



Diagnostic and Statistical Manual of Mental Disorders: A Comparative Review of DSM-IV and DSM-5

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Abstract

The Diagnostic and Statistical Manual of Mental Disorders (DSM), which is an American Psychiatric Association publication, is the primary system of classification of mental disorders and is essential in clinical diagnosis, research, education, and mental health policy across the world. The DSM-5 introduction was a radical change in the conceptualization and structured representation of mental disorders, as well as their diagnosis. This is a review paper that seeks to give a comparative analysis, on a systematic basis, of the two DSM-IV and DSM-5, as to the key structural, conceptual, and diagnostic differences in the new edition. The review incorporates data on the DSM manuals and peer-reviewed academic literature and analyzes such changes as the abandonment of the multiaxial system, the shift to dimensional assessment, changes to diagnostic criteria within the main disorder groups, and the improvement of the focus on cultural and developmental issues. The paper also addresses the clinical, research, and ethical implications of these amendments in addition to major criticisms and controversies of DSM-5. Through critical assessment of these two versions, this review can be applied in understanding the development of psychiatric classification and what it means to mental health practice and future diagnostic models.

Keywords: DSM-IV, DSM-5, psychiatric diagnosis, mental disorders, comparative review

I. Introduction

Dementia and mental diagnosis have been issues of central concern in the field of psychiatry, psychology, and related mental health fields. The most significant diagnostic tool applied in clinical practice, research, training, and policy development by the American Psychiatric Association is the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is used internationally. Its strength is its standardization of diagnostic criteria

that are meant to enhance the reliability of the diagnostic criteria, as well as enhance communication among professionals and empirical researchers. The DSM has not been without its own, however, with a long-standing scholarly dispute over its conceptual background, psychometric reliability, and practical value (Borsboom, 2008; Frances and Egger, 1999).

DSM-IV, which was published in 1994, was a historic milestone in psychiatric nosology since it included operationalized diagnostic criteria and a multiaxial system to reflect the complexity of mental health conditions in the biological, psychological, and social domains (Naftolowitz et al., 1994; Cooper, 1995). The multiaxial method promoted the use of not only clinical syndromes but also personality disorders, general medical conditions, psychosocial stressors, and global functioning by clinicians. In spite of these developments, DSM-IV was increasingly criticized on grounds of rigid categorical format, insensitivity to the level of symptom severity, and insensitivity to developmental and cultural variability (Frances and Egger, 1999; Segal, 2010). Empirical research also doubted the reliability and validity of various DSM-IV diagnoses among populations and clinical settings (Chmielewski et al., 2015; Lecavalier et al., 2009).

The release of DSM-5 in 2013 was a significant change and not a regular update. DSM-5 removed the multiaxial method, redesigned diagnostic classes in line with the new evidence of common symptomatology dimensions, and focused on dimensional assessment and severity indicators more (Regier et al., 2013). These changes are meant to aid in addressing some of the longstanding problems with the diagnostic heterogeneity, false-positive diagnoses, and poor clinical utility of purely categorical classifications (Wakefield, 2016; Allsopp et al., 2019). In the studies of DSM-5 criteria, significant shifts in the prevalence rates has been noted, which is especially true of substance use



disorders, autism spectrum disorder and mood disorders, which also raises significant questions regarding diagnostic thresholds and clinical implications (Livne et al., 2021; Peters and Matson, 2019; Hasin and Stohl, 2024).

Meanwhile, there is a lot of publicity for DSM-5. Some critics think that some of the revisions may result in diagnostic inflation, over-medicalization, over-lack of specificity - others suggest that they raise enduring problems of diagnostic validity, etiological ambiguity, and lack of robust biological markers of most psychiatric diagnoses (Maj, 2018; Alda, 2021; Waszkiewicz, 2020). Recent studies are beginning to make demands for alternative methods that go beyond the traditional syndromal diagnosis and in favor of trait- and dimensional-based and systems-oriented psychopathology models (Krueger and Hobbs, 2020; Fried, 2022; Forbes et al., 2024).

