図 1　ロンドンとニューヨークにおける双極性障害と統合失調症診断の割合比較[3]

DSM の歴史に触れるうえで欠かせないのが，1960〜1970 年代にロンドンとニューヨークにおいて行われた，現在でいう統合失調症と双極性障害の有病率調査である[3]．この調査では統合失調症の有病率がニューヨークにおいて非常に高いかのような結果が得られたが，実際にはニューヨークの医師に躁症状を精神病性症状とみなす傾向があり，2 つの精神疾患の診断が共通して用いられていなかったことが判明した（図1）．この調査以降，診断基準の信頼性，つまり共通の診断基準を用いることによってだれでも同じ診断に至ることが担保される診断分類システムが必要であるとの機運が高まった．ここで登場したのが DSM-Ⅲ[4] である．DSM はそれまでにも第 1 版，第 2 版が出版されていたが，DSM-Ⅲ では操作的診断基準が

はじめて全面的に採用されたため，高い信頼性と共通言語としての診断基準を求めるユーザーに広く受け入れられ，急速に普及することとなった．また，医療財政計画から新薬の治験まであらゆる分野において DSM-Ⅲ が用いられるようになったため，DSM-Ⅲ から DSM-Ⅳ[5] への変更は必要最小限にとどめるのが DSM-Ⅳ 作成時の基本方針であった．

DSM-Ⅲ 作成当時から数えれば実に 30 年もの間，臨床と研究の領域において用いられていた DSM の改訂にあたり，DSM-5 実行委員会への風当たりは改訂作業開始当初から強かった．とくに DSM-Ⅲ と DSM-Ⅳ 作成をそれぞれ担った Frances や Spitzer らはあらたに神経生物学的エビデンスが得られたわけでもないのに DSM を改訂する根拠はなく，むしろ臨床および研究に混乱をきたすものであるとの批判を繰り返した[6]．実行委員会としても診断分類を根幹から見直すエビデンスに乏しいことは認めており[7,8]，DSM-5 作成における目的は過去に十分蓄積された知見の反映と臨床的有用性の向上に焦点が絞られることとなった．

発達的視点の取入れ

DSM-5 作成においてはまず発達的視点の取り入れが重視された．DSM-Ⅳ-TR までは横断的診断における高い信頼性が重視されてきた関係上，ある精神疾患がライフスパンを通しどのように臨床像を変化させるのか，また発達段階によってどのように顕在化するのかなど，発達的な視点が不十分であった側面がある．今回の改訂では診断分類システムの臨床での利用における発達的視点が

表 1　DSM-ⅣとDSM-5の章立て比較[13]

DSM-Ⅳ (1994)	DSM-5 (2013)
通常，幼児期，小児期，また青年期にはじめて診断される障害	神経発達症
せん妄，痴呆，健忘および他の認知障害	統合失調症スペクトラム障害および他の精神病性障害群
一般身体疾患による精神疾患	双極性障害および関連障害群
物質関連障害	抑うつ障害群
精神分裂病および他の精神病性障害	不安症群［不安障害群］
気分障害	強迫性および関連症群［強迫性障害および関連障害群］
不安障害	心的外傷およびストレス因関連障害群
身体表現性障害	解離症群［解離性障害群］
虚偽性障害	身体症状症および関連症群
解離性障害	食行動障害および摂食障害群
性障害および性同一性障害	排泄症群
摂食障害	睡眠・覚醒障害群
カテゴリー	性機能不全群
他のどこにも分類されない衝動制御の障害	性別違和
適応障害	秩序破壊的・衝動制御・素行症群
人格障害	物質関連障害と嗜癖性障害群
臨床的関与の対象となることのある他の状態	神経認知障害群
	パーソナリティ障害群
	パラフィリア障害群
	他の精神障害

重視され，全体の章立てから個別の診断カテゴリーの診断基準まで，さまざまな形で発達段階への配慮がなされることとなった．

　実際の変更点をいくつか例にとると，まず章立てが DSM Ⅳ-TR と比較し大きく変化していることがわかる（表1）．厳密ではないが，おおまかに生物遺伝学的負因の大きなものからライフスパンのより後期に発症するものへと配置されている，また，DSM-Ⅳ-TR まで発症が早期であるとの共通項からまとめられていた章（"通常，幼児期，小児期，または青年期にはじめて診断される障害"）が解体され，臨床症状からより適切と思われる章への再分類がなされている（例：反応性アタッチメント［愛着］障害は心的外傷およびストレス因関連障害群に，異食症は食行動障害および摂食障害群に）．

　同一診断カテゴリーにおいて診断基準を年齢により別々に設定したものもある．ADHD は従来，就学以前に症状表出があることを診断の条件としており，成人以降の診断に関しては言及がなかった．これに対し，DSM-5では症状表出時期が7歳以前から12歳以前に引き上げられている．また，17歳以上では成長に伴う適応の工夫や向上の可能性も加味し，診断時に満たす必要のある基準の

総数を16歳以下と比較して1つ少ない5つとしている．6歳以下における PTSD の診断基準においては成人のそれと比較し閾値が低く設定されている．また，発達段階によって症状表出が成人の場合とは異なる可能性への言及も明示されている．

カテゴリカルからディメンショナルへの限局的な移行

　診断分類の領域において精神疾患をカテゴリカルでなくディメンショナルな概念として考えようという発想が主流となりつつある．ある人が診断カテゴリー A に該当するか否か，症状があるかないかでなく，診断カテゴリー A にどの程度合致し，症状がどの程度重いかという，いわば連続性のなかでとらえようとする発想と表現してもよいであろう．この発想は臨床的に有用であることが期待される一方，カテゴリカルな分類法に依拠する既存の診断分類システムからの変更は大規模なものとならざるをえない．臨床のみならず行政などへの影響も加味され，最終的にディメンショナルな評定方法の採用は限定的なものとなった．具体的には，抑うつ症状，不安症状，不眠症状などを，診断カテゴリーにかかわらず評定する案（"cross-cutting measures" とよばれる）や，精神

病症状の重症度評価が DSM-5 への収載を期待されたが、最終的には Section Ⅲ とよばれる、今後引き続き検討されるべき尺度とモデルのセクションに収録された.

DSM-5 においてディメンショナルな発想が反映された領域としては、広汎性発達障害があげられる. 自閉症、アスペルガー症候群、広汎性発達障害 NOS などさまざまなカテゴリーが広汎性発達障害には含まれていたが、このカテゴリー間の区別が廃止され、自閉スペクトラム症として、その名称がさすとおりスペクトラム上に再概念化されることとなった. また、症状もコミュニケーションと限局的・反復的行動の2領域における重症度が段階的に評価されるようになった. 自閉スペクトラム症は発達障害の有識者間で普及して久しく、今回の改訂における採用は比較的妥当との判断がなされたものと思われる.

臨床への有用性を鑑みた情報の追加と削除

既存の診断分類システムが臨床的有用性の点で抱える問題は幅広く指摘されてきた[9-12]. なかでも臨床現場において問題となるのは同一診断名がつく患者どうしであっても臨床像が実に多様であること(つまり診断名が臨床上の情報伝達において役割を十分に果たさない)と、治療に直結しない情報まで特定を求められる(つまり診断分類システムの使用が臨床業務を必要以上に煩雑にする)ことの2点があげられる. 言い換えれば、診断分類システムが臨床家に特定を求める情報の項目が臨床の現状に即さず過不足を呈しているということである. この問題に対し、治療や予後への関連を鑑みて情報の追加と削除が試みられた.

