

Psychological Research and DSM-5 Applications Critical Analysis

Posted on September 16, 2019

Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* is one of the most influential classification systems in mental health practice. Psychologists, psychiatrists, nurses, counselors, social workers, researchers, insurance providers, and legal professionals use its terminology to describe patterns of psychological distress and impairment. The fifth edition, known as DSM-5, was published by the American Psychiatric Association in 2013. Its text revision, DSM-5-TR, was released in 2022 and remains the current version.

The DSM does not discover mental disorders in the same way that a laboratory test detects a specific virus. Most psychiatric diagnoses are based on patterns of symptoms, duration, severity, distress, functional impairment, developmental history, and the exclusion of other explanations. Psychological research is therefore essential for determining whether a proposed disorder can be defined reliably, distinguished from related conditions, measured consistently, and used beneficially in clinical practice.

Research contributed to DSM-5 through literature reviews, data analysis, field trials, expert consultation, public comments, and studies of diagnostic reliability and validity. However, research did not eliminate controversy. Decisions concerning hypersexual disorder, grief and major depression, generalized anxiety disorder, and nonsuicidal self-injury illustrate the difficulty of deciding where normal human variation ends and mental disorder begins.

This paper argues that psychological research has made substantial contributions to the DSM by improving diagnostic criteria, creating common terminology, identifying clinically significant syndromes, and testing whether clinicians can apply diagnoses consistently. Nevertheless, DSM categories remain provisional scientific constructs rather than final explanations of mental illness. Research must continue examining diagnostic validity, cultural fairness, symptom dimensions, comorbidity, treatment outcomes, and the danger of pathologizing ordinary behavior.

The Applied Purpose of the DSM

The DSM provides a shared language for describing mental disorders. Without standardized criteria, two clinicians might use the same diagnostic term to describe very different patients or use different terms for similar clinical presentations. Common criteria improve communication among professionals

and make it easier to compare research findings across settings.

Diagnostic classification also supports treatment planning, although a diagnosis alone does not determine the correct treatment. Two people who meet the criteria for major depressive disorder may differ substantially in symptom severity, suicide risk, trauma history, medical conditions, family support, and response to previous treatment. Clinical decisions must therefore extend beyond the diagnostic label.

The DSM also affects access to services. Insurance systems, disability programs, schools, courts, hospitals, and public health agencies may require a recognized diagnosis before authorizing treatment or accommodations. Inclusion in the manual can therefore make a condition more visible and improve access to care. At the same time, an inaccurate or overly broad diagnosis may create stigma, unnecessary treatment, financial costs, and a misleading medical explanation for ordinary distress.

These consequences explain why DSM revisions attract controversy. Decisions about diagnostic boundaries are simultaneously scientific, clinical, ethical, economic, and social. Research evidence must be strong enough to justify the benefits and risks of creating or modifying a diagnosis.

How Psychological Research Contributes to Diagnostic Classification

Psychological research contributes to the DSM in several interrelated ways.

Reliability

Reliability concerns whether clinicians can apply a diagnosis consistently. If two properly trained clinicians independently assess the same patient, they should reach reasonably similar conclusions. A diagnosis with poor reliability cannot provide a stable foundation for research or treatment.

The DSM-5 field trials evaluated the test-retest reliability of selected diagnoses in clinical settings. Different clinicians assessed patients independently to determine whether the diagnoses remained consistent across evaluations. The results were mixed. Some conditions demonstrated good or very good reliability, while others produced questionable or unacceptable agreement. The findings showed that diagnostic inconsistency was not merely a theoretical concern and that some psychiatric categories remained difficult to apply reliably in ordinary practice (Regier et al., 2013).

Reliability is necessary but does not prove validity. Clinicians could agree consistently on a diagnosis that does not represent a distinct or meaningful disorder. Research must therefore address additional questions.

Validity

Validity concerns whether a diagnosis accurately represents the phenomenon it claims to identify. Researchers may examine whether people meeting the criteria share characteristic symptoms, risk factors, patterns of impairment, illness courses, treatment responses, or biological and psychological features.

No single study can establish the validity of a psychiatric diagnosis. Evidence accumulates from epidemiological, developmental, clinical, genetic, neurological, cognitive, and treatment research. A strong diagnosis should also be distinguishable from related conditions and from ordinary reactions to life events.

Clinical Utility

Clinical utility refers to whether a diagnosis helps professionals understand patients, communicate effectively, select interventions, estimate prognosis, or coordinate care. A category may demonstrate statistical consistency but still have limited value if it does not improve clinical decisions.