It is in this context that a comparative review of DSM-IV and DSM-5 is timely as well as necessary to be systematic. These two editions have seen incredible conceptual development, diagnostic changes and empirical implications that are fundamental in guiding the clinician, researcher and policy maker through the modern mental health practice. This review paper will, therefore, aim to critically compare DSM-IV and DSM-5 in terms of structural changes, disorder-specific changes, psychometrics, and general issues related to clinical, cultural, and ethical factors. The paper tries to contribute to the informed academic discussion of the strengths, limitations, and future of psychiatric diagnostic systems by summing up the evidence, both foundational and based on recent empirical research.

II. Historical Background and Evolution of the DSM

Since its first publication in 1952, the Diagnostic and Statistical Manual of Mental Disorders has gone through several revisions as efforts have been made to perfect the categorization of mental disorders as per current clinical knowledge and research. Every update to the DSM has been influenced by the popular theoretical frameworks, empirical evidence, and the general socio-cultural factors, which led to unceasing controversies on defining mental disorder and its limits (Frances and Egger, 1999; Alda, 2021).

This era of psychiatric diagnosis was associated with the development of DSM-IV, with its focus on descriptive phenomenology and diagnostic reliability. DSM-IV was published in 1994, and its main goal was to unify the research-

supported evidence and field trial information to enhance the consistency of diagnosis among clinicians and different environments (Naftolowitz et al., 1994; Cooper, 1995). The manual took a categorical approach to diagnosis, which presupposed the fact that mental illnesses could have a clear boundary between normal functioning and mental illnesses themselves. The operationalized criteria set supported this approach and were aimed at reducing subjectivity in clinical decision-making (Borsboom, 2008). Nonetheless, the accumulating empirical data indicated a lot of overlap between diagnostic categories, high comorbidity, and high heterogeneity within diagnosis, which questioned the validity of categorical classification (Allsopp et al., 2019).

Moreover, the multiaxial system that was showcased in DSM-IV became one of the structural characteristics. This model meant that clinicians would affect people based on five axes including clinical disorders, personality disorders, general medical conditions, psychosocial and environmental issues and global functioning. Although multi-axial format was deemed from a theoretical standpoint as broad, its practical application was becoming questionable by virtue of inconsistent application and non-influence on the treatment plan (Segal, 2010; Maj, 2018).

The impetus for this shift to DSM-5 was the recognition of these shortcomings, as well as the need to increasingly bring psychiatric diagnosis into a neuroscience context, incorporating genetic evidence and dimensional models of psychopathology. DSM-5 was published in the year 2013 and was a break with the multiaxial system and attempted to re-arrange the disorders around their common underlying characteristics and patterns of development (Regier et al, 2013). The revision itself was also indicative of more general arguments surrounding the definition of mental disorder itself, inaccurate diagnoses, and the ever-growing frontiers of psychiatric classification (Wakefield, 2016; Telles-Correia et al., 2018).

In general, the move towards DSM-5 reflects the volatile and controversial nature of psychiatric nosology. Instead of being a clear fix offering a solution to the problems of diagnosing mental disorders, DSM-5 is a continuous attempt to acquire the balance between clinical usefulness, scientific validity, and ethical accountability in categorization of mental disorders (Maj, 2020; Stein et al., 2021).



III. Structural and Conceptual Framework of DSM-IV

DSM IV was designed in a very categorical model of diagnosis, which is based on descriptive psychopathology which is contrasted with etiological explanations. Its primary goal was to maximize the predictive value by providing pure and operationalized definitional specifications for each of the mental illnesses to reduce the subjectivity of clinical judgment (Naftolowitz et al., 1994; Cooper, 1995). The manual assumed that mental disorders can be sensibly divided into separate categories, which are defined by a certain constellation of symptoms, time conditions and exclusion criteria.

One structural characteristic of DSM-IV was the multi-axial system aspect of diagnosis, that is, it required clinicians to assess the individuals on five separate axes. Axis I included clinical disorders and other conditions that could be a focus of clinical attention, whereas Axis II covered personality disorders and intellectual disability. Axis III was used to capture relevant general medical conditions, Axis IV to capture psychosocial and environmental stressors, and Axis V to give a Global Assessment of Functioning (GAF) score, which was intended to sum up general psychological, social, and occupational functioning. This format also corresponded to a biopsychosocial approach and was aimed at the facilitation of thorough assessment and treatment planning (Segal, 2010).

