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Views of Japanese Psychiatrists on Making Diagnoses: Clinical Use of Conventional Versus Operational Diagnostic Criteria

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This study aimed to ascertain the views of Japanese psychiatrists on the meaning of making diagnoses and on the clinical use of operational diagnoses. A questionnaire asking about attitudes towards making diagnoses was sent to 283 members of the Japanese Society for Psychiatric Diagnosis. The response rate was 54%. The majority of psychiatrists felt that diagnosing a patient did not necessarily contribute to the patient's treatment, even when the psychiatrist was aware that one of the purposes of diagnosing is to aid in the formulation of an adequate treatment plan. Seventeen percent of respondents denied the significance of making a differential diagnosis of "cases-in-between" schizophrenia and mood disorder, chiefly because they thought that this differential diagnosis did not significantly affect the initial management of this group of patients. Fifty-two percent of respondents used operational diagnostic criteria for clinical purposes despite their perceived lack of depth, while the disadvantage of conventional diagnoses is considered to be the lack of explicit criteria. The results regarding the diagnoses of patients with the co-occurrence of major depression and panic disorder indicated that more respondents were critical of the cross-sectional comorbidity approach (54%) than they were of the lifetime comorbidity approach (39%). Seventy-three percent thought that diagnostic concepts unique to Japanese psychiatry should be actively employed. The findings of the present study suggest that the clinical use of operational diagnostic criteria remains controversial among Japanese psychiatrists, most of whom make complementary use of conventional and operational diagnostic methods with an awareness of their usefulness and limitations.

Key Words: Japanese psychiatrists, conventional diagnosis, operational diagnosis

Introduction

The introduction of operational diagnostic criteria such as the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (DSM-III)[1] has greatly facilitated empirical studies and led to a substantial increase in research on psychiatric diagnoses. Nevertheless, literature is lacking regarding the views of psychiatrists on the meaning of and potential problems associated with making a psychiatric diagnosis and, more specifically, on how they should use various concepts or systems for categorizing mental disorders, including conventional and operational diagnostic concepts, in clinical settings. However, psychiatrists generally agree that operational diagnostic criteria should be used in research settings. The aims of the present survey were to: (a) obtain the views of Japanese psychiatrists on what they consider to be the purposes and problems of making a psychiatric diagnosis, and (b) ascertain their views on the clinical use of conventional and operational diagnostic concepts.

Methods

A questionnaire was constructed, which was divided into three parts: respondents' demographic

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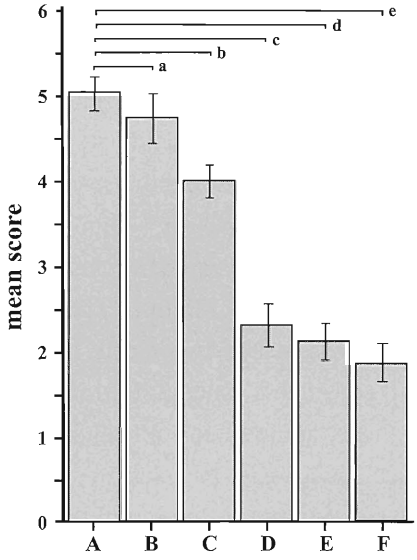

Fig. 1 Mean ranking scores for each factor considered to be relevant to the aims of making a psychiatric diagnosis (95% CI)
The factors were as follows: (A) formulating an adequate treatment plan, (B) characterizing the psychopathological state, (C) predicting the clinical course and outcome, (D) facilitating communication among psychiatrists, (E) understanding of pathogenesis, (F) providing information to the patient and family. a: NS; b-f: $p<0.0001$.

data and the general and special issues involved in making a psychiatric diagnosis. A draft version was piloted with 60 psychiatrists and modifications were made in the light of their comments before sending out the final version.

All 283 members of the Japanese Society for Psychiatric Diagnosis, who were considered the most likely to be interested in psychiatric diagnoses among Japanese psychiatrists, were sent the final version of the questionnaire, consisting of 20 questions, a covering letter explaining the aims of the survey, and a prepaid return envelope in June 2012. The questionnaire was in rank-order and multiple-choice format with space for additional comments. The following six principal areas were explored: (I) the aims and problems of making a psychiatric diagnosis in the clinical setting; (II) the meaning of making a differential diagnosis of "intermediate psychotic area"[2]; (III) the distribution of respondents utilizing conventional versus operational diagnostic concepts; (IV) the advantages and disadvantages of conventional versus operational diagnoses; (V) the attitudes of respondents towards the comorbidity diagnostic approach, considered to be one of the highlighted themes of operational diagnosis; and (VI) the attitudes of respondents towards the use of conventional diagnostic concepts unique to Japanese psychiatry.

