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The reports of needs and support systems what the families with mental disorders have

-in the applying to prefectures the united of families with mental disorders(UFMD) presented -

MIKI Ryoko

The support systems of community life for mental disorders have varied a lot, like "The vision of development for mental health welfare(2006)" , "The law for disorders to independent(2008)" and so on. On the other hands, it has been no idea to support the families in the many policies of mental disorders, even if that is so significant thinking. There are so many thing why we have to think about to support the families. The families with mental disorder have cared them from first symptom of mental illness, to whole life for long time. In one aspect, it is normal the family have to care the family , but in other hand, the families with mental disorder have been so tired that have to been support by others.

In this report, it aimed to bring the result of the details of survey in the applying to prefectures UFMD, so that we have to know the problem and needs what families have and to think and establish the supported systems for families.

In result of survey, the majority of need is for the support system for mental disorders themselves, not so much for families and UFMD. In details, there are several key words about medical system, the medical grant system for severely disorders, the law for disorders to independent, residence, the mental disorder papers, employment or occupation, enlightenment, difference, for family or for UMFD , outreach, and others. In real, all of these problem will be not only family also disorders themselves, because the majority of them are with their family in home and their family is getting older, so we have to establish the communities to live safety for mental disorders and their families as soon as possible. Therefore, we have to regard the support system for mental health not only for them and their families, as community problem including administration, people, people engaged in mental health issues and so on.

Keyword: mental disorder, family, applying, family support

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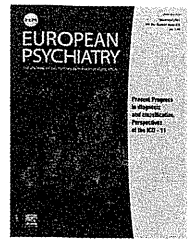

The ICD-10 in the diagnosis and classification of mental disorders in Japan and other Asian countries

T. Maruta*, C. Matsumoto, M. Iimori

Department of Psychiatry, Tokyo Medical University, 6-7-1 Nishishinjuku, Shinjuku-ku, Tokyo 160-0023, Japan.

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ABSTRACT

The ICD-10 is widely used in Japanese clinical and other mental health services settings. Since the publication of the Japanese translation, the most significant event was the renaming of the term schizophrenia in Japanese in 2002. In addition, the Japanese term equivalent to dementia was changed to a supposedly less stigmatizing term in 2006. The renamed versions are now widely accepted by both clinicians and patients and their families.

In addition to the renaming movement, what is notable as part of psychiatry in Japan is the clinical research projects that are being performed, including neuroimaging and molecular studies. Situations about suicide in Japan, which is one of the biggest problems in the mental health field with the number of victims exceeding 30,000 since 1998, are also discussed.

Concerning contributions to the ICD revision process, the Japanese Society of Psychiatry and Neurology (JSPN) organized the ICD committee under the Committee of International Affairs, and the committee has held a meeting every 4 months. In addition, the JSPN organized the ICD-11 committee which collaborates with the Japanese Society for Psychiatric Diagnosis, consisting of subgroups for F1 - F9 category and a comprehensive group. The ICD-11 committee is reviewing all proposals, and will submit particularly relevant opinions for the revision process of the ICD-10.

Finally, concerning use of the ICD-10 and DSM-IV in Asian countries, the survey showed that psychiatrists in China and Japan routinely use the ICD-10, while the DSM-IV was dominant in Korea and Taiwan.

1. Introduction

As was pointed out by Kato [1], there have been some major Japanese contributions to psychiatry: Morita therapy, immodithymic character of depression described by Shimoda, and atypical psychosis by Mitsuda.

There are 90 Societies involved with psychiatry related to the Japanese Society for Psychiatry and Neurology in Japan, ranging from psychopathology to biological psychiatry.

In this chapter, we would like to introduce the most important recent Japanese contributions regarding the diagnosis and classification of mental disorders in Japan, and finally also describe the use of the ICD-10 and the DSM-IV in other Asian countries.

* Corresponding author.
E-mail address: maruta@tokyo-med.ac.jp

2. Use of the ICD in Japan

The Japanese Government adopted the ICD for the national statistics for all diseases and mortality. When the DSM-III was published in 1980, it had an impact on Japanese psychiatrists. Initially it was not accepted, because it adopted a more operational diagnostic system and diagnostic criteria defined by a polythetic format. There were two obstacles to be overcome by Japanese psychiatrists for the DSM to be used in mainstream psychiatry; many psychiatrists were educated in traditional psychopathology, and cross-sectional diagnosis was familiar to them.

In 1981, a research group on psychiatric diagnoses was organized, which later developed into the Japanese Society for Psychiatric Diagnosis in 1991. In the early stage of its development, the topic discussed foremost was related to the diagnostic criteria of the DSM-III.

Since its publication in Japan in 1994, the ICD-10, mental and behavior disorders, as well as the DSM-III-R, has steadily gained

recognition and acceptance among Japanese psychiatrists. Today the ICD-10 is used in administrative, occupational and forensic psychiatry fields, in addition to clinical settings.

3. Schizophrenia and related disorders

In Japan, the diagnosis of schizophrenia had been thought to consist primarily of the first ranked symptoms defined by Schneider. Since the introduction of the DSM-III-R and the ICD-10, however, psychiatrists have come to rely on the diagnostic system, as in the case of other mental disorders.

