症状評価と診断学：発表論文

原著

北村俊則：うつ状態における時間認識の研究．慶応医学, 8; 239-254, 1981.

Twenty-three newly admitted depressive inpatients and the same number of matched nonpsychiatric controls were examined three times (day 0, day 14 and day 28) by administering time perception tests and Hamilton's Rating Scale for Depression. Three aspects emerged. 1) The patients felt time passing slowly. This was correlated with neurotic symptoms, lack of genetic loading and specific situations. The subjective feeling of slow time flow is, therefore a reflection of depressive mood regardless of the clinical diagnosis. 2) Patients of endogenous type oriented to the past whilst those of neurotic type, like controls, oriented to the future. This tendency persisted even after recovery, therefore suggesting its correlation with a constitutional factor. 3) Lowered score of time production test and overestimation of a 20 second time span were correlated with presence of psychomotor retardation. This is suggestive that the "biological clock"runs more quickly when retarded than when not.

北村俊則，Kahn, A., Kumar, R.: 慢性精神分裂病の評価尺度．I. WingのSymptom Rating ScaleとWard Behaviour Rating Scale について．慶応医学, 59; 385-400, 1982.

Wing's Symptom Rating Scale (SRS) and Ward Behaviour Rating Scale (WBRS) were applied to 20 Caucasian chronic schizophrenic in-patients, 16 males and 4 females. SRS was independently rated by two psychiatrists in the interviews with the sample patients ("live interview"). The interviews were video-recorded. The two psychiatrists viewed them 6 months later and rated SRS again independently ("audio-visual review"). WBRS was rated by independently by pairs of ward sisters/charge nurses on the wards twice with a 4 month interval. Both scales were found to show satisfactory inter-rater and test-retest reliabilities though in the "live interview", unlike the "audio-visual review", slight differences were found between the two psychiatrists. Principle component analysis yielded three factors, "factor of decreased interest in self and catatonic behaviours", "factor of decreased motility", and "factor of decreased sociability". WBRS items and the subclassification of chronic schizophrenia calculated from them manifested positive correlations with all the SRS items but "coherent delusions". It may be, therefore, concluded that Wing's SRS and WBRS are both reliable instruments to measure psychopathology and functioning of chronic schizophrenic patients and that clinical judgement should be preferably based on video-recorded interviews.

Kitamura, T. and Kumar, R.: Time passes slowly for patients with depressive state. Acta Psychiatrica Scandinavica, 65; 415-420, 1982.

Twenty-three depressive inpatients and the same number of matched non-psychiatric controls were examined on three occasions – following admission, 14 days after, and 28 days after the admission – by administering a self-rating questionnaire of time awareness and Hamilton's Rating Scale for Depression (HRS). The patients were found to feel time passing slowly. This was correlated with the severity of depression expressed as the total HRS score. No significant

differences emerged between diagnostic groups, namely endogenous depression, neurotic depression, and schizophrenia or paranoid state with depressive symptoms. Correlations of the time awareness with symptoms listed in the HRS also denied a specific relationship of time awareness to specific diagnoses. The subjective feeling of slow time flow reflects, therefore, the depth of depressive state in general, which is nevertheless not specific to any diagnostic subcategory.

北村俊則, Kahn, A., Kumar, R.: 慢性精神分裂病の評価尺度. Ⅱ. Brief Psychiatric Rating Scale とPresent State Examination について. 慶応医学, 60; 177-187, 1983.

Kitamura, T. and Kumar, R.: Time estimation and time production in depressive patients. Acta Psychiatrica Scandinavica, 68; 15-21, 1983.

Twenty-three depressive inpatients and matched controls were studied three times at 2-week intervals. Both patients and controls initially overestimated, and subsequently approximated to, the “short” time spans (5-240 sec) whilst both correctly estimated the “long” ones (15 and 30 min) over the three occasions (Time Estimation Test, TET). There were no differences in the TET scores among the patients themselves, or between the patients and controls with the exception of one time span which the patients overestimated more than the controls. Among the depressive symptoms, only retardation was correlated with the TET scores. Similarly in the production of 30 sec (Time Production Test, TPT) there were no differences among the patients or between patients and controls. Again, only retardation was negatively correlated with the TPT score. Since the TET scores of the “short” time spans were negatively correlated with the TPT scores, it was speculated that both results derived from a single faculty, which was clinically manifested as retardation.

Mackintosh, J. H., Kumar, R., and Kitamura, T.: Blink rate in psychiatric illness. British Journal of Psychiatry, 143; 55-57, 1983.

Twenty-three patients diagnosed as depressed and a matched group of normal subjects were interviewed on three occasions using standardised procedures. Their behaviour was quantified from video recordings. The results indicate that blink rate is increased in depression and falls to normal levels during treatment. The effect on blink rate was found to be independent of medication, but was related to the degree of improvement in the patients' condition. By contrast a sample of schizophrenic patients seen on one occasion showed a reduced blink rate which was probably a result of neuroleptic administration.

北村俊則, Kahn, A., Kumar, R.: 3 種類の評価尺度からみた慢性精神分裂病の症状について－英国における研究－. 精神医学, 25; 1207-1211, 1983.

慢性精神分裂病の多種な症状を定量化するために 3 種類の評価尺度, Brief Psychiatric Rating Scale (BPRS), Symptom Rating Scale (SRS), Ward Behaviour Rating Scale (WBRS) を 20 名の入院患者に適用し, 各尺度の相関に加え, BPRS と WBRS の主成分分析を行なった. WBRS によって測定される病棟内での適応能力は WPRS や SRS からはほぼ独立した現象であった. BPRS の主成分分析からは 4 つの主成分, すなわち, (1) 分裂病の陽性症状と非特異的症状, (2) 抑うつ

症状, (3) 陰性症状, (4) 緊張病性の症状が出現した．第 1 成分のうちでは非特異的症状が陽性症状とは異なり WBRS と負の相関を示した．このことから慢性精神分裂病の症状を，陽性症状，陰性症状，緊張病症状，抑うつ症状，非特異的神経症様症状，適応力の障害に分類する可能性を指摘した.

Kitamura, T. and Kumar, R.: Controlled study on time reproduction of depressive patients. Psychopathology, 17; 24-27, 1984.

Depressive inpatients and the same number of matched nonpsychiatric controls were examined three times: following admission, and 14 and 28 days thereafter. Hamilton's Rating Scale for Depression and the Time Reproduction Test were administered. Time reproduction was found not to be different between patients and normal controls and within patients. Nor was a significant correlation found with any clinical symptoms.

Kitamura, T., Kahn, A., Kumar, R. and Mackintosh, J. H.: Blink rate and blunted affect among chronic schizophrenic patients. Biological Psychiatry, 19; 429-434, 1984.

The blink rate of schizophrenic patients has been reported to be greater than that of controls (Cegalis and Sweeny, 1979, Stevens, 1978). These patients, however, were being treated (Cegalis and Sweeny, 1979) or had been recently treated.(Stevens, 1978) with antipsychotics. When antipsychotic medications were washed out the blink rate of schizophrenics was correlated with any psychopathology. In our study of nonverbal behaviors of schizophrenics (Kumar, 1980; Kitamura *et al* , 1982), we found that the blink rate is negatively correlated with the severity of blunted affect.

北村俊則，島悟，崎尾英子，加藤元一郎：症例要旨法による家族歴研究診断基準 (FH-RDC) の信頼度検定．社会精神医学, 7; 308-312, 1984.

北村俊則，島悟，崎尾英子，加藤元一郎：症例要旨を用いたファイナー診断基準の信頼度検定．精神医学, 26; 1203-1207, 1984.

ファイナー診断基準の診断一致度をみるため 4 名の精神科医が New York State Psychiatric Institute が RDC 信頼度検定用に作製した症例要旨 31 症例について独立して診断し，その上で討論を通じて最終診断を導き，最後に New York State Psychiatric Institute による RDC 診断の「正解」と照合した．感情病の診断一致率は高かったが精神分裂病のそれは低かった．この原因として，1) 残遺期と寛解期の判別が困難，2) ファイナー診断基準では精神分裂病残遺状態に重なった抑うつ症候群の扱いが不明, 3) 精神病像にアルコール症が合併している場合の扱いが不明，などの点が指摘された. 診断されない精神医学的疾病が診断の半数を占めたが，これは各基準が疾患概念を狭く規定しているためであり，臨床研究において均一な患者集団を選別する操作基準としてファイナー診断基準は有用であると思われた.

北村俊則，島悟，崎尾英子，高橋龍太郎，加藤元一郎 : 症状チェックリストとしての「感情病および精神分裂病用面接基準」 (SADS) と「現在症診察表」 (PSE) の比較．臨床精神医学, 13; 293-299, 1984.

精神疾患の診断基準の信頼度を改良するためには，面接の指針に従っていわゆる標準化された面接を行い，症状チェックリストを使用することが望ましい．こういう試みとして有名な「感情病および精神分裂病用面接基準」（SADS）と「現在症診察表」（PSE）があり，今回は両者を比較した．両者の項目数（症状数）はほぼ同じであるが SADS は情動面の症状に, PSE は精神病的症状に重点が置いてある．しかし面接の様子をビデオテープに録画しておけば両者の互換性は著しく高い．既往歴（生涯診断），病態の変化の追跡，ハミルトンうつ病評価尺度への変換，家族歴の調査などについては PSE に比較し SADS が優れていると思えた．

Kitamura, T., Kahn, A. and Kumar, R.: Reliability of clinical assessment of blunted affect. Acta Psychiatrica Scandinavica, 69; 242-249, 1984.

The affect of 20 chronic schizophrenic in-patients was assessed by two psychiatrists using two rating scales. The interview recordings were reviewed three times--firstly with the auditory information only (the "audio review"), secondly with the visual information only (the "visual review") and thirdly with both (the "audio-visual review"). The "blunted affect score" correlated strongly with the total score of the verbal items of scales, but did not when a single mode of information was given. Since the absolute values of the "blunted affect score" were lower in the "visual review" than in the live interview and in the "audio-visual review", it was speculated that speech tended to bias the assessment of affect.

北村俊則，島悟：慢性精神分裂病における陰性症状評価尺度の評定者間信頼度．慶応医学, 61; 277-283, 1984.

Andreasen’s Scale for the Assessment of Negative Symptoms (SANS) was applied to 72 in-patients with DSM-Ⅲ chronic schizophrenia by pairs of psychiatrists. Inter-rater reliability of each item of SANS expressed as Cohen’s weighted kappa was found satisfactory. Among five negative symptoms (affective flattening or blunting, alogia, avolition-apathy, anhedonia-asociality, and attention) only alogia manifested relatively poor inter-rater agreement. Reliability was excellent for most of the items for which ad hoc definitions had been given prior to the interviews.

土居健郎，中川泰彬，高橋宏，岡上和雄，大塚俊男，池田由子，高橋徹，丸山晋，町沢静夫，北村俊則：精神障害の病態の変容とそれに伴う診断基準の対応に関する研究について．精神衛生研究, 31; 143-152, 1985.

This article describes the background and development of a multicentre study on the variability of and diagnostic considerations for the clinical pictures of functional mental disorders at the present time. Approximately 250 subjects who fulfil the criteria of RDC Schizophrenia, Major Depressive Disorder, Manic Disorder, Schizoaffective Disorder or Unspecified Functional Psychoses will be selected and examined by using an ad hoc interview guide (and symptom profiles), Brief Psychiatric Rating Scale, Hamilton’s Rating Scale for Depression, Scale for the Assessment of Negative Symptoms, Global Assessment Scale, Family History Questionnaire and Family History-Research Diagnostic Criteria, and Dexamethasone Suppression Test. They will also be prospectively followed up for 9 months. Experienced psychiatrists will be invited to examine the subjects independently and their diagnostic opinions will be carefully studied and compared with those made through the above operational psychopathological instruments. The present project aims at clarifying ‘difficult’ cases in terms of psychopathology and psychobiology.

島悟，鹿野達男，北村俊則，浅井昌弘：新しい抑うつ性自己評価尺度について．精神医学, 27; 717-723, 1985.

米国国立精神衛生研究所でうつ病の疫学研究用に開発された自己評価尺度（the Center for Epidemiologic Studies Depression Scale：CES-D Scale）と Hamilton のうつ病評価尺度を自己評価用に改変した評価尺度（the Carroll Rating Scale for Depression：CRS）を訳出し，これらの尺度の臨床的有用性を検討した．正常対照群 224 症例, 感情障害群 34 症例, 神経症群 24 症例, 精神病群 18 症例を対象とした．再検査法, 切半法で高い信頼性が得られ, Zung の Self-Rating Depression Scale, Hamilton のうつ病評価尺度との併存的妥当性も良好であった．感情障害群では, 他の 3 例に比べ（CRS）,あるいは正常対照群と神経症群に比べ (CES-D Scale) 有意に高い総得点が得られた．また同時に施行した Visual Analogue Mood Scale は簡便で臨床上有用な自己評価尺度であることが確認された．

北村俊則，丸山晋，大塚俊男，下仲順子，中里克治：ＤＳＭ－Ⅲ痴呆診断および柄澤式ぼけ評価尺度の評定者間信頼度．老年精神医学, 2; 774-777, 1985.

特別養護老人ホーム入所者 52 人（男性 26 人, 女性 26 人, 年齢 62〜97 歳, 平均 79.0 歳）を 10 年以上の臨床経験をもつ精神科医 3 人が同席面接を行い, DSM-III の痴呆の各診断項目と最終判定, および柄澤式ぼけ評価尺度を独立して評点したうえで, その評定者間信頼度（一致度）を求めた．DSM-Ⅲの項目のなかで人格変化, 特異的器質因子に関する項目が, やや信頼度が低かったことを除けば, どの項目も満足のいく信頼度が得られ, DSM-Ⅲの最終判定および柄澤式ぼけ評価尺度についても満足のいく信頼度が認められた．

北村俊則, Kahn, A., Kumar, R.: 慢性精神分裂病の症状と人口統計学的諸指標との関係－英国における研究－．精神医学, 27; 1289-1295, 1985.

