

Psychiatric Diagnosis in Japan

1. A Study on Diagnostic Labels Used by Practitioners

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Abstract. In a questionnaire survey, a list of 64 psychiatric diagnostic labels was presented to 20 randomly selected Japanese psychiatrists affiliated to a university department of psychiatry. For each label, they were asked (a) whether they used it in everyday practice, (b) whether they rarely used it but would do so if faced with such a case, or (c) whether they had never and would never use it. It was found that these Japanese psychiatrists used a relatively small number of diagnostic categories; in their classificatory system, functional mental disorders would be dichotomized into psychoses and neuroses with the former further divided into schizophrenic, atypical and manic-depressive psychoses, and the latter divided into seven subcategories, i.e., anxiety neurosis, hysteria, depressive neurosis, phobia, obsessive compulsive neurosis, depersonalization neurosis and hypochondriasis.

Introduction

Ample evidence has been accumulated to suggest that psychiatrists all too often disagree over the diagnosis of the same subjects. This can occur between psychiatrists in different countries, those in the same country, or those in the same hospital, or may even arise in the same physician on different occasions [Leff, 1977]. Diagnostic disagreement is observed when psychiatrists jointly interview the same patients or view the same video-recordings of psychiatric interviews, thereby being exposed to the same set of information [Katz et al., 1969]. This has led

to close scrutiny of the reasons for such disagreement, and lately to the development of structured (standardized) interview guides and operational diagnostic criteria, enabling research psychiatrists to reduce such biases [Spitzer et al., 1975].

Despite these attempts of research workers to operationalize symptom assessment and diagnosis, it is widely recognized that clinical psychiatrists tend to cling to their own conventional diagnostic system [Kendell, 1981; Saugstad and Ødegård, 1983]. Their insistence on the use of conventional diagnostic systems and nomenclature may partly explain why standard classificatory or

diagnostic systems for mental illness are, though desirable, not yet internationally accepted.

If, therefore, research psychiatrists or administrators, when developing or introducing a new set of diagnostic criteria, wish to compromise with conventional or local diagnostic systems and terminologies so as to make the former more acceptable in both research and clinical practice, they must learn how mental disorders are termed and categorized and recognize the 'image' of each diagnostic category in the conventional diagnostic system [Stengel, 1960].

In a preliminary survey on the diagnostic habits of Japanese psychiatrists, a set of questionnaires was sent to 20 practitioners in psychiatry. They were asked about the diagnostic categories they used for adult patients with non-organic mental disorders and then presented with 29 different case vignettes of functional mental disorders for which their diagnostic and therapeutic opinions were requested. This report is the first of a series of articles on this preliminary study.

Method

Participant Psychiatrists

Twenty psychiatrists were randomly selected from those affiliated to the Department of Neuropsychiatry, School of Medicine, Keio Gijuku University, Tokyo. It might be argued that they are not a representative sample of all psychiatrists practising in Japan. However, the department, opened in 1930, is one of the oldest in Japan. The proportion of departmental affiliates ($n = 355$) to the total membership of the Japanese Society of Neurology and Psychiatry ($n =$ approximately 4,000) can be regarded as very high if it is taken into account that there are at present approximately 70 Departments of Psychiatry in Japan. We therefore considered it

reasonable to choose the above departmental affiliates as the study sample.

Keio Gijuku University was established in 1858 by Yukichi Fukuzawa, an educator of the Meiji Period. Its Medical School was started in 1917 by Shiba-saburo Kitasato, an eminent bacteriologist. Since its initiation in 1921, the Department of Neuropsychiatry has long enjoyed a reputation as a leading group in Japanese psychiatry. Its main influences have been German and French psychiatry, and a number of affiliates have spent their postgraduate years in either of these countries. Recent influence from English-speaking countries has not, however, been negligible.

