Psychopathology 1989;22:250–259

0254–4962/89/0225–0250$2.75/0

Psychiatric Diagnosis in Japan

2. Reliability of Conventional Diagnosis and Discrepancies with Research Diagnostic Criteria Diagnosis

Toshinori Kitamura[a], *Satoru Shima*[b], *Eiko Sakio*[b], *Motoichiro Kato*[b]

[a] Division of Psychogeriatrics, National Institute of Mental Health, Ichikawa, and
[b] Department of Neuropsychiatry, School of Medicine, Keio Gijuku University, Tokyo, Japan

Abstract. 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.

Introduction

The first report of the present survey on psychiatric diagnostic practice in Japan has shown that Japanese psychiatrists use a wide range of psychiatric nomenclatures when diagnosing patients but that the number of diagnostic categories unanimously used is surprisingly small. It has been speculated, therefore, that the conventional classificatory system of psychiatric disorders adopted among Japanese psychiatrists is relatively simple [Kitamura et al., 1989].

Since a conventional classificatory system of psychiatric disorders has been transmitted from generation to generation, it is often presumed that physicians have an implicit definition for each diagnostic category. In fact the issue of the reliability of psychiatric diagnosis in Japan was rarely attacked [Kitamura et al., 1986]. Nevertheless, recent studies have indicated that psychiatrists often disagree on diagnosis between different countries and even in the same country [Leff, 1977]. If, therefore, conventional diagnostic categories are to survive when introducing internationally accepted classificatory systems such as the International Classification of Diseases (ICD) or research-based diagnostic instruments such as the Research Diagnostic Criteria (RDC) [Spitzer et al., 1978], it will be required to examine not only the interrater reliability of conventional diagnosis but its relationship with them. It has also been noted in recent studies that the same terms, be they those of symptoms or diagnoses, do not necessarily reflect the same phenomena [Kitamura et al., 1986]. Marked

discrepancies with regard to the same diagnostic category have been repeatedly observed between different countries or from the ICD [Kitamura et al., 1986; Leff, 1977]. Without a precise understanding of these discrepancies, the introduction of an international psychiatric nomenclature may result in confusion in practice.

This part of the present series of investigations will, by adopting a case vignette design, focus on the interrater reliability of conventional psychiatric diagnoses and on their convergence with and divergence from those of the RDC [Spitzer et al., 1978], an operationally defined diagnostic system.

Methods

Twenty psychiatrists were randomly selected from those affiliated to a medical school in Tokyo and were invited to participate in a case vignette study. Their demographic characteristics have been reported in a companion paper [Kitamura et al., 1989]. In a questionnaire survey, they were administered 29 case vignettes of different RDC categories (table 1). These vignettes were prepared by the Biometric Research Department, New York State Psychiatric Institute. For each case, they were required to decide on a (1) diagnosis according to their conventional psychiatric diagnostic system; (2) diagnosis according to the ICD-9; (3) prognosis, and (4) treatment plan. They were instructed that (1) any symptoms and behaviors described in case vignettes should be regarded as existing; (2) symptoms and behaviours not described should be regarded as nonexisting; (3) any laboratory examinations, unless specifically noted, should be regarded as within normal range, and (4) organic conditions and substance abuse should be regarded as nonexisting unless specifically noted. Choices were reserved for suspension of diagnosis if accompanied by a statement of its explanation and further areas of information needed to finalize diagnosis, and no diagnosis (psychiatrically normal) for cases that seemed free from any psychiatrically diagnosable conditions.

The present report will focus on the Japanese psychiatrists' conventional diagnostic habit. Their ICD-9 diagnosis will be referred to when necessary. The issues of prognosis and treatment plan will be reported elsewhere.

