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国立精神衛生研究所

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ま　え　が　き

本研究所が昭和27年に設立されてから、昭和52年で25年の月日が経った。精神医学、臨床心理学、社会福祉学、社会学などの諸科学による学際的、国際的研究を念願して、今日まで種々の起伏をたどってきたのが、国立精神神衛生研究所の歴史であった。

今回25周年記念誌を発刊するにあたり、ここ数年間、当研究所で行ってきた主な研究課題について、その概要と成果を述べるとともに、比較的最近、所員が国際学会で発表またはその予定になっている英文の論文を掲載することとし、今後の研究発展のマイルストーンにしたいと思う。また、今回の英文による研究紹介を通じて、世界各国の精神衛生領域の研究者との交流をはかることをも目的としている。

もとより、これらの学際的、国際的な精神衛生研究には、なお未完成なものが残されている。その発展を将来に向けて志向していく意図であるが、各領域の方からの御叱正と御援助を頂ければ幸いである。

昭和53年11月

国立精神衛生研究所長

加　藤　正　明

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b. 思春期児童の適応障害（自殺、非行、退学等）に関する研究。

c. 児童精神衛生領域における統計および各国との資料の交換。

4. 個人ならびに集団の精神病理に関する総合的研究

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b. 精神分裂病の家族治療に関する研究。

c. 青年の人格発達ならびに精神病理に関する研究。

d. 対人恐怖の臨床的研究。

上記の研究の継続発展を志向している。

5. 精神薄弱に関する研究（とくにその診断とケアに関する総合研究）

a. 臨床診断法の開発とその応用に関する研究。

b. 早期老化の実態とその対策に関する研究。

c. 地域医療、保健、福祉計画の体系化と技術開発に関する研究。

d. 精神薄弱関係職員の研修プログラムの開発と研修の方法に関する研究。

とくに今後、臨床診断法の開発と応用に関し、外部の研究者との協同研究を行うとともに、関係諸団体の協力を得て実態把握の調査研究を行っていく計画である。

6. 精神身体病理に関する研究

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e. 音刺激負荷による実験的睡眠障害。

f. デジタルコンピューターによる臨床脳波の周波数解析。

g. 脳波の集団検診法。

h. 心拍と呼吸の記録と解析

今後上記の研究に、内分泌研究を加えて、精神症状の分析、環境への適応反応、生体情報の処理に関する研究を行う計画である。

7. 老化と生活・社会適応および老人性精神障害に関する研究

a. 老人の精神・身体、社会的老化度の評価法の開発に関する研究。

b. 老人の生活史と現在の生活適応および精神健康の相互関連に関する研究。

c. 老人の精神老化と脳機能に関する研究。

d. アメリカ在住日系一世の老化と社会適応に関する研究。

今後の課題として、千葉県下の老人福祉センターの現状分析、RIを利用する脳老化と内分泌機能の研究、南米の日系老人の老化と社会適応に関する研究などを行っていく計画である。

8. 精神衛生における社会科学的研究

a. 精神衛生に関する社会指標作成の研究。

b. 保健、医療の組織と従事者に関する研究。

c. 精神障害者の家族および家族会に関する研究。

d. ボランティアの役割と機能に関する研究。

e. 地域社会における生活構造とコンクリクトムに関する研究。

今後、地域精神衛生の需要と供給に関する研究を行っていく計画である。

精神衛生研究の方法論に関する問題

以上に示される精神衛生研究は、きわめて広汎囲な問題を含んでおり、これらをさらに統合していく必要がある。それには学際的・国際的研究の方法論としての「社会精神医学」方法論を確立すること、疫学精神医学の方法論を採用すること、広義の行動科学方法論を問いなおすことなどの根本問題があると思われる。

第1の社会精神医学的アプローチは、乳幼児、学童前期、学童期、思春期、成人期、老年期という発達段階に応じ、また家族、学校、職場、地域共同体といった人間関係問題として、おのおのに特有な精神衛生に関する研究が行われてきた。人間の発達から衰退までの心身の状態と社会適応の問題が、いろいろな形でとり上げられた。その意味で「双生児を用いた児童の人格発達に関する研究」「乳幼児健診、未熟児健診の方法の検討」「思春期児童の適応障害」「青年の人格発達ならびに精神病理に関する研究」「老化と生活・社会適応に関する研究」「早期老化の実態とその対策」などは前者に属する研究であり、「家族力動の精神病理」「家族治療の研究」「学校精神衛生に対するコンサルテーション」「地域環境変化の異なる地域における住民の生活構造の差と心身の健康度との関連」などの研究は後者に属する。

このさい、最も重要なことは、いずれの研究にしても、精神－身体－社会の3要因のいずれも欠如してはならず、この3要因の間の関連が検討されなければならない。ややもすればその

うちの一要因を全く無視した研究になることに、もっと注意して研究を行う必要がある。その反面、おのおのの小領域における基礎的研究を推進することも必要である。

問題は精神衛生の研究に関する限り、多次元的なアプローチがきわめて大切であって、一側面からのアプローチの結果を一挙に拡大し一般化することは危険である。社会精神医学は本来、精神障害者の発生、診断、治療に関連する社会的要因を多元的にとらえること、また生物学的要因をも無視しないこと、マスとしてのみならず個としてみることをも怠らないことなどが強調されなければならない。つまり臨床研究へのフィードバックである。このことは、昭和47～49年度に科学技術庁の特別研究として行なわれた「都市生活における精神健康度に関する総合的研究」でも用いられた方法であった。

第2の疫学的方法については、まだ方法論の点で多くの問題があるが、かつて行なわれた一斉調査法には事例発見（事例性）の相対性と、精神科診断と治療をすすめるためのケアシステムの確立が考慮されねばならない。従っていわゆる疫学的データは、特定の地域人口に対する長期間のサービスによってはじめて明らかになる。本研究所においては、とくに市川市および浦安でこのようなサービスをつづけており、「学校精神衛生に対するコンサルテーションの研究」、「在宅精神障害者の医療に関する研究」「乳幼児健診、未熟児健診に関する研究」「精神薄弱児(者)の地域医療、保健、福祉に関する研究」「老人の老化と適応に関する研究」などはいずれも基本的にこのような考えに基づいている。今後その他の地域人口に対するサービスを続けるなかで、この方法を検討していかなければならない。

第3の行動科学的研究方法としては、「夜間および日中覚醒時の脳波パターン」「精神作業時の心拍」などのような研究がいれられるが、行動科学といっても条件反射学方法から、サイバネティックス理論、バイオフィードバックまでさまざまであろう。この方法については本研究所でも一部に行なわれているにすぎず、今後大いに考えていく必要があろう。

以上の社会精神医学的方法、疫学的方法および行動科学的方法を用いていくには、研究チームによる学際的研究が不可欠なことは、改めていう必要もないことである。

（加藤 正明）

I. 地域精神衛生に関する研究

I. 緒　　言

地域精神衛生研究班は、地域社会を対象とした調査研究と、班員自身が実際に地域社会の中で精神衛生活動を行うことを通して研究を進めるアクション・リサーチの2つの方法をとりながら、地域社会における精神衛生上の諸問題を発掘、解明し、さらに地域レベルにおける対策のシステム化のモデル実験等を行うことを目的とした長期プロジェクト・チームとして発足した。

その分担内容を大別すると次のようなものである。

1) 地域の社会構造の変動とそれに対応する住民層の流動と生活構造の変化に関する社会学的研究。

2) 地域環境変化の異る地域において、住民の生活構造の差と心身の健康度との関連に関する研究。

3) 在宅精神障害者の医療及び生活実態と社会適応状態の把握並びに地域社会における精神障害者とその家族に対する援助活動の実践研究。

4) 学校精神衛生に対するコンサルテーション・プログラムに関する実験研究。

5) 知能障害(児)者の地域ケアーのシステムの確立に関する実験研究。

以上のような標題について、モデル地区を設定し、調査及び実験的研究を行ってきた。

II. 各分担研究の内容及び経過

1) 地域の社会構造の変動とそれに対応する住民層の流動と生活構造の変化に関する社会学的研究。

当研究所の所在地である市川市全域を対象とする一方で、歴史的にも地理的にも独立性を持ち、かつ近年地下鉄の開通により急激な人口増加をみて変貌しつつある行徳地区に焦点をしぼって調査対象とした。精神衛生研究において地域社会が問題になるのは、それが精神不健康の発生の場であると同時に、精神障害者の地域ケアーの場となるという二重の意味を持つところにある。本研究では、地域社会の基礎過程を捉えることを主眼として、変化の激しい都市化地域において、従来から住んでいる地付き層の担つてきた伝統的地域社会の構造が、いまや多数派にまでなる勢いで増加する来住層の合流によって、どのように崩壊し、どのような新しい形の地域社会形成の芽が現れるかに焦点を当てた。

研究はさらに原木と呼ばれる一近隣コミュニティ（徳川時代のムラ）における詳細な調査と、市川市全域をカバーする調査として、町内会、自治会の全数調査、また、市の教育研究所における学校教師の集団研究活動に参与しての人口急増地区と停滞地区との比較の視点から児童生徒の教育環境の調査を行なった。

その結果は、市内の地区差、とりわけ人口の流動性の高さとの関連で、住民家族の生活構造が異なり、学童の生活、教育環境も異なること、従って、生活上の問題点、行政への要望内容、また行政への対応形態も異っていることが明らかになった。

2) 地域環境変化の異る地域において、住民の生活構造の差と心身の健康度との関連に関する研究。

都市化現象の異なる4地区の比較調査を行なった。対象都市は千葉県I市、静岡県F市、三重県S市、静岡県K市で、家庭の主婦と面接し、環境変化調査票、生活構造調査票、家庭についてのイメージ調査票を用いて調査を行ない、この4種類のデーターにもとづき、「地域環境変化が異なる地域において住民の生活構造の差が心身の健康度にどのように関連するか」を検証した。また、三重県S市は同市内に人口が増加した地区と人口が減少した地区を有するため、人口増加地区における地付き層の主婦と来住層の主婦、および人口減少地区の地付き層の主婦の3者間の特性の比較検討を行なった。

3) 在宅精神障害者の医療及び生活実態と社会適応状態の把握並びに地域社会における精神障害者とその家族に対する援助活動の実践研究。

研究対象地区として、市川行徳、南行徳地区を選んだ。その理由は、1.これらの地区が市川市の1地域であり、研究所と距離的に近いこと、2.対象人口が両地区合せて約3万人であり、研究班を1活動チームと考えた場合、適当な大きさであったこと、3.行徳、南行徳地区は昭和30、31年に市川市に合併されるまで、それぞれ独立の行政単位であり、固有の歴史と文化、経済基盤を持っており、現在でも市川市行徳支所の管括として別個になっていること、4.昭和45年3月の地下鉄東西線の開通に向って地域全体に各分野において変動が始まっており、精神衛生上のことがらにも何らかの影響が予測されたこと、などである。

研究の目標は、1.精神障害者の医療、社会復帰、生活実態の把握、2.さまざまな問題の所在をクローズアップさせること、3.これらの問題に対処していくことを通して、必要な医療、社会復帰援助、生活指導のシステムを形作っていくこと、その際、これらに個々バラバラに対応するものではなく、常に統合されたものとしてのシステムを作りあげることであった。また、これらのことは本来保健所の業務領域に属するものと考え、将来、保健所の日常業務として引き継がれることを期待し、そのためには保健所がどのようなことについて活動可能であるかの検討も必要であった。

実践の活動として、先ず、市川市行徳支所の2階に「心の健康相談室」を開設し、市の広報や回覧板で直接住民に知らせると、同時に、民生委員会、自治会役員会などでもその主旨を説明した。

相談室来訪者は精神障害者やその家族の他に地域リーダーが、自分のかかえている問題について相談に来ることも多かった。

一方、住民の関心の程度の調査、精神障害者への態度調査や、国民健康保険加入者及び国立国府台病院受診者から地域の精神障害者の動態や受診圏など疫学的研究も行なった。

また、受診圏の精神病院との協力で退院者の訪問調査を行ない、社会復帰指導を行ない、地域内の原木山妙行寺の宗教活動を一つの民間精神療法としてとらえ、住民の精神生活との結びつきを検討した。

昭和45年4月に千葉県において各保健所に対する嘱託医制が設けられ、市川保健所において毎月1回相談日が開かれることになり、昭和46年4月には精神衛生相談員が配属され、精神衛生サービスが保健所の業務として取り上げられ、相談活動も充実し、訪問指導も可能になった。ここにおいて行徳支所で行なっていた「心の健康相談室」は、その活動の大部分が保健所業務として引き継がれることとなり、研究活動の発展として閉鎖することとし、保健所の精神衛生サービス活動に協力するという形に転じていった。

昭和47年4月には市川保健所を含む東葛地区の6保健所の相談員と嘱託医を中心として東葛ブロック精神衛生研究会が結成された。この会の目的は保健所所属の相談員、保健婦、関係職員の精神衛生活動における技術水準の向上、保健管内の関係機関はじめ関係者の知識普及、保健所間の情報交換等である。

昭和49年4月から市川保健所が県から精神衛生特別都市対策事業の指定をうけ、精神衛生活動にとりくむ態勢は大きく前進した。この事業の1つとして昭和49年9月に地域の協力団体として市川市・浦安町精神衛生推進協議会が結成された。

昭和51年から協議会の中に雇傭促進小委員会が設けられ具体的な事業活動が充実されてきた。研究班としては初期の目標が達せられ、別個に独自の活動を行なうことには終止符を打ち、以後は保健所における事業に協力しつつ精神衛生システムの研究、評価を続けることになった。

4) 学校精神衛生に対するコンサルテーション・プログラムに関する実験研究。

市川市の教育委員会および教師を対象として、学校精神衛生コンサルテーションの技術開発。自閉児に対する地域援助プログラムにおけるノンプロフェショナルの人材の活用に関する研究、クライシス・インターベンションの技術開発等が行なわれている。

実践活動としては、毎月1回行なわれる特殊学級担任教師のケース研究会議において、班員によるコンサルテーションサービス。教育研究所に対するコンサルテーションサービスを行ない、自閉児とその親に対する援助活動として、自閉児のグループ・プレイセラピーおよび親のグループ・ワークが毎週水曜日の午後に国立精神衛生研究所内で行なわれている。また、ボランティアとしてこれに参加する形でノンプロフェッショナルの人材の活用についての実験的研究が行なわれている。

5) 知能障害(児)者の地域ケアーのシステムの確立に関する実験研究。

知能障害者に対する行政レベルにおける地域ケアーのネットワークの確立を目標に実験研究を行なってきた。

実験活動の1つとして、在社会精神薄弱者の社会適応の安定化を計るための援助活動として、精神薄弱者のためのソシアル・クラブの運営技術開発の実験を東京都渋谷区内で行なってきた。この実験においては、障害者によるクラブ活動の自主運営が目標とされ、その可能性の限界や、

そのための組織のあり方、運営内容、クラブ活動の中におけるボランティアの態度並びに位置づけ等が検討されてきた。現在では自治体より運営費を得て、地域におけるボランティア活動として組織が定着するに至っている。一方、市川市においては昭和45年に心身障害児指導連絡会が発足し、児童相談所を中心として教育、福祉、医療、親の会等の連絡と疎通性を改善することが計られるようになり、班員がこの構成メンバーとして参加する形で、システム運営の研究および評価を行なっている。この会の事業の１つとして、昭和52年に心身障害(児)者をかかえる家庭の福祉要求調査が行なわれ、会の活動の資料とするため目下集計中である。

昭和48年に市川市が文部省の特殊教育推進地区に指定されたのを機会に市川市特殊教育推進協議会が発足し、市川市に在住する心身障害児童・生徒の教育の振興をはかる活動機構が一応形態の上で成立した。昭和49年６月より、従来の特殊学級入学者判別委員会が廃止され、新たに市川市心身障害児就学指導委員会が発足し、すべての障害児童・生徒に適切な教育が行なわれるように就学並びに進路指導の充実強化がはかられることとなった。研究班としてはこれに参加することによって、障害児の就学における処遇改善のための技術およびシステム開発の研究を行なっている。

さらに、市川市立の就学前年齢の障害児の通園施設及び障害者通園施設、福祉作業所等に対するコンサルテーション・システムの検討を行なっている。

III. 展　　望

本研究班は当研究所の研究態勢の変化により、昭和52年度をもつて一応開散した、しかしながら、この研究班の中で行なわれていたアクション・リサーチの面は、地域レベルにおけるモデル実験研究であるので、最終的には地方行政の改革にまで目標が向けられることになる。われわれが現在実験中であるコンサルテーション・プログラムや地域ケアーのシステムが確立され、地方行政の中で、これらが運営されるようになって、初めてこの研究が完了することになる。そのためには相当長期の活動を必要とするものと考えられる。従って、研究班としては開散したが、現在もそれぞれの活動は継続されているので、今後もメンバー間の情報交換を行なってゆく予定である。

研究参加者名及び職種

小林　晋	精神医学
山本和郎	心理学
斉藤和子	社会福祉学
石原邦雄	社会学
飯田　誠	精神医学

（文責　飯田　誠）

2. 精神障害者の社会復帰に関する研究

Ⅰ. はじめに

社会復帰研究班は、デイ・ケア・センターの運営を中心に「精神障害者の社会復帰に関する研究」にとり組んでいる。我々は、週4日デイ・ケアを実施し、そのプログラム・グループへの参加を通して、