病態がより詳述された例に、まず強迫症関連がある. OCD をはじめ、ためこみ症(hoarding disorder;DSM-5 で新設)、身体醜形症(DSM-Ⅳ-TR では強迫性でなく身体表現性障害に分類)を含む強迫症群では病識の程度が表記できるようになった. これは自らの病態への認識の程度が予後に大きく関連するとの理由からである. PTSD における解離性サブタイプの追加もこの例に含んでよいであろう. 解離性症状を伴う PTSD 患者への治療方針は解離性症状がない場合と比較し配慮が必要であり、予後にも関連するとの理由から従来の PTSD 診断に当該サブタイプが設けられた. 臨床への直接的貢献を見込んだ情報の追加という点では軽度の(mild)神経認知障害の診断カテゴリー新設もここに含められる. 従来の認知症に相当する診断カテゴリー(major neurocognitive disorder)に加え、近年では画像診断などから認知症未満の病態も診断と治療の対象に含められるようになってきている. そこで、DSM-5 では認知機能の障害が major と minor の2段階で評価されるようになった.

反対に、臨床的意義の観点から簡略化された診断カテゴリーも存在する. 身体表現性障害は従来複数の診断カテゴリーが設けられていたが、DSM-5 では身体面での症状を呈する病態は基本的に身体症状症で一本化され、疼痛、持続期間、重症度はすべて特定用語による表記となった(唯一、実際の身体症状を伴わない身体疾患にまつわる不安をのみを訴える病態は illness anxiety disorder として別途診断カテゴリーが設けられている). 物質使用に関する診断分類も同様に簡略化の方向で見直しが試みられ、従来の依存と乱用が物質使用障害に一本化されることとなった. 具体的には DSM-Ⅳ-TR の依存と乱用の診断基準を合わせたうち、2つ以上を満たすと物質使用障害の診断となる(依存では3つ以上、乱用では1つ以上であった). なお、物質使用障害においては該当する診断基準の総数により重症度評価が特定用語で示される.

最後に、経時変化が大きく信頼性や妥当性が低いとの理由に加え、治療方針の決定や予後の予測に役立たないとの理由から DSM-5 で廃止された統合失調症の亜型分類にも触れておく. 統合失調症は病像の記述にあたり DSM-Ⅳ-TR まで亜型分類が用いられてきたが、これに相当する情報を補完する代替的手段は、緊張型を除き、上述の身体症状症や物質使用障害と異なりとくに用意されていない. 臨床への直接的または具体的なメリットが期待できないとしても患者の臨床像の記述や伝達に貢献していた可能性は除外できず、亜型でなく特定用語とするなど漸次的措置がいっさい講じられなかったことに懸念が残る.

臨床家による裁量の拡大

　診断基準の信頼性は基準が操作的であればあるほど，つまり客観的かつ具体的で，解釈の余地が少ないほど信頼性は高まる．冒頭で述べたとおりDSMは長らく診断基準を非常に操作的に記述することで高い信頼性を誇ってきた．一方，操作的診断基準が厳格であるあまりに臨床的有用性が損なわれる側面も指摘されてきた．端的な例として神経性やせ症［神経性無食欲症］における低体重の基準があげられる．DSM-Ⅳ-TRまで有意な低体重の基準は操作的にBMIが年齢相応の85％未満と定義されており，たとえば他の基準をすべて満たすのにBMIが86％の患者はNOSと診断せざるを得なかった．これがDSM-5ではBMIの数値への言及は重症度評価にのみ用いられ，診断の要件ではなくなった．患者の体重が有意に低いかどうかの判断は最終的には臨床家への判断に委ねられることとなっている．

　臨床家による裁量が拡大されたと解釈できる領域は他にも及ぶ．伝統的に知的障害の重症度はIQの数値に依拠していたが，DSM-5では知的障害の診断にあたりconceptual, social, practicalの3領域における機能の程度が記述されており，この記述に照らし合わせる形で重症度が評価されるようになっている．

　抑うつ障害における死別体験の除外基準の削除もここに含めてよいであろう．死別反応と抑うつ状態または抑うつ障害との関連は今日において明らかに示されていない．死別体験後に抑うつ状態を呈するのは正常な反応であり，この反応を"障害"とするのは行き過ぎであり不当であるとの意見がある．一方では死別体験もストレス因子の一種にすぎず，死別体験により誘発されたとみられる抑うつ状態を他のストレス因子による抑うつ状態から区別する根拠は乏しく，発症の契機となったライフイベントの種類にかかわらず治療を必要とする患者への加療を認めるべきとの意見もある．DSM-Ⅳ-TRまで，死別を発症2カ月以内に体験している場合はうつ病性障害の診断対象から除外するとの記載があったが，DSM-5では死別体験後の典型的または健常な反応と，診断対象とすべき病態を詳細に記述し，各臨床家がその記述に則り判断するかたちとなった．

おわりに

　上述の変更点は臨床での使用における柔軟性が高まったという点において評価される一方，信頼性の高さからとくに学術分野で重用されてきたDSMの歴史を考えると診断基準に厳密さが要求される領域において困難が生じるとの懸念もある．

　今回の改訂ではとくに疫学を中心とする研究領域の継続性を損ねず，かつ臨床的有用性の向上をめざすというバランス感覚が要求された．改訂のプロセスにおいて幾度となく実行委員会が主張してきたのは，living documentとしてのDSM，つまりあくまでも現在において最新の診断分類システムという位置づけであり，あらたなエビデンスを随時取り込み，将来的に発展する含みをもたせる姿勢である．

　本稿はDSM-5の総論ということで，変更点を網羅的に記述することはできなかったが，読者が歴史的背景や文脈を念頭にDSM-5を手に取る一助となれば幸いである．

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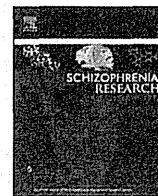
Letter to the Editor

Should schizophrenia still be named so?

Keshavan et al. (2013) seem open to discuss whether the term schizophrenia should be renamed. Recently, we conducted a global survey of renaming schizophrenia, the results of which we intend to share in hopes of encouraging further discussion. In 2002, the Japanese Society of Psychiatry and Neurology changed the official term for schizophrenia. Its corresponding Japanese term had been "*seishinbunretsu-byo*," literally meaning "split-mind disease", and it was changed to "*togoshitcho-sho*," meaning "loss of coordination disorder" (Kim, 2002; Sato, 2006). South Korea followed this movement, and changed the term for schizophrenia in 2011 from "*jeongshin-bunyeol-byung*," an expression equivalent to "split-mind disorder," to "*johyun-byung*," meaning "attunement disorder" (Park et al., 2012). The climate toward accepting this change has been particularly prominent in countries where the Chinese writing system is used, such as Japan and South Korea; however, it is also developing in Europe (van Os, 2009; George and Klijn, 2013). When Maruta and Iimori conducted a survey in 2008, 53% of experts said that the term "schizophrenia" (even in English) had a stigmatizing meaning (Maruta and Iimori, 2008).

We investigated how schizophrenia experts perceive the possible renaming of schizophrenia in the midst of the revision process for the International Classification of Diseases and Related Health Problems (ICD) initiated by the World Health Organization. We surveyed the members of the Sections on Schizophrenia of the World Psychiatric Association (N = 35) and those of the European Psychiatric Association (N = 44). The memberships of 13 individuals were found to overlap and their response was treated as that of one respondent. The questionnaire was sent via e-mail to 66 members, and 38 members (57%) responded. The mean length of their career as a psychiatrist was 25 years (SD = 11 years). This survey was carried out from April to May, 2013.

The idea of renaming seemed somewhat supported, with 57% of the respondents expressing their opinion that the term "schizophrenia" was not appropriate. A total of 84% of such individuals thought schizophrenia denoted stigma, 72% of which explicitly supported renaming schizophrenia. Concerning the timing of renaming, 57% of the respondents thought that it would be desirable to bring about the change by the publication of the 11th revision of the ICD (ICD-11) (Table 1).