Research should therefore examine whether using a diagnosis produces better outcomes than alternative ways of describing the same symptoms. It should also investigate unintended consequences, such as stigma, false-positive diagnoses, or inappropriate medication.

Cultural and Developmental Validity

Mental health symptoms are expressed and interpreted within cultural and developmental contexts. A behavior that appears unusual in one community may be accepted in another. Children may express distress differently from adults, and cultural beliefs can shape explanations of grief, anxiety, sexuality, spirituality, and self-harm.

DSM-5-TR expanded its discussion of culture, racism, discrimination, and non-stigmatizing language. This development reflects growing research showing that diagnosis cannot be separated from social context.

Hypersexual Disorder and the Limits of Available Evidence

One controversy discussed by Halter et al. (2013) concerned the proposed inclusion of hypersexual disorder. It was intended to describe a persistent pattern of intense sexual fantasies, urges, or behaviors that caused clinically significant distress or impairment and that the individual repeatedly struggled to control.

The proposal attempted to distinguish a clinically impairing pattern from a naturally high sexual desire. This distinction was essential because frequent sexual thoughts or behavior do not automatically indicate mental illness. A diagnosis should not be based only on whether behavior violates cultural, religious, or personal moral expectations.

Research provided some support for the proposed criteria. A field trial involving treatment-seeking participants reported evidence that trained clinicians could apply the criteria with meaningful reliability and that the proposed diagnosis distinguished many patients seeking help for problematic sexual behavior from psychiatric and community comparison groups (Reid et al., 2012).

Nevertheless, hypersexual disorder was not included as a formal DSM-5 diagnosis. Concerns included uncertainty about its boundaries, causes, relationship to impulse-control disorders or behavioral addictions, and potential for pathologizing consensual sexual behavior. Researchers also debated whether distress caused entirely by moral disapproval should qualify someone for a psychiatric diagnosis.

The exclusion demonstrates that positive findings from one field trial do not automatically justify adding a disorder. Evidence must be replicated across diverse populations and settings. Researchers must also establish that the diagnosis offers benefits beyond existing categories and does not create unacceptable false-positive results.

The issue has not disappeared. The World Health Organization's ICD-11 includes compulsive sexual behavior disorder as an impulse-control disorder rather than classifying it as a substance-related addiction. The condition requires a persistent failure to control repetitive sexual behavior that produces significant impairment. Distress based only on moral condemnation is insufficient (Kraus et al., 2018).

The difference between the DSM and ICD shows that classification systems can interpret the same evidence differently. It also demonstrates that diagnostic science develops through continued debate rather than a single final decision.

Grief, Major Depression, and Prolonged Grief Disorder

The original discussion incorrectly states that DSM-5 excluded grief as a primary type of depression. Grief was not classified as a form of major depression. The actual controversy concerned the removal of the DSM-IV bereavement exclusion.

Under DSM-IV, clinicians were generally advised not to diagnose a major depressive episode during the first two months after the death of a loved one unless particularly severe features were present. The rule attempted to prevent normal bereavement from being labeled a mental disorder.

DSM-5 removed this automatic exclusion. A recently bereaved person may therefore receive a diagnosis of major depressive disorder if the individual meets the full criteria and the clinician determines that the symptoms represent depression rather than an expected grief response. The change did not mean that everyone who grieves for more than two weeks has a mental disorder. Clinicians must still assess the nature, severity, duration, context, and functional consequences of the symptoms.

Supporters of removing the exclusion argued that bereavement does not protect a person from developing major depression. Depression following a death can resemble depression arising after divorce, unemployment, illness, or no obvious stressor. Severe depressive symptoms, persistent worthlessness, broad loss of interest, impaired functioning, and suicidal thinking may require evaluation and treatment regardless of the precipitating event (Zisook et al., 2012).

Critics feared that the change would pathologize a universal human experience. Sadness, sleep disturbance, reduced appetite, reduced concentration, and temporary withdrawal can occur during ordinary bereavement. A brief symptom checklist may not capture the meaning of loss, cultural mourning practices, or the natural variation in grief.

Both positions raise valid concerns. Failing to recognize severe depression can leave a bereaved person without needed care, particularly when suicide risk is present. Diagnosing normal grief too quickly can medicalize suffering that may require compassion, social support, spiritual care, and time rather than psychiatric treatment.