Among the most remarkable changes in the past decade concerning schizophrenia in Japan was the renaming of schizophrenia. Some psychiatric diagnoses are stigmatizing. In August, 2002, at the annual congress of the Japanese Society of Psychiatry and Neurology, the Society decided to change the name of schizophrenia in Japanese from *seishinbunretsu-byō* (split-mind disease) to *tōgōshitchō-shō* (where *tōgō* means integration or coordination, *shitchō* means ataxia or collapse and *shō* means disorder) [2,3].

In accordance with the above developments, the Subcommittee for the Classification of Disease and Morbidity of the Statistics Committee of the Social Council of the Ministry of Health, Labor and Welfare (MHLW) decided to adopt *tōgōshitchō-shō* and *ninchi-shō* (a new term for dementia in Japanese; in place of the previous term, *chihō*, which was considered to be more stigmatizing) in October, 2005. Consequently, these new terms were employed in the 10th Japanese edition of the International Classification of Disease (ICD-10) [4]. Furthermore, in this revision, all diagnostic terms related to schizophrenia were also changed, *e.g.* F21 schizotypal disorder (*tōgōschitchō-shō-kei shogai*, where "*kei*" means "type" and "*shōgai*" means disorder), F25 schizoaffective disorder (*tōgōschitchō-kanjo shōgai*, where "*kanjō*" means "affect" in technical parlance) and F60.1 schizoid personality disorder (*tōgōschitchō-shō-shitsu-sei jinkaku-shōgai*, where "*shitsu-sei*" means "nature" or "character", and "*jinkaku*" means "personality") [5] . Now the terms *seishinbunretsu-byō* and *chihō* are no longer in official use.

Changing traditional medical terms is difficult. In the case of *tōgōshitchō-shō*, it took nine years. If a better diagnostic term, especially one that is less stigmatizing, could be identified and adopted, this might have a positive effect on patient understanding and care. Ono et al. [5] reported that within only 2 months after adopting *tōgōschitchō-shō*, the rate of such patients who were informed about their diagnosis in Japan increased by 20%. In addition, after the renaming of schizophrenia in Japan, the diagnosis of schizophrenia does not seem to be seen as an untreatable illness any more, which leads us to conclude that the renaming has so far had a favorable impression at least on the families of patients. Yet another study [6] found that just less than half (45%) of members of the Section on Classification, Diagnostic Assessment and Nomenclature of the World Psychiatric Association considered the English term "schizophrenia" as stigmatizing and advocated its renaming. The number of respondents in their study was rather small and thus we cannot extrapolate from these results. However, in light of the favorable reactions in Japan toward renaming schizophrenia, it appears worthwhile to explore the possibility of changing the term for schizophrenia, not only in English but also other languages, in the ICD-11. Of course the implications of such a decision must be carefully considered.

4. Affective Disorders

Concerning Japanese contributions to the diagnosis and treatment of depression, it is essential to mention the hypothesis, originally proposed by Shimoda [7], that the immordithymic character can been seen as a premorbid personality trait that indicates a great predisposition toward endogeneous depression. Before the introduction of the DSM-III to Japan, there was much research on premorbid characteristics and personality traits in association with depression. Kasahara and Kimura [8] proposed a multi-axial classification of depression. Depression is routinely seen in the clinical setting, especially in occupational mental health. There are several epidemiological reports. For example, Ikawa et al. [9], reported that the prevalence of depressive episodes was 5.9% using 6,306 random samples employing MINI. Kawakami et al. [10,11] reported that the prevalence of major depression was 2.9% using the World Mental Health version of the World Health Organization (WHO) Composite International Diagnostic Interview (WMH-CIDI).

As Higuchi [12] pointed out, there are several issues regarding diagnosis and classification of mood disorder in the ICD-10:

- some diagnostic criteria and classifications appear repetitive, which consequently make them seem more complicated than they actually are;
- the relationship among the degree of severity of each episode, somatic symptoms and exsistence of psychotic symptoms should be clarified;
- the diagnostic criteria of the degree of severity in depressive episodes should be clarified.

Concerning dysthymic disorders, Endo et al. [13] reported that psychiatrists with less than 10 years of experience used the diagnosis of dysthymic disorder more often than those who had practiced for 10 years or more. Furukawa et al. [14] investigated cultural differences of depressive symptoms using the Hamilton Rating Scale for Depression (HRSD), but detected no significant differences between Japan, Europe and North America.

Bipolar II disorders (BPII) are increasingly seen in the clinical setting. Utsumi et al. [15] reported that BPII cases had a high frequency of the manic type of premorbid personality, indicating the usefulness of this variable for the prediction of hypomanias. They also found that BP disorders often developed during hospitalization exclusively among BPII, which supports the possibility of BPD as a conditional effect of BPII.

5. Neurotic, stress-related and somatoform disorders

Panic disorder is extremely common in Japan. Aoki et al. [16] reported that the lifetime incidence of panic disorder in Japan is 2.4%. The DSM-IV is more commonly used for the classification and diagnostic criteria of panic disorder in Japan than the ICD-10.

Instead of the traditional Japanese category "*taijin-kyōfu-shō*", social phobia (social anxiety disorder in the DSM-IV) is now used for clinical practice and research.