In addition to appropriateness of the term and possible timing for renaming, respondents were asked about possible alternatives. Of note, due to the exploratory nature of our study, respondents were allowed to name up to 3 alternatives, which resulted in over 20 suggested terms. We observed that the alternatives tended to be centered around 5 themes: (1) nominative (Bleuler's syndrome, Eugen Bleuler syndrome, Schneider syndrome, Kraepelin disease, John Nash syndrome), (2) failure in organization (Brain tuning disorder, Discoordination disorder, Dysfunctional thought disorder, Disorganized disorder, Disorganized thinking disorder, Thought disorder), (3) failure in integration (Disintegration disorder, Disintegration disorder of the brain, Brain disintegration disorder, Integration disorder, Integrative mental disorder, Mind integration failure disorder, Salience dysregulation syndrome),

(4) neurodevelopmental process (Developmental psychosis, Neurodevelopmental psychosis, Neurodevelopmental vulnerability disorder, Vulnerability-based psychosis, Social brain disorder), and (5) others (Idiopathic psychosis, Endogenous psychosis, Psychosis, Psychosis spectrum disorder, Nonaffective (enduring) psychosis, Dopamine dysregulation disorder). It is important to note the presence of multiple themes among the suggestions: in the absence of a consensus on what should be the focus for the new term, schizophrenia remains the most supported term for the condition in question. Also, the possibility that some respondents may have refrained from explicitly supporting renaming due to the lack of a viable alternative should be pointed out.

Interestingly, however, renaming "schizoid" and "schizotypal" drew only modest interest, with 54% of the respondents considering them as needing renaming.

Table 1
Questionnaire on the term "schizophrenia".

	Yes	No
1. How long have you been working as a psychiatrist? (*Space was provided for an answer.*)		
2. Do you use the term "schizophrenia" or its equivalent in your language when you explain the diagnosis to the patient?	28	10
3. If you do not use the word "schizophrenia", please write the term you use and which language it is. (*Space was provided for indicating the term and language.*)		
4. Do you think that the term "schizophrenia" is an appropriate term for the disorder?	16	21
5. Do you think that the term "schizophrenia" denotes stigma?	31	6
6. If you answered "Yes" to No. 5, should "schizophrenia" be changed to another term to reduce stigma?	21	8
7. In your language, is the term "schizophrenia" concordant with the meaning of "split-mind disease"?	28	5
If you answered "No" to No. 7, what does it mean in English? (*Space was provided for an answer.*)		
8. In your country or in your main psychiatric society, is there any action or movement to change the term "schizophrenia"?	4	34
9. If you answered "Yes" to No. 6, please mark when it should be changed.		
a) As soon as possible	5	–
b) By the publication of ICD-11	12	–
c) Later	3	–
d) Did not answer "Yes" to Q.6	1	–
10. If you answered "Yes" to No. 6, what term do you think is more appropriate than the current term, i.e., "schizophrenia"? Please provide your suggestions below. (*Space was provided for suggestions.*)		
11. Should the new name convey an acceptable scientific concept or concepts?	27	4
12. If you answered "Yes" to No. 11, what scientific concept(s) should be reflected? (*Space was provided for an answer.*)		
13. If you answered "No" to No. 11, why do you not think so? (*Space was provided for an answer.*)		
14. Do you think that the terms "schizoid" and "schizotypal" should also be changed?	17	20
15. For question 14, if you answered "Yes", what terms do you think are more appropriate instead of the terms "schizoid" and "schizotypal"? Please write your suggestions below. (*Space was provided for suggestions.*)		

Some researchers are against renaming schizophrenia (Lieberman and First, 2007). Indeed, one of the limitations of our study is that it failed to finely delineate the relationship between the term "schizophrenia" itself and its perceived stigma, that is, we do not know whether the respondents' recognition of stigma associated with the term "schizophrenia" can be attributed to the term itself or the public concept associated with the term, or both, the latter of which, although not explicitly explored in our study, unquestionably requires just as much attention. Nonetheless, this survey revealed that many experts do think schizophrenia denotes stigma and hence support renaming. With the publication of the ICD-11 approaching, the authors urge mental health professionals, clinicians and researchers both to re-examine the appropriateness of the term schizophrenia and to change it if necessary. On a last note, we would like to emphasize that we believe in renaming schizophrenia by utilizing evidence and knowledge accumulated up to the present, and we hope that it will result in lessened stigma and hopelessness felt among the patients and their family members.

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Toshimasa Maruta*
Department of Psychiatry, Tokyo Medical University, Tokyo, Japan
*Corresponding author at: Department of Psychiatry, Tokyo Medical University, 6-7-1 Nishishinjuku, Shinjuku-ku, Tokyo 160-0023, Japan.
Tel.: +81 3 3342 6111x5754; fax: +81 3 3340 4499.
E-mail address: maruta@tokyo-med.ac.jp.

Umberto Volpe
*Department of Mental Health, University of Naples SUN,
Largo Madonna delle Grazie, 80138 Naples, Italy
Section Secretary on Schizophrenia, European Psychiatric Association,
15 Avenue de la Liberté, 67000 Strasbourg, France*

Wolfgang Gaebel
*Department of Psychiatry and Psychotherapy, Medical Faculty,
Heinrich Heine University, Bergische Landstr. 2,
D-40629 Düsseldorf, Germany
Section Chairman on Schizophrenia, World Psychiatric Association,
Geneva University Psychiatric Hospital, Bâtiment Les Voirons 2,
Chemin du Petit Bel-Air, 1225 Chêne-Bourg, Geneva, Switzerland*

Chihiro Matsumoto
Department of Psychiatry, Tokyo Medical University, Tokyo, Japan

Makio Iimori
Department of Psychiatry, Tokyo Medical University, Tokyo, Japan

2 August 2013

LETTERS

"Prosumers" and Recovery

To the Editor: In an open e-mail to his colleagues, psychologist Frederick Frese, Ph.D., an acknowledged "prosumer" (a mental health professional who has experienced mental illness) pointed out that of 137,000 members of the American Psychological Association, only ten were known to him to have revealed a psychiatric history. Among psychiatrists, some may reveal their status to trusted friends. However, very few have been openly willing to utilize their psychiatric histories as areas of special expertise. Among these are Suzanne Vogel-Scibilia, M.D., who speaks often of her diagnosis of bipolar disorder, and Daniel Fisher, M.D., Ph.D., a psychiatrist with a diagnosis of schizophrenia and a leadership role in the consumer movement. All acknowledge prior episodes of psychosis and psychiatric hospitalizations. Yet all are functioning as practitioners or as nationally known advocates.

Where are the others? Hidden from view, they presumably are reluctant to be forthcoming because of their fear of stigma and of being demeaned by fellow professionals. Concerned about being labeled "impaired," mental health professionals have good reason to hide a psychiatric diagnosis. In *An Unquiet Mind*, noted psychologist Kay Jamison wrote tellingly of what happened when she revealed her bipolar disorder to an old friend and colleague: an immediate drop in status, an instant perception of an unforeseen defect.

Prosumers do not reveal their status because they fear devaluation and mistrust of their skills. Yet objectively, those who are in recovery and intact enough to conduct their work may also be viewed as superior in important respects. They are able to control their symptoms, overcome external and internalized stigma, and utilize a battery of coping strategies when confronting stress. Consider the accomplishments of the aforementioned mental health professionals with major axis I diagnoses. For many years Fred Frese was director of psychology at a large state psychiatric hospital in Ohio. Dan Fisher is long-time director of the SAMHSA-funded National Empowerment Center in Massachusetts. Suzanne Vogel-Scibilia, a former president of the National Alliance on Mental Illness, has a substantial practice and is active in the American Association of Community Psychiatrists. All have lectured widely and participated in national policy-making venues. How many others could influence policy and training if they were willing to lend their personal expertise to these enterprises?

Prosumers who are able to function in their professions are to be admired. They should be proud to acknowledge their diagnoses and take credit for their coping skills in going the extra mile. Fears of disclosure demean their enormous courage in overcoming deficits and turning them into strengths. They are our role models for recovery.

Harriet P. Lefley, Ph.D.

Dr. Lefley is with the Department of Psychiatry, University of Miami School of Medicine, Miami, Florida.

