at the service of care. The DSM, therefore, confirms itself as a success and a problem at the same time. Its ambivalence recalls the theme of wonder as a limit-experience: the moment in which the order of sense falters and experience shows itself in its opacity. In this fragile space, the possibility of a non-reductive clinical practice opens up, and this is capable of accommodating the singularity without dissolving it into codes, keeping the tension between control and openness to otherness alive.

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