Brief Psychiatric Rating Scale, Symptom Rating Scale, Ward Behaviour Rating Scale を 20 名の慢性精神分裂病入院患者に適用し, 各症状と年齢, 発症年齢, 罹病期間, 入院回数, 今回の入院期間, 投与されている抗精神病薬の chlorpromazine 換算量による 1 日量のそれぞれとの相関を求め, さらにそれぞれの症状について各指標を説明変数として重回帰分析を施行した．その結果, (1) 罹病期間が長いほど病棟の内外の適応能力が低い (2) 入院期間が長いほど思考の障害が重い (3) 入院回数が多いほど感情的ひこもりが軽い (4) 投与薬剤の量が多いほど情動の障害が強い (5) 陽性症状, 抑うつ症状, 非特異的神経症様症状に対しては上記の指標の寄与はきわめて少ないことが認められた．このことから陰性症状と一括される種々の症状が成因上異なるものである可能性が指摘された．

北村俊則，町澤静夫，丸山晋，中川泰彬，森田昌宏，佐藤哲哉，須賀良一，南海昌博，内山真，藤原茂樹，杠岳文，伊藤順一郎，児玉和宏，古関啓二郎，高沢昇，森平淳子：オックスフォード大学版 Brief Psychiatric Rating Scale (BPRS) の再試験信頼度－国立精神衛生研究所主催多施設共同研究の予備調査－．精神衛生研究，32; 1-15, 1985.

Oxford version of the Brief Psychiatric Rating Scale (BPRS) was developed by Kolakowska to make the original scale more operationalised in severity assessment and the interview more structured. This BPRS was translated into Japanese by the senior author. It was applied for 25 psychiatric in-patients by pairs of psychiatrists in a test-retest

fashion. The scores of the two raters were found highly correlated for most of the rating items.

Kitamura, T., Kahn, A., Kumar, R. and Mackintosh, J. H.: Blink rate and blunted affect among chronic schizophrenic patients. Biological Psychiatry, 19; 429-434, 1984.

The blink rate of schizophrenic patients has been reported to be greater than that of controls. These patients, however, were being treated or had been recently treated with antipsychotics. When antipsychotic medications were washed out the blink rate increased significantly. It was thus still not clear whether the blink rate of schizophrenics was correlated with any psychopathology. In our study of nonverbal behaviors of schizophrenics, we found that the blink rate is negatively correlated with the severity of blunted affect.

大塚俊男，丸山晋，北村俊則，下仲順子，中里克治，谷口幸一，佐藤真一，池田央：痴呆スクリーニング・テストの開発に関する研究．精神衛生研究, 32; 39-48, 1985.

近年，高齢化社会を迎え，痴呆性老人が急激に増加してきている．そのような状況下で，地域の中で痴呆性老人を早期に発見し，相談，指導，ケアなど各種保健活動を進める上で，保健婦などのコ・メディカルスタッフが容易に施行でき，かつ評価鑑別できる痴呆スクリーニング・テストの開発を試みた．そこで, 9 種類の我が国および欧米の簡便な痴呆評価スケールに使われている質問項目を参考にして，新たに作成したテストを 5 回にわたり予備テストし，改良を加え最終的に 16 項目（20 採点項目）のテストを作成した．それを用いて, 203 名（男性 59 名，女性 144 名）の正常な老人から痴呆を疑われる老人までを対象に本調査を施行した．その結果，本テストが高い内容整合性と信頼性を持つものであることが明らかとなった．また妥当性に関しては，臨床診断(DSM-Ⅲによる痴呆診断基準および柄澤のぼけ判定基準)，長谷川式痴呆診査スケールおよび Mental Status Questionnaire を基準として検討したが，本テストの痴呆スクリーニング・テストとしての充分な有効性が確かめられた．

北村俊則, 島悟：感情病および精神分裂病用面接基準 (SADS) と研究用診断基準 (RDC) の評定者間信頼度．精神医学, 28; 41-45, 1986.

2 名の精神科医が一組となり 29 名の患者について同席面接により感情病および精神分裂病用面接基準（SADS）に基づく評価ならびに研究用診断基準（RDC）に準拠した診断を独立して行い，各症状および診断の一致度（信頼度）を Cohen の k にて求めた．RDC の各診断類型の現在挿話診断および生涯診断の信頼度は大変高いものであった．SADS の各項目もおおむね良好な一致度であったが，信頼度の低い項目も散見された．RDC 診断に重大でない症状，陰性症状，面接場面からのみでは判断の困難な症状の信頼度は比較的低く出ることが明らかとなった．従って診断の信頼度が高くても症状判断の信頼度は独立して検討されなければならない．しかし今回の所見から SADS が本邦においても運用上特別の困難なく，かつ満足のゆく信頼度を持って使用できることが考えられた．

北村俊則，長瀬輝諠，竹中奎子，丸山晋，斎藤和子，大塚俊男：痴呆入院患者に対する Critchton 行動評価尺度の利用と妥当性の検討．老年精神医学, 3; 101-107, 1986.

精神病院入院中で DSM-III に痴呆の基準を満たす 52 人について，日常生活能力（ADL）の測定尺度の一つである Critchton 尺度を担当看護婦が適用した．Critchton 尺度の 11 項目および総合得点について因子分析を行ったところ二つ

の主たる因子が出現し，第 1 因子は移動，見当識といった痴呆患者の総合的機能を示すもの，第 2 因子は気分，対人接触など情動を示すものであることが明らかになった．これと同時に精神科医が痴呆の重症度 (abbreviated mental test) と抑うつ状態の重症度 (Bojanovski うつ病評価尺度) を測定したが, Critchton 尺度の第 1 因子に属する項目は前者と，第 2 因子に属する項目は後者とそれぞれ相関が認められた．したがって Critchton 尺度はこれら二つの側面を反映する妥当性のある行動評価尺度であると思われた.

Kitamura, T., Shima, S., Sakio, E. and Kato, M.: Application of Research Diagnostic Criteria and International Classification of Diseases to case vignettes. Journal of Clinical Psychiatry, 47; 78-80, 1986.

Thirty-one case vignettes prepared by the New York State Psychiatric Institute for the Research Diagnostic Criteria (RDC) reliability training were read and independently rated by four Japanese psychiatrists using the RDC and the ICD-9. The psychiatrists obtained the same interrater reliability with both systems for the diagnoses of schizophrenia, schizoaffective disorder, manic type, and major depressive disorder. Reliability was initially low for the RDC diagnoses of schizoaffective disorder, depressed type, and schizotypal features, but an eventual agreement was reached, concordant with the opinion of the New York experts. Case vignette training may enable non-English-speaking psychiatrists to handle the RDC as effectively as the ICD-9.

北村俊則，鈴木忠治：日本語版Social Desirability Scale について．社会精神医学，9; 173-180, 1986.

McDonald-Scott, P.，北村俊則，島悟：精神医学研究における SADS の役割 I. 臨床評価の不一致の原因と SADS の成立．精神医学, 28; 743-749, 1986.

精神症状の評価や精神科診断の不一致の原因として，被検者分散，状況分散，情報分散，基準分散，観察分散，があるが，最後の 3 者に由来する不一致を少なくするためにさまざまな構造化面接が作製されている．米国国立精神衛生研究所の主催した多施設共同うつ病研究計画において研究用診断基準（RDC）に準拠した診断を行なうために必要な情報を収集できるよう編集された構造化面接が感情病および精神分裂病用面接基準（SADS）である．SADS は目的に応じて，標準版（第 1 部は現在挿話もしくは過去 1 年間の症状の有無と重症度を評価し，第 2 部は過去に出現した精神障害について簡略化した形で記載する），生涯版（非患者を対象とする），追跡版（症状の変化を記載する）が作られている．さらに総合評価尺度（GAS），分野別総合評価，ハミルトンうつ病評価尺度への変換式が備えられている.

McDonald-Scott, P.，北村俊則，島悟：精神医学研究におけるSADSの役割 II. SADSの信頼性と他の面接基準との比較．精神医学, 28; 889-895, 1986.

米国における SADS の標準版第 1 部の項目の信頼度は全般的に，1）再試験法，2）ビデオ面接法，3）同席面接法の順に高い値が示された．期待された高い信頼度が得られない項目もいくつかあったが，分野別総合評価はどれも高い信頼度が得られた．最も厳密な検定法と考えられる再試験法によって調べられた標準版第 2 部および生涯版 SADS の項目はやや低いものであったが，感情障害や自殺行動については満足のゆくものであった．日本においても SADS の日本語版が研究場面で使用され，信頼性も確認されている．また SADS は DSM-Ⅲのいくつかの第 1 軸障害（精神病性障害，主だった感情障害とその亜型，不安定障害，アルコール乱用）と第 4 軸についての情報を与えることができる．さらに，

DSM-Ⅲ診断を目的とした診断用面接基準（DIS）や DSM-Ⅲ用構成化面接基準（SCID）と異なり, SADS は各症状の重症度の段階評価が行なえる.

北村俊則, 島悟, 加藤元一郎, 神庭重信, 藤原茂樹, 市川洋子, 神庭靖子, 生田憲正, 千葉忠吉：Wingによる慢性精神分裂病の重症度評価について. 精神科治療学, 1; 395-401, 1986.

Wing の Symptom Rating Scale (SRS) は 4 症状の評価から慢性精神分裂病の重症度の下位分類を行う尺度である. DSM-Ⅲの慢性精神分裂病入院患者 36 名について 2 名の精神科医がペアになり同席面接を施行し, SRS に加えて陰性症状評価尺度 Scale for the Assessment of Negative Symptoms (SANS) , Brief Psychiatric Rating Scale (BPRS) を用いて精神症状を評価した. SRS の各項目および下位分類の評定者間信頼度は概して高いものであった. SRS の重症度下位分類が重症になるほど SANS の下位尺度得点および総合得点が高くなったが, BPRS の各陽性症状の得点, 陽性症状の合計点, BPRS の綜合点に関してはこの傾向は認められなかった. したがって, SRS の下位分類の慢性精神分裂病の重症度を評価する妥当性が, SANS と BPRS を外的基準として示されたといえる.

北村俊則, 千葉浩彦, 宗像恒次, 仲尾唯治, 藤原茂樹, 生田憲正, 菅原健介：疫学調査用自己記入式精神障害調査票－ Community Psychopathology Questionnaire (CPQ) の開発について. 精神衛生研究, 33: 53-65,1986.

千葉浩彦, 佐藤達哉, 北村俊則：ＲＤＣ定型うつ病の症状論的研究. 精神科治療学, 2; 77-86, 1987.

38 名の定型うつ病患者を対象として, 研究用診断基準 Research Diagnostic Criteria (RDC) の抑うつ関連症状間の相対出現頻度を検討した結果, 8 症状中には質的に異なる中核症状も症状間の階層的な関係も見出されなかった. 次に, RDC の各亜型分類に該当する者の抑うつ症状を, Hamilton Rating Scale for Depression (HRS) を用いて比較した結果, 従来内因性－反応性を区別するといわれてきた諸特徴は, 実際は効果的に弁別していないことが見出された. また, これらの特徴によって分類された重症機能不全型, 内因性, 非状況因性, 精神病性などの亜型は, 一部の重なりを示しただけであった. このように, 症状の上から見ると内因性と反応性といううつ病の 2 分法は妥当性が低いことが示された.

須賀良一, 森田昌宏, 伊藤順一郎, 北村俊則 : 操作的診断基準の信頼性とその問題点Ｉ. 症例要旨法による研究用診断基準 (RDC) の評定者間信頼度検定. 精神医学, 29; 273-378, 1987.

精神科臨床経験２～５年の１２名の医師が, New York State Psychiatric Institute の症例要旨集を使用しそれぞれ独立して現在挿話 RDC 診断を行い, その結果に基づいて RDC の評定者間信頼度検定を行った. その結果, RDC 診断に必要な精神症状の評価や診断概念についての評定者間の一致度はおおむね高く, 日本においても操作的診断基準として RDC は充分に使用できると推論された. しかし, 一部の精神症状の評価や診断概念については評定者側の要因によって評価がかなり左右されており, 検討を要すると思われた.

大塚俊男，下仲順子，北村俊則，中里克治，丸山晋，谷口幸一，佐藤真一，池田央：痴呆スクリーニング・テストの開発. 精神医学, 29; 395-402, 1987.

地域の中で痴呆性老人を早期に発見し，相談，指導，ケアなど各種保健活動を進める上で保健婦などのコ・メディカルスタッフが容易に施行でき，かつ鑑別できる痴呆スクリーニング・テストの開発を試みた．わが国および欧米の９種類の簡便な痴呆評価スケールに使われている質問項目を参考にして，新たに作製したテストを５回にわたり調査，修正して改良を加え，最終的に２０採点項目のテストを作製した．正常な老人から痴呆を疑われる老人までを含む２０３名（男性５９名，女性１４４名）よりなる集団を対象に本調査を行った．本テストが高い内的整合性と信頼性，かつ妥当性を有することを臨床診断（DSM-Ⅲによる痴呆診断基準および柄澤のぼけの評定基準による），長谷川式痴呆調査スケールおよび Mental Status Questionnaire (MSQ) を外的基準として検討した．本テストの痴呆スクリーニング・テストとしての十分な有効性が確かめられた．

伊藤順一郎, 森田昌宏, 須賀良一, 北村俊則 : 操作的診断基準の信頼性とその問題点Ⅱ. 症例要旨法による家族歴研究診断基準 (FH-RDC) の評定者間信頼度検定. 精神医学, 29; 475-480, 1987.

臨床経験２〜５年の１２名の精神科医が，ニューヨーク州立精神医学研究所の症例要旨集を使用しそれぞれ独立して家族歴研究診断基準（FH-RDC）による診断を行い，その結果に基づいて FH-RDC の評定者間信頼度検定を行った．各診断概念について，評定者間の一致度はおおむね満足のいくものであったが，分裂感情病躁型，特定不能の機能性精神病，その他の精神障害，再発単極性は一致度が低かった．また評定者の多数意見の反映である最終診断はニューヨーク州立精神医学研究所の示す「正解」と概して高い一致度を示した．

北村俊則, 須賀良一, 森田昌宏, 伊藤順一郎 : 操作的診断基準の信頼性とその問題点Ⅲ. 再試験法による研究用診断基準 (RDC)，ハミルトンうつ病評価尺度，陰性症状評価尺度の信頼度検定. 精神医学, 29; 579-585, 1987.

12 名の精神科医がそれぞれ２名１組となり，総計 29 名の入院患者について日をおいて別個に面接を施行し，研究用診断基準(RDC)の決定, RDC 診断に必要な症状項目ならびにハミルトンうつ病評価尺度(HRS)，陰性症状評価尺度(SANS)の各項目の評価を行った．再試験法による RDC 定型うつ病（k = 0.93）と精神分裂病（k = 1.00）の診断の一致率は大変高かったが，分裂感情病うつ型（k = 0.46）と躁病 （k = 0.63）のそれは低かった．RDC 診断のための症状項目, HRS, SANS の各項目は概して高い一致率もしくは相関が示された．

北村俊則，島悟，加藤元一郎，岩下覚，神庭重信，白土俊幸，藤原茂樹，市川洋子，加藤雅高，神庭靖子，飯野利仁，生田憲正，宮岡等，武井茂樹，樋山光教，越川裕樹，柘野雅之，千葉忠吉 : 慢性精神分裂病に対する臨床評価尺度の信頼度. 精神医学, 29; 933-940, 1987.