Theoretically, DSM-IV was more focused on diagnostic reliability than it was on diagnostic validity because it was more about consistency among clinicians despite the fact that the nature of disorders was not known (Borsboom, 2008). Although this method helped in communication and standardization of research, it was also the cause of a high rate of comorbidity and diagnostic overlaps, making one question the reality of diagnostic categories as discrete conditions (Frances and Egger, 1999; Allsopp et al., 2019). Empirical studies also reported a high level of heterogeneity in diagnostic categories and indicated that patients with the same diagnosis may have significantly different symptom patterns and clinical courses (Chmielewski et al., 2015).

DSM-IV also prescribed a polythetic method of diagnosis, that is, patients did not have to fulfil all the criteria listed to obtain a diagnosis. This increased flexibility, though, increased within-diagnosis variability and made it more difficult to determine apparent boundaries between disorders. These restrictions especially occurred in

developmental and neurodevelopmental disorders, the manifestation of which was diverse in age and contexts (Lecavalier et al., 2009; Matson et al., 2012).

Nevertheless, these criticisms notwithstanding, DSM-IV was a significant advance in the standardization of psychiatric diagnosis and was the preeminent scheme of diagnosis throughout almost 20 years. Its systematic criteria and multi-axial model were the building blocks based on which later revisions, such as DSM-5, attempted to develop and overcome the outstanding conceptual and empirical issues.

IV. Structural and Conceptual Framework of DSM-5

DSM-5 is a major restructuring of psychiatric nomenclature, an attempt to deal with the conceptual and practical shortcomings of DSM-IV. Instead of being a minor revision, DSM-5 brought some fundamental changes in the structure and underlying philosophy of diagnosis. The main aim of these changes was to increase diagnostic validity and clinical usefulness as well as continuity with the established diagnostic practices (Regier et al., 2013).

The abolition of the multi-axial system was one of the biggest changes in the structure of DSM-5. Clinical disorders, personality disorders, and general medical conditions were all listed in one list of diagnosis and psychosocial and contextual factors were handled using different notation and the application of standardized assessment tools. This change was supposed to make diagnosis easier and bring DSM closer to the World Mental Health Framework, but the critics claimed that it diluted the direct focus on psychosocial and functional evaluation found in DSM-IV (Maj, 2018; Maj, 2020).

In theory, DSM-5 emphasized more on dimensional assessment because it recognized the fact that many psychiatric symptoms occur in continua and not in discrete forms. The cross-cutting symptom measures and severity specifiers were developed to measure the intensity, frequency, and functional impact of the symptoms across the boundaries of the diagnoses (Regier et al., 2013; Wakefield, 2016). The rationale behind this method was the growing amount of evidence of diagnostic overlap and symptom heterogeneity, which undermined the validity of narrowly categorical classifications (Allsopp et al., 2019).

The organization of groups of disorders in DSM-5 was also changed to be consistent across the common symptomatology, developmental course,



and hypothetical mechanisms. As an illustration, disorders were organized in a lifespan-based arrangement, starting with neurodevelopmental disorders, then moving on to disorders that are found to be more commonly diagnosed in adulthood. In a process of reorganization, the new structures were supposed to make the developmental sensitivity and conceptual coherence increase, especially in the case of autism spectrum disorder and schizophrenia spectrum disorders (Matson et al., 2012; Peters and Matson, 2019).

The other conceptual change in DSM-5 that was also remarkable was that of a focus on the cultural context and diagnostic equity. The manual expanded the principles of the cultural formulation and included the use of the Cultural Formulation Interview to use in the evaluation of cultures. These additions were proportional to the growing awareness of the importance of sociocultural issues on the expression of symptoms, the help-seeking behavior and the interpretation of diagnoses (Telles-Correia et al., 2018).

In spite of these developments, DSM-5 has been a matter of quite a heated debate. Critics have raised the concerns of lower diagnostic criteria and potential over-diagnosis and the absence of etiological basis for most such disorders (Wakefield, 2016; Alda, 2021). Nonetheless, DSM-5 is a substantial bridge transition model that is pointing to a slow shift towards more flexible, dimensional, and integrative psychiatric diagnosis models.