Statistical comparisons for categorical variables were performed using the chi-squared test or the two-tailed Fisher's exact test where appropriate. Multiple comparisons were made using one-way analyses of variance (ANOVAs) followed by post hoc tests or by using the Friedman test followed by the Wilcoxon signed-rank test with the Bonferroni correction when necessary. The level of significance was set at $p<0.05$. All statistical procedures were performed with SPSS, version 20 (SPSS Inc., Chicago, IL, USA).

Results

Respondents

The response rate was 54.1% (153/283). The mean duration of experience in psychiatry of the respondents was 22.8 years (range: 2–57; 95% confidence interval [CI]: 20.8–24.76). The distributions regarding the respondents' places of work were as follows: 50% worked in a university department of psychiatry, 25% in a mental hospital, 8% in a private outpatient clinic, 7% in a psychiatric unit of a general hospital, and 10% worked at other locations. The distributions of the respondents' psychiatric subspecialties were as follows: 42% specialized in biological psychiatry, 16% in clinical psychiatry and psychopathology, 12% specialized in both of the former two subspecialties, and 30% specialized in other areas (e.g., social psychiatry, psychotherapy, forensic psychiatry, geriatric psychiatry).

Aims and general problems of making diagnoses in clinical settings

Respondents were asked to rank, in descending order of clinical importance, six factors considered by the author to be relevant to the aims of making a psychiatric diagnosis. Scores assigned ranged from 1 (least important) to 6 (most important). Significant differences in ranking order were found among the six factors ($p<0.0001$, Friedman test). As Fig. 1 shows, the mean scores for the two highest ranked

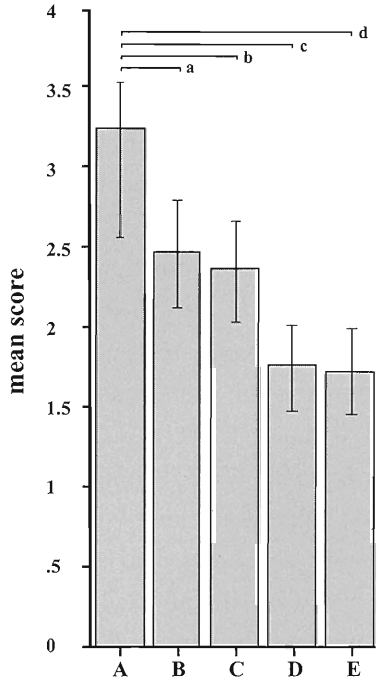

Fig. 2 Mean ranking scores for each factor considered to be problematic in making a psychiatric diagnosis (95% CI)
The factors were as follows: (A) diagnosing does not necessarily contribute to treatment, (B) difficulty in making essential diagnosis due to uncertainty of the etiology, (C) diagnosing does not necessarily contribute to predicting the course and outcome, (D) poor interrater reliability, (E) diagnosing is merely labeling of psychiatric conditions. a: $p=0.0019$; b-d: $p<0.0001$.

items (i.e., formulating an adequate treatment plan [A] and characterizing the psychopathological state [B]) were similar and significantly higher ($p<0.0001$, Wilcoxon signed-rank test) than the scores for the remaining items (i.e., predicting the clinical course and outcome [C], facilitating communication among psychiatrists [D], understanding of pathogenesis [E], and providing information to the patient and family [F]).

Respondents were also asked to rank, in descending order of problematic level, five factors considered to be problematic when making a psychiatric diagnosis. Scores assigned ranged from 1 (least problematic) to 5 (most problematic). Significant differences in ranking order were found among the five factors ($p<0.0001$, Friedman test). As shown in Fig. 2, the highest mean score was for item (A), which stated that diagnosing does not necessarily contribute to treatment.

Diagnosis of "intermediate psychotic area"

In the questionnaire, a case vignette was presented of a 32-year-old male who had previously experienced two manic and one depressive episode(s) and who has concurrently manifested manic and schizophrenic symptomatology, including Schneider's first-rank symptoms[3], for one month. Respondents were asked to indicate to what extent they would consider it meaningful to make a differential diagnosis among schizophrenia, mood disorder, atypical psychosis, and schizo-affective disorder before starting the treatment of this case, which corresponds to "intermediate psychotic area" or "cases-in-between"[2]. The distribution of respondents regarding the response to the Likert-type question was as follows: 32 respondents answered very meaningful (21%), 69 said meaningful (45%), 25 said somewhat meaningful (16%), and 26 answered not meaningful (17%). The 26 respondents who considered that there was no need to make a differential diagnosis in the "intermediate psychotic area" were asked to indicate the reason. The most frequent response (76%) to this question was that making a differential diagnosis does not appear to contribute to the management and treatment of "cases-in-between."

