attention, as do stroke and other neurological conditions. Current literature has not often systematically assessed anosmia,[3] and pathological studies have been unable to elucidate whether this symptom is due to direct infection or secondary to mucosal involvement.[4]

Vijay Pattni and colleagues correctly observe that the frequency of post-traumatic stress disorder (PTSD) following admission to an intensive treatment unit is high, regardless of the illness. However, it is also probable that factors specific to the current pandemic are relevant, such as extreme social isolation, staff wearing full personal protective equipment, health-care professionals working outside their primary area of expertise, treatment with corticosteroids, and use of second-line agents for sedation. Current naturalistic studies struggle to disentangle these issues.

Any recommendations should be proportionate and evidence-based. Pattni and colleagues suggest screening to identify patients at risk of developing PTSD, but we should exercise caution,[5] since outcomes could be variable and targeting individuals who have yet to develop a psychiatric disorder could have unintended consequences.[6]

Before implementing novel interventions, further research is required to identify an evidence base and subsequently establish clinical guidelines for minimising psychological harm after infection with SARS-CoV-2. Equally important, as suggested by Latha Velayudhan and colleagues, is implementation of existing evidence, such as appropriate management of delirium, which is likely to be seen frequently.

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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 standardisation in research and practice, it has also led to several unintended and undesirable consequences.

Chief amongst these consequences is the well known problem of diagnostic heterogeneity. In their recent contribution to *The Lancet Psychiatry*, Eiko Fried and colleagues[1] note 10 377 unique symptom profiles for major depression, a number that only increases when the specifier, melancholia, is considered (ie, generating 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, and 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 emphasise 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,[1] operationalism also resulted in an overly simplified approach to the psychopathological description of syndromes and symptoms.[2] In the case of melancholic depression, for example, this simplification prompted 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, such as melancholia or schizophrenia, but rather a resuscitation of detailed 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.[1] 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 operational approach to challenge

the idea that melancholia (and potentially other specifiers) identifies a more homogenous group of patients. In a way, the operationalism of DSM is not questioned or abandoned here, but merely turned against itself.

This implicit acceptance of the operational approach is also apparent in the symptom-oriented solution to the problem of diagnostic heterogeneity, championed by the first author (eg, in an article[5] published in 2015). Focusing on symptoms rather than broader categories is currently a popular proposal and is, for example, one of the basic tenets behind novel network-approaches to psychopathology. Yet, it is perhaps insufficiently emphasised how the very idea of focusing on symptoms, regardless of how they are meaningfully embedded in broader psychopathological gestalts, is a continuation of the operationalism of DSM, rather than a radical break with it.[2,6] Indeed, a distinctive feature of this approach was the definition of clinical syndromes (eg, schizophrenia) in terms of combinations of individual symptoms (eg, hallucinations and delusions), which could be described independently of the clinical syndrome. Yet, such a 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 (eg, see Stanghellini and colleagues[7] for empirical evidence in the case of hallucinations).

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

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Authors' reply

We previously showed that if one were to endorse DSM-5 operationalism to define categories of major depressive disorder, the DSM-5 fails by its own standards because the melancholic specifier, which is supposed to identify a more homogeneous subset of patients, has more potential symptom profiles than major depressive disorder.[1] We thank Jasper Feyaerts and Tim Thornton for their rejoinder and agree with three points discussed. First, we agree with their statement that operationalism has "resulted in an overly simplified approach to the psychopathological description of syndromes and symptoms", a notion that appears to be widely shared nowadays and has even been endorsed formally by the National Institutes of Mental Health.[2] Ironically, the simplified DSM approach produced a relatively complex system with many categories that might lack validity. Second, we agree that psychopathology is more than DSM-5 symptoms, and Feyaerts and Thornton argue correctly that there is more to nosology than the symptoms versus syndromes debate—a point that we have stressed in some detail.[3,4] Third, we agree that the melancholic specifier adds more criteria, which necessarily increases heterogeneity. However, note that this specifier also constrains the direction of some major depressive disorder symptoms, thereby potentially decreasing heterogeneity. Our letter[1] used combinatorics to determine the outcome of these two contrasting forces. It is also worth remembering that not all DSM specifiers rely on added symptoms (eg, the seasonal pattern specifier), and that it remains to be seen how many symptom profiles patients actually endorse. Overall, Feyaerts and Thornton argue that it is time to critically revisit the larger operational project itself. We see two broad pathways forward: splitting diagnoses (eg, studying specific biopsychosocial endophenotypes, including specific symptoms); and lumping diagnoses (eg, using transdiagnostic approaches).[5] The holy grail of psychiatric nosology is identifying, vetting, and implementing a framework that can replace operationalism. We note, however, that Feyaerts and Thornton did not propose any replacements in their rejoinder.

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Hope and Homes for Children welcomes the new *Lancet* Group Commission

The *Lancet* Group Commission[1] on the institutionalisation and deinstitutionalisation of children is important because it presents further evidence that placing children in institutions is unnecessary and harmful, and that family-based alternatives exist that deliver far better outcomes. The Commission is also important because of its timing. Amid a global pandemic, it is too easy to view the need for reform of care for children as a separate or lower priority than the public health response. Supporting families to care for children is a fundamental element in ensuring the success of any public health response and is essential in strengthening the capabilities of communities to deal with shocks. Whether as part of an emergency response or as a long-term social policy initiative, the Commission should not be viewed as a cost but as an investment. With this in mind, on behalf of Hope and Homes for Children, I offer the following reflections on the Commission.

Reform of care for children and investment in family-based care are crucial issues, because they deliver multiple dividends to the child-care sector and to broader society over time.[2] These changes are fundamental to building more effective child protection systems and yield substantial benefits to initiatives to improve child health and education and to address child poverty. In this regard, the effect of moving to family-based care is rapid, but also has intergenerational benefits.

The converse is also true. Underinvestment in family-based care for children and reliance on institutions leads to lifelong secondary consequences for children when they leave institutional care as young adults.[3] These consequences include increased likelihood of long-term dependency on state welfare support, especially for housing and unemployment, increased incidence of sex work and suicide, and increased likelihood of the children of those who had themselves been institutionalised being taken into care. These are all expensive human and financial costs that can be transmitted across generations.

Family-based care is not more expensive than institutionalised care.[4,5] After initial investment, family-based care rapidly becomes cheaper and much more cost effective. Hope and Homes for Children has been at the forefront of developing practice for family-based care internationally for more than 20 years. In every location we operate in globally, the costs of properly supported, quality family-based care have been less per child than the cost of confinement in an institution, and the outcomes have been substantially better for the child, with additional benefits for both siblings and parents.[6] Put simply, investment in family care delivers much more benefit, and causes much less harm, than the expensive costs of building and running institutions.

The humanitarian crisis precipitated by the COVID-19 pandemic is playing out in households behind closed doors. The progress that had been made in tackling extreme poverty and other global development challenges is being reversed. Worldwide, probable deaths among children aged 5 years and younger resulting from the disruption caused by the pandemic have been estimated to be 1·2 million in just 6 months.[1] The humanitarian response is struggling to deal with this. Those countries with established or active commitments to family-based care are better able to mitigate and prevent this impact because they have the pre-existing infrastructure and relationships to facilitate engagement with people at a household level. In this regard, family-based care builds more resilient communities.

I am Chief Executive Officer of the charity Hope and Homes for Children. Hope and Homes for Children is the Global Fundraising Partner of RELX, owner of Elsevier, which publishes the *Lancet* journals.

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