DSM-III の慢性精神分裂病の基準を満たす入院患者について２名の精神科医が陰性症状評価尺度（SANS），Brief Psychiatric Rating Scale (BPRS) を，２名の看護婦が Ward Behaviour Rating Scale (WBRS) をそれぞれ独立して用いて臨床症状の評価を行った．SANS，BPRS のいくつかの項目で主治医の評価が非主治医の評価より重症に傾いたものの，ほと

んどの項目で両者の間に顕著な評価の偏りはなく，評定者間信頼度も高く，両者の評定の間に実際上問題となる差はないと考えられた．WBRS の評定者間信頼度も満足のゆくものであった．

北村俊則，越川法子，島悟，藤原茂樹，鈴木忠治，宮岡等，片山信吾，萩生田晃代，伊藤斉：不安性障害の臨床的研究― DSM-III Rの適用ー．精神医学, 29; 1073-1079, 1987.

DSM-III の改訂版である DSM-III-R（草案）の不安定障害の基準を８４名の外来および入院患者にあてはめた結果，１）恐慌性障害（４５名）と社会恐怖（２１名）が高頻度に認められ，空間恐怖が多い欧米の結果と差異を生じた．２）発症年齢について不安性障害の亜型ごとに特徴があり，発症年齢からは恐慌発作を伴う空間恐怖は純粋の空間恐怖よりも（空間恐怖を伴わない）恐慌障害に近く，これは DSM-ⅢR の新しい亜型分類を支持するものと考えられた．３）強迫性障害の親族の４０％に不安性障害を認めた．４）経過中に抑うつ状態を認めたものは１３％であり，抑うつ状態は不安性障害の罹患期間の比較的長い患者に出現し，二次性のものであると考えられた．DSM-ⅢR の適用自体も問題なく行えた．

藤原茂樹，生田憲正，千葉浩彦，菅原健介，仲尾唯治，宗像恒次，北村俊則：心理学者による精神科診断の症例要旨法による信頼度検定－精神科医との比較－．臨床精神医学, 17; 1081-1087, 1988.

ニューヨーク州立精神医学研究所が，精神医学研究診断基準（RDC）の信頼度検討用に準備した症例要旨集の日本語訳を使用し，臨床心理士７名がそれぞれ独立して診断を行い，すでに報告されている精神科医間の一致度と比較した．その結果，感情障害に関する症状および診断の評定者間診断一致度は精神科医間の一致度と同様に良好であった．定型うつ病の亜型分類についての一致度は比較的良好であった．そこでうつ病の診断に関しては，操作的診断基準をもつ RDC は，精神科医以外の評定者も高い信頼度をもって使用することができ，臨床上有用であることが示された．しかし精神分裂病の症状および診断に関してはその一致度が低く，検討を要するものと思われた．

北村俊則，島悟，加藤元一郎，岩下覚，神庭重信，白土俊幸，藤原茂樹，市川洋子，加藤雅高，神庭靖子，飯野利仁，生田憲正，宮岡等，武井茂樹，樋山光教，越川裕樹，栢野雅之，千葉忠吉：慢性精神分裂病の臨床症状と人口統計学的指標．精神保健研究, 1; 27-35, 1987.

慢性精神分裂病の主要な陽性症状と主要な陰性症状について人口統計学的諸指標との関係を調査した．陽性症状のなかでは妄想が男性より女性に重症であり，陰性症状のなかでは情動の平板化・情動鈍麻，思考の貧困，注意の障害が低教育歴において重症であり，陽性症状と陰性症状で異なる傾向がうかがわれた．しかし，臨床的指標（現在の年齢，発症年齢，罹病期間，入院回数，全入院期間，治療期間，電撃療法の回数，抗精神病薬投与用量）を独立変数とした重回帰分析からは症状を強く説明する変数は認められなかった．

Otsuka, T., Shimonaka, Y., Maruyama, S., Nakazato, K., Kitamura, T., Yaguchi, K., Sato, S. and Ikeda, H.: A new screening test for dementia. Japanese Journal of Psychiatry and Neurology. 42; 223-229, 1988.

The purpose of this study is to develop a new screening test for detecting the demented elderly in the early stage in communities. The test is easy to apply for consultation, guidance and care and is capable of administering differential diagnoses. Based on the 9 dementia rating scales used in Japan, Europe and the U.S., a new test was completed after investigating and modifying the design 5 times. The test consists of 20 items. This test was given to 203 subjects (59 males and 144 females) including normal elderly as well as those suspected of suffering from dementia. The internal consistency, reliability and validity were studied using clinical diagnoses (diagnostic criteria of Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-Ⅲ) and Karasawa's Criteria for Judging Senility), Hasegawa's Dementia Rating Scale and Mental Status Questionnaire (MSQ) as external criteria. The present test was confirmed to have sufficient effectiveness as the screening test for dementia.

北村俊則，島悟，加藤元一郎，岩下覚，神庭重信，白土俊幸，藤原茂樹，市川洋子，加藤雅高，神庭靖子，飯野利仁，生田憲正，宮岡等，武井茂樹，樋山光教，越川裕樹，柘野雅之，千葉忠吉：慢性精神分裂病の陽性症状と陰性症状．精神医学, 31; 131-136, 1989.

慢性精神分裂病の入院患者 72 例を陰性症状評価尺度(SANS),Brief Psychiatric Rating Scale, Ward Behaviour Rating Scale を用いて評価した.主要な陽性症状と主要な陰性症状の因子分析からは陽性症状,陰性症状が独立した因子を構成していた.SANS の 25 項目の因子分析からは「機能の量的低下の因子」「自己評価の因子」「社会活動の障害の因子」「機能の質的変化の因子」「注意の障害の因子」の 5 因子が認められた.陽性症状と陰性症状は独立した 2 群を形成しているが,陰性症状はさらにいくつかの亜群に分けられる可能性があると推論された

Kitamura, T., Sugawara, M., Aoki, M. and Shima, S.: Validity of the Japanese version of the GHQ among antenatal clinic attendants. Psychological Medicine, 19; 507-511, 1989.

The validity of the Japanese version of the 30-item General Health Questionnaire (GHQ) was examined against the semi-structured interview-based Research Diagnostic Criteria (RDC) as external criteria. The GHQ total score discriminated 'cases 'and 'non-cases' satisfactorily but its recommended cut-off point was higher (7/8) than that of the original English version (4/5). Discriminant function analysis revealed that only 13 items contributed to the discriminatory power and that their discriminant function score was better than a simple summation of the 30 GHQ item scores in terms of validity.

竹内美香，鈴木忠治，北村俊則：両親の養育態度に関する因子分析的研究．周産期医学, 19; 852-856, 1989.

Kitamura, T., Shima, S., Sakio, E. and Kato, M.: Psychiatric diagnosis in Japan. I. A study on diagnostic labels used by practitioners. Psychopathology, 22; 239-249, 1989.

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.

Kitamura, T., Shima, S., Sakio, E. and Kato, M.: Psychiatric diagnosis in Japan. II. Reliability of conventional diagnosis and discrepancies with RDC diagnosis. Psychopathology, 22; 250-259, 1989.

Twenty Japanese psychiatrists were asked for their conventional diagnoses for each of 29 case vignettes already diagnosed according to Research Diagnostic Criteria. The reliability coefficients of Japanese conventional diagnoses were low; only two categories exceeded the intraclass correlation coefficient of 0.7. However, the low reliability was found to be due not to random variations but to the difference of individual psychiatrists in setting boundaries of diagnostic entities though sharing the common prototype for each diagnostic category.

Kitamura, T., Takazawa, N. and Moridaira, J.: Family history study of major psychiatric disorders and syndromes. International Journal of Social Psychiatry, 35; 333-342, 1989.

The family history of major psychiatric disorders was examined among relatives of 193 in-patients fulfilling the Research Diagnostic Criteria (RDC) for Schizophrenia, Unspecified Functional Psychoses, Schizoaffective Disorder, Manic Disorder or Major Depressive Disorder. The morbid risk (MR) for schizophrenia was greater among the relatives of probands with non-affective psychoses whereas the MR for mania was greater among the relatives of probands with affective bipolar disorder. When major psychiatric syndromes were examined, only manic syndrome showed familial aggregation.

北村俊則，島悟：RDC 定型うつ病患者における幼少期の喪失体験と臨床像の関連．精神保健研究, 35; 83-87, 1989.

37 名の RDC 定型うつ病患者で,喪失体験の有無は RDC 定型うつ病の基準 B の各項目,RDC 定型うつ病の各亜型分類,ハミルトンうつ病評価尺度の各項目との間に有意の関係もしくは有意差を認めなかった.幼少期の喪失体験はうつ病の病型や病像形成には関与していない

竹内美香，北村俊則：Social desirability 判断の形成に関する発達的研究－大学生とその両親の比較－．精神保健研究, 35; 133-137, 1989.

Crowne らの Social Desirability (SD) Scale を大学生とその父親・母親に配布し，調査を実施した．SD Scale の総合得点の相関は，両親間，学生－母親で弱いながらも有意であったが，学生－父親間では有意相関は見られなかった．学生の SD Scale 総合得点は両親よりも有意に低かった．SD scale 項目の因子分析からは 3 因子が抽出された；それらは「自制」,「誠実」,「自己完結」である．これらの所見から以下が示唆された；1) SD は配偶者間で類似している，2) 子供の SD は主に母親の影響を受ける，3) 若年の子供は両親よりも「社会的望ましさ」に従ったやり方で回答することが少ない，そして 4) SD は道徳性とは異なった概念であり，3 つのエレメントから構成されていることが推察された．

北村俊則，杠岳文，森田昌宏，伊藤順一郎，須賀良一，中川泰彬：オックスフォード大学版BPRSの下位尺度の作成とその妥当性．精神科診断学, 1; 101-107, 1990.

193 名の入院患者に対するオックスフォード大学版 BPRS の因子分析より主として 4 因子を抽出し，それぞれ「陽性症状」「陰性症状」「気分変調」「躁症状」の因子であると解釈した．この因子構造にもとづいて作成した 4 下位尺度の得点は，RDC 診断（定形うつ病，躁病，分裂感情病抑うつ型，分裂感情病躁型，非感情性精神病）・ハミルトンうつ病評価尺度・陰性症状評価尺度とも予想された関係を示し，妥当性あるものと考えられた．

加藤知佳子，渡辺さちや，永田俊明，北村俊則：心理学専攻者による操作的診断基準の信頼度検定．教育心理学, 38; 413-417, 1990.

Agreement of diagnosis of psychiatric disorders by psychologists was examined in case vignette and inter-rater designs. In the case vignette design, the agreement of 3 graduate psychology students for the Research Diagnostic Criteria (RDC) diagnosis was high for the most of the RDC diagnostic categories, except for Schizotypal Features. In the inter-rater design, disagreement was only observed among 2 out of 11 psychiatric in-patients. This suggested that an operationalized criteria could enable psychologists to establish diagnosis of psychiatric disorders reliably and there-fore communicate and collaborate with psychiatric researchers.

Kitamura, T. and Suga, R.: Depressive and negative symptoms in major psychiatric disorders. Comprehensive Psychiatry, 32; 88-94, 1991.

Among 193 inpatients with Research Diagnostic Criteria (RDC) major psychiatric disorders, the scores in Hamilton's Rating Scale for Depression (HRSD) were higher among those patients with RDC schizoaffective disorder depressed type and major depressive disorder, whereas the scores in the Scale for Assessment of Negative Symptoms (SANS) were higher among patients with these two disorders, as well as those with RDC nonaffective psychoses (schizophrenia and unspecified functional psychosis). The HRSD and SANS items were factor-analyzed, yielding nine factors that discriminated depressive and negative symptoms. These findings suggest that although depressive and negative symptoms frequently coexist, they constitute discrete syndromes.

Takeuchi, M. and Kitamura, T.: The factor structure of the General Health Questionnaire in a Japanese highschool and university student sample. International Journal of Social Psychiatry, 37; 99-106, 1991.

Factor structures of the 60- and 30-item versions of the General Health Questionnaire (GHQ) were explored, using data collected from 236 Japanese high-school and university students. The 60-item version produced factors interpretable as social functioning, anxiety, somatic symptoms, and severe depression; the 30-item version produced general dysphoria, social functioning depressive thoughts, difficulty in concentration and insomnia. Although the two version of the GHQ produced the same number of factors, their structures differed in content. Thus it may be necessary to examine the factor structures of the GHQ when using it in a study of a population containing subjects with different cultural backgrounds.

北村俊則：精神分裂病の症候学における統計学的研究．精神神経学雑誌，93; 823-829, 1991.

精神分裂病は単一の疾患ではなく，複数の症候群の集合体であるとの認識は，その病名が提示された当時から存在した．異なる症候群には異なる病態生理が存在し，それらは，重複はあるものの，異なる病因に由来し，さらに場合によっては各種治療法に対して異なる反応を示すことを想定することも，不自然ではない．こうした仮説の検定に際しては，まず臨床症状をいくつかの群に分けることが必要であり，臨床症状群の決定のよしあしが病態・病因・治療研究の成否を左右する．

北村俊則，藤縄昭，吉野雅博，三浦勇夫，笠原嘉：ICD-10（草案）診断と従来診断の対比について－全国精神科医療機関における実地施行の結果から－．精神科診断学, 3; 349-363, 1992.

厚生省精神保健医療研究「精神障害の診断基準の作成に関する研究」班（研究責任者：藤縄昭）が行なった全国規模の ICD-10 実地試行における総計 2870 回の診断機会について, ICD-10 (草案) の 2 桁診断を従来診断の各病院ごとに対比した．従来診断の精神分裂病，うつ病，躁病，不安神経症，ヒステリー，恐怖症，強迫症，離人症，心気症に対しては ICD-10 (草案) の相応する 2 桁診断が与えられていた．しかし，非定型精神病には F2 (79%) と F3 (21%) が，抑うつ神経症には F3 (62%) と F4 (34%) が，心因反応には F2 (48%) , F3 (11%) , F4 (33%) が，人格障害には F2 (36%) , F3 (14%) , F4 (11%) , F6 (31%) が，境界例には F2 (33%) , F4 (13%) , F5 (17%) , F6 (29%) がそれぞれ対応する ICD-10 (草案) 診断として与えられていた．したがってこれらの従来病名は ICD-10 (草案) には一対一の反応をせず, ICD-10 導入にあたって慎重な検討が必要である．

北村俊則，藤縄昭，岡崎祐士，高橋三郎，笠原嘉：日本における非定型精神病診断の概念と症状構造－全国多施設共同研究のから－．精神神経学雑誌, 94; 1194-1201, 1992.