No significant associations emerged between the attitudes of respondents towards differential diagnoses of "cases-in-between" and their psychiatric subspecialties or their affinity for conventional versus operational diagnostic schemata. There were also no significant differences between the respondents with and without positive attitudes towards the meaning of differential diagnoses of "cases-in-between" in terms of the duration of their experience in psychiatry.

Conventional versus operational diagnosis

Respondents were asked to indicate whether they make a diagnosis according to non-operational conventional diagnostic concepts, such as Schneider's[3] and the ninth edition of the International Classification of Diseases (ICD-9)[4], or according to operational diagnostic criteria, such as the DSM-IV[5] and ICD-10[6]. As indicated in Fig. 3, among

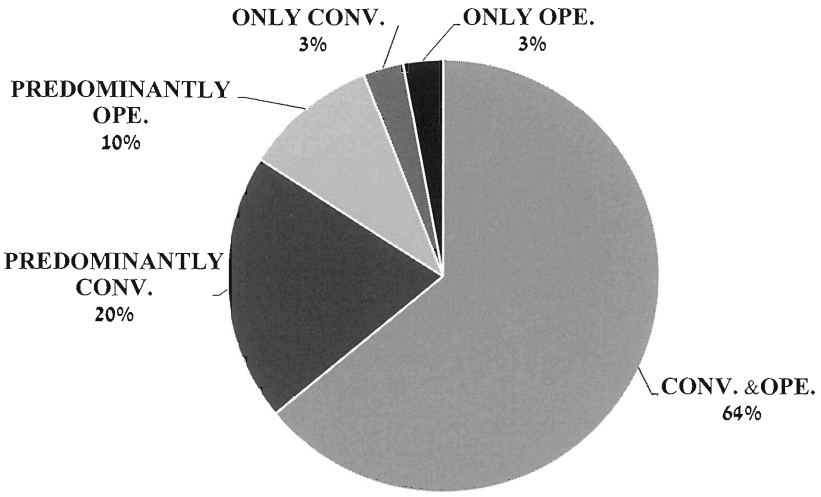

Fig. 3 Distribution of respondents according to their use of conventional versus operational diagnostic criteria
CONV: conventional diagnostic criteria, OPE: operational diagnostic criteria.

the respondents, 100 (64%) reported that they use both conventional diagnostic concepts and operational diagnostic criteria, 30 (20%) stated that they predominantly use conventional diagnostic concepts, 15 (10%) indicated that they predominantly use operational diagnostic criteria, and 8 (5%) reported that they only use conventional diagnostic concepts (n = 4) or operational diagnostic criteria (n = 4). A one-way ANOVA revealed significant differences among the respondents who only or predominantly use conventional diagnostic concepts (n = 34, referred to as the conventional group), those who only or predominantly use operational diagnostic criteria (n = 19, referred to as the operational group), and those who use both diagnostic schemata (n = 100) with regards to the mean duration of their experience in psychiatry ($F_{2,149} = 3.05$, $p = 0.05$). Bonnferoni / Dunn's multiple comparison test showed that the conventional group had significantly more years of psychiatric experience than did the operational group (mean: 26.3 years, CI: 22.2–30.4 vs. mean: 18.0 years, CI: 12–24; $p = 0.015$). Respondents with a subspecialty of biological psychiatry were more likely to use operational diagnostic criteria than were respondents with a subspecialty of clinical psychiatry or psychopathology (47.6 vs. 9.1%, $p = 0.033$, Fisher's exact test).

One hundred forty-five respondents, excluding those who only use conventional diagnostic concepts (n = 4) or operational diagnostic criteria (n = 4), were also asked to indicate how they actually use the two different diagnostic schemata. As shown in Fig. 4, the distribution of responses to this question was as follows: 42% of respondents use conventional diagnostic concepts in clinical settings and operational diagnostic criteria in research settings, 42% make an effort to use both diagnostic schemata in clinical settings, and 8% use operational diagnostic criteria in clinical settings only for specific diagnostic categories such as personality disorder.