Psychological research later contributed to a more specific development. DSM-5-TR added prolonged grief disorder as a formal diagnosis. It describes persistent and disabling grief that continues beyond expected cultural, social, or religious norms. For adults, the death must have occurred at least 12 months earlier; a shorter period applies to children and adolescents.

Research supporting the criteria found that prolonged grief symptoms formed a coherent construct and were associated with clinically meaningful distress and impairment. The American Psychiatric Association explains that the diagnosis provides a “common standard to differentiate” ordinary grief from persistent and disabling grief (American Psychiatric Association, 2022).

This development illustrates the constructive role of research. Rather than treating all bereavement as either normal or depressive, researchers identified a distinct pattern characterized by persistent yearning, preoccupation, emotional pain, difficulty accepting the death, and substantial impairment.

Generalized Anxiety Disorder and the Difference Between Proposals and Final Criteria

Halter et al. (2013) discussed a draft proposal to change the criteria for generalized anxiety disorder.

The proposed revision would have shortened the required duration from six months to three months and reduced the number of associated symptoms required for adults.

However, this proposal was not adopted in the final DSM-5 criteria. DSM-5 and DSM-5-TR retained the requirement that excessive anxiety and worry occur more days than not for at least six months. Adults must also experience multiple associated symptoms, such as restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbance.

The distinction between a draft proposal and an adopted criterion is important. DSM development involved several stages during which proposed changes were revised or rejected following professional debate, public feedback, and review of research evidence. Halter et al. correctly described a controversy occurring during development, but the proposal should not be presented as the final DSM-5 standard.

Researchers who supported a shorter duration argued that the six-month threshold might exclude people with clinically significant anxiety and impairment. A person suffering for four months could experience severe disruption but fail to meet the duration criterion.

Opponents argued that reducing the duration and symptom thresholds could increase false-positive diagnoses. Temporary anxiety associated with financial stress, illness, examinations, relationship conflict, or other life events might be classified as a chronic psychiatric disorder.

This debate illustrates the problem of diagnostic thresholds. Symptoms usually exist on a continuum rather than appearing only after an exact number of months. A person does not suddenly become psychologically different on the first day of the sixth month. However, diagnostic systems require operational boundaries so clinicians and researchers can communicate consistently.

Research contributes by examining whether thresholds predict persistence, impairment, treatment response, and meaningful differences from ordinary anxiety. Thresholds should be neither so restrictive that severely distressed people are denied recognition nor so broad that normal worry becomes a disorder.

Nonsuicidal Self-Injury as a Condition for Further Study

Nonsuicidal self-injury refers to deliberate, direct damage to one's body without the immediate intention of causing death. Examples may include cutting, burning, hitting, or interfering with wound healing. People may engage in the behavior to reduce overwhelming emotion, interrupt numbness, punish themselves, communicate distress, or obtain temporary relief.

Nonsuicidal self-injury must be distinguished from a suicide attempt, but the distinction should never be interpreted to mean that it is harmless. A person may report no intention to die during a particular

act while still experiencing elevated long-term suicide risk. Intent can also be mixed, uncertain, or change over time.

DSM-5 placed nonsuicidal self-injury disorder in Section III as a condition requiring further study rather than recognizing it as a formal independent diagnosis in the main diagnostic section. This decision reflected the need for more evidence concerning the reliability, validity, prevalence, boundaries, developmental course, and clinical usefulness of the proposed criteria (Zetterqvist, 2015).

Research conducted after DSM-5 has strengthened the argument that nonsuicidal self-injury can be measured as a clinically meaningful syndrome. Gratz et al. (2015) developed and tested a structured interview for the proposed disorder and found encouraging evidence of reliability and validity. More recent clinical research has found substantial impairment, psychiatric comorbidity, repeated self-injury, and elevated histories of suicide attempts among people meeting proposed criteria.

DSM-5-TR added symptom codes that allow clinicians to indicate suicidal behavior and nonsuicidal self-injury. However, nonsuicidal self-injury disorder has not yet become a full standalone diagnosis in the principal diagnostic section.

This cautious approach demonstrates one of the strengths of the DSM revision process. A proposed condition can be given standardized research criteria without being prematurely declared an established disorder. Researchers can then investigate whether it is sufficiently distinct from borderline personality disorder, depression, trauma-related disorders, eating disorders, and suicidal behavior.

Improving the Proposed Research Question

The original paper suggests asking whether people who harm themselves intend to die or merely seek relief. This question identifies an important distinction but is too narrow and uses the word “merely” in a way that may minimize serious distress.