A total of 355 affiliates of the Department were found to be practising at the time of the investigation. They consisted of 337 men and 18 women; mean age (\pm SD), 48.7 ± 12.1 years; mean duration of experience in psychiatry (\pm SD), 21.8 ± 12.1 years. The institutions they worked for were university departments of psychiatry ($n = 73$), psychiatric hospitals ($n = 180$), psychiatric units of general hospitals ($n = 37$), private outpatient clinics ($n = 50$) or other psychiatric institutions ($n = 15$). Psychologists affiliated to the Department itself were excluded because diagnostic practice in Japan is almost entirely monopolized by medical practitioners.

The names of all 355 psychiatrists were fed into a computer, which yielded a random sample of 20 psychiatrists. Their demographic features are summarized in table 1. It was found that these 20 psychiatrists did not differ significantly from the affiliates of the Department as a whole in terms of any of the demographic features listed. All the 20 psychiatrists were approached personally by the senior author and invited to participate in the questionnaire survey. None of them refused.

Questionnaire

Psychiatric diagnostic labels appearing in medical charts were scrutinized at the Keio Gijuku University Hospital and three other affiliated hospitals. A list of these and the diagnostic categories in the ICD-9, 64 in all, were categorized into five major groups (table 2). Labels indicating conditions mainly observed among children, organic conditions, and substance-use disorders were all excluded. These labels were presented to the participating psychiatrists in the form of a questionnaire. For each label, the participants were asked whether they used it in their everyday practice (diag-

Table 1. Characteristics of participating psychiatrists

No.	Age	Present institution	Experience in psychiatry, years					
			total	U	A	G	C	O
1	29	A	2.5	1.0	1.5	-	-	-
2	49	G	24.5	7.5	1.0	-	-	-
3	41	O	14.0	3.0	3.0	16.0	-	-
4	56	U	32.0	5.5	26.5	3.0	-	5.0
5	42	A	16.0	5.0	1.0	-	-	-
6	52	A	24.0	6.0	17.0	10.0	-	-
7	57	U	30.0	10.0	20.0	1.0	-	-
8	29	G	3.0	1.0	-	-	-	-
9	54	G	27.0	6.0	13.0	2.0	-	-
10	36	A	10.0	2.0	8.0	8.0	-	-
11	36	U	11.0	6.0	5.0	-	-	-
12	45	U	17.5	14.0	3.5	-	-	-
13	35	A	9.0	1.0	8.0	-	-	-
14	52	A	24.0	9.0	14.0	1.0	-	-
15	49	G	22.0	4.0	7.0	11.0	-	-
16	76	A	50.0	6.0	44.0	-	-	-
17	34	A	7.0	1.0	3.0	-	-	-
18	51	G	26.0	9.0	-	3.0	-	-
19	43	U	17.0	16.0	1.0	17.0	-	-
20	51	A	26.0	1.0	25.0	-	-	-

U = University departments of psychiatry; A = asylums (mental hospitals); G = psychiatric departments of general hospitals; C = private outpatient clinics; O = other institutions.

nostic attitude A), whether they rarely used it but would do so if faced with a suitable case (diagnostic attitude B), or whether they had never used it and would never use it (diagnostic attitude C). The survey was conducted in 1982.

Results

Diagnostic labels and diagnostic attitudes of participant psychiatrists are summarized in table 2. It can be seen from the table that only four categories, i.e., schizophrenia, manic-depressive psychosis, depression and neurosis, were used in everyday practice by all the participant psychiatrists.

