Table 9–13. Psychosocial intervention strategies for treatment-resistant schizophrenia

The selection of appropriate and effective psychosocial treatments needs to be driven by the individual patient's needs and his or her social circumstances.

- Cognitive-behavioral therapy (CBT) is focused on patients with persistent delusions and hallucinations based on a cognitive model of psychopathology. Cognitive-behavioral approaches have small to medium effect sizes on positive symptoms, negative symptoms, community functioning, hopelessness, and social anxiety.
- Cognitive remediation aims to improve cognitive functioning through stimulation of impaired areas of cognition and teach patients strategies to compensate for deficits. Cognitive remediation approaches are associated with small to medium effect sizes for cognitive performance (medium), psychosocial functioning (slightly lower), and symptoms (small). Cognitive remediation yields greater benefits in functional outcomes when combined with adjunctive psychiatric rehabilitation than when provided alone.
- Case management is the coordination, integration, and allocation of care according to the needs of each individual. Assertive Community Treatment (ACT) is a multidisciplinary approach to community-based care that delivers treatment and care for patients with serious mental health problems in the community.
  - Whereas case management reduces the number of hospital days but increases the number of total admissions, ACT reduces both.
  - Case management and ACT have shown some efficacy in reducing family burden, cost of care, symptoms, and dropout rates; increasing family and patients' satisfaction with services and patients' contacts with services; and improving social functioning.

levels was associated with greater improvements in quality of life. This suggests that patients who experience more improvement in symptoms with a better pharmacological treatment have a greater potential to benefit from psychosocial treatments.

Cognitive-Behavioral Therapy

It is well documented that psychotic symptoms are only weakly correlated with psychosocial functioning, given that they respond to antipsychotic medications and that their severity can vary dramatically throughout the illness course. However, some evidence indicates that worsening of psychotic symptoms (Angell and Test 2002) and persistence of psychotic symptoms (Racen-

stein et al. 2002) can reduce social and work functioning. Alternative approaches to treatment-resistant psychotic symptoms are needed that can ameliorate both the distress caused by the symptoms and the functional impairment that accompanies them.

CBT initially was focused on patients with persistent delusions and hallucinations based on a cognitive model of psychopathology. According to the model, current psychotic symptoms are seen as resulting from misattributions of perceptions of events prompted by viewing them through the prism of a faulty developmental belief structure, exacerbated by ongoing logical errors. These faulty attributional styles are also enhanced by a tendency to "jump to conclusions" and personalizing bias. More recently, greater attention has been paid to applying the cognitive model of psychosis to negative symptoms (Kern et al. 2009). In schizophrenia, the development of positive symptoms and underlying cognitive deficits results in many experiences that might be taken as disgraceful failures, such as being unable to attend in school, follow conversations with friends, succeed at a job, or manage hygiene. Negative symptoms are conceptualized as understandable, but maladaptive, responses to these circumstances. The behaviors and attitudes that are related to negative symptoms likely reflect, at least in part, negative self-beliefs.

Although some variability exists within the school of CBT, Garety et al. (2000) noted that all CBT includes the following components: 1) engagement and assessment; 2) coping enhancement; 3) developing a shared understanding of the experience of psychosis; 4) working on delusions and hallucinations, often using gentle challenging; 5) addressing mood and negative self-evaluations; and 6) managing the risk of relapse and social disability.

A review of CBT concluded that although more studies are needed, the evidence to date supports adjunctive use of CBT with antipsychotic medications for persistent psychotic symptoms of schizophrenia (Turkington et al. 2006). A more recent meta-analysis of RCTs comparing CBT with a control group, including primarily patients with schizophrenia and some who were treatment resistant, found that CBT had small to medium effect sizes (d=0.19–0.44) on positive symptoms, negative symptoms, community functioning, hopelessness, and social anxiety, whereas the number of cited studies ranged from 2 (for social anxiety) to 32 (for positive symptoms) (Wykes et al. 2008). NICE guidelines recommend the use of CBT for the treatment of persistent psychotic symptoms rather than for acute symptoms (National Institute for Clinical Ex-

cellence 2002). These guidelines suggest that the benefits of CBT are most marked when treatment is continued for more than 6 months and involves more than 10 treatment sessions. Finally, CBT is highly manualized and is designed to be independently mastered by practicing clinical psychiatrists, psychologists, and community mental health professionals, in contrast to other psychosocial treatments with requirements for expertise or supervision.

