精神保健福祉法改正に対し法律家の立場から*

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*Key Words*** 保護者制度，医療保護入院，家族等の同意

はじめに

自らの同意によって入院する状態にない精神障害者に対する医療提供については，本人，家族，市町村等の公的主体，地域社会等がどのように関与していくのかが課題となる。本稿は，精神保健福祉法の平成25年改正について，主として家族の位置付けに着目しつつ，その意義と課題について検討するものである。

改正法においては，①保護者制度の廃止により家族の負担を軽減することが目指されたが，②医療保護入院において，保護者に代わって家族等のうちのいずれかの者の同意が要件とされるなど，家族等になお一定の位置付けが与えられ，さらに③退院後の環境調整に関して専門家の関与が求められ，成年後見の活用が示唆されるなど，地域社会での受け入れ体制整備が図られている。

結論を先取りし，標語的に評すれば，改正法は家族から社会へという流れの上にあるといえるが，家族に認められた地位はあいまいであり，過渡的な性格の立法といえる。

保護者に課せられていた義務の削除

保護者制度の廃止については，一方で，保護者に課せられていた義務等がなくなることにより本人の利益が損なわれることにならないかが，他方で，家族等にはなお，なんらかの関与等が認められないのかが問題となる。個別の義務ごとにみていこう。

本人の財産上の利益の保護（旧法第22条第1項：以下，平成25年改正の前後の精神保健福祉法をそれぞれ「旧法」「新法」という）は，成年後見（後見，保佐，補助および任意後見），日常生活自立支援事業，事務管理によることになる。従来の保護者の財産上の利益の保護義務については，保護者に財産保護の義務を課しているだけで，保護者による財産の扱い等について監督の体制を欠いており，他方で，保護者が代理権を有するとは解されないために，保護者のなした行為の効果が不明確であるなどの問題があった。この点，原則に戻って成年後見制度が利用されれば，入院中の住居や労働をめぐる関係の処理等は後見人等が後見監督を受けつつ，代理権に基づいて処理することが可能となる。

患者本人の判断能力の程度が成年後見を開始するほどでないときには，日常生活自立支援事業の利用が期待される。家族等が事実上本人の財産に関わる行為をしたときには，事務管理として事後的に正当化されることもあり得るが，事務管理制度は行為者に権限等の基礎付けを与えるものではなく，本人の財産上の利益の保護のための制度として積極的に位置付けられるものではない。

なお，入院中に財産の保護をめぐって問題となる事項は，上記の住居や労働のように，高価な財産に関わり本人への影響が大きいものから，身辺の動産の扱いなど日常的で一見すると瑣末な事項まで多様であり得るところ，成年後見等の既存の制度を柔軟かつ安全に活用し，有効な対応ができるかについて，なお不確かな面がある。しかし，それは精神障害者の入院の場面に限らず，自ら財産を管理できない者または適切な管理がなされていないような財産について，誰がどのように関与

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* On the amendment of the Mental Health and Welfare Act − from a legal viewpoint
** guardian system, special guardian for mental health, consent to a hospitalization

していくかという一般的な問題に帰着するといえよう。

治療を受けさせ，医師に協力し，その指示に従う義務（旧法第22条各項）については，今後は精神科診療に限らない医療の場面で患者の家族に認められるべき地位という問題の一環として考えられるべきであるが，一般的な法状況は必ずしも明確ではない。医療は患者本人の意思に基づいて提供されるべきものであり，患者の配偶者や家族は，配偶者等であるからといって当然に情報を得られるわけではなく，また，患者の利益のためであっても，患者の代わりに医療に関わる決定や同意ができるわけではない。ただし，本人の利益（とくに生命，身体の保護）のために緊急の必要がある場合は，例外的な取扱いが正当化される。このような例外を示したものと考えられるのが，「医療・介護関係事業者における個人情報の適切な取扱いのためのガイドライン」の次のような指針である。

同ガイドラインは，患者本人の同意を得ずに医師が家族等へ病状を説明できる場合として，「意識不明で身元不明の患者について，関係機関へ照会したり，家族または関係者等からの安否確認に対して必要な情報提供を行う場合，意識不明の患者の病状や重度の認知症の高齢者の状況を家族等に説明する場合等は，『人の生命，身体又は財産の保護のために必要がある場合であって，本人の同意を得ることが困難であるとき』（個人情報保護法第23条第1項第二号）に該当し，家族等への病状の説明が可能」であり，この場合の，「本人の同意を得ることが困難であるとき」には，「本人に同意を求めても同意しない場合」も含まれており，「人の生命，身体又は財産の保護のために必要がある場合」に当たるなら，本人の同意を得なくても家族等への病状説明が可能であるとする[注1)]。