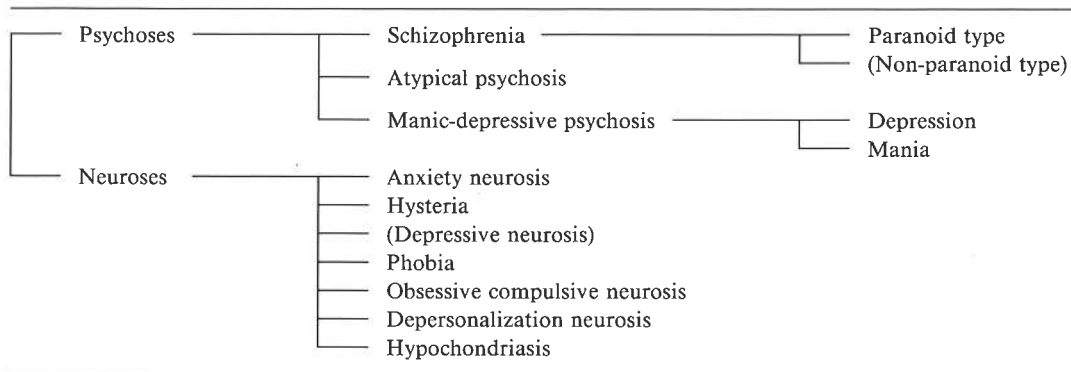
Since it was expected that psychiatrists working for different institutions might encounter patients of different diagnostic groups, we combined the first two attitudes (i.e., use in everyday practice and rare but possible use if faced with an appropriate case) into a single category, 'users', and the last (i.e., never used and will never do so) into another category, 'non-users'.

All the participants were classified as 'users' for schizophrenia, schizophrenia paranoid type, atypical psychosis, manic-depressive psychosis, depression, mania, neurosis, anxiety neurosis, hysteria, phobia, obsessive compulsive neurosis, depersonalization neu-

Table 2. Diagnostic labels and diagnostic attitudes of participant psychiatrists

Diagnostic labels	Participants' attitudes			Diagnostic labels	Participants' attitudes		
	A	B	C		A	B	C
<i>Group I</i>				<i>Group IV</i>			
Schizophrenia	20	0	0	Religious psychosis	4	11	5
Schizophrenia, simple type	6	8	6	Acute schizophrenic episode	2	6	12
Hebephrenia	12	6	2	Monosymptomatic			
Catatonia	13	6	1	hypochondriacal delusion	8	8	4
Schizophrenia, paranoid type	12	8	0	Cenesthopathia	11	7	2
Paraphrenia	3	13	4	Olfactopathia	13	6	1
Schizo-affective disorder	3	6	11	'Periodische Verstimmung'	10	9	1
Atypical psychosis	16	4	0	<i>Group V</i>			
'Pfropfschizophrenie'	11	8	1	Personality disorder	2	9	9
Latent schizophrenia	1	6	13	Character disorder	12	5	3
Residual schizophrenia	2	5	13	Abnormal personality	4	4	12
<i>Group II</i>				Psychopathic disorder	5	6	9
Manic-depressive psychosis (illness)	20	0	0	Paranoid personality disorder	0	10	10
Depression	20	0	0	Affective personality disorder	0	10	10
Involuntal melancholia	17	2	1	Schizoid personality disorder	1	10	9
Senile depression	13	5	2	Explosive personality disorder	2	10	8
Neurotic depressive state	6	9	5	Anankastic (obsessive)			
Depressive neurosis	11	5	4	personality disorder	4	8	8
Neurotic depression	7	5	8	Hysterical personality disorder	4	7	9
Mild depression	9	3	8	Asthenic personality disorder	3	9	8
Mania	17	3	0	Antisocial personality disorder	1	10	9
<i>Group III</i>				Immature personality disorder	1	10	9
Paranoid state	17	1	2	Borderline personality disorder	13	6	1
Paranoia	7	12	1				
Induced psychosis	11	8	1				
De Clerambault's syndrome	4	5	11				
Psychogenic reaction	16	2	2				
Reactive depression	12	3	5				
Reactive depressive state	11	4	5				
Reactive confusion	5	6	9				
Acute confusion							
('Bouffée délirante')	16	3	1				
Paranoid reaction	14	5	1				
Reactive psychosis	8	7	5				
Schizophrenic reaction	4	7	9				
Sensitive idea of reference							
('sensitiver Beziehungswahn')	7	11	2				

Diagnostic attitudes are A = Use in everyday practice; B = rare but possible use if faced with a suitable case; C = never used and will never use.

