The Need for a Validity-Based Diagnostic Hierarchy in DSM-6

Mark L. Ruffalo[1,2,3] and Ronald W. Pies[2,4]

1. University of Central Florida College of Medicine

2. Department of Psychiatry, Tufts University School of Medicine

3. The New Jersey Institute for Training in Psychoanalysis

4. Department of Psychiatry, State University of New York Upstate Medical University

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Highlights

- The DSM's abandonment of diagnostic hierarchy has contributed to diagnostic inflation and spurious comorbidity by encouraging clinicians to assign multiple overlapping diagnoses rather than identifying the most explanatory underlying disorder.
- The original concept of comorbidity, as defined by Alvan Feinstein, referred to the co-occurrence of distinct disease entities, whereas contemporary psychiatric usage often conflates symptom overlap with the presence of multiple independent disorders.
- DSM-6 should restore a validity-based diagnostic hierarchy that prioritizes disorders with the strongest empirical support, distinguishes true from false comorbidity, and improves both diagnostic clarity and treatment selection.

Abstract

The DSM's loss of diagnostic hierarchy has contributed to widespread diagnostic proliferation and a misunderstanding of comorbidity. Feinstein's original concept referred to the co-occurrence of two distinct disease entities, each with its own etiology and pathology. In psychiatry, by contrast, comorbidity has come to mean the accumulation of multiple DSM diagnoses, many of which have overlapping criteria and limited construct validity. This shift accelerated after DSM-III, which emphasized reliability over parsimony and encouraged clinicians to treat symptom clusters as separate disorders. The authors argue that DSM-6 should restore a diagnostic hierarchy grounded in construct validity. This would privilege disorders with strong empirical validators, distinguish true from false comorbidity, reduce diagnostic inflation, clarify etiological relationships, and improve treatment selection. Drawing on Feinstein's original intentions, the historical contrast between DSM-II and DSM-III, and contemporary work by Ghaemi, the authors outline a path toward a more coherent and scientific psychiatric classification.

Keywords: Comorbidity, construct validity, DSM, classification, nosology

In its various iterations, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) has long aimed to provide a common language for psychiatric diagnosis. Yet, in our view, the system has lost one of the most fundamental principles in medicine: diagnostic hierarchy. In its absence, clinicians often accumulate multiple diagnoses for a single patient, treating complex presentations as though they reflect multiple, independent disease processes rather than a single underlying condition. This conceptual drift has shaped both clinical practice and psychiatric epidemiology, especially through the expansion of "comorbidity"—a concept whose original meaning has been widely misunderstood.

This problem has long been recognized by psychiatrists. Indeed, nearly 20 years ago, Tew and Pincus [1] argued that,

> The original version of DSM was a descriptive system that incorporated many of the concepts and the structure of Emil Kraepelin's classifications of mental disorders. Compared with subsequent revisions, DSM-I and DSM-II followed a "one disease-one diagnosis" model. The clinician strove to diagnose parsimoniously, using qualifying phrases (such as "with neurotic reaction" and "with psychotic reaction") to describe complex cases. Implicit in these early DSM systems were many assumptions about the etiology and nature of mental disorders. DSM-III, however, took a different approach of splitting diagnoses into a large number of relatively narrowly defined psychiatric disorders, providing operationalized criteria for each. For example, DSM-III split the single DSM-II category "phobic neurosis" into 5 distinct DSM-III categories. DSM-III did not encourage practitioners to assume that a wide variety of phobic reactions (such as separation anxiety disorder and simple phobia) were simply variants of the same disorder. Not surprisingly, from DSM-II to DSM-IV, the number of distinct psychiatric diagnoses

nearly doubled. Diagnostic splitting comes at the risk of spurious comorbidity (attributing a single set of symptoms toward criteria for several disorders).