Respondents were asked to rank, in descending order of problematic level, six factors considered to be problematic in the operational diagnostic approach. Scores assigned ranged from 1 (least problematic) to 6 (most problematic). Significant differences in ranking order were perceived among the five factors ($p < 0.0001$, Friedman test). As indicated in Fig. 5, the mean scores for the items of "lack of depth and comprehensiveness" and "changing of criteria for a relatively short period" were significantly higher ($p < 0.0001$, Wilcoxon signed-rank test) than the scores for the other factors.

Respondents were also asked to rank, in descending order of problematic level, five factors considered to be problematic in the conventional diagnostic approach. Scores assigned ranged from 1 (least problematic) to 5 (most problematic). The Friedman test revealed significant differences ($p < 0.0001$) in

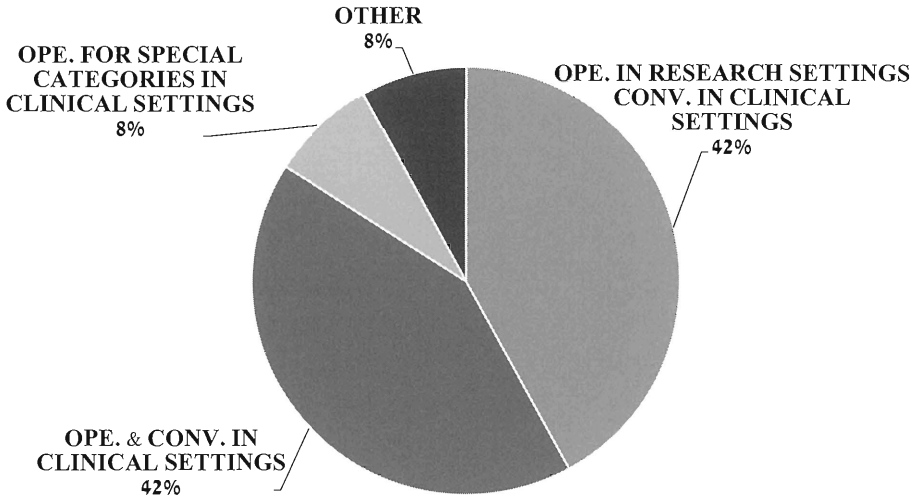

Fig. 4 Distribution of respondents according to their use of conventional versus operational diagnostic methods for clinical or research purposes
CONV: conventional diagnostic criteria, OPE: operational diagnostic criteria.

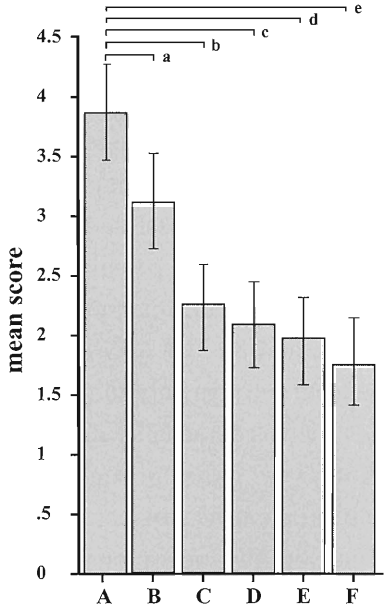

Fig. 5 Mean ranking scores for each factor considered to be problematic in the operational diagnostic approach (95% CI)
The factors were as follows: (A) lack of depth and comprehensiveness, (B) changing of criteria for a relatively short period, (C) neglect of early diagnosis, (D) lack of theoretical basis, (E) obstructing treatment, (F) conventional diagnostic concepts are useful enough for diagnosing. a: $p = 0.0129$; b-e: $p < 0.0001$.

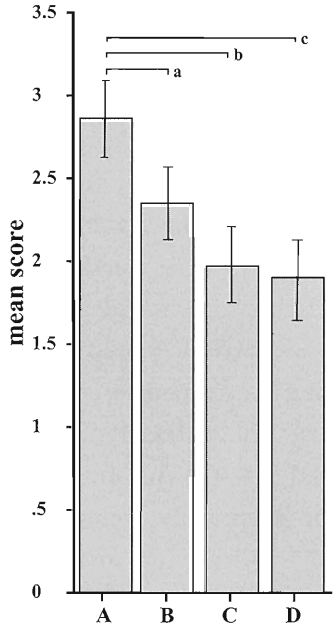

Fig. 6 Mean ranking scores for each factor considered to be problematic in the conventional diagnostic approach (95% CI)
The factors were as follows: (A) lack of explicit criteria, (B) poor interrater reliability, (C) conventional classification systems differ among schools, (D) conventional diagnosis is likely to be influenced by intuition and preoccupation. a: $p = 0.0015$; b, c: $p < 0.0001$.

the ranking order among the four factors. As Fig. 6 shows, the highest mean score was for item (A), "lack of explicit criteria."