① 社会復帰技術としてのデイ・ケアの運営の研究

② デイ・ケアの個々の対象者における治療的意味の研究

③ 集団的接近と個別的接近の統合の考察を行ない、加えて、

④ 家族および家族会への援助と研究

⑤ 地域社会における社会復帰活動との連携等を目指して研究活動を続けている。

ここでは、10数年に及ぶデイ・ケア活動の流れをふり返りながら、我々の現在のデイ・ケアについて報告したい。

Ⅱ. 研究内容

(1) デイ・ケアへのかかわり方の変化

当研究所でデイ・ケアが始まってから13年余になる。当初多くのスタッフは、デイ通所者に対し「精神的に弱い人」として、保護的な接し方をしていた。例えば刺戟的言葉使いを避けたり、新入メンバーはまず数人の新人だけのグループを作ってから既成のグループに入れる等の配慮をしたり、仲間の入院のニュースを極力ひかえたりであった。つまり、スタッフは、メンバーが精神的動揺をきたして不安定にならないよう優しく接し、プログラムに適応できるようにと気づかっていた。やがてこのような気くばりが無駄なばかりかむしろメンバーの成長にとってマイナスでさえあることを、我々はデイ運営の中から知ったのである。つまりデイ・ケア活動を通してのふれ合いの中から、メンバーは弱い面をもつがしかし自分の現実に向かい得る力のあること、その内面の力を用いて各自が自分の問題を自分で解決する以外に、自立はないとの考えに至ったのである。この観点から、通所者自身が一人で歩く試みをできるような社会的な場として、デイ・センターを位置づけるようになってきたのである。

メンバーが自分が社会で生きていくための自立への一つの場として過程として、デイ・ケア・センターを積極的に利用するというこの考えは、単なる研究仮説や理念としてあるのではない。13年余の、むしろ実りの少ない歴史の中で、たどりついた共通理解の一つなのである。1週に4日の活動といっても実質20時間余のデイ・センター内でのつき合いで何ができるというのだろうか。メンバーはより多くの時間を、家族と隣人と病院のスタッフや友人と過ごし、その社会的環境から受ける影響の方がはるかに大きいのである。とすると、デイ・ケアの中での治療的配慮とか、入所の条件は、ほとんど意味をもたなくなってくる。友人の入院をデイ・セ

ンターで秘密にしてもよそからその情報を知るし、同じ病名の人ばかりを集めてグループにしてみても、一歩センターを出れば種々の背景や思想をもつ人々の中に身を置くという現実がある。デイ・センターの中の配慮等は、実験的意味はあっても、反面閉鎖性を増し社会での抵抗力を低めるおそれすらあるのではないか。むしろ各メンバーが、デイの中だけでなく家庭でも地域社会でも生きていけるように、スタッフや他のメンバーの力を利用し、さらに自分の力も友人にさし出すという形で、相互援助を続けていくしかない。こうして治療共同体としてのデイ・ケアへと移行していったのである。ここでは、スタッフが何とかしてくれるだろうという幻想は徐々に消され、日常のつき合いの中で明らかにされていくスタッフの考えや行動を見て、メンバーがそこから利用できるものを見つけて利用していくということになるのである。我々は現在、したがって入所の条件も設けていないし、確固たる統一された治療理論なるものも持っていない。スタッフが立っている共通の基本理念は、各自が自分の責任において個性的行動をとってよいが、自分の考えや行動については、他のスタッフやメンバーの前にそれをオープンにし批判を受け、それによって動いていくということである。その際、相互批判を正しく生かすことが重要であり、それをどの程度受け入れられるかが、スタッフにとっての大きな課題である。

(2) プログラムについて

前述のような流れの中で、定期的活動としてのプログラムも当然変化していった。当初はスタッフが準備したプログラムであった。料理を作って食べれば楽しいだろうとか、社会の出来事に関心を持ってもらおうとの発想から時事問題の時間を設けるとか、声を出すのがにがての人が多いから元気よくコーラスの時間を作ってみようとか。現在もこれらと似たような内容のものが日課として残ってはいるが、それを日課として組む際の姿勢は、かなり当初とは異なっている。前述のような方針でデイ・ケアを行なう場合、当然プログラム決定にもメンバーが参加しなくては意味がない。「皆がやりたいことを最低一つずつあげてみよう」ということでスタートしたプログラム作りも、もう6年になろうとしている。プログラムとして各個人がやってみたいことをあげ、それに加わりたい人が3人以上集まれば一つのプログラム・グループとして成り立つというのが、現在のプログラム作りの方法である。少数のスタッフが考えた案、それも一こま一種目のプログラムでは、それを気に入らない人はさぼったり消極的参加になりがちだが、一こまに数種のプログラムを準備すれば、多少やりたいものを選べるし、少くとも週1回ぐらいは自分の好みのものをやれるだろう。そうなると日課への参加の仕方にも積極性を期待できるだろう。こうして我々は現在、一こまに数種のプログラム・グループを設置し、その中から各自が選択によって自分の日課を決める形をとっている。

表1のように、多くのプログラム・グループが準備されているが、これらを大まかに説明すると、お菓子グループはお菓子を作って食べることを楽しもうというグループ、せいグループは天文学を学ぼうという人が集まって、宇宙人やＵＦＯについてしゃべっていたのが、やがて星、性、成、聖、生といわゆるせいと名のつく諸々のことについて話しをしようというグルー

表Ⅰ　プログラム（昭和52年12月現在）

①　定期的プログラム

曜日＼時間	10：00～10：30	10：30～12：00	12：00～1：00	1：00～2：30	2：30～3：00
月曜	朝の集り	お菓子グループ せいグループ 器楽グループ 書道グループ	昼休み	全体集会	お茶の時間
火曜	朝の集り	料理グループ スポーツグループ	昼休み	小グループ別話し合い	お茶の時間
水曜	朝の集り	文章創作グループ 茶道グループ 小グループ料理 雑談	昼休み	音楽グループ 洋裁グループ 心理学グループ	お茶の時間
金曜	朝の集り	スポーツグループ 自由グループ	昼休み	皮細工グループ 英会話グループ 美術グループ	お茶の時間

②　不定期活動　　春・秋：ハイキング（日帰り）
夏　　：キャンプ（2泊3日位）
冬　　：クリスマス、忘年会、など

プに変わって現在に至たり、器楽グループはギターを中心に器楽演奏を身につけようというグループ、書道グループはおとなしい感じのメンバーが集まって静かに字を書く時間をもっており、ここは唯一のスタッフなしのグループである。月曜午後の全体集会は、精研デイ・センターの要ともいえる時間で、各メンバーが別々のグループに参加している中で、唯一の全員が揃ろう時間であり、ここでデイ・センターの運営方針、プログラムグループ新設または廃止の問題から、ハイキング等不定期活動の計画作り、他人への質問や批判などが行なわれる。火曜日の午前中は料理グループと、スポーツグループで、スポーツの種目としてはソフトボール、バレーボール、サッカー等をやる機会が多い。午後の小グループ討議は、3つのグループに分れて、自分の気持を表現したり、他人の問題を共に考えたりする時間だが、この他に映画やテレビの話題なども結構多く話される。文章創作グループは詩や文を書いて、お互いに読み、感想を交換し合うことが多く、茶道は、もと通所者の母親がボランティアとして月2回指導をしてくれ、雑談グループは家族への不満や異性のこと、そして映画のこと等いろいろとまさに雑談をするグループである。午後の音楽グループは歌ったりレコード音楽を鑑賞するグループで、洋裁・手芸グループは、ボランティアである一母親の指導で、洋裁をにがてとする人が基礎を学ぼうとしており、心理学グループは、心理学関係のテストや本について学習したり、箱庭を作って、その表現しているものの説明や解釈などを行なっている。金曜日の午前中はほとんどの人がスポーツに参加し、ごく少数が自由というより勝手にブラブラと過ごしている。午後は、皮で財布やペンケース等を作る皮細工グループと、英会話の基礎をマスターしよう、英語の歌

を楽しもうという英会話グループ。一方美術グループは、個人や集団で絵をかき、批判し合っているが、テーマは決める場合もあるし、そうでない場合もある。

以上のように、各地のデイ・ケア・センターで一般にみられるプログラムからめずらしいものまで、種類は雑多であるが、ここに貫かれているものは、デイ・センターにかかわる誰か（メンバー・スタッフを問わず）の提案に対し、３人以上の人が賛同して作られたということである。その内容は、実生活上役に立つものから、現実性のうすい遊びのようなものまでいろいろであるが、誰かがやりたくて、何人かがそれを一緒にやっていこうとしていること、そこに自分たちの意志が働いており、それが自分たちの場としてデイ・センターを活用していくことの実現の一助となるものと考えている。

Ⅲ．今後の課題

一人歩きのできる社会人が育っていくためには、デイ・ケアはどのように行なわれればよいのか、その場の設定の仕方、内容の評価、スタッフ・メンバーを含む相互批判とその生産的活用の仕方、地域社会における問題との関係など、たえず検討していかなければならない。そのために我々がやっていることは、一つは各グループ毎の記録をとっていること（これは皆で交代でその時間にやったことや感想などを書いている）。さらにこの記録を読んで他のグループに関心をもつよう期待されている。もう一つは毎日４時からのスタッフミーティングで、ここではケース・カンファレンス的なものだけでなく、スタッフの行動や考えについて議論することも多い。現在のところ、スタッフにとっては、このミーティングが一日のプログラムグループへの参加の中での諸々の経験を深化し、デイ・ケアによる社会復帰援助活動の意味を検討・考察する機会となっている。

このような日常のデイ・ケア活動を中心とした研究に加えて、地域社会における社会復帰活動との連携とそのあり方等が、我々が今後すすめていきたい研究の方向である。

なお、デイ・ケアのプログラム・グループの具体的活動内容については、社会復帰研究班昭和51年度報告書「デイ・ケア活動の実際」（国立精神衛生研究所、昭和52年３月発行）を参照されたい。

昭和52年度に、この研究班に属したスタッフは、筆者の他に、当研究所員では、柏木昭（社会福祉学）、越智浩二郎（心理学）、片山ますえ（看護学）、吉沢きみ子（作業療法）、牟田隆郎（心理学）、非常勤および研究協力者では、早瀬真知子、宗像恒康、渡辺孝憲、下平唯子、釜野靖央、近藤彦一、上田陽子、今井雅子、六川和子、小野京子である。

（文責、松永宏子）

3. 児童精神衛生に関する研究

児童精神衛生部の研究は、その開設以来大別すると2方面に分けることが出来る。即ち基礎的研究と臨床的、応用的研究である。近年後者の一部として、地域精神衛生に関する実践も含まれるようになった。

基礎的研究としては、児童の人格発達に関する研究、とくに双生児を用いた研究があり、1952年以来続けられている。とくに1967年以来、第二次研究として千葉県の二つの市の乳児双生児を登録し、彼らの心身の発達を追跡した。更に双生児相談室を開き、双生児キャンプを行なうことにより、第一次の双生児研究より、人格発達に関するさまざまの要因の、より精緻な力動的相関を探究することが可能になった。

現在までに登録した約180組の双生児の中には、6組の登校拒否、12組の自閉的傾向を持つ双生児などが含まれており、これらについて詳細な事例研究と卵性診断を行なうことにより、児童期における精神障害の発生原因に関しても、多くの寄与をなすと思われる。すでにMurphyその他により指摘されたように、われわれの研究は社会的、人類学的観点も含んでおり、双生児に対する文化的、家族的態度に関する報告は、障害をもつ双生児のいくつかの報告と共にすでに国際学会や海外の公刊図書で発表されている。

臨床的研究としては、研究所創立当初、初代部長高木が米国の児童相談クリニックの形式を紹介して以来、いわゆる臨床チームにより児童精神障害の診断、治療に関する仕事が続けられている。登校拒否、自閉症、言語発達遅滞、チック、その他の対象に対して、他の諸施設との協力のもとに、個人療法、集団療法、絵画療法、治療キャンプ、デイ・ケア治療などが行なわれており、これらの児童の母親の問題についても報告されている。

これらの研究のうち、厚生省研究班の一員として、1歳半健診を含む乳幼児健診、未熟児健診の方法の検討、児童精神障害とくに自閉症の診断と治療に関する研究、児童相談所における医師の役割に関する研究などが過去数年来行なわれている。

地域の医療、福祉、教育、司法施設との協力のもとに虐待に関する調査、研究も続けられている。なお、双生児研究と共に行なわれている縦断的研究として、乳児院収容児の長期予後調査的研究があり、施設でのみ育った子ども、里子・養子に出た子ども、実父母の許に帰った子どもの3群の予後が、1977年第6回世界精神医学会議に池田により発表されている。

今後の研究としては、(1) 双生児法による人格発達の研究 (2) 自閉症等精神障害を有する双生児の予後調査的研究、(3) 児童期精神障害に対する診断と治療に関する研究、(4) 乳児の精神生理学的研究(呼吸型、心拍等を含む)、(5) 思春期児童の適応障害(自殺、非行、浪人等)に関する研究、(6) 児童精神衛生領域における調査、統計、各国資料との交換などが挙げられる。

研究参加者名

池田由子	精神医学
今田芳枝	社会福祉学
西川祐一	精神医学
河野洋二郎	心理学

（文責　池田由子）

4. 個人ならびに集団の精神病理に関する研究

I. はじめに

国立精神衛生研究所における精神病理学的研究（主として、青年および成人）は、当研究所創立以来、精神衛生部の中で行なわれてきたが　昭和45年より始められた研究班体制下では、「個人並びに集団の精神病理に関する総合的研究」（D班）のもとに推進されるようになり、個人の精神病理に関する研究にとどまらず、個人を含む家族や小集団の精神病理をも含む総合的な研究へと発展した。

研究班体制がとられる以前の精神病理学的研究は、当研究所の相談室に来訪した事例を主とした臨床研究が中心であった。それは医療というよりは精神療法、カウンセリングを中心とした相談活動であり、従って、その研究の対象は、入院治療や薬物投与を必要としている精神病者よりは、むしろ通所可能な神経症者や適応障害者等に偏る傾向があった。しかし、そうした限界はあったが、心理療法やカウンセリングの技術、心理診断の技法等の開発や国際疾病分類の研究が活発に行なわれ、これらの領域の研究業績は今日もなお、高く評価されている。

抗精神薬の発見、普及にともない精神障害者の外来通院が可能となるにつれて、地域ケアーや社会復帰の重要性が叫ばれるようになり始め、その頃より精神病の精神病理学的研究が次第にわれわれの重大関心事となった。この動きは、精神衛生行政が精神障害者対策を重要視するようになった時期と期を一つにしている。

さて、過去５年間にわたるわれわれの精神病理研究は、概ね次の三つのテーマに要約することができる。第一は、分裂病を中心とした家族精神病理学的研究と家族精神療法の研究、第二は、青年の人格発達並びに精神病理に関する研究、第三は、対人恐怖の臨床的研究である。

II. 研究内容

1. 分裂病の家族力動に関する精神病理学的研究（国立国府台病院　高臣武史、国立精神衛生研究所　鈴木浩二、田頭寿子 他）

かつて、黒丸は「……現在、分裂病者の家族研究によって、その病因が論ぜられるというほどの決定的な決め手があるとは考えられないが、現実の問題として、その家族の力動を把握せぬかぎり、その治療は一歩も前進しないのではなかろうか。……病者はいつも、家族という集団を介して、社会と接触している点に注目すべきである。発病の動機、発病による家族各員の動揺、治療後の家庭および職場への復帰、はては再発の問題まで、どの問題をとってみても、分裂病者の家族力動を抜きにしては現実は一歩も前進しない。私見であるが、……分裂病者は（小児の場合も含めて）個人として患者にのみあるのではなく、実は家族全体として病みつづける病気だと思う」と述べ、この種の研究の必要性を指摘しているように、この研究は病者の精神病理の解明のみならず、分裂病の成因研究に新しい道を開くものとして大いに期待されて

いるところのものである。

われわれは、家族構成員の個々の精神病理と彼らがつくり出すところの家族力動の病理とを総合的に研究するために、家族合意ロールシャッハ法を開発し、これを分裂病の家族研究に適用した。そしてそこに得られた知見を「精神衛生研究20、21、22号」「ロールシャッハ研究XII」等々において報告した。それらの結果は次の如く概略できよう。

(1) 分裂病者の家族員には、その根底に強い不安感があり、そのために他者を配慮する余裕がない。それ故、他者との関わりはこの不安感の増強を結果することとなり、新しい相互理解や解決法が見出せないこと。

(2) 従来の欧米の家族病理論をそのままわが国の家族研究に適用することには多くの問題がある。特に、分裂病者が男であるか女であるかによって家族力動に大きな違いがあるし、欧米の分析理論に相応しない親子の力動的関係が認められることなどである。

2. 分裂病の家族治療に関する研究　(国立精研　鈴木浩二、順大精神科　牧原　浩)