Although Tew and Pincus suggested several possible solutions, the problem of spurious comorbidity persists in the current DSM-5 and DSM-5-TR, as we will discuss presently. This paper argues that DSM-6 should restore a diagnostic hierarchy grounded in construct validity. This would clarify the boundaries between disorders, reduce diagnostic inflation, improve treatment selection, and align psychiatry more closely with general medical nosology. Our argument is based on three considerations: Alvan Feinstein's original definition of comorbidity and the confusion its abandonment has generated; the shift away from the expectation that clinicians make parsimonious diagnoses; and contemporary work by Nassir Ghaemi demonstrating that hierarchical classification offers several advantages over an approach in which all diagnoses are treated as equally valid. We believe that these comments also have relevance to classifications outside of the DSM system, such as the International Classification of Diseases and other attempts at psychiatric nosology.

By "construct validity," we refer to the classical framework articulated by Robins and Guze [2], which includes clinical description, laboratory studies, delimitation from other disorders, follow-up studies, and family studies. These validators are not binary but dimensional [3], and disorders may meet them to varying degrees. Accordingly, our proposal does not assume that validity judgments are free of subjectivity. Rather, we suggest that DSM-6 workgroups adopt explicit, operational criteria for evaluating each validator—for example, requiring multiple independent studies demonstrating specificity and reproducibility for laboratory markers or longitudinal course. While disagreement is inevitable, greater transparency in how validity is

assessed would represent a significant advance over the current system, in which all diagnoses are implicitly treated as equivalent.

What Is the DSM For?

Any proposal for DSM-6 should begin by identifying the manual's functions. The DSM provides a common language for clinical communication, research, education, epidemiology, and administration. DSM-III's operational criteria were intended in large part to remedy the poor interrater agreement of earlier systems and permit researchers in different settings to study comparably defined populations. In this respect, DSM-III was successful: its initial field trials reported substantially higher reliability than had generally been achieved with DSM-I and DSM-II [4].

Reliability, however, is agreement, not proof that a category identifies a distinct disease or condition. A reproducible rule can consistently group heterogeneous patients or divide manifestations of one illness across several diagnoses. The hierarchy proposed here would therefore preserve explicit criteria and common terminology while adding validity-based precedence rules. Researchers could still enroll participants using standardized criteria, while reporting whether additional syndromes were independent disorders or subordinate features. Whether this produces more homogeneous samples or better prediction is a testable empirical question, not an assumed benefit.

The Original Meaning of Comorbidity

Alvan R. Feinstein introduced the term comorbidity in 1970 to address a specific problem in medical research: how to conceptualize the co-occurrence of two distinct disease entities in the same patient [5]. For Feinstein, comorbidity meant that an individual might, for example, have

melanoma *and* diabetes—two disorders with distinct etiologies, pathophysiology, prognoses, and treatments. Comorbidity presupposed that each diagnosis represents an ontologically discrete—i.e., independently existing—disease or syndrome. The term was never meant to describe the presence of multiple symptoms within a single condition, such as anxiety in the context of a major mood disorder; or the tendency of one disorder's clinical manifestations to mimic those of another, such as abandonment depression in borderline personality disorder mimicking major depression. These are problems of *symptom heterogeneity*—not comorbidity in Feinstein's sense.

The framers of DSM-III, however, adopted the term in an entirely different manner. Under DSM-III and its successors, comorbidity came to mean the co-occurrence of multiple DSM diagnoses—many of them lacking clear boundaries or strong validation—within the same individual. Understandably, comorbidity rates skyrocketed [6]—not because patients were suddenly suffering from more disorders, but because the diagnostic system encouraged clinicians to diagnose individual symptom clusters or syndromes as separate disorders.

Furthermore, without a validity-based hierarchy, the DSMs have effectively treated all diagnoses as ontologically equivalent. Schizophrenia, narcissistic personality disorder, generalized anxiety disorder, etc., are all considered equally valid or "real." In fact, however, some DSM disorders possess strong construct validity across genetic factors, longitudinal course, neurobiology, and treatment response [2]. In contrast, many other DSM categories represent dimensional traits, nonspecific symptom clusters, or descriptive placeholders [7].

The absence of a diagnostic hierarchy thus confuses underlying causal structures with surface-level phenomenology. As Feinstein warned, conflating symptom overlap with comorbidity obscures the true nature of disease and leads to misunderstanding of the patient's condition. Furthermore, in our view, the DSM's inappropriate use of "comorbidity" disguises

diagnostic imprecision by treating it as though it were a property of patients rather than of the diagnostic system itself.