Comorbidity diagnosis

Two case vignettes were presented that fulfilled the DSM-IV criteria of both major depression and panic disorder together in one episode of illness or in different episodes, and asked respondents to indicate their diagnoses and attitudes towards the cross-sectional and lifetime comorbidity approaches[7], respectively. Of the respondents, 83 (54%)

offered opposition to the cross-sectional comorbidity approach (concurrent presence of more than one disorder) and 60 respondents (39%) argued against the lifetime comorbidity approach (sequential presence of disorders over the whole lifespan). Respondents who favored conventional diagnosis (conventional group) were significantly more likely to be opposed to the cross-sectional comorbidity diagnosis (75.0 vs. 35%, $\chi^2 = 7.37$, df = 1, p = 0.0066) and the lifetime comorbidity diagnosis (61.5 vs. 23.1%, p = 0.0407, Fisher's exact test) than were those who favored operational diagnostic criteria (operational group). These respondents were asked to give reasons for their objection to the comorbidity approach. The most frequent response (87%) to this question was that additional diagnoses such as panic disorder should be incorporated into the most essential diagnosis, such as major depression, which corresponds to the patient's comprehensive main dimension of psychopathology.

Furthermore, respondents were presented with a case vignette of a 22-year-old female who demonstrated only two DSM-IV criteria for borderline personality disorder such as a pattern of unstable interpersonal relationships and identity disturbance since the age of 17, but who for the last two months has concurrently fulfilled all eight DSM-IV criteria for borderline personality disorder and the criteria for a major depressive episode with melancholic features specifier. In response to the question "What is your diagnosis for this case?", a variety of responses were recorded, with the most frequent being Axis I: major depressive episode and Axis II: borderline personality disorder according to DSM-IV criteria (33.6%); Axis I: major depressive episode and Axis II: borderline personality features (17.1%); only borderline personality disorder according to conventional diagnostic concepts (11.8%); Axis I: major depressive episode and Axis II: borderline personality disorder according to DSM-IV criteria and only borderline personality disorder according to conventional diagnostic concepts (10.5%); and only depressive illness according to conventional diagnostic concepts (5.3%).

Diagnostic concepts unique to Japanese psychiatry

There are several diagnostic concepts unique to Japanese psychiatry, which relate to not only culture-bound syndromes, but also to a typology of premorbid personality of depressive illness, the diagnostic classification system of depressive state, a nosological entity (atypical psychosis of Mitsuda[8]), and subcategories of depressive illness and schizophrenia.

Respondents were asked to indicate whether they thought such diagnostic concepts should be actively employed in clinical settings, although they have not yet received international acceptance. Of the respondents, 109 (73%) favored this idea, whereas 44 (27%) were opposed to the use of such concepts. Respondents who only or predominantly use conventional diagnostic concepts were more likely to be in favor of the use of Japanese diagnostic concepts than were those who only or predominantly use operational diagnosis (73.3 vs. 25.7%, $\chi^2 = 6.34$, df = 1, p = 0.012).

Discussion

Although previous studies have used questionnaire surveys to investigate psychiatrists' conventional diagnostic habits[9][10] and their attitudes towards particular diagnostic categories such as borderline personality disorder[11], dissociative disorder[12], and somatization disorder[13], this is the first survey to assess the views of psychiatrists on the meaning of and problems associated with making a psychiatric diagnosis, as well as the clinical use of conventional and operational diagnostic concepts.

Methodological considerations

It may be difficult to generalize the findings from this survey of the members of the Japanese Society for Psychiatric Diagnoses to Japanese psychiatrists in general. However, the respondents included a large number of prominent professors, senior consultant psychiatrists, and directors of facilities who are considered to be the leading psychiatrists in Japan. Considering their great influence on Japanese psychiatry, the findings of the present survey may represent the mainstream viewpoint of Japanese psychiatrists.

Although the test-retest reliability should be examined to confirm the findings of some of the questions, particularly those where respondents were asked to rank attributes in order of their importance, such temporal reliabilities were not examined. However, the results of the present study revealed highly significant rank-order differences for these questions, which could mitigate such methodological weaknesses.

Aims of making a psychiatric diagnosis

The responses to the questions regarding the aims and problems of making a psychiatric diagnosis may reveal a dilemma common to most psychiatrists. Namely, these responses suggest that most psychiatrists feel that making a diagnosis does not necessarily contribute to the treatment, even when they consider formulating an adequate treatment plan to be the most important purpose of making a diagnosis.