分裂病の家族研究の一貫として、われわれは、合同面接を主とした家族治療の研究を行ない、分裂病家族の様態を明らかにするとともに、家族内の諸問題(コミュニケーションの歪み、疎通性の悪さ、情緒的、感情的対立、役割期待、遂行のずれ等々)を解決するための技法の探索を試みた。

未だ症例が少なく多くを語ることはできないが、(1) これらの家族の構成員は、他者に愛情を与える余裕がなく、むしろ強くそれを他者に求め合っており、それぞれは与えるよりも求め合っているため、相互に欲求不満をきたし、コミュニケーションが悪くなっている、(2) 特にネガティブな感情を処理することができず、相互にこれを陰蔽する傾向がある、ことを見出した。そして、これらの家族様態に対して、「前回の面接内容を想起させる技法」を用いて、感情の連続性をもたせるようにしたり、「治療的二重拘束技法」、「役割交換技法」等々を用いて、家族治療の危機状況を克服したりした経験を「日本精神分析学会」(1972)において報告した。

3. 青年の人格発達並びに精神病理に関する研究(村瀬孝雄)

青年期の精神病理の研究は、ごく最近のことである。われわれは1970年より青年の正常ないし異常な人格発達に関して継続的な研究を行なった。市川市内の中学一年生500名のうちより70名を研究対象とした。そして、その際、人格の歪みやその精神健康の状態を考慮し、正常・異常、各35名づつをもって構成するようにした。これらの対象に対して、少なくとも、年1回づつ、面接、心理検査(TAT、SCT、Baum テスト、ロールシャッハ・テスト)を施行し、その発達を研究した。

この研究の結果は、次の2論文の中で詳細に報告した、「精神衛生研究22、24号」

4. 対人恐怖の臨床的研究(高橋　徹)

対人恐怖はとくに青年期に好発するノイローゼで、ごく一部の患者は精神科的治療を受けに来るが、他の大半は、非医師によって試みられている数々の方法(性格矯正、催眠、ヨガ、断食等々)による治療を受けていることが知られており、また、人知れず悩む青年も多く、その

数はかなり多いことが推定されている。また、登校拒否、自殺企図、職場不適応、などの問題行動を示す者があり、これらの点からもこのノイローゼはとくに青年期の精神衛生にとって重要な課題のひとつとなるものと言うことができる。

さらに、巨視的にみると、対人恐怖と日本人の心性とのあいだには、共通した点が数々認められることが、比較文化精神医学的視点からの研究によって指摘されている。

三好郁男[1]は、従来の対人恐怖研究の動向として、森田神経質理論にもとづく動向、精神分析理論にもとづく動向、比較文化精神医学的研究の動向、および微視社会学的研究の動向をあげているが、とくに微視社会学的研究は高橋[2]によってはじめられたもので、D班のこの「対人恐怖の臨床的研究」はその延長上にある。

対人恐怖症例の臨床的観察ならびに治療をとおして得られた臨床的事実を、対人的相互伝達論および微視社会学的理論によって分析し、対人恐怖の精神病理学的なモデルが得られつつある[3]。

残された問題は数多いが、現在着手しているのは、このモデルにしたがっての対人恐怖の重症型、境界線症例、さらには敏感パラノイアの症例などの解釈で、これによって、対人恐怖ノイローゼの疾病論上の位置づけが、さらに明確になることが期待される。

また、対人恐怖の予防および有効な治療の相互伝達論からの指針が得られることが期待される。

III. 今後の課題

以上概略した如き研究が今日までに行なわれてきた。すでに述べた如く、それぞれの研究は精神健康の保持増進に貢献する多くの知見を生んでいる。家族の研究は精神病の疾病概念、治療論等々に新しい視点を与えることであろうし、青年期の精神病理に関する継時的研究はユニークであり、人格発達の理論の展開に大いに貢献するものがあると考えられる。また対人恐怖の精神病理学的研究は、予防並びに治療の指針を与えるものと期待される。

なお、蛇足だが、精神病理の研究には、狭義の医療をも行なえる臨床施設が必須であり、これがないことは、この種の研究には致命的である。現在、われわれはやむなく大学病院、国公私立精神病院等の医療機関に出向き、そこで研究をすすめており、時間的にも経済的にも無理を強いられている。この種の施設が附設され、これまで以上のインテンシーブな研究ができる態勢が一日も早くでき上がることを期待してやまない。

研究参加者名　鈴木浩二　社会心理　　高橋　徹　精神医学
　　田頭寿子　臨床心理

（文責　鈴木浩二）

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(1) 三好郁男　対人恐怖について　日本精神病理・精神療法学会　第6回大会　3.(1969)
(2) 高橋　徹　対人恐怖の精神病理　精神神経学雑誌　68、31.(1966)
(3) 高橋　徹　対人恐怖　医学書院　1976.

5．精神薄弱に関する研究

本格的な精神薄弱研究は、昭和35年に精神薄弱者福祉法の制定とともに精神薄弱部が新設され、精神薄弱の類型および発生原因、診断、治療、指導など精神薄弱の調査研究が開始されたのにはじまる。

精神薄弱研究の特色は精神医学、臨床病理学、保健学、心理学、教育学、社会学および社会福祉学などの関連諸科学の協力によって総合的、多面的におこなわれている点にある。

最近の精神薄弱研究の動向を概観すると、次のような4本の柱からなる「精神薄弱児・者の診断とケアに関する総合研究」をおこなっている。

1．臨床診断法の開発とその応用に関する研究

精神薄弱の診断基準の確立と臨床検査技術の向上をめざして医学診断・心理診断・社会診断ならびに総合診断の体系化、精神薄弱の程度別判定指標の作成、先天性甲状腺機能低下症、ガラクトース血症および進行性筋ジストロフィー症などの集団検診技術の改善と開発、騒音の内分泌系への影響などの研究をおこなっている。

精神薄弱の程度の判定に関する基準作成の研究は年金・手当などの経済給付の公正を期するために、また適正な処遇をおこなう手がかりとなる指標を必要とする見地から関係者の間で強く要望されている。これにこたえてわれわれは、厚生省心身障害研究費補助金の交付をうけて上出（東京都児童相談センター所長）、仁科（市川児童相談所々長）、宮本（千葉大学教育学部教授）、塩野（千葉市教委指導主事）、下平および小林（厚生省児童家庭局専門官）などの協力のもとに判定指標作成の作業に取り組んでいる。この判定指標の特徴は従来の「疾病性」重視の判定基準を見直し、精神薄弱児・者の人間的成長や自己実現を援助する諸活動（医療、教育、福祉）に役立つ手がかりとなる「事例性」を重視する立場から精神薄弱児・者の身体的、精神的および社会的側面について実際的、具体的な臨床像を多面的、総合的に把握することをねらい、判定の視点は知能指数の偏重をあらため知的機能と適応行動両面の障害がもたらす行動水準におき、対象はすべての年令段階を網羅したものであり、その完成が各方面から期待されている。

また、ガラクトース血症（異型）の診断システム開発の研究は現在全国的に実施されている先天性代謝異常マススクリーニング（ボイトラー法）において数多く出現しているガラクトース血症の疑陽性を同一の濾紙上乾燥血液を用いて電気泳動によって速やかに判定する方法を開発しようとするものであり、これによって、(1)再採血の負担を軽減し、(2)再検査の手間をはぶき、(3)マススクリーニングでは見逃されていた治療の必要な悪性の異型を発見できるなどの利点が考えられ、関係各方面から実用化が待望されている。なお、進行性筋ジストロフィー症に関する国内外の研究は大勢が治療法の開発にむけられているが、簡便な方法によって早期に発見し、家族指導を含めて適切な療育指導をおこなうことは患児および家族にとってきわめて重

要である。したがって厚生省心身障害研究費補助金の援助をうけて吉田（東邦大学理学部教授）らと共同でおこなっている血清によるクレアチンホスホキナーゼの測定法を修正して濾紙上乾燥血液による微量測定法の実用化をはかる研究は今後の治療法開発の進展をふまえた研究という意味からも価値あるものといえよう。

現代社会では騒音などの環境ストレスの人間生活におよぼす影響が重視されており、精神薄弱児・者についても十分な配慮がなされなければならない。この方面の研究として、騒音のヒト下垂体ホルモン分泌およびラット性周期におよぼす影響についての研究が進められ、前者ではプロラクチンについて、後者では連続発情ないし非発情の誘発について興味ある知見がえられ、目下、連続発情・非発情との関連が推測される松果体ホルモン、メラトニン分泌の反応をみるために同ホルモンの測定法を開発中である。

2. 早期老化の実態とその対策に関する研究

精神薄弱者の「老化」の概念の検討、尼子式老化度測定による実態把握、早期老化と適応行動など日常生活に関連する因子との関係、成人ダウン症候群脳波の定量分析、体液性免疫機能の測定、ＲＩを応用したダウン症候群の加齢と内分泌機能の関連の解明などの研究や疫学的調査によって早期老化の実態把握と対策の検討をおこなおうとするものである。

最近の一般人の平均余命の伸びにともない精神薄弱者の保健・福祉対策上の重要課題として浮かびあがってきた高齢精神薄弱者の実態把握と早期老化の解明については関係者の間で要望が強く、国でも厚生省心身障害研究費補助金を支出して問題の解明に力をいれている。

われわれもこの補助金の交付をうけ、東京大学精神神経科、脳研究施設、帝京大学精神神経科、小児科、埼玉医科大学精神神経科の関係者および埼玉県熊谷精神薄弱者更生相談所、はるな郷、津久井山百合園、美里学園、老人ホーム松寿園などの協力をえて問題の究明にあたってきたが、現在までに次の諸点が明らかになった。すなわち、(1) 全国の精神薄弱者援護施設在園者の年齢別推移をみると若年層の減少とともに40才以上が着実に増加しており、高齢者問題が顕在化してきている。一方、在宅の高齢精薄者については年齢別人口比が一般人にくらべて低く、一般の高齢者の場合ほど社会問題化していないが、高齢精薄者の特徴として、(i)40才位で急激に老化する。(ii)指導効果が期待できない。(iii)精神機能の低下が著しい者が多い。(iv)一般老人と異なり完全に孤立してしまったり、浮浪状態を示す者が多い。(v)両親の老齢化や死亡のために養護上、同胞などの家族の経済的、精神的負担が大きいなどの諸点が関係者の間で指摘され、特別な対策を望む声が強い。(2) 尼子式老化度測定（外見上）による老化度指標と暦年齢との相関は一般精薄群0.66、ダウン症候群0.61、正常若年群0.77、正常老人群0.48と老人群がやや低いほかはいずれもかなり高い相関がみられた。(3) 暦年齢に対する老化度指標の分散について回帰直線を各群ごとに求めて比較してみると精薄群は正常群にくらべて早期老化の傾向が認められ、その傾向はダウン症候群に顕著であった。(4) ダウン症候群の安静閉眼時脳波を定量分析し、脳波成分におよぼす加齢の影響を検討した結果、徐波および中間速波

が特に中心部で多く、全般に不規則波形であったが、これが20才代で最も少なく、30才代以後再び増加する傾向がみられ、加齢の影響がうかがわれた。(5) 一般精薄群、ダウン症候群について体液性免疫機能を検討した結果、正常者にくらべてIgG、IgAが高く、抗A・抗B凝集素価は低い傾向があり、ダウン症候群ではその傾向がより著明で早期老化傾向との関連が注目された。(6) 精薄関係の福祉職員は早期老化の現象を認めているが、老人ホーム関係者はかなりの高齢者についても老化を認めず、両者の間に老化度評価の視点の差異がみられる。また精薄関係者の間でも「老化」のとらえ方がまちまちであり、尼子式老化度測定の結果と福祉職員による老化度評価とがかならずしも一致しない。(7) 尼子式老化度測定と日常生活に関連する因子との相関は暦年齢以外には認められず、社会生活力は知能や現在状況、将来の見通しなどと平行関係が認められた。(8) 老人ホーム在園群（正常老人）と精薄施設在園群について尼子式老化度指標および社会生活力評価の項目別比較をおこなったが老化に共通する特徴がみられず、一般老人との比較において精神薄弱者の老化の特徴をとらえることに困難が感じられた。今後は生物学的老化を厳密に評価するための手段として対象をダウン症候群にしぼり、施設在園のダウン症候群高齢者の実態把握をおこない、加齢の影響を検討する予定であり、すでに全国の精薄児・者施設1,000余を対象に実態調査をおこなっており、またラジオイムノアツセイなどを用いて甲状腺刺激ホルモンなどの下垂体ホルモンの測定をおこない、加齢と内分泌機能の関連について検討をはじめている。

3. 地域医療・保健・福祉計画の体系化と技術開発に関する研究

精神薄弱児・者の早期発見や在宅治療などの地域ケア技術の開発と体系化の確立をめざして、わが国における地域ケアの実態分析、地域医療・保健・福祉サービスのシステム化、精神薄弱児・者の適応行動水準の改善・家族への働きかけ・地域住民の態度や意識の変容をはかる諸技術の向上などに関する研究をおこなっている。

全国各地の地域福祉計画の実態を把握し、わが国における地域ケアのあり方を検討するための研究は学界や親の会をはじめとする関係団体、行政当局などから強く要望されており、それにこたえて、われわれは日本精神薄弱者福祉連盟に協力して厚生省心身障害研究費補助金や丸紅基金助成金などをもとに全国11地域を対象に各地の地域活動の現況把握と地域活動を成功させるための条件の分析、地域活動にかかわる専門家および対象者のニード把握に関する調査研究をおこない、現在までに、各地の活動の理念と内容の明確化および活動の客観的な評価と今後の方向性の検討などをおこなう必要性を明らかにするとともに、地域活動の生成発展の過程とそれにかかわる専門家や対象者のニードを明らかにした。

また、全国心身障害児福祉財団の協力をえて、心身障害児の在宅ケアにかかわる専門職員などの実態把握と療育指導システムに関する研究、在宅心身障害児家庭の実態と家族に対する指導技術に関する研究を厚生省心身障害研究費補助金などの援助によっておこなっている。在宅対策の確立に寄与するこれらの研究の成果が関係者の間で期待されている。

4. 精薄関係職員の研修計画に関する研究

全国心身障害児福祉財団（在宅心身障害児療育指導者研修会）、日本精神薄弱者愛護協会（通信教育スクーリング認定講習会・はるな郷治療教育研修会）などに協力して精薄関係職員の研修プログラムの開発と職員研修の方法について検討している。

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（櫻 井 芳 郎）

6. 精神身体病理に関する研究

I. はじめに

国立精神衛生研究所の生物学的研究は、研究所の創立当初は生理学形態学部の中で、人脳の組織病理学と臨床脳波および実験研究によつて始められた。しかし、昭和30年に脳病理学者は転出し、その後補充されておらず、脳病理学領域での研究は行なわれていない。

昭和35年10月、部名は現在の精神身体病理部に改められ、「精神と身体の相関の生理及び病理に関すること」が所管業務となった。定員は部長の他に生理研究室長と研究員（現在は主任研究官）1名の計3名の精神科医である。

心身相関現象の生理及び病理とは、人間の正常の行動および精神病的行動に含まれる心理的内容を、生理学的な方法と用語とによって分析し説明する、あるいはその逆もあるがこれによって、人間の行動や精神障害状態を理解する基礎を作る目的をもつ。この際に主として用いられる方法は精神生理学的方法であるといってよい。

M.Lader （1975） がいっているように、精神生理学は精神医学の問題に2つの側面から新しい取り組みをしている。1つは精神疾患の随伴現象を正確に査定することである。これは患者の状態や症状の経過を観察する臨床的方法を拡張して、機械化・客観化したものといえる。2つ目は精神生理学的技法を使って精神疾患の成立機制を明らかにしようとするものである。このために脳波や自律神経系・内分泌系の測定が行なわれて、精神障害や行動変動に伴なう活動水準や情動の変化を把えるのである。

心身医学というものは臨床精神生理学であり、いずれも心身相関に関して同一の理念をもっているとは、D.T. Graham （1971）のことばであるが、精神衛生の扱う主な問題が、神経症や心身症および適応障害のような、精神－身体－社会環境の関係から生じる現象であるという点から、精神生理学的方法は精神衛生における科学的研究の適切な武器となり得るものである。つまり、この方法では被験者に観血的処置を施すことなく、生活状態に近い自然な動作を記録することができるのである。

疾病の追究から人間の正常な機能や健康状態の理解に近接するのが臨床医学の立場であるが、精神衛生には、この臨床医学つまり精神医学の立場に加えて、精神健康の意味を健康状態の追究から理解に向う側面を持っていると思える。この側面からの研究目的に、精神生理学の方法がきわめて相応しいといえるのである。

II. 研究内容

われわれがこの約十年間に行なった精神生理学的研究は、正常の精神活動および阻害条件の加えられたときの精神活動時の生理学的指標の変動の分析と、生体情報資料の解析方法に関するものであったとまとめることができる。

その１つは人間の通常の精神活動時における中枢神経系および自律神経系の変動パターンを分析するものである。これに属する研究には、一定の精神作業を遂行させる状況で、対応する生理学的指標の変動、ことに自律神経系の変動を把えるもの、特別の刺激や作業を負荷せずに通常の状態で、日中覚醒時および夜間の睡眠時の脳波を記録分析するものである。