The Historical Shift with DSM-III and Beyond

Prior to DSM-III, comorbidity was relatively uncommon in psychiatric practice [8]. DSM-II, like its predecessor, adopted a parsimonious approach to diagnosis. Clinicians were instructed to select the single most explanatory diagnosis, or at most a small number of diagnoses, that captured the essential psychopathology. DSM-II stated explicitly,

> The diagnostician…should not lose sight of the rule of parsimony and diagnose more conditions than are necessary to account for the clinical picture. The opportunity to make multiple diagnoses does not lessen the physician's responsibility to make a careful differential diagnosis…[furthermore]…the diagnostician [should] underscore the disorder on the patient's record that he considers the underlying one" [9].

Secondary diagnoses were permitted only when clearly warranted. DSM-II's psychodynamic orientation was built on the plausible assumption that symptoms reflected coherent underlying conditions and personality structures rather than multiple discrete, modular disorders.

With DSM-III, psychiatric diagnoses were operationalized as constellations of observable signs and symptoms, in part to maximize interrater reliability and remain agnostic regarding contested etiologies [8]. This descriptive caution was a strength. At the same time, DSM-III treated signs and symptoms largely as surface-level indicators that could be counted without reference to organizing psychopathology. Many of the same features, such as irritability, insomnia, or poor concentration, became criteria for multiple disorders. As a result, a single clinical presentation could generate several diagnoses without a coherent account of what was

primary or secondary, what illness best explained the presentation, or how the observed symptoms were causally related.

That said, it is important to note that DSM-III did not entirely abolish hierarchical relationships. In fact, it retained elements of the traditional hierarchy inherited from DSM-II, most notably through *exclusion criteria* that prevented certain diagnoses from being made when criteria were met for disorders presumed to be higher in the hierarchy; e.g., anxiety disorders were excluded in the presence of mood or psychotic disorders (see below). However, the DSM-III exclusion rules were not made on the basis of the Robins-Guze criteria for diagnostic validity. Rather, they were intended to foster interrater reliability and diagnostic parsimony, assuming, for example, that generalized anxiety symptoms were likely secondary features of a "dominant" or more severe condition. In any case, many of the DSM-III exclusion rules were subsequently removed in DSM-III-R, a change that substantially increased rates of diagnosed comorbidity [6,10].

For example, in DSM-III, generalized anxiety disorder (GAD) carried an exclusionary rule stating it could not be diagnosed if another Axis I disorder—such as major depression or panic disorder—was present. If a patient met the criteria for a "dominant" disorder, the generalized anxiety symptoms were attributed to that disorder alone. Importantly, DSM-III-R changed this. This exclusionary rule was removed, allowing GAD to be diagnosed concurrently with other Axis I disorders. In effect, clinicians could recognize GAD as an independent condition even if the patient also suffered from major depression or other anxiety disorders. None of this was done on the basis of *diagnostic validation*, following the Robins-Guze criteria. Nevertheless, some clinicians argued in favor of removing this particular exclusion rule. For example, Zimmerman and Chelminski [11] found that depressed outpatients with comorbid

DSM-IV GAD had a greater level of suicidal ideation, poorer social functioning, and a greater frequency of other anxiety disorders, compared to depressed outpatients without GAD.

In any case, the general trend from DSM-III-R to DSM-IV, to DSM-5, and DSM-5-TR has been to de-emphasize hierarchical diagnosis and to favor diagnostic comorbidity. For example, unlike previous editions of the DSM, DSM-5 now explicitly allows a comorbid diagnosis of attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD), which was previously forbidden. DSM-5 also removed the exclusionary criteria that previously prevented an obsessive compulsive disorder (OCD) diagnosis if symptoms were "better explained" by a psychotic disorder. To be sure, elimination of such exclusionary criteria has its defenders. For example, Leitner [12] has argued that,

> Research specifically focusing on co-occurring ADHD and ASD has only recently evolved, being previously limited by the DSM-IV exclusion criteria. What we have so far learned is that both disorders frequently co-occur, and when they do, they cause greater morbidity, and create a more complicated clinical challenge. The new DSM-V, allowing for a dual diagnosis, will hopefully facilitate research, by eliminating the exclusion of many patients and allowing the study of broader phenotypes.