V. Key Conceptual Changes from DSM-IV to DSM-5

The recommendation to change DSM-IV into DSM-5 is an intentional attempt to resolve the conceptual, empirical, and clinical constraints of psychiatric diagnosis that have existed over time. Instead of making individual changes, DSM-5 had assimilated a set of interconnected conceptual changes, which combined to point to a shift in psychiatric nosology. The most common changes are the shift in the direction of less strict categorical frameworks, the reorganization of diagnostic structures, and the reestablishment of some of the main principles of diagnosis (Regier et al., 2013).

One of the fundamental changes in thinking is the renunciation of the multiaxial diagnostic system. The five-axis system of DSM-IV was created to facilitate a holistic evaluation of clinical, personality, medical, psychosocial, and functional spheres. Nevertheless, empirical research and clinical practice showed that the axes are inconsistently used and have little impact on treatment planning (Segal, 2010; Maj, 2018). DSM-

5 incorporated these areas into one diagnostic system with dimensional measures and contextual descriptors added to it, focusing on clinical efficiency and meeting international diagnostic standards.

The other significant change is that of relocating the purely categorical approach to dimensional conceptualization. The DSM-IV approach to mental disorders as discrete entities with diagnostic cutpoints helped to promote high levels of comorbidity and diagnostic overlap (Borsboom, 2008; Frances and Egger, 1999). DSM-5 recognizes that psychopathology commonly lies alongside continua, which suggest severity specifications, cross-cutting symptom scales, and dimensional rating scales to define the intensity of the symptoms and their functional effects across conditions (Regier et al., 2013; Wakefield, 2016). This shift represents the increasing evidence of the fact that the distributions of symptoms are not categorical in nature but continuous (Allsopp et al., 2019).

DSM-5 has also undergone changes in diagnostic thresholds and criteria structure used in several disorders, with the result of the changes being a measurable alteration in prevalence estimates. Comparison studies have also shown that some disorders, such as substance use disorders and autism spectrum disorder, had higher rates of diagnosis with the DSM-5 criteria compared to DSM-IV, especially as a result of updated thresholds on the symptoms and consolidation of criteria (Livne et al., 2021; Peters and Matson, 2019; Hasin and Stohl, 2024). Though these changes have been seen as an enhancement of sensitivity and an early diagnosis, critics have sounded an alarm of rising overdiagnosis and diagnostic inflation (Wakefield, 2016).

Also, the DSM-5 is indicative of a broader emphasis on developmental and lifespan approaches. The disorders are displayed in a chronological order that reflects the typical age of onset, that is typical and it focuses on continuity between childhood and adult psychopathology. This change is especially noticeable in the reconceptualization of neurodevelopmental disorders, where DSM-5 has brought together categories that were previously separate into wider spectrum-related diagnoses (Matson et al., 2012; Lecavalier et al., 2009).

All these conceptual shifts indicate the efforts by DSM-5 to achieve a balance between continuity and innovation. Although the manual does not answer the essential questions regarding the nature and the limits of mental disorders, it is an



incremental step towards more flexible, evidence-based, and clinically responsive models of psychiatric diagnosis (Maj, 2020; Stein et al., 2021).

VI. Disorder-Wise Comparative Analysis of DSM-IV and DSM-5

Disorder-specific revisions are the most substantive areas of difference between DSM-IV and DSM-5. The changes are indicators of more general conceptual changes that are aimed at the dimensionality, spectrum-based classification, and changes in diagnostic thresholds, which have considerable consequences in terms of prevalence, clinical practice, and research.

6.1 Neurodevelopmental Disorders

DSM-5 has brought about a significant re-conceptualization of the neurodevelopmental disorders through the generalization of multiple, previously different diagnoses with wider spectrum headings. Autism Spectrum Disorder (ASD) is the most notable, where the categories of Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified were combined into one spectrum diagnosis, DSM-IV. Comparative empirical studies on DSM-IV and DSM-5 criteria show that there have been shifts in the diagnostic rates and there are concerns of both under- and over-identification that depend on the severity of symptoms and age (Matson et al., 2012; Peters and Matson, 2019). Although the supporters emphasize that the spectrum model enhances the clarity of concepts and the sensitivity of development, opponents point to the possible risks in service eligibility and continuation of care (Lecavalier et al., 2009; Lo et al., 2018).