Table 3. Classification of functional mental disorders according to the consensus of the participant psychiatrists

rosis and hypochondriasis. It was therefore considered that these 13 categories were unanimously regarded among these psychiatrists as clinically valid diagnostic categories for functional psychiatric disorders. A general consensus may therefore be obtained that functional mental disorders are classifiable within a relatively simple format (table 3).

The distribution of 'users' and 'non-users' was examined for each diagnostic category in terms of the institution they worked for most of the time and the duration of their experience in psychiatry. Here the institution for which each participant psychiatrist worked most of the time was examined rather than the present institution because the former seemed most likely to have influenced their diagnostic attitudes. The institutions were dichotomized into asylums (mental hospitals, $n = 11$) and non-asylums ($n = 9$). The latter consisted of 3 university departments, 5 psychiatric departments of general hospitals and 1 other institution. The duration of experience in psychiatry was divided, with a median of 20 years as a cut-off

point, into short (i.e., 2–20 years, $n = 10$) and long (i.e., 21 years or more, $n = 10$). The distribution of 'users' and 'non-users' for all of the labels did not differ between the asylum and non-asylum groups or between the long and short experience groups. No difference was observed even when the cut-off point for age was reduced to 5 years ($n = 5$ and 15). This suggests that the diagnostic attitudes of Japanese psychiatrists, though variable, may not be influenced by the places for which they work or by the duration of their past experience.

It was of interest to inspect the characteristics of the pattern of 'users' and 'non-users' for major groups separately. As already described, the consensus reached by the participants was that psychoses could be trichotomized into schizophrenic, atypical and manic-depressive types. Although all the participants were 'users' of the label schizophrenia, 13 of the 20 psychiatrists claimed that they were 'non-users' of residual schizophrenia, 13 of latent schizophrenia, 11 of schizo-affective disorder, 6 of schizophrenia simple type, 4 of paraphrenia, 2 of hebephre-

Table 4. 'Users' and 'non-users' of categories of schizophrenia and related conditions

Diagnostic category	Participant No.																			
	1	3	15	6	10	5	7	8	14	20	13	16	18	2	9	11	12	17	4	19
Residual	N	N	N	N	N	N	-	N	N	-	N	N	N	-	-	N	-	N	-	-
Latent	N	N	N	N	N	N	N	-	N	N	N	-	N	N	-	-	N	-	-	-
Schizo-affective	-	N	N	N	N	N	N	N	N	N	-	N	-	-	N	-	-	-	-	-
Simple	N	N	N	N	-	-	-	N	-	N	-	-	-	-	-	-	-	-	-	-
Paraphrenia	N	-	N	-	N	-	N	-	-	-	-	-	-	-	-	-	-	-	-	-
Hebephrenia	N	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Catatonic	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
'Ppropfschizophrenie'	-	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

N stands for 'non-user'; - stands for 'user'.

Table 5. 'Users' and 'non-users' of categories of non-endogenous depression

Diagnostic category	Participant No.																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Neurotic depression	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Reactive depression	-	-	N	-	-	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mild depression	N	N	-	-	N	-	N	N	-	N	-	-	-	-	N	-	-	-	-	N

N stands for 'non-user'; - stands for 'user'.

nia, and 1 each of catatonic type and 'Ppropfschizophrenie'. It can be seen in table 4 that the above categories were favoured in a hierarchical order. Thus those psychiatrists who were 'non-users' of a given category usually did not use those of lower 'popularity'.