Kitamura, T. and Suzuki, T.: A validation study of the Parental Bonding Instrument in a Japanese population. Japanese Journal of Psychiatry and Neurology, 47; 29-36, 1993.

Parker, Tupling & Brown’s Parental Bonding Instrument (PBI), a self-rating scale for the measurement of perceived reading attitudes of parents, was translated into Japanese and distributed to final-year high school students and to

their parents. For each PBI score, ratings of each parent, made independently by family members, were weakly but significantly correlated. The social desirability score showed only a modest correlation to PBI scores. A factor analysis of the data, limiting the number of the factors retained to two, resulted in factor loading patterns similar to those reported by Parker, Tupling & Brown.

Kitamura, T., Shima, S., Toda, M. A. and Sugawara, M.: Comparison of different scoring systems for the Japanese version of the General Health Questionnaire. Psychopathology, 26; 108-112, 1993.

The General Health Questionnaire (GHQ) is a self-rating questionnaire to identify current non-organic non-psychotic morbidity. Each item of the GHQ has four response codes; the left-side one represents the most healthy while the right-side one the most ill. The ability of four scoring systems of the GHQ items to discriminate psychiatric cases from non-cases, 0-0-0-1 (codes 1-3=0, code 4=1), 0-0-1-1 (codes 1 and 2=0, codes 3 and 4=1, the original GHQ scoring) and 0-1-1-1 (code 1=0, codes 2-4=1), were compared against the greatest increase in the rate of cases between neighbouring codes and by using discriminant function analysis with the three scoring systems as predictors among 108 antenatal clinic attenders. The data revealed that the original GHQ scoring was the most valid in its ability to identify psychiatric cases.

Kitamura, T., Nakagawa, Y. and Machizawa, S.: Grading depression severity by symptom scores: Is it a valid way of subclassifying depressive disorders? Comprehensive Psychiatry, 34; 280-283, 1993.

Recent diagnostic criteria such as the DSM-Ⅲ and the 10 th Revision of the International Classification of Diseases (ICD-10) have proposed that depression should be subcategorized according to severity. Among 75 inpatients with Research Diagnostic Criteria (RDC) major depressive disorder, the total number of criterion B items (N=8) used as the measure of severity was validated against the global assessment scale (GAS) score for the worst week of the episode; the correlation between the two was r= -. 232. This suggests that even if the total number of identified diagnostic items reflects a different aspect of severity, there should be caution about its use unless validated by further study.

Kitamura, T. and Suzuki, T.: Perceived rearing attitudes and psychiatric morbidity among Japanese adolescents. Japanese Journal of Psychiatry and Neurology, 47; 531-535, 1993.

The relationship between perceived rearing experiences and minor psychiatric morbidity was studied in a sample of Japanese adolescents. Their perceived rearing experiences were measured by the Parental Bonding Instrument (PBI) and minor psychiatric morbidity by the General Health Questionnaire (GHQ). The total GHQ score was slightly but significantly higher (r=0.28) among those recording high maternal protection than among those with low maternal protection, but of the subscale scores of the GHQ, only the anxiety and insomnia subscale retained this same relationship with perceived rearing experiences. The parental age, educational career, and sibship position showed no

correlation with the PBI scores.

Kitamura, T., Fujihara, S., Yuzuriha, T. and Nakagawa, Y.: Sex differences in schizophrenia: a demographic, symptomatic, life history and genetic study. Japanese Journal of Psychiatry and Neurology, 47; 819-824, 1993.

Twenty-one male and 32 female inpatients who met the criteria of schizophrenia according to the Research Diagnostic Criteria were compared for demographic, symptomatic, life history, and genetic variables. Female schizophrenics were marginally less likely to have auditory hallucinations; They were more likely to have early loss experiences (either bereavement or separation from a parent) before the age of 16. No other differences were found between the men and women.

Takeuchi, M., Yoshino, A., Kato, M., Ono, Y. and Kitamura, T.: Reliability and validity of the Japanese version of the Tridimensional Personality Questionnaire among university students. Comprehensive Psychiatry, 34; 273-279, 1993.

The Tridimensional Personality Questionnaire (TPQ) is a self-rating questionnaire, based on a general biosocial theory, for the clinical description and classification of both normal and abnormal personality variants. It was translated into Japanese and administered with the General Health Questionnaire (GHQ) and the 10 item version of the Social Desirability Scale (SDS) to 450 university students on two occasions 2 months apart. Pearson Product-Moment Correlation Coefficients and k-coefficients between TPQ scale scores for the two occasions were significantly high, as were Cronbach's α-coefficients of TPQ scales and subcategories at the first wave. Correlations between the TPQ scale score and GHQ and SDS scores were negligible. The TPQ thus appears to have test-retest reliability and content validity among a Japanese student population; it is uninfluenced by psychiatric morbidity or social desirability.

Kitamura, T., Toda, M. A., Shima, S. and Sugawara, M.: Validity of the repeated GHQ among pregnant women: a study in a Japanese general hospital. International Journal of Psychiatry in Medicine, 24; 149-156, 1994.

The authors examined the variability of the validity of the General Health Questionnaire (GHQ) on two different occasions. Method: The subjects were 120 pregnant women attending an antenatal clinic of a general hospital in Japan. The GHQ was distributed twice－in the first and third trimesters. They were then interviewed by a psychiatrist blind to the GHQ scores using the standard and the "change" version of the Schedule for Affective Disorders and Schizophrenia (SADS). Results: Of the 120 women, 108 and ninety-eight completed the GHQ and were successfully interviewed in the first and third trimesters, respectively. Seventeen percent (18/108) and 13 percent (13/98) women were given RDC diagnoses in the first and third trimesters, respectively: They were designated as cases. Despite a satisfactory discriminatory power of the GHQ on the first occasion, the validity measures of the GHQ on the second occasion were generally poor. Thus, the sensitivity was 39 percent and specificity 82 percent for the cut-off point of 7/8. Conclusions: The GHQ should be validated separately when distributed repeatedly to the same subjects.

Yoshino, A., Kato, M., Takeuchi, M., Ono, Y. and Kitamura, T.: Examination of the tridimensional personality hypothesis of alcoholism using empirically multivariate typology. Alcoholism: Clinical and Experimental Research, 18; 1121-1124, 1994.

Cloninger (1987) has hypothesized tridimensional personality theory for two types of alcoholism, type 1 and type 2, that exhibit opposing clinical characteristics and personality traits. The Tridimensional Personality Questionnaire (TPQ) is designed to test this hypothesis on three independent dimensions－novelty seeking (NS), harm avoidance (HA), and reward dependence (RD)－to evaluate the personality trait. We examined the tridimensional personality hypothesis by comparing TPQ scores between two empirically derived multivariate types of alcoholism. The present study included 191 male subjects with alcoholism. A cluster analysis was conducted using clinical characteristics, and two empirical types, type A and type B, were identified Type A is similar to Cloninger’s type 1 and type B is similar to type 2.The TPQ scores given to these two empirical types were compared. Scores on the NS and RD scales were in good agreement with the hypothesis, whereas the HA score was discordant with the hypothesis. HA is highly correlated with the depression scale score that is elevated in type B. We discussed the possibility that type B, which may be called a familial early-onset alcoholism, is related to character spectrum disorder.

Kitamura, T., Shima, S., Sugawara, M. and Toda, M. A.: Temporal variation of validity of self-rating questionnaires: Repeated use of the General Health Questionnaire and Zung’s Self-rating Depression Scale among women during antenatal and postnatal periods. Acta Psychiatrica Scandinavica, 90; 446-450, 1994.

The 30-item General Health Questionnaire (GHQ) and Zung’s Self-Rating Depression Scale (SDS) were distributed to 120 pregnant women 4 times － in early and late pregnancy and 5 days and 1 month after the child was born. The validity of the questionnaires was assessed against the subjects’ Research Diagnostic Criteria (RDC) diagnoses. Both the GHQ and SDS sufficiently identified cases of minor mental disorder and depressive disorders respectively in early pregnancy; they lost their validity on the subsequent two occasions, but gained it again 1 month after the birth; the optimal cut-off points varied accordingly. This study suggests that the optimal cut-off point for a questionnaire should be validated against an externally determined clinical diagnosis whenever the instrument is used repeatedly on the same population.

Kitamura, T., Okazaki, Y., Fujinawa, A., Yoshino, M. and Kasahara Y.: Symptoms of psychoses: a factor-analytic study. British Journal of Psychiatry, 166; 236-240, 1995.

Background. The literature on the statistical analysis of symptoms of psychoses was limited to positive and negative symptoms in schizophrenia. The present study explored the relationship between positive and negative symptoms as well as affective symptoms in a wider category of psychotic disorders. ***Method.*** The symptoms of 584 psychiatric patients, consecutively admitted to any of the 95 mental hospitals in Japan, were studied. They manifested at least one

of the following: (a) delusions, (b) hallucinations, (c) formal thought disorder, (d) catatonic symptoms, or (e) negative (defect) symptoms. ***Results.*** Factor analysis yielded five factors interpretable as (a) manic symptoms, (b) depressive symptoms, (c) negative (defect) symptoms and formal thought disorders, (d) positive (psychotic) symptoms, and (e) catatonic symptoms. ***Conclusion.*** These results suggest that although major symptoms seen among psychotic patients can be categorized into positive, negative, manic, and depressive groups, corresponding to current knowledge of phenomenology, catatonic symptoms constitute a discrete syndrome, while formal thought disorders merge into the negative syndrome.

Kitamura, T., Watanabe, M., Aoki, M., Fujino, M., Ura, C. and Fujihara, S.: Factorial structure and correlates of marital adjustment in a Japanese population. Journal of Community Psychology, 23; 117-126, 1995.

A total of 146 married inhabitants (67 men and 79 women) in a provincial city of Japan were interviewed to examine marital adjustment and its psychosocial determinants. Fifteen items of the Short Marital Adjustment Test (Lock &Wallace, 1959) (LWT), a self-rating questionnaire, were transformed into a semi-structured interview together with two new items. Factor analysis yielded five factors which were interpreted as dyadic consensus, satisfaction, flexibility, home-loving, and interest-sharing. Better marital adjustment in women was correlated with higher standard of living, lower neuroticism, and more caring father, whereas in men it was correlated with lower psychoticism and a more caring mother. Longitudinal studies are needed to throw more light on the determinants of marital adjustment.

Kitamura, T., Takazawa, N., Moridaira, J., Machizawa, S. and Nakagawa, Y.: Genetic and clinical correlates of season of birth of schizophrenics. Psychiatry and Clinical Neurosciences, 49; 189-193, 1995.

The genetic and clinical characteristics of 55 patients with schizophrenia and 138 control patients (with major psychiatric disorders), were studied in relation to the season of birth. The morbid risk (MR) of schizophrenia was significantly higher among relatives of the schizophrenic probands born in Spring than among those of the psychiatric controls born in the same season. The MR of schizophrenia was also significantly higher among relatives of schizophrenic probands born in Winter or Spring (6.9%) than in those of schizophrenic probands born in Summer or Autumn (0%). Among the schizophrenic cases, Winter births were marginally related to the paranoid subtype, whereas other clinical variables showed no clear relationship with the season of birth.

宮岡等，片山義郎，北村俊則，寺田久子，大江正恵，宮岡佳子，松島雅子：Alexithymiaは神経症，心身症とどのような関係にあるか．心身医学, 35; 693-699, 1995.

In Japan some authors have said that alexithymia is opposite to neurotic personality and that alexithymia is specifically found among patients suffering from psychosomatic disorders, though there have been no valid reports. The purpose of this paper is to answer these two problems. Problem A. Is alexithymia opposite to neurotic personality? The Eysenck Personality Questionnaire (EPQ) and the Schalling-Sifneos Personality Scale-revised version (SSPS-R)

were administered to a total of 522 employees in some companies and university students to assess neurotic and alexithymic personalities, respectively. Spearman's rank-order coefficient between the neuroticism scores of the EPQ and SSPS-R scores was 0.00 ($p < 0.01$). Thirty-five patients suffering from anxiety disorders (panic disorder and generalized anxiety disorder) and 35 healthy controls were assessed using SSPS-R. All the anxiety patients and 20 controls were assessed by Beth Israel Hospital Psychosomatic Questionnaire (BIQ). The average SSPS-R score among the patients was 7.5 (SD 2.5) and that among the controls was 7.0 (2.4). The average BIQ score among the patients was 4.0 (1.9) and that among the controls was 4.4 (1.7). There is no significant difference of alexithymic trait between neurotic patients and control subjects. These results show that alexithymia is not a personality trait opposite to a neurotic one. Problem B. Is alexithymia specifically found among patients suffering from psychosomatic disorders? Subjects were 94 patients suffering from peptic ulcer (38) and bronchial asthma (56) and 94 healthy controls. Alexithymic trait was assessed by SSPS-R. The average SSPS-R score among the patients was 8.8 (2.6) and that among the controls was 8.3 (2.7). The difference was not statistically significant. The severity of psychosocial stressors among 55 patients suffering from peptic ulcer and bronchial asthma was assessed according to the Axis IV of DSM-Ⅲ-R. Twenty patients had had no stressors for a year before diagnosed, whole 12 had had more than "moderate" stressors. The average BIQ and SSPS-R scores among the 20 patients having no stressors were 4.1 (1.6) and 8.8 (2.7). Those among the 12 patients having stressors were 4.2 (1.4) and 8.9 (2.4), respectively. There is no significant difference between the patients who have had stressors and those having no stressors. These results show that it is not the case that the patients suffering from bronchial asthma and peptic ulcer, which are often called as "psychosomatic disorder," are more alexithymic. Among the patients psychosocial stressors have nothing to do with the degree of alexithymic trait. Conclusions. Alexithymia is not opposite to neurotic personality. It is not specifically found among patients suffering from psychosomatic disorders.

木島伸彦，斎藤令衣，鈴木美香，吉野相英，大野裕，加藤元一郎，北村俊則：Cloninger の気質と性格の 7 因子モデルおよび日本語版 Temperament and Character Inventory (TCI). 精神科診断学, 7; 379-399, 1996.