Since posttraumatic stress disorder (PTSD) was introduced as a new category, it has gradually been gaining awareness and recognition in Japan.

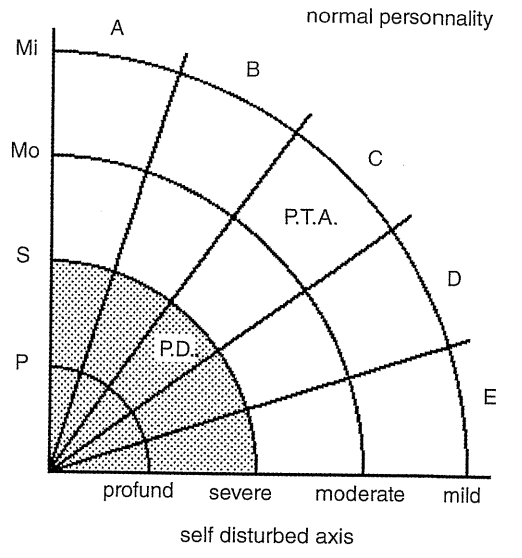
Matsunaga et al. [17] reported the transcultural stability of the symptom structure of obsessive compulsive disorder (OCD), which is consistent with the hypothesis that OCD is mediated by universal psychobiological mechanisms.

Abundant research has been done with regard to PTSD after natural disasters, including the Hanshin-Awaji earthquake, the Tokyo sarin attack, the 2004 Mid-Niigata Prefecture earthquake and the 2006 Niigata Prefecture earthquake. Many practicing psychiatrists often encounter victims of traffic accidents. In addition, this category causes many problems when judging labor-related accidents. In particular, as was pointed by Kuroki [18], the criteria concerning the severity of a given event are problematic.

Concerning adjustment disorder, the differences among mixed anxiety, depressive disorders and mild depressive episodes could be problematic in the ICD-11 if their definition is very arbitrary.

The great difference between the ICD-10 and the DSM-IV in the classification of neurotic, stress-related and somatoform disorders is due to the ambiguity in how conversion disorder should be conceptualized. These are classified as dissociative (conversion) disorders in the ICD-10 and as somatoform disorders in the DSM-IV, respectively. Somatoform disorder in the ICD-10 is also a controversial category and its definition is ambiguous.

Neurasthenia is a very rare diagnosis in Japan, although its relation to chronic fatigue syndrome has been suggested by some researchers.



ICD-10
A: Dissocial personality disorder
B: Histrionic and emotionally unstable personality disorders
C: Paranoid and/or schizoid personality disorders
D: Anankastic, Anxious (avoidant), and dependent personality disorders
E: Other and unspecified personality disorders

DSM-III-R
A: Antisocial personality disorder
B: DEE (dramatic, emotional, and erratic) personality disorders
C: odd and eccentric personality disorders
D: Anxious and fearful personality disorders
E: Personality disorder NOS

Fig. 1. Kato's model of diagnosis and classification in personality disorder.

6. Personality disorders

Despite numerous attempts to find a solution for classifying personality disorders, the current classification of personality disorders seems insufficient. The only categories remaining in official classifications such as the ICD-8, 9, 10 and the DSM-III (-R), IV are paranoid, compulsive (anankastic) and hysterical (histrionic). After examining several theories of personality disorders [19], Kato [20] proposed a theoretical model which enables an international comparison of personality disorders (Fig. 1).

Discussion as to whether to employ categorical or dimensional approach still remains. Several dimensional models have been proposed, such as 3 temperaments and 4 characters by Cloninger [21], the big-5 model by Costa and McCrae [22], 18 dimensions by Livesley [23], etc. Efforts have been made to validate the Japanese versions of instruments to assess the models mentioned above, including the translation of the TCI by Kijima et al. [24], the NEO-PI by Yoshimura [25] and the DAPP-BQ by Maruta [26]. However, such efforts have not provided evidence that is powerful enough to support the superiority of dimensional models.

Another issue concerning personality disorders is where the clinical threshold of each disorder should be set. For example, of all 177 patients given diagnoses of personality disorders in the author's department from May, 2002 to July, 2007, 77.4% received a diagnosis of borderline personality disorder [27]. Schizoid, Dysocial and Anankastic, in contrast, were extremely uncommon. This apparent difference in the frequency of each disorder raises questions about whether the currently employed threshold for diagnoses is justified.

Moreover the term "dissocial" should be changed to a character-based term like callous or affectionless, because "dissocial" is not a medical concept but rather comes from observable behavior.

7. Dementia

In December of 2004, the Committee for the Renaming of Dementia, of the Ministry of Health, Labor and Welfare of Japan (MHLW) decided to alter the Japanese term for dementia from *chihō* (idiocy or to be in a daze) to *ninchi-shō* (disorder of cognition), because the former was deemed to have a pejorative effect, depriving elderly patients of their dignity, and could actually impose an obstacle for prophylaxis. Of these two renaming processes, namely for schizophrenia and dementia, the initiative for the latter was taken by the Japanese government. The Japanese Psychogeriatric Society later adopted "*ninchi-shō*" in June 2006.