Results

Interrater Reliability of Conventional Diagnosis

As expected, diagnostic labels used according to conventional diagnosis were diverse. For the sake of brevity, they were grouped deliberately into Schizophrenic Psychoses, Affective Psychoses, Atypical Psychosis, Paranoid State, Other Psychoses, Neuroses, Personality Disorders, Borderline Case, Miscellaneous Disorders, Diagnosis Suspended, and Normal. It should be noted that schizoaffective psychosis was categorized under Atypical Psychosis; paranoid reaction, paranoia, paranoid state, paraphrenia, and senile and presenile paranoid states under Paranoid State; and acute confusion, psychogenic reaction, and acute delusional hallucinatory state under Other Psychoses. Miscellaneous Disorders included anorexia nervosa, developmental disorder, early infantile autism, behavioral abnormality, mental retardation, and brain organic syndrome. The interrater reliability for each of these groups was generally low (table 2). Thus the highest intraclass correlation (ICC) [Fleiss, 1965] was 0.75 for Schizophrenic Psychoses; only 2 of 11 groups exceeded 0.6 of ICC.

Manic-depressive psychosis as a conventional term was assigned to some cases with a depressive episode, some with a manic episode and some others with a cycling or mixed affective episode; the term manic-depressive (affective) psychoses was, there-

Table 1. Number of diagnoses made for conventional and RDC diagnosis

RDC diagnosis	Conventional diagnosis												
	SP	CDI	M	MD	AP	PS	OP	NDN	PD	BC	MC	DS	N
SCH/acute/p	18	0	0	0	0	1	0	0	0	0	0	1	0
SCH/acute/d	17	0	0	0	0	0	0	0	0	0	1	2	0
SCH/acute/c	18	0	0	0	0	0	0	0	0	0	0	2	0
SCH/acute/u	15	0	0	0	0	0	5	0	0	0	0	0	0
SCH/chronic/p	20	0	0	0	0	0	0	0	0	0	0	0	0
SCH/chronic/d	20	0	0	0	0	0	0	0	0	0	0	0	0
SCH/chronic/c	18	0	0	0	0	0	1	0	0	0	0	1	0
SCH/chronic/u	14	0	0	0	0	0	0	0	0	0	6	0	0
SCH/chronic/r	19	0	0	0	0	1	0	0	0	0	0	0	0
SAD/m/acute/s	5	0	5	0	7	0	2	0	0	0	0	1	0
SAD/m/acute/a	3	0	2	0	7	1	2	0	1	0	0	4	0
SAD/dp/acute/s	20	0	0	0	0	0	0	0	0	0	0	0	0
SAD/dp/acute/a	3	3	0	0	0	12	1	0	0	0	0	1	0
DSSRS	19	0	0	0	0	0	1	0	0	0	0	0	0
Manic Disorder	1	0	7	4	2	0	3	1	0	1	0	1	0
MDD/psy/agit/end	0	20	0	0	0	0	0	0	0	0	0	0	0
MDD/end	0	18	0	0	0	0	0	0	0	0	0	2	0
MDD/sit/end	0	17	0	0	0	0	1	2	0	0	0	0	0
NDD	0	13	0	0	0	0	2	3	0	0	0	2	0
IDD	0	2	0	0	0	0	0	8	6	0	0	1	3
Panic Disorder	0	0	0	0	0	0	0	20	0	0	0	0	0
GAD	0	4	0	0	0	0	0	14	1	0	0	0	1
Cyclothymic P	0	0	0	8	0	0	0	0	10	0	0	1	1
Briquet's D	0	0	0	0	0	0	0	13	0	0	1	6	0
Antisocial P	0	0	0	0	0	0	0	0	17	0	0	2	1
OCD	0	1	0	0	0	0	0	19	0	0	0	0	0
Phobic Disorder	0	0	0	0	0	0	0	18	0	0	0	0	2
Schizotypal PD	7	0	0	0	0	0	0	7	1	4	0	1	0
Never mentally ill	0	0	0	0	0	0	0	2	0	0	0	2	16