A stronger research question would be:

Which psychological, interpersonal, and behavioral factors distinguish nonsuicidal self-injury from suicide attempts, and which factors predict a later transition from nonsuicidal self-injury to suicidal behavior?

This question recognizes that intent can change and that nonsuicidal self-injury may serve several functions. It also focuses on the clinically important issue of future suicide risk.

A simple community questionnaire asking people for their opinions would not adequately answer the question. Public beliefs cannot establish the motives or clinical characteristics of people who engage in self-injury. The study should recruit participants with lived experience and use validated clinical assessments.

A Stronger Research Design for Nonsuicidal Self-Injury

A useful investigation would employ a multisite longitudinal design. Participants could be recruited from community mental health clinics, hospitals, schools, counseling centers, and outpatient programs. Including adolescents and adults would allow researchers to examine developmental differences.

At the initial assessment, trained clinicians should conduct structured interviews to evaluate:

- frequency and methods of self-injury;
- suicidal intent during each episode;
- reasons or functions associated with the behavior;
- emotional states before and after the act;
- psychiatric symptoms and diagnoses;
- trauma and adverse life experiences;
- interpersonal conflict;
- impulsivity and emotional regulation;
- substance use;
- social support;
- previous suicide attempts; and
- access to treatment.

Participants should then be followed at regular intervals, such as every three or six months, for at least two years. Researchers could examine which baseline characteristics predict continued nonsuicidal self-injury, discontinuation, escalation in medical severity, or later suicide attempts.

A mixed-method approach would be valuable. Quantitative measures could identify statistical patterns, while confidential qualitative interviews could clarify how individuals understand the purpose and meaning of their behavior.

Ethical safeguards would be essential. Researchers must establish immediate procedures for responding to suicide risk, severe injury, abuse disclosures, or medical emergencies. Informed consent should explain the limits of confidentiality, and adolescent participation would require careful procedures involving consent and assent.

Such a study would contribute more directly to future diagnostic decisions than a general survey because it would test reliability, predictive validity, clinical distinctiveness, and treatment relevance.

Psychological Research and the Strengths of DSM-5

Psychological research has strengthened the DSM in several ways. It has provided operational criteria that allow clinicians and researchers to discuss similar phenomena. Field trials have exposed categories with weak reliability rather than allowing diagnostic inconsistency to remain hidden. Research has also supported the introduction of clinically meaningful diagnoses such as prolonged grief disorder and encouraged the cautious study of emerging conditions such as nonsuicidal self-injury disorder.

The DSM-5 also introduced greater dimensional assessment. Cross-cutting symptom measures allow clinicians to assess domains such as depression, anxiety, sleep difficulties, substance use, psychosis, and suicidal thoughts across traditional diagnostic categories. Research suggests that these measures can provide useful information because patients often experience symptoms that do not fit neatly within one disorder (Narrow et al., 2013).

This is important because comorbidity is common. A person may meet criteria for depression, generalized anxiety disorder, post-traumatic stress disorder, and substance use disorder simultaneously. Cross-cutting assessment helps clinicians see the broader symptom profile rather than focusing exclusively on one label.

Limitations of DSM Classification

Despite these contributions, the DSM remains limited by its largely categorical structure. Many symptoms occur along continua. The boundary between disorder and nondisorder is often based on a threshold involving a specified number of symptoms, a minimum duration, and functional impairment.

Categorical diagnoses may also contain substantial heterogeneity. Two individuals can receive the same diagnosis while sharing relatively few symptoms. Conversely, different diagnostic categories may include overlapping features, producing high rates of comorbidity.

Reliability remains another concern. DSM-5 field trials revealed that some diagnoses could be applied more consistently than others. Diagnostic disagreement may arise from ambiguous criteria, differences in interviewing skill, incomplete information, cultural interpretation, or the complexity of the patient's presentation.

The DSM also emphasizes description more than explanation. A diagnosis identifies a recognizable pattern but does not necessarily reveal its cause. Similar symptoms may emerge from different combinations of biological vulnerability, learning, trauma, social adversity, medical illness, and environmental stress.

Finally, diagnoses can produce stigma or identity reduction. A person may begin to be viewed as “a borderline,” “a schizophrenic,” or “an addict” rather than an individual experiencing a particular pattern of difficulties. Diagnostic language should therefore be used carefully and accompanied by a person-centered understanding of strengths, history, relationships, goals, and social circumstances.