Cloninger の気質と性格の 7 次元モデル seven-factor model of temperament and character は，パーソナリティの構成概念を気質と性格に分け，それぞれ 4 次元と 3 次元の下位次元を想定している．Cloninger の理念における気質とは，遺伝性であり，主として幼年期に顕われ，認知記憶や習慣形成の際に前概念的バイアスを伴うものである．気質の 4 次元は, (1)行動の触発（新奇性追求）, (2)維持（報酬依存）, (3)抑制（損害回避）, (4)固着（固執）である．また, Cloninger の理論における性格とは，自己概念について洞察学習することによって，成人期に成熟し，自己の或いは社会の有効性に影響するものである．性格の 3 次元は，自己を同定する程度によって異なる，つまり(1)自律的個人（自己志向）, (2)人類社会の統合的部分（協調）, (3)全体としての宇宙の統合的部分（自己超越）である．この Cloninger の理念に基づくパーソナリティ構造を測定するための自己記入式質問紙 Temperament and Character Inventory (TCI) を日本語に翻訳し，再英訳による確認作業の後，日本人のサンプルを用いて日本語版 TCI の信頼性・妥当性検定を行なった．その結果，高い内的整合性および，構成概念妥当性が確認され，軽度精神症状および，社会的望ましさ反応バイアスからの低い被影響がみられ，日本語版 TCI の適用の可能性が保証された．

Tanaka, E., Sakamoto, S., Ono, Y., Fujihara, S. and Kitamura, T.: Hopelessness in a community population in Japan. Journal of Clinical Psychology, 52; 609-615, 1996.

The Japanese version of the Back Hopelessness Scale was administered to a total of 154 community residents. The internal consistency (KR-20) was .86. The mean BHS score was 8.6 (SD = 3.9), approximately one standard deviation higher than the reported mean for an Irish general population. The BHS scores were found to be significantly correlated with the age and the number of people living together. Significant negative correlations were found with subjective physical fitness, self-confidence, satisfaction with accommodation and marital state, and adjustment in the work place. The mean BHS score was significantly higher among those individuals who had experienced early maternal or paternal death than those who had not.

Hasui, C., Sugiura, T., Tanaka, E., Sakamoto, S., Sugawara, M., Kitamura, T. and Aoki, Y.: Reliability of childhood mental disorder diagnoses by Japanese psychologists. Psychiatry and Clinical Neurosciences, 53; 57-61, 1999.

The recent entry of psychologists into psychiatric practices and school in Japan calls for diagnostic skills, because psychiatrists are less available in such settings. We examined the reliability of the diagnoses of 10 DSM-III childhood mental disorders by 11 Japanese psychologists, using 20 case vignettes. Most categories had good reliability (k), except for attention deficit hyperactivity disorder. Japanese clinical psychologists may be able to use DSM-III reliably as a tool for diagnosis of childhood psychiatric disorders, if sufficient training is provided.

Furukawa, T., Anraku, K., Hiroe, T., Takahashi, K., Yoshimura, R., Hirai, T., Kitamura, T. and Takahashi, K.: A polydiagnostic study of depressive disorders according to DSM-IV and 23 classical diagnostic systems. Psychiatry and Clinical Neurosciences, 53; 387-396, 1999.

The classification of mood disorders is one of the most highly debated topics in modern psychiatry. The introduction of DSM-III (and its followers) has set a new standard in this controversy but little empirical evidence is available as to how the various classical diagnostic categories of mood disorders by Kraepelin, Schneider, Leonhard, Hamilton, Kielholz, Winokur and others compare with this new standard. The Intensive Prospective Study arm of the Group for Longitudinal Affective Disorders Study has studied a broad spectrum of mood disorders in 23 participating centres from all over Japan with a polydiagnostic semistructured interview called Comprehensive Assessment List of Affective disorders. In this paper we examined how the various classical diagnostic systems of depressive disorders correspond to the DSM-Ⅳ diagnoses, and found the following: (1) The classical 'neurotic' or 'psychogenic' depressions are diagnosed as major depression and not as dysthymia in DSM-III; although dysthymia was dubbed as 'depressive neurosis' in DSM-III, its criteria were not true to the traditional usage of the term. Viewed from the other side of the coin, DSM-III can be said to stand in the unitary tradition. (2) Some of the classical diagnostic categories such as Schneider's depressive psychopathy and Klein's acute dysphoria as well as modern ones such as Akiskal's subaffec-

tive dysthymia and Angst's recurrent brief depression were rarely seen in traditional psychiatric treatment settings. (3) Comparisons of the unique diagnostic systems such as those by Leonhard, Winokur and Berner warrant further studies on their validity.

平井利幸，古川壽亮，北村俊則，高橋清久：感情症候群の発症様式と 2 年後の転帰．精神神経学雑誌, 101, 495-508, 1999.

近年，感情障害をより軽症のレベルで把握し診断しようとする傾向がある．感情障害は，軽症のものまで含めると，（躁）うつ病の主症状であるにとどまらず，精神障害全般に分布する症候群である．本研究の目的は，ごく軽症の感情症状まで広く含む広義の感情障害を感情症候群として位置付け，その縦断面からみた臨床特徴をとらえることにある．外来を初診した精神障害患者計 90 例を対象として，前方視的追跡調査により発症様式及び 2 年後の転帰を調査した．独自に開発された半構造化面接により，軽症の感情症状の有無に注目して症候群分けをし比較検討した．主たる対象である感情症候群は，「今回病態中抑うつ気分，興味喪失または高揚気分，開放気分，易怒的気分が少なくとも 4 日間持続する」症例で計 49 例である．その内，躁症候群はわずか 2 例であったので，今回の比較検討から除外した．すなわち 47 例の抑うつ症候群を主たる対象とし，今回病態中感情症状がみられないものから精神病症候群 18 例，神経症症候群 23 例を対象群として選択した.結果は以下のようである．この 3 群は，性・年齢で差がない．発症様式から比較すると, 10 日間以内に発症を同定できる急性発症の割合は，抑うつ症候群の 64.4%，精神病症候群の 42.2%，神経症症候群の 30.4% であった. 2 年後の転帰を比較すると，抑うつ症候群の 70.2%，精神病症候群の 38.9%，神経症症候群の 45.5% が寛解に至った. 2 年後の GAS 得点（M±SD）は抑うつ症候群 76.2±12.5 点，精神病症候群 62.8±11.7 点，神経症症候群 78.2±9.9 点であった．この調査から抑うつ症候群の「発症がより急性で，転帰が症状面でも機能面でも良好である」という結果を得た．抑うつ症候群は精神病症候群のみならず，神経症症候群と比較しても症状面での転帰が良好であった.

Sugawara, M., Sakamoto, S., Kitamura, T., Toda M. A. and Shima, S.: Structure of depressive symptoms in pregnancy and postpartum period. Journal of Affective Disorders, 54, 161-169, 1999.

Background: The present study investigated the structure of depressive symptoms in the perinatal period. ***Method*:** The Zung Self-Rating Depression Scale (SDS) was administered to a total of 1329 women in early, middle and late pregnancy and 5 days, 1 month, 6 months, 12 months and 18 months after the delivery. ***Results*:** A number of somatic items and the suicidal ideation item of the SDS made low contributions to the evaluation of the severity of depression, and as a consequence these were excluded in the principal component analysis. Three factors were interpretable as "Cognitive", "Affective insomnia" and "Attentional" emerged at all eight assessment points. The goodness-of-fit index (GFI) generated by confirmatory factor analyses (LISREL 7.20) proved sufficiently high on all eight occasions. ***Limitation*:** The present study investigated only one self-rating scale and the sample comprised Japanese mothers only. ***Conclusion*:** The three-factor model of the SDS in the perinatal period was derived from exploratory and confirmatory factor analyses. It is noteworthy that the same three-factor structure emerged at all eight collection points in present study.

Kitamura, T., Sugawara, M., Shima, S. and Toda, M. A.: Temporal variation of validity of self-rating questionnaires: improved validity of repeated use of Zung's Self-rating Depression Scale among women during perinatal period. Journal of Psychosomatic Obstetrics and Gynaecology, 20; 112-117, 1999.

It has been reported that Zung's Self-Rating Depression Scale (SDS) loses its validity in predicting cases of depression when used repeatedly. The validity of SDS was tested against the subject's Research Diagnostic Criteria (RDC) diagnoses of major/minor depressive disorders in 120 pregnant women four times throughout the perinatal period. Different sets of predictive SDS items were found at different time points. We developed an 'RDC-like' algorithm from SDS items. Though varying in sensitivity, we found that this formula yielded low, but stable, positive predictive values and constantly high negative predictive values. We suggest that the RDC-like algorithm is a better alternative for screening depression among perinatal women.

Kijima, N., Tanaka, E., Suzuki, N., Higuchi, H. and Kitamura, T.: Reliability and validity of the Japanese version of the Temperament and Character Inventory. Psychological Reports, 86; 1050-1058, 2000.

The Temperament and Character Inventory was translated into Japanese, and to confirm the psychometric properties of the inventory, three samples were recruited from a nonpatient population. In nonpatient population A (N=555), the full version (240 items) of the inventory with dichotomous measuring, along with the General Health Questionnaire and the Social Desirability Scale, were distributed to the subjects. Factor analyses of the subscales showed that the factor structure of the inventory was consistent with Cloninger's theory. Correlations of the scale scores with the General Health Questionnaire and the Social Desirability Scale scores were almost negligible, indicating that the scale is resistant to the current psychopathology and response bias. In this and the other two university student samples (ns=395 and 377), Cronbach coefficients α of the scale scores were substantially high except for the short version (125 items) of the inventory with dichotomous measures. The Japanese version of the inventory appears to have internal reliability and content and construct validity in a Japanese population.

Ono, Y., Yoshimura, K., Yamauchi, K., Asai, M., Young, J, Fujihara, S. and Kitamura, T.: Somatoform symptoms in a Japanese community population: Prevalence and association with personality characteristics. Journal of Transcultural Psychiatry, 37; 217-227, 2000.

To investigate the prevalence rates and characteristics of poorly explained or unexplained somatic symptoms in the general population of Japan, questionnaires were administered to 132 people aged 18years or older in a small community in the city of Kofu. The participants were then interviewed by trained interviews using a semi-structured interview schedule. Of the 132 participants in our study, 55 (41%) reported somatic symptoms. Of these 55, nine (16%) were diagnosed with a specific DSM-Ⅳsomatoform disorder. Multiple regression analyses revealed that the number of poorly explained symptoms among women was related to personality characteristics. Moreover, our analysis also

revealed a gender difference in the pattern of these relationships. None of the respondents who reported medically unexplained somatic symptoms had sought psychiatric care.

北村俊則 : 精神疾患診断の問題点と操作診断の必要性. 精神科診断学, 11; 191-218, 2000.

「従来診断」の診断一致率は低い. 精神科診断を操作的に規定することは, (1)インフォームド・コンセントにおける病名告知, (2)強制入院の際の根拠としての診断, (3)チーム医療の共通言語, の3点において社会的責任を有している. 診断の信頼性を向上させるには構造化面接が必要である. さらに, 精神科診断には妥当性が要求される. そのためには症状が因子構造としてもまとまっていることを示す必要がある. 今後は生物学的・心理社会的原因を組み込んだ基準作成が必要になろう.

Tomita, T., Aoyama, H., Kitamura, T., Sekiguchi, C., Murai, T. and Matsuda, T.: Factor structure of psychobiological seven-factor model of personality: A model revision. Personality and Individual Differences, 29; 709-727, 2000.

The purpose of this study was to examine the factor structure in the Temperament and Character Inventory [TCI; Cloninger, C. R., Svrakic, D. M., & Przybeck, T. R. (1993). A psychobiological model of temperament and character. Archives of General Psychiatry, 50, 975-990.] and to determine appropriate subscales and items to assess the psychobiological seven-factor model with a nonclinical Japanese sample by the use of the TCI short version. Among 383 ex-members of the Japanese Antarctic Research Expedition, confirmatory factor analysis of the TCI showed that temperament consisted of four factor and character of three, as the original model suggested. Harm Avoidance, Reward Dependence, Self Transcendence and Cooperativeness may be interpreted as a constellation of interrelated but possibly discrete dimensions. Most of the items were loaded into each corresponding subscale, although a few of the items were not confirmed as appropriate. Implications and the future direction of personality research are discussed.

Furukawa, T. A., Kitamura, T. and Takahashi, K.: Time to recovery of an inception cohort of hitherto untreated unipolar major depressive episodes. British journal of Psychiatry, 177; 331-335, 2000.

Background: Generalisability of existing studies on the naturalistic history of major depression is undermined by overrepresentation of in-patients and tertiary care academic centres, inclusion of patients already on treatment and / or incomplete follow-up. Aims: To report the time to recovery of an inception cohort of unipolar major depressive episodes. Method: A multi-centre prospective follow-up study of patients with a mood disorder, who had been selected to be representative of the untreated first-visit patients at 23 psychiatric settings from all over Japan.
Results: The median time to recovery of the index episode after treatment commencement was 3 months (95% CI 2.5-3.6): 26% of the cohort reached asymptomatic or minimally symptomatic status by 1 month, 63% by 3 months, 85% by 12 months and 88% by 24 months. Conclusions: Our estimate of the episode length was 25-50% shorter than estimates reported in the literature.
Declaration of interest: No conflict of interest. Funding from the Ministry of Health and Welfare, Japan.

Furukawa, T. A., Konno, W., Morinobu, S., Harai, H., Kitamura, T. and Takahashi, K.: Course and outcome of depressive episodes: Comparison between bipolar, unipolar and subthreshold depression. Psychiatry Research, 96; 211-220, 2000.

It is pragmatically important to know the comparative prognoses of bipolar, unipolar and subthreshold depressions after they present to clinical attention. Previous studies focusing on bipolar and / or unipolar depressions have questionable generalizability because of overrepresentation of inpatients and / or refractory patients, and no study has yet focused on the length of subthreshold depression. The Group for Longitudinal Affective Disorders Study (GRADS) in Japan is conducting a prospective, serial follow-up study of broadly defined mood disorder patients, who had not received treatment for their index episode before study entry. The median time to recovery for bipolar depression was 2.0 months (95% CI: 0.9-3.1), that for unipolar depression 3.0 (2.5-3.6), and that for subthreshold depression 3.2 (0-12.3). Survival analyses revealed no statistically significant difference among the three. Neither was the total time unwell significantly different among the three: on average, these patients were symptomatic with two or more significant affective symptoms for 9.5 (8.0-10.9) months out of the initial 24 months of follow-up. The bipolar depressed patients tended to present with graver functional impairment at intake, but thereafter there was no statistically significant difference in the global functioning of these three diagnostic subgroups. In our sample, patients with depressive disorder not otherwise specified appeared to suffer both symptomatologically and functionally as much as patients with major mood disorders.

Tomita, T. and Kitamura T.: Diagnostic reliability and accuracy of pathological grief and psychiatric disorders among Japanese psychologists and psychology students. Psychological Reports, 88; 743-746, 2001.

The present study examined the reliability and accuracy of diagnoses regarding pathological grief and other psychiatric disorders using a case vignette design. Two Japanese psychologists (PH. D. and M. A. levels) and five graduate students in psychology participated. Analysis suggests that psychologists and psychology students can reliably apply the diagnostic criteria for pathological grief and other psychiatric disorders.