SCH, Schizophrenia; p, paranoid type; d, disorganized type; c, catatonic type; u, undifferentiated type; r, residual type; SAD, Schizoaffective Disorder; m, manic type; dp, depressed type: s, mainly schizophrenic, a, mainly affective; DSSRS, Depressive Syndrome Superimposed on Residual Schizophrenia; MDD, Major Depressive Disorder; psy, psychotic subtype; agit, agitated subtype; end, endogenous subtype; sit, situational subtype; NDD, Minor Depressive Disorder; IDD, Intermittent Depressive Disorder; GAD, Generalized Anxiety Disorder; P, Personality; D, Disorder; OCD, Obsessive Compulsive Disorder.

fore, deliberately subdivided into either Depression, Mania or Manic Depression. Other conventional terms that belonged to Affective Psychoses were allocated to Depression or Mania accordingly. The interrater reliability expressed by ICC was 0.63 for Depression, 0.22 for Mania and 0.28 for Manic Depression.

Among the conventional diagnostic categories allocated to Neuroses, terms indicating Depressive Neurosis had as high a base rate as 0.17. When Neurosis was divided into Nondepressive Neurosis and Depressive Neurosis, the interrater reliability coefficient was slightly raised for the former (ICC 0.66) while being reduced for the latter (ICC 0.36). Since the participant psychiatrists could agree on the existence of the depressive syndrome, even if they disagreed on its endogenous/neurotic subdivision, the categories of Depression and Depressive Neurosis were combined and examined for interrater reliability. Its ICC was 0.73, the second highest to Schizophrenic Psychoses. The combined category of Depression and Depressive Neurosis seems, therefore, to form a relatively discrete entity in the conventional Japanese classification of mental disorders.

From these findings, it was concluded that the conventional diagnostic nomenclatures could be classified into 13 groups; Schizophrenic Psychoses (SP), Depression combined with Depressive Neurosis (hereafter Combined Depressive Illness, CDI), Mania (M), Manic Depression (MD), Atypical Psychosis (AP), Paranoid State (PS), Other Psychoses (OP), Nondepressive Neuroses (NDN), Personality Disorder (PD), Borderline Case (BC), Miscellaneous Disorders (MC), Diagnosis Suspended (DS), and Normal (N).

Table 2. Interrater reliability of conventional Japanese psychiatric diagnosis

Diagnosis	Base rate, %	ICC
Schizophrenic psychoses	55	0.75
Affective psychoses	41	0.51
Depression	28	0.63
Mania	10	0.22
Manic depression	7	0.28
Atypical psychosis	10	0.26
Paranoid state	14	0.45
Other psychoses	31	0.06
Neuroses	41	0.64
Nondepressive neuroses	38	0.66
Depressive neurosis	17	0.36
CDI	28	0.73
Personality disorder	21	0.54
Borderline case	7	0.12
Miscellaneous disorders	10	0.19
Diagnosis suspended	5	0.05
Normal	21	0.52

CDI = Depression and depressive neurosis combined.

Discrepancies between the Conventional and RDC Diagnoses

Although the interrater reliability of the conventional psychiatric diagnosis was unsatisfactorily low, it was speculated from clinical experience that the low concordance was not necessarily caused by random variations of conventional diagnosis but that psychiatrists agreed on the prototype of each diagnostic category and yet differed in setting the boundaries between categories. To examine this hypothesis, two analyses were conducted. Firstly, the number of the participant psychiatrists assigning each conventional diagnosis was counted over the RDC diagnoses (table 1). Secondly, diagnostic