主な研究課題：

夜間睡眠および日中覚醒時の脳波パターンの研究（中 川 泰 彬）

精神作業時の心拍変動の研究（高 橋　　宏）

つぎに、通常の精神活動が阻害された状態の研究に属するものとしては、神経症・心身症・適応障害の被験者の、精神作業時の自律神経系の変動、飲酒や精神安定剤の服用による影響に関するもの、騒音による夜間睡眠時脳波パターンの変化に関するもの、うつ状態の脳波異常に関するものなどがある。

主な研究課題：

アルコールと薬物併用の精神作業に及ぼす影響（高 橋　　宏）

脳波異常を伴ううつ状態の研究（高 橋 和 明）

音刺激負荷による実験的睡眠障害（中 川 泰 彬）

正常にせよ異常にせよ、実験記録を分析し必要な情報を正確に抽出するには、生体現象のアナログ信号を適切に処理することが要求される。生体情報処理の手法と装置についての研究は、上記の研究課題の実施と平行してすすめられてきたが、これは殊にミニコンピューターの現機種ＰＤＰ－11/40が導入されてからは、脳波の波形解析を中心として充実された。

主な研究課題：

デジタルコンピューターによる臨床脳波の周波数解析（高 橋 和 明）

脳波の集団検診法（中 川 泰 彬）

心拍と呼吸の記録と解析（高 橋　　宏）

III.　今後の展望

既述のように、現在行なわれている研究は主として脳波や自律神経系の変動を生体電気現象として把える方法によっている。しかし人間関係や物理的環境の変化など外的刺激が加えられた人体の反応は、殊に自律神経系では、電気生理学的現象であると同時に、内分泌的変化としても現われるのである。例えば、ストレス状況では皮膚電位や心拍数の変動と共に、尿中のカテコーラミン排出量が変化することが知られており、個体の刺激に対する応答を知る重要な指標の１っとなっている。

現在われわれは内分泌研究の機能をもっていないため、精神症状や環境への適応反応に関する資料に大きく空白をあけているので、内分泌の研究機能を整備させる必要が痛感される。生体情報の処理に関する研究も、電気生理的変数に加えて、内分泌的変数について、さらに両者の相関についてもすすめる必要が当然生じる。

以上は単にわれわれの精神生理学研究を充実させるにとどまらない。幅の広い精神生理学的方法は、精神障害、殊に神経症・心身症および適応障害の症状・状態像の把握や治療効果の判定に関する生物学的基準を提供することによって、精神衛生領域の他の研究者たちとの協力や学際的研究をさらにすすめること、医療・保健施策の基礎資料の充実化が図れるものと期待するのである。

研究参加者名	高橋　宏	精神医学
	中川泰彬	精神医学
	高橋和明	精神医学

（文責　高橋　宏）

7. 老人精神衛生に関する研究

I. 老人研究のはじまり

研究所において老人研究に手がつけられたのは昭和47年秋のことであり、はじめは老人問題に関心をもつ研究員による研究会であった。

老人問題がとりあげられた背景には次のようなことがらが考えられる。

第1は平均余命の延長とこれに伴う老令人口の増加である。老年期が、人生の終局のわづかな時間であった時代から現在では、仮に60才で区切るとすれば平均余命は男17.4年、女20.8年であるからほぼ20年の長さとなり、青年期、壮年期に匹敵する一つの時期となっている。また人口10万あたりの年令60の生存数は男約8万4千、女約9万であり、老人問題はほとんど全ての人に共通の最も関心のひかれる問題となっている。

第2は老人をとりまく生活環境、社会環境の変化である。これは単に老親扶養の問題というようないわば家族の内輪の変化のみでなく、生活全般におよぶ合理化、地域社会における交通や産業のしくみの変化、道徳や価値観の変化などが同時に進行しており、老人に対しても直接的に影響を与えているということである。したがって、老人の生き方も前の時代の老人の生活パターンの踏襲ではすまなくなり、自ら新しい適応のし方を創造しなければならなくなっている。ここにさまざまな精神衛生上の問題が発生する状況がつくられているといえるのである。

第3はこのような状況にあって老人自身の意識にも変化が起っていることである。「老人」といわれることをきらい、依存し、従属し、衰退していくものというイメージを拒否し、老年期を第3の人生として、あるいは自己の完成の時代として積極的に自律的に生きようという意欲をもった人が増えてきていることである。

第4は、精神衛生上の問題をもつ老人の増加である。この中には老人性精神障害、すでに精神障害であった者で老人になった者が含まれており、精神病院の老令化という現象をひきおこしている。しかしながらこのことにも増して今後憂慮されることは、特に神経症や不適応といわれるものの増加が予想されることである。先にのべた生活環境の変化や周囲の求める老人像および本人の意欲などは、時に老化を許さない状況をつくることにもなり、心理的な葛藤状況をつくりやすくするのではないかと思われるからである。

以上のような状況を反映したものの一つが老人の生きがいとは何かということが先頃広く話題になったことであろう。個々の老人はどのように生きれば満足し、生きがいを感じるのか。寿命がのびたことは幸せなことなのであろうかということが問われた。我々の研究も畢竟はここにつきるので、寿命ののびと幸せをいかにして一致させるかまた一致させることを妨げる要因は何かということを追求することである。

このような背景をふまえて我々の研究ははじまった。

II. 研究の展開

研究は一般の在宅老人を対象として、過去の生活史、現在の健康・生活・社会適応の研究からはじまり、精神および身体機能の老化の問題へとすすんだ。一貫して心身の老化と生活・社会適応を課題としており、精神老化度、身体老化度、生活・社会適応のそれぞれの評価法の開発、相互の関係の分析を行ってきた。以下にその経過と研究組織の発展を順を追って紹介する。

実際の研究活動は昭和48年2月の府中市における調査からはじまった。これは地域の在宅老人を対象に、「高令者の生活史と現在の社会的適応および精神健康の評価と相互の関係」をテーマとして訪問調査を行ったものである。

同年9月には同じ調査を東京都養育院において都立老人総合研究所社会福祉研究室と協同で実施し、両者の比較は翌年の第10回日本老年社会科学で発表した。

この間、昭和48年7月に老人精神衛生部が新設された。しかし部長1人の部であり、この1名の増員も実際には総定員法による1名減と相殺という状況であった。しかしともかく老人精神衛生部の新設はそれまでの我々の研究に公の場を与えられたことであり、国も老人に対して単に福祉政策のみでなく、積極的に老人の精神健康の保持増進のための研究の必要を認識し、その推進を具体的に打ち出したものと評価された。ここに国の研究機関としては唯一の老人問題研究部としての役割をはたすこととなった。

このような基礎の上に昭和49年4月には老人研究班が正式に発足した。

同じく49年4月には特別研究費の交付を受けることができた。課題は「老人の精神衛生に関する研究」である。協力機関は石川県立高松病院、琉球大学、東京都立老人総合研究所心理学部であり、研究所自身の研究協力地区として千葉県東葛飾郡浦安町が選ばれた。

浦安町は東京都と市川市行徳・南行徳地区とにはさまれた江戸川河口の旧漁村である。市川保健所管括であるため、在宅精神障害者の研究を行っている折に国保保健婦との交流があり老人問題へ進展するいとぐちとなった。49年5月に浦安町に老人福祉センターが開設され、その健康相談室で健康指導、相談活動の依頼をうけることになった。以来研究所から最も近いフィールドとして、常時血圧測定、健康相談、生活指導を行っている。

49年7月には老人精神衛生部に老化度研究室が新設され室長1名の増員があった。今回は実質的増員であったが研究員の不足はなを絶対的なものであった。

50年4月には新規に特別研究費の交付を受けた。課題は「老年期の老化と適応に関する研究」であり3年間継続の予定であった。この研究は、同一対象者に対して身心の老化と社会的生活適応につき継年的、縦断的に追跡しようというものである。これは身心の老化には個人差があり、生活史の個別性も加って老年期の社会的適応は個別的なものとなるために、正しく老化と適応をとらえるには1人の人間について縦断的に追跡する必要もあるからである。研究内容は精神老化の他に身体老化評価が加った。すなわち、脳波、心電図、胸部レントゲン撮影、血液生化学検査、腎臓機能検査、肝臓機能検査などの一連の臨床検査と尼子式をもととした外観的

老化度評価である。研究協力機関はひきつづき石川県立高松病院、琉球大学、新たに東京医大が加った。研究所のフィールドとしては、浦安町の他に、野田市のキッコーマン醤油株式会社退職者クラブ紫光会が加った。

50年6月にはそれまでの研究のまとめを、エルサレム市で開かれた第11回国際老年学会において発表した。

51年度は特別研究第2年度となり、課題は「老人の精神老化と脳機能に関する研究」であり、50年度と同じ地区で同一対象者に対して同じ技法、評価法を用いて研究を行った。内容は精神老化、身体老化、生活適応、満足度等の各領域において新たな検査項目、評価法をいくつかづつ加えた。

52年度は特別研究第3年度となり、52年度と同じ課題で研究を行い現在に至っている。

研究成果は毎年度厚生省へ報告書として提出したほか、日本老年社会科学あるいは日本老年医学会において報告している。

53年4月には待望の老人精神衛生部長が着任し、5月には研究員1名の移籍があり、ここに老人精神衛生部は部長1名、研究員2名、合せて3名の陣容となり、研究の充実が大いに期待されることとなった。

III. 日系人調査

この間、昭和52年9月には日本学術振興会の研究助成をうけて、アメリカロスアンゼル市の日系一世老人の調査を行うことができた。調査内容はこれまで各地域で行ってきたものとほぼ同じものである。この結果は比較文化の上に立って日本在住老人とアメリカ在住の日系一世老人の老化と生活適応を分析検討しているが、その結果は、戦後急激に〝アメリカナイズ〟された日本社会で老年期を過さなければならなくなった日本の老人に何らかの寄与をするものと考えられる。

この研究はその後も現地協力者によって二世老人についても行われている。また53年9月には52年の対象者について事例研究、補足調査を行うことになっている。これが完了すると、日本在住の日本人老人、アメリカ移住の日系一世老人、アメリカ生れの日系二世老人の3群の比較研究ができることになり、成果が期待される。

IV. 今後の課題

今後の研究計画のうち当面の課題は現在地域社会において、老化にともなう精神衛生上の問題をもつ老人への対策はいかにあるべきかということである。もちろん老化において精神あるいは身体のいづれかの面のみを扱うということは現実的ではない。精神衛生上の問題をもつ者も多少によらず身体的な問題を伴っていると考えておかねばならない。これらの老人を家庭の中であるいは地域社会の中でいかに扱っていくかということは大きな課題である。現在65才以上の老人のほぼ75パーセントは子あるいは子の家族と同居しており、各種アンケートによれば、

病気になったとき、体が動かなくなったときというのを含めるとほとんどの人がいづれは家族と同居し、最後を看ってもらうことを望んでいる。しかしながら実際の家族のおかれている状況は住宅問題、成員の間の生活内容の多様化、生活時間のズレなどのため、老人を介護するゆとりがもてなくなってしまっている。地域社会もまた種々の面でめまぐるしく変化し、住民の間でも何らかの具体的で実利的な目標に関して以外では連帯的共感をもちにくくなっている。つまり家庭も地域社会もかって老人を支えてきたいろいろの性質の力を失いつつあるといってよい。そこで一方では老人自身にできるだけ自立的生活を維持させ、あるいは取り戻させるための指導および訓練の場を、他方では家族や地域社会の力を補うような機能というものが必要となってくる。そのような補足的機能あるいはサービスが地域社会に存在すれば家族も地域も老人と共に生活できるということは充分考えられることである。このようなサービスの一つが〝老人デイケアー〟である。

研究所では昭和52，53年度にわたって社会復帰・相談部門の施設拡充が行われ、この中に老人デイケアーのための施設も準備されている。今後必要な人員の補充をまって老人デイケアーの実験的研究を行い、適応対象者の種類、活動内容、運営のモデルをつくっていく予定である。

研究参加者名　大塚俊夫　精神医学　老人精神衛生部
斉藤和子　社会福祉　〃
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（文責　斉藤和子）

8. 精神衛生における社会科学的研究

Ⅰ. 精神衛生研究所における社会学研究の歩み

1952年当研究所発足段階から5部のうちのひとつとして社会学部が設けられていたが、スタッフは横山定雄部長のみで、3年後に田村健二が加わったものの、その後永く定員2名の範囲で研究が担われてきた。

彼ら自身による研究の回顧等を参照しながら、当研究所における社会学研究の歩みをたどってみると、おおよそ次の4つの時期にまとめられる。

第1期　学際研究の萌芽

アメリカのモデルを小型化して移殖した当研究所の設置の経緯から、社会学も精神衛生研究の基礎的方法論（アプローチ）のひとつとして認知されたとはいえ、日本においてはそれまで精神衛生の領域に社会学者が取組んだ研究の伝統は皆無といってよい状態であったし、当然ながら、精神衛生研究の中核を占めた精神医学者たちにも、社会学の方法論を理解して学際研究を進めるという姿勢は充分でなかった。

社会学的研究の初期段階は、自らの方法論を充分に発揮できず、「精神衛生にかかわる問題」にも充分接近しえなかったことは想像に難くない。こうした中で志向されたひとつの展開方向は、青少年の非行防止、健全育成をめざす地域対策設定のための学際的地域総合調査と地域組織化プログラムの試行であった。内郷（茨城県）、富里（千葉県）などの総合調査や研究所の地元である市川市における精神衛生協議会の組織化などがこれである。これらは先駆的業績として記憶されるべきものであり、「モザイク的」との批判もあるが、学際的調査研究の萌芽ともいうべきものであろう。

第2期　〝臨床社会学〟への志向

力動精神医学（dynamic psychiatry）をベースにした研究所の研究動向では、個人（ケース）を対象とする臨床的研究が中心となることは当然の流れであり、従来の社会学的方法論が充分発揮されえなかったことはやむをえないことであった。その中で社会学者も〝臨床〟をめざすことによって精神衛生研究の中に自己を確立しようとしたこともまたある意味で当然の流れであったろう。

こうして、横山は産業カウンセリングや、産業人事管理へのセンシティヴィティ・トレーニングの応用の領域で、また田村はマリッジ・カウンセリングにおいて、それぞれ日本におけるパイオニアとなり、〝臨床〟を踏まえた社会学者として、研究所内に新しい研究領域をつけ加えると共に、学会においても応用領域の先駆者としての高い評価を得るに至った。

第3期　過渡期

田村の後任として家庭裁判所調査官から転任した佐竹洋人は、地域精神衛生のアクション・リサーチと、家族病理研究にとり組み、横山の後任者である山口節郎は、社会哲学的な理論研

究による独自の展開を示し、横山・田村に代って過渡期における社会学者の役割を果した。

この時期は、精神衛生法が改正されて、行政としても地域精神衛生を志向し始め、他方、従来の精神科医療について激しい批判が浴びせられた時期であり、また研究所内では、新たに学際的チーム研究の必要が求められた再編期でもあった。個人中心の力動精神医学的研究に留まらず、地域精神衛生や社会精神医学そしてその対極としての生理・生化学的研究などが研究ブロックを形成し、多様化が進んだという点でも再編期であったといってよい。

佐竹の後任である石原邦雄も、市川市をフィールドとする地域精神衛生の研究チームに加わったが、医学・心理学・ソーシアルワークによるサービス（臨床）研究の体制が整わぬ中で、地域社会学的、家族社会学的な調査研究を独自に展開した感が強い。但しこの間、特別研究費による、都市の過密状況や、企業社会における社会的・心理的ストレスに関する学際的調査研究に中心的メンバーとして参与する形で、学際的精神衛生研究の可能性を一歩進めることができた。

第4期　精神衛生研究における社会学的方法論の再確立をめざして（Ⅰ班の成立と展開）

この間地域精神衛生の必要と精神医療の反省が唱えられる中で、社会科学、とりわけ社会学への期待は大きくなってきたが、社会学の側でこれに充分応えるだけの力量をまだ備えていなかったことは否めない。こうした中で、ソーシアル・ワークの実践（臨床）を踏まえた上で社会学的理論を軸にして福祉的援助の基礎理論の再構築をめざす必要を痛感した坪上宏を中心に、「社会福祉の社会科学的研究」をめざす研究チーム（Ⅰ班）が、社会学の和田修一（山口の後任）、石原も参加して組織された。ここに精研における社会（科）学的研究の方法論的再確立をめざす新たな展開が開始された。新チーム発足後間もなく大学へ転出した坪上の後任に医療・保健社会学専攻の宗像恒次が招かれた。こうして精研発足以来初めて社会学専攻者3名となり、社会福祉学の柏木昭の参加も得て4名が結集して協同研究を組織する態勢が整った。社会学会においても福祉・医療問題への関心が増す中で、精神衛生に取組む研究者も増えてきており、明らかに日本における社会学的精神衛生研究は新たな展開期に入りつつある。

Ⅱ．研究の現状と展望

我々の「精神衛生の社会科学的研究班」（Ⅰ班）は、1977年度より「精神衛生におけるソーシアル・アドミニストレーションの研究」をテーマとして共同研究に取組んでいる。そこでは、精神衛生を広義の社会福祉の中に位置づけ、主として社会学的方法論にもとづいて理論的および実証的に把握していこうとしている。その際、広い問題領の中で、従来日本の「精神衛生」の中心部分であった「精神医療」および「精神障害」の問題に焦点をしぼることにした。具体的には、以下の諸点について研究を進めている。