However, note that Leitner's thesis implicitly assumes that ADHD is itself a *well-validated diagnosis*—a claim that has been challenged [7]. While there are several neurobiological correlates associated with ADHD, it remains unclear whether the DSM-5 construct fully satisfies all five Robins-Guze criteria for diagnostic validity. One comprehensive review concluded that "there is no good reason to accept that ADHD has moved beyond face validity as described by Spitzer and Cantwell (1980)" [7]. This debate illustrates a broader point:

the degree of validation for many DSM categories remains contested, reinforcing the need for a system that differentiates disorders according to the strength of their empirical support.

It is also important to acknowledge that DSM-5 has, in some respects, moved toward greater attention to validity. For example, the consolidation of autism-related diagnoses into autism spectrum disorder and the creation of the obsessive-compulsive and related disorders category were informed by shared validators such as neurobiology and treatment response. These developments suggest that the DSM framework is not inherently incompatible with hierarchical reasoning, but that such reasoning has not been consistently or explicitly applied.

Cumulative Disease Burden and Genuine Comorbidity

Of course, we acknowledge Leitner's point that genuine comorbidity can and does exist, such that the cumulative disease burden—rather than a single index disorder—serves as an important driver of morbidity and mortality. We observe this, for example, when co-existing substance abuse worsens the course and outcome of schizophrenia [13]. We also acknowledge that genuine comorbidity may sometimes be missed by clinicians using unstructured interviews [14].

Here, *course and sequence of illness* are crucial, but not decisive. Consider a patient who develops OCD at age 12, has no psychotic symptoms for eight years, and then meets full DSM criteria for schizophrenia at age 20. Because OCD and schizophrenia are both comparatively well-validated, this pattern may represent genuine comorbidity [15]. However, early obsessive-compulsive symptoms could also be prodromal. An independent OCD diagnosis would be strengthened by characteristic obsessions and compulsions, persistence outside psychotic episodes, an autonomous course, and treatment needs not explained by schizophrenia.

In contrast, consider a patient with recent onset of schizophrenia accompanied by a compulsive need to wash his hands twenty times per day. The latter is clearly related to the patient's delusional belief that his hands have been "infected with Ebola virus." This scenario most likely does *not* represent co-morbidity; i.e., two independent, co-occurring disorders (schizophrenia and OCD). Indeed, "…obsessive compulsive (OC) symptoms in schizophrenia have been described in various forms as a part of the schizophrenic phenomena for over a century" [16].

Temporal sequence is not itself a Robins-Guze validator and cannot settle the question. A higher-order diagnosis such as schizophrenia also would not automatically bar every additional diagnosis; it would change the burden of evidence. Clinicians should ask whether the second syndrome has distinct phenomenology, an independent course before or outside psychosis, and persistence during psychotic remission. Thus, childhood OCD in the first example may remain an independent diagnosis if those features are demonstrated, whereas delusion-driven handwashing in the second is better understood as a manifestation of schizophrenia. Hierarchy therefore supplements longitudinal assessment rather than replacing it.

The Case for a Diagnostic Hierarchy

While we acknowledge that there may sometimes be plausible reasons for removing DSM exclusion criteria, it is nevertheless true that the aforementioned changes from DSM-III to DSM-5 have substantially increased rates of diagnosed comorbidity [10]. The net effect over time is a diagnostic system increasingly permissive of multiple simultaneous diagnoses, without clear guidance regarding nosological (or ontological) priority, or underlying disease structure.