Furukawa, T. A., Takeuchi, H., Hiroe, T., Mashiko, H., Kamei, K., Kitamura, T. and Takahashi, K.: Symptomatic recovery and social functioning in major depression. Acta Psychiatrica Scandinavica, 103; 257-261, 2001.

Objective: To determine whether social functional recovery precedes, runs in parallel with, or lags behind symptomatic recovery from major depressive episodes. Method: Psychiatric out-patients or in-patients aged 18 years or over, diagnosed with unipolar major depressive disorder according to DSM-III, and who had received no antidepressant medication in the preceding 3 months were identified at 23 collaborating centres from all over Japan (n = 95). They were rated with the 17-item Hamilton Rating Scale for Depression (HRSD) and the Global Assessment Scale (GAS) monthly, and with the Social Adjustment Scale-Self Report (SAS-SR) 6-monthly. Remission was defined as 7 or less

on the HRSD and recovery as 2 or more consecutive months of remission. Results: The GAS ratings showed continuous amelioration from baseline to remission, remission to recovery, and after sustained recovery. The same trends were observed for SAS-SR scores. Conclusion: We can expect further amelioration in social adjustment after symptomatic remission and recovery of major depressive episodes.

Tomita, T. and Kitamura, T.: Clinical and research measures of grief: A reconsideration, Comprehensive Psychiatry, 43; 95-102, 2002.

Bereavement-induced grief and psychological intervention are important social issues and worthy of attention from researchers and clinicians. Here we review currently available measures of grief and discuss the differentiation of normal grief reaction from pathological grief and major depression. Finally, we propose future directions for research on the development of new grief measures and the effects of normal and pathological grief on psychological and physical health.

Suzuki, Y., Sakurai, A., Yasuda, T., Harai, H., Kitamura, T., Takahashi , K. and Furukawa, T. A.: Reliability, validity and standardization of the Japanese version of the Social Adjustment Scale-Self Report. Psychiatry and Clinical Neurosciences, 57; 441-446, 2003.

The purpose of the present paper was to examine the reliability and validity of the Japanese version of the Social Adjustment Scale-Self Report (SAS-SR) and to present its normative data. The SAS-SR was administered to a random sample of all the employees of a large general hospital, together with the General Health Questionnaire (n = 363). It was also administered to a representative subset of first-visit patients at 33 psychiatric hospitals and clinics from all over Japan, along with the semistructured psychiatric interview to ascertain the patients' diagnoses (n = 1581). For the internal consistency reliability of the subscales and the overall scale of the SAS-SR, Cronbach's alpha was between 0.61 and 0.73. The Pearson product-moment correlations between the subscale and overall scale scores with the GHQ score were mostly >0.3. The scores were statistically significantly and substantively different between the normal sample and the patient samples, and were also meaningful, differentiating between various diagnostic subgroups. The reference ranges of the SAS-SR scores for mentally healthy subjects were calculated as 95% prediction intervals; for example, 1.22-2.22 for the overall score. The Japanese version of the SAS-SR has good reliability and satisfactory validity. The present study provided reference ranges for its scores in order to increase their interpretability. With its ease of administration and its rich subscales, the scale promises to offer a psychometrically sound measure with which to assess social adjustment in people with various psychiatric disorders.

Kanai, T., Furukawa, T. A., Yoshimura, R., Imaizumi, T., Kitamura, T., and Takahashi, K.: Time to recurrence after remission from major depressive episodes and its predictors. Psychological Medicine, 33; 839-845, 2003.

BACKGROUND: Depression is a remitting but recurring disease. However, there is a paucity of prospectively rec-

orded data on the course of depression after recovery. ***METHOD:*** A multi-centre prospective serial follow-up study of an inception cohort of hitherto untreated unipolar major depression (N = 95) for 6 years. We report the time to recurrence after recovery from the index depressive episode and their predictors. ***RESULTS:*** The cumulative probability of remaining well without subthreshold symptoms was 57% (95% CI, 46 to 68%) at 1 year, 47% (95% CI, 36 to 58%) at 2 years and 35% (95% CI, 23 to 47%) at 5 years. The same without full relapse was 79% (95% CI, 70 to 88%) at 1 year, 70% (95% CI, 60 to 80%) at 2 years and 58% (95% CI, 46 to 70%) at 5 years. The median duration of well-interval from the end of the index episode to the beginning of the subthreshold episode was 19-0 months (95% CI, 2-4 to 35-7), and that to the end of the full episode was over 6 years. Residual symptoms at time of recovery predicted earlier recurrence. ***CONCLUSIONS:*** The median length of the well-interval was much longer than previously reported in studies employing similar definitions but dealing with a more severe spectrum of patients. However, the sobering fact remains that less than half of the patients can expect to remain virtually symptom-free for 2 years or more after recovery from the depressive episode.

Ito, T., Tomita, T., Hasui, C., Otsuka, A., Katayama, Y., Kawamura, Y., Muraoka, M., Miwa, M., Sakamoto, S., Agari, I. and Kitamura, T.: The link between response styles and major depression and anxiety disorders after child-loss. Comprehensive Psychiatry, 44: 396-403, 2003.

Although several studies have indicated that persons with a high ruminative coping style experience higher depression after the loss of a loved one, the relationship between ruminative coping and the occurrence of clinical depression and anxiety disorders after a loss has not been thoroughly investigated. This study investigated the relationship between response styles (ruminative coping v distractive coping) and the onset of major depression and anxiety disorders in a sample of parents who had experienced sudden child-loss (N = 106). The incidence of major depression after the loss of a child was very high (69%). After controlling for demographic variables and psychiatric history, ruminative coping was significantly associated with the onset of major depression, as defined by DSM-IV, but not with the onset of anxiety disorders. Thus ruminative coping after the loss of a child appears to be a risk factor specifically for major depression.

Kitamura, T., Kishida, Y., Gatayama, R., Matsuoka, T., Miura, S. and Yamabe, K.: Ryff's psychological well-being inventory: factorial structure and life history correlates among Japanese university students. Psychological Reports, 94; 83-103, 2003.

The theoretical model of psychological well-being that encompasses six domains (self-acceptance, positive rotations with others, autonomy, environmental mastery, purpose in life, and personal growth)was tested with a Japanese university student population(N=574) using a Japanese translation of Ryff's 1989 Psychological Well Being Inventory. A factor structure similar to Ryff's original model emerged. Both depression and anxiety correlated only moderately with scores on some subscales of the inventory, suggesting the relative independence of these dimensions

Yamada, K., Nagayama, H., Tsutiyama, K., Kitamura T., and Furukawa, T.: Coping behavior in depressed patients: A longitudinal study. Psychiatry Research, 121, 169-177, 2003.

The relationship of coping behavior to outcome in depressed patients was examined. Subjects (n=105) with major depressive disorder (n=85), depressive disorder not otherwise specified (n=7) or major depressive disorder with axis I comorbidity (n=13) were followed for 6 months. Their coping behavior (i.e. rumination, active distraction, cognitive distraction and dangerous activities) was defined using the Comprehensive Assessment List for Affective Disorders. Based on their Hamilton Rating Scale for Depression (HRSD) scores at 6 months, the patients were categorized as having had a good or a poor outcome. Severity of depression and coping behavior were similar among the three diagnostic groups. At baseline assessment, coping behavior was not correlated with either HRSD score or age. However, males were significantly more likely to be engaged in dangerous activity as a coping behavior than females. Patients with a good outcome at 6 months were significantly more likely to use rumination as a coping behavior while patients with a poor outcome were significantly more likely to use dangerous activity. Multiple regression analysis confirmed this finding, indicating that rumination and dangerous activity were significant predictors of outcome at 6 months. Rumination might be associated with good outcomes in depressed patients while dangerous activity might be associated with poor outcomes.

Kitamura, T., Hirano, H., Chen, Z. and Hirata, M.: Factor structure of the Zung Self-rating Depression Scale in first-year university students in Japan. Psychiatry Research, 128; 281-287, 2004.

The Zung-Self-Rating Depression Scale (SDS) was distributed to 28,588 first-year university students. Factor analysis using PROMAX rotation revealed three factors interpretable as affective, cognitive, and somatic symptoms. The confirmatory factor analysis showed a goodness-of fit index of 0.976 and an adjust goodness of fit index of 0.967. The two sexes exhibited virtually the same factor structure. The result suggests that studies with this scale should use these three subscales rather than a total score.

Kitamura, T.: Looking with both the eyes and heart open: the meaning of life in psychiatric diagnosis. World Psychiatry, 4; 93-94, 2005.

Tanaka, N., Uji, M., Hiramura, H., Chen, Z., Shikai, N. and Kitamura, T.: Cognitive patterns and depression: Study of a Japanese university student population. Psychiatry and Clinical Neurosciences, 60; 358-364, 2006.

According to Beck's cognitive theory, individuals who endure negative self-schemas (dysfunctional attitudes) are more likely to present automatic thoughts consisting of negative schemata of oneself and one's world while experiencing depression. In order to examine the relationships between depression, automatic thought, and dysfunctional

attitude, 329 Japanese university students were given a set of questionnaires, including the Center for Epidemiologic Studies Depression Scale (CES-D), Automatic Thought Questionnaire-revised (ATQ-R), and Dysfunctional Attitude Scale (DAS). A structural equation model revealed that depression was predicted predominantly by automatic thought, which was in turn predicted by dysfunctional attitude. The male gender had a tendency to predict dysfunctional attitude. The link between a student's depression and dysfunctional attitude was mediated by automatic thought.

Yamashita, H., Ariyoshi, A., Uchida, H., Tanishima, H., Kitamura, T. and Nakano, H.: Japanese midwives as psychiatric diagnosticians: Application of criteria of DSM-IV mood and anxiety disorders to case vignettes. Psychiatry and Clinical Neurosciences, 61; 226-233, 2007.

It is believed in Japan that only psychiatrists are capable of providing reliable psychiatric diagnosis. However, more awareness of mental health issues related to perinatal care means that midwives are now required to have psychiatric diagnostic skills. The purpose of the present paper was to examine how well Japanese midwives agreed with a psychiatrist on diagnoses of different psychiatric disorders. Vignettes of 29 cases including DSM-IV mood disorders (major depressive disorder and bipolar disorder) and anxiety disorders (generalized anxiety disorder, panic disorder, phobic disorders, and obsessive-compulsive disorder) were distributed to 12 Japanese midwives. They decided the DSM-IV diagnoses independently and compared them with those made by an expert. The kappa coefficients of the diagnoses with a base rate of 0.1 or more were moderate to almost perfect (0.64-0.83). The accuracy of symptom assessment was also satisfactory. Appropriately trained Japanese midwives can use the diagnostic criteria for psychiatric disorders reliably. It is therefore feasible to dispatch midwives who are trained in psychiatric diagnosis to antenatal clinics.

Ekino, S., Susa, M., Ninomiya, T., Imamura, K., and Kitamura, T.: Minamata diseases revisited: An update on the acute and chronic manifestations of methyl mercury poisoning. Journal of Neurological Sciences, 262; 131-144, 2007.

The first well-documented outbreak of acute methyl mercury (MeHg) poisoning by consumption of contaminated fish occurred in Minamata, Japan, in 1953. The clinical picture was officially recognized and called Minamata disease (MD) in 1956. However, 50 years later there are still arguments about the definition of MD in terms of clinical symptoms and extent of lesions. We provide a historical review of this epidemic and an update of the problem of MeHg toxicity. Since MeHg dispersed from Minamata to the Shiranui Sea, residents living around the sea were exposed to low-dose MeHg through fish consumption for about 20 years (at least from 1950 to 1968). These patients with chronic MeHg poisoning continue to complain of distal paresthesias of the extremities and the lips even 30 years after cessation of exposure to MeHg. Based on findings in these patients the symptoms and lesions in MeHg poisoning are reappraised. The persisting somatosensory disorders after discontinuation of exposure to MeHg were induced by diffuse damage to the somatosensory cortex, but not by damage to the peripheral nervous system, as previously believed.

症例報告

Kitamura, T. and Hara, S.: Imipramine-induced hallucinations. Bulletin of Institute of Psychiatry Tokyo, 23; 113-115, 1984. (with Japn. abstract)

成田秀章，北村俊則：精神分裂病様症状を呈した XXY 症状群. 臨床精神医学, 14; 1501-1509, 1985.

奇異な妄想, 頻回の幻聴, 作為体験, 離人症状, 反復洗浄を主とする強迫傾向などがあり, 経過も 6 ヶ月を越え, 症状論的には精神分裂病と診断できる, XXY 男子の 1 例を報告した. 各種の研究にも言及し, その病態について考察した.

Hashimoto, K., Ikegami, K., Nakajima, H., and Kitamura, T.: Werner Syndrome with Psychosis: A case report. Psychiatry and Clinical Neurosciences, 60; 773-443, 2006.

総説

Kitamura, T.: Time perception of patients with depression: A review. Bulletin of Institute of Psychiatry Tokyo, 22; 115-123, 1979-1982. (with Japn. abstract)

中里克治，下仲順子，谷口幸一，佐藤真一，池田央，丸山晋，北村俊則，大塚俊男：老年期における痴呆の評価法. 臨床精神医学, 15; 1403-1409, 1986.

わが国の人口高齢化は急激に進み, 昭和 60 年には 65 歳以上の老人は全人口の 10% を越えることが確実視され, 老人問題はその重要性を増している. なかでも, 老人の痴呆には精神医学者のみならず, 広く一般の人々の関心が集まっている. わが国における痴呆の出現率は, 65 歳以上の人口の 4.6%, 85 歳以上では 23.4% と更に高率となる. したがって, 痴呆の予防と痴呆老人を適切な医療や福祉のルートの乗せるための対策が必要とされている. ところが, 痴呆の専門家や痴呆老人を扱う専門機関が少なく, 痴呆の有効な治療法がないなど, 問題は山積している. しかしながら, 昭和 57 年の老人保健法の制定を契機に, パラメディカル・スタッフが痴呆老人とかかわる機会もさらに増え, 現場からも, 痴呆の可能性のある人をスクリーニングし, 治療のルートに乗せるべきか否かを早急に明らかにすることが求められている. そのためには, 老年精神科医でなくとも痴呆をスクリーニングできる評価法の確立が必要であろう. 本論文の目的は, これまでに公けにされた心理学的手法による痴呆の評価法を, タイプ別に総説することである. 痴呆の鑑別を目的として作られた評価法を, 心理テストによるものと行動チェック・リストによるものに分けて総説する. 最後に, インベントリーに近い形に整備された痴呆の診断基準の明確化の研究にも触れる.