1）社会指標の研究

マクロな社会診断の技法として、社会指標としての精神衛生指標の作成を試みる。但し、この分野はまだ研究の開発途上であり、解決すべき理論的課題も少なくない。また、精神衛生の

指標となるインプット・データをどこまでの領域にとるか、についても単純には決め難い。当面は、精神衛生あるいはその下位システムの構成要素を理論的に研究したり、操作化（すなわち測定可能なタームに直す）しようと試みている。

2）保健・医療の組織および従事者に関する研究

日本における精神衛生・医療サービスを担う主な機関としての精神病院、保健所、精神衛生センターなどの組織動態を類型化し、ケア・システムとしての展望を明らかにする。目下、精神衛生センターと保健所に着目して、その組織動態の類型化を試みている。

3）精神障害者の家族および家族会に関する研究

精神障害者と深く関連する家族の問題について、制度論的および生活構造論的な立場から分析するとともに、当事者のニーズを政策・行政に反映させる社会運動のひとつとしての家族会活動の意義と可能性について理論的・実証的に捉える。

4）ボランティア活動の役割と機能に関する研究

精神衛生においては、専門職能を補完するという消極的な面にとどまらず、より積極的な意味でボランティアの果す役割は大きい。日本において、これの未発達な状況がどのように克服されうるかについて理論的・実証的に究明する。

5）地域社会における生活構造とコンクリクトに関する研究

精神衛生問題の発生の場であり、「障害者」が再適応していくべき場でもある地域社会について、その社会構造変動と住民の生活構造の関連性、および地域社会内部における葛藤への住民の対応行動の側面から調査研究する。

まだ共同研究を始めて間もないので顕著な成果を上げるに至っていないが、1977年のコミュニティ・サイコロジー・シンポジウムに共同研究者各人の問題関心からそれぞれ報告を行った。また、当研究所では1978年から３ヵ年計画で、特別研究「地域における精神衛生の需給システムの実態把握と評価法に関する研究」が学際的プロジェクトとして取り組まれるが、我々のチームはこれの理論的な枠組を提供して、中核メンバーとして参画する予定である。

日本における精神衛生研究に対する社会学の貢献は今後益々その重要性を増すであろう。精神衛生における、医療をはじめとする個別のサービス技術の進展も、そうした技術を社会システムの中にどう有効に組み込んでいくかについて方途が構じられなければ、大きな成果を期待できない。社会学は、精神不健康現象の疫学的調査や社会的発生論の面にとどまらず、上記のようなソーシアル・アドミニストレーションの観点からも大いに貢献しうると期待される。そして将来は、狭義の精神障害問題に限らず、広義の精神衛生問題を、社会福祉、社会病理の問題として取り上げる研究体制への展開が不可欠となるだろう。

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II. 英文論文抄録

第9回国際疾病分類およびＡＰＡ第3回診断統計マニュアルにおける事例性と疾病性の問題について

加　藤　正　明

1975年ＷＨＯによる第9回修正国際疾病分類ＩＣＤの改正に伴い、わが国でもその実施を求められており、その全訳および修正が、死因および疾病統計分類として採用されることになった。アメリカ精神医学会（APA）においても、これを契機にSpitzerらによる第3回診断統計マニュアル（DSMⅢ）が作成され検討中である。この2つの新分類について、疾病性Illnessと事例性Casenessの2つの次元による検討がきわめて重要な課題となっているので、すくなくとも二次元以上の多軸診断の必要性と、上記の2つの新分類における問題点について述べ、とくにその理論的背景を明確にし、わが国における疾病統計にも適用すべきであることを力説した。

診断的理解と治療的理解の本質的相違と両者の関係について——ＴＡＴの“かかわり”分析への出発点

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心理臨床の場面において患者を理解する基本姿勢として、診断的理解と治療的理解の二つがある。ここでは、その二つの人間理解のもつ基本構造の相違とその両者の関係について論じた。まず、人間理解の構造には、見る者と見られる者との関係がある。見る者が見られる者を理解しようとする時用いている方法は現象学的接近法である。こうした前提のもとに、二つの人間理解の構造の相違点を①見る者の置く視点の位置、②現象学的方法の適用の対象、③あらわれに対する了解の過程、④二つの理解が見る者と見られる者及び両者の関係にもたらす結果、の諸点から論じた。さらに診断的理解にもとづく治療と治療的理解にもとづく診断についてその特性を論じた。最後に治療的理解の上に立った診断こそ必要であることを主張し、一つの診断であるＴＡＴをとりあげ、新しい解釈論として「かかわり分析」の方向性を論じた。その意味、ＴＡＴ「かかわり分析」の出発点となった論文である。

日本における集団精神療法

児童精神衛生部　池　田　由　子

第二次大戦後、海外で学んだ若い精神科医らにより力動精神医学の考え方が伝えられ、個人精神療法の理解が進むと共に集団精神療法発達の基礎が出来上った。厚生省の研究班が精神科領域の種々の患者にこの治療を試みたのは1956年のことである。著者は1958年米国で直接この治療を学び、最初に児童相談室で問題幼児と母親に試み、次いで精神病院の精神病・神経症患

者、地域で精神障害回復者、身体障害者などに実施した。初期には患者及び治療者とも、わが国の文化、家族構造に影響された、さまざまの特徴ある行動を示した。たとえば「良き聴き手」として他の患者の発言の中断を避け、治療者に依存することや、治療者が「権威的」になるまいとして、患者のタイプにあった適当な方向づけを与えられなかったりなどである。しかし、20年後このような現象はへり、集団精神療法はより広く応用されるようになった。

対人恐怖症候群

高　橋　　徹

赤面恐怖に代表される、著しい対人不安を中核とする恐怖症の一群があり、その群のまとまりについては、P.Janet の交際恐怖の概念をはじめ、なん人かの学者が論じているが、とくにわが国では、その一群を対人恐怖と呼んでおり、森田正馬の「優越への欲望」の理論以来、数多くの対人恐怖論が試みられている。しかし、臨床的な一単位としての対人恐怖の記述は、最近になってやっと試みられはじめたばかりである。

著者は、自験例をもとに、対人恐怖症候群の臨床像について、要約を試みた。

好発年齢があり、それは青年期（前期）である。性別については、やや男性が多い。発症前の性格特徴や已往歴などには特記すべきものはみられない。発症の契機は過半数の患者が報告しているが、心的外傷体験として著しいような契機は稀にしか報告されていない。

対人場面での些細な失敗体験や自意識過剰の体験（対人不安）が契機となる。その結果、赤面、その他の症状に対するこだわりが生じ、そのこだわりから恐怖症へと発展する。

普通、赤面、自己表情、自己視線、自己臭などに対する恐怖症として記載される症状を呈するが、これらの恐怖症には、関係念慮としての特徴が同時にそなわっている。それは、他の関係妄想とは、次の点で区別される。　1）本人は、その自己関係づけがあくまで自身の他者に対するこだわりから生じていることを自覚しており、他者の側からの働きかけ（スパイされる、幻聴をとおして他者から統制される、あやつられる、等）によるものでないこと。　2）自己関係づけの内容は、被害的な色彩を欠くこと。

ただし、笠原　嘉らが重症対人恐怖と名づけている一群では、この二点が、幾分不分明になっている。

概して予後は良好で、三十歳をこえると、症状の重篤さが急に軽くなる。

以上の諸点から、対人恐怖症候群は、青年期特有の神経症とみられる。

なお、経過においては、しばしば症状推移がみられ、或る一定の傾向が認められること、恐怖惹起場面を相互伝達論の見方から分析することによって、この症候群の本質、特徴が見出されること、などにもふれた。

「精神障害者」と日本の家族 ——社会学的序説——

石　原　邦　雄

「精神障害」と家族の関連について家族社会学の立場からのアプローチの可能性について論じ、特に日本の場合、伝統的な家族の形態（「家」制度）が、精神衛生の制度に深く関連している点を指摘し、家族と社会の変動に伴って「精神障害者」と家族の関係が新しい問題を呈していることを概観した。

老人の社会的適応に係わる諸要素の評価に関する研究

老人精神衛生部　　斉　藤　和　子
国立精神衛生研究所所長　　加　藤　正　明

第10回国際老年学会発表　1975年　イスラエル

研究の目的は老化による精神的、身体的変化をいかに評価するかということと、これら精神的、身体的変化と社会的適応との関係を明らかにすることである。

対象者は、浦安町86人、東京都142人、那覇市150人で、合計 378人である。

調査内容は精神老化には長谷川式簡易痴呆テストを、身体老化には既応歴、現在の健康状況のききとりと尼子式外観的老化チェックを実施した。社会的適応の評価としては生活史、現在の生活適応状況についての面接、最後にニューガルテンの人生満足度テストを行った。

結果は以下の通りである。

1. 身体老化度は那覇で高く東京で低く、浦安はその中間である。
2. 精神老化度は那覇で高く浦安で低く、東京はその中間である。
3. 人生満足度は那覇で高く東京で低く、浦安はその中間である。

この結果から、東京と那覇が対蹠的であるといえる。すなわち、那覇では身体老化・精神老化ともにすすんでいるが人生満足度は高い。一方東京は、身体および精神老化は高くないが満足度は低いということになる。

次に満足度と家族形態との関係をみると、浦安および那覇では子供と同居している老人は満足度が高かったが、東京では単身かあるいは老夫婦のみの老人の方に満足度が高いという結果が出た。これから、たとえば東京のような大都市居住者にあっては単なる多世代家族、あるいは子供と同居ということは、老人にそれほどの満足を与えていないと推測された。

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National Institute of Mental Health

Japan

I

Recent Researches

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II

Monograph

Problems of Caseness and Illness in Multiaxial Diagnoses in 9th ICD and DSM-III (presented at the VI World Congress of Psychiatry, August 28 ~ September 3, Honolulu, Hawaii, 1977) Masaaki Kato, M.D. 39

On the Essential Difference between Diagnostic Understanding and Therapeutic Understanding -- starting point of TAT "Kakawari" Analysis Kazuo Yamamoto

Group Psychotherapy in Japan Yoshiko Ikeda, M.D.

Social Phobia as a Clinical Syndrome Tooru Takahashi, M.D.

The "Mentally Disordered" and the Family in Japan

Kunio Ishihara

On the Evaluation of the Factors Connected with Adjustment of the Aged (10th International Congress of Gerontology, Jerusalem, 1975)

Kazuko Saito, Masaaki kato

On the recent Researches of the National Institute of Mental Health

Since 1952, interdisciplinary researches for mental health with the cooperation of psychiatry, clinical psychology, psychiatric social work, sociology and other social sciences have been carried out in Japan National Institute of Mental Health. Recently, the following 8 research projects were investigated, which should be mile-stones for future studies of the Institute.

1. Research for the community mental health activities
   a. Sociological research on the change of community structure of residents under the influences of these changes.
   b. On the relationship between physical and mental health, and life structures under different types of changing environment.
   c. Exploration of a service model for the mentally disordered and their families.
   d. On the consultation programmes for school systems and service model for autistic children and their parents.
   e. Community care systems for the mentally retarded in Ichikawa.

2. Study on rehabilitation of mentally disordered
   a. Administration of day-care as a technique of rehabilitation.
   b. On the effects of day-care treatment for each individual clients.
   c. Integration of individual and group approaches.
   d. Services for the relatives of psychiatric patients.
   e. Cooperation with community resources.

3. Research on child mental health

a. Basic study on personality development centered around the study of twins.

b. Clinical and psychopathological studies on school refusal, autistic child and other emotionally disturbed child through psychotherapy, art therapy, day-care treatment and therapeutic camp.

c. Psychopathological study on child abuse.

d. Long term follow-up study on baby admitted in institution.

e. A study on personality development of the children.

4. Psychopathological studies on individual and family

a. Family dynamics of schizophrenics.

b. Treatment of families of schizophrenics.

c. Personality development and psychopathology of the youth.

d. Clinical psychiatric study of social phobia.

5. Research on mental retardation

a. Exploitation of clinical diagnostic technique to define mental retardation and its application.

b. On rapid senility of mentally retarded.

c. Systematization and technical exploitation of community medicare, public health care and social welfare programmes.

d. Training programme for the specialists related to the institutions for the mentally retarded.

6. Biological Researches in Mental Health

a. Studies on EEG patterns in noctural and daytime sleep.

b. Changes of heart-beats by mental work.

c. Effects of alcohol and drugs to mental work.

d. EEG studies in depressive states.

e. Experimental insomnia by stimulation of noises.

f. Clinical EEG analysis using digital computer.

7. Research on the relationship between aging and social adjustment

a. Evaluation of mental, physical and social aging.

b. Relationship between life history, present life and mental health among the aged.

c. Brainfunctions and psychogeriatrics.

d. Aging and social adjustment among the Japanese Issei Americans.

8. Social scientific research on mental health

a. Social index in the field of mental health.

b. Study on systems and workers in the field of mental health.

c. Study on the families and relative's association for the psychiatric patients.

d. Role and function of volunteer in mental health.

e. Life structure and social conflict in the community.

On the methodology of mental health studies

As far as the methodology of interdisciplinary and international mental health studies are concerned, those of social psychiatry, epidemiological psychiatry and behavioral science might be most important to be applied.

The first, our researches from the view point of social psychiatry have been carried out on mental health of infant, preschool and school children, adlescent, adult and elderly, i.e., chronological mental health studies from growth to decay and on environmental mental health in family, school, industry and community.

As examples of chronological mental health approaches, "Basic study on personality development, centered around the study of twin (3a)", "Psychopathological study on adlescent (3d)", "Personality development of the youth (4c)", "On the relationship between aging and social adjustment (6)" and so forth, can be

cited.

As to the environmental approaches, "researches on community mental health activities (1)", "Rehabilitation of mental disordered (2)", "Family dynamics of schizophrenics (4a)", "Social index in the field of mental health (8a)", "Life structure and conflict in the community (8e)" have been carried out. However, methodology of social psychiatry by both chronological and environmental approach must be further investigated.

The second, methodology of epidemiological psychiatry was applied to various field of community services, i.e., school consultation (1d), medicare of expatients (2), medical inspection of infant and immature baby (3b), exploitation of clinical diagnostic technique to define mentally retarded (5a) and maladjustment in the elderly in several catchment areas (7). To carry out epidemiological survey, it is extremely important to continue several years services in a particular population. It is from these researches that the author think of a hypothesis of "caseness" and "illness", which was contributed in this journal.

The third methodology of behavioral science was used on the psychophysiological study of EEG pattern in noctural and daytime sleep (6a) and the changes of heart beats by mental work (6b). In this field, many other important themes are still remained to be investigated.

(Masaaki Kato)

I. Research for the Community Mental Health Activities

I. Introduction

The Community Mental Health Research Group is a long-term project team with a dual purpose: (1) the exploration and analysis of mental health problems in community; and, (2) the demonstration of an experimental model of community service system, through sociological and social psychiatric research and clinical service action in community settings.

The research group has carried out the following sub-projects:

1) Sociological research on the changes of community structure, mobility, and life structure of residents under the influence of changing communities.
2) Research on the relationship between physical and mental health and life structure under different types of changing community environments.
3) Exploration of a service model for the mentally disordered and their families in the community and a social psychiatric survey concerned with the pattern of social adjustment of ex-patients and the system of medical service for ex-patients.
4) Mental health consultation program for school systems and helping service model for autistic children and their parents.
5) Experimental research on the establishment of community care systems for the mentally retarted.

Most of the above researches were carried out in Ichikawa-city of Chiba prefecture, in which National Institute of Mental health is located.

II. Contents and Processes of Sub-projects

1) Sociological research on the change of community structure, and the mobility and life structure of residents under the influence of changing community.

The community structure of Ichikawa-city is the target of this sociological survey. Particularly, we focused on Gyotoku-district of Ichikawa, because the district has increased in population extensively in recent years by the opening of a subway across Gyotoku to Tokyo metropolice, and had maintained a traditional community structure before many newcomers came to live.

The community is an important factor for mental health research because it produces mental illness and also provides resources for a care network to the mentally disordered. The purpose of this research is mainly to grasp the changing process of the community; how the traditional community structure maintained by the native residents has been destroyed by increasing newcomers who are mostly urbanized people, and what kind of new community structure will emerge.

The following research was carried out. The first study was a detail sociological survey about the neighborhood community structure of Baraki area in Gyotoku, which included historical data related to the development of this neighborhood since the Edo era. The second was a sociological research on the structure of whole neighborhood associations (chonai-kai, jichi-kai) in Ichikawa-city, a close relationship of neighbors which has become loose in urbanized districts. The third was a comparative study on the educational environment between districts of increased population and non-increased population. It was a cooperative research project with Ichikawa Educational Committee.

The findings showed that there are various differences among the districts in Ichikawa-city. Particularly, the life structure of residents, the educational environment and children's life structure, the problems of living, and the need and the attitude of residents for the city administration differ between high and low mobility districts in Ichikawa city.

2) Research on the relationship between physical and mental health and life structure under different types of changing community environments.