Alternative Research Frameworks

Recognition of DSM limitations has encouraged alternative research frameworks. The National Institute of Mental Health developed the Research Domain Criteria initiative, commonly called RDoC. It examines psychological functioning through dimensions such as threat response, reward processing, cognition, social processes, and arousal. It seeks to integrate information ranging from behavior and self-report to neural circuits and genetics rather than beginning exclusively with existing diagnostic categories.

Another approach is the Hierarchical Taxonomy of Psychopathology, or HiTOP. It organizes symptoms dimensionally and hierarchically based on recurring patterns found in quantitative research. Broader dimensions include internalizing problems, thought disorder, disinhibition, antagonism, and detachment. The model attempts to address diagnostic overlap, instability, heterogeneity, and arbitrary category boundaries (Kotov et al., 2017).

Neither RDoC nor HiTOP currently replaces the DSM in ordinary clinical administration. They illustrate, however, how psychological research may shape future diagnostic systems. The future of classification may combine practical diagnostic categories with dimensional profiles, biological findings, developmental information, and individualized functional assessments.

Summary of the Controversies

Controversial issue	What was proposed or changed	Research contribution	Current applied position
Hypersexual disorder	Proposed as a new diagnosis	Field trials examined reliability and validity	Not included in DSM-5 or DSM-5-TR; related condition appears in ICD-11
Bereavement exclusion	DSM-IV restriction on diagnosing depression after loss was removed	Research compared bereavement-related depression with other depressive episodes	Grief remains normal; major depression may be diagnosed when full criteria are met

Controversial issue	What was proposed or changed	Research contribution	Current applied position
Prolonged grief	Persistent disabling grief studied as a distinct syndrome	Validation research supported reliability, coherence, and impairment	Added as prolonged grief disorder in DSM-5-TR
Generalized anxiety disorder	Draft proposal considered shorter duration and fewer symptoms	Debate examined underdiagnosis versus false positives	Final DSM-5 retained the six-month duration requirement
Nonsuicidal self-injury	Proposed as an independent disorder	Studies continue evaluating reliability, validity, functions, and suicide risk	Remains an area of continuing study rather than a main standalone diagnosis

Recommendations for Future DSM Research

Future revisions should require strong evidence from diverse clinical and community populations. Diagnostic studies should include participants from different racial, cultural, linguistic, socioeconomic, age, gender, and geographic groups. Criteria developed primarily within one population may not function accurately elsewhere.

Researchers should distinguish statistical significance from clinical usefulness. A proposed category may be measurable without improving treatment decisions or patient outcomes. Studies should therefore evaluate whether diagnosis leads to better care.

Longitudinal evidence is also essential. Cross-sectional research can show that symptoms occur together, but it cannot establish how a condition develops, changes, predicts impairment, or responds to intervention.

Future DSM revisions should give greater attention to dimensional measures. Categories remain useful for communication and service systems, but severity ratings and symptom profiles can provide a more accurate understanding of individual patients.

People with lived experience should also contribute to research and revision. Patients and families can identify stigmatizing language, overlooked symptoms, cultural problems, treatment barriers, and unintended consequences that may not be obvious to researchers.

Finally, diagnostic changes should be communicated accurately. Draft proposals should not be presented as final criteria, and a diagnosis should never be interpreted as a complete description of a person.

Conclusion

Psychological research has made essential contributions to DSM-5 and DSM-5-TR. It has helped define symptom patterns, establish diagnostic thresholds, test reliability, evaluate validity, identify impairment, and examine whether proposed conditions should be included, excluded, or studied further.

The controversies involving hypersexual disorder, bereavement, generalized anxiety disorder, and nonsuicidal self-injury demonstrate that classification decisions are rarely simple. Hypersexual disorder received some empirical support but was excluded because the evidence and conceptual boundaries remained uncertain. The bereavement exclusion was removed because grief does not prevent major depression, but clinicians must still avoid pathologizing normal mourning. Research later supported the inclusion of prolonged grief disorder for persistent and disabling grief.

The proposal to shorten the generalized anxiety disorder duration requirement was debated but not adopted. This example illustrates why draft recommendations must be distinguished from final DSM criteria. Nonsuicidal self-injury remains a particularly important research area because it is distinct from suicidal behavior but associated with substantial distress and future risk.

The DSM should therefore be viewed as an evolving scientific and clinical instrument rather than an unquestionable authority. Its categories provide practical benefits, but they do not represent final biological truths. Reliable diagnosis requires clinical judgment, cultural awareness, developmental understanding, functional assessment, and attention to the individual's complete circumstances.