Cognitive Remediation

Cognitive deficits are now recognized as a core feature of schizophrenia that is strongly related to functioning in the community and also a strong predictor of response to psychiatric rehabilitation. Because the effects of pharmacological approaches targeting cognitive deficits have been rather more limited than initially expected, cognition-enhancing agents or psychosocial treatments are urgently needed for patients with severe mental illnesses and poor functioning. Cognitive-enhancing psychosocial approaches aim to improve cognitive functioning through stimulation of impaired areas of cognition, such as attention, memory, and problem solving. The approach is based on the neuroplasticity model of brain development, in which it is believed that engaging in tasks that challenge particular neural processes will enhance those functions. The goal of these cognitive remediation programs is to improve cognitive functioning and teach patients strategies to compensate for deficits. The different approaches of cognitive remediation include personal or small-group sessions; computer-based programs or paper-and-pencil exercises; teaching strategies to improve cognitive functioning; compensatory strategies to reduce the burden of cognitive capacities; group discussions; bridging the exercises in the program to daily living activities; and emphasizing meta-cognitive processes such as learning styles.

Results of a meta-analysis of 26 RCTs of cognitive remediation in schizophrenia including 1,151 patients were reported by McGurk et al. (2007). The investigators suggested that cognitive remediation was associated with significant improvements across all three outcomes, with a medium effect size for cognitive performance (0.41), a slightly lower effect size for psychosocial functioning (0.36), and a small effect size for symptoms (0.28). The effects of cognitive remediation on psychosocial functioning were significantly stronger in studies that provided adjunctive psychiatric rehabilitation than in those that provided cognitive remediation alone.

Case Management and Assertive Community Treatment

Since the 1960s, the movement toward deinstitutionalization pushed large psychiatric hospitals to close down and to treat patients in outpatient clinics, day centers, or community mental health centers. However, readmission rates were such that this type of community was thought to be less effective than expected. In the 1970s, case management along with ACT arose as a new means of community-based care of severely mentally ill patients.

Case management. Many patients with schizophrenia have a broad range of needs for health and social care. Case management is the coordination, integration, and allocation of care according to the needs of each individual. Case management includes the following components: 1) psychosocial needs assessment, 2) individual care planning, 3) referral and linking to appropriate services or supports, 4) ongoing monitoring of the care plan, 5) advocacy, 6) monitoring the patient's mental state, 7) compliance with medication and possible side effects, 8) establishment and maintenance of a therapeutic relationship, and 9) supportive counseling.

Assertive Community Treatment. ACT is a specific model of community-based care that delivers treatment and care for patients with serious mental health problems in the community who are at risk for hospital readmission and whose symptoms cannot be maintained by more conventional community-based treatment. ACT involves a multidisciplinary approach in which a team of social workers, nurses, psychiatrists, and other health professionals work together to provide all psychiatric and social care for the patient. ACT is provided exclusively for a group of patients defined as having "serious mental illness." Care is provided at home or in the workplace and involves assertiveness with patients who are uncooperative and reluctant service users. The specific goals of the treatment are 1) monitoring patients who are unwell but do not require hospital admission; 2) reducing the number of hospital admissions; and 3) improving patients' social functioning and quality of life within the community in which they reside.

Efficacy of ACT and case management. In regard to ACT, a Cochrane review (Marshall and Lockwood 1998) indicated that, compared with patients receiving standard community care, those receiving ACT were more likely to remain in contact with services and less likely to be admitted to the hospital;

they also spent less time in the hospital. In addition, ACT showed a better outcome than standard community care in the domains of accommodation, employment, and patient satisfaction, whereas no differences were seen between ACT and control treatments on mental state or social functioning. Therefore, it was implied that ACT is an effective approach for the care of severely mentally ill patients in the community, especially for the high users of inpatient care.

Evidence on the effects of case management has been contradictory. A Cochrane review (Marshall et al. 1998) presented a negative view of the effectiveness of case management other than ACT on several domains. The review found indications that case management retained more people in contact with psychiatric services and also increased hospital admission rates. However, except for a positive finding on compliance from one study, case management showed no significant advantages over standard care on any psychiatric or social variables.