The results on the attitudes of respondents to the meaning of making a differential diagnosis of "cases-in-between" schizophrenia and mood disorder may provide further insight into this dilemma. Seventeen percent of respondents denied the significance of making a differential diagnosis of "cases-in-between," chiefly because they thought that differential diagnoses made no significant difference to the initial management of this group of patients. Their view may be based on their everyday practice, in which "cases-in-between" used to all be treated using neuroleptics irrespective of their differential diagnosis. Their view may be further facilitated by the marked discrepancies in conventional diagnostic concepts of schizo-affective disorder advocated by several authors. Their critique of the differential diagnosis of "cases-in-between" might reflect one of the reasons why the conventional diagnosis of schizo-affective disorder is rarely used by Japanese psychiatrists[9]. Thus, Japanese psychiatrists tended to give a conventional diagnosis of schizophrenia or atypical psychosis, as has been advocated by Mitsuda[8] and widely adopted in Japan, to patients with DSM-IV schizo-affective disorder or bipolar disorder with mood incongruent psychotic features[9][10].

However, when considering that making a differential diagnosis among schizophrenia, schizo-affective disorder, and mood disorder has profound implications for the use of mood stabilizers such as lithium carbonate, which has been confirmed to contribute to the course and outcome of patients diagnosed as having DSM schizo-affective disorder[14] or DSM bipolar disorder including mood incongruent psychotic features[15], the importance of differential diagnosis of "cases-in-between" can be better appreciated.

In contrast, there may also be patients for whom making a differential diagnosis does not necessarily contribute to treatment. For instance, many psychiatrists no longer believe that the endogenous/non-endogenous (e.g., neurotic or reactive) dichotomy of depressive illness has treatment implications[16]~[19], although this subcategorization has been regarded as important in conventional psychiatric treatment settings in Japan[9].

Conventional versus operational diagnostic approaches

The present study indicated that most of the respondents used both conventional diagnostic concepts and operational diagnostic criteria, while only a few respondents (5%) exclusively used either system. Although most respondents seemed to utilize conventional diagnostic concepts in everyday practice, it was also noted that more respondents (52.4%) than expected used operational diagnostic criteria such as the DSM-IV not only for research, but also for clinical purposes. The respondents regarded the lack of explicit criteria and the lower interrater reliability of conventional diagnostic methods as the most problematic features of these schemata, and these factors may explain why psychiatrists employ operational diagnostic criteria in clinical settings. However, it should also be noted that increased reliability does not necessarily guarantee increased diagnostic validity.

In addition to the results of the present study, recent debates held at an annual meeting of the Japanese Society of Psychiatry and Neurology[20][21] revealed that the clinical use of operational diagnostic criteria still remains controversial among Japanese

psychiatrists. A strong argument against the clinical use of the DSM-IV was that it neglects early and probable diagnosis, suggesting that the DSM-IV does not represent clinical diagnostic criteria, but rather a nosological classification system[21]. On the other hand, in addition to increased interrater reliability, the fact that most DSM diagnoses have associated empirical data sets that include information on the epidemiology, clinical course, treatment response, outcome, and familial pattern is considered to lend support to the clinical utility of the DSM-IV[20].

The results suggest that psychiatrists with a shorter duration of experience in psychiatry and those with a more intimate affinity for biological psychiatry were more likely to employ operational diagnostic criteria. It should be ensured that this tendency among younger psychiatrists without substantial clinical training and experience does not increase the risk of their oversimplifying complex psychopathological pictures and misunderstanding psychopathological essentials[22]; these risks may arise because of the lack of depth and comprehensiveness of operational diagnostic criteria, which the respondents in the current study considered as the most problematic features of operational diagnostic methods. Thus, the use of operational diagnostic criteria such as the DSM-IV in clinical and educational settings should be informed by an awareness of its risks and limitations.

Since the publication of the DSM-III-R[23], the concept of comorbidity has gained increased attention in the field of psychiatry[7]. Nevertheless, the results showing significant differences in the rates of acceptance of the comorbidity approach between respondents who favor operational diagnosis and those who favor conventional diagnosis suggests that the comorbidity concept is a subject of considerable controversy among Japanese psychiatrists. The results regarding the diagnoses of patients with co-occurrence of major depression and panic disorder indicated that more respondents were critical of the cross-sectional comorbidity approach (54%) than they were of the lifetime comorbidity approach (39%). This finding suggests that a large number of Japanese psychiatrists still doubt the validity of eliminating the DSM-III hierarchical exclusionary rule that gives major depression precedence over the anxiety disorders. In addition to family genetic studies[24][25] and retrospective clinical studies[26], further prospective clinical studies are needed to dispel these doubts. Such studies need to determine whether patients with co-occurrence of major depression and anxiety disorder in the same episode of illness go on to develop further episodes of major depression alone and/or anxiety disorder alone in their longitudinal courses. If major depression and anxiety conditions always co-occur in further episodes, the validity of the cross-sectional comorbidity diagnostic approach should be reconsidered.