さらに，裁判例のなかには，一定の状況のもとでは，患者本人の意向にかかわらず，医師が患者の家族に診断結果等を説明する義務が生じることを認めるものがある。事案は，医師が患者を末期がんであると診断しながら，その旨を当該患者の妻子に説明しなかったことについて，妻子から医師に対して損害賠償請求がなされたものであったが，裁判所は「患者が末期的疾患にり患し余命が限られている旨の診断をした医師が，患者本人にはその旨を告知すべきではないと判断した場合には，患者本人やその家族にとってのその診断結果の重大性に照らすと，当該医師は・・・少なくとも，患者の家族等のうち連絡が容易な者に対しては接触し，同人・・・等に対する告知の適否を検討し，告知が適当であると判断できたときには，その診断結果等を説明すべき義務を負う・・・。なぜならば，このようにして告知を受けた家族等の側では，医師側の治療方針を理解したうえで，物心両面において患者の治療を支え，また，患者の余命がより安らかで充実したものとなるように家族等としてのできる限りの手厚い配慮をすることができることになり，適時の告知によって行われるであろうこのような家族等の協力と配慮は，患者本人にとって法的保護に値する利益であるというべきであるからである」と判断した[注2)]。

この裁判例は，余命の限られた末期がんの場合についての判断であり，家族の医療への関わりについて一般的に述べたものではないことに注意が必要であるが，家族等による患者への協力と配慮の可能性を前提に，医師に対してそのような家族への説明を一定の場合に求めたことは注目に値する。今後は，精神科診療の場面において，患者本人の同意は得られないが，家族等による協力と配慮を確保することが本人の法的な利益に適うために，家族等への診断名等の説明が正当化されるのはどのような場合か，さらに，上記ガイドライン

注1) 同ガイドラインでは，本人が拒んでいる場合については，「生命，身体又は財産の保護のために必要がある場合」に該当するかについては，本人が拒んでいることを考慮に入れると，ある程度限定的に判断されるべきとの注記がなされている。

注2) 最判 平成14年9月24日 判例タイムズ1106号87頁（最高裁判所のウェブサイト〈http://www.courts.go.jp/search/jhsp0030?hanreiid=76088&hanreiKbn=02〉（2013.10.24）でも閲覧可能）。

が言及するような，患者本人が拒んでいるにもかかわらず，家族等と連絡をとることが「生命，身体又は財産の保護のために」正当化されるのはどのような場合なのかを具体的に明確化していくことが必要である。

精神障害者の加害行為についての監督義務者としての損害賠償責任は，もともと保護者の負う義務から直接に導かれるものではない[注3]ため，保護者の義務の廃止が損害賠償の責任を負わないとの結論に直結するものではない。しかし，今後は，保護者でない家族等がどのような場合に責任を負うかについては，個別具体的な事情のもとでの加害行為の予見可能性の評価が，より一層重みをもつことになると考えられる。

医療及び保護の費用について（旧法第42条）は，保護者制度の有無にかかわらず，入院への同意と費用の負担は本来区別可能な問題であるため，医療費等の負担一般の問題に還元される。

医療保護入院

医療保護入院制度は，保護者の同意に代わり，本人の「家族等のうちいずれかの者」（新法第33条第1項）の同意によるものに改変された。「家族等」とは，入院の必要がある精神障害者の「配偶者，親権を行う者，扶養義務者及び後見人又は保佐人」（同第33条第2項）とされる。医療保護入院の見直しの趣旨は，精神障害により治療を要するとみられる者の人身の自由を侵害することなく，かつ，必要な入院治療につなげることにあったはずであるが，新たな制度はどちらの観点からも問題が多い。

一方で，本人の人身の自由の保障の観点からは，新法で定義される「家族等」が，入院の要否の判断過程において本人の利益を代表する者として適格かについては疑問がある。家族は本人の最適の理解者・保護者であり得ると同時に，密室内での身近な関係のなかで葛藤や利害対立を起こしやすいという両義的な存在であり，時には，家族が入院する者の利益を害する役割を果たすことは周知の弊害である。配偶者など最近親の家族を本人の利益を保護する最適任者とみなすことには一定の合理性が存しようが，すでに平成12年の成年後見制度の改正時において，配偶者が後見人に就任するとの規定（同改正前の民法第840条）が削除されていることを考えると，最近親の者であっても，家族等を本人の人権の擁護者とみなすことは適切ではない。いわんや，他国に比べて扶養義務者の範囲が広すぎると指摘されることの多い日本法[注4]において，扶養義務者が限定文言なく「家族等」の定義に含まれていることは疑問である。