Table 3. Conventional diagnosis of Schizophrenic Psychosis assigned to RDC cases

RDC diagnosis	Participant No.																			
	9	17	1	12	7	8	14	20	2	4	11	16	18	19	3	6	15	10	13	5
SAD/dp/acute/s	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SCH/chr/p	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SCH/chr/d	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SCH/chr/c	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	–	–	x	x	x
SCH/chr/r	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	–	x	x	x
DSSRS	x	x	x	x	x	x	x	x	x	x	x	x	–	x	x	x	x	x	x	x
SCH/acute/p	x	x	x	–	x	x	x	x	x	x	x	x	x	x	x	x	–	x	x	x
SCH/acute/d	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	–	–	x	–	–
SCH/acute/c	x	x	x	x	x	x	x	x	x	x	x	x	x	x	–	x	x	x	x	–
SCH/chr/u	x	x	–	x	x	x	x	–	x	x	x	x	x	–	–	x	x	x	–	–
SCH/acute/u	x	x	x	–	x	x	x	–	x	x	x	x	x	x	x	x	x	–	–	–
SAD/m/acute/s	x	x	x	–	–	–	x	x	–	–	–	–	–	–	–	–	–	–	–	–
SAD/dp/acute/a	x	–	–	–	x	x	–	–	–	–	–	–	–	–	–	–	–	–	–	–
SAD/m/acute/a	–	x	x	x	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Manic Disorder	x	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

x = SP diagnosis; – = non-SP diagnosis. See footnote of table 1 for other abbreviations.

boundaries were examined for each psychiatrist.

Schizophrenic Psychoses. SP was the conventional diagnosis almost unanimously made for cases of RDC paranoid, disorganized and catatonic Schizophrenia, and Schizoaffective Disorder, depressed type, acute, mainly schizophrenic. The number of psychiatrists assigning the diagnosis SP was reduced for cases of RDC undifferentiated Schizophrenia; Schizoaffective Disorder, manic, of mainly schizophrenic type; Schizoaffective Disorder, depressed, of mainly affective type; and Manic Disorder in order of frequency.

This order of correspondence of the Japanese psychiatrists' diagnosis of SP over RDC categories seemed to be ordered hierarchically. Thus, as seen in table 3, those psychiatrists who assigned the conventional diagnosis of SP to a certain RDC case usually did so for RDC cases of greater 'popularity'.

The first paper of the present series of reports showed that Japanese psychiatrists were generally reluctant to diagnose subtypes of SP. In the present case vignette survey, this was confirmed. Thus, the frequency of no subtype specification was 91% (62/68 assignments) for RDC Acute Schizophrenia cases and 80% (88/110) for RDC Chronic Schizophrenia cases.

Combined Depressive Illness. The diagnosis Depression of endogenous or nonendogenous type was almost unanimously assigned to RDC cases of Major Depressive Disorder. The CDI diagnosis was also assigned, though to a lesser extent, to cases of RDC Minor Depressive Disorder, Generalized Anxiety Disorder, Intermittent Depressive Disorder and Obsessive Compulsive Disorder in the

order of frequency. The RDC cases assigned the conventional CDI diagnosis were again hierarchically ordered. When the conventional CDI was assigned to a certain RDC case, the CDI was usually assigned by the same psychiatrist to RDC cases of a higher order, too [table, not shown, may be available on request from the senior author].

The RDC case of Schizoaffective Disorder, depressed, acute, mainly affective type, was assigned the conventional CDI diagnosis only by 15% of the participant psychiatrists. Two RDC cases with major depressive syndrome, i.e., Schizoaffective Disorder, depressed, acute, of mainly schizophrenic type and Depressive Syndrome Superimposed on Residual Schizophrenia were never assigned the CDI diagnosis.

Mania. As expected, the conventional diagnosis M was the most favored for RDC Manic Disorder. A few psychiatrists assigned the diagnosis of M to cases of RDC Schizoaffective Disorder of manic type.

Manic Depression. Nearly half the present psychiatrists assigned the diagnosis of MD to RDC Cyclothymic Personality. Obviously MD here indicates a circular type of affective disorder. Of interest is that the other half of the participants assigned the conventional diagnosis of PD to RDC Cyclothymic Personality. This RDC category seemed, therefore, to be recognised by Japanese psychiatrists either as a variant of affective disorder or as a type of personality disorders.

Other RDC cases assigned the conventional MD were those of Manic Disorder. From the inspection of the responses and comments made by the psychiatrists, it was understood that MD here indicated a mixed affective state.