Alternative Settings: Unintended Consequences

To the Editor: The November issue includes a timely review by Thomas and Rickwood (1) of residential alternatives to psychiatric hospitalization for patients who need acute care. Their main conclusion was that care provided in these settings can improve symptoms at least as well as care provided in psychiatric hospitals and that the alternative settings appear to be cost-effective. At a time when saving money is becoming increasingly important, it is essential to look closely at these findings. The authors noted the enormous variation among these services. They also remarked that the studies they reviewed did not provide much detail about the patients and the actual treatment and support provided. A recent review of nonresidential alternatives to psychiatric hospitalization also mentioned the omission of such details (2), and we agree with the authors that these aspects should be investigated further.

However, there is a point that was not emphasized by Thomas and Rickwood. Not only are details lacking about the patients and treatments, but virtually no information has been reported about what happens in the rest of the service system when a "crisis house" is introduced. Tyrer and colleagues (3) described the introduction of a home treatment team and mentioned that the number of suicides in the catchment area increased, although none of the patients who killed themselves were under the care of the home treatment team. It may have been the case that experienced staff had moved to the home treatment team and that community mental health teams thus became less effective. Something similar might happen with the introduction of crisis houses.

For economic evaluations of residential alternatives, it is also important to observe what happens in other parts of the system. For example, introduction of a home treatment team or a residential alternative may increase the number of empty hospital beds. Therefore, even though the alternative setting is cheaper per patient, the increased costs for the system of the empty beds may mean that offering care in the alternative setting is more

expensive than offering standard inpatient care.

Dieneke A. A. Hubbeling, M.Sc., M.R.C.Psych.
David Chang, M.B.B.S., M.R.C.Psych.

The authors are affiliated with Wandsworth Crisis and Home Treatment Team, South West London, and with St. George's Trust, London, United Kingdom.

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In Reply: Hubbeling and Chang raise important issues and highlight the fact that changes in one area of mental health care have an impact on other parts of the system. The mental health care system provides a continuum of services of treatment and support. Ideally, clients are able to move between levels of service according to changes in their symptoms and wellbeing; the aim is to provide care in the least restrictive environment. For example, both Australia (1) and the United Kingdom (2) have such a system.

The flow-on effects of changes in available services and client movements within a system are difficult to determine. Doing so requires a systemwide focus rather than evaluation of unique service types within a system, which was the type of review we undertook. Collateral effects of changes in provision of mental health services were not reported in any of the research articles that were included in our systematic review.

We acknowledge that a skilled workforce is essential to the effectiveness of mental health care and that staff movements within the continuum of services—or staff movements out of the mental health care system—will have an impact on the quality of services provided.

Kerry A. Thomas, B.Sc.(Psych.), B.Soc.Sc.(Psych.)
Debra Rickwood, Ph.D., B.A.

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ICD-11 and DSM-5 Classifications: A Survey of Japanese Psychiatrists

To the Editor: The World Health Organization is currently working on the 11th revision of the *International Classification of Diseases (ICD-11)* (1), and *DSM-5* (2) was released in May 2013. Some criticized the process of developing *DSM-5* (3). Thus we thought that it would be worthwhile to investigate how Japanese psychiatrists view the *ICD* and *DSM* revision processes and how they would like the diagnostic classifications to change.

The aim of this study was to clarify how *ICD-10* (4) and *DSM-IV-TR* (5) have been perceived in clinical, administrative, and forensic settings in Japan. In addition, we solicited opinions on the diagnostic classifications proposed for *ICD-11*. A questionnaire was mailed in February 2011 to 452 members of the council of the Japanese Society for Psychiatric Diagnosis and 80 chief professors from every psychiatry department at universities in Japan. They were asked to provide their opinions and perspectives on issues regarding diagnostic classification in general, rather than on specific disorders or domains in the *ICD-10* and *DSM-IV-TR*.

Data were collected from 245 respondents (response rate of 46%), of which 219 were men and 26 were women. The mean±SD age of respondents was 50.0±12.9 years, and the mean length of their experience as a psychiatrist was 23.9±12.4 years. [A table presenting the 12 questions and the responses is available in an online data supplement to this letter.]

Survey results appeared to indicate that respondents were rather hesitant about making major changes, such as reorganizing the classification system. The coexistence of two major diagnostic systems, namely the *ICD* and *DSM*, has been a concern among many clinicians. The Research Domain Criteria proposed by the National Institute of Mental Health in the United States were favorably seen by Japanese psychiatrists; 74% approved this approach.

Hesitation about making major changes was evident in responses to an item about recent molecular genetic research suggesting that bipolar disorder is closer to schizophrenia than to depression. Respondents were not comfortable combining bipolar disorder and schizophrenia as psychotic disorders; instead, 69% agreed that bipolar disorder should continue to be included in the category of mood disorders.

Two items asked about the many "not otherwise specified" (NOS) diagnoses and "comorbid" diagnoses that are yielded by the *ICD-10* and *DSM-IV-TR*. Responses indicated a desire that revisions to the classification systems would lead to fewer such diagnoses; however, many respondents acknowledged that NOS and comorbid diagnoses were an unavoidable outcome of using operational diagnostic criteria.

These results were obtained from Japanese psychiatrists and therefore cannot be generalized to psychiatrists worldwide. However, we hope that these findings will help inform *ICD-11* revision efforts.

Toshimasa Maruta, M.D., Ph.D.
Yutaka Ono, M.D., Ph.D.
Chihiro Matsumoto, M.A.

Dr. Maruta and Ms. Matsumoto are affiliated with the Department of Psychiatry, Tokyo Medical University, Tokyo. Dr. Ono is with the National Center for Cognitive Behavioral Therapy and Research and the National Center of Neurology and Psychiatry, Tokyo.

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Disengagement in a Torture Treatment Program

To the Editor: Treatment programs for torture survivors often provide care without specifying discharge timelines—natural conditions in which to test service engagement. Although needs persist in this group (1), variance in pre- and postmigration stressors (2) suggests that needs are not uniformly chronic. We used survival analysis of data gathered from April 2008 to October 2013 at a New York program to predict disengagement, hypothesizing that posttraumatic stress disorder (PTSD) and associated characteristics would predict later disengagement and that practices accommodating immigrants would predict earlier disengagement.

The consecutive sample of 665 was mostly male (N=397, 60%). The mean±SD age was 33.93±9.65, 509 (77%) reported formal education (mode 12 years), and 249 (37%) spoke functional English. Represented were 75 countries across Africa (N=343, 52%), Asia (N=210, 32%), Europe (N=83, 13%), and the Americas (N=24, 4%). At intake, 515 patients (77%) had unstable immigration status (undocumented or asylum applicant). A total of 555 (83%) met criteria for the U.N. Convention Against Torture, 48 (7%)

met World Medical Association criteria only, and 62 (9%) met other criteria. Mean PTSD scores on the Harvard Trauma Questionnaire (HTQ) (3) were 2.59±.62 at intake, and 2.14±.57 at six-month assessment (N=414, 62 %), indicating improved symptoms.

A total of 305 patients (46%) received services from French- or Tibetan-speaking bilingual staff; others received services in English (N=227, 34%) or through telephonic interpreters (N=62, 9%). A total of 556 (84%) used social services, 529 (80%) used mental health care (individual and group therapy and psychopharmacology), and 503 (76%) received legal assistance.

Disengagement was defined as no use of services for six months. Mean days to disengagement was 816.74± 25.85; a quarter (27%) did not disengage. Mean days for receipt of social services was 756.04±28.16; mental health care, 616.76±26.61; and legal assistance, 604.79±26.00. Predictors of earlier disengagement were age ≤25 (hazard ratio [HR]=.62; 95% confidence interval [CI]=.49–.79), formal education (HR=.68, CI=.49–.79), European country of origin (HR=.61, CI=.46–.82), functional English (HR=.58, CI=.48–.72), not using bilingual staff (HR=.54, CI=.44–.66), and stable immigration status (HR=.56, CI=.39–.80). Not predicting disengagement were gender, number of persecution types, detention, sexual assault, head injury, and HTQ scores at intake and six months. The most parsimonious Cox regression model predicting earlier disengagement comprised not using bilingual staff (HR=.55, CI=.44–.69) and stable immigration status (HR=.55, CI=.39–.80).