8. Biomarkers and neuroimaging research

Concerning biomarker studies on mental disorder, Hashimoto et al. [28] reported that serum levels of D-serine in the patients

with schizophrenia were significantly lower than those of healthy controls. In contrast, serum levels of total (D and L) serine and L-serine in the schizophrenic patients were significantly higher than those of controls. In addition, the percentage of the D-serine component in total serine in the schizophrenic patients was significantly lower than that of controls, suggesting that the activity of serine racemase, an enzyme catalyzing the formation of D-serine from L-serine, may be low in schizophrenic patients. They concluded that low levels of D-serine may play a role in the pathophysiology of schizophrenia, and serum D- and L-serine levels might provide a measurable biological marker for schizophrenia.

Kikuuchi et al. [29] found that XBP1, a pivotal gene in the endoplasmic reticulum (ER) stress response, may be a contributing factor for the genetic risk of BPD. In their study, the DNA microarray analysis of lymphoblastoid cells derived from two pairs of twins was carried out. Tochigi et al. [30] reported that there was no evidence for significant association between GABA receptor genes in chromosome 15q11-q13 and autism in the Japanese population. This is in contrast with the fact that the gamma-aminobutyric acid (GABA) receptor genes GABRB3, GABRA5, and GABRG3 located on chromosome 15q11-q13 have been major candidates for susceptibility genes for autism, a neurodevelopmental disorder with a complex genetic etiology.

Concerning neuroimaging studies, Kasai et al. [31] reported that patients with first-episode schizophrenia showed significant decreases in gray matter volume over time in the left superior temporal gyrus compared with patients with first-episode affective psychosis or healthy controls. Neuroimaging studies using near-infrared spectroscopy (NIRS) are also popular in Japan [32].

9. Suicide in Japan

Suicide is a pressing issue in Japan. Over 30,000 cases of suicide (25.8 per 100,000 in 2009) have been annually reported since 1998, and despite national efforts to counteract this trend, the number has not decreased in Japan [33].

Overall, suicide among men is slightly more frequent than that among women. However, the male-female ratio differs depending on the age group. The discrepancy between genders widens as the ages increases (the ratio is approximately 10: 3 in the age 50 to 59 age group where the discrepancy is greatest), and at age 80 and over, the discrepancy is minimal. In association with age, the number of suicide cases is relatively stable for women (between 1,000 to 1,650 throughout, except for teenagers), while the number greatly varies for men (over 2,000 in the 3rd decades, gradually increasing to over 5,000 in the 6th decades, then down to about1,000 at 80 and over), which suggests that there may be strong age-associated factors, especially for men.

Although the relationship of suicide to age and gender has not been totally clarified, there are several factors suspected to be associated with particular groups.

Overall, health problems were identified as the number one motive (48%) for suicide as of 2008. However, examining the data more closely, it can be seen that mental health-related problems are more centered on the 30 to 59 age group: Depression alone accounts for almost to over half of health problems (57% in 30s, 54% in 40s, 44% in 50s). On the other hand, physical health problems seem to be an important factor among the elderly. The proportion of physical health problems as a motive for suicide sharply increases from the 60s, in contradistinction of the mental-to-physical ratio (45% and 37% in 60s, 54% and 32% in 70s, 64% and 21% in 80s for physical and mental health problems, respectively).

Financial problems take the heaviest toll on the working age group: financial problems account for 21% of all suicide cases in the 30s, 31% in the 40s, 36% in the 50s, and 27% in the 60s. Moreover, the ratio between genders is especially striking: in the age between 30 and 59, men were found to be as much as 10 times more likely to commit suicide for financial reasons than women (the man-to-woman ratio: 950 to 99 in 30s, 1500 to 138 in 40s, 2144 to 199 in 50s).

From the above results, one can see the strong influences of both the economic recession and the increasing aging of society on suicide in Japan. The working age group, notably 30 to 59, is most likely to experience depression and financial difficulties, which are probably interrelated. Taking into consideration that men among this specific population commit suicide far more frequently, a picture emerges in which men, in the midst of national- and global-scale economic recession, are more likely to unsuccessfully struggle with the responsibility to maintain a family. Health issues were found to be most prominent among the elderly, but in relation to the financial issues so prevalent in the majority of families today, health issues in this population are probably closely related to the cost for medical care.

10. The contribution of Japan to the current revision process of the ICD-10

The Japanese Government organized the Subcommittee of Classification of Disease and Morbidity, the Statistics Committee of the Social Council of the Ministry of Health, Labor and Welfare ICD committee in 26, June, 2006. Consequently the Japanese Society of Psychiatry and Neurology (JSPN) organized the ICD committee (Chair: Dr. Iimori) under the committee of International Affairs (Chair: Dr. Okazaki), which meets every 4 months. In addition, the JSPN organized the ICD-11 committee which collaborates with the Japanese Society for Psychiatric Diagnosis, consisting of subgroups for F1 - F9 category and a comprehensive group.

The ICD-11 committee will review as many opinions as possible, and will propose particularly relevant opinions for the revision process of the ICD-10.

11. Use of the ICD in other Asian countries

Takahashi et al, [34] using a questionnaire developed by Mellsop et al. [35] reported on the use of the ICD in other Asian countries. This survey showed that there are differences in preference for ICD and DSM. ICF was found to be not commonly used. (Table 1)

The survey showed that psychiatrists in China and Japan routinely use the ICD-10, while the DSM-IV was dominant in Korea and Taiwan. This difference could be explained by the close relationship of Korea and Taiwan with the US in their development of psychiatry (Table 1).