Among the present nomenclatures, the ways that affective disorders are subcategorized can be divided into two (group II). The first subcategorization is that of age of onset. Only 2 participants denied using the term senile depression, whereas 1 denied using involuntional depression. The second subcategorization was that of endogenous/non-en-

dogenous depressions. For the sake of argument, we deliberately divided the non-endogenous depressions into 'neurotic' (neurotic depression, depressive neurosis and neurotic depressive state), 'reactive' (reactive depression, reactive depressive state) and 'mild' depressions. These terminologies rest upon symptomatology ('neurotic'), aetiology ('reactive'), or severity ('mild') though all three may overlap considerably. It was found that all the participants use at least one subcategory of non-endogenous depression (table 5). The one most favoured was the 'neurotic' subcategory in which either

Table 6. 'Users' and 'non-users' of categories of 'reactive' psychiatric condition

Diagnostic category	Participant No.																			
	3	7	1	15	5	6	8	10	19	20	2	11	13	16	18	4	9	12	14	17
Acute schizophrenic episode	N	N	N	N	N	N	N	-	-	N	N	N	-	N	N	-	-	-	-	-
Reactive confusion	N	N	N	N	-	N	N	N	N	-	-	-	N	-	-	-	-	-	-	-
Schizophrenic reaction	N	-	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-
Reactive psychosis	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Psychogenic reaction	N	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute confusion	-	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Paranoid reaction	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

N stands for 'non-user'; - stands for 'user'.

neurotic depression, depressive neurosis or neurotic depressive state was used.

Next, we inspected the distribution of 'users' and 'non-users' of psychotic conditions of a brief and reactive nature (group III). These include acute schizophrenic episode, reactive confusion, schizophrenic reaction, reactive psychosis, psychogenic reaction, acute confusion and paranoid reaction. Here again, the choice of diagnostic labels seemed to be hierarchical with paranoid reaction and acute confusion the most popular and acute schizophrenic episode the least favoured (table 6). Psychiatrists not using a certain label seemed unlikely to use the lower labels in the hierarchy.

Among the neurotic categories (group V), unfavoured labels were 'Nervosität', neurasthenia and agoraphobia. Other labels of neurotic conditions were recognized as usual diagnostic labels.

Four generic terms to describe psychiatric conditions regarding personality (character) were presented. These were personality disorder, character disorder, abnormal personality and psychopathic disorder. Unlike the

other generic categories (e.g., schizophrenia, manic-depressive psychosis and neurosis), these labels indicating abnormalities of personality were given much less acceptance. Thus 9, 3, 12 and 9 psychiatrists were 'non-users' of personality disorder, character disorder, abnormal personality and psychopathic disorder, respectively. Only 6 psychiatrists were 'users' of all four of the generic labels whilst 1 refused to use any of them. Six psychiatrists used only one generic term, 5 used two terms, and 2 used three terms.

When inspecting the distribution of 'users' of subcategories of personality abnormalities, it was recognized that the participant psychiatrists had a strong tendency either to use all of the subcategories or to refuse to employ any of them (table 7). Thus, 8 of the 20 psychiatrists were found to use almost none of the subcategories of personality abnormalities whilst 12 were found to use almost all. Exceptions were immature personality and borderline cases. Four of the 8 psychiatrists who denied using the other subcategories stated that they used the term im-

Table 7. 'Users' and 'non-users' of categories of personality diagnosis

Diagnostic category	Participant No.																			
	1	3	5	6	7	10	13	15	2	4	8	9	11	12	14	16	17	18	19	20
Personality disorder	N	N	-	N	N	-	-	N	-	-	-	-	N	-	N	N	-	-	-	N
Character disorder	-	-	-	-	-	-	-	N	-	N	-	-	-	-	-	N	-	-	-	-
Abnormal personality	N	N	N	N	N	N	-	N	-	-	N	-	N	-	N	-	N	-	-	N
Psychopathic disorder	N	N	N	-	N	N	-	N	-	-	N	-	N	-	-	-	-	-	-	N
Paranoid personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	N	-	-	N	-
Affective personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	N
Schizoid personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	N
Explosive personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	-
Anankastic personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	-
Hysterical personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	-
Asthenic personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	-	-	-	-	-	-	-
Antisocial personality disorder	N	N	N	N	N	N	N	N	-	-	-	-	-	N	-	-	-	-	-	-
Immature personality disorder	N	-	-	-	N	N	-	N	-	-	-	-	-	-	-	-	N	-	-	-
Borderline personality disorder	-	N	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

N stands for 'non-user'; - stands for 'user'.

mature personality. Only 1 psychiatrist who denied using any of these generic terms to describe abnormalities of personality claimed that they used the term borderline case.