6.2 Schizophrenia Spectrum and Other Psychotic Disorders

DSM-5 kept the fundamental diagnostic framework of schizophrenia but scrapped traditional subtypes of schizophrenia, like paranoid and disorganized schizophrenia, as they were not very reliable and did not have a significant clinical role. More focus had been given to the rise of symptom severity ratings and dimensional ratings of psychotic features. These amendments were meant to deal with the heterogeneity of schizophrenia diagnoses and enhance longitudinal characterization (Regier et al., 2013; Allsopp et al., 2019). Nonetheless, there is still discussion on how far these revisions contribute to diagnostic validity or repackage uncertainties (Alda, 2021).

6.3 Mood, Depressive, and Bipolar Disorders

Another important change in the concept of DSM-5 was the division of Depressive Disorders into Bipolar and Related Disorders because they differ in course, genetics, and response to treatment. It is also with DSM-5 that new diagnoses and specifiers were introduced, including disruptive mood dysregulation disorder, which created controversy on the issue of diagnostic expansions and over-pathologization of normal emotional fluctuation (Wakefield, 2016; Maj, 2018). Research reviews of DSM-5 criteria of depression demonstrate modifications in the measurement of severity and its effects on clinical decision-making (Tolentino and Schmidt, 2018).

6.4 Substance-Related and Addictive Disorders

DSM-5 combined DSM-IV substance abuse with substance dependence into one Substance Use Disorder, which is characterized by a continuum of severity. Empirical comparisons show that higher levels of prevalence are estimated with DSM-5, in part due to the absence of the diagnostic orphan category that exists in DSM-IV (Livne et al., 2021; Hasin and Stohl, 2024; Compton et al., 2024). Although this dimensional approach is better in terms of sensitivity and clinical relevance, lower diagnostic thresholds and the risks of false positives have also been noted (Wakefield, 2016).

6.5 Personality Disorders

DSM-5 adopted the categorical personality disorder diagnoses of DSM-IV, but had a separate section of the Alternative Model of Personality Disorders. This model focuses on dimensional evaluation of traits and the degree of personality dysfunction. Empirical studies indicate that DSM-IV classifications are conceptually more consistent and consistent with ICD-11, but the clinical adoption is limited (Hopwood et al., 2012; Krueger and Hobbs, 2020; Bornstein, 2025).

All in all, comparing disorders in terms of disorder, DSM-5 is more dimensional and severity-focused, and at the same time is concerned about the problems of diagnostic inflation, the lack of compatibility with previous studies, and issues with clinical implementation.

VII. Psychometric, Cultural, and Clinical Implications of the DSM Revisions

Both conceptual and structural changes that are presented in DSM-5 have serious psychometric implications, especially with regard to diagnostic reliability and validity. Although DSM-IV focused on inter-rater reliability using operationalized



criteria, later studies found that variability was significant across disorders and settings (Chmielewski et al., 2015). The presence of the dimensional measures in DSM-5 is expected to better represent symptom severity, but evidence on their daily clinical applicability is inconclusive (Tan et al., 2025).

Culturally, DSM-5 broadened guidelines on cultural formulation to respond to the criticism that previous versions were based on largely Western diagnostic standards. The aspect of the incorporation of culturally informed assessment tools is a step in progress to diagnostic equity, but researchers claim that the cultural context is not as thoroughly enforced in the fundamental diagnostic criterion, which restricts its applicability to other parts of the world (Telles-Correia et al., 2018; Tse and Haslam, 2023).

Revisions of DSM-5 have changed prevalence rates, treatment courses, and access to mental health care. The alternations of diagnostic thresholds, especially for substance use and neurodevelopmental disorders, have their practical implications on access to care and distribution of resources (Hasin and Stohl, 2024; Peters and Matson, 2019). Meanwhile, critics warn that greater diagnostic sensitivity will contribute to over-medicalization and distort normality and disorder lineages (Wakefield, 2016; Maj, 2020).

The implication of all these is that DSM-5 is an incremental but not definitive progress in psychiatric diagnosis. Although it also covers some of the limitations of DSM-IV, it also brings to the fore the long-lasting problems of balanced reliability, validity, cultural sensitivity, and clinical utility in mental health classification (Stein et al., 2021; Fried, 2022).