Findings suggest that the needs of half of torture survivors can be reduced to a minimal level within two years. About a quarter may have chronic needs. Disengagement predictors are consistent with research showing education and English ability to be associated with multiple positive outcomes among immigrants (4). Use of bilingual staff predicted later disengagement, countering a hypothesis and

suggesting that patients' preference for services delivered by practitioners who speak their languages (5) prolongs their care. Null trauma findings may seem inconsistent with clinical common sense but reflect research suggesting that many needs of forced migrants are due more to displacement than to trauma severity (2). Programs should emphasize obtaining stable immigration status and redouble English education efforts.

Andrew Rasmussen, Ph.D.
Eva Keatley, B.S.
Claudia Paz, B.A.

Dr. Rasmussen is with the Department of Psychology, Fordham University, Bronx, New York. Ms. Keatley is a graduate student in the Department of Psychology, University of Windsor, Windsor, Ontario, Canada. Ms. Paz is a graduate student in the Wagner School of Public Service, New York University, New York City.

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● 発達障害とは何か

DSM，ICD における発達障害診断の新分類について

* 東京医科大学 精神医学講座　** 同 准教授　*** 同 主任教授

松本 ちひろ*　　　丸田 敏雅**　　　飯森 眞喜雄***

要　旨

　我が国を含め世界的に広く用いられている診断分類システムが，改訂の時期を迎えている．『国際疾病分類』(ICD)，『精神疾患の診断・統計マニュアル』(DSM) が扱う精神障害は多岐にわたるが，発達障害は近年特に著しく理解が進んだ分野であり，これを反映して大幅な改変が試みられている．本稿では，注意欠陥多動性障害（ADHD）と自閉症スペクトラム障害に関して，主にDSM-5 における大分類の再編成に伴う発達障害の再概念化や診断基準の具体的な変更点について紹介し，教育や行政への影響について考察した．

は　じ　め　に

　2013 年 5 月に『精神疾患の診断・統計マニュアル』(DSM) 第 5 版 (DSM-5)[1] が発刊を迎え，『国際疾病分類』(ICD) は 2015 年の第 11 版 (ICD-11) 完成を目指し改訂作業が進められている．DSM 第 4 版新訂版 (DSM-Ⅳ-TR)[2]，ICD 第 10 版[3] 作成当時と比較し，発達障害に対する注目度は近年非常に高まっている．また同時に，発達障害は，診断概念や治療における発展が比較的著しい領域でもある．本稿では，発達障害診断における新分類の概要を紹介する．

キーワード：発達障害，DSM-5，ICD-11

新たな診断分類システムについて

　発達障害の診断分類の前に，DSM-5 および ICD-11 のタイムラインについて述べる．DSM は米国精神医学会により作成されており，ICD の改訂は世界保健機関が行っている．今回この 2 つの診断分類システム改訂の時期が大幅に重なり，両者間においてハーモナイゼーションに向けた努力が試みられた．しかし，ハーモナイゼーションはあくまでも協調できる範囲のことであり，これらのシステムが全く同一のものとなるとは考えにくい．

　本稿執筆時点（2013 年 6 月）において，DSM-5 は完成しているのに対し，ICD-11 は大分類の概要がある程度まとまった段階で，今後細部の変更が十分考えられる．したがって，本稿において決定事項として紹介できるのは DSM-5 における新分類である．また，我が国においては DSM が学術分野において広く用いられている一方，医療や行政では ICD の影響力が大きいため，今後の ICD-11 の動向にも注視が必要であることをここで述べておく．

"神経発達障害" の大分類

　DSM-IV-TR から DSM-5 への改訂にあたり，大分類が大幅に再編成された（図 1）．DSM-IV-TR においては知的障害，学習障害，運動能力障害，コミュニケーション障害，広汎性発達障害，注意欠陥多動性障害（ADHD）に加え，破壊的行動障害，哺育・摂食障害，排泄障害，愛着障害なども，"通常，幼児期，小児期，または青年期に初めて診断される障害" にひとまとめに分類されていた．これに対し，DSM-5 において "神経発達障害" の章に含まれるのは，知的障害，コミュニケーション障害，自閉症スペクトラム障害（ASD），ADHD，学習障害，運動能力障害のみとなっており，ほかの障害はおのおのより適切と考えられる，ほかの章に分類されることとなった（例：反応性愛着障害は "トラウマとストレス関連障害" の章，異食症は "哺育と摂食の障害" の章，反抗挑戦性障害は "破壊的，衝動制御および行為障害" の章にて分類）．本稿では，本誌の主眼とされている ADHD と ASD についてふれるものとする．

図 1　DSM-IV-TR と DSM-5 の大分類の比較（文献より引用改変）
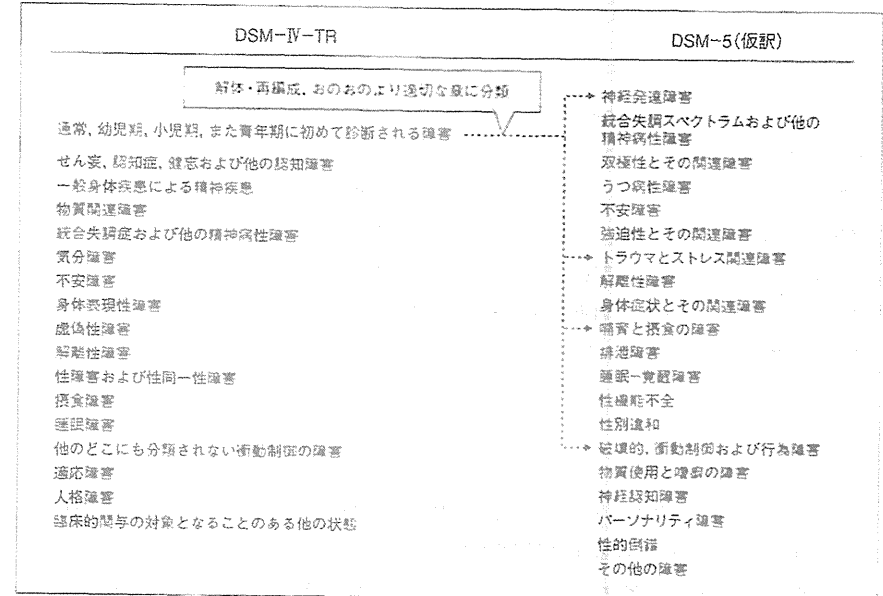
注意欠陥多動性障害（ADHD）について

　DSM-5 における ADHD について，特筆すべき点は 2 つある．まず，DSM-IV-TR から大きく変わった点として，素行や衝動制御の問題と明確に区別されたこと，次に児童期以降における ADHD について明確な診断基準が示されたことである．

衝動制御の問題との明確な区別

　DSM-IV-TR において，ADHD は行為障害，反抗挑戦性障害とひとまとめに "注意欠陥および破壊的行動障害" に分類されていた．しかし，ADHD は先天的な注意と多動の問題を主症状とするのに対し，ADHD を除く上述の 2 つの精神障害は，素行と，ケースによってはパーソナリティの問題と見なされるものであり，これら 2 群の精神障害における臨床像はかなり異なるものである．今回の改訂過程においても，症状が外在的に観察されるという観点から ADHD を素行と衝

動制御の問題と同じ章内で扱おうとする動きがあったが，最終的に，ADHD は素行と衝動制御の問題よりも神経発達の問題に分類すべき，との結論に至ったようである．

その是非はともかくとして，行為障害は児童思春期における，反社会性パーソナリティ障害としばしば見なされる診断名である．ADHD がこれらの障害とは質的に別のものであると見なされたことで，ADHD に対する偏見の緩和が期待できるかも知れない．また，ADHD は，先に述べた障害の症状に似た苛立ち，かんしゃくなど，二次的な症状ないし問題につながることが少なからずあるが，それら二次的な問題のみに焦点を当てた対応は根本的解決にはつながらず，むしろ主症状である注意と多動の問題への対処を考えることが，長期的に見て治療上有効かも知れない．