Finally, diagnostic labels were inspected according to the International Classification of Diseases, 9th Revision (table, not shown, may be obtained from the senior author on request).

As expected from the observations obtained thus far, the distribution of 'users' and 'non-users' was not even over the ICD-9 categories. Only a few generic categories (e.g., 295. schizophrenic psychoses, 296. affective psychoses, and 300. neurotic disorders) and subcategories (e.g., 295.3 schizophrenic psychosis paranoid type, 296.0 manic-depressive psychosis manic type, 296.1 manic-depressive psychosis depressed type,

300.0 anxiety states, 300.2 phobic states, 300.3 obsessive-compulsive disorders, 300.6 depersonalization syndrome, and 300.7 hypochondriasis) were used by all of the participating psychiatrists. Nearly half of them did not use the categories 295.4 acute schizophrenic episode, 295.5 latent schizophrenia, 295.6 residual schizophrenia, and 295.7 schizophrenic psychosis schizo-affective type. Approximately two thirds of them did not use the categories 298.2 reactive confusion, 300.4 neurotic depression, 301 personality disorder, 301.0 paranoid personality disorder, 301.2 schizoid personality disorder, 301.3 explosive personality disorder, 301.4 anankastic personality disorder, 301.5 hysterical personality disorder, 301.6 asthenic personality disorder, and 301.7 personality disorder with predominantly sociopathic or asocial manifestation.

Discussion

It is difficult to extract individuals that are representative of psychiatrists in one country because their diagnostic habits are likely to be influenced by their undergraduate and postgraduate education and experience, theoretical orientation, subspeciality, duration of clinical experience, institutions they work for, journals they read regularly and many other factors. It seems impossible to control for all these variables. We therefore adopted an alternative approach by selecting affiliates of one university department of psychiatry. Keio Gijuku University was chosen not only because we were graduates of that institute and therefore had easy access to its affiliates, but also because its affiliates accounted for a large proportion of the membership of the Japanese Association of Psychiatry and Neurology.

The fact that the number of diagnostic categories used unanimously by all the participating psychiatrists was restricted (table 2) indicates that these psychiatrists communicated using a relatively simple classificatory system for functional mental disorders. As shown in table 3, functional disorders were dichotomized into psychoses and neuroses; psychoses were further divided into schizophrenia, atypical psychosis, and manic-depressive psychosis; neuroses into anxiety neurosis, hysteria, phobia, obsessive compulsive neurosis, depersonalization neurosis, hypochondriasis and at least one of the non-endogenous depressions. Schizophrenia was subcategorized into paranoid type and others; manic-depressive psychosis into depression and mania.

Of interest was the unanimous agreement on the use of the category atypical psychosis. This term is not consistent with DSM-III

Atypical Psychosis but rather with the German concept of cycloid psychoses [Leonhard, 1961, for review see Perris, 1988]. 'Atypische Psychose' has long been advocated as a clinical entity by Mitsuda [1942, 1962] in Japan. The image of this atypical psychosis held by the participant psychiatrists will be examined in a companion article, which discusses the results of the case vignette questionnaire survey [Kitamura et al., submitted].

Despite the use of a variety of subcategories of schizophrenia in the literature, the present participants were found to use a surprisingly small number of subcategories: paranoid and non-paranoid. The distribution of the 'non-users' of schizophrenic subcategories may explain the unexpected distribution of subcategories in epidemiological surveys in Japan. Thus, Kato [1982] reported that the estimated numbers of patients treated in 1978 were 30 for schizophrenic psychosis simple type, 1,997 for hebephrenic type, 202 for catatonic type, 160 for paranoid type, 120 for schizo-affective type, 8,461 for other schizophrenia, and 183,708 for unspecified schizophrenia. It is obvious from these findings that Japanese psychiatrists rarely diagnose subcategories of schizophrenia and that, even among the subcategories diagnosed, hebephrenic type is the most favoured whilst residual type is never diagnosed. The refusal of more than half of the present psychiatrists to use the residual subtype (table 2) seems to reflect the general tendency in Japan. We plan to see how these psychiatrists diagnose cases of residual subtype in the case vignette questionnaire. The latent type of schizophrenia was an equally unfavoured label, making a contrast to the almost unanimous use of borderline case, and will be of great interest when discussing