Table 1
The frequencies of use both of the ICD and DSM in clinical setting in Japan, China, South Korea and Taiwan.

	Japan	China	South Korea	Taiwan
DSM-IV, Axis I	61%	31%	94%	96%
DSM-IV, Axis II	35%	19%	56%	48%
DSM-IV, Axis III	19%	17%	37%	39%
DSM-IV, Axis IV	17%	9%	31%	24%
DSM-IV, Axis V	9%	5%	34%	16%
ICD10 (Clinical diagnosis)	72%	52%	25%	27%
ICD 10 (Functional evaluation based on ICF Axes)	10%	20%	6%	5%

Takahashi et al. [35] also reported that most Chinese psychiatrists felt that the psychiatric classification should be used only by psychiatrists. On the other hand, psychiatrists in Japan and Taiwan felt that diagnostic classification should be used by clinicians in other fields.

This discrepancy between their opinions may derive from differences in actual psychiatric practices in their respective countries. In all four countries, more than half of the psychiatrists reported have experienced difficulties in applying either the DSM or ICD in their clinical practice, irrespective of cultures. Many psychiatrists felt that Asian views should be incorporated in the further revisions of the ICD and the DSM.

Declarations of interests

The authors have no interests that may be affected by the publication of this paper.

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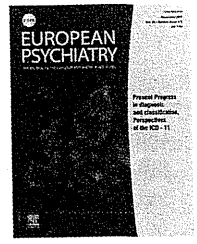

Unresolved problems concerning somatoform disorders and post traumatic disorder

T. Maruta*, M. Kato†, C. Matsumoto, M. Iimori

Department of Psychiatry, Tokyo Medical University, 6-7-1 Nishishinjuku, Shinjuku-ku, Tokyo 160-0023, Japan.

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ABSTRACT

Somatization disorder and post-traumatic stress disorder (PTSD) first appeared as diagnostic categories in the DSM-III. Although both concepts have long histories, their validity has been rather controversial. Somatization disorder overlaps with conversion disorder in terms of concept, and it can be difficult to make a differential diagnosis between these two. According to Patient Report in Japan in 2008, the ratio of diagnosis of "F45.8 Other somatoform disorders" and "F45.9 Somatoform disorder, unspecified" totaled 50% among F45 Somatoform disorder.
We present 3 cases of PTSD, which together illustrate that insufficient or the absence of predisposing factor leads to the level of acute stress reaction disorder, and presence of predisposing and precipitating factors constitutes PTSD, or "war-time neurosis".

1. Introduction

About 30 years have passed since somatization disorder and post traumatic stress disorder (PTSD) appeared in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, (DSM-III) [1]. Numerous studies have examined these two categories. However, essential questions concerning them are unresolved. Both diagnostic concepts have a long history, and their nomenclature and concepts have changed over times. We would like to review them briefly and point out problems on theses categories.

2. Problems regarding somatization disorder

2.1. The concept of somatoform and somatization disorder

We would like to start with proposing two hypotheses on the concept somatoform and somatization disorders.

Somatization itself might be different from communication of psychological distress in the form of physical symptoms, yet it might be neither a disorder nor diagnostic entity.

In the Diagnostic and Statistical Manual of Mental Disorders, Forth Edition,(DSM-IV) [2], a term of "somatoform disorder" which is a higher-rank concept of somatization disorder, included both conversion and somatization disorders. The DSM-III classified a classical category "hysteria" into two categories; one was conversion disorder as a subcategory of somatoform disorder, and the other was dissociative disorder. However, ICD-10 differentiated conversion disorder from somatoform disorder and conversion and dissociative disorders were combined together into a dissociative (conversion) disorder. If conversion disorder is not a subcategory of somatoform disorder, the definition of somatoform disorder would become very ambiguous. Somatoform disorder without conversion disorder would be very difficult to define.

The term of "somatization" has been used as a multidimensional concept, *i.e.*, as a pattern of predominantly somatic rather than cognitive response to stress. There are many types of somatizers in any type of neurotic disorder. These somatizers are prevalent in particular cultures and situations, where expression of emotion is traditionally inhibited. During World War II, tremendous amounts of conversion and hypochondrical disorders were generated among Japanese soldiers [3]. That means, in wartime, some expression of somatization was necessary to be

* Corresponding author.
E-mail address: maruta@tokyo-med.ac.jp
†Masaaki Kato, deceased

diagnosed among patients, particularly more among soldiers than officers. Somatization was a necessary tool to be sick in Japanese army where expression of emotion was strictly controlled for soldiers of lower rank.

In any culture, there are particular elements of somatization and body language, which are used as emotional distress or eustress in ordinary daily life.

The diagnostic criteria of somatization disorder in the DSM-IV, include conversion symptoms in criteria B [4]. The only criteria that enables differential diagnosis for conversion disorder is that "psychological factors are judged to be associated with the symptom or deficit cause the initiation or exacerbation of the symptom or deficit preceded by conflicts or other stressors", which suggests that establishing a differential diagnosis can be extremely difficult. Moreover, when "conflicts" and "other stressors" for this diagnostic criterion B are broadly defined, it practically ceases to help make a differential diagnosis and many forms of somatization disorder are seen as no different from conversion disorder. Jablensky[4] argues that two thirds of psychiatric disorders present some form of physical symptoms, and it is questionable whether this criterion B alone is sufficient to enable a differential diagnosis between somatization disorder and conversion disorder.