児童期以降における注意欠陥多動性障害（ADHD）の診断

前述のとおり，ADHD は DSM-IV-TR まで "通常，幼児期，小児期，または青年期に初めて診断される障害" の大分類に含まれており，ADHD が認知され始めた当初は "子どもの障害" のイメージが強かった．しかし近年，成人期における ADHD がメディアなどでしばしば取り上げられているとおり，成人における ADHD は，児童期のそれと比較し症状表出は変化するものの，成人となっても ADHD が完治するわけではない実態が明らかとなってきた．このような知見の蓄積を踏まえ，DSM-5 においては，児童後期以降における ADHD の明確な診断基準が新たに設定された．

表1は DSM-IV-TR と DSM-5 における ADHD 診断基準を比較したものである．DSM-IV-TR は，7歳以前に症状が生活に支障を来していることが基準となっていたが，DSM-5 では，症状の発現時期が12歳までに引き上げられ，また症状のもたらす機能障害への言及が，緩やかになっていることが分かる．

広汎性発達障害から自閉症スペクトラム障害（ASD）へ

DSM-IV-TR では，自閉症障害，レット障害，小児期崩壊性障害，アスペルガー障害，特定不能の広汎性発達障害が広汎性発達障害とし

表1　DSM-IV-TR と DSM-5 における注意欠陥多動性障害（ADHD）診断の比較

	DSM-IV-TR	DSM-5
症状表出時の年齢への言及	症状の幾つかが7歳以前に存在	症状の幾つかが12歳以前に存在
青年・成人における診断への言及	なし	17歳以上における診断基準を新設（不注意，多動性／衝動性の各領域において，16歳以下よりも1つ少ない5つの症状が見られれば診断基準を満たす）
機能障害への言及	社会的，学業的，または職業的機能において，著しい障害が存在	社会的，学業的，または職業的機能における妨げ，または質の低下が見られる

て扱われていた．これらの診断名は DSM-5 においては個々の障害として扱われなくなり，ほとんどのケースは "ASD" として扱われることとなる．これは，今回の改訂において，近年蓄積された知見を踏まえ，全面的な見直しが試みられた領域であり，新たな診断基準から行政などの社会的な影響までを含め，包括的に変更点を紹介する．

自閉症スペクトラム障害（ASD）とは

ASD は，コミュニケーションと限局的興味・関心と反復的行動の，2つの領域において障害が見られる場合に診断される障害とされている．DSM-IV-TR によれば，自閉症，アスペルガー障害，特定不能の広汎性発達障害の診断を受ける個人の大半が，DSM-5 においては自閉症スペクトラム障害に相当し，上述の3つの診断の診断名は，個々の疾患単位ではなくなる．

"ASD" の呼称が診断分類システムに導入されるのは DSM-5 が初めてであるが，発達障害の専門家間で，発達障害全般をスペクトラムととらえる考え方は長く支持されてきた．後に詳述するアスペルガー障害に関しても，スペクトラム上において，ある特徴的な発達の偏りを見せる一群の患者を指すものと表現されることとなる．

消えるアスペルガー障害の診断名

アスペルガー障害という診断名は国内で認知度が近年急激に高まっ

ており，それが新診断分類システムにおいて姿を消すことについてのとまどいの声が散見される．しかし，この診断に関しては，疾患単位としての妥当性に対し疑問を呈する声が少なからずあった．言い換えれば，アスペルガー障害ないし症候群の診断名は，特定の症状を示す一群の患者の臨床像の記述に有用である点から用いられ，また認知度を高めてきたものとも言える．DSM-5 作成に際し，アスペルガー障害の疾患単位としての妥当性が見直され，結果的に，ほかの病態と比較した際の独立性が十分でない[4]として，アスペルガー障害は ASD に吸収されるかたちとなった．

診断の対象となる個人は減るのか

DSM-5 は 2010 年から草案をウェブサイト上で公開しており，新たに提唱された基準による診断が行われた際，診断の閾値を満たす患者数が大幅に減るとの報告があった[5]．この調査結果は，学術誌にとどまらず一般にも広く報道され，DSM-IV-TR から DSM-5 への移行に際し，これまで受けられていた必要なサービスが受けられなくなる個人が多数出るのでは，との懸念につながった．

DSM-5 実行委員会はこの報道により広まった動揺への対応に追われ，DSM-IV-TR において，広汎性発達障害の診断を受けている個人が，DSM-5 への移行に際し，診断の対象からはずれることはないと繰り返し強調した．

実際，診断基準そのものを比較してみると，DSM-5 におけるASD の診断基準は，DSM-IV-TR の広汎性発達障害のそれと比較し，感度が向上している面もある（表2）．

行政面への影響

発達障害の診断基準は，教育や行政に直接的な影響を及ぼす．行政にとって発達障害の診断分類は，限られたリソースをどの範囲までの個人を対象にどのように配分するかを判断する際の大きな指標となる．発達の問題が見られる子どもの保護者にとっては，今後も我が子が教育的支援やサービスの対象となるのか，動向を注視せざるをえない．

しかし，診断分類が教育や行政に及ぼす影響は一方的なものであろ

表2　DSM-IV-TR における広汎性発達障害と DSM-5 における自閉症スペクトラム障害（ASD）の感度の比較の例

項目の例	具体的記述
対人場面での症状の記述	DSM-IV-TR："発達水準に相応した仲間関係を作ることの失敗"に限定 DSM-5："さまざまな対人場面において適切な行動がとれない"を含む高次の対人場面での困難全般を想定 →同年齢の児童との交流がなくても判断が可能に
症状表出の時期への言及	DSM-IV-TR：症状表出は 3 歳以前 DSM-5："発達早期""社会的要求が能力を超えて初めて症状が顕在化する"ケースも想定 →3 歳以前の状態の把握が困難な場合でも診断可能に

図2　多施設間の自閉症スペクトラム障害（ASD）診断基準を満たす患者のカテゴリ別最良推定診断の割合比較（文献[5]より引用改変）
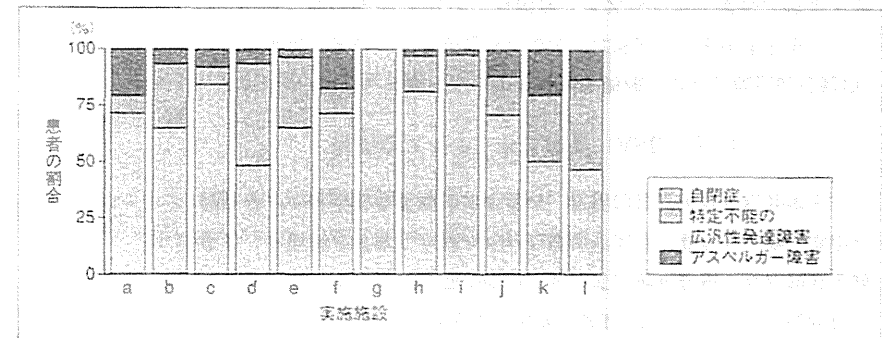
うか．図2は，米国において，ASD に含まれる患者のカテゴリ別診断名の割合を，実施箇所別に示したものである．一般的有病率と比較的近い割合で，アスペルガー障害や特定不能の広汎性発達障害の診断がつけられている地域もあるのに対し，ほぼ全員が自閉症の診断を受けている地域もある．これは明らかに，診断基準の信頼性の問題ではない．本調査の結果について DSM-5 のワーキンググループは，各施設のある地域ごとの，発達障害に対する行政サービスの差と関連づけて考察している．つまり，自閉症以外の診断名の児童に対しても教育サービスが提供される州では診断基準を遵守したかたちでの診断が，自閉症以外の診断名ではサービスの提供対象とならない地域では，当該児童の利益のため，実際はほかにより適切な診断名があっても，