Atypical Psychosis. The Japanese concept of AP is, as explained in a companion paper, akin to the German category cycloid psychosis [Leonhard, 1961]. Table 3 shows that AP was most frequently assigned to RDC cases of Schizoaffective Disorder of manic type, followed by a case of Manic Disorder. Although Mitsuda [1942], an advocate of AP, described cases of AP with depressive symptomatology, AP in this study was never assigned to cases of RDC Schizoaffective Disorder of depressed type.

Paranoid State and Other Psychoses. As may be seen in table 1 PS and OP are independent in the classificatory system of the Japanese psychiatrists; the former was usually assigned to RDC cases of Schizoaffective Disorder, depressed, of mainly affective type, while the latter was used for cases of acute Schizophrenia of undifferentiated type.

Nondepressive Neuroses. As expected, NDN was the conventional diagnosis assigned by the majority of the psychiatrists to RDC cases of Panic Disorder, Obsessive Compulsive Disorder, Phobic Disorder, Generalized Anxiety Disorder, and Briquet's Disorder. It was also a diagnostic choice of some physicians for RDC Intermittent Depressive Disorder, Schizotypal Personality Disorder, Minor Depressive Disorder and Major Depressive Disorder. Even RDC Manic Disorder and Never Mentally Ill were assigned to NDN by a small portion of psychiatrists.

It can be recognized from an inspection of the details of the conventional NDN diagnosis that a high concordance with the conventional diagnosis has been reached for RDC Obsessive Compulsive Disorder, Phobic Disorder, and Briquet's Disorder (conventionally Hysteria). However, Panic Disorder was assigned either to Anxiety Neurosis or Cardiac Neurosis; Generalized Anxiety Dis-

Table 4. Conventional diagnoses of NDN

RDC Panic Disorder (n = 20)	
Anxiety Neurosis	12
Anxiety Attack	1
Neurosis	1
Cardiac Neurosis	6
RDC Obsessive Compulsive Disorder (n = 19)	
Obsessive-Compulsive Neurosis	18
Neurosis	1
RDC Phobic Disorder (n = 18)	
Phobia	17
Neurosis	1
RDC Generalized Anxiety Disorder (n = 14)	
Neurosis	9
Character Neurosis	2
Social Phobia	1
Anxiety Neurosis	2
RDC Briquet's Disorder (n = 13)	
Hysteria	11
Hypochondriasis	1
Character Neurosis	1
RDC Intermittent Depressive Disorder (n = 8)	
Neurosis	3
Character Neurosis	5
DSM-III Schizotypal Personality Disorder (n = 7)	
Depersonalization Neurosis	6
Neurosis	1

n = Number of assignments of NDN. Each RDC or DSM-III category may also be assigned conventional diagnoses other than NDN (see table 1).

order was dominated by Neurosis (a generic term); and Intermittent Depressive Disorderwas divided into Neurosis and Character Neurosis (table 4).

Personality Disorder. PD was assigned by the majority of psychiatrists to RDC Antisocial Personality and Cyclothymic Personality. Intermittent Depressive Disorder was also classified as PD by 6 psychiatrists. Another 5 psychiatrists assigned Character Neurosis to the RDC Intermittent Depressive Disorder category. Since Character Neurosis is usually thought of as a neurotic disorder developed among those with enduring personality (character) disturbance, it is feasible to think that a total of 11 psychiatrists allocated the cases of RDC Intermittent Depressive Disorder to the PD category.

Borderline Case. For the cases of DSM-III Schizotypal Personality Disorder 4 psychiatrists made a diagnosis of BC, 7 of SP, 6 of Depersonalization Neurosis, and 1 each of Neurosis and PD. No other RDC categories were assigned the conventional BC. It is of note that all of 4 psychiatrists assigning BC to the DSM-III Schizotypal Personality Disorder named Latent Schizophrenia as the corresponding ICD-9 category.

