# Operationalism and its discontents

The introduction of polythetic diagnostic criteria and their operational definitions from DSM-III onwards has been a mixed blessing for clinical and scientific psychiatry. While enhancing reliability and standardization in research and practice, it also led to a number of unintended and undesirable consequences.

Chief amongst these is the well-known problem of diagnostic heterogeneity. In their recent contribution to this journal[1], Fried et al note 10 377 unique symptom profiles for major depression, a number which only *increases* when the specifier melancholia is considered (i.e., 341 737 unique profiles). Obviously, this is not so much an empirical discovery, as a *logical* consequence of the operational decision to define disorders in terms of additive independent criteria: the more criteria, the more possible combinations, the more potential diagnostic heterogeneity.

It remains unclear, however, which precise lessons we should take home from this mathematical *reductio ad absurdum*.

A first possible lesson might emphasize the urgent need to critically reconsider the larger operational approach to psychiatric diagnosis itself. Apart from the artificial inflation of diagnostic heterogeneity stressed by the authors, operationalism also resulted in an overly simplified approach to psychopathological description of syndromes and symptoms.[2] In the case of (melancholic) depression, e.g., this spurred a questionable expansion of the concept to include an all-embracing class of various states of general unhappiness with indistinct boundaries to states of normal psychology.[3] On this account, what is needed is not so much a discarding or downgrading of traditional diagnostic categories like, e.g., melancholia or schizophrenia, but rather a resuscitation of fine-grained psychopathological understanding and assessment *beyond* the checklist-approach of counting criteria and symptoms.[4]

However, this does not seem to be the lesson presented by the authors. In fact, rather than exposing the absurdity of the operational-criteriological approach to psychiatric diagnosis through their mathematical exercise, they assume the *validity* of the latter approach to challenge the idea that melancholia (and potentially other specifiers) identifies a more homogenous group of patients. In a way, DSM's operationalism is not questioned or abandoned here but merely turned against itself.

This is also apparent in the symptom-oriented solution to the problem of diagnostic heterogeneity championed by the first author (e.g.[5]). Focusing on symptoms rather than broader categories is a currently popular proposal and is, e.g., one of the basic tenets behind novel network-approaches to psychopathology. Yet, it is perhaps insufficiently emphasized how the very idea of focusing on symptoms regardless of how they are meaningfully embedded in broader psychopathological Gestalts is a continuation of DSM's operationalism, rather than a radical break with it.[2,6] Indeed, a novel feature of that approach was the definition of clinical syndromes (e.g., schizophrenia) in terms of combinations of individual symptoms (e.g., hallucinations and delusions) which could be described *independently* from

the former. Yet, such context-independent definition of individual symptoms requires that they are formulated in a more *general* or *abstract* way.[6] Importantly, this means that whatever heterogeneity one hoped to avoid by turning to individual symptoms can now be expected to return at this supposedly more basic level of description (see[7] for empirical evidence in the case of hallucinations).

In sum, the operational approach to psychiatric diagnosis has had a number of unwelcome consequences of which heterogeneity is but the most obvious outcome. In our view, this is not solved by choosing between syndromes or symptoms, but by critically revisiting that larger operational project itself.

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