Future classification will likely become more dimensional and integrative. Frameworks such as RDoC and HiTOP demonstrate how research can move beyond rigid categories while preserving the practical advantages of standardized terminology. The most valuable psychological research will not simply create more diagnoses. It will help clinicians identify genuine suffering accurately, avoid unnecessary labeling, select effective interventions, and understand patients as people rather than collections of symptoms.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th

ed., text rev.).

Cuthbert, B. N. (2022). Research Domain Criteria: Progress and potential. *Current Directions in Psychological Science*, 31(5), 455–462.

Gratz, K. L., Dixon-Gordon, K. L., Chapman, A. L., & Tull, M. T. (2015). Diagnosis and characterization of DSM-5 nonsuicidal self-injury disorder using the Clinician-Administered Nonsuicidal Self-Injury Disorder Index. *Assessment*, 22(5), 527–539. doi:10.1177/1073191114565878

Halter, M. J., Rolin-Kenny, D., & Dzurec, L. C. (2013). An overview of the DSM-5: Changes, controversy, and implications for psychiatric nursing. *Journal of Psychosocial Nursing and Mental Health Services*, 51(4), 30–39. doi:10.3928/02793695-20130226-02

Kotov, R., Krueger, R. F., Watson, D., Achenbach, T. M., Althoff, R. R., Bagby, R. M., Brown, T. A., Carpenter, W. T., Caspi, A., Clark, L. A., Eaton, N. R., Forbes, M. K., Forbush, K. T., Goldberg, D., Hasin, D., Hyman, S. E., Ivanova, M. Y., Lynam, D. R., Markon, K., ... Zimmerman, M. (2017). The Hierarchical Taxonomy of Psychopathology: A dimensional alternative to traditional nosologies. *Journal of Abnormal Psychology*, 126(4), 454–477. doi:10.1037/abn0000258

Kraus, S. W., Krueger, R. B., Briken, P., First, M. B., Stein, D. J., Kaplan, M. S., Voon, V., Abdo, C. H. N., Grant, J. E., Atalla, E., & Reed, G. M. (2018). Compulsive sexual behaviour disorder in the ICD-11. *World Psychiatry*, 17(1), 109–110. doi:10.1002/wps.20499

Morrison, J. (2014). *DSM-5 made easy: The clinician's guide to diagnosis*. Guilford Press.

Narrow, W. E., Clarke, D. E., Kuramoto, S. J., Kraemer, H. C., Kupfer, D. J., Greiner, L., & Regier, D. A. (2013). DSM-5 field trials in the United States and Canada, Part III: Development and reliability testing of a cross-cutting symptom assessment for DSM-5. *American Journal of Psychiatry*, 170(1), 71–82. doi:10.1176/appi.ajp.2012.12071000

Prigerson, H. G., Boelen, P. A., Xu, J., Smith, K. V., & Maciejewski, P. K. (2021). Validation of the new DSM-5-TR criteria for prolonged grief disorder and the PG-13-Revised scale. *World Psychiatry*, 20(1), 96–106. doi:10.1002/wps.20823

Regier, D. A., Narrow, W. E., Clarke, D. E., Kraemer, H. C., Kuramoto, S. J., Kuhl, E. A., & Kupfer, D. J. (2013). DSM-5 field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses. *American Journal of Psychiatry*, 170(1), 59–70. doi:10.1176/appi.ajp.2012.12070999

Reid, R. C., Carpenter, B. N., Hook, J. N., Garos, S., Manning, J. C., Gilliland, R., Cooper, E. B., McKittrick, H., Davtian, M., & Fong, T. (2012). Report of findings in a DSM-5 field trial for hypersexual disorder. *The Journal of Sexual Medicine*, 9(11), 2868–2877. doi:10.1111/j.1743-6109.2012.02936.x

Zetterqvist, M. (2015). The DSM-5 diagnosis of nonsuicidal self-injury disorder: A review of the

empirical literature. *Child and Adolescent Psychiatry and Mental Health*, 9, Article 31.
doi:10.1186/s13034-015-0062-7

Zisook, S., Corruble, E., Duan, N., Iglewicz, A., Karam, E. G., Lanuette, N., Lebowitz, B., Pies, R., Reynolds, C., Seay, K., Shear, M. K., Simon, N., & Young, I. T. (2012). The bereavement exclusion and DSM-5. *Depression and Anxiety*, 29(5), 425–443. doi:10.1002/da.21927