Nearly half of the respondents gave a dual diagnosis of major depression and borderline personality disorder, according to the DSM-IV, to a patient with borderline personality features who manifested the full-blown syndrome of borderline personality disorder solely during a major depressive episode. This finding suggests that a lack of recognition of the transient modification of personality features by Axis I disorders such as major depression could lead to an overdiagnosis of personality disorder.

More respondents (73%) than expected were in favor of the use of diagnostic concepts unique to Japanese psychiatry while simultaneously being aware of the difficulty in introducing such diagnostic concepts using a "common language" for international communication. This difficulty was considered by respondents who favored operational diagnostic criteria to be the major objection to the clinical use of such concepts. These results suggest that a large number of Japanese psychiatrists may employ such concepts in clinical settings based on an awareness of their "dialectal" usefulness and limitations.

Conclusion

The results of the present study suggest that a large number of Japanese psychiatrists feel that making a psychiatric diagnosis does not necessarily contribute to treatment, even though they are

aware that a main reason for establishing a diagnosis is to formulate an adequate treatment plan. The results showing that conventional diagnostic concepts, including those unique to Japanese psychiatry, are being employed in clinical settings by the majority of respondents suggest that most Japanese psychiatrists appreciate the clinical utility of these concepts despite their various limitations. More than half of the respondents argued against the clinical use of cross-sectional comorbidity diagnoses, suggesting that they do not consider such operational concepts to be useful in everyday practice. In contrast, the clinical usefulness of operational diagnostic criteria such as the DSM-IV was suggested, for instance, by the view that the differential diagnosis of "cases-in-between" according to operational criteria rather than conventional concepts could make a contribution to treatment. Nevertheless, it must also be emphasized that operational diagnostic criteria should be employed by psychiatrists who have appropriate clinical experience[5] and who are familiar with such diagnostic systems. Lack of such familiarity may lead to, for instance, the overdiagnosis of personality disorder, as suggested by the current findings.

In summary, the results of the current study suggest that Japanese psychiatrists do not make exclusive use of either conventional or operational diagnostic methods in clinical settings, but rather make complementary use of both with an awareness of the usefulness and limitations of each, thereby enabling them to achieve the aims of diagnosing.

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References

1) **American Psychiatric Association**: Diagnostic and Statistical Manual of Mental Disorders, 3rd edition. (DSM-III). American Psychiatric Press, Washington, DC (1980)
2) **Marneros A, Tsuang MT**: Schizoaffective disorders: present level and perspectives. *In* Schizoaffective Psychoses (Marnseros A, Tsuang MT eds), pp 309－318, Springer Verlag, Berlin-Heidelberg (1986)
3) **Schneider K**: Klinische Psychopathologie, Georg Thieme, Stuttgart-New York (1967)
4) **World Health Organization**: Mental Disorders: Glossary and Guide to their Classification in Accordance with the Ninth Revision of the International Classification of Diseases, (ICD-9). WHO, Geneva (1978)
5) **American Psychiatric Association**: Diagnostic and Statistical Manual of Mental Disorders, 4th edition. (DSM-IV). American Psychiatric Press, Washington, DC (1994)
6) **World Health Organization**: The ICD-10 Classification of Mental and Behavioral Disorders. Clinical descriptions and diagnostic guidelines, WHO, Geneva (1992)
7) **Wittchen HU**: Critical issues in the evaluation of comorbidity of psychiatric disorders. Br J Psychiatry Suppl **30**: 9–16, 1996
8) **Mitsuda H**: The concept of atypical psychoses: from the aspect of clinical genetics. Folia Psychiatr Neurol Jpn **16**: 214–221, 1962
9) **Kitamura T, Shima S, Sakio E et al**: Psychiatric diagnosis in Japan. 1. A study on diagnostic labels used by practitioners. Psychopathology **22**: 239–249, 1989
10) **Kitamura T, Shima S, Sakio E et al**: Psychiatric diagnosis in Japan. 2. Reliability of conventional diagnosis and discrepancies with Research Diagnostic Criteria diagnosis. Psychopathology **22**: 250–259, 1989
11) **Tarnopolsky A, Berelowitz M**: 'Borderline personality': diagnostic attitudes at the Maudsley Hospital. Br J Psychiatry **144**: 364–369, 1984
12) **Pope HG Jr, Oliva PS, Hudson JI et al**: Attitudes toward DSM-IV dissociative disorders diagnoses among board-certified American psychiatrists. Am J Psychiatry **156**: 321–323, 1999
13) **Stern J, Murphy M, Bass C**: Attitudes of British psychiatrists to the diagnosis of somatisation disorder. A questionnaire survey. Br J Psychiatry **162**: 463–466, 1993
14) **Keck PE Jr, McElroy SL, Strakowski SM**: New developments in the pharmacological treatment of schizoaffective disorder. J Clin Psychiatry **57** (Suppl 9): 41–48, 1996
15) **American Psychiatric Association**: Practice guideline for the treatment of patients with bipolar disorder. Am J Psychiatry **151** (Suppl 12): 1–36, 1994
16) **Garvey MJ, Schaffer CB, Tuason VB**: Comparison of pharmacological treatment response between situational and non-situational depressions. Br J Psychiatry **145**: 363–365, 1984
17) **Paykel ES, Priest RG**: Recognition and management of depression in general practice: consensus statement. BMJ **305**: 1198–1202, 1992
18) **Montgomery SA, Bebbington P, Cowen P et al**: Guidelines for treating depressive illness with antidepressants: a statement from the British Association for Psychopharmacology. J Psychopharmacol **7**