A meta-analytic review by Ziguras and Stuart (2000) proposed an alternative view of the effectiveness of case management. These investigators analyzed 44 studies (compared with 11 in the Cochrane review); 35 compared ACT or clinical case management with usual treatment, and 9 directly compared ACT with clinical case management. Because Ziguras and colleagues believed that ACT and case management share common features to a great extent, they referred to those studies on ACT and case management collectively rather than separately, unlike the Cochrane review. Moreover, they included quasi-experimental studies in addition to RCTs, whereas the Cochrane reviewers used RCTs only. Furthermore, Ziguras and Stuart included domains measured with nonpublished scales and also parametric analysis of skewed data, both of which were excluded in the Cochrane review. These differences resulted in greater statistical power with a larger data set (Ziguras and Stuart 2000; Ziguras et al. 2002); consequently, both types of case management were found to be more effective than usual treatment in three outcome domains: family burden, family satisfaction with services, and cost of care. The total number of admissions and the proportion of patients hospitalized were reduced in ACT and increased in case management. The number of hospital days was reduced in both programs, but ACT was significantly more effective than case management. Although patients in case management had more admissions than did those in usual treatment, the admissions were shorter,

which reduced the total number of hospital days. The two types of case management were equally effective in reducing symptoms, increasing patients' contacts with services, reducing dropout rates, improving social functioning, and increasing patients' satisfaction (Ziguras et al. 2002).

Although these two reviews of case management appear to contradict each other, the results were curiously the same for the two domains common to both analyses. Both studies found that case management was effective in preventing patients from dropping out of services and led to a greater proportion of patients being hospitalized. However, Ziguras and Stuart (2000) found a range of other domains in which case management showed benefit and concluded that it produced small to moderate improvements in care provided to people with a serious mental illness. In a conflictual relationship between increasing statistical power and adherence to rigorous methodology, the partial overlap in the results of the Cochrane review (Marshall et al. 1998) and the meta-analytic reviews of Ziguras and colleagues (Ziguras and Stuart 2000; Ziguras et al. 2002) implies that methodologies other than randomized controlled designs do not necessarily provide a lower level of evidence when reviewing valid psychosocial interventions.

Conclusion

Refining the definition of treatment resistance holds both advantages and disadvantages. Consensually developed definitions may yield good criteria to guide the use of specialized treatment agents such as clozapine. Broader definitions may provide more chances for patients to receive trials of such treatments. But what if those trials end up in failure? Because we have few pharmacological options beyond the step of using clozapine, definition may lead to additional serious stigma. The definitions of treatment resistance widely accepted today actually represent "drug resistance," to the extent that psychosocial approaches are ignored or inadequately implemented. Now that we have more resources in terms of psychosocial treatments, we surely need to take these approaches into consideration in future efforts to define true treatment resistance. We should keep in mind that our ultimate goal is not merely to broaden the criteria; rather, it is to ensure that no patient remains in a state of treatment nonresponse.

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総説

「統合失調症の社会的機能をどのように測定するか」
How is social functioning of schizophrenia measured?

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抄録:
精神障害を持つ人が当たり前に地域で暮らすことは重要な治療目標であるために、社会生活能力の評価は重要である。また神経・社会認知機能の重要性が注目され、脳機能の解明や、改善のための介入研究のアウトカムとしての社会機能の評価が重要視されるようになっている。 本論では社会機能を評価する上での視座を明確にし、現状でよく使用されている社会機能の評価尺度を簡潔に紹介し、開発が望まれる評価方法について論じ、臨床場面や研究において社会機能の評価をどう行っていくことができるかを紹介している。測定ツールを分類する基軸としては、行う能力・実世界での行動、主観的評価・客観的評価、評定・行動測定などがある。実世界での行動を評価する尺度として、NIMH-MATRICS のプロセスと並行して 6 つの尺度が選定されており、それぞれの特徴について概説した。ほとんどの測定方法は、情報提供者への面接に基づく客観評価である。診察室などの場でパフォーマンスを求めてその評価を行うのが「行う能力」であるが、行う能力の評価については課題遂行能力については広く用いられている尺度が存在するが、対人スキルや社会的問題解決能力についてはそうした尺度がまだ存在しない。生活環境、年齢や性別や置かれている文化によって、取るべき対人行動が大きく異なることがその原因の一つであろう。診察室で測定できる脳機能と、行う能力や実世界での行動をつなぐ変数として、内発的動機づけ、メタ認知、自己効力感、得られる支援や置かれている環境などがあり、相互の関連性が低くなる要因と考えられる。臨床でアセスメントを行うには、狭義の社会的機能だけではなく、こうした介在変数や、希望や支援のニーズなどの主観的評価、もともとの機能や障害の影響を知るうえでの生活歴が必要であり、評価尺度だけでは不十分である。介入研究の効果測定には客観的行動評定の尺度などが有用である。