Indeed, post-DSM-III, epidemiologists soon documented extremely high rates of supposed comorbidity: e.g., major depression with GAD; PTSD with borderline personality

disorder; ADHD with bipolar disorder, etc. [6,17]. But this statistical explosion may largely reflect the flawed diagnostic system more than the actual co-occurrence of discrete disorders, or the underlying structure of the patient's psychopathology. It may be the case that diagnostic proliferation occurred not because more patients developed multiple disorders, but because the DSMs encouraged clinicians to multiply diagnostic categories. This problem was compounded because the DSM framework does not give the clinician any obvious way of distinguishing a disorder with many strong validators from those with few. Without a hierarchy that privileges strong construct validity, the most recent DSMs offer little guidance for determining which diagnosis should take precedence when multiple conditions appear to apply. In our experience, this may lead to treatment based on symptom-level interventions rather than on an understanding of the patient's core psychopathology, or a recognition of the underlying disorder. A hierarchical approach would prioritize diagnoses with the strongest validators, reduce the overuse of poorly-validated categories, and clarify when multiple diagnoses reflect true comorbidity.

Nassir Ghaemi has been one of the most prominent contemporary advocates for a diagnostic hierarchy in psychiatry. Ghaemi [18,19] argues that diagnostic systems must distinguish between primary illnesses—essentially, those with strong validators—and secondary or epiphenomenal conditions that often arise as consequences of the primary disorder. In mood disorders, for example, he notes that anxiety symptoms frequently accompany unipolar depression or bipolar disorder, yet clinicians often diagnose a separate anxiety disorder. Ghaemi argues that this practice obscures the underlying illness and may lead, in some cases, to inappropriate polypharmacy and fragmented treatment approaches. While multiple diagnoses do not necessarily lead to polypharmacy, some clinicians treat symptom clusters independently rather than selecting interventions that address the underlying disorder. For example, insomnia in

depression may be treated with a sedating antidepressant, yet some clinicians prescribe both an antidepressant and a benzodiazepine [20]. Such practices may be exacerbated when separate diagnoses are assigned to what may represent a single underlying condition. A hierarchical system would treat the mood disorder as primary, and the anxiety symptoms as subordinate features. The availability of a medication for a symptom cluster does not itself establish that the cluster is a valid independent disorder.

Ghaemi's hierarchy is grounded in a realist philosophy of nosology. He argues that diagnostic categories should reflect natural distinctions in psychopathology—differences that correspond to real patterns in nature, not merely to consensus or convention. When a condition consistently demonstrates strong genetic, longitudinal, biological, and treatment validators, it should be granted ontological priority within the classification system. By ontological priority, we mean priority accorded to conditions that plausibly correspond to naturally-occurring patterns of psychopathology, rather than to purely pragmatic or consensual groupings of symptoms. In general, disorders with weak or few validators should be considered trait dimensions, subtypes of well-validated conditions, or nonspecific manifestations. Importantly, the presence of biological or genetic correlates alone does not confer validated disease status; e.g., traits such as impulsivity may demonstrate heritability or neurobiological associations, yet still fail to meet most Robins-Guze criteria for an independent disease entity; e.g., these traits may lack a characteristic course, syndromal coherence, or specific treatment response.

This logic aligns closely with classical medicine, where diagnostic hierarchy is deeply embedded. A patient with pulmonary embolism who presents with dyspnea, chest pain, and tachycardia is not diagnosed with shortness-of-breath disorder, chest pain disorder, and tachycardia disorder. These manifestations are understood as subordinate expressions of the

embolic disease process. Similarly, a patient presenting with a goiter (neck swelling), bulging eyes, and a racing heart is diagnosed with Graves' Disease rather than three separate disorders (goiter, exophthalmos, and tachycardia). In contrast, the present DSM diagnostic framework routinely fragments what may be a single disorder into multiple DSM diagnoses.

Of course, the analogy to general medicine has limits: pulmonary embolism and Graves' disease have more explicated causal pathways than even the best-validated psychiatric disorders. Our proposal does not require a single known etiology or biomarker. Robins-Guze validity rests on convergence across multiple independent lines of evidence, none decisive alone. We therefore do not claim that current data support a final hierarchy across the DSM. Schizophrenia is a reasonable high-priority candidate because of its syndromal coherence, longitudinal course, familial aggregation, and biological correlates; bipolar I disorder and OCD merit similar consideration within their domains. Within personality disorders, borderline and antisocial syndromes possess greatest validity [21]. Many other conditions would require more provisional placement and explicit evidence review.