北村俊則：精神症状評価尺度の方法論—薬効判定の基礎—. 神経精神薬理, 8; 647-666,

1986.

北村俊則：不安性障害の診断学・症状学. 精神科治療学, 2; 303-305, 1987.

北村俊則：GHQの成立過程と使用上の問題点. 心理判定ジャーナル, 23; 6-11, 1987.

北村俊則：精神障害の亜型分類について－笠原敏彦ら「心気症の分類と臨床的特徴」に対する批判的考察－. 精神神経学雑誌, 92; 242-244, 1990.

精神疾患の分類と診断基準は単に症候論や疾病分類学の作業のみにとどまらず，精神医学の他の領域においても重要な意味を持っている．精神疾患のなかでもこれまで診断学上の検討があまり行われていなかった心気症について，精神科国際診断基準研究会・神経症圏障害検討小委員会作製の診断基準（案）による亜型分類を比較した笠原ら（精神経誌, 91; 133-151, 1989）報告は時宜を得たものといえる．しかし，上記亜型分類の有効性を認める笠原らの結論には，方法論上いささかの疑義があるので，以下に述べてみたい．

北村俊則：精神症状判定・評価の問題点. 老年精神医学雑誌, 1; 396-402, 1990.

北村俊則, 栗田広, 藤縄昭：ICD-10 を中心とした精神疾患診断基準の動向. 精神医学, 32; 686-694, 1990.

北村俊則：構造化面接の効用と限界. 精神科診断学, 1; 473-478, 1990

精神科面接の目的は診断と治療に二大別される．現在流布されているさまざまな構造化面接は前者のためのものである．十分な経験と技術を持った精神科医にとっては構造化面接は不要だが，（１）患者の関心と医師のそれが必ずしも一致せず，したがって問診しなければ確認できない重要な症状が多い，（２）臨床研究では，均一の情報を漏れなく確認することが要求される，（３）地域精神医療や一般人口における精神科疫学調査を行う場合には精神科医以外の医療従事者や研究員が最小限度の必要な症状を確認できる「道具」が必要である，といった要請から，構造化面接は臨床と研究のいずれにおいても必要な手技である．構造化面接は信頼性の向上に寄与するが，それは妥当性を保証するものではない．後者については慎重な検討が必要である．

北村俊則：精神医学における操作的診断基準とDSM-Ⅲ-R －従来診断の実証的視点の欠落に触れて－. 精神科治療学, 6; 521-531, 1991.

「診断」という用語には nosological category と diagnostic formulation という 2 つの意味がある．前者は異なる病像から共通項を抽出して診断（疾患単位）の prototype を作る事後的全体的事実確認作業であるのに対し，後者は疾病分類学的 prototype ではおさまりきらない個々の症例の臨床上重要な特徴を列記し，そこから治療方針の決定と治療反応性の予測を立てる事前的個別的仮説設定作業である．中安が言う「臨床診断」は diagnostic formulation であり，操作的診断基準は nosological category であり，「診断」という用語は文脈ごとに区別して使用すべきである．中安の提唱する初期分裂病のような疾病概念についての実証的妥当性検討を広く行うことが，精神科診断学の発展に寄与すると思われる．

藤縄昭, 北村俊則：精神医学における操作的疾病分類学・症状学の効用と限界. 精神科治療学, 6(5); 549-554, 1991.

(1) 通常の臨床医は, 日本における従来診断の評定者間信頼度は高いという印象を抱いていたが, これは実際には低いことが確認されている.「共通言語」としての操作的診断基準の必要性は高い. (2) 操作的診断基準が取り扱える現象は観察可能な範囲に限られているという誤解がある. 再現性が保証されれば抽象的概念も用いることができる. (3) 診断は医師と患者の関係の中のみに存在するという考えがある. こうした考え方では経験を普遍化することが困難で, チーム医療には不適で, かつ強制入院の要件としての診断や告知同意の内容としての診断といった社会的要請にこたえることができない. (4)早期診断に用いられないという非難があるが, 通常の臨床場面では「最終」診断を求めてからでなければ治療は開始されないというものではない. (5)頻回に改訂される基準は真実とはいえないという主張は, 実証的研究成果を無視するものである.

北村俊則：分類感情病の疾病学的位置づけ. 精神科診断学, 2; 385-400.

同一挿話中に精神病像と感情病像を示す病態を, 英語圏では分裂感情病 schizoaffective disorder (SAD) と呼ぶことが多い. SAD の疾病単位としての独立性について, 症状, 家族歴, 転帰, 治療反応性, 検査所見ごとに検討した. SAD の亜型の中で, 躁型（双極型）, 主として感情病性, 非慢性のものが純粋な感情病に近く, 抑うつ型, 主として精神分裂病性, 慢性のものはむしろ精神分裂病に近いと考えられる. しかし一致しない所見も多い. 今後は, SAD を経過と横断面症状ごとに検討し, 疾病分類学的に意味のある症状群の抽出が望まれる.

古川壽亮, 北村俊則：精神医学における実証主義と操作化と計量的手法. 臨床精神病理学, 13; 89-100, 1992.

宮岡等, 竹内美香, 北村俊則：精神症状の測定法：評価尺度. 高橋三郎, 花田耕一 （編） 精神科MOOK 28 精神科診断基準, pp. 31-44, 1992.

人の心理現象や行動を再現性の高い方法で評価する手法が評価尺度, 質問票, 面接基準であり, これらは操作的方法と総括される. これらの評価方法の目的には, 重症度評価, スクリーニング, 診断, 症状プロフィールの把握などがあり, 目的に応じて使い分けなければならない. 外国で用いられている評価尺度を本邦で使用する場合, 通常, 原著者の許可, 日本語版の再英訳に対する原著者の承諾, 本邦での妥当性, 信頼性検討が必要である. 主な評価尺度を精神症状全般に対する包括的な評価尺度, 精神分裂病, うつ病, 躁病, 神経症, 痴呆, 経過, 転帰の評価尺度などに分類し, 概説した. 評価尺度は精神症状の評価における評価者間のばらつきを小さくするだけでなく, 精神症状全般に目を向けることを促すこと, 評価しにくい精神症状をより細かい要素に分けて評価しやすくするように試みていることなどの点で臨床的に有効である. 一方, 評価者間の一致度を高めようとする努力が熟練した診察能力の意義を薄める可能性を否定できないこと, 通常の臨床面接のなかに自然な形で組み込みにくいことなどの問題がある. 操作的手法では, 特定の目的を前提にしてその方法が成立していることを理解しておくことが不可欠であり, それのみで症状評価や診断が完了するものではなく, さらに必要に応じて詳細な臨床的検討が行われなければならない.

北村俊則：自記式調査票の効用と限界．精神科診断学, 3; 407-411, 1992

評価の対象となる個人がみずから設問に記入･回答する評価手段を自記式調査票と称し，近年，診察と研究に多用されている．自記式調査票は，対象者が多数であったり，直接面接が困難な際に適しており，主として重症度評価もしくはスクリーニングのために作られている．信頼性は再試験法で測定し，妥当性は臨床評価を外的基準として測定する．スクリーニング用自記式調査票の妥当性については，少なくとも sensitivity と specificity を求める．外国で作られた調査票の翻訳にあたっては，再翻訳を行うことで原文と一致していることを確認しなければならない．

竹内美香，吉野相英，大野裕，加藤元一郎，北村俊則：Cloningerの 3 次元人格(TPQ)理論および日本語版Tridimensional Personality Questionnaire (TPQ)．精神科診断学，3; 491-505, 1992.

Cloninger の 3 次元人格 tridimensional personality (TDP) 構造は，不安障害患者や動物を用いた学習心理学的実験における抗不安薬の効果などの経験的事実から演繹された行動の触発・維持・抑制を含む 3 つの脳神経システムを仮定している．理論を構成する 3 つの次元は，行動の触発（新奇性追求），維持（報酬依存），抑制（損害回避）であり，各々dopamine, norepinephrine, serotonin の個体的代謝特性に支えられている．構造を測定するための自己記入式質問紙 Tridimensional Personality Questionnaire (TPQ) を日本語に翻訳し，再英訳による確認作業の後，日本の一般大学生（450 名）に予備調査を行なった．その結果，高い再テスト信頼性と内的整合性，軽度精神症状および社会的望ましさ反応バイアスからの低い被影響性が見られ，日本語版 TPQ の適用の可能性が保証された．

北村俊則：DSM-Ⅳの多軸診断について．精神科診断学, 4; 483-488, 1993.

多軸診断の導入は DSM の新機軸であった．DSM の第 4 軸と第 5 軸は疾病分類学的診断には有用性がないが，個別患者の治療計画立案に際しての diagnostic formulation のためにはたいへん有用である．DSM-Ⅳ最終草案では，第 4 軸（心理社会的ストレス）が強さの測定を廃し新しく問題領域を選択する方法を採用した．第 5 軸ではその評価期間を現在の機能に限定し，評価段階に 91～100 点を追加した．対人関係上の機能評価，防衛規制の評価，重症度，経過様式などの軸を加えることも検討されたが最終草案に採用されるには至らなかった．多軸診断の試みは診断学の意味を医師のための診断学から患者のための診断学に変更するきっかけを与えるものであろう．

北村俊則：妊娠中の精神疾患の診断学．精神科診断学, 5; 303-309,1994.

従来は妊娠期間は女性の精神保健にとって安全な時期と考えられてきたが，精神科非受診の一般妊婦を対象とした近年の疫学的調査の結果，妊娠が少なくとも一部の女性にとっては心理的ストレッサーであることが明らかになった．妊娠期間中にことに頻回に出現する病態はうつ病である．妊娠うつ病は 15%ほどの妊婦に発生し，その発症は妊娠前期に多い．発症に関連する要因として，初回妊娠，初産，過去の人工中絶，早期の喪失体験，特定の人格傾向，望まない妊娠，妊娠に対する夫の否定的態度，集合住宅などの不良な住環境，夫の心理的支援（新密度）の不足があげられている．妊娠うつ病は出産までに消失し，産後うつ病との関連はない．

大渕憲一, 北村俊則, 織田信男，市原眞紀：攻撃性の自己評定法：文献展望．精神科診断学, 5; 443-455, 1994.

攻撃性の自己評定法を収集・分類し，この作業を通して，攻撃性の概念構成とその測定項目を検討した．精神医学および心理学の臨床，人格，社会の主要な学術雑誌を 1970 年以降調査し，関連する研究文献から攻撃性の自己評定法を収集した．全部で 80 個が見出されたが，項目文を入手できたのはそのうち 30 個（下位尺度としては 68 個）だった．測定しようとする概念内容の違いを検討し，これらの下位尺度をわれわれは 12 カテゴリーに分類した．それは，身体的攻撃反応傾向，言語的攻撃反応傾向，間接的攻撃傾向，敵対的な対人態度・認知・信念，攻撃的情動，罪悪感と敵意の抑制，サディズムと暴力衝動，攻撃性に関連した諸特性，対人葛藤への反応傾向，加害体験と被害体験，対女性暴力，攻撃性に関連する病理である．

北村俊則：精神分裂病の診断．こころの科学, 60; 14-17, 1995.

住山孝寛, 北村俊則：BPRS改訂版，下位尺度，信頼性と妥当性．精神科診断学, 6; 203-218, 1995.

Brief psychiatric Rating Scale (BPRS) は，精神科医が症状の変化を評価する際によりどころとする少数の症状を，統計的・臨床的方法により抽出し尺度化することで，精神症状の変化の評価を，包括的かつ簡便にし，しかも定量的におこなうことを可能にした．さらに，疾患特異的な尺度として用いるために，各種の下位尺度が作られたり，評価対象となる疾患の範囲をひろげるための項目数増大，信頼性向上のための構造化やアンカーポイントの明示，などといった変更のなされた，各種の改訂版がつくられた．こうした多様な発展をみせる BPRS について，原版，改訂版，下位尺度などを紹介し，信頼性，妥当性の観点から論じた．

北村俊則：分裂感情障害研究の方法論的批判．精神医学, 40; 163-165, 1998.

富田拓郎，北村俊則：精神症状評価尺度の妥当性に関する方法論的問題点．臨床精神神経薬理, 2; 13-17.

精神症状評価尺度は広く用いられているが，その妥当性をめぐっていくつかの方法論的な問題点を残している．本稿ではこれらの問題について考察し，今後の指針を提示した．はじめに，妥当性とは何かを展望し，その方法論を簡潔に述べた．次に，因子的妥当性と尺度構造について述べ，精神症状の評価における問題点を考察した．さらに，予測的妥当性の指標として用いられる特異性と敏感性が尺度の頻回使用によって変化することを述べた．最後に精神症状評価尺度を作成する場合に，今後どのような点に注意すべきかについて提言した．

北村俊則：EBMは医療を変えるか？　上島国利，三村将，中込和幸，平島奈津子（編）EBM精神疾患の治療 pp. 2006-2007．中外医学社，東京, 2006.

今井美緒，北村俊則：SCID による面接の方法．助産雑誌，61; 930-935, 2007.

Matsudaira, T., Fukuhara, T., and Kitamura, T.: Factor structure of the Japanese interpersonal competence scale. Psychiatry and Clinical Neurosciences, 62; 142-151,

2008.

AIM: Assessing social competence is important for clinical and preventive interventions of depression. The aim of the present paper was to examine the factor structure of the Japanese Interpersonal Competence Scale (JICS). ***METHODS:*** Exploratory and confirmatory factor analysis was performed on the survey responses of 730 participants. Simultaneous multigroup analyses were conducted to confirm factor stability across psychological health status and sex differences. ***RESULTS:*** Two factors, which represent Perceptive Ability and Self-Restraint, were confirmed to show a moderate correlation. Perceptive Ability involves a more cognitive aspect of social competence, while Self-Restraint involves a more behavioral aspect, both of which are considered to reflect the emotion-based relating style specific to the Japanese people: indulgent dependence (amae) and harmony (wa). In addition, Self-Restraint may be linked to social functioning. Both constructs may confound a respondent's perceived confidence. ***CONCLUSION:*** Despite its shortcomings, the JICS is a unique measure of social competence in the Japanese cultural context.

Furukawa, T. A., Yoshimura, R., Harai, H., Imaizumi, T., Takeuchi, H., Kitamura, T., and Takahashi, K.: How many well vs. unwell days can you expect over 10 years, once you become depressed? Acta Psychiatrica Scandinavica, 119; 290-297, 2009.