自閉症と診断名を付けざるをえなかったのであろう，との推察である．

実際に，この研究結果は DSM-5 作成の際におおいに援用された．DSM-5 が自閉症，アスペルガー障害などの疾患単位の垣根を取り払い，1つのスペクトラムとしてとらえる手段を採用した背景には，各児童の発達の状態における多角的評価を推奨する目的に加え，教育的配慮や補助が必要な児童が行政サービスから抜け落ちてしまわないように，との目的もある．

お わ り に

先に述べたとおり，発達障害の診断分類とその臨床における適用の関係は，単純なものではない．また，日本国内では，国家統計，保険診療および行政的なサービスなど，公的に用いられる診断分類システムは ICD-11 であり，新たな診断分類による実際の影響が見られるのは数年後であろう．ただし現段階において，ICD-11 の基本方針は DSM-5 と大筋で似たものとなることが予想される（例：広汎性発達障害を ASD として再概念化および再編成）．

おわりに，ICD-11 の完成，翻訳，および国内での正式な適応などを考えると，今後の発達障害のある児童への対応が我が国でどのようにあるべきかについての十分な議論が，今から行われることを期待して擱筆したい．

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New Diagnostic Classification of Developmental Disorders
in DSM and ICD

Chihiro Matsumoto, Toshimasa Maruta, Makio Iimori

Department of Psychiatry, Tokyo Medical University

Editorial

Towards the ICD-11: Initiatives taken by the Japanese Society for Psychiatry and Neurology to address needs of patients and clinicians

A LONG WITH A few other neighboring countries, Japan uses the Chinese writing systems, and our writing system for the nomenclature of mental disorders is no exception. With the aim of reducing the stigma associated with schizophrenia, the Japanese Society for Psychiatry and Neurology (JSPN) played a key role in changing the term for schizophrenia in 2002 and dementia in 2004. Specifically, the equivalent term for schizophrenia was changed from *seishinbunretsu-byo* ('split mind disease') to *togoshitcho-sho* ('loss of coordination disorder'),[1] and that for dementia to *ninchi-sho* ('cognitive disorder').

The ICD, which has been published and revised by the World Health Organization (WHO), is closely related to the DSM, issued by the American Psychiatric Association (APA). The 5th edition of the DSM[2] was just released in May, 2013, and the 11th revision of the ICD is to be released in the near future. The new diagnostic categories to appear in these classification systems have been discussed by the JSPN, which had set up two committees with specific topics to discuss, respectively, namely the Committee for the Psychiatric Glossary of DSM/ICD Classification and the ICD-11 committee.

The term 'disorder' has turned out to be especially problematic for the Committee for the Psychiatric Glossary, as its equivalent term in Japanese, 'shougai', is also an equivalent term for disability (i.e. 'intellectual disability'). Disorder and disability are two different concepts, and in Japan the question has been raised as to whether we can or should continue to use the same word for both disorder and disability. The implication of this problem is serious, especially for pediatric diagnoses. Children, understandably ignorant of this complex issue in our nomenclature, automatically associate and often equate or confuse 'disorder' with 'disability' and its resulting handicap. In other words, a child diagnosed with a mental disorder faces a great risk of being seen as disabled, which implies irreversibility and a marked handicap and further subjects the child to teasing and alienation.

Aside from the issues inherent to the nature of translation, there also remains some controversy as to what terms should be used to refer to specific illnesses, that is, disorder, disease or syndrome.[3] One may say that some illnesses are closer in nature to 'disease' in that we know their biophysiological mechanism better than others'; in contrast, some illnesses may be more appropriately addressed as syndromes, for our relative lack of knowledge on their cause, heterogeneity of symptom presentations among patients with the same diagnostic label, etc.

The Committee for the Psychiatric Glossary has adapted the following seven criteria for deciding on an official translation of nomenclature.[4] The translation has to: (i) reflect the concept and background of the nomenclature; (ii) reflect the difference from and relevance to the traditional Japanese terminology; (iii) reflect the original meaning in English; (iv) be as concise as possible; (v) be self-explanatory enough for the general public to deduce what symptoms would be manifested; (vi) be unambiguously distinguishable from other disorders and their symptoms; and (vii) not facilitate prejudice against the patients.

Considerable changes can be seen in parts of the classification and nomenclature of the ICD-11 and DSM-5 in comparison to their previous editions. Not all disorder labels used in the previous editions were adapted with much transparency in terms of how the final agreement was reached and for what grounds. For instance, the term 'somatoform disorders', which first appeared in the 3rd edition of the DSM,[5] is expected to be replaced with 'somatic symptom disorders'.

The nomenclature of mental disorders inevitably goes through changes over time and with accumulation of new scientific knowledge. The recent movement toward person-centered medicine[6] is particularly notable, and it has become a critical factor to

consider how the nomenclature will be perceived and understood by the patient who receives the diagnosis. In Japan, upon the publication of the DSM-5 in May 2013, the glossary committee is planning to publicize the draft of translated disorder labels and call for public comments on their website.

In Japan, because the ICD is used for the national statistics, the Japanese government launched the Sub-committee of the Classification of Disease and Morbidity and the Statistics Committee of the Social Council of the Ministry of Health, Labor and Welfare from the outset to revise the ICD-11 and smoothly introduce the ICD-11 to established organizations throughout Japan.

The JSPN has established a mechanism to handle translation of the ICD-11 and of material to be used in field trials. Among the key activities that the JSPN has taken a lead in is recruitment for a network called Global Clinical Practice Network (GCPN),[7] which is expected to function as a pool for registrants to participate in web-based field studies. At preset the number of registrants from Japan is more than 700 (as of May, 2013), and it is expected to increase further. In addition, the JSPN has been successful in establishing the Field Studies Center Network, with approximately 30 institutions and organizations nominated nationwide to conduct field studies with real patients. The first face-to-face meeting was held with an attendance of the senior project officer from the WHO in March 2013. With the ICD-11 projected to be published in 2015, a series of web-based studies will be conducted, followed by field trials with real patients.

To the authors' knowledge, in the Asian region it appears that no academic society has made collective efforts of this scale yet, and we hope that the progress that we have made in Japan will serve as a useful example. In particular, our experiences in translation and how we handled difficulties associated with translation may be relevant to China, Taiwan, Korea and Hong Kong, where the Chinese writing system is also used. We believe that the JSPN, in the series of aforementioned activities, contributes not only to the people of Japan, including patients, caregivers and health-care professionals

alike, but also to the neighboring countries, by providing a valuable example.

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Toshimasa Maruta, MD, PhD,[1,2,7,8]
Chihiro Matsumoto, MA[1,8] and
Shigenobu Kanba, MD, PhD[2,3,4,5,6]
[1]Department of Psychiatry, Tokyo Medical University, [2]The ICD-11 Committee of Japanese Society for Psychiatry and Neurology, [3]The Committee for Psychiatric Glossary, [4]The Committee for Glossary of DSM/ICD Classification of Japanese Society for Psychiatry and Neurology, [5]Subcommittee of Classification of Disease and Morbidity, Statistics Committee of the Social Security Council of the Ministry of Health, Labor and Welfare of Japan, Tokyo, [6]Department of Neuropsychiatry, Graduate School of Medical Sciences, Kyusyu University, Fukuoka, Japan, and [7]The WHO International Advisory Group for the Revision for ICD-10 Mental and Behavioural Disorders (Representative of the Government of Japan), and [8]The WHO International Advisory Group for the Revision for ICD-10 Mental and Behavioural Disorders, The Field Studies Coordination Group, Geneva, Switzerland

Mental Health Professionals' Natural Taxonomies of Mental Disorders: Implications for the Clinical Utility of the ICD-11 and the DSM-5