Integrating diagnostic hierarchy into DSM-6 could generate several testable benefits:

First, *clearer etiological hypotheses.* Hierarchy may help determine when one disorder explains another clinical feature.

Second, *less false comorbidity.* Some apparent comorbidities may reflect overlapping criteria rather than distinct diseases.

Third, *more coherent treatment selection.* Identifying a primary disorder may support targeted intervention and reduce unnecessary polypharmacy.

Fourth, *greater emphasis on construct validity.* Hierarchy would require explicit attention to the strength of validators.

These are proposed advantages and should thus be tested by comparing hierarchical and nonhierarchical assessments on diagnostic agreement, predictive validity, treatment selection, medication burden, and patient outcomes.

Perhaps most importantly, hierarchy helps bridge traditional psychiatric nosology and modern dimensional models. Rather than discarding categories in favor of pure dimensions, a hierarchical approach acknowledges that some categories (like schizophrenia) may reflect ontologically real, independent disorders, whereas others (like most personality disorders) may reflect dimensional variance.

Toward a Hierarchical DSM

Reintroducing diagnostic hierarchy would not require rejecting the reliability gains achieved by DSM-III. It would simply reassert that reliability is not the only, nor the most important, criterion for nosology [22]. Importantly, the following proposals are not intended as algorithmic rules to be applied mechanically by the clinician, nor do they presume a complete understanding of psychiatric pathophysiology. Rather, they are intended as guiding principles for DSM-6 workgroups charged with evaluating diagnostic categories in light of construct validity, longitudinal course, and explanatory coherence—much as hierarchy functions in the rest of medicine despite incomplete etiological knowledge.

A hierarchical system could be implemented by: prioritizing diagnoses with strong construct validity by granting them classificatory precedence when overlapping symptom criteria are present; clarifying which symptom clusters represent expressions of underlying syndromes rather than independent diseases; distinguishing true comorbidity (in Feinstein's sense) from false comorbidity created by overlapping criteria; encouraging clinicians to identify a principal

(primary) diagnosis before assigning additional ones; and integrating dimensional ratings as specifiers rather than stand-alone disorders.

Finally, it is also important to distinguish the validity-based hierarchy proposed here from the Hierarchical Taxonomy of Psychopathology (HiTOP), a dimensional framework that organizes psychopathology exclusively on the basis of symptom covariance. HiTOP is said to be "hierarchical" because it organizes mental health symptoms by their level of generality, moving from highly specific behaviors at the bottom to broad, overarching domains at the top. This structure is based on empirical data showing that symptoms often co-occur in predictable patterns. If a person has a "high-level" vulnerability, it likely manifests as several "low-level" symptoms [23]. But whereas HiTOP employs the language of hierarchy, it explicitly brackets—sets aside—questions of ontologically "real" disease entities, longitudinal course, and external validators such as biomarkers or familial aggregation. As a result, HiTOP risks flattening fundamentally different forms of psychopathology into symptom spectra, rather than distinguishing disorders that plausibly represent discrete illnesses from those better understood as dimensional traits or nonspecific manifestations. The present proposal is therefore complementary to neither HiTOP nor to purely dimensional models. Rather, it reflects a medical nosology grounded in construct validity and the classic diagnostic validators—especially, in the importance of course of illness.

Relationship to RDoC

The National Institute of Mental Health's Research Domain Criteria (RDoC) is a research framework, not a clinical diagnostic system. It studies dimensions of neurobehavioral functioning across the normal-to-abnormal range and integrates units of analysis from genes and circuits to behavior and self-report [24]. RDoC addresses the heterogeneity and apparent

comorbidity of DSM categories by examining processes that cut across them, thereby supplying a neurobehavioral framework distinct from both DSM-III's descriptive agnosticism and DSM-II's psychodynamic assumptions. Our proposal begins instead with clinical syndromes and the full set of external validators, especially longitudinal course and delimitation. RDoC findings could strengthen the laboratory and mechanistic components of validity judgments, but should not by themselves determine clinical precedence. RDoC and a diagnostic hierarchy are therefore complementary: one can generate evidence that informs the other.