索引用語: 社会的機能、統合失調症、実世界での行動、行う能力、　パフォーマンステスト

Summary:

Measuring social functioning of schizophrenia has been becoming important clinical issue in era of community care where persons with mental illness can live as a citizen. Importance of neuro- and social-cognitive functions for outcome of schizophrenia focuses on researching brain functioning of these functions, and social functioning as a co-primary outcome measure of intervention. In this review, the viewpoint of measuring social functioning is clarified, usual used and recommended assessment scales are introduced, methods to be developed for measurement are discussed, and how to measure social function in clinical and research settings is summarized. The axes of classifying measures are functional capacity/ real world functioning, subjective/ objective evaluation, rating/ observing behaviors, and so on. Six social functioning scales were chosen as recommended scales in the study of real world functioning as a co-primary measure in NEMH-MATRICS. Almost all scales are objective rating with interview of informants. Functional capacity or competence is evaluated in performance tasks. While the scale of processing tasks of everyday function (UPSA) was recommended in many studies, there is no standard for assessing social skills or social problem solving skills, because these skills are much different depending on sex, age, and culture. Intervening variables among neuro /social cognitive functioning, functional capacity, and real world functioning are intrinsic motivation, meta-cognition, self-efficacy, expected support, and environment and support which might decrease association of basic cognition and functional outcome. In clinical setting, these intervening variables, hope and subjective evaluation of support needs, and life history about previous capacity are needed as well as assessment scales to make a plan for intervention. Objective assessment scales are useful for measuring effects of intervention.

（訳は邦文抄録に同じ）

Key words: social functioning, schizophrenia, real-world functioning, functional capacity, performance test

Ⅰ．本論の問題意識及び目的

わが国の治療文化からも医療・福祉制度の上でも、精神障害を持つ人たちが当たり前に地域で暮らすことが治療の目標になる中で、社会生活能力評価が重要な課題になりつつある。

英国では，脱施設化が進行した1950年代に集中して評価尺度が開発された。これらの尺度は，どのような入院患者が地域での自立生活を送ることが可能か，また安定した生活を予測する因子は何かといった地道な研究から生まれた。Wingの Ward Behavior Rating Scale (WBRS)[33]はその先駆である。WBRSはその後,WHOの作製したPsychiatric Disability Rating Scale (DAS) [31]の「病棟内行動尺度」に発展し，また地域生活をおくる患者に適用できるSocial Behavior Schedule (SBS) [34]に発展した。米国でも，脱施設化の進んだ1960～1970年代にかけて，社会的な機能を評価する尺度が多数開発された。それらについてはよい総説 (Anthonyら[1]， Wallace[30]，Bakerら[2]) がある。わが国においても，1980年代には，多くの尺度が開発されている[15,35,36]。しかし，社会機能を評価する手法で、標準的に用いられる尺度はまだ見あたらないといってよい。それは，社会機能が多岐にわたり，また社会の価値観が評価に含まれざるを得ないこと，性差、文化差、年齢などの社会的立場によって、適切な社会行動が大きく変化せざるを得ないこと、行動レベルでは把握できない評価内容も含まれることなどの原因による。社会機能という呼称に包含される概念もさまざまといってよい。しかしこうした困難を超えて、標準的な社会機能の評価を確立することは、社会生活を改善する介入の標的を明確にし、効果を確定するうえでゆるがせにできない喫緊の課題である。

近年はまた、神経認知機能や社会的認知機能の重要性が注目され、脳機能の解明や、改善のための介入研究が行われるようになっており、そのアウトカムとしての社会機能の評価が重要視されるようになっている。米国では大規模なプロジェクトとして、the National Institute of Mental Health Measurement and Treatment Research to Improve Cognition in Schizophrenia (NIMH-MATRICS)[20]が立ちあげられ、統合失調症の認知機能改善のための創薬の試みがおこなわれている。その中で神経認知機能の評価のための神経心理テストバッテリーの標準化作業が行われた。同時に、患者や家族にとって認知機能よりも意味の大きな日常生活機能の改善に対しても評価を行い、認知機能改善薬が社会的に妥当なものであることを裏付ける必要性から、MATRICSでは、もうひとつのエンドポイント (co-primary measure) としての社会機能の評価についても検討が行われた[10]。この論文でGreenらは、地域生活の実際を評価することは、環境や個人の生活経験など様々な媒介因子があって、直接的に認知機能を反映しない可能性があることや、認知機能の改善があっても、地域生活の改善をもたらすまでにはタイムラグがあったり、治験では統制できないさまざまな要

因（心理社会的リハビリテーションの有無、社会的サポート、雇用・経済情勢など）があることから、もう一つのエンドポイントとしては適切ではないと考え、認知機能の変化を直接反映するであろう評価手法として、「実際に地域でやっていることを評価する」のではなくて、「どの程度行う能力を持っているか」（functional capacity または competence）と、「患者がどの程度認知機能障害を認識しているか、そしてそれがどの程度日常生活を障害していると感じているか」を評価するやり方を選択した。そして 4 種の評価ツールが選ばれたが、これらは神経認知機能との相関がみられる一方、実際の社会生活（real-world functioning）との関連は必ずしも高くないことから、Green らは結論として、まだ一つの尺度を選択する段階ではないとしている。行う能力(functional capacity)についても、まだ標準版はないということである。

本論においては、まず多様な社会機能を評価するうえでの視座を明確にし、これらの視座に沿って現状でよく使用されている社会機能の評価尺度を簡潔に紹介したうえで、それぞれの評価方法の利点と限界を明らかにし、開発が望まれる評価手法について論じたい。さらに現状をふまえて、臨床場面や研究において社会機能の評価をどう行っていくかについても触れたいと考える。

Ⅱ．これまでの社会機能測定ツールの現状

（1）測定ツールはどのように分類できるか

測定ツールを分類する基軸としては以下のものがあげられる。1）どの水準の社会機能を評価するのか（行う能力・実世界での行動）、2）誰が評価するのか（主観的評価・客観的評価）、3）どのような評価方法であるのか（評定・行動測定）、4）どのような目的を持っているのか（治療開始前のアセスメント（機能評価）と援助プランの作成・治療の進展を把握するためのモニタリング・治療の効果を明らかにするための効果判定）、5）どのような社会生活領域を評価するのか（居住・日常生活技能・対人技能・職業生活など）。

1）どの水準の社会機能を評価するのか（行う能力・実世界での行動）

診察室などの場で与えられた社会機能の課題についてのパフォーマンスを求めてその評価を行うのが「行う能力」であり、病院の診察のための予約の電話を掛ける課題、物品を購入してお釣りを計算する課題、隣人と会話をつづける課題などである。「行う能力」の評価の意義についての Green らの見解についてはすでに前述した。それに対して、一般的には社会機能の評価でイメージされるのが「実世界での行動」の評価である。どのように情報収集を行うかで、ケアしている人へのインタビューを行う、本人に記述してもらう、日常生活の場で行動観察する、診療録などの記録をもとに評価する、これらの手段をいくつ

か組み合わせて行う、などの方法がある。行う能力と実世界での行動の間には、当然一定の連関があるはずであるが、先に述べた要因から必ずしも現実の評価結果においては密接な相関がみられるわけではない。この問題については、また改めて考察する。

Bowie ら[6]は認知機能リハビリテーション及び社会的スキルへの介入プログラムの効果を検討するにあたり、①神経認知機能を Brief Assessment of Cognition in Schizophrenia (BACS) で評価し、②行う能力のうち対人スキルについては the Social Skills Performance Assessment(SSPA) を用い、課題処理スキルについては UCSD Performance-based Skills Assessment(UPSA)、The advanced finances test (小切手を書く、紙幣で支払いをする、口座に残金を残す、収支のバランスを考えるなどの課題) 、The Medication Management Ability Assessment (ロールプレイで複数の処方薬剤を正確な量と時間に服薬する) を用いている。そして③実世界での行動 (real-world functioning) については、the Specific Levels of Functioning Scale(SLOF)により、行動を観察して5段階判定した。このように介入を行ったときに標的となった機能とともに、その影響がどの程度日常生活に及んでいるかを区別して評価することが、理論的には望ましい方法と思われる。

2) 誰が評価するのか (主観的評価・客観的評価)

当事者であるのか，他者であっても治療者であるのか，それ以外の専門家であるのか，家族を含めた関係者であるのかによって，得られる情報は異なる。どの評価者を選択するかは、どのような情報を得たいと思うかによって決まってくるし、どちらがどちらの代替となるという関係ではない。

3) どのような測定方法であるのか (評定・行動測定)

評定は「ほぼあてはまる、当てはまらない」などの判断を交えて評価を行うものであり、行動測定は一定の行動の生起の有無や頻度を評価するものである。前項も含めて、本人による行動報告 (または自己行動監視法) や自己評定と、観察者による行動測定と評定に分けられる。容易に想像されるように、行動測定や本人による行動報告は客観性に優れ，行動療法の効果判定など，研究面で広く用いられている。Time-Sample 法がその代表であろう。しかし要援助かどうかなどの判定には，社会的価値観などの介在する観察者や自己による評定が重要になってくる。具体例を挙げると，一定時間に何秒相手と視線を合わせていたかの測定は行動評価に属し，視線の合わせ方が社会的に適切かどうか，対人技能を損なう (本人が困っている) ので援助が必要かどうかの判定は，行動 (自己) 評定に属する。

４）どのような目的を持っているのか

入院中、デイケアなどでのリハビリテーション中、老齢者など、被験者の生活しているセッティングや状況によって、想定する機能水準が異なる。

さらに評価によって何を獲得したいかということによっても、尺度の構成は異なってくる。臨床場面で，個人の治療・援助に役立てるアセスメントにあたっては，さまざまな生活領域について検討を加え，介入の方策を立てることが必要で，直接の行動観察，面接，自記式調査票などが用いられる。治療の進展度や，その後の治療目標や介入技法の修正のために行う評価がモニタリングで、自己評価法，治療場面での行動観察，家族などによる報告などが用いられる。治療効果判定にあたっては，新たな能力の獲得の程度，その能力は実際の生活でどこまで活用されているか、日常生活全般の改善度について，階層的に考える必要がある。

５）どのような社会生活領域を評価するのか

入院しているのか、仕事をしているのか、結婚して子育てしているのかなどにより、社会生活領域の重みが異なり、取り上げる評価領域がさまざまなことが、標準化が困難な原因の一つとなっている。実際に日常生活でどのような行動を行っているのか、そして支援の必要性がどの程度であるかを知ろうとする際には、環境評価も重要な領域である。半身麻痺の例を挙げるとわかりやすいが，どの筋に萎縮があるか，歩行が可能かどうか，近くの店まで買い物に行けるかどうかは，それぞれ関連しているもののある程度独立した事象である。ことに 3 点目については，車椅子が使えるか，傾斜路ができているか，援助してくれる人がいるかなど，周囲の環境によって規定される部分が大きい。

さらに社会機能の評価を複雑にする要因として、実際の社会生活では問題行動や症状などが適応に大きな影響を与えるために、それらが含まれている尺度がみられる。

（２）推奨されている社会的機能の評価尺度はどのような特徴を持っているか

１）実世界での行動を評価する尺度

Leifker ら[19]は、NIMH-MATRICS のプロセスと並行して、実世界での社会機能の尺度策定に取り組んでいる。Validating of Everyday Real World Outcomes (VALERO) study と名付けたプロジェクトで、エキスパートによるパネルを構成し、MATRICS によって神経心理テストが選定されたのと同様のプロセスによって、既存の尺度から推奨できる「実世界での行動」評価尺度を選定する作業を行った。まず 59 尺度が選定され、パネルによる討論を経て、社会機能（人付き合いなど)、日常生活能力（家事など)、前述の 2 つの混合を評価する尺度から 2 つずつの合計 6 尺度が選定された。それは以下のものである。

・Quality-of-Life Scale　(QLS,混合尺度)

・Specific Levels of Functioning Scale　(SLOF,混合尺度)

・Social Behavior Schedule　(SBS,社会機能)

・Social Functioning Scale　(SFS,社会機能)

・Independent Living Skills Survey　(ILSS,日常生活能力)

・Life Skills Profile　(LSP,日常生活能力)

なおVALEROでは、統合失調症の当事者による自己評価は、その他の情報提供者に基づく評価との相関が低いことを指摘している。

さらに、MATRICSでの議論を受けて、Kleinmanら[16]が新たに神経認知機能を反映すると想定する社会機能評価尺度　The Schizophrenia Outcomes Functioning Interview (SOFI)を開発した。エキスパートによりまず評価の4領域が選ばれ、これまでの評価尺度を調べて362項目を抽出し、4領域に配置した。さらに122項目が追加された後で、最終的な項目を絞り込んだ。その後信頼性、妥当性、実用性などにつき、検証が行われた。そこで以上の7尺度について、Ⅱ．これまでの社会機能測定ツールの現状、(1)測定ツールはどのように分類できるか、の項で紹介した2)～5)の項目に対応付けて表1にまとめた。なお1)どの水準の社会機能評価するのか(行う能力・実世界での行動、については、いずれの尺度も実世界での行動についての尺度であるため省いてある。

(表1)

2)「行う能力」を評価する尺度

前述したように、Greenらは「行う能力」と、「認知機能障害の認識」を評価する尺度を検討し、以下の4種の評価ツールが選ばれた。

・行う能力の評価

The Maryland Assessment of Social Competence (MASC)

The UCSD Performance-Based Skills Assessment (UPSA)

・面接による認知機能の認識についての評価：患者及び情報提供者への面接を実施して評価

Schizophrenia Cognition Rating Scale (SCoRS)

Clinical Global Impression of Cognition in Schizophrenia (CGI-CogS)

これらの4種類の尺度は、MATRCISの5つの施設で、テスト―再テスト信頼性、反復測定の可能性、神経心理テストによる認知機能評価との相関、実際の地域生活評価との相関、実用性・患者の耐性が検討され、いずれも尺度としては妥当かつ有用なものであると結論付けられたが、神経認知機能評価との関連はUPSAが高かった。実際の地域生活の評価との相関は、4種ともあまり高くなかった。その後の効果研究では、介入の主要なアウトカム指

標の一つとしてUPSAがよく利用されるようになっている。UPSAの概観を表2に示した。

（表2）

Bowieら[5]は、a.神経認知機能と、b. UPSAで評価した課題処理能力とロールプレイで評価する対人適応能力と、c.実際の日常生活評価とを評価して、それぞれの関係についてパス解析を行っているが、神経認知機能は、2種類の能力（課題処理及び対人適応）を介在して、もしくは直接に、実際の日常生活に影響を与えていること、対人適応能力は日常の対人関係と、社会適応能力は地域生活や家事への従事と関連があるなど、評価領域によって異なる関連性があることが報告されている。

これまで述べてきたように「行う能力」は対人機能と課題処理能力に分けて考える必要がある。対人機能はさらに、人と親しく付き合い信頼関係を気づいていくための親和的技能と、社会的な目的を達成するための道具的技能もしくは社会的問題解決能力に分けられる。対人機能について「行う能力」を測定するツールは、評価を行う場所でなんらかの社会的な状況を設定し、その設定に沿って被験者と検査者とがロールプレイを行う形で行われる。文献上よく使われている3種類の対人機能評価ツールと、筆者が作成にかかわった改訂版ロールプレイテストとを表3に示す。

（表3）

Maryland assessment of Social Competence (MASC)[3]は社会生活の6場面をビデオ提示し、会話の能力を評価する。Social Skills Performance Assessment (SSPA)[22]は2場面において親和的技能と道具的技能を評価する。Assessment of Interpersonal Problem-Solving Skills (AIPSS)[9]は社会的問題解決が必要な13場面について評価する。改訂版ロールプレイテストは受信・処理・送信技能の3段階を評価できるのが特色である。

なお本論においては評価尺度の様々な略語が出現するので、読者の便宜のためその一覧を表4に掲げる。

（表4）

（3）評価水準の違いに基づく特徴

1）「実世界での行動」の評価

表1で示した7尺度ともに客観的評価であり、実世界での社会機能を測定するためにはやはり客観的評価がよいことがわかる。主観的評価は、本人が生活の質をどう評価するかを知り、援助を組み立てていくうえで抜きがたい重要な情報である。

測定の方法の上では、情報提供者への面接が多く、情報提供者による尺度記入も見られる。評価者自身がつぶさに実際の生活を観察することは実際には困難であるので、care giverによる情報の確度が高く実用的であるためと思われる。より確度を高めるために、面