(Suppl 1): 19–23, 1993
19) **American Psychiatric Association**: Practice guideline for major depressive disorder in adults. Am J Psychiatry **150** (Suppl 4): 1–26, 1993
20) **Kitamura T**: Problems of psychiatric diagnosis and necessity of operational diagnosis. Psychiatrica et Neurologica Japonica **99**: 742–746, 1997 (in Japanese)
21) **Nakayasu N**: An idea of clinical diagnosis-what are needed for operational diagnostic criteria. Psychiatrica et Neurologica Japonica **99**: 736–746, 1997 (in Japanese)
22) **Maj M**: Critique of the DSM-IV operational diagnostic criteria for schizophrenia. Br J Psychiatry **172**: 458–460, 1998
23) **American Psychiatric Association**: Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, Revised, (DSM-III-R). American Psychiatric Press, Washington, DC (1987)
24) **Leckman JF, Merikangas KR, Pauls DL et al**: Anxiety disorders and depression: contradictions between family study data and DSM-III conventions. Am J Psychiatry **140**: 880–882, 1983
25) **Leckman JF, Weissman MM, Merikangas KR et al**: Panic disorder and major depression. Increased risk of depression, alcoholism, panic, and phobic disorders in families of depressed probands with panic disorder. Arch Gen Psychiatry **40**: 1055–1060, 1983
26) **Breier A, Charney DS, Heninger GR et al**: Major depression in patients with agoraphobia and panic disorder. Arch Gen Psychiatry **41**: 1129–1135, 1984

診断に関する日本の精神科医の見解—伝統的診断と操作的診断基準の臨床使用

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本研究では，診断の意義や操作的診断の臨床使用に関する日本の精神科医の見解を検討することを目的とした．日本精神科診断学会の会員283名に精神科診断の意義に関する調査用紙を送付した．回収率は，54%であった．診断決定は，十分な治療計画策定のためになされることがその目的のひとつであることを意識しながらも，多くの精神科医は診断決定が必ずしも治療に貢献していないと感じていた．回答者の17%は，統合失調症と気分障害の中間領域の症例の鑑別診断をしても，そうした症例の初期の治療には有意な影響を与えないという理由で，その鑑別診断の意義を否定していた．回答者の52%は，操作的診断基準は表層的な診断方法であると意識しながらも臨床に使用していた．一方伝統的診断の問題点としては明確な診断基準項目が挙げられていないことが指摘された．大うつ病とパニック障害の操作的診断基準を同一エピソード中にあるいは異なるエピソードで満たす症例の診断については，横断面的な併存（comorbidity）診断に反対する精神科医（54%）は，縦断的な併存診断に反対する精神科医（37%）よりも多かった．回答者の73%は，日本特有の伝統的診断概念を積極的に使用すべきだと回答していた．本研究の結果から，操作的診断基準の臨床的使用は，日本の精神科医にとってまだ議論のあるところであり，多くの精神科医は伝統的診断概念と操作的診断基準の両者の有用性と限界を意識しながら両者を相補的に使用していることが示唆された．