Developing a Hierarchy

In practice, constructing a diagnostic hierarchy would require explicit methodological guidelines. One approach would involve systematically evaluating each disorder according to the Robins-Guze validators and assigning relative weight to each domain. DSM-6 workgroups could establish operational thresholds—for example, requiring multiple independent studies demonstrating specificity for laboratory markers, or consistent longitudinal course across populations. Disorders could then be grouped according to the number and strength of validators satisfied.

We do not necessarily envision a single, linear hierarchy, but rather multiple partially overlapping hierarchies corresponding to major domains of psychopathology. Within each domain, higher-order conditions would take precedence when they parsimoniously account for lower-level symptom clusters. While such determinations would inevitably involve some degree of expert judgment, this is already the case in DSM revisions. The proposed approach would at least make these judgments explicit and grounded in shared criteria.

DSM covers too broad a territory for a single linear hierarchy to be applied uniformly. Each domain requires its own evidence review. In child psychiatry, developmental stage changes

the meaning of symptoms and the longitudinal course is still unfolding; hierarchy should distinguish age-normative variation, developmental disorders, and early expressions of later syndromes without delaying needed care. Neurocognitive disorders may shift more rapidly as biomarkers and etiologic evidence emerge. A "living" hierarchy could therefore use periodically updated evidence tables for each validator, with placements revised as replicated findings accumulate. Provisionality is a key feature of this approach.

Subtypes and Symptom Clusters

The current proposal for a validity-based hierarchy does not require a specific architecture of subtypes or spectra. Symptom clusters, such as obsessions and compulsions, should be interpreted in their syndromal context. When they demonstrate independent validators, they may warrant classification as separate disorders; otherwise, they are better treated as specifiers, subtypes, or manifestations of a broader condition. DSM-5's consolidation of autism diagnoses illustrates that broader spectrum categories can be useful when variants share validators. Analogous anxiety, depressive, or psychotic spectra should not be adopted from symptom resemblance alone, but tested for gains in validity, prognosis, and treatment selection. Etiologic specifiers, such as psychosis due to a known condition versus an unknown causal process, could be retained within such groupings.

Potential Limitations of a Hierarchical System

We acknowledge several potential limitations of the proposed hierarchical model. First, hierarchical classification may risk overlooking clinically meaningful comorbidity in some cases, particularly when treatment of a subsumed condition differs from that of the primary disorder. However, our proposal is not intended to eliminate recognition of true comorbidity, but rather to distinguish it from artifactual comorbidity arising from overlapping criteria.

Second, concerns may be raised that hierarchical systems could inadvertently reinforce stigma toward conditions placed lower in the hierarchy. We find no clear evidence that degree of validation correlates with stigma; indeed, highly validated disorders such as schizophrenia remain among the most stigmatized conditions in medicine [25].

Third, given the current limits of etiological knowledge in psychiatry, any hierarchy would be provisional and revisable. This is why we propose domain-specific evidence tables and periodic review rather than a rigid algorithm.

Finally, it is possible that prioritizing conceptual clarity may, in some cases, conflict with clinical pragmatism. Whether a hierarchical system improves patient outcomes is ultimately an empirical question requiring prospective study.

Conclusion

Nearly 20 years ago, Tew and Pincus [1] concluded that, "…the current strategy of diagnosing maximal comorbidity may not be optimal. The practice of listing multiple diagnoses has the power to both enhance and obscure important clinical information." We believe that, in the intervening years, the pendulum has swung too far in the direction of encouraging spurious comorbidity. As DSM-6 deliberations begin, we believe the reforms outlined here may help curb diagnostic inflation, reduce inappropriate polypharmacy, and restore conceptual clarity to psychiatric diagnosis. They could also bring the DSM back into alignment with the broader medical tradition, in which diagnostic hierarchy is indispensable for understanding disease mechanisms and guiding treatment. A hierarchical approach could clarify longstanding conceptual confusions, separate true comorbidity from artifacts of descriptive criteria, and foreground those diagnoses supported by the strongest empirical validators. We believe the result would be a more coherent and clinically meaningful nosology.

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