3. Conversion disorder and somatization disorder in Patient Report in Japan

According to the 1996 – 2008 Patient Report in Japan [5], the breakdown of "F45 Somatoform disorder" in the International Statistical Classification of Diseases and Related Health Problems,Tenth Revision (ICD-10) [6] diagnoses has considerably changed (Table 1).

In 1996 "Somatoform autonomic dysfunction" was the most frequent diagnosis, but decreased over time. The most recent statistics from 2008 indicate that the ratio of diagnosis of "F45.8 Other somatoform disorders" and "F45.9 Somatoform disorder, unspecified" totaled 50% among F45 Somatoform disorder.

When the term "somatization" was introduced by Stekel [7], a hypothesis was made that a "deep-seated" neurosis could cause a bodily disorder. Menninger [8] also defined "somatization" as "visceral expression of anxiety which thereby prevented from being conscious". Thus the concept of somatization was clearly related to that of conversion, if not identical. Before its appearance in DSM-III, the term of somatization had been used by psychoanalysts, to connote an unconscious defense mechanism. In contrast, psychiatrists who belonged to descriptive schools also came to use a term of somatization which did not imply a putative defense mechanism.

The ICD-10 excluded conversion disorder from somatoform disorder, and included it into "F44 Dissociative (conversion) disorder". It seems very important that the DSM-III, the DSM-III-R [9] and the DSM-IV used the term of somatoform and somatization in a descriptive way but used a term of conversion to refer to some unconscious meaning.

It is not easy to classify *unexplained medical symptoms*. It might be meaningful that the term somatoform disorder was employed in the DSM-III to classify unexplained medical symptoms. This new category represented a continuation of Sydenham's concept [10] of "hysteria-hypochondriasis." However, the currently included 7 disorders in the DSM-IV-TR [11] and 7 disorders in the ICD-10 overlap each other and their validities should be definitively considered again because the revisions of both the ICD-11 and the DSM-5 are approaching.

4. Problems concerning PTSD

PTSD has attracted both controversy and skepticism since it appeared in the DSM-III in 1980. Over 30 years, the diagnostic criteria have been revised, and acute stress disorder added in DSM-IV. One of the main criticisms of PTSD is its validity as a diagnostic entity. Historically, The German psychiatrist, Oppenheim [12] first used traumatic neurosis.

The idea that stress triggers mental disorders has an earlier origin than descriptive nosological classification systems. Before the development of libidinal theory of neurosis by Freud [13], his initial theory was that hysteria had traumatic origins although he subsequently rejected this idea [14].

During World Wars I and II, the relationship between trauma and psychiatric symptoms was investigated. The term "shell shock" first appeared in a medical article by Myers [15].

Kardiner [16] started with treating the World War II veterans who had just come back, and observed their symptoms in great details. His observation influenced the conceptualization of PTSD in DSM-III, which was published in 1980.

Haley [17] was most directly involved in adapting PTSD as a diagnostic entity for DSM-III. Diagnostic categories that had been treated separately (*e.g.* Rape trauma syndrome, Battered person syndrome, Vietnam syndrome were all incorporated under the new diagnostic category).

The DSM-III was translated into Japanese in 1982, and PTSD was translated as "post-psycho traumatic stress disorder," which attracted attention. Psychiatry in Japan had been heavily influenced by medicine in Germany, and traumatic neurosis and compensatory neurosis with injury had been almost interchangeable. The translation of ICD-10 which was supported by the Japanese Ministry of Health and Welfare treated PTSD as "post traumatic stress disorder" (*i.e.* identical to the English original), and the element of "psycho" was not present. In the meanwhile the Glossary of Psychiatry and Neurology, 6th edition (The Japanese Society for Psychiatry and Neurology) [18] translated PTSD as post-psycho traumatic stress disorder. This difference might appear insignificant, but the inclusion of the term "psycho" practically indicates the psychogenic nature of the trauma, and its implication for the legal matter of compensation was to be heatedly debated.

Below are three cases [19] that we believe to be informative today, even though they are old, considering that concepts of Nostalgia in Civil War, shell shock in World War I, wartime neuroses and battle fatigue in World War II, Brainwashing in Korean War, PTSD in Vietnam War, Gulf War syndrome in Gulf War and PTSD have been always changed with historical developments.