This research was carried out on four cities: Ichikawa city, Chiba, Fuji city, Shizuoka, Suzuka city, Mie, and Kakegawa city, Shizuoka; which differ from each other in their degree of urbanization. House wives living in these cities were interviewed using Environmental Change Survey Form, Life Structure Survey Form, Health Survey Form and Family Image Test (SCT). The relationship between physiological and mental health, and life structure was examined based on the data of four cities showing different environmental changes. Further, the data of Suzuka city showed different characteristics of mental health and life structure among the native and the newcomer housewives living in a district of increased population composed with native housewives living in a district of decreased population.

3) Exploration of a service model for the mentally disordered and their families in the community, and a social psychiatric survey concerned with the pattern of social adjustment of ex-patients and the system of medical service for ex-patients.

The reasons why we set up Gyotoku and south Gyotoku districts research and clinical study are the following. First, these districts are close to National Institute of Mental health and have about 30,000 residents. Second, the conditions of distance and size of population are convenient for research and service activities. Third, these districts still have independent sub-administrative control under the branch of administration agency because they have been separate and independent administrative districts before affiliation with Ichikawa city. Fourth, many aspects of community structures in these districts have changed by the opening of subway to Tokyo metropolice, so that mental health problem are expected to be increased by

such community changes.

The purposes of this research are to know how medical care and rehabilitation service are given to the mentally disordered in the community, how they are living in the community to clarify what problems there are related to the medical services and their community life, and further to develop a necessary service system including medical care, rehabilitation service, and life guidance for the patients living in the community. This service system was designed to become comprehensive and well-organized, with many community mental health resources rather than separated ones, and also expected to be succeeded by the public health center of Ichikawa city, because this service must be charged by the public health center under the law of mental health in Japan. The public health center started to prepare this service and needed to know a service model for the mentally disordered in the community. So we examined the possibility of mental health service activities in the public health center.

First of all, we set up a small mental health clinic in the Gyotoku branch of city administration and announced the service program to residents by a city bulletin and at the same time we explained the purpose of this clinic to key members of the community welfare committee and neighborhood associations. Many mentally disordered people and their families visited to the small clinic as did community leaders taking care of patients who came for consultation.

On the other hand, several studies were carried out in terms of the interests and attitudes of residents living in Gyotoku district toward the mentally disordered. Also an epidemiological survey was done on the movement and utility of medical services for patients living in the community, based on the information of National health insurance subscribers and the clients of Konodai National Hospital. Further, we gave

rehabilitative guidance service to ex-patients with the cooperation of several private mental hospitals, which were still taking care of these ex-patients, while we were doing the epidemiological survey. In this research we discovered that a temple of Barakisan located at Gyotoku district still gives a kind of folk therapy to the mentally disordered, so we analyzed the religious activity of mental therapy related to the mental life of the native people.

The public health center of Ichikawa city developed its own mental health service program which was able to provide home a visiting service and outpatient clinical service by assignment of mental health workers and a consultant psychiatrist. After the Gyotoku mental health clinic was closed and the content of this service was succeeded by the public health center, we started to give consultation services to public health nurses and do evaluative research of the public health center.

4) Mental health consultation program for school system and helping service model for autistic children and their parents.

The purpose of this research is: the development of a mental health consultation technique for the educational committee and school teachers in Ichikawa city; the development of a new community care system for autistic children, their parents, and the school teachers taking care of them in their class room; the development of non-professional man power for mental health service; and, the development of crisis intervention technique for emotionally disturbed people. We are giving regular consultation service to the staff of the educational guidance clinic in Ichikawa Educational Committee, and group consultation service to a group of teachers who have charge of a special class room for mentally retarded children. Further we give case consultation to the teacher who can not deal with emotionally disturbed child. On the other hand, we set up a community care system for the autistic children which provides play

therapy and behavior training to the autistic children, group consultation and individual guidance to their parents, visiting consultation service to teachers having charge of the children, and advice and professional information to the staff of the Educational Committee. We have tried to keep a good relationship with the Child Guidance Clinic, child psychiatric clinic and other mental health and welfare community resources. In this community care system we are using undergraduate and graduate students as voluntary non-professional manpower who mainly give play therapy and behavior training to the children.

A consultation program demonstrated that this methodology is very useful for the teachers to understand and cope with problem children in their class room, and that this program affected positively the attitudes of Educational Committee staff toward mentally handicaped children. The community care system for autistic children showed that this care system influenced positively the attitude of parents and teachers, which facilitated the development of the children. Furthermore, the educational environment for the children in school was maintained by a consultation service to the teacher in charge of the child, the schoolmaster, and the staff of Educational Committee, without severe segreation of the child. The "naive enthusiastic" attitude of volunteer students provides good stimulation to the children and their parents, and the experience of students participated in this program influenced the personality development of students themselves.

5) Experimental research on the establishment of community care systems for the mentally retarted.

The purpose of this research is to establish a community care network at the administrative level for the mentally retarted. We tried to develop a managing technique, the social club, for the mentally retarted which intends to give helping service for social adjustment for those living in Shibuya district

in Tokyo. In this research we examined the possibility and limitation of an autonomous social club administrated by the mentally retarted people, and the role and attitude of volunteers helping the mentally retarted in this social club. This social club became a stable organization as a community volunteer activity supported by Shibuya-ku funds.

On the other hand when Ichikawa city set up the Liaison and Guidance Committee for the physically and mentally handicapped, whose purpose is to improve communication among educational, welfare and medical systems under the liaison office of Child Guidance Clinic, some research staff participated into the Committee and had a chance to do research on the service system for the physically and mentally handicapped in Ichikawa city. We aid a survey on the welfare needs of families having handicapped members in Ichikawa city as one of tasks of this Committee.

When the Ministry of Education appointed Ichikawa city a promotive district of special education, Ichikawa city could develop an improved system for the physically and mentally handicapped children. At this time a new system of the Educational Guidance Committee for the physically and mentally handicapped children was started instead of a former system of the Judgement Committee for Special Education. The new system gave a more substantial service of providing education and career guidance for handicapped children after school age. One of our research staff is participating on the Committee and doing research on the improvement of treatment techniques and care systems. The research focus on planning consultation services to the preschool, day-care center for the handicapped children, the adult day care and training center, and welfare workshop in Ichikawa city. (Kazuo Yamamoto)

2. Study on Rehabilitation of Mentally Disored

- Practice of Day Care -

1. Thirteen years have elapsed since the Day Care Center started its operation at the National Institute of Mental Health (NIMH) in Japan. Only a few reports remain as to record of its history of operation and the latest of them is dated 1969. This report states "At the Day Care Center the basic objectives are considered to help exmental patients in (1) correction of behaviors which caused difficulties in their human relations, and (2) rehabilitation by giving them occupational training."

In spite of the statement made above, our feeling now is that such an assumption as objectives could be focused only in those two phases is just too formal and such over simplification of problems would just restrict the process of resolutions. It is true that there are many clients who experienced failure and difficulties in human relations. But could it be concluded that it was due to his/her individual or biological fault? Problems in human relations cannot be attributed to the individual or his/her biological causes alone as the problems are very sociological in its nature. Therefore, we came to the belief that the basic role of Day Care Center is not to correct the individual behaviors, but rather to present a social space where the client can practice his/her vast individual characteristics and capabilities which might have been distorted under special circumstances or backgrounds and reasons.

2. Previous reports reveal the role of the staff members as protector for the clients. Clients were called "patients" and expected to be weak (or inferior) with variety of mental problems, and therefore the staff members had to protect them in case any

unusual situation arose. Such attitude was based on the assumption that each staff had an ample knowledge over the total fate of the individual client, and if his instruction was to be followed faithfully, the client shouldn't face any more difficulties. Here we cannot see any insurance that the client is facing or grasping his/her reality surrounding them, or any improvement from there on. It seems as the duty of the staff members was considered to monopolize the total information, and within his own frame of reference, the selection was made to which portion of the information was to be passed on to the client for his benefit.

3. Program Organization: From its start in 1963 to late 1974, the Day Care Center program was planned by the staff members who selected the items which they considered suitable to help "clients" for rehabilitation/socialization. Clients were to participate in the preplanned program, and staff members worked hard at adjusting clients to the program, and great effort was paid as not to make any drop-outs. However, as of April 1972, all participants at the Center, the staff and clients alike, reached an agreement to have a meeting something similar to curriculum programing committee where everybody submits proposals. This movement was initiated by the staff, but once started everybody participated in it enthusiastically. Now the staff is there to cooperate in discussion and decision making. No longer the staff takes leadership of its operation. Roles in programming operation are shared equally among the staff and the members. Over thirty proposals were made at the meeting, and the variety of subjects were so rich that they made the previous program look dim and poor. Out of the proposed subjects, final selection of the items was made by votes for inclusion in the program. Further, if minimum three people voted for an item, it was considered valuable enough to be included in the program. In contrast to the previous program which was organized with the therapeutic

purpose in mind, this program was based on the wishes expressed by all the members. Only requirements imposed were that it had to be wanted by "us" and had to be carried out "together." The members experienced the processes which derived consensus on variety of subjects. And such experience in group participation itself brought about the results or changes in members meaningful from the standpoints of therapy and social adjustment.

4. As a conclusion of this report I would like to note the need of increased number of staff members at the center. The staff will have to participate in this operation openly and be free from fear of exposing themselves to any danger of making errors or criticism either by the staff or group members. They are expected to communicate to all participants without reservation. Such is the summary of objectives of the Day Care Center activity. We are unable to specify any other therapeutic objectives or theories defined as such at this time.

(Akira Kashiwagi)

3. Reserch on Child Mental Health

In the immediate post-war years, at the dawn of the history of child psychiatry and child mental health here in Japan, we feel proud of the fact that our Division of Child Mental Health played an important role for advancement in this field. Child psychiatrist, as seen elsewhere, did not exist here in Japan until the beginning of 1950. Until the end of the World War II, the understanding of psychiatric problems in childhood seemed very superficial, borrowing the ideas from adult psychiatry.

And psychiatrists showed interest only in the serious cases of childhood psychosis and psychoneurosis.

Since psychiatrists placed much emphasis on hereditary and constitutional factors in those days, professionals in child mental health also tended to be pessimistic and fatalistic, when dealing with psychiatric problems in childhood. Some researchers in child mental health considered the importance of the environmental factors. But they merely evaluated the pure physiological aspects, such as the size of the house, the number of the rooms, sun light, ventilation and the neighborhood, etc., without giving thoughts to the dynamic and the finer interaction between the child and his family, and social and cultural environments. Since Takagi introduced the idea of the Child Guidance Clinic from the U.S.A. in 1950's, the out-patient clinic of the Japanese National Institute of Mental Health became one of the first clinics to have a so-called "Clinic Team", consisting of a psychiatrist, a clinical psychologist and a social worker.

And the clinic also began enthusiastically to conduct individual and group psychotherapy, play therapy for problem children and counseling for parents. As a result, many young professionals gathered at this clinic and received training in this new field.

The main subjects of clinical studies in the last 25 years of our division were as follows:
childhood schizophrenia, infantile autism, various psychoneurosis, psychosomatic disorders, and nervous habits, including school phobia, tic, hystria and speech retardation and premature babies.

The influence of maternal deprivation interested some researchers shortly after the war when they found many abandoned babies and mixed blood infants in the street. In 1950's, Ikeda began to study 64 infants in the S baby home affiliated with a general hospital in Tokyo. The direct study on 64 infants showed the following results. Their mean I Q and D Q was very low. They revealed retardation in motor function and social maturity, especially in speech.

They also revealed chronic physical and psychological symptoms caused by prolonged institutionalization, such as poor sleep, pallidness, diarrhoea, various nervous habits (head banging, thumbsucking, etc.), blankness of facial expression, etc. After babies left this baby home, they scattered in three groups, namely (1) natural parent group, (2) institution group, and (3) adoption group. Ikeda interviewed them regularly and performed psychological testings and met staff members of each institution, biological parents, adoptive parents, foster parents and school teachers.

She has been able to continue to follow up 52 infants out of 64 during these 25 years.

The results of this longitudinal study have given much insight into the effects of maternal deprivation as well as cultural background of adoption here in Japan. A part of her results was presented at the 6th World Congress on Psychiatry held in Hawaii in 1977.

Besides these clinical studies, the basic investigation of personality development in normal children have always interested

and drawn the attention of researchers in the Division of Child Mental Health.

One of these studies has been a study on twins, especially a longitudinal study from babyhood to adulthood.

Compared to other twin studies in Japan, some special features of our twin study were: we dealt with not only twins with psychiatric problems but also normal twins, especially very younger children (babies and infants) and paid attention to social and cultural attitudes towards twins from anthropological and psychological points of view.

Through our studies, our team made it clear that Japanese culture had characteristic attitudes toward twins, namely, (1) dislike of twins, at times, prejudices and superstitions, (2) discrimination between the elder and the younger and a boy and a girl. The results of the study on cultural and parental attitudes toward twins was presented by Ikeda in 1970 at the Culture and Mental Health Conference held in Hawaii, U.S.A. and later published abroad in English.

Since 1967, twin babies in two cilties were all registered and summer camp program for twin children was held every year until they finished primary school. More than 180 pairs of twins were registered and observed. Among them the team observed various types of problems, six pairs of school phobia, 11 pairs of autistic twins, and other types of psychoneurosis.

Ikeda reported the effects of psychotherapy with two pairs of autistic twins at the International Congress of Psychotherapy held in Paris, France in 1976 and Nishikawa also presented a paper on neurotic twins brought up apart at the World Congress on Psychiatry, in Hawaii, U.S.A. in 1977.

The concondance and discordance of these psychiatric problems in identical and fraternal twins has shed new light on the classic, but meaningful discussion of "Nature and Nurture".

Meeting the demands of modern society, the area of community

mental health for children has become one of the newest and most important fields of study. In cooperation with Public Health Center, Child Welfare Agencies and medical facilities, our research team conducted health examination (both mental and physical) for premature babies, normal babies (three months, six months, nine months and 18 months) and examined the methods of health examination.

Working with social work agencies including child guidance clinics and family counseling centers, our team have taken up actual cases of child abuse for study, holding discussion to find ways of preventing and handling child abuse cases.

Future plans of studies of our division are as follows:

1) A basic study on personality development centered around a study of twins by Ikeda, Kohno and Nishikawa.
2) A follow up study on autistic twins by Ikeda, Kohno and Nishikawa.
3) Clinical and psychopathological studies including psychotherapy, art therapy, day care program and therapeutic camp by Ikeda, Imada, Kohno and Nishikawa.
4) An experimental and psychophysiological study in babyhood by Kohno.
5) A psychopathological study on adolescence by Nishikawa.
6) An exchange of informations, data, statistics, case studies on child mental health with researchers in Japan as well as abroad by Ikeda and Imada.

(Yoshiko Ikeda, M.D.)

A Study On Personality Development Of The Children

We have yearly followed-up 120 children of five groups for six years, since they were five years old, in order to clarify the relationship between social factors or family backgrounds and personality development.

The characteristics of five groups were as follows: F1 Group: The children who have been the subjects of our study were graduates from the kindergarten attached to a junior college in Matsudo-City that is the neighbouring city of Tokyo. Their fathers' occupations were: half of them were merchants and managers of minor enterprises and the rest of them were salaried men. About 85 % were nuclear families. 56 % of the fathers were college graduates and 71 % of the mothers were high school graduates. F2 Group: The children who have been the subjects of our study were graduates from the kindergarten, attached to the same junior college, at a large size danchi in Matsudo-City. Many of them were residents of the apartments built by the Public Cooperation. 85 % of the fathers were salaried men. 92.5 % of the families were nuclear families. 55 % of the fathers were college graduates and 81% of the mothers were high school graduates. The half of the couples were in the same companies and acquainted with each other. After the marriage the wives left the jobs. D Group: The children who have been the subjects of our study were graduates from a private nursery school at thickly settled area, down town, in Tokyo. Most of the residents lived relatively long. About 40% were three generations' families. Most of the fathers were doing petty enterprises in their homes with their wives. The most both parents were graduates from junior high schools. B Group: The children who have been the subjects of our study were

graduates from a municipal nursery school of Nagareyama-City, that is the neighbouring city of Matsudo-City. It has relatively slowly developed as a city compared with Matsudo-City that has fast developed. Most of them lived at street area of the city. Most of the parents were natives of this area. Most of the fathers were merchants or salaried men. The half of the mothers were working outside home. About 20 % of the mothers had piece work. C Group: The children who have been the subjects of our study were graduates from a municipal nursery school of Nagareyama-City. Most of them lived at residential district in the city. Most of the families moved from Tokyo areas. Both of the parents were relatively young among the groups. Most of them were graduates from high schools. Most of the fathers were merchants or managers of minor enterprises helped by their wives.

We have used multiple methods in order to achieve the purpose of the research; that is, projective tests such as CAT, SCT and individual interviews and questionnaires to the children and the mothers and group meetings with the fathers and home visiting.