the case of DSM-III borderline personality disorder presented in the case vignette questionnaire.

The finding that Japanese psychiatrists prefer the generic term schizophrenia to its subcategories may sound puzzling to European readers. We speculate that this is because Japanese psychiatrists regard it as a clinical entity rather than grouped heterogeneous conditions and also recognize temporal variability of schizophrenic symptoms and syndromes. This tendency may be further facilitated by the Japanese medical insurance system in which syndromal diagnoses are not requested.

Another surprising finding that the diagnostic label residual state is not used at all in Japan may be explained by Japanese psychiatrists' view that schizophrenia is an unremitting chronic disorder with progressing process. If, therefore, faced with a psychotic case with a short duration and complete recovery such as seen in those with acute schizophrenic episode, they tend to decline the schizophrenic diagnosis.

It is not unexpected that all the participants chose at least one label for the non-endogenous depressions and that some chose several labels for them. The choice of dichotomous terminologies for depressive illness, however, does not guarantee that Japanese psychiatrists view the illness in the same way as those in English-speaking countries.

A group of conditions usually characterized by acute onset, existence of precipitants, short duration, excellent premorbid personality, mixed emotional and psychotic states, occasional limited disturbance of consciousness and excellent response to treatment were presented (table 6). These seem to correspond to the French term 'bouffée délirante' [Pichot, 1982, 1984], DSM-III brief

reactive psychosis and the Scandinavian psychogenic psychosis, and possibly reflect the traditional hysterical psychosis. Many of the participants chose the terms paranoid reaction, acute confusion, psychogenic reaction, and reactive psychosis. The finding that acute schizophrenic episode was least favoured may be due to the Japanese psychiatrists' view that schizophrenia is characterized by poor outcome and resistance to treatment.

For the categories of neurosis, the majority of the participating psychiatrists were 'users'. Thus, the neurotic subcategories seem fairly popular and stable in Japan.

Although all but 1 of the participants employed at least one generic term of personality disorder, they were clearly dichotomized into 'users' and 'non-users' as to the use of the subcategories of personality disorders. Immature personality and borderline case escaped from this selective denial. This suggests that even the 'non-users' of personality disorder subcategories did not regard these two as personality disorders. Immature personality may be seen as a character trait rather than a pathological condition. Borderline case may be seen as a subtype of psychotic condition, as will be indicated by a subsequent article.

Since the participants unanimously agreed on a relatively limited number of diagnostic categories, it was not surprising that the distribution of 'users' and 'non-users' for the ICD-9 categories was greatly uneven. All of the participants seemed to understand that the ICD-9 was the only official classificatory system employed in Japan. Their strong rejection of some of the ICD-9 categories even 4 years after its introduction indicates that caution should be exercised when viewing the results obtained in epide-

miological studies with the ICD-9 in Japan. Kendell [1973] found that the introduction of the ICD-8 into Britain had resulted in no marked change of diagnostic habits among British psychiatrists. Saugstad and Ødegård [1983] also reported that the introduction of the ICD-8 was met with a persistent discrepancy in international psychiatric diagnostic practice. These and the present findings suggest that clinicians are conservative in their diagnostic habits and resistant to an abrupt change of nomenclature and concepts of mental disorders. Therefore, when introducing a new official diagnostic system, such as the forthcoming ICD-10, care must be taken in adjusting both the conventional and newly created terminologies and in proposing diagnostic criteria that are easily acceptable by practising clinicians.

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