これに対し，少なくとも一定の年齢までの未成年者の場合には，本来，親権者がその子の人格・人身に関わる事項について専ら決定する権限を有し，かつその権限の濫用には一定の制限措置も備えられている（親権喪失〔民法第834条〕または親権の一時停止〔民法第834条の2〕）ことから，「家族等」ではなく，親権者のみが同意者とされるべきである。

他方で，必要な入院治療へのアクセスの観点からは，従前の保護者には順位が定められ，または家庭裁判所の選任が予定されていたのに対し，新法では家族等の定義に該当する複数者を順位付けせずに挙げていることが問題となる。条文の文言上は，家族等の間で意見の相違があるときでも，そのうちの1人が同意をすれば入院が可能だと解し得るが，現実には家族等の意見の対立状況のもとで入院の手続が円滑に進まない事態が懸念される。また，市町村長の同意により得るのは「家族等の全員」が「その意思を表示することができない場合」に限られる（新法第33条第3項）点も，入院治療への間口を狭める恐れがある。

なお，新しい医療保護入院制度には，本人以外

注3）後掲文献1），2）参照。

注4）夫婦相互および夫婦と未成熟子の間には，相互に同じ生活水準となる程度までの扶養（経済的給付）の義務，直系血族および兄弟姉妹の間では自己の相応の生活水準を落とさずに可能な範囲で相手の最低限の生活を保つ程度の義務が課せられるのに加え，家庭裁判所が特別の事情があると認めるときには3親等内の親族（たとえば叔父・叔母と姪・甥の間）が扶養の義務を負うことがある（民法第877条）。

の私人の同意を要件とするという基本枠組みが保たれたことで，同意の有する意味があいまいであるという従前からの問題が引き継がれていることも指摘しておきたい。

指定医1名の判断による入院制度には，患者の人権保障の観点から疑問の余地があることも確かであろうが，両義的な性格の家族に人権保障の砦を期待することの危うさも，また明らかである。医療保護入院により入院させられた者が，同意をした家族構成員に対して不法行為に基づく損害賠償を請求して認められた裁判例が存するところ[注5]，それらの存在は，入院治療の必要性の判断者としての専門家も人権の擁護者としての家族も，絶対的なものではないという当然の事理を示唆しているといえよう。人権侵害の防止と治療へのアクセスの保障を両立させる制度設計は容易ではないが，司法の関与または入院後の評価，監督手続きの大幅な充実[注6]などがあるべき方向性であり，新たな医療保護入院制度は，次善の過渡的な性格のものというべきであろう。

地域社会の体制整備

今般の法改正の趣旨は「精神障害者の地域における生活への移行を促進する」点に存する[注7]。そのための措置として，新たに，精神科病院の管理者は退院後の生活環境に関する相談指導を行う退院後生活環境相談員を選任しなければならないこと（新法第33条の4），入院者またはその家族等からの求めに応じて地域の相談支援事業者等を紹介するよう努めること（新法第33条の5）が規定された。

また，市町村による成年後見の開始の請求に関連して，市町村および都道府県に対して後見等を適正に行う人材の活用を図る努力義務が課せられたことも注目される（新法第51条の11の3）。これらは，努力義務にとどまる事項が多いなど，なお萌芽的な段階の規定ともいえるが，専門家を活用した地域生活への移行促進の方向性は，すでに介護保険法等で採られているケア等の社会化の理念と共通するものであり，成年後見制度の活用と改善，地域の社会福祉制度の充実および両者の連携の促進が期待される。

おわりに

最後に，今回の改正では，本人の位置付け，とりわけその意思の尊重に関しては抜本的な変更は見送られている。本人の利益を代表する者が入院の前から継続的に関与することの重要性が説かれつつも，その具体化には至っていない。

今後の法改正に向けて，本人の意向に沿った医療福祉の実現が，より一層重視されるべきであろう。

文　献

1）久保野恵美子：精神保健福祉法と民法714条－責任無能力者の監督義務，責任．精神医学　54：137，2012.
2）町野　朔：保護者制度の改革と精神医療．法と精神医療　27：43，2012.