We published papers related to this research, although it is presently still going on. Those were as follows: "A Study on Personality Development of the Children with Behavior Problems in the Five-Year Old Children's Groups." "A Study on the Children's Effects of Entrance to the Primary School — Related to the Family and Community Factors." "A Study on the Relationship between Parents and Children, I. II. — From the Follow-Up Study." "A Study on Personality Development of the Children — On Formation of Self-Concept in Childhood — On the Place of the Third Graders of the primary School." "A Study on Personality Development of the Children — On Formation of Self-Concept in Childhood — On Mothers' Value-Orientations."

(Michiko Yamazaki)

4. Psychopathological Studies on Individual and Group

Recent studies we have performed as follows:-

(1) *Family Studies of Mental Disorders*

a. Studies on the pathology of schizophrenic patient's families.

To analyze behaviors and attitudes of family members of schizophrenic patient toward the other member, especially toward the patient, we used a Rorschach technique specially designed for testing of family consensus (Family Consensus Rorschach Test) applicable to the set of family. At the same time, we recorded whole conversation of testees (family members) as well as delicate changes of their non-verbal expressions during the testing by the video tape recorder.

Having investigated more than thirty families of normals and schizophrenic patients, we found general characteristics in the family of schizophrenics. These are resumed as follows: "There is a strong sense of anxiety underneath the examinees; they are busy to defending themselves against breaking up, so there is no room for them to think of others. Having contact with other people intensifies this feeling of anxiety."

In respect to this field of research, the following papers were published.

Suzuki, K., (1971) History and Future of Family Consensus Rorschach Research. *Porschachiana Japonica*, Vol. XIII, 179-193

_____, (1972) A Study of Families of Schizophrenic Patients — A Study Utilizing the Family Consensus Rorschach. *Journal of Mental Health*, 20, 1-40

Takatomi, T., Suzuki, K., and Dendo, H.,(1971) A Study of Families of Schizophrenic Patients: II. Differences between the Characteristic Features found in the Patients of Male Patients and Those of Female Patients. *Journal of Mental Health*, 20, 41-76

_____, (1973) A Study of the Families of Schizophrenic Patients: III. Child Discipline in Our Country and "Family Dynamics of Schizophrenics". *Journal of Mental Health*, 21, 137-158

_____, (1974) A Study of the Families of Schizophrenic Patients: V. A Family Study of "Autistic Children". *Journal of Mental Health*, 22, 95-112

Dendo, H.,(1971) Family Consensus Rorschach Method Applied to A Schizophrenic Patient and Her Family: Struggle Between the Schizophrenic Daughter and her Mother concerning her Father. *Rorschachiana Japonica*, Vol. XIII.

Dendo, H., Suzuki, K. and Takatomi, T.,(1973) A Study of the Families of Schizophrenic Patients: IV. The Characteristics of the Patients Revealed in "Liked Card" and "Disliked Card" of the Rorschach Test. *Journal of Mental Health*, 21, 159-182

b. *Studies on Family Psychotherapy for Schizophrenia*

The purpose of these studies are (1) to explore the interpersonal dynamics of the schizophrenic families, and (2) to discover some useful and effective therapeutic techniques for families of schizophrenic patients.

The family therapy sessions were conducted by co-therapists on a once-a-week basis. We found the characteristics of the interpersonal dynamics of the family as follows:

1) A great many marital conflicts were suspected; however, they were being covered up, and expressed through a detour

attack on the patient.

2) The family is divided into two alliances: the father and the daughter; the mother and the patient.
3) The mother-patient relationship is so ambivalent that internal needs are expressed outwardly in active hostility.
4) The triangle is observed. In an actual conflict between the mother and the patient, whenever the father steps into the situation, the fight becomes worse.
5) When this conflict became severe, the father withdrows and takes an indifferent attitude.
6) In a conflict between the father and patient, the mother takes an indifferent attitude to both and withdraws from the situation.
7) It is very rare for both parents to attack the patient.
8) Generally, unpleasant feelings are usually followed by a fight. However, the family appears to discontinue the negative feelings until the next sessions, and acts though there were no conflict among them.

The following techniques were useful in handling the families.

1) Recalling Previous Session Technique: For the purpose of keeping the continuation from one session to the next session, the therapists guide the members to recall the events and the feelings involved in from the previous session. This technique usually carries the risk of provoking hostile feelings directed to each other and to the therapists.
2) Therapeutic Double Bind Technique: As strong hostility directed to the therapists becomes the main obstacle in the therapy, then the patient is forced to be in a paradoxical situation; that is the patient may be told that he may discontinue therapy, and that is also a therapy.
3) Take Over Technique: When the conflict among the family becomes worse, the therapists forbid them to speak. The two

therapists take over all the conversation, and they become the patient and his members of the family; then between the two, the problem is solved for the patient and his family in their presense. Therefore, the family learns a most harmonious and peaceful way of solving their problem.

In this respect the next two papers were published.

Suzuki, K. and Makihara, H.,(1978) An Experience of Family Psychotherapy for A Schizophrenic Patient. *Journal of Psychoanalysis*, 22: 4

Suzuki, K.,(1978) Family Psychotherapy. *Gendai Seishin Igaku Taikei, Vol. 5A: Psychiatric Treatments I*, 16, 346-387, Nakayama Shoten, Tokyo

(2) *Developmental and Psychopathological Studies on Adolescence*

We started a prospective research on normal and abnormal development of adolescents in 1970. We selected 70 adolescent students from 500 students of 1st grade of a junior high school in Ichikawa city, Chiba prefecture.

This cohort of 70 adolescents was composed of normals (35 cases) and abnormals (35 cases) in respect to personality deviations and other mental health conditions. At least once a year, we have checked all of these 70 cases by interviews and psychological testings; these includes T.A.T., S.C.T., Baum Test and Rorschach Test.

Several cases have been supported by psychotherapy in their developmental crisis.

The results of this research were reported as follows:

Murase, T. and Murase, K.,(1974) Personality Development of the Two Normative Adolescent Boys: A Longitudinal Case

Study in Five Consecutive Years. *Journal of Mental Health*, 22, 11-26

Murase, T. (1977) Saburo's Adolescence: A Longitudinal Case Study on Personality Development. *Journal of Mental Health*, 24, 109-134

(3) *Clinical Studies on Social Phobia*

We started with analyses of complaints of so-called social phobics. From the record of clinical interviews with social phobic patients and their autobiographical accounts, 445 items of principal complaints were derived. Then, we made a questionnaire test composed of these items with 7 points evaluating scale to obtain more salient characteristics of social phobic complaints.

The result of this test executed for 100 normals and 50 patients showed that out of these 445 items 277 items were highly significant (0.1 percent) and almost every items were closely connected with communication performances with not so intimate as well as not so distant people.

Next, we have examined clinical records of 179 patients with social phobics and been impressed that the central cluster of this phobias is similar in most cases, particularly in respect of their onset ages, of modes of the onset, of their attitudes toward feared objects, of reactions to psychotherapy, or of the prognosis of their disorder and forms a coherent clinical syndrome.

From analysis of their feared situations, we have got several interesting findings; we found, for example, that their feared situations consist of a certain modulation of the mode of interpersonal affinity. Based on these findings as well as on clinical observations, we begin to construct a conceptual model of social phobic syndrome.

In respect to these researches, the following papers were published.

Takahashi, T., Yamaguchi, S. and Ogawa, K., (1971) The Psychosociological Aspect of the Complaints of So-called Anthropophobics. *Journal of Mental Health*, 19. 45-70

Takahashi, T., (1975) A Social Club spontaneously formed by Ex-patients Who had suffered from Anthropophobia. *Internat. J. of Social Psychiatry*, 21, 2

_____, (1976) A Study on Social Phobias -- An Analysis of Communication. Igaku Shoin.

(Koji Suzuki)

5. Research on Mental Retardation

In studying the problem of mental retardation, attention must be paid to realize full potential of the mentally handicapped or to minimize those factors that may interfere with it. With this orientation in mind, we have laid emphasis on the comprehensive and multidisciplinary approaches including psychiatry, clinical chemistry, psychology and sociology.

Now we are focussing our investigations on "the research program aimed at diagnoses and methods for the care of the mentally handicapped", which consist of the following:

1. Development of diagnostic techniques and their clinical application
   a) the development of assessment technique which is more directed to "caseness" than "illness"
   b) the development of screening system for congenital hypothyroidism using enzyme-immunoassay for thyroid-stimulating hormone
   c) the development of detection systems for the variant type of galactosemia
   d) the development of screening technique for progressive muscular dystrophy
   e) the study of effect which noisy stimulations may give to the endocrine system

2. Premature senility and its evaluation in the mentally handicapped
   a) the study of premature senility expressed in immune-function and in neurophysiological function as measured by computerized EEG analysis
   b) the study of correlation between aging and endocrine functions as measured by radioimmunoassay of various humoral

substances

c) the study of correlation between aging and behavioral/socio-psychiatric characteristics of the mentally handicapped

3. Systematization of community welfare, medical and health care project for the mentally handicapped

a) the investigation into the actual condition of activities focussed on community care for the mentally handicapped

b) the adjustment of collaborating services by professionals helpful to home-nursing of the mentally handicapped

c) the investigation into the conditions of families with the mentally handicapped at home and the preparation of family guidance

4. Preparation of training programs for the staffs concerned with the mentally handicapped.

(Yoshiro Sakurai)

6. The Biological Researches in Mental Health

The biological researches in the National Institute of Mental Health of Japan inaugurated at the beginning of the Institute in the Division of Physiology and Morphology, where histological studies of human brains and experimental studies in electroencephalogram had been done.

Since 1960, in the renamed Division of Psychosomatic Research, the main research works are the problems of mind-body correlation in human behaviours and in mental disorders. Now three psychiatrists are researching stuffs including the director of the division.

The object for work of the Division is defined to deal the problems of physiological and pathophysiological phenomena in mind-body correlation. To carry this object our researches are based on psychiatric and psychophysiological procedures.

Psychophysiology offers, as M. Lader (1975) says, novel approaches to psychiatric problems in two ways. As first approach, it provides methods for the accurate assessment of concomitants of mental illness. For example, drug treatment can be monitored providing that the interactions between the drug and the measures are known. In this respect the psychophysiological measures are being used as extensions of clinical observations. The second one is for psychophysiological techniques to be applied in attempts to elucidate the pathological mechanisms of mental illness.

And as D.T. Graham (1971) stated, "psychosomatic medicine is clinical psychophysiology, and there is no question in psychophysiology that does not have an exactly analogous counterpart in psychosomatic medicine. Both disciplines can adopt an identical philosophy with respect to the mind-body relationship, namely assumption of psychophysical paralleism.

The most problems treated in the domain of mental health are

phenomena raised from mind-body-social environment relationship, e.g., neuroses, psychosomatic disorders, and social maladjustments.

The psychophysiological research is based on the above mentioned situation. It does not apply any surgical operations, so the subjects can act keeping natural manner same as ordinary life. From this point of view, psychophysiological procedure is considered appropriate as scientific manoeuvre (biological approach) to the human behaviours in the domain of mental health.

In this decade, researches made in our Division can be divided grossly into the following three groups:

1) Studies on the fluctuation of the physiological indices in normal mental activities. The electroencephalogram and/or the autonomic nervous variables were recorded, being analyzed under the conditions of performing mental task or during night sleep and awaking state in daytime.

— Studies on EEG patterns and rhythms during night sleep and waking state. (Y. Nakagawa).

— Variations of the heart beat rhythm during mental task. (H. Takahashi).

2) Studies on the physiologics under the conditions that the normal mental activities are affected. For instance, perturbated the CNS and the ANS were studied in subjects influenced by alcohol and/or drugs, in fatigue, and with maladjustment or with mental illness, such as, depressive state.

— The influence of alcohol and other drugs on the mental task performance. (H. Takahashi).

— A study on depressive state with abnormal EEG. (K. Takahashi).

— Sleep disturbance caused by tone pulse stimulation. (Y. Nakagawa).

3) Studies on the bio-electric data processing. These had been intensified and more developed since actual digital computer

system (PDP-11/40) was established in 1976, especially, in automatic analysis of clinical EEG with a digital computer.

— Frequency analysis of clinical EEG with a digital computer - comparative study with Fourier analysis. (K. Takahashi).

— Studies on EEG screening examination in the large population. (Y. Nakagawa).

— Recording and analyzing of heart beat and respiration in psychophysiology. (H. Takahashi).

(Hiroshi Takahashi)

7. Reseach on the Relationship between Aging and Social Adjustment

Research for Psychogeriatrics was begun at our Institute in the autumn of 1972 by a group of researchers who were interested in the problems of aged people.

Background Problems

Problems that motivated our research were as follows;

1. Improvement in the expectation of life and the increase in number of the aged people:
   The expectation of life at sixty years old was 17 for men and 21 for women as of 1975, so that the period of old age would last about twenty years. The number of survivals at sixty years old was estimated at eightyfour thousand per hundred thousand born for men and ninety thousand for women. So, the problem of ageing has become one of the most important subjects for a majority of people.
2. Increase in number of the aged people who have the problems of Psychogeriatrics:
   Accordingly, there is an increase in the number of aged people with disorders. There are two categories, namely, mental disorders caused by ageing, and mental disorders who have become old. People with former disorders are seen not only in the department of Psychiatry or Psychogeriatrics, but also in other clinical departments, while those with the latter disorders are causing a serious problem in psychiatric institutions.
3. Changes of living and social circumstances:
   Changes in the moral standards and the value orientations of the family and community, in parallel with similar changes in the supporting system for the aged parents in a family, have been such that for aged people today, it is impossible to live

as the aged did in the past. They must now find ways of corping with life by themselves.

4. Changes in the attitudes of aged people themselves:
   An increasing number of aged people dislike being called "old", refuse the image of the dependent, subordinate, declining old person, and wish to live the rest of their life positively and independently.

With these problems in mind, we discussed the meaning of life for elderly people. We saw the ultimate purpose of our research as contributing to the healthy, independent, and worthwhile lives of the aged.

Deployment of research

The aims of the research were as follows: first, to establish the methods of evaluation of physical ageing, mental ageing, and social adjustment of elderly people; second, to evaluate ageing with the established methods; and third, to examine the correlations among the different evaluation areas. The research started with a study of life history and social adjustment, and continued with an evaluation of ageing.

In 1973, research was carried out in Fuchu city in Tokyo prefecture. We interviewed the aged people at their homes. We asked them about their life histories, and evaluated their physical and mental functions and social adjustment.

In the same year, we conducted a similar study in Yoikuin, a public nursing home in Tokyo, in cooperation with the Tokyo Metropolitan Institute of Gerontology, and compared the results of the two studies.

In 1974, we received a special one-year research grant for "Research on mental health of the aged".

In 1975, we received a three-year special research grant for "Research on mental ageing and brain function". We carried out

our research at the following five places: two community clubs for senior citizens in Naha (in Okinawa prefecture) and Kanazawa; the Geriatric Out-Patient Clinic at Tokyo Medical School; the Community Welfare Center for Senior Citizens in Urayasu; and Shikokai, a club for people retired from a major soy sauce company.

As the latter two places were close to our institute, we carried out the research by ourselves. Urayasu, a fishing village in the Tokyo Bay area that has drastically changed with industrialization of the area, we visit once a week and conduct health consultations.

The battery of evaluations is as follows;

I. Physical ageing
  1. Medical examinations:
     EEG, ECG, X-p of breast, anaemia, total cholesterol, B-lypoprotein, kidney function, liver function, blood pressure
  2. Amako's evaluation of ageing in outward appearance:
     loss of the hair of the head, white or gray hair, loss of teeth, wrinkles in a face, elasticity of skin, eyesight, hearing, lines of the nails, and bending of the spinal column
II. Mental ageing
  1. Hasegawa's dementia test
  2. Benton's Visual Retention Test
III. Life history
IV. Social adjustment
  1. Present living condition
  2. Role inventory
  3. Neugarten's Life Satisfaction Inventory
  4. TAT
  5. Sentence Completion Test
V. Personality
VI. Interviewer's check

VII. Family interview

We reported partial results of the research at the 10th International Congress of Gerontology in Israel in 1975, and have reported at the Japanese Association of Gerontology every year.

In 1977, we carried out a crosscultural study with Japanese ancestry immigrants in Los Angeles in the United States. We applied the same battery we used in Japan. The result of this study, in comparison with that in Japan, will be presented at the 11th International Congress of Gerontology in Tokyo in 1978.

Further interests

Important additional interests of research are as follows:

1. The evaluation of physical ageing by measurement of hormones;
2. Community program for elderly people with mental disorders (e.g., daycare centers may be one of the most useful facilities);
3. Crosscultural research for ageing;
4. Epidemiology and statistics of ageing.

(Kazuko Saito)

8. Social Scientific Research on Mental Health Present Situation and Perspective

Sociological research at the National Institute of Mental Health (NIMH) started in 1952 at the time NIMH was founded. Its contribution has been significant in obtaining information from the social environment in order to help formulate techniques and methods to solve problems in the area of mental health. And necessity of interdisciplinary studies has become very important in last 20 years.

This report is to summarize the present situation and perspective of sociological studies.

The research team I is known as the study group specialized in the relationship of mental health and its social connotation. Our theme since 1977 has been "Social Administration over Problems on Mental Health," where we have to define the meaning of mental health within the context of social welfare, using analytical tools and theoretical concepts of sociology. As historically mental health has been the concern of medical field, psychiatric treatment and general problems associated with mental disorder have been depicted for our research objectives shown below.