5. Case 1

He was born to a wealthy family as the elder son of three siblings, with a younger brother and sister. His father was the president of the shopping district. He was rather introverted and

Table 1
Estimated patients number in dissociative, somatoform and other neurotic disorders in Japan

		1996	1999	2002	2005	2008
F44 Dissociative [conversion] disorder						
F44.0	Dissociative amnesia	-	0.0	0.0	0.0	0.0
F44.1	Dissociative fugue	0.0	-	-	0.0	0.0
F44.2	Dissociative stupor	0.0	0.0	0.0	0.0	0.0
F44.3	Trance and possession disorders	0.0	-	0.0	-	-
F44.4	Dissociative motor disorders	-	0.0	0.0	0.0	0.0
F44.5	Dissociative convulsion	-	-	0.0	-	0.0
F44.6	Dissociative anaesthesia and sensory loss	0.0	0.0	0.0	0.1	0.1
F44.7	Mixed dissociative [conversion] disorders	-	-	-	0.0	-
F44.8	Other dissociative [conversion] disorders	0.0	0.0	0.0	0.0	0.0
F44.9	Dissociative conversion disorder, unspecified	0.5	0.6	0.8	0.9	1.1
F45 Somatoform disorder						
F45.0	Somatization disorder	0.0	0.1	0.2	0.8	0.1
F45.1	Undifferentiated somatoform disorder	-	0.0	0.0	-	0.0
F45.2	Hypochondrical disorder	1.4	1.6	1.0	0.8	0.5
F45.3	Somatoform autonomic dysfunction	3.4	2.8	2.7	2.6	1.7
F45.4	Persistent somatoform pain disorder	0.0	0.0	0.1	0.0	0.0
F45.8	Other somatoform disorders	0.0	0.1	0.3	0.5	1.0
F45.9	Somatoform disorder, unspecified	1.5	2.1	2.8	4.1	3.3
F48 Other neurotic disorder						
F48.0	Neurasthenia	1.2	1.1	0.5	0.3	0.2
F48.1	Depersonalization - derealization disorder	0.0	0.0	0.0	0.0	0.0
F48.8	Other specified neurotic disorders	2.6	2.4	0.7	0.5	0.2
F48.9	Neurotic disorder, unspecified	27.3	21.7	24.6	18.2	18.3

(per 100,000)

always felt inferior to his younger brother, who was active and high-achieving at school.

After graduating from high school he was helping his family business. He joined the military in 1938, left for China to take part in a three-day forced march. It was the middle of summer and many collapsed while marching on the second day. He was among those who collapsed and was rushed to hospital, where his limbs were immobilized and totally tense. He was able to eat when fed and also to communicate, but he rarely spoke spontaneously. His nervous reflex was increased but apparently not pathological, and physically no abnormality was observed from various tests including X-ray.

He was transferred to Kohnodai Army Hospital without a definite diagnosis. His physical functioning was thoroughly examined but no major alternation was found.

ECT was administered as a last resort, and his limbs were temporarily mobile again. At this opportunity he was asked about his situation, and he told that, after his draft, he had been notified by his mother about the family's decision to pass the business onto his younger brother, according to his father's will. He started to open up about his feeling since then. It became clear that the forced march took place after he came to learn about his father's decision.

In summary, his tonic state was caused by the precipitating factor, namely the forced march, in combination with the predisposing factor.

6. Case 2

He was born to a farming family, and only had graduated from elementary school. He was working as a farmer with his mother and younger sister. He was called up to the military in 1937, when The Second Sino-Japanese war broke out, and drafted to the northern part of China. That fall there was a river-crossing mission in which all foot soldiers had to fight Chinese. A bullet passed over his helmet while trying to cross the river, and he collapsed on the spot. His comrade saved him and he was brought back to the camp, and was attended to by a combat medic. Later he was sent to a field hospital. Initially his symptoms were mainly headache, dizziness and nausea, but after he was transferred to Shanghai Hospital he started to have convulsions.

He was sent back to the mainland and transferred to Hiroshima Military Hospital. He started to have a problem with walking, and he always exhibited a convulsion whenever he tried to have his leg lifted up. He spread his arms as if trying to fly, which was different from an epileptic seizure. During the prolonged hospitalization he started talking with the doctor. Soon the doctor learned that he was called up to the military immediately after he got engaged with a woman, whose father, a monk, asked him about changing his name to the monk's name.

He had a letter from his father-in-law-to-be who was a monk a month before the river-crossing mission, in which he was asked

to break off his engagement with the monk's daughter. He was upset with the sudden notice and unable to send back a reply, and this is when he got injured in the river-crossing mission. In this case too, the symptoms appeared as a result of both the predisposing and precipitating factors. He received brief psychotherapy, which lead to disappearance of convulsions and improvement in walking. He left hospital with a temporary pension, and decided to give up on the marriage and take up a job.

In this case as well the predisposing factor seemed to played a bigger role than the precipitating factor.

7. Case 3

He was a serious young man born to a farming family. He volunteered for the military. He happened to witness a large-scale bombing by the British military when he was stationed in Burma as a private. He was supposed to be a guard that night, but because of the fierce carpet-bombing by dozens of aircrafts, the entire troop hid in a shelter and spent the night there.

However, he refused took a shelter because of his role as a guard. He stood outside the shelter in the midst of bombing, and later he was brought into the infirmary after collapsing early in the morning. He was unconscious but he was not injured. He came to consciousness after dawn when the bombing was over, and walked back in a sound state. He spent another four years in the same troop. He had been physically very well throughout his service, and he went back home upon discharge.

A case like this is considered as acute stress reaction, which is to be differentiated from PTSD, and it was called and diagnosed as "shell shock" or "combat reaction."