注5）離婚した原告が元の夫の職場に抗議の手紙を送るなどの行動をすることについて，社会的な迷惑および自分たちの信用への影響を恐れた原告の親族が医療保護入院により原告を精神科病院に入院させた事例（東京地判　平成22年4月23日　判例時報2081号30頁）や，原告との間で離婚訴訟係争中の夫が民間救急搬送業者を利用して原告を医療保護入院により精神科病院に入院させた事例（大阪地判　平成23年7月5日　法学教室396号165頁）で，各原告を入院させる際に同意した親族の不法行為に基づく損害賠償責任が認められている。どちらの事例も特殊な個別事情を含むが，なお，本文で述べたような示唆を得ることが可能であろう。

注6）入院後の入院要件充足の確認，入院中の定期的な評価，監督を実質化することで，入院の不要な長期化を防ぐものであり，従来の制度の延長で考えれば，精神医療審査会の体制および審理の拡充が求められることとなる。

注7）「精神保健及び精神障害者福祉に関する法律の一部を改正する法律案要綱」〈http://www.mhlw.go.jp/topics/bukyoku/soumu/houritu/dl/183-34.pdf〉（2013.10.24）の「第一　改正の趣旨」を参照。

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

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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.

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JOURNAL OF CLINICAL PSYCHOLOGY, Vol. 00(00), 1–15 (2014)

Published online in Wiley Online Library (wileyonlinelibrary.com/journal/jclp). DOI: 10.1002/jclp.22145

of mental and behavioral disorders in WHO's ICD-11 are discussed. 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

Published online in Wiley Online Library (wileyonlinelibrary.com/journal/jclp). DOI: 10.1002/jclp.22145

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 occured 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 participants[1] 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.

[1]This 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 psychologists[2] ($n = 73$, 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

[2]As 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 ($n = 305$) n	%	In Reed et al. (2013) ($n = 517$) %
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 degree[3] ($SD = 3.8$, 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.

[3]Questions 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 show 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 Subthemes, 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 *per se*)	$n = 181$ (17.0%)
	Examples: Primary (nonorganic) insomnia: *"symptom or part of disorders, does not represent a category"*; Persistent somatoform pain disorder: *"a type of somatoform disorder"*	
	Subtheme 1b: **Diagnoses that are combinations of disorders** (redundant category)	$n = 14$ 1.3%
	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"*	
	Subtheme 1c: **Nonspecific category** (imprecise description, nonspecific diagnostic descriptions, very general category)	$n = 56$ 5.3%
	Examples: Schizoaffective disorder: *"It should be better defined"*; Intermittent explosive disorder: *"Far too over-inclusive""... It is not well described"*	
	Subtheme 1d: **Misclassification of a mental disorder** (as subtype or part of another group or spectrum of mental disorders)	$n = 20$ 1.9%
	Examples: Schizotypal disorder: *"It belongs to the psychoses spectrum; it is not a personality disorder"*; Pathological gambling: *"It should be OCD spectrum"*	
	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)	$n = 70$ 6.6%
	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"*	
	Subtheme 2b: **Diagnoses that represent stigmatization of a way of being or behaving**	$n = 257$ 24.1%
	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"*	

(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)	$n = 162$ 15.2%
	Examples: Specific developmental disorders of scholastic skills: "*Learning problems in children. This condition is not a psychiatric illness. Treatment requires intervention by special educators rather than mental health professionals*"; Oppositional defiant disorder: "*Just poor parenting skills*"	
	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)	$n = 256$ 24.0%
	Examples: Alzheimer's and Vascular dementias: "*Should be in Neurology*"; Autistic disorder: "*It's an organic or genetic problem, not disordered thinking or behavior*"	
Theme 4: **Nonexistent, implausible or untreatable conditions** (No subthemes)	Categories that are nonexistent, implausible or cannot be treated	$n = 50$ 4.7%
	Examples: Cyclothymia: "*Have never seen this*"; Persistent somatoform pain disorder: "*Impossible to prove*"; Factitious disorder: "*Can't be treated*"	

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%) $X^2 = 16.9$, $df = 7$, $p < 0.01$.

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 reflects 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

[4]This 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.

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特集
日本の精神科医は
米国DSM-5を
どう読むか

〈総　論〉

DSM作成までの経緯

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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が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 Study[10]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評価が可能なように人

The process of developing the DSM-5

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