Discussion

The present study demonstrated that the interrater reliability of Japanese psychiatrists' diagnosis was generally low. Kitamura et al. [1986], in a similar reliability study using a case vignette design, showed mean kappa coefficients of 0.84 for Schizophrenic Psychosis, 0.88 for Affective Psychosis, 0.47 for Other Nonorganic Psychoses, and 0.71 for Neurotic Disorders. They employed 4 Japanese psychiatrists in the same generation, trained in the same institute while the characteristics of the psychiatrists in the present study were more diverse. The reliability coefficients reported in this study were lower than those reported by Kitamura et al. [1986], warning against a continued use of a conventional diagnostic system without considering possible causes for its unreliability.

Examination of the number of psychiatrists assigning each conventional diagnostic category suggested a gradation of the popularity of diagnostic categories. Thus, the conventional SP diagnosis was the most popular for cases of the paranoid, disorganized and catatonic subtypes of RDC Schizophrenia regardless of its subtype based on the course of the illness; RDC Schizoaffective Disorder, depressed type, mainly schizophrenic, also gained unanimous assignment of the conventional SP. The popularity of SP was reduced for cases of the undifferentiated subtype of RDC Schizophrenia, and of RDC Schizoaffective Disorders other than its depressed, mainly schizophrenic subtype. Assignments of non-SP categories for the above cases were OP or MS for the undifferentiated subtype of RDC Schizophrenia, PS for the Schizoaffective Disorder, depressed type, mainly affective, and AP or M for Schizoaffective Disorder, manic type. The gradation of the SP popularity was also the case among individual psychiatrists; those who assigned SP to a certain case tended to do so for cases with higher popularity. Thus, each psychiatrist seems to have his own concept of the boundaries of a diagnostic entity for the SP diagnosis, sharing the common overlapping area.

A similar observation was confirmed for CDI and M cases. The conventional CDI was assigned unanimously for the psychotic subtype of RDC Major Depressive Disorder. The rate of assignment of CDI was reduced slightly if Major Depressive Disorder was of the situational subtype: it further decreased for RDC Minor and Intermittent Depressive Disorders. The assignment of M was usually made for RDC Manic Disorder but it also occurred in a few cases of the manic type of RDC Schizoaffective Disorder. As in the SP, the gradation of diagnostic popularity was recognized at the level of individual psychiatrists.

As regards the conventional NDN, most of the RDC categories corresponded to the conventional counterparts. However, RDC Generalized Anxiety Disorder was, in most cases, assigned the generic term Neurosis: this may reflect the puzzlement the psychiatrists encountered. On the other hand, there is the assignment of Anxiety Neurosis to RDC Panic Disorder. Japanese psychiatrists seem to regard having panic attacks as a prerequisite condition in anxiety neurosis and a case of anxiety without panic attacks as nonspecific Neurosis.

PD was the most popular conventional diagnosis for RDC cases of Antisocial Personality, Cyclothymic Personality and Intermittent Depressive Disorder. They seem to correspond to the ICD-9 categories of Antisocial, Affective and Asthenic Personality Disorders, respectively. It was also found that although both Personality Disorder and Character Disorder were accepted as a diagnostic label in the first part of the survey [Kitamura et al., 1989], in the case vignette study they preferred the term Character Disorder.

It is of interest that DSM-III schizotypal Personality Disorder escaped from the conventional PD but was regarded by the present psychiatrists as either SP or BC. When assigning BC they referred to the ICD-9 Latent Schizophrenia. These facts may suggest that in the Japanese conventional diagnostic system BC is a subtype of SP rather than of PD and that Schizotypal Personality Disorder is closer to SP than PD. We have already found that even those psychiatrists who deny using almost all subcategories of PD still acknowledge using BC.

Table 5. Comparison of RDC and Japanese conventional diagnoses

RDC	Japanese conventional
Schizophrenia	schizophrenia
Acute	
Chronic	
DSSRS	
Schizotypal Personality Disorder	
Schizoaffective Disorder	
Depressed/schizophrenic	
Depressed/affective	paranoid state
Manic/schizophrenic	atypical psychoses
Manic/affective	
Manic Disorder	mania
Major Depressive Disorder	depression
Minor Depressive Disorder	
Panic Disorder	anxiety neurosis
Briquet's Disorder	hysteria
Obsessive-Compulsive Disorder	obsessive compulsive neurosis
Phobic Disorder	phobia
Generalized Anxiety Disorder	neurosis
Intermittent Depressive Disorder	character disorder
Cyclothymic Personality	
Antisocial Personality	

This may be explained by their perception of BC as being closer to SP.