OBJECTIVE: Prognostic studies of major depression have mainly focused on episode remission and relapse, and only a limited number of studies have examined long-term course of depressive symptomatology at threshold and subthreshold levels. ***METHOD:*** The Group for Longitudinal Affective Disorders Study has conducted prospective serial assessments of a cohort of heretofore untreated major depressive episodes for 10 years under naturalistic conditions. ***RESULTS:*** Of the 94 patients in the cohort, the follow-up rate was 70% of the 11,280 person-months. Around 77% of the follow-up months were spent in euthymia, 16% in subthreshold depression and 7% in major depression. Duration of the index episode before reaching recovery was the only significant predictor of the ensuing well time. ***CONCLUSION:*** On average, patients with major depression starting treatment today may expect to spend three quarters of the next decade in euthymia but the remaining one quarter in subthreshold or threshold depression.

Matsudaira, T., Igarashi, H., Kikuchi, H., Kano, R., Mitoma, H., Ohuchi, K., and Kitamura, T.: Factor structure of the Hospital Anxiety and Depression Scale in Japanese psychiatric outpatient and student populations. Health and Quality of Life Outcomes, 7; 42, 2009.

BACKGROUND: The Hospital Anxiety and Depression Scale (HADS) is a common screening instrument excluding somatic symptoms of depression and anxiety, but previous studies have reported inconsistencies of its factor structure. The construct validity of the Japanese version of the HADS has yet to be reported. To examine the factor structure of the HADS in a Japanese population is needed. ***METHODS:*** Exploratory and confirmatory factor analyses were conducted in the combined data of 408 psychiatric outpatients and 1069 undergraduate students. The data pool was randomly split in half for a cross validation. An exploratory factor analysis was performed on one half of the data, and the fitness of the plausible model was examined in the other half of the data using a con-

firmatory factor analysis. Simultaneous multi-group analyses between the subgroups (outpatients vs. students, and men vs. women) were subsequently conducted. ***RESULTS:*** A two-factor model where items 6 and 7 had dual loadings was supported. These factors were interpreted as reflecting anxiety and depression. Item 10 showed low contributions to both of the factors. Simultaneous multi-group analyses indicated a factor pattern stability across the subgroups.***CONCLUSION:*** The Japanese version of HADS indicated good factorial validity in our samples. However, ambiguous wording of item 7 should be clarified in future revisions

Igarashi, H., Kikuchi, H., Kano, R., Mitoma, H., Shono, M., Hasui, C., and Kitamura, T.: The Inventory of Personality Organisation: Its psychometric properties among student and clinical populations in Japan. Annals of General Psychiatry, 8; 9, 2009.

BACKGROUND: The Inventory of Personality Organisation (IPO) is a self-report measure that reflects personality traits, as theorized by Kernberg. ***METHODS:*** In study 1, the Japanese version of the IPO was distributed to a population of Japanese university students (N = 701). The students were randomly divided into two groups. The factor structure derived from an exploratory factor analysis among one subsample was tested using a confirmatory factor structure among another subsample. In study 2, the factor-driven subscales of the IPO were correlated with other variables that would function as external criteria to validate the scale in a combined population of the students used in study 1 and psychiatric outpatients (N = 177). ***RESULTS:*** In study 1 the five-factor structure presented by the original authors was replicated in exploratory factor analyses in one subgroup of students. However, this was through reduction of the number of items (the number of the primary items was reduced from 57 to 24 whereas the number of the additional items was reduced from 26 to 13) due to low endorsement frequencies as well as low factor loadings on a designated factor. The new factor structure was endorsed by a confirmatory factor analysis in the other student subgroup. In study 2 the new five subscales of the Japanese IPO were likely to be correlated with younger age, more personality psychopathology (borderline and narcissistic), more dysphoric mood, less psychological well-being, more insecure adult attachment style, lower self-efficacy, and more frequent history of childhood adversity. The IPO scores were found to predict the increase in suicidal ideation in a week's time in a longitudinal follow-up.
CONCLUSION: Although losing more than 40% of the original items, the Japanese IPO may be a reliable and valid measure of Kernberg's personality organisation for Japanese populations.

Kitamura, T.: Do mental disorders really exist? Eubios Journal of Asian and International Bioethics, 20; 72-74, 2010.

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北村俊則：精神分裂病・うつ病とまばたき．田多英興，山田冨美雄，福田恭介（編）まばたきの心理学，pp. 232-238，北大路書房，京都，1991.

北村俊則：まばたきとドパミン仮説．田多英興，山田冨美雄，福田恭介（編）まばたきの心理学，pp. 242，北大路書房，京都，1991.

懸田克躬（監修）岡庭武，大塚俊男，柿本康男，柏瀬宏隆，風祭元，加藤伸勝，北村俊則，工藤義男，白橋宏一郎，高柳功，西園昌久，藤谷豊，保崎秀夫，牧武，松岡浩，三浦勇夫，山崎敏雄，井上令一：精神科治療ガイドブック．金原出版，東京，1991.

北村俊則：Mini-Mental State (MMS)．大塚俊男，本間昭（監修）高齢者の知的機能検査の手引き. pp35-38,ワールドプランニング，東京，1991.

加藤正明，保崎秀夫，笠原嘉，宮本忠雄，小此木啓吾，浅井昌弘，海老原英彦，太田龍朗，大野裕，柏瀬宏隆，加藤敏，北村俊則，北山修，富永格，中河原通夫，中澤欣哉，中谷陽二，渡辺久子（編集）新版精神医学事典．弘文堂，東京，1993.

Kitamura, T.: The ICD-10 Chapter of mental disorders versus conventional diagnosis in Japan. In (eds.) Mezzich, J. E., Honda, Y., Kastrup, M. Psychiatric Diagnosis: A World Perspective. pp. 136-142, Springer, New York, 1994.

北村俊則：精神症状測定の理論と実際－評価尺度，質問票，面接基準の方法論的考察－第 2 版．海鳴社，東京，　1995.

Furukawa, T., Takahashi, K., Kitamura, T., Okawa, M., Miyaoka, H., Hirai, T., Ueda, H., Sakamoto, K., Miki, K., Fujita, K., Anraku, K., Yokouchi, T., Mizukawa, R., Hirano, M., Iida, S., Yoshimura, R., Mamei, K., Tsuboi, K., Yoneda, H. and Ban T. A.: The Comprehensive Assessment List for Affective Disorders (COALA): A polydiagnostic, comprehensive, and serial semistructured interview system for affective and re-

lated disorders. Acta Psychiatrica Scandinavica Supplementum No. 387, Vol. 91, 1995.

This supplement describes the development and structure of the Comprehensive Assessment List of Affective Disorders (COALA) system, which was recently developed for a collaborative follow-up study of a broad spectrum of affective disorders in Japan and which consists of a series of semistructured interviews for affective and related disorders. The COALA distinguishes itself from the extant semistructured interviews by being able to provide polydiagnostic, comprehensive and serial assessments. It is polydiagnostic because it derives diagnoses according to 29 historical and modern diagnostic systems through computer algorithms. It is comprehensive because it not only depicts the symptoms profile and rates their severity according to various endogenicity indices and severity rating scales but also measures, in the psychosocial domain, the life events and their characteristics. In addition, it has sections for past illnesses and family history. It is serial because the system includes follow-up semistructured interviews that can be administered monthly and that monitor changes in the psychopathological and psychosocial features. The theoretical underpinnings of the COALA system, especially its polydiagnostic approach to a broad spectrum of affective disorders and its treatment of psychosocial factors, are discussed in view of recent proposals for the future nosological research. The findings of the interrater reliability study (n=107) are also presented, with satisfactory to excellent results for almost all of the psychopathological and psychosocial variables, all of the composite severity ratings and most of the polydiagnostic evaluations.

Okano, T., Nomura, J., Kaneko, E., Tamaki, R., Murata, M., Koshikawa, N., Kitamura, T., Stein, G. and Kumar, R.: Epidemiological and biological aspects of postpartum psychiatric illness. in (ed. J. Nomura) Neurobiology of Depression and Related Disorders. pp 143-161. Mie Academic Press. Tsu, 1998.

Childbirth is a crisis point in life and mothers can be overwhelmed by psychosocial as well as biological factors. Many studies have been done on postpartum psychiatric illness since Marce' (1858) described its characteristic feature as “delire triste” or depressive confusion and there has been an awareness of the importance of childbirth related mental illnesses in terms of their contribution to the general amount of women's psychiatric morbidity as well as in terms of consequences for family members, especially the developing infant (Hay et al., 1995). On the other hand, the clinical nosology of postpartum psychiatric illnesses had been neglected in the area of perinatal psychiatry until the 1980's (Hamiltom, 1982; Okano et al., 1994). However, the Marce' Society was established in 1982 and has been playing an important role in this area. In the 1990's, we can find the category of “Mental or behavioural disorders associated with the puerperium, not classifiable elsewhere” in ICD-10 (International Classification of Disease: 10 th version, 1990). In DSM-III (Diagnostic and Statistical Manual of Mental Disorders: 4 th edition, 1994), there is the specifier of “postpartum onset” in mood disorders. The approach to postpartum psychiatric illness provides a unique opportunity not only to query the hypotheses about socio-cultural contributions to the etiology of these illnesses, but also to study the hormonal influence which may be triggered by the childbirth. We present the epidemiological and biological findings of postpartum psychiatric illnesses.

北村俊則：精神症状評価尺度．小椋力，田辺敬貴，（編）臨床精神医学講座 16 精神医学的診断法と検査法, pp. 43-49, 1999.

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翻訳

Spitzer, R.L. and Endicott, J.: Schedule for affective disorders and schizophrenia. 保崎秀夫（監修）北村俊則，加藤元一郎，崎尾英子，島悟，高橋龍太郎（共訳）感情病及び精神分裂病用面接基準．星和書店，東京，1983.

Andreasen, N. C.: Scale for the assessment of negative symptoms 陰性症状評価尺度 (SANS) 岡崎祐士，安西信雄，太田敏男，島悟，北村俊則（共訳）臨床精神医学，13; 999-1010, 1984.

Endicott, J., Andreasen, N. C. and Spitzer, R. L.: Family History-Research Diagnostic Criteria (FH-RDC) 加藤元一郎，北村俊則（共訳）家族歴研究診断基準 (FH-RDC)．社会精神医学, 8; 55-64, 1985.

Weismann, M. M., Schooler, N., Hogarty, G.: Social Adjustment Scale II/ Social Adjustment Scale: Self-Report.仲尾唯治，北村俊則（訳），精神衛生研究, 33:67-119, 1986.

Marziali, E. A.: People in Your Life Scale. 北村俊則（訳）自記式社会援助評価尺度 (PIYL). 精神保健研究, 1; 53-65, 1987.

Endicott, J., Spitzer, R. L. et al北村俊則（訳・編）崎尾英子，高橋龍太郎，島悟，加藤元一郎，藤原茂樹（訳）精神科診断学ケースブック：RDC とDSM-III-R の症例用紙・解答・解説，医学振興社，東京，1989.

Andreasen, N. C.: Scale for the Assessment of Positive Symptoms (SAPS)．岡崎祐士，北村俊則，安西信雄，太田敏男，島悟，McDonald, P.（訳）：陽性症状評価尺度 (SAPS)．精神科診断学, 3(3); 365-377, 1992.

訳者らは先に Andreasen 教授が作成した陰性症状評価尺度（SANS）を翻訳紹介したことがある．今日研究や臨床にお

いて臨床症状を陽性症状と陰性症状に分けて検討することが，ある程度定着しつつあるようである. SANS は陰性症状の評価に比較的よく使用されるようになった．わが国でも例外ではない．しかし陽性症状評価尺度（SANS）の日本訳がなかったために，簡易精神症状評価尺度（BPRS）などと組み合わせて使用せざるをえないなどの不便があった．訳者らもそのような声を聞くことがあり, SANS の姉妹版である SAPS の翻訳紹介の必要性を感じていた．しかしそれぞれが忙しい仕事をかかえており，実現が遅れたが, McDonald-Scott さんの参加を得て，訳出は急速に進んだ．オリジナルの意味理解は正確なものになったと思う．しかし日本文としてはぎこちないところが沢山のこっている．これはひとえに McDonald-Scott さんを除く訳者，とりわけ分担訳をまとめた私の責任である．お気付きの点ご指摘いただければ幸いである．SAPS 日本版が，SANS と一緒に使用されて，臨床や研究に少しでも役立つならば原著者はもとより訳者らの喜びとするところである.

Zigmond, A. S. and Snaith, R. P.: Hospital Anxiety and Depression Scale (HAD尺度) 北村俊則.（訳） 精神科診断学, 4(3); 371-372, 1993.

身体疾患を有する患者の精神症状（抑うつと不安）を測定する自己記入式質問票として世界的に汎用されている Hospital Anxiety and Depression Scale (HAD 尺度) を，原著者の許可を得て翻訳した.

Andreasen, N. C.: Comprehensive Assessment of Symptoms and History (CASH) . 岡崎祐士, 北村俊則，安西信雄，島悟，太田敏男：CASH：精神病性・感情病性精神疾患の現在症と病歴の包括的面接と評価基準．星和書店，東京，1994.

Spitzer, R. L., Gibbon, M. and Endicott, J.: Global Assessment Scale 北村俊則，加藤元一郎，崎尾英子，島悟（共訳）総合評価尺度と症例要旨集．精神科診断学, 8; 281-304, 1997.

総合評価尺度 Global Assessment Scale (GAS) は，診断にかかわりなく被検者の機能全体を評価するために作成された尺度である．本来米国国立精神衛生研究所主催の「うつ病の精神生物学に関する多施設共同研究」で用いられた感情病および精神分裂病用面接基準 Schedule for Affective Disorders and Schizophrenia (SADS) の一部として組み込まれていた. 1978 年の発表以降，うつ病に限らず各種の疾患を対象とした多くの臨床研究で利用され，現在の DSM-III の GAF 尺度の基礎となった．しかし, GAS は単一得点 (1〜100 点) による尺度であるため，訓練なしに使用すると評定者間一致率が不良になりやすい．すでにニューヨーク州立精神医学研究所では GAS 訓練用の症例要旨集を作成し，面接員の教育に使用している．今回は著者の許可を得て, GAS 尺度，使用マニュアル，練習用症例要旨，解答と解説を翻訳した．なお, GAS は評価者が記載するものであるため再英訳による文言の妥当性確認は行っていない．GAS を臨床あるいは研究で使用する場合は，事前に本訓練用症例要旨を用いて理解を深め，評定者間信頼度を確認することが望ましい．なお, GAS を用いた文献を MEDLINE を用いて調査したので，その一覧表を文末に添付した.

First, M., Spitzer, R. L., Gibbon, M. and Williams, J. B. W.: Structured Clinical Interview for DSM-IV Axis I Disorders. 高橋三郎（監修）北村俊則，岡野禎治（訳）精神科診断面接マニュアル［第 2 版］．日本評論社，東京, 2010.