The 3 cases above alone are not sufficient to draw any conclusion, but it can be inferred that insufficient or the absence of predisposing factor leads to the level of acute stress reaction disorder, and presence of predisposing and precipitating factors constitutes PTSD, or war-time neurosis. The predisposing factor to which we refer here does not include experiences in infanthood or individual vulnerability, and we argue that the predisposing factor that is closer to the precipitating factor plays a bigger role.

Even today these present a great problem, in situations such as compensation in a time of disaster, or labor-related accidents where familial and financial stresses are all intertwined.

The onset and duration of PTSD in DSM-III, -III-R,-IV and ICD-10 are summarized in Table 2. PTSD chronic type that has been used since DSM-III seems to add to related problems. ICD-10 treats the late chronic sequence of stress. i.e., those manifest decades after the stressful experience, as F62.0 (Enduring personality change after catastrophic experience).

8. Conclusion

In psychiatry today, it appears that somatization disorder and PTSD have established a position in diagnostic classification. However, these have been subject to historical developments and contain issues related to diagnostic criteria.

Table 2
Criteria on onset and duration of PTSD from the DSM-III to the DSM-IV and the ICD-10

DSM-III
PTSD, Acute
Onset of symptoms within six months of the trauma.
Duration of symptoms less than six months.
PTSD, Chronic or Delayed
Either of the following, or both:
Duration of symptoms six months or more (chronic)
Onset of symptoms at least six months after the trauma (delayed)
DSM-III-R
E. Duration of disturbance (symptoms in B, C, and D) of at least one month
Specified delayed onset if the onset of symptoms was at least six months after the trauma
DSM-IV
PTSD
E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
Specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor
Acute Stress Disorder
G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
ICD-10
The onset follows the trauma with a latency period which may range from a few weeks to months (but rarely exceeds 6 months).

As efforts for revising both the ICD-11and the DSM-5 are being made, we hope that heuristic diagnostic criteria that are beneficial for the future will be made.

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Declarations of interests

None, except Toshimasa Maruta is a participant in the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders convened by the WHO. This paper in no way reflects the views of that Committee.

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Ⅳ. 研究班名簿

平成23年度
「精神保健医療福祉体系の改革に関する研究」
研究班名簿

研究代表者	竹島　　正	(独)国立精神・神経医療研究センター精神保健研究所
研究分担者	立森　久照	(独)国立精神・神経医療研究センター精神保健研究所
	大塚　俊弘	長崎県長崎こども・女性・障害者支援センター
	山下　俊幸	京都府立洛南病院
	安西　信雄	(独)国立精神・神経医療研究センター病院
	萱間　真美	聖路加看護大学
	白石　弘巳	東洋大学ライフデザイン学部
	河崎　建人	水間病院
	丸田　敏雅	東京医科大学精神医学講座
研究協力者	赤澤　正人	(独)国立精神・神経医療研究センター精神保健研究所
	浅井　邦彦	浅井病院
	東　　司	小阪病院
	有海　清彦	山形県精神保健福祉センター
	池淵　恵美	帝京大学
	石元　康仁	徳島県精神保健福祉センター
	伊藤　千尋	法政大学現代福祉学部
	稲沢　公一	法政大学現代福祉学部
	大熊　恵子	聖路加看護大学大学院博士課程
	太田順一郎	岡山市こころの健康センター
	大橋　明子	聖路加看護大学
	岡崎　伸郎	仙台医療センター
	岡部　英男	神奈川県衛生研究所／茅ヶ崎保健福祉事務所／全国保健所長会
	織田　信生	アーティスト
	小野さや香	アーティスト
	樫本　　修	宮城県リハビリテーション支援センター
	片岡　博喜	愛知県師勝保健所
	上小鶴正弘	(独)国立印刷局東京病院
	川崎　洋子	全国精神保健福祉会連合会「みんなねっと」
	川関　和俊	東京都立中部総合精神保健福祉センター

北端　裕司　国保日高総合病院
吉川　武彦　全国精神保健福祉連絡協議会
黒田　安計　さいたま市こころの健康センター
小泉　典章　長野県精神保健福祉センター
河野　稔明　(独)国立精神・神経医療研究センター精神保健研究所
鴻巣　泰治　埼玉県立精神保健福祉センター
小山明日香　熊本大学大学院生命科学研究部脳機能病態学分野
坂田　増弘　(独)国立精神・神経医療研究センター病院
佐藤　光正　駒澤大学文学部
四方田　清　順天堂大学
白川　教人　横浜市こころの健康相談センター
高橋　祥友　防衛医科大学校防衛医学研究センター
田辺　　等　北海道立精神保健福祉センター
田上美千佳　東京都精神医学総合研究所
趙　　香花　(独)国立精神・神経医療研究センター精神保健研究所
角田　　秋　聖路加看護大学
永岡　秀之　島根県立心と体の相談センター
中島　豊爾　岡山県精神科医療センター
長沼　葉月　首都大学東京
長沼　洋一　(独)国立精神・神経医療研究センター精神保健研究所
永野貫太郎　第二東京弁護士会
中村江美子　井之頭病院
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　　研究代表者　竹島　正
発 行 所　独立行政法人 国立精神・神経医療研究センター精神保健研究所
　　〒187-8553　東京都小平市小川東町4-1-1
　　TEL：042-341-2712(6209)　　FAX：042-346-1950