Geoffrey M. Reed,[1] Michael C. Roberts,[2] Jared Keeley,[3] Catherine Hooppell,[1] Chihiro Matsumoto,[4] Pratap Sharan,[5] Rebeca Robles,[6] Hudson Carvalho,[7] Chunyan Wu,[8] Oye Gureje,[9] Itzear Leal-Leturia,[10] Elizabeth H. Flanagan,[11] João Mendonça Correia,[1] Toshimasa Maruta,[4] José Luís Ayuso-Mateos,[10] Jair de Jesus Mari,[7] Zeping Xiao,[12] Spencer C. Evans,[2] Shekhar Saxena,[1] and María Elena Medina-Mora[6]

[1] World Health Organization
[2] University of Kansas
[3] Mississippi State University
[4] Tokyo Medical University
[5] All India Institute of Medical Sciences
[6] National Institute of Psychiatry Ramon de la Fuente Muñiz
[7] Federal University of São Paulo
[8] Shanghai Mental Health Center
[9] University of Ibadan
[10] Universidad Autónoma de Madrid
[11] Yale School of Medicine
[12] Shanghai Jiaotong University School of Medicine

Objective: To examine the conceptualizations held by psychiatrists and psychologists around the world of the relationships among mental disorders in order to inform decisions about the structure of the classification of mental and behavioral disorders in World Health Organization's International Classification of Diseases and Related Health Problems 11th Revision (ICD-11). **Method:** 517 mental health professionals in 8 countries sorted 60 cards containing the names of mental disorders into groups of similar disorders, and then formed a hierarchical structure by aggregating and disaggregating these groupings. Distance matrices were created from the sorting data and used in cluster and

correlation analyses. **Results:** Clinicians' taxonomies were rational, interpretable, and extremely stable across countries, diagnostic system used, and profession. Clinicians' consensus classification structure was different from ICD-10 and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV), but in many respects consistent with ICD-11 proposals. **Conclusions:** The clinical utility of the ICD-11 may be improved by making its structure more compatible with the common conceptual organization of mental disorders observed across diverse global clinicians. © 2013 Wiley Periodicals, Inc. J. Clin. Psychol. 69:1191–1212, 2013.

The World Health Organization (WHO) is currently revising the International Classification of Diseases and Related Health Problems Tenth Revision (ICD-10; WHO, 1992), with the ICD-11 slated for approval by the World Health Assembly in 2015. The WHO Department of Mental Health and Substance Abuse is responsible for managing the technical work of developing the ICD-11 chapter on mental and behavioral disorders, within the context of broader policies developed by the overall ICD-11 classifications team. Serious problems with the clinical utility of both the ICD-10 and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV) classifications of mental disorders are widely acknowledged (e.g., Andrews et al., 2009; Kendell & Jablensky, 2003; First, 2010). Some of these problems are: (a) extensive use of "Unspecified" or "Not Otherwise Specified" categories of no informational value; (b) artificial and inflated comorbidity among mental disorders categories; (c) many of the distinctions clinicians are asked to make in diagnostic classification systems have no relevance for treatment, while important diagnostic heterogeneity in other areas is obscured; and (d) the sheer complexity of current diagnostic systems, with each revision including more categories, more subtypes, and more specifiers (see Reed, 2010).

A major goal of the WHO Department of Mental Health and Substance Abuse for the current revision is to improve the clinical utility of this part of the ICD-11 (Reed, 2010; International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011). "People are only likely to have access to the most appropriate mental health services when the conditions that define identification, eligibility and treatment selection are supported by a precise, valid, and clinically useful classification system" (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011, p. 90). In order for the ICD-11 classification of mental and behavioral disorders to be a more effective tool for meeting international public health goals, the new system will need to be usable for implementation throughout the world at the point where people with mental health needs are most likely to come into contact with the health system.

What Is Clinical Utility and Why Is It Important to WHO?

For the purpose of this program of work and drawing on previous definitions of clinical utility (First et al., 2004; Kendell & Jablensky, 2003; Mullins-Sweatt & Widiger, 2009), WHO has conceptualized the clinical utility of a classification, construct, or category for mental and behavioral disorders as: (a) its value in *communicating* (e.g., among practitioners, patients, families, administrators); (b) its *implementation characteristics* in clinical practice, including its goodness of fit (i.e., accuracy of description), its ease of use, and the time required to use it (i.e., feasibility); (c) its usefulness in *selecting interventions* and making *clinical management* decisions; and (d) the extent to which it is associated with improvements in clinical outcomes at the individual level and in health status at the population level (see Reed, 2010).

WHO is interested in clinical utility because it is critical to the interface between clinical practice and health information. Global health care systems are overburdened; clinicians are under enormous time pressure, and only a very small minority of persons with mental health needs will ever see a specialist mental health professional. A mental disorders classification that

is difficult and cumbersome to implement in clinical practice and does not provide information that is of immediate value to the clinician has no hope of being implemented accurately at the encounter level in real-word health care settings (Reed, 2010; Roberts et al., 2012). In that event, clinical practice will not be guided by the standardization and operationalization of concepts and categories that are inherent in the classification, and important opportunities for practice improvement and outcomes assessment will be lost. In turn, a diagnostic system that is characterized by poor clinical utility at the encounter level cannot generate data based on those encounters that will be a valid basis for health programs and policies, or for global health statistics.

Clinical Utility and the Architecture of Diagnostic Classification

The appropriate architecture of a diagnostic classification of mental and behavioral disorders is an issue that has received substantial recent attention. Andrews et al. (2009) offered a particularly ambitious proposal of five broad clusters of mental and behavioral disorders and examined the evidence for these a priori clusters based on eleven "validators." The authors claimed that such a simplified structure would enhance clinical utility by reducing complexity. However, this reduction in complexity was partly due to the fact that more than half of existing mental disorders categories were not encompassed by the five groupings (First, 2009). The authors did not explain the mechanisms through which an improvement in clinical utility would occur or provide any supporting evidence for this claim, which was strenuously challenged in a series of commentaries published simultaneously with the proposals (First, 2009; Jablensky, 2009; Wittchen, Beesdo, & Gloster, 2009).

Andrews and colleagues' implicit perspective is that what is most important in creating the structure of a mental disorder classification is to reflect the most current and accurate scientific understanding about the "true" relationships among mental disorders. Unfortunately, as Jablensky (2009) and Wittchen et al. (2009) pointed out, a review of currently available evidence does not provide uniform or definitive support for one particular architecture. Moreover, Hyman (2010) has suggested that the foundation for such an effort is shaky when many of the disorders themselves may not be valid and distinct disease entities; it is not possible to have a valid biomarker for a fictive category.

From a clinical utility perspective, particularly in terms of improving the interface between health information and clinical practice, the most important and desirable features of a classification's organization would be that (a) it helps clinicians find the categories that most accurately describe the patients they encounter as quickly, easily, and intuitively as possible and (b) the diagnostic categories so obtained would provide them with clinically useful information about treatment and management. An organization based on Andrews et al.'s (2009) "validators" would not contribute to this objective unless individual data for these parameters (e.g., genetic risk factors, biomarkers) were routinely available in the clinical setting and contributed meaningfully to treatment and management decisions, which for many of them is clearly not currently the case.

Given current technology, it is possible to develop a comprehensive and uniform taxonomic system that underlies a classification, with unique identifiers for each individual category to facilitate interoperability across different applications that are distinct from how those categories are presented to users. For example, the structure and logic of airline reservation codes are meaningless to most travelers—who are more concerned with the date, time, and destination of their flights—but perfectly interpretable to computers. The underlying architecture of the identifiers is completely independent of how that information might be presented to users for a particular purpose. As an illustration of a similar process, different Amazon.com users can find the same book by searching under mysteries, bestsellers, the works of a particular author, or books published in June 2011, rather than having to use the 10-digit International Standard Book Number (ISBN) of the International Organization for Standardization (ISO) to make their purchase; that is, the unique identifier for each book—its code in the classification— is independent of how the material is presented to the user, because the presentation can be