VIII. Criticisms and Controversies Surrounding DSM-5

DSM-5 has been widely criticised and subject to professional criticism despite its attempt to overcome the shortcomings of DSM-IV. The issue of diagnostic inflation and the potential rise in false-positive diagnoses is one of the most outstanding ones. According to critics, the decreased standards of diagnosis and the broadening of criteria of some disorders can turn normal differences in actions and emotional experience into pathologies and therefore heighten the risk of over-medicalization (Wakefield, 2016; Maj, 2018). These concerns have been exacerbated by empirical data that suggest increases in prevalence estimates of disorders in DSM-5, like substance use disorders (Hasin and Stohl, 2024; Compton et al., 2024).

Another significant debate is the fact that psychiatric diagnosis has been lacking etiological basis over the years. Although DSM-5 took positive steps of making dimensional assessments and reclassifying diagnostic categories, it still uses mostly symptom-based descriptions as opposed to biological or mechanistic markers. Researchers have suggested that this restricts diagnostic validity and limits the development of precision psychiatry (Alda, 2021; Waszkiewicz, 2020). The absence of validated biomarkers has reinforced the absence of confidence in the capacity of the DSM to reflect underlying disorders, particularly in complex and diverse disorders such as mood and psychotic disorders (Stein et al., 2021).

Issues of heterogeneity in the categories of diagnosis have been raised as well. Studies show that people that fit the criteria of symptoms of the same diagnosis of the DSM-5 can have vastly different symptom profiles, trajectories, and responses to treatment, thus making the diagnosis seem a homogenous concept that is problematic (Allsopp et al., 2019; Fried, 2022). The constraints have led to the recommendations of the alternative models of classification focusing on symptom networks, dimensions based on traits, and clinical characterization of each person (Forbes et al., 2024).

IX. Emerging Alternatives and Future Directions in Psychiatric Diagnosis

As a reaction to ongoing condemnations of categorical diagnostic systems, alternative and complementary methods to psychiatric classification have been increasingly popular. Models such as the DSM-5 Alternative Model of Personality Disorders and the system of ICD-11 are attempts to move past the traditional diagnostic category and to more flexible and useful clinical constructs (Krueger and Hobbs, 2020; Bach et al., 2020; Bornstein, 2025).

Empirically-based views of psychopathology have become increasingly popular, and vast empirical studies have proven that the symptom structures tend to transcend the limits of diagnosis. The findings support changing the way mental illnesses are classified, in terms of overlapping dimensions of symptoms and transdiagnostic procedures rather than particular syndromes (Forbes et al., 2024; Fried, 2022). These are methods in consonance with more significant initiatives to improve the accuracy of the diagnosis and personalization of treatment.

Also, growing awareness of the pertinence of functional assessment and clinical characterization of non-categorical diagnoses is growing. The focus on symptom prioritization,



illness staging and longitudinal course has been proposed as a solution to address the enhancement on clinical decision-making and therapeutic outcomes (Leucht et al., 2024; McGorry et al., 2025). These changes are indicative of a steady transition in the direction of the field of integrative models that don't exclude the current diagnostic systems but complement them.

X. Conclusion

The relative comparison between DSM-IV and DSM-5 demonstrates the changing nature of psychiatric categorization, and the long-standing dilemma that accompanies the diagnosis of mental illnesses. DSM-IV has provided a consistent and reliable framework that has further increased standardization in mental health practice; however, the categorical rigidity, high rates of comorbidity, and low sensitivity to the severity of symptoms have created the need to revise it. DSM-5 corrected these shortcomings by structurally reorganizing and eliminating the multi-axial system and introducing more insights from dimensions and development.

Although DSM-5 is a significant advancement towards a more viable clinical utility and philosophical consistency, there are no solutions offered to deeply rooted controversies on the diagnostic validity, etiological clarity, and cultural relevance. The traditional fears of diagnostic inflation, heterogeneity and absence of biological indicators underscore the view that psychiatric nosology is to be refined and further innovated (Wakefield, 2016; Maj, 2020; Alda, 2021). The trends in the field of psychiatric diagnosis are expected to turn towards integrative models which entail the use of categorical classification, as well as dimensional assessment, trait-based characterization, and data-driven approaches of psychopathology.

In this regard, we must see DSM-5 as a provisional step in a process of scientific and clinical change. The critical perception of both DSM-IV and DSM-5 is a key to informed clinical practice, high-quality research, and the responsible development of mental health diagnostics.

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