The above findings suggest that the Japanese psychiatrists share the core definition for each major conventional diagnostic category but differ in defining the boundaries, thereby reducing the interrater reliability of diagnosis. It was also found that for some conditions the Japanese psychiatrists' views differ considerably. Operationalization of diagnosis as a form of diagnostic criteria can, therefore, be justified and is needed for clinicians as well as researchers.

In so doing caution should be exercised with regard to a few issues. Firstly, comparisons of conventional and international terminologies are requested to avoid unnecessary misunderstanding or emotional refusal of new terms. For example, the term Schizoaffective Disorder, which was rarely used by Japanese psychiatrists [Kitamura et al., 1989], and AP, a common conventional category, overlapped significantly in the present study. Another example is the concordance between the RDC Panic Disorder and the conventional Anxiety Neurosis. Table 5 is a summary of comparisons of RDC and conventional diagnostic labels extracted from the above findings. It will be necessary, when introducing new international categories into everyday practice, to rename or put them in brackets so as to make them correspond to the conventional categories.

Secondly, conventional categories with relatively wide boundaries may have to be subcategorized to correspond to an international classification. For example, a wide range of conventional SP must be separated into some subtypes if, for example, it needs to be converted into the RDC system, e.g., into acute and chronic subtypes, or into with and without depressive syndrome.

Thirdly, some concepts need empirical clarification. For example, AP was unanimously recognized as a diagnostic category in Japan [Kitamura et al., 1989], but it was used not by all the psychiatrists in the present study and it was limited only to cases of RDC manic type of Schizoaffective Disorder. AP may cover other clinical pictures we did not examine in the present study. Further empirical study on the concept of AP is warranted. DSM-III Borderline and other Personality Disorders are another area which was not discussed in the present inves-

tigation. Since the disturbance of personality seems very likely to be shaped by cultural factors, compatibility of international and local diagnoses is to be confirmed before adopting an international criteria as the official diagnostic guideline.

Since Japan has been using the ICD as official guideline for diagnosis, the forthcoming ICD-10 should and will be introduced when its draft is finalized. Nevertheless, the drastic change of its contents as well as terminologies may well result in confusion or emotional refusal among Japanese practitioners. We hope this will be avoided by the findings of the present and further studies.

Acknowledgement

We are grateful for the invaluable cooperation of the anonymous psychiatrists who participated in the present study.

References

Fleiss, J.L.: Estimating the accuracy of dichotomous judgments. Psychometrika *30:* 469–479 (1965).

Kitamura, T.; Shima, S.; Sakio, E.; Kato, M.: Application of Research Diagnostic Criteria and International Classification of Diseases to case vignettes. J. clin. Psychiat. *47:* 78–80 (1986).

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

Leff, J.: International variation in the diagnosis of psychiatric illness. Br. J. Psychiat. *131:* 329–338 (1977).

Leonhard, K.: Cycloid psychoses: endogenous psychoses which are neither schizophrenic nor manic depressive. J. ment. Sci. *107:* 632–648 (1961).

Mitsuda, H.: Klinisch-erbbiologische Untersuchung der Schizophrenie (in Japanese with German abstract). Psychiatria Neurol. jap. *46:* 298–360 (1942).

Spitzer, R.L.; Endicott, J.; Robins, E.: Research Diagnostic Criteria (RDC) for a selected group of functional disorders; 3rd ed. (New York State Psychiatric Institute, New York 1978).

T. Kitamura, MRCPsych
Section of Mental Health for the Elderly
Division of Psychogeriatrics
National Institute of Mental Health
1-7-3 Konodai, Ichikawa
Chiba 272 (Japan)