(1) Search for Social Indicator/Method of Diagnosis: It is not easy to determine how far the collected data should be utilized as to form a measurement and it is neither a simple process to line up collected material as standardized system for diagnosis. Presently, effort is being made to obtain information to analyze components of the systems and the subsystems of mental health. Thus we try to translate the data into measurable terms.

(2) Study of Professional Staff and Organizations Affiliated with Health and Medicine: Attempts are being made to categorize organizational dynamics of mental health institutions such as mental hospitals, public health centers, mental health centers, etc. to figure out better processing of the care system.

Presently, we try to formulate and test hypotheses about forces and processes present in the organizations.

(3) Study on Families of the Mentally Disordered and Family Associations: Such problems of families as related to mental disorder are being studied from the view points of social system. The results such as needs defined are publicized to be reflected in social policy making and legislations.

(4) Study on Roles/Functions of Volunteers: In the field of mental health volunteers play not only supplemental roles to professional staff but also have positive function to form a social environment for the mentally disordered. Services of volunteers are to be studied as to how they have developed in this country.

(5) Study of Community - Its Organization and Conflict within: This is where the mentally disordered is produced, and where he/she has to readjust to. Relations between social dynamics and community organization, behavior patterns on how conflicts are solved, etc. are studied.

In this short period of time (less than a year) we have not yield presentable finished products. But each of us presented a report on individual interest at Community Psychology Symposium in 1977.

Sociologists will participate as staff members in the 3-year interdisciplinary projects beginning in 1978. The project will be entitled "Basic Research on Demands and Supplies in the Area of Community Mental Health."

Sociological contribution to the field of mental health is being developed. As needs for medical treatment, individual treatment techniques, and their utilization into social system increase, it is expected that sociology will have to cover social causes of mental disorder and statistics of epidemiology, and further contribute to social administration.

Problems of Caseness and Illness in Multiaxial Diagnoses in 9th ICD and DSM-III

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ABSTRACT

Health is viewed as a problem of medically defined illness versus socio-culturally defined caseness. Definition of health by WHO is interpreted in terms of the dimensions of illness and caseness, and the 9th revision of the ICD and DSM-III of American Psychiatric Association are discussed with respect to nosologic issues that arise when these dimensions are confused.

WHO's Definition of Health and nosologic analysis of the 9th ICD

The well-known charter of WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The definition is anything but clear, and one is tempted to disregard it, but its ambiguity is too consequential to ignore. How does "the absence of disease or infirmity" relates to "well-being"? The wording "not merely" may include "the absence of disease or infirmity" within the province of "physical, mental and social well-being", or it may imply that these two categories are separated dimensions of Health.

The nosologic analysis of the 9th ICD does not clarify the WHO definition of health. The "main code of ICD" includes a "section of Mental Disorders"[1], while the Supplementary "V code" classification[2] provides for "Personal history of mental disorder" (V11), "Mental and behavioral problems" (V40), "Housing, household and economic circumstances" (V60), "Other family circumstances" (V61), "Other psychosocial circumstances" (V62)[3] and "Observation and evaluation for suspected conditions, mental" (V71)[4]. The "V code" is clearly intended to cover the classification of any service that cannot be nominally reduced to an established "disease" or "disease unit".

Indeed, it seems that the "main code" of ICD is concerned with nominal "disease" or "disorders", while the "V code" supplement takes care of "diagnoses" and "problems" that evade classification

as "diseases" and "disorders". Health services rendered for reasons related to personal or familial "histories" of any disease or disorder will be tallied the "V code", while services rendered in treatment of manifest symptoms of established diseases or disorders will be tallied according to the "main code" of ICD. The "V code" is also called upon to classify nonclassifiable and negative diagnosis resulting from observation, investigation, examination and screening made for a variety of reasons including "suspected conditions". For example, health services rendered for possible "mental disorders" will be classified under the "V code", should syndromes of a classifiable disorder not be observed.

The distinction between the "main code" and the "V code" of ICD would thus far seems to be one of "medical" versus "premedical", "postmedical" and "nonmedical". But, is everything in the "main code" really "medical"? Referring to the WHO definition of health, one is tempted to define the "V code" as "the absence of disease or infirmity", but the "V code" is apparently concerned with any health service that cannot be directly related to a "disease unit" of the "main code" of ICD. But what about the "physical, mental and social well-being"?

For example, the "main code" of ICD includes "disease unit" as "Sexual deviation and disorder" (302)[5], "Nondependent abuse of drugs" (305)[6], "Adjustment reaction" (309)[7], and "Disturbance of conduct" (312)[8]. The glossaries include qualifying phrases like;" the limits and features of normal sexual inclination and behaviour have not been stated absolutely in different societies and cultures" (302), "cases where a person has come under medical care because of the maladaptive effect of a drug he has taken on his own initiative to the detriment of his health or social functioning" and "when drug abuse is secondary to a psychiatric disorder, code the disorder" (305). Other qualifying statements also relate to socially induced conditions".

The "Mental disorders" section of the "main code" nominally marked by Roman numeral "V" overlaps with related "Mental health" categories of the "V" code in ways that raise many nosological issues related to crosscultural definitions of health. The glossaries of the "main code" clearly imply that a number of established "disease units" are subject to considerable cultural variation. It would seem that indeed health is "not merely the absence of a disease or infirmity" but rather "absence of cultural values or medical traditions that would recognize and label a given behaviour a disorder or problem".

The "V code" therefore becomes a place where one community might classify a behaviour that another community would label a disorder in terms of the "main code" of ICD. A delusional schizophrenic that becomes a ward case in one community might qualify as a religious leader in another. "Drug abuse" is usually a problem of forensic psychiatry. Even when the manner of use of a certain drug is such as to constitute medical dependency is regarded as a "disorder" or a "problem", depend on whether such behaviour is culturally accepted by members of the community in which it is encountered.

Similar nomenclature issues in other areas of ICD codes have led me to approach clinical diagnosis along two dimensions, which I would like to call illness and caseness. By illness I mean any condition definable in medical terms, whether or not the conditions arises genetically or spontaneously or in close association with social or other environmental inducements, while caseness refers to cultural and social evaluation of a condition. Diagnosis along the dimension of illness ideally involve nominally universal, objective, absolute evaluation criteria, while diagnoses along the dimension of caseness will ideally involve nominally subjective, cultural, sociopsychological and other none absolute value judgements.

Generally speaking, medical illness is closely connected with

cultural caseness in the sense that the recognition and labelling of supposedly "objective" biological conditions depend largely on "subjective" sociopsychological conditions. The occurrence of not a few biological conditions is closely associated with sociopsychological factors that are not easily measured in terms of medical parameters. The phylosopher may wish to avoid such "chicken and egg" conundrums by viewing "absolutist" as either side of a Möbius strip, thus making objective illness and subjective caseness coterminus at different places on the Möbius strip for different cultures at different times. But for practical nosological purposes, we can gain considerable insight into crosscultural labelling issues by considering the dimensions of illness and caseness as being more-or-less independent.

The ICD would be much more useful as a basis for compiling health statistics, were it to require double coding along the dimensions of illness and caseness as the author defined these terms. The present coding system allows absolute medical evaluation criteria to govern relativistic cultural evaluation criteria. The same "disease unit" which approximately allow the clinician freedom in judgement but confuse the meaning of health statistics. A double-coding system in terms of biomedical illness and psychocultural caseness would continue to allow the clinician to ascertain whether a condition is problematic in terms of the values of the community in which the evaluation is made, while generating nosologic data that more meaning for studies of ethnopsychiatry and others involved in crosscultural studies of mental health.

Multiaxial coding in DSM-III[9]

The American Psychiatric Association published a Draft of DSM-III by the Task Force on Nomenclature and Statistics in July 1977. In this Draft of DSM-III, five-axial classification was recommended as follows;

Axis I: Clinical Psychiatric Syndrome and Other Conditions.

Axis II: Personality Disorders (adults) and Specific Developmental Disorders (children and adlescent).

Axis III: Non-mental Medical Disorders.

Axis IV: Severity of Psychosocial Stress.

Axis V: Highest Level of Adjustive Functioning Past Year.

Generally speaking, DSM-III seems to be reluctant to diagnose "illness" from an etiological standpoint, and diagnose them from a symptomatological standpoint (Axis I) and/or from personality dimension, although in the special instruction of Axis III it was described that "in some instances the condition may be etiologic (E.G., a neurologic disorder associated with Dementia), and other instances the medical disorder may not be etiologic but is important in the overall management of the individual (e.g., Diabetes in a child with a Conduct Disorder)".

Although the Axis I, II and III in DSM-III are closely connected with diagnostic criteria of "illness", Axis IV and V are different from that of "caseness", i.e., Axis IV is an evaluation by the severity of stressors in the patients' environment and the Axis V reflects the level of adjustive functioning of the patients themselves. What the author means by "caseness" is not the severity of stressors nor the level of adjustive functioning, but those factors which are related to the cause of why, when and by whom a person was identified and treated as a "case".

Discussion

Psychiatrists are always diagnosing and treating patients on the basis of these two dimensions of illness and caseness that the author has been describing. For psychiatrists as well as for medics in other specialities, it is often perplexing when something diagnosed in terms of illness is directly translated in terms of caseness. For example, an illness diagnosis of schizophrenia or neurosis, in many committees, immediately becomes socially problematic. The clinician intuitively work along these two

dimensions of diagnosis, in which a medicopsychiatric judgement is blended with a sociopsychiatric evaluation. But in doing this, the author fear that we tend to push everything towards the medical without sufficient consideration of the social. That is, we tend to suppress caseness by endeavoring to label a case not a case. The opposite may also be found to occur, that is, the tendency to push everything towards the social without adequate treatment of the medical. In this case, as in antipsychiatry, we tend to suppress illness by endeavoring to label a disease not a disease.

The problems the author has tried to illustrate with the simplest examples seem to arise because of a demands on clinicians to force two-dimensional judgement guided by sociolegalistic values from those based on biomedically demonstrable symptoms. Towards this end the author expects we might begin with a new definition of health that clearly distinguishes "material, physical, mental and social well-being" as the basis for all caseness, in contrast with the "absence of biomedical symptoms" as the basis of illness. This would allow one to be ill without being a case, or a case without being ill, or both. Such a two-dimensional approach to health would certainly relieve the clinician from forcing illness into caseness, or caseness into illness, simply because the siciolegalistic values of the clinician's community happen to prefer to the other.

It has been the author's purpose here to suggest two-dimensions of evaluation and coding that might help us better clarify the kinds of culturally relativistic issues we encounter as our experiences of medicine and behaviour in many cultures and subcultures of the world deepen.

References

1) World Health Organization; International Classification of Disease, Vol. I, p. 13, 1977.
2) Ibid: p. 635.
3) Ibid: p. 639, 647, 655.
4) Ibid: p. 660.
5) Ibid: p. 196.
6) Ibid: p. 199.
7) Ibid: p. 203.
8) Ibid: p. 208.
9) American Psychiatric Association; DSM-III Draft, 1977.

Table I. Mental Disorders by 9th ICD
(V. Mental Disorders)

Organic psychotic conditions (290-294)
290 Senile and presenile organic psychotic conditions
291 Alcoholic psychoses
292 Drug psychoses
293 Transient organic psychotic conditions
294 Other organic psychotic conditions (chronic)

Other psychoses (295-299)
295 Schizophrenic psychoses
296 Affective psychoses
297 Paranoid states
298 Other nonorganic psychoses
299 Psychoses with origin specific to childhood

Neurotic disorders, personality disorders and other nonpsychotic mental disorders (300-316)
300 Neurotic disorders
301 Personality disorders
302 Sexual deviations and disorders

303 Alcohol dependence syndrome
304 Drug dependence
305 Nondependent abuse of drugs
306 Physiological malfunction arising from mental factors
307 Special symptoms or syndromes not elsewhere classified
308 Acute reaction to stress
309 Adjustment reaction
310 Specific nonpsychotic mental disorders following organic brain damage
311 Depressive disorder, not elsewhere classified
312 Disturbance of conduct not elsewhere classified
313 Disturbance of emotions specific to childhood and adolescence
314 Hyperkinetic syndrome of childhood
315 Specific delays in development
316 Psychic factors associated with diseases classified elsewhere

Mental retardation (317-319)
317 Mild mental retardation
318 Other specified mental retardation
319 Unspecified mental retardation

Table II. Supplementary Classification of Factors Influencing Health Status and Contact with Health Services

This classification is provided to deal with occasions when circumstances other than a disease or injury classifiable to categories 000-999, the main part of ICD, or to the E code, are recorded as "diagnoses" or "problems". This can arise in two main ways:

a) When a person who is not currently sick encounters the health services for some specific purpose, such as to act as a donor of an organ or tissue, to receive prophylactic vaccination or to

discuss a problem which is in itself not a disease or injury. This will be a fairly rare occurrence amongst hospital inpatients but will be relatively more common amongst hospital outpatients and patients of family practitioners, health clinics, etc. In these circumstances, it is permissible for the V code to be used in providing single cause tabulations.

b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Such factors may be elicited during population surveys, when the person may or may not be currently sick, or be recorded as an additional factor to be borne in mind when the person is receiving care for some illness or injury. In the latter circumstances the V code should be used only as a supplementary code and should not be the one selected for use in primary, single cause tabulations. Examples of these circumstances are a personal history of certain diseases, or a person with an artificial heart valve in situ.

Table III.

V 40	Mental and behavioural problems
V 40.0	Problems with learning
V 40.1	Problems with communication (including speech)
V 40.2	Other mental problems
V 40.3	Other behavioural problems
V 40.9	Unspecified mental or behavioural problems

Table IV. Persons Encountering Health Services in Other Circumstances (V60-V68)

V60 Housing, household and economic circumstances

V60.0 Lack of housing

Hobos Transients

Social migrants Vagabonds

Tramps

V60.1 Inadequate housing

Lack of heating Technical defects in home preventing

Restriction of space adequate care

V60.2 Inadequate material resources

Economic problem Poverty NOS

V60.3 Person living alone

V60.4 No other household member able to render care

Person requiring care (has)(is):

family member too handicapped, ill or otherwise unsuited to render care

partner temporarily away from home

temporarily away from usual place of above

Excludes: holiday relief care (V60.5)

V60.5 Holiday relief care

Provision of health care facilities to a person normally cared for at home, to enable relatives to take a vacation

V60.6 Person living in residential institution

Boarding school resident

V60.8 Other

V60.9 Unspecified

V61 Other family circumstances

Includes: when these circumstances or fear of them, affecting the person directly involved or others, are mentioned as the reason, justified or not, for seeking or receiving medical advice or care

V61.0 Family disruption

Divorce Estrangement

V61.1 Marital problems

Marital conflict

Excludes: problems related to:
psychosexual disorders (302.-)
sexual function (V41.7)

V61.2 Parent-child problems

Child:
abuse
battering
neglect

Concern about behaviour of child
Parent-child conflict
Problem concerning adopted or foster child

Excludes: effect of maltreatment on the child (995.5)

V61.3 Problems with aged parents or in-laws

V61.4 Health problems within family

Alcoholism in family

Care of / Presence of } sick or handicapped person in family or household

V61.5 Multiparity

V61.6 Illegitimacy or illegitimate pregnancy

V61.7 Other unwanted pregnancy

V61.8 Other

V61.9 Unspecified

V62 Other psychosocial circumstances

Includes: when these circumstances or fear of them, affecting the person directly involved or others, are mentioned as the reason, justified or not, for seeking or receiving medical advice or care

Excludes: previous psychological trauma (V15.4)

V62.0 Unemployment

Excludes: when main problem is inadequate material resources (V60.2)

V62.1 Adverse effects of work environment

V62.2 Other occupational circumstances or maladjustment

Career choice problem Dissatisfaction with employment

V62.3 Educational circumstances

Dissatisfaction with school environment Educational handicap

V62.4 Social maladjustment

Cultural depreviation Social:

Political, religious or sex discrimination isolation

persecution

V62.5 Legal circumstances

Imprisonment Prosecution

Litigation

V62.6 Refusal of treatment for reasons of religion or conscience

V62.8 Other psychological or physical strain, not elsewhere classified

V62.9 Unspecified

V71.0 Mental

Dyssocial behaviour
Gang activity } without psychiatric behaviour

Table V.

302 Sexual deviations and disorders

Abnormal sexual inclinations or behaviour which are part of a referral problem. The limits and features of normal sexual inclination and behaviour have not been stated absolutely in different societies and cultures but are broadly such as serve approved social and biological purposes. The sexual activity of affected persons is directed primarily either towards people not of the opposite sex, or towards sexual acts not associated with coitus normally, or towards coitus performed under abnormal circumstances. If the anomalous behaviour becomes manifest only during psychosis or other mental illness the condition should be classified under the major illness. It is common for more than

one anomaly to occur together in the same individual; in that case the predominant deviation is classified. It is preferable not to include in this category individuals who perform deviant sexual acts when normal sexual outlets are not available to them.

305 Nondependent abuse of drugs

Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent (as defined in 304.) and that he has taken on his own initiative to the detriment of his health or social functioning. When drug abuse is secondary to a psychