

図1 精神科病院における平均退院率の推移
 平均退院率：前年6月1か月間の新入院患者のうち、前年6月～当年5月の各月末時点までの累計退院患者数の平均値を、前年6月1か月間の新入院患者数で割った値。

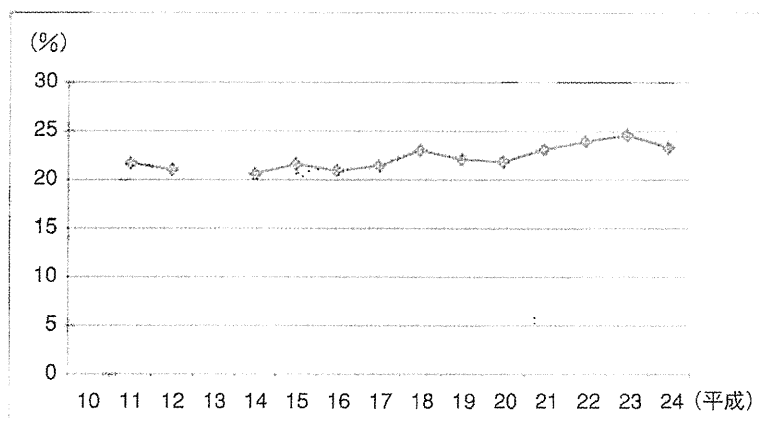


図2 精神科病院における退院率(1年以上群)の推移
 退院率(1年以上群)：在院期間が1年以上の在院患者における当年6月1か月間の退院患者数を12倍して1年間の退院患者数相当と見なし、当年6月30日現在の在院期間が1年以上の在院患者数で割った値。平成11年から算出しており、平成13年の退院率については調査票改訂における調査対象年の変更により値が欠落している。

たため、本節でも平均退院率を用いる。両者は平均退院率=100-平均残存率(%)の関係にあるので、平均退院率の目標値は76%以上となる。」「各都道府県の退院率(1年以上群)を29%以上とする」という目標値を示したが、平均退院率および退院率の算出には、630調査の項目に含まれる入退院の動態に関する数値の把握が不可欠であった⁷¹⁸⁾(「精神保健福祉資料」より、平均退院率は、前年の6月1か月間の新入院患者のうち、前年6月～当年5月の各月末時点までの累計退院患

者数の平均値を、前年6月1か月間の新入院患者数で割った値、また退院率は、在院期間が1年以上の在院患者における当年6月1か月間の退院患者数を12倍して1年間の退院患者数相当と見なし、同年6月30日現在の在院期間が1年以上の在院患者数で割った値として求められる)。平均退院率については、改革ビジョンの示された平成16年は69.9%、平成24年は70.9%と増加している(図1)。退院率は平成16年は21.6%、平成24年は23.3%である(図2)。両指標とも改善の

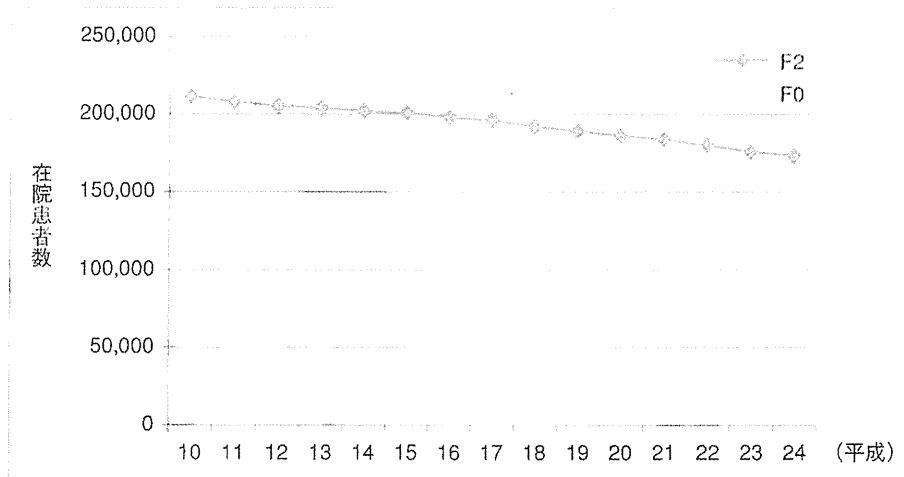


図3 統合失調症等(F2)と認知症等(F0)による在院患者数の推移

F2：統合失調症，統合失調症型障害および妄想性障害(統合失調症等)，F0：症状性を含む器質性精神障害(認知症等)

傾向にはあるものの、改革ビジョンに示された目標値の達成は困難な状況となっている。平成21年に公表された、改革ビジョンの後期5か年の重点施策群を策定した「今後の精神保健医療福祉のあり方等に関する検討会報告書」では、新たに統合失調症と認知症の在院患者に関する目標値の設置の必要性が指摘され、前者については後期5か年の間にその数を約15万人以下にするとの目標値が示された。平成10年から平成24年にかけての統合失調症、統合失調症型障害および妄想性障害(F2, 以下統合失調症等)、症状性を含む器質性精神障害(F0, 以下認知症等)の在院患者数の推移を図3に示した。統合失調症等による在院患者は一貫して減少しており、目標値の示された平成21年から平成24年にかけては、18万3,700人から17万3,417人に減少している。統合失調症等の人口万対患者数については、都道府県ごとに大きな差があり、人口減少の続く、人口万対患者数の多い地域で、いかに改革の取り組みを進めることができるかは大きな課題である。認知症等による在院患者は一貫して増加しており、平成21年は6万4,329人、平成24年は6万8,183人であった。今後の高齢化の進行を踏まえると、認知症等による入院患者数はさらに増加する可能性がある。

630調査データを用いた研究

小山らは、平成16年度630調査の県別集計値を用い、各県の平均残存率と精神科医療保健福祉に関する指標との関連について分析を行った。その結果、病院勤務のコメディカルスタッフあたりの患者数が多い県、精神病床数に占める精神療養病床の割合が低い県、また九州地方において平均残存率が高かった⁹⁾。1年未満在院者から算出する平均残存率と、主に長期在院者が占める精神療養病床割合との相関について、著者らは療養病床の割合がその都道府県における精神科医療の機能分化の状況と関連しており、機能分化が進んだ県では、結果として低い平均残存率と関連している可能性があると考えしている。また、十分なコメディカル人員の確保とチーム医療の重要性や、改革ビジョンに示された平均残存率の数値目標は各都道府県共通となっているが、実際の達成度を評価する際には地域特性を考慮する必要があると指摘している。

長沼らは精神科病院における精神科デイ・ケア等の実施件数の多寡と退院に関する指標[平均残存率、1～12か月時点退院率、退院率(1年以上)、社会復帰率]の関連を分析している¹⁰⁾。対象となった病院は、精神病床数あたりのデイ・ケア等利用者数の中央値により、デイ・ケア等の

件数の多い病院と少ない病院に群別され、両群間で退院に関する指標の平均値が比較された。件数の多い病院群では、平均残存率は有意に低く、3~12か月時点退院率、退院率、社会復帰率は有意に高かった。1か月時点、2か月時点退院率も件数の多い病院群で高かったが、有意差はなかった。著者らはこの結果から、病床規模に比べてデイ・ケア等の件数が多い病院では、少ない病院に比べ新規入院患者の退院までの期間が短く、また入院期間が比較的長期にわたる患者についても、より早期の退院となる可能性を指摘している。

竹島らは、精神療養病棟は病床ベースで27%にも及び、実態としてその機能は多様になっている可能性があることから、異なる入院料病棟の間で在院患者の特性(年齢、在院期間)を比較した¹¹⁾。さらに、専門病棟の設置時期やそれと職員配置との関連を調査し、精神科病院の機能分化における精神療養病棟の役割を検討した。その結果、精神療養病棟は、他の特定入院料病棟よりも在院患者の年齢および在院期間が広く分布し、実態として担っている機能が多様となっていることが示唆された。また精神療養病棟の設置は、その後の職員配置の充実や、それにより可能となる急性期型の専門病棟の設置への基盤づくりに寄与してきた可能性があることが示唆された。

今後の630調査の展望

平成25(2013)年精神保健福祉法改正に伴い、入院医療中心の精神医療から精神障害者の地域生活を支えるための精神医療への改革の実現に向け、精神障害者に対する保健・医療・福祉に携わるすべての関係者が目指すべき方向性として「良質かつ適切な精神障害者に対する医療の提供を確保するための指針」が定められた。この指針は、(第1)精神病床の機能分化に関する事項、(第2)精神障害者の居宅等における保健医療サービス及び福祉サービスの提供に関する事項、(第3)精神障害者に対する医療の提供に当たっての医師、看護師その他の医療従事者と精神保健福祉士その他の精神障害者の保健及び福祉に関する専門的知識を有する者との連携に関する事項、

(第4)その他良質かつ適切な精神障害者に対する医療の提供の確保に関する重要事項で構成され、(第1)には、入院期間が1年未満の精神障害者に対する医療を提供するための体制の確保、重度かつ慢性の症状を有する精神障害者以外の、入院期間が1年以上の長期入院精神障害者に対する医療を提供するための体制の確保等の項目がある。改革ビジョンにおいて長期入院を1年以上とするという考え方が定まったが、それから10年を経過し、630調査等の分析結果を基に、長期入院の定義を短縮する日も遠くはないかもしれない。また、「地域における医療および介護の総合的確保を推進するための関係法律の整備等に関する法律」(医療介護法)が平成26(2014)年6月に成立し、今後の医療法の改正の中で、2025年に目指すべき医療機能別必要量等、医療提供体制の枠組みと実現方策が策定される見込みであり、精神科医療においても機能別必要量の算定方法の検討が課題となっている。そのことを踏まえ、平成26年度630調査においては、①精神科病院における平成26年1~6月の新入院患者、②精神科病院および精神科診療所等における平成26年6月30日外来受診者、③都道府県・政令指定都市が平成26年1~6月の6か月間に受理した通報等に関する追加調査を実施し、より実態を踏まえた、実効性の高い政策立案に寄与することを目的とし、今後の地域における精神保健医療福祉の充実に資することとしている。平成26年度調査は、今後の630調査のあり方と内容にも影響を与える可能性があるが、何よりも、630調査が国・都道府県の行政だけでなく、精神科医療の提供者、そして利用者である国民にも役立つ、公平な資料として提供されるよう、さらに努力を続ける必要がある。

文 献

- 1) 竹島 正, 小山明日香, 河野稔明, ほか. 「改革ビジョン」の進捗状況のモニタリングと評価に関する研究—「かえるかわる 精神保健医療福祉の改革ビジョン研究ページ」の改訂—. 平成21年度厚生労働科学研究費補助金(こころの健康科学研究事業)「精神保健医療福祉体系の改革に関する研究(研究代表者:竹島 正)」総括・分担研究報告書, 2010.

- p. 21.
- 2) 下田陽樹, 竹島 正, 立森久照. 精神保健医療福祉のモニタリングとしての630調査の経緯と今後の方向. 精神保健研究 2014 ; 60 : 3.
 - 3) 立森久照. 数字で押さえる精神保健医療福祉～630調査から見えること 精神保健福祉資料630調査とは? 公衆衛生情報 2011 ; 41 : 20.
 - 4) 立森久照. 精神病院・社会復帰施設等の実態データの収集方法とその有効活用に関する研究. 平成16年度厚生労働科学研究費補助金(障害保健福祉総合研究事業)「精神病院・社会復帰施設等の実態把握及び情報提供に関する研究(主任研究者:竹島 正)」総括・分担研究報告書. 2005. p. 45.
 - 5) 竹島 正, 河野稔明, 小山明日香, ほか. 「改革ビジョン」の進捗状況のモニタリングと評価に関する研究—「精神保健福祉資料」に係る電子調査票の開発と本運用—. 平成21年度厚生労働科学研究費補助金(こころの健康科学研究事業)「精神保健医療福祉体系の改革に関する研究(研究代表者:竹島 正)」総括・分担研究報告書. 2010. p. 9.
 - 6) 立森久照, 臼田謙太郎, 後藤基行, ほか. 630調査等による精神保健医療福祉のマクロ動向の分析に関する研究. 平成25年度厚生労働科学研究費補助金(障害者対策総合研究事業)「新たな地域精神保健医療体制の構築のための実態把握および活動の評価等に関する研究(研究代表者:竹島 正)」総括・分担研究報告書. 2014. p. 35.
 - 7) 竹島 正, 立森久照, 長沼洋一, ほか. 新たな精神病床算定式の合理性の検証と精神医療改革の実現に関する研究—新たな病床算定式による各都道府県別の基準病床数に関する研究—. 平成16年度厚生労働科学研究費補助金(厚生労働科学特別研究事業)「新たな精神病床算定式に基づく, 早期退院と社会復帰促進のための精神保健福祉システムに関する研究(主任研究者:竹島 正)」総括・分担研究報告書. 2005. p. 15.
 - 8) 立森久照, 長沼洋一, 小山明日香, 竹島 正. 精神保健医療の現状把握に関する研究. 平成19年度厚生労働科学研究費補助金(こころの健康科学研究事業)「精神保健医療福祉の改革ビジョンの成果に関する研究(主任研究者:竹島 正)」総括・分担研究報告書. 2008. p. 197.
 - 9) 小山明日香, 小山智典, 立森久照, ほか. 各都道府県の1年未満在院患者群の退院に関する指標「平均残存率」に関連する要因の検討. 日本社会精神医学会雑誌 2008 ; 17 : 159.
 - 10) 長沼洋一, 立森久照, 小山明日香, 竹島 正. 精神科病院における精神科デイケア等の実施状況と患者の退院状況の関連. 日本社会精神医学会雑誌 2008 ; 17 : 3.
 - 11) 竹島 正, 河野稔明, 立森久照, 森 隆夫. 既存の統計資料を用いた機能分化の現状分析と将来予測. 平成22年度厚生労働科学研究費補助金(障害者対策総合研究事業)「精神科病院の機能分化に関する実態の分析と方法論の開発に関する研究(主任研究者:山内慶太)」総括・分担研究報告書. 2011. p. 119.

* * *

Categories That Should Be Removed From Mental Disorders Classifications: Perspectives and Rationales of Clinicians From Eight Countries

Rebeca Robles,¹ Ana Fresán,¹ María Elena Medina-Mora,¹ Pratap Sharan,² Michael C. Roberts,³ Jair de Jesus Mari,⁴ Chihiro Matsumoto,⁵ Toshimasa Maruta,⁵ Oye Gureje,⁶ José Luís Ayuso-Mateos,⁷ Zeping Xiao,⁸ and Geoffrey M. Reed⁹

¹*National Institute of Psychiatry Ramón de la Fuente Muñiz*

²*All India Institute of Medical Sciences*

³*University of Kansas*

⁴*Federal University of São Paulo*

⁵*Tokyo Medical University*

⁶*University of Ibadan*

⁷*Universidad Autónoma de Madrid*

⁸*Shanghai Jiao Tong University*

⁹*World Health Organization*

Objective: To explore the rationales of mental health professionals (mainly psychiatrists and psychologists) from 8 countries for removing specific diagnostic categories from mental disorders classification systems. **Method:** As part of a larger study, 505 participants indicated which of 60 major disorders should be omitted from mental disorders classification systems and provided rationales. Rationale statements were analyzed using inductive content analysis. **Results:** The majority of clinicians (60.4%) indicated that 1 or more disorders should be removed. The most common rationales were (a) problematic boundaries between normal and psychopathological conditions (45.9% of total removal recommendations), (b) problematic boundaries among mental disorders (25.4%), and (c) problematic boundaries between mental and physical disorders (24.0%). The categories most frequently recommended for deletion were gender identity disorder, sexual dysfunction, and paraphilias, usually because clinicians viewed these categories as being based on stigmatization of a way of being and behaving. A range of neurocognitive disorders were described as better conceptualized as nonpsychiatric medical conditions. Results were analyzed by country and country income level. Although gender identity disorder was the category most frequently recommended for removal overall, clinicians from Spain, India, and Mexico were most likely to do so and clinicians from Nigeria and Japan least likely, probably because of social and systemic factors that vary by country. Systematic differences in removal rationales by country income level may be related to the development, structure, and functioning of health systems. **Conclusion:** Implications for development and dissemination of the classification

The World Health Organization Department of Mental Health and Substance Abuse has received direct support that contributed to the conduct of this study from several sources: The International Union of Psychological Science, the National Institute of Mental Health (USA), the World Psychiatric Association, the Spanish Foundation of Psychiatry and Mental Health (Spain), and the Santander Bank UAM/UNAM endowed Chair for Psychiatry (Spain/Mexico).

R. Robles, M. E. Medina-Mora, P. Sharan, M. Roberts, J. Mari J, C. Matsumoto, T. Maruta, O Gureje, J.L. Ayuso-Mateos and Z. Xiao are members of the WHO International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders or of Working Groups that report to the International Advisory Group. G. Reed is a member of the WHO Secretariat, Department of Mental Health and Substance Abuse, WHO. Unless specifically stated, the views expressed in this article are those of the authors and do not represent the official policies or positions of WHO.

Please address correspondence to: Geoffrey M. Reed, Department of Mental Health and Substance Abuse, World Health Organization, 20, Avenue Appia, CH-1211 Geneva, Switzerland; e-mail: reedg@who.int

of mental and behavioral disorders in WHO's ICD-11 are discussed. © 2014 Wiley Periodicals, Inc. The World Health Organization retains copyright and all other rights in the manuscript of this article as submitted for publication. *J. Clin. Psychol.* 00:1–15, 2014.

Keywords: mental disorders; classification; International Classification of Diseases (ICD); Diagnostic and Statistical Manual of Mental Disorders (DSM); clinical utility; psychologists; psychiatrists; stigma

The World Health Organization (WHO) is currently revising the International Classification of Diseases and Related Health Problems (ICD-10; WHO, 1992a), including the chapter on mental and behavioral disorders (WHO, 1992b). WHO considers that there are three major stakeholder groups for the ICD revision: (a) governments of WHO member countries, (b) mental health service users, and (c) health care professionals (International Advisory Group for the Revision of the ICD-10 Mental and Behavioral Disorders, 2011). The perspectives of mental health professionals who are in daily contact with persons requiring treatment are clearly important to inform the development of the classification of mental and behavioral disorders in ICD-11 (Reed, Correia, Esparza, Saxena, & Maj, 2011), and their direct participation in its development is expected to result in improved clinical utility of the classification.

Major problems with the clinical utility of both the ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association have been widely acknowledged (e.g., Andrews et al., 2009; First, 2010; Kendell & Jablensky, 2003). These include (a) the extensive use of “Unspecified” or “Not Otherwise Specified” diagnostic categories of limited informational value, (b) artificial and inflated comorbidity between mental disorders, (c) the fact that many of the distinctions clinicians are asked to make in diagnostic systems have no relevance for treatment, and (d) the overly complex nature of current diagnostic systems (Reed, 2010).

At the same time, global surveys conducted by WHO in collaboration with the World Psychiatric Association (WPA; Reed et al., 2011) and the International Union for Psychological Science (IUPsyS; Evans et al., 2013) indicated that the overwhelming majority of psychiatrists and psychologists favored a diagnostic system for mental disorders with many fewer disorders (i.e., fewer than 100 categories as compared to the more than 200 categories that currently exist). To achieve this goal, many existing mental disorders categories would have to be eliminated from mental disorders classifications, but little is known about mental health professionals' perceptions about which mental disorders should be removed and their rationales for doing so.

Recently, in a study of “natural taxonomies” of mental disorders among experienced clinicians from eight different countries in various WHO regions, Reed and colleagues (2013) reported that 19.4% of participating clinicians recommended removal of gender identity disorder and 10.1% recommended removal of sexual dysfunction from mental disorders classifications. These results may have been partly explained by a lack of knowledge about these conditions or their lower prevalence among patients in mental health services settings. On the other hand, high proportions of clinicians reported that they had never seen a patient with certain other diagnoses, including reactive attachment disorder (47.1%) and intermittent explosive disorder (38.5%), though a much smaller percentage recommended removal of these categories. Reed and colleagues (2013) did not provide information about clinicians' rationales for recommending deletion of particular categories from classifications of mental and behavioral disorders.

The present study is based on data collected as a part of the same natural taxonomy study (Reed et al., 2013). The main purpose of the present study was to more fully identify categories that practicing mental health professionals from different countries recommended for removal from mental disorders classifications, and to explore their rationales for deletion of these categories through a content analysis of the opened-ended questions included in the study. Based on previous literature in the field, we expected that the main reasons for suggesting the elimination of certain diagnoses from mental disorders classifications would include specificity problems involving boundaries among mental disorders (Andrews et al., 2009; First, 2010; Kendell & Jablensky, 2003; Reed, 2010); lack of validity due to problems regarding boundaries between

normal and pathological behavior, stigma attached to labeling particular behaviors or traits as mental disorders (e.g., Drescher, 2010; George & Klijn, 2014); and classification problems reflecting unclear boundaries between mental disorders and problems of a physiological, medical, or other nature (Horwitz, 2002; Wakefield, 1992).

One of the most important findings of the Reed and colleagues (2013) natural taxonomy study was an extremely high degree of consistency in the structure of the classification system generated by clinicians during the experimental task, across professions, countries, and classification system used (i.e., ICD-10 or DSM-IV). Though clinician's taxonomies of mental disorders were highly similar to one another, they were less similar to the ICD-10 and to the DSM-IV, indicating that clinicians were not simply replicating the structure that they had learned. In the present study, we examined differences in categories recommended for removal and rationales for doing so because the questions of what is and what is not a disorder and where it is placed may to a certain extent be considered a political and social issue in addition to a scientific and clinical one (Cochran et al., 2014). In addition, we expected that rationales for removal recommendations in different countries would be related to practice patterns and the structure and functioning of the health system in those countries. However, it is very important to keep in mind that any differences observed among countries occurred within the context of overwhelming similarity across countries in clinicians' views of the structure of mental disorders.

Method

Participants

The sample for this study comprised participants who selected one or more categories to be excluded from mental disorders classifications in the previously published "natural taxonomy" study (Reed et al., 2013). This study involved a detailed face-to-face classification task completed by 517 practicing mental health professionals (including psychiatrists, psychologists, social workers and psychiatric nurses) with a wide range of clinical experience in diagnosis and treatment across a spectrum of mental disorders. A requirement for inclusion in the study was that participants had least 2 years of professional experience after completion of clinical training and provided mental health services to patients during a minimum of 10 hours per week. Participants were contacted through local researchers in eight countries: Brazil (n = 60), China (n = 62), India (n = 61), Japan (n = 73), Mexico (n = 67), Nigeria (n = 60), Spain (n = 75) and the United States (n = 60). (See Reed et al., 2013, for a detailed description of the sample). As part of the experimental task, 505 participants¹ were asked to indicate which of 60 major categories should be excluded from a mental disorders classification system and to provide a rationale for their suggestions.

Materials

The stimuli materials were 60 mental and behavioral disorders diagnostic category names, each one printed on a 2.5"x3.5" laminated cards. The list of diagnostic category names used in the study is shown in Table 1. The list was formulated by WHO and adjusted on the basis of feedback from global experts in order to provide a range of categories with adequate representation across all classes of mental disorders while limiting the total number so as to be manageable in relation to the experimental task (see Reed et al., 2013 for further information). Categories were labeled so as to be recognizable to people familiar with either the ICD-10 or the DSM-IV.

¹This part of the procedure was added after the first 12 participants from Japan had already completed the study, accounting for the difference in sample size between the original study (Reed et al., 2013) and the present analysis.

Table 1
Mental and Behavioral Disorder Categories Used in the Study

Alzheimer's dementia	Conversion disorders
Vascular dementia	Hypochondriacal disorder
Amnestic disorder (organic)	Persistent somatoform pain disorder
Delirium	Body dysmorphic disorder
Mood disorder due to a general medical condition	Anorexia nervosa
Alcohol dependence	Primary (nonorganic) insomnia
Opioid dependence	Sexual dysfunction
Cocaine dependence	Abuse of nondependence producing substances (e.g., steroids, hormones)
Cannabinoid abuse	Paranoid personality disorder
Abuse of volatile solvents (inhalants)	Antisocial (dissocial) personality disorder
Tobacco (nicotine) dependence	Borderline personality disorder
Substance-induced psychotic disorder	Dependent personality disorder
Schizophrenia	Pathological gambling
Schizotypal disorder	Intermittent explosive disorder
Delusional disorder	Paraphilias
Acute and transient (brief) psychotic disorder	Gender identity disorder
Schizoaffective disorder	Factitious disorder
Bipolar I disorder	Intellectual disability (mental retardation)
Bipolar II disorder	Specific developmental disorders of speech and language
Depressive disorder (major)	Specific developmental disorders of scholastic skills
Cyclothymia	Autistic disorder
Dysthymia	Asperger's syndrome
Panic disorder	Attention deficit-hyperactivity (hyperkinetic) disorder
Social phobia	Conduct disorder
Generalized anxiety disorder	Oppositional defiant disorder
Mixed anxiety and depressive disorder	Childhood separation anxiety disorder
Obsessive-compulsive disorder	Reactive attachment disorder
Posttraumatic stress disorder	Tic disorders
Adjustment disorders	Nonorganic enuresis
Dissociative disorders	
Somatization disorder	

Procedure

The study involved a procedure in which a trained research associate followed a written and standardized protocol, which is summarized here. (See Reed et al., 2013, for a more detailed description.) Prior to the study session, the research associate screened the participant for eligibility, explained the overall purpose and requirements for the study, provided written material about the study and answered any questions the participant might have. If the clinician agreed to participate, he or she was scheduled to participate in a one-on-one experimental session with the research associate lasting between 60 and 90 minutes.

During the session, participants were given the set of 60 cards, shuffled prior to beginning the session, and asked to sort them into groups, based on their own clinical experience of how similar they were and how they approached the clinical management of these conditions. Participants were informed that slight differences between disorder names used in this study and the category names in ICD and DSM were not intended to be meaningful. Participants were instructed to set aside any the card for any particular disorder diagnosis of which he or she did not have basic knowledge. Participants were then asked to form higher or lower order groups starting from the groups they had formed, to yield a hierarchical arrangement of up to three levels. (See Reed et al., 2013, for details.)

After the sorting task was completed, participants were asked to look through the cards one by one and to identify any cards that corresponded to diagnostic categories that they had

never used in clinical practice (in other words, they had never assessed or treated a patient with that diagnosis). Next, participants were asked to look through the cards again and identify any disorders they felt *should not be included in a classification system of mental and behavioral disorders* (e.g., because they did not consider them to be mental disorders). For each category identified, the researcher recorded the participant's rationale or reason why the category should not be included in the classification system. Last, all participants completed a brief background questionnaire to collect information on their demographic and professional characteristics.

The study was administered in the local language of each country ($n = 5$: Chinese, English, Japanese, Portuguese, and Spanish). The original English version of all materials, including the cards with the names of mental disorder categories, the procedure protocol and the final questionnaire, were translated into the local language by bilingual research collaborators. All sorting data and rationale statements were recorded verbatim on paper forms by the research associate and subsequently entered by them into an online data entry platform developed for this purpose by WHO. All research associates were fully bilingual in their national language and in English and entered the rationale statements in the data platform in the language in which the study was administered, as well as providing an English translation for each. The English version of all rationale statements was used for coding and analysis in the present study.

Analysis

For the present study, participants' reasons for indicating that any diagnoses should not be included in a diagnostic classification of mental disorders were analyzed using an inductive content analysis framework, a procedure designed to identify the frequent, dominant, or significant themes inherent in raw data through the development of summary themes or categories (i.e., data reduction) using a model or framework that captures key themes and processes judged to be important by the researcher (Thomas, 2006).

The first two authors (RR and AF) independently completed the content analysis of reported reasons. Agreement between coders before the consensus review was high ($\kappa = 0.89$, 95% confidence interval [CI] [0.88, 0.89]).

Differences between countries and by income level were analyzed. For categorical variables, descriptive statistics were calculated and chi-square analyses used for comparisons. Means, standard deviations, and ranges were calculated for continuous variables. Logistic regression analyses were performed to determine the likelihood of categories being recommended for removal by country. All analyses were performed using SPSS-X (version 20).

Results

Of the 505 participants asked to indicate which of the 60 disorders should be excluded from mental disorders classifications, 305 (60.4%) indicated that one or more diagnoses should be removed and were asked to provide the rationales for their suggestions. This subgroup of 305 participants constitutes the sample for the present study and did not differ statistically by age, profession, years of training after academic degree, years of experience after training, and hours of clinical work per week from the 212 participants (40.6%) who did not suggest removing any diagnosis from the classification.

Sample Description

The majority of the 305 participants included in the present sample were psychiatrists ($n = 226$, 74.1%), followed by psychologists² ($n = 73$, 23.9%). A small number were members of other professions, such as nursing and social work ($n = 6$, 1.96%). The mean age of participants in the present sample was 42.1 years (standard deviation [SD] = 9.9, range = 25–76). Participants had

²As indicated, the study required that participants be authorized to practice as mental health professionals in their own countries and have at least 2 years of experience after completion of their professional training. Therefore, in the United States, individuals identifying themselves as psychologists were generally doctoral-

Table 2
Mental Disorders Most Frequently Recommended for Removal from Mental Disorders Classifications (by More than 10% of Sample)

Disorders	In present study (<i>n</i> = 305)		In Reed et al. (2013) (<i>n</i> = 517)
	<i>n</i>	%	%
1. Gender identity disorder	98	32.1	19.4
2. Sexual dysfunction	52	17.0	10.3
3. Paraphilias	46	15.1	9.1
4. Primary insomnia	45	14.8	8.9
5. Specific developmental disorders of scholastic skills	43	14.1	8.5
6. Non-organic enuresis	43	14.1	8.5
7. Amnesic disorder (organic)	38	12.5	7.5
8. Intermittent explosive disorder	37	12.1	7.3
9. Specific developmental disorders of speech and language	34	11.1	6.7
10. Vascular dementia	33	10.8	6.5
11. Alzheimer's dementia	31	10.2	6.1
12. Reactive attachment disorder	31	10.2	6.1

Note. The sample for the present study comprised participants who recommended removing at least one category. The Reed et al. (2013) sample included participants who did not recommend removing any category.

an average of 5.8 years of clinical training after completion of their academic degree³ ($SD = 3.8$, range = 0–28), and 11.6 years of clinical experience after completion of their clinical training ($SD = 8.9$, range = 1–40). Participants spent an average of 26.4 hours per week providing clinical mental health services ($SD = 12.7$, range = 0–77).

Mental Disorders Recommended for Removal

Among the 305 participants who recommended removing any disorder, the mean number of mental disorder diagnoses recommended for removal was 3.5 ($SD = 3.8$, range = 1–29) for a total number of 1,081 recommendations for removal. Of the 60 disorder categories presented to the participants in the study, only schizophrenia was not recommended for removal by any participant. Table 2 presents the diagnoses most commonly cited for removal.

Rationales for Removing Disorders

Open-ended rationale statements for each of these recommendations were included in a content analysis. Several themes emerged. The final coding system used to analyze the rationales provided for removing disorders was organized into four general themes:

- Theme 1: Diagnoses that represent problematic boundaries among mental disorders
- Theme 2: Diagnoses that represent problematic boundaries between normal and psychopathological conditions

level professionals. In other countries participating in this study, the academic portion of the requirement to practice as a psychologist is typically a qualifying master's degree.

³Questions about training were asked in such a way as to allow for differences in the structure of training across countries. For example, in many countries outside the United States, the academic equivalent of medical school is provided as part of a 5-year undergraduate university degree. "Years of training" in this study therefore refers to training after completion of the academic portion of professional training, and therefore includes residency for psychiatrists.

- Theme 3: Diagnoses that problematic boundaries between mental and physical disorders
- Theme 4: Nonexistent, implausible, or untreatable conditions

Theme 1 was further divided into three more specific subthemes, and theme 2 was further divided into four specific subthemes. The complete coding system, with brief descriptions of each theme and subtheme and examples from rationales provided by clinicians, is shown in Table 3.

Most Cited Reasons for Removing Mental Disorders Categories

Of the 1081 suggestions for the removal of mental disorders, 1,066 were classified under one of the above general themes or specific subthemes. Fifteen rationale statements (1.4%) could not be classified using this system because they were too general or too vague or did not actually provide a rationale for removal and were therefore excluded from the analysis. Examples of rationale statements that could not be coded include “Change the name to Polymorphic Affective Syndrome” (in relation to borderline personality disorder) and “There is a lot to study about this disorder.”

Frequency and percentage of total coded removal rationale statements ($N = 1066$) for each theme and subtheme are also shown in Table 3. The theme most frequently cited overall was Theme 2, *Diagnoses that represent problematic boundaries between normal and psychopathological conditions* (cited 489 times; 45.9% of the 1,066 codable removal recommendations). The Theme 2 subtheme most frequently cited as a rationale for removal of a diagnostic category was Subtheme 2b, *Diagnoses that represent stigmatization of a way of being and behaving* (cited 257 times, 24.1%), followed by Subtheme 2c, *Diagnoses that represent problems that are not health or mental health conditions* (cited 162 times, 15.2%).

The second most frequently cited theme was Theme 1, *Diagnoses that represent problematic boundaries among mental disorders* (cited 271 times; 25.4%). The most frequently cited Theme 1 subtheme was Subtheme 1a, *Diagnoses that are symptoms, parts, or subtypes of other disorders* (cited 181 times, 17.0%). Theme 3, *Diagnoses that represent problematic boundaries between mental and physical disorders*, was cited 256 times (24.0%). Theme 4, *Nonexistent, implausible or untreatable conditions*, was the least commonly cited rationale for category removal (cited 50 times; 4.7%).

Consistency of Rationales for Specific Removal Recommendations

Of the disorders most frequently recommended for removal, vascular dementia was the diagnosis with the highest consistency in terms of participants' rationales for removing it from the mental disorders classification. Of those who suggested that this category should be removed, 90.9% ($n = 30$) agreed that it was a neurological problem that has been misclassified as a mental disorder (Theme 3).

In contrast, participants offered the greatest diversity of rationales for removing gender identity disorder, even though this was the diagnosis most frequently recommended for removal. All of the themes and subthemes were cited by one or more professionals in their rationales for removing this category, with the exception of Subtheme 1b, *Diagnoses that are combinations of disorders*. Nevertheless, Subtheme 2b, *Diagnoses that represent stigmatization of a way of being or behaving*, was the most commonly cited rationale for removal of this category from the classification of mental disorders ($n = 73$, 75.3% of those recommending removal of the category).

Diagnoses Recommended for Removal: Comparisons by Country

Percentages of the main diagnoses recommended for removal (see Table 2) were compared across the countries from which the clinicians were sampled. Significant differences by country emerged for proportions of clinicians recommending removal of gender identity disorder, sexual dysfunction, paraphilias, specific developmental disorders of scholastic skills, and non-organic enuresis. There were no significant differences across countries in proportions of participants recommending removal of other diagnoses.

Table 3
Clinicians' Rationales for Removing Mental Disorder Categories: General Themes, Specific Sub-themes, Examples, and Frequency and Percentage of Coded Removal Rationales Accounted for by Each Category of Rationale Statement

General themes	Specific subthemes	Frequency and percentage of coded removal rationales (N = 1066)
Theme 1: Diagnoses that represent problematic boundaries among mental disorders	Subtheme 1a: Diagnoses that are symptoms, parts or subtypes of other disorders (not a specific disorder <i>per se</i>) Examples: Primary (nonorganic) insomnia: "symptom or part of disorders, does not represent a category"; Persistent somatoform pain disorder: "a type of somatoform disorder"	n = 181 (17.0%)
	Subtheme 1b: Diagnoses that are combinations of disorders (redundant category) Examples: Mixed anxiety and depressive disorder: "It is essential to determine whether it is a depression or an anxiety"; Schizoaffective disorder: "Seem to be a mix between mood and psychoses; it is not a pure category"	n = 14 1.3%
	Subtheme 1c: Nonspecific category (imprecise description, nonspecific diagnostic descriptions, very general category) Examples: Schizoaffective disorder: "It should be better defined"; Intermittent explosive disorder: "Far too over-inclusive" . . . It is not well described"	n = 56 5.3%
	Subtheme 1d: Misclassification of a mental disorder (as subtype or part of another group or spectrum of mental disorders) Examples: Schizotypal disorder: "It belongs to the psychoses spectrum; it is not a personality disorder"; Pathological gambling: "It should be OCD spectrum"	n = 20 1.9%
	Total Theme 1	n = 271 25.4%
Theme 2: Diagnoses that represent problematic boundaries between normal and psychopathological conditions	Subtheme 2a: Diagnoses that are pathologizing of natural and adaptative behaviour (as a part of development or in light of special circumstances) Examples: Childhood separation anxiety disorder: "It is a natural reaction; when is intense it becomes another disorder"; Adjustment disorders: "People need some time to adapt to a new environment . . . it can't be considered a sick condition"	n = 70 6.6%
	Subtheme 2b: Diagnoses that represent stigmatization of a way of being or behaving Examples: Gender identity disorder: "I don't think that this is a medical/clinical condition; it has to do with the overt preference and sexual behavior of the person"; Pathological gambling: "It is a dynamic and not a disorder; it is a way of functioning"	n = 257 24.1%

(Continued)

Table 3
Continued

General themes	Specific subthemes	Frequency and percentage of coded removal rationales (N = 1066)
	Subtheme 2c: Diagnoses that represent problems that are not health or mental health conditions (psychological, educational, family, socio-cultural or legal problems) Examples: Specific developmental disorders of scholastic skills: " <i>Learning problems in children. This condition is not a psychiatric illness. Treatment requires intervention by special educators rather than mental health professionals</i> "; Oppositional defiant disorder: " <i>Just poor parenting skills</i> "	n = 162 15.2%
	Total Theme 2	n = 489 45.9%
Theme 3: Diagnoses that represent problematic boundaries between mental and physical disorders (No subthemes)	Diagnoses that should be considered non-psychiatric in nature or represent symptoms of a non-psychiatric physical illness or medical condition (neurological, urological, metabolic, genetic vs. psychiatric) Examples: Alzheimer's and Vascular dementias: " <i>Should be in Neurology</i> "; Autistic disorder: " <i>It's an organic or genetic problem, not disordered thinking or behavior</i> "	n = 256 24.0%
Theme 4: Nonexistent, implausible or untreatable conditions (No subthemes)	Categories that are nonexistent, implausible or cannot be treated Examples: Cyclothymia: " <i>Have never seen this</i> "; Persistent somatoform pain disorder: " <i>Impossible to prove</i> "; Factitious disorder: " <i>Can't be treated</i> "	n = 50 4.7%

For gender identity disorder, participants from Spain ($n = 24$, 34.8% of Spanish participants included in the present analysis), India ($n = 8$, 27.6%), and Mexico ($n = 15$, 24.6%) were more likely than participants from other countries to recommend removal of this category from the mental disorders classification (odds ratio [OR] = 2.30, CI [1.51, 3.51], $p \leq 0.001$), while participants from Japan ($n = 6$, 9.8%) were less likely to do so and no participant from Nigeria recommended removal of the disorder, $X^2 = 30.9$, degree of freedom [df] = 7, $p \leq 0.001$.

Participants from Japan and China were most likely to suggest removal of sexual dysfunction ($n = 14$, 23.0% and $n = 9$, 15.3%, respectively; OR = 3.12, CI [1.73, 5.60], $p \leq 0.001$), while participants from three countries were less likely to do so (India $n = 1$, 3.4%, Mexico $n = 2$, 3.3% and Spain $n = 2$, 2.9%) $X^2 = 23.3$, $df = 7$, $p \leq 0.001$.

Higher proportions of participants from Japan ($n = 17$, 27.9%) and India ($n = 8$, 27.6%) than from other countries recommended removal of paraphilias from the diagnostic classification of mental disorders (OR = 6.75, CI [3.69, 12.37], $p \leq 0.001$), with lower proportions of participants from Brazil ($n = 3.4%$) and Nigeria ($n = 1$, 2.2%) recommending removal, $X^2 = 51.7$, $df = 7$, $p \leq 0.001$.

Mexico and Nigeria were the nations where specific developmental disorders of scholastic skills were most likely to be recommended for removal ($n = 10$, 16.4% and $n = 6$, 13.3%, respectively; OR = 2.43, CI [1.28, 4.60], $p = 0.006$), while clinicians from India ($n = 1$, 3.4%) and Japan ($n = 2$, 3.3%) were less likely to do so. No mental health professional from Spain recommended removal of these diagnoses, $X^2 = 18.0$, $df = 7$, $p = 0.01$.

Higher proportions of Nigerian clinicians recommended removal of nonorganic enuresis from the classification than clinicians from other countries ($n = 9$, 20%; $OR = 3.12$, $CI = 1.45$ – 6.74 , $p = 0.004$), while this recommendation was made by much lower proportions of clinicians from India ($n = 1$, 3.4%), Mexico ($n = 2$, 3.3%), and Spain ($n = 2$, 2.9%) $\chi^2 = 16.9$, $df = 7$, $p < 0.01$.

Rationales for Removing Disorders: Comparisons by Country

The greatest proportion of removal recommendations were provided by clinicians from the United States, accounting for 21.9% ($n = 233$) of the total recommendations for removing specific diagnoses from the classification of mental disorders. This was most often due to U.S. clinicians' view that categories identified for removal were better conceptualized as nonpsychiatric medical conditions (Theme 3, cited 91 times). The second highest proportion of removal recommendations by country was accounted by Brazil ($n = 166$; 15.6% of all removal recommendations). The rationales provided by Brazilian clinicians most frequently related to their view that these categories were better conceptualized as symptoms, parts, or subtypes of other disorders (Subtheme 1a, cited 64 times).

Clinicians from Spain accounted for the third highest proportion of removal recommendations (13.7%, $n = 146$), followed by Mexico and China (12%, $n = 128$ each). Like Brazilian clinicians, Spanish clinicians most frequently cited problems with boundaries among mental disorders as their rationale for removal (Theme 1, cited 61 times), specifically because they saw these conditions as better conceptualized as symptoms, parts, or subtypes of other disorders (Subtheme 1a, $n = 37$). Mexican and Chinese clinicians most frequently cited problems with boundaries between normal and psychopathological conditions as the rationale for their removal recommendations (Theme 2, $n = 68$ for Mexico and $n = 99$ for China), most often because these categories stigmatized or medicalized a way of being or behaving (Subtheme 2b, $n = 45$ and $n = 39$, respectively).

Japanese clinicians accounted for 11.4% of the removal recommendations ($n = 122$), most commonly related to problems with boundaries between normal and psychopathological conditions (Theme 2; $n = 55$) and, more specifically, to stigmatization of a way of being or behaving (Subtheme 2b, $n = 42$).

Clinicians from Nigeria and India provided the smallest proportions of suggestions for the removal of mental disorders ($n = 90$, 8.4% of total removal recommendations and $n = 52$, 4.9%, respectively). In both countries, the rationale most frequently cited was related to problems with the boundaries between normal and psychopathological conditions (Theme 2, $n = 47$, 52.2% for Nigeria and 41, 78.8% for India), specifically because the categories recommended for removal were seen as representing problems that are not health or mental health conditions (Subtheme 2c; Nigeria $n = 26$, 28.9%; India $n = 20$, 38.5%).

Rationales for Removing Disorders: Comparisons by Country Income Level

Clinicians' rationales for removal of diagnoses from mental disorders classifications were also analyzed by country income level: lower middle (India and Nigeria, $n = 142$, 13.1% of the sample), upper middle (Brazil, China, and Mexico, $n = 423$, 39.1% of the sample), and high income (Japan, Spain and USA, $n = 516$, 47.7% of the sample). Among lower middle income countries, concerns about diagnoses that represent problems that are not health or mental health conditions (Subtheme 2c) was the specific rationale most frequently cited as the reason for removal ($n = 46$, 32.4%). Among upper middle income countries, concerns about stigmatization of a way of being or behaving (Subtheme 2b) was the most frequently cited rationale ($n = 108$, 25.6%). Among high-income countries the most common rationale for removal was related to the boundary between mental disorders and nonpsychiatric medical conditions (Theme 3, $n = 148$, 29.5%).

Discussion

This study constitutes a part of WHO's effort to understand mental health clinicians' perceptions of mental disorders classifications and their suggestions for changes in order to inform the ICD-11 development process, a main goal of which is to improve the clinical utility of the classification

(International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011; Reed, 2010).

Although this study involved a limited set of disorder stimuli (60 diagnoses compared to the whole range of more than 200 diagnostic categories in the ICD-10 and the DSM), the list of diagnoses includes the full spectrum of mental and behavioral disorders, with representation of each existing group or category (see Table 1). The same set of disorders was used in another study on clinicians' conceptualization of relationships among mental disorders (Roberts et al., 2012) and is similar to one used in an earlier U.S. study on clinicians' natural taxonomies of mental disorders (Flanagan, Keeley, & Blashfield, 2008). The range of stimuli was sufficient to allow significant inferences regarding clinicians' views of categories that should be removed from mental disorder classifications.

Categories Most Frequently Recommended for Removal

Many of the recommendations for removal involved conditions related to gender identity and sexuality, specifically gender identity disorders, sexual dysfunction, and paraphilias. It should be emphasized that clinicians' recommendations to remove these categories from mental disorders classifications does not necessarily suggest that they question the validity of the categories themselves but rather their placement in the classification of mental disorders. According to between 15% and 32% of clinicians from eight different countries, at least some of these disorders should be removed from mental disorders classifications, mainly because of problems related to stigma and unclear boundaries between normal behavior and psychopathology.

The results of this study support the recommendations of the ICD-11 Working Group on Sexual Disorders and Sexual Health regarding: (a) the removal of gender identity disorder categories from the ICD-11 chapter on mental and behavioral disorders (Drescher, Cohen-Kettenis, & Winter, 2012), renaming the category "gender incongruence" to reduce pathologization of identity (i.e., stigma), and modification of the current diagnostic guidelines to ensure access to health services; (b) the placement of sexual dysfunctions in a new chapter of the ICD-11 classification (removing it from the mental and behavioral disorders chapter), to unify the classification of sexual dysfunctions by eliminating the false dichotomy between mind and body that is inherent in the current classification and to reduce stigma and encourage treatment; (c) the elimination of categories related to sexual orientation (Cochran et al., 2014); and (d) the reformulation and clarification of paraphilic disorders in the ICD-11, including the removal of diagnoses that involve consensual or solitary sexual behavior and result in stigmatization without a discernible public health benefit (Wright, 2010).

Another cluster of disorders commonly recommended for removal were neurocognitive disorders, which clinicians viewed as being better conceptualized as neurological disorders (e.g., amnestic disorder, vascular dementia, Alzheimer's dementia). Consistent with this perspective, according to current proposals for ICD-11, vascular dementia and Alzheimer's dementia will be classified under diseases of the nervous system, but cross-referenced in mental and behavioral disorders because mental health professionals, particularly neuropsychologists, are frequently responsible for the evaluation of deficits, severity, and impairment associated with dementias. Amnestic disorder will be retained in the neurocognitive disorders grouping of the Mental and Behavioural Disorders chapter, but will be cross-referenced in the Diseases of the Nervous System chapter.

Some clinicians also recommended the exclusion of specific developmental disorders of speech and language and specific developmental disorders of scholastic skills on the grounds that such learning problems require the intervention of special educators rather than mental health professionals. However, mental health experts specializing in childhood and developmental disorders do not share this opinion (Rutter & Uher, 2012). The current proposal for ICD-11 is to retain developmental speech and language disorders and developmental learning disorders under the grouping of neurodevelopmental disorders in the ICD-11 classification of mental and behavioral disorders. These findings suggest a need for field studies to evaluate the clinical utility of the corresponding proposals and their proposed placement in ICD-11, as well as education

related to the underlying logic for their inclusion in the Mental and Behavioural Disorders chapter.

Primary insomnia and non-organic enuresis were also commonly recommended for removal, primarily because they were seen as representing symptoms rather than separate disorders *per se*. According to current proposals for ICD-11, chronic insomnia and short-term insomnia will be included in a new chapter on Sleep-Wake Disorders rather than being classified as mental and behavioral disorders. Enuresis will be retained under neurodevelopmental disorders in the Mental and Behavioural Disorders chapter for use when it represents a recurrent problem that represents an independent focus of clinical attention and that is not due to a medical condition that interferes with continence (e.g., neurological or musculoskeletal disorders) or to congenital or acquired abnormalities of the urinary tract. Enuresis that is temporary or secondary to another condition can be coded in the ICD-11 chapter on Symptoms, Signs, Clinical Forms, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified.

The frequency with which intermittent explosive disorder and reactive attachment disorder were recommended for removal from the classification of mental disorders is most likely due to lack of familiarity with these conditions among participating clinicians. Intermittent explosive disorder is not a separate category in ICD-10. In the larger original study (Reed et al., 2013), more participants indicated that they lacked sufficient basic familiarity with these two disorders to include them in the sorting task (13% for intermittent explosive disorder and 11% for reactive attachment disorder) and that they had never used them in clinical practice (38.6% for intermittent explosive disorder and 47.1% for reactive attachment disorder) than was the case for any of the other categories.

It is unclear why there were differences in the overall frequency of removal recommendations by country. One possibility is that these reflect country-level differences in the overall rate of diagnostic activity as a part of practice, with practitioners in countries in which diagnosis is not a routine aspect of their practice less likely to recommend the deletion of diagnostic entities because they have less experiential basis for doing so. However, other available data do not support this hypothesis. For example, in a survey of nearly 5,000 psychiatrists in 44 countries (Reed et al., 2011), rates with which psychiatrists reported often, almost always, or always using a formal classification system in day-to-day clinical practice in Brazil, China, India, Japan, Nigeria, Spain, and the United States—all countries participating in the present study—were similar and ranged from 74% (Japan) to 94% (Nigeria).⁴ Another possibility is that these differences reflect more deferential attitudes toward the authority structures represented by formal classification systems in countries in which participants were less likely to make removal recommendations.

Turning to observed differences among countries in the specific categories recommended for removal, one possibility is that these reflect real differences in population prevalence, such that practitioners in which particular disorders are simply less common were more likely to recommend their deletion. Again, available data do not support this hypothesis. Although comprehensive global epidemiological data are not available for all categories used in this study, existing research indicates roughly comparable levels of specific mental disorders around the world, with a small number of notable exceptions (Kessler et al., 2009; Whiteford et al., 2013; WHO World Mental Health Survey Consortium, 2004). For example, differing patterns of cultural and legal prohibitions related to the use of alcohol are associated with substantially variable prevalence rates of alcohol-related disorders by country. The differences observed in this study are therefore more likely that to reflect country-level differences in practice patterns and in the structure and functioning of health systems. For example, some conditions may be seen as part of the responsibility of the medical or educational systems rather than the mental health system.

However, social attitudes and systemic factors that vary by country are also likely to play a role, particularly with regard to certain categories. Gender identity disorder provides the most

⁴This survey did not include a Mexican sample, but diagnosis is a core aspect of psychiatric practice in Mexico.

dramatic example of potentially relevant social and contextual factors. This was the category most frequently recommended for removal overall, and clinicians from Spain, India, and Mexico were particularly likely to do so. In each of these countries, there are laws that support self-determination and prohibit discrimination based on gender identity and expression (Government of Mexico, 2003; Government of Spain, 2007; National Legal Services Authority v. Union of India and others, 2014), as well as active civil society organizations that advocate on behalf of transgender people. In contrast, in Nigeria, where no clinician recommended removal of gender identity disorder as a mental disorder, there are no laws protecting gender identity and gender expression, and indeed a new law has recently been enacted that criminalizes participation in “gay clubs, societies, and organisation,” specifying a penalty of 10 years imprisonment for such participation (Same Sex Marriage Prohibition Act, 2013). This would obviously have a chilling effect on civil society advocacy on behalf of transgender people. Given the complexity of the legal, social, and political contexts within which the ICD-11 will be implemented, WHO is undertaking an assessment in several countries of the relevant legal, regulatory, and policy environment related to gender identity, its effects on transgender people, and their potential effect on the implementation of a proposed new classification of gender incongruence in ICD-11.

Rationales for Removal of Mental Disorders Categories

Consistent with the literature in the field (e.g., First, 2010; Horwitz, 2002; Wakefield, 1992), the rationales or reasons for suggesting the removal of mental disorders from psychiatric classifications were mainly related to problems with boundaries among mental disorders, boundaries between normal behavior and psychopathology, and boundaries between mental disorders and medical conditions. Across countries, the most commonly cited subtheme provided as a rationale for removal was clinicians' view that a category stigmatized or medicalized a way of being or behaving, accounting for nearly one fourth of all removal recommendations. However, different types of rationales were given different weight in different countries. For example, U.S. clinicians emphasized the boundary between mental disorders and medical conditions, while Brazilian clinicians most frequently cited issues related to boundaries among mental disorders.

The suggestion that such differences may be partly related to differences among countries in the development, structure, and functioning of country-level health systems is supported by the analysis of the relationship between types of rationale statements and country income group. Among lower middle countries (Nigeria and India), the most frequently cited specific rationale for removal related to concerns about diagnoses that represent problems that are not health or mental health conditions, such as educational or social problems (Subtheme 2c). Among upper middle income countries (Brazil, China, and Mexico), concerns about stigmatization and medicalization of a way of being or behaving (Subtheme 2b) was the most frequently cited specific rationale for removal. For high-income countries (Japan, Spain, United States), the most common rationale for removal was related to the misplacement or confusion about the boundary between mental disorders and nonpsychiatric medical conditions (Theme 3).

It is interesting to speculate, and an appealing topic for future research, that as countries develop and their health care systems evolve, the areas that are the focus of consideration in terms of what is and what is not a mental disorder shift from (a) how to specify a realistic and achievable role for mental health services in the context of much broader social needs, to (b) concerns about stigmatization of people who need mental health services, to (c) concerns about differential diagnosis, particularly with neurological conditions, an activity likely to require tests that are simply not available in low-resource settings.

Limitations

The specificity of the sample included and the nonprobabilistic approach limits the generalizability of these findings. These findings should not be interpreted as representative of all clinicians or countries in the world, but they do provide specific suggestions and rationales offered by clinicians—mainly psychiatrists and psychologists—in various contexts that can be useful in the development and implementation of the ICD-11. This is especially true when these findings can

be integrated with advances in the scientific literature and developments in clinical disciplines in terms of professional training and practice roles. As WHO pursues this agenda, this represents only one of a series of studies that can help WHO to improve the clinical utility of the classification of mental and behavioral disorders.

Conclusions

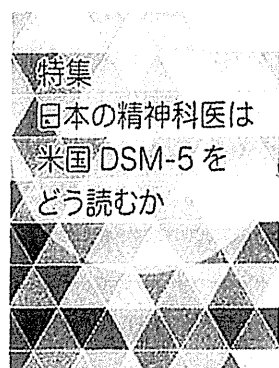
These findings highlight a number of significant challenges to be addressed in introducing ICD-11 in the various regions in the world. Although these findings point to some interesting differences by country and by country income level, it is important to interpret these within the context of the overwhelming consistency across countries, languages, and disciplines in clinicians' implicit models of mental disorders classification (Reed et al., 2013; Roberts et al., 2012). These results do suggest areas that may be important targets of enhanced educational efforts when the new classification system is implemented, particularly regarding the need for certain diagnostic categories and the rationale for their placement (whether inside or outside the Mental and Behavioural Disorders chapter). The need for specific categories often relates to ensuring access to care for people who need mental health services or other types of treatment, which in most countries requires the provision of a diagnosis as a condition for coverage by government-sponsored health plans or third-party payors.

Finally, these results underscore the usefulness and importance of international studies of clinicians' perspectives within the context of global mental health care. Further research of this kind is a critically important aspect of the development of a genuinely universally accepted diagnostic classification system for mental and behavioral disorders.

References

- Andrews, G., Goldberg, D. P., Krueger, R. F., Carpenter, W. T. Jr., Hyman, S. E., Sachdev, P., & Pine, D. S. (2009). Exploring the feasibility of a meta-structure for DSM-V and ICD-11: Could it improve utility and validity? *Psychological Medicine*, 39, 1993–2000.
- Cochran, S. D., Drescher, J., Kismödi, E., Giami, A., García-Moreno, C., Atalla, E., ... & Reed, G. M. (2014). Proposed declassification of disease categories related to sexual orientation in ICD-11: Rationale and evidence from the Working Group on Sexual Disorders and Sexual Health. Retrieved from http://www.who.int/bulletin/online_first/BLT.14.135541.pdf?ua=1
- Drescher, J. (2010). Queer diagnoses: Parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual. *Archives of Sexual Behavior*, 39, 427–460.
- Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: Situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*, 24, 568–577.
- Evans, S. C., Reed, G. M., Roberts, M. C., Esparza, P., Watts, A. D., Correia, J. M., ... & Saxena, S. (2013). Psychologists' perspectives on the diagnostic classification of mental disorders: Results from the WHO-IUPsyS Global Survey. *International Journal of Psychology*, 48, 177–193.
- First, M. B. (2010). Clinical utility in the revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM). *Professional Psychology: Research and Practice*, 41, 465–473.
- Flanagan, E. H., Keeley, J., & Blashfield, R. K. (2008). An alternative hierarchical organization of the mental disorders of DSM-IV. *Journal of Abnormal Psychology*, 117, 693–698.
- George, B., & Klijn, A. (2014). Psychosis susceptibility syndrome: A new name for schizophrenia. *The Lancet Psychiatry*, 1, 110–111.
- Government of Mexico. (2003). Ley Federal para prevenir y eliminar la discriminación [Federal law for the prevention and elimination of discrimination]. Retrieved from <http://www.diputados.gob.mx/LeyesBiblio/pdf/262.pdf>
- Government of Spain. (2007). Ley 3/2007, de 15 de marzo, reguladora de la rectificación registral de la mención relativa al sexo de las personas [Law 3/2007, of March 15, regulating the correction of gender registration in official records]. Retrieved from <http://www.boe.es/buscar/doc.php?id=BOE-A-2007-5585>
- Horwitz, A. V. (2002). *Creating mental illness*. Chicago, IL: University of Chicago Press.

- International advisory group for the revision of the ICD- 10 mental and behavioural disorders. (2011). A conceptual framework for the revision of the ICD-10 classification of mental and behavioral disorders. *World Psychiatry*, 10, 86–92.
- Kendell, R., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry*, 160, 4–12.
- Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., ... & Wang, P. S. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiologia e Psichiatria Sociale*, 18, 23–33.
- National Legal Services Authority v. Union of India and others. (2014). Write Petition (Civil) No. 400 of 2012, Supreme Court of India. Retrieved from <http://www.refworld.org/docid/5356279d4.html>
- Reed, G. M. (2010). Toward ICD-11: Improving the clinical utility of WHO's International Classification of Mental Disorders. *Professional Psychology: Research and Practice*, 41, 457–464.
- Reed, G. M., Correia, J., Esparza, P., Saxena, S., & Maj, M. (2011). The WPA-WHO global survey of psychiatrists' attitudes towards mental disorders classification. *World Psychiatry*, 10, 118–131.
- Reed, G. M., Roberts, M. C., Keeley, J., Hoopell, C., Matsumoto, C., Sharan P., . . . & Saxena, S. (2013). Mental health professionals' natural taxonomies of mental disorders: Implications for the clinical utility of the ICD-11 and the DSM-5. *Journal of Clinical Psychology*, 69, 1191–1212.
- Roberts, M. C., Reed, G. M., Medina-Mora, M. E., Keeley, J. W., Sharan, P., Johnson, D. K., . . . & Saxena, S. (2012). A global clinicians' map of mental disorders to improve ICD-11: Analyzing meta-structure to enhance clinical utility. *International Review of Psychiatry*, 24, 578–590.
- Rutter, M., & Uher, R. (2012). Classification issues and challenges in child and adolescent psychopathology. *International Review Psychiatry*, 24, 514–29.
- Same Sex Marriage. (Prohibition) Act, Federal Republic of Nigeria (2013). Retrieved from <http://www.placng.org/new/laws/Same%20Sex%20Marriage%20%28Prohibition%29%20Act,%202013.pdf>
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27(2), 237–246.
- Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist*, 47, 373–388.
- Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., . . . & Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. *The Lancet*, 382, 1575–1586.
- WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association*, 291(21), 2581–2590.
- World Health Organization. (1992a). *International classification of diseases and related health problems (10th rev.)*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (1992b). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: World Health Organization.
- Wright, S. (2010). Depathologizing consensual sexual sadism, sexual masochism, transvestic fetishism, and fetishism. *Archives of Sexual Behavior*, 39, 1229–1230.



〈総論〉

DSM作成までの経緯

松本ちひろ* 丸田 敏雅*

KEY WORDS

DSM-5, 診断 (diagnosis), 分類 (classification), ICD-11

抄録：2013年5月にDSM第5版が完成と発刊を迎え、わが国においてもその翌年2014年に早くも日本語版が刊行されている。本稿では、DSMの歴史、特に信頼性の偏重と診断基準の操作的な性質をもたらす臨床場面への影響をまとめ、DSM-5が臨床場面での有用性の重視に少なからず方針転換した背景を考察した。また、DSMがすでに近い将来の改訂を見据え、DSM-5のliving documentとしての位置づけについても記した。

1 はじめに

2013年5月、米国精神医学会の作成する診断分類システムであるDiagnostic and Statistical Manualの第5版(以下DSM-5)が完成と発刊を迎えた。本邦においても、今年2014年6月には早々に日本語版が刊行された。DSM-5発刊以降、前版からの変更点やその経緯が種々のメディアを通して紹介されてきたが、日本語版の発刊により、DSM-5はさらに身近なものとなるだろう。各論の詳細は本特集号の各稿に譲り、本稿ではDSM-5という最終成果物がどのような経緯を経て完成したものであるかについて、背景と改訂のプロセスを紹介する。

2 DSMの歴史

DSM-5の改訂プロセスを振り返る前に、DSMそのものの歴史に触れておく。世界保

健機関の作成する国際疾病分類(International Classification of Diseases: ICD)と並び、DSMは今日、精神保健関連の事象を語るうえで共通言語のような役割を果たしているが、この共通言語という機能こそ、DSMに期待されてきた中核的役割といえる。

共通言語の欠如が露見し、またそれに対するニーズが広く認知されるようになった契機として頻繁に紹介される調査研究に、1960～1970年代にかけて行われたUS-UK Study¹⁰⁾と呼ばれる有病率調査がある。この調査で、現在でいうところの統合失調症と双極性障害の有病率をロンドンとニューヨークで調べたところ、一見これらの障害の有病率が大きく異なるかのような結果が得られた。しかし実際には、これは診断基準が共通して用いられていなかったためであったことが明らかになった、というものである。

この反省から、各診断カテゴリに対し、できるだけ具体的かつ客観的の評価が可能のように人

The process of developing the DSM-5

* MATSUMOTO Chihiro and MARUTA Toshimasa 東京医科大学精神医学分野 [〒160-0023 東京都新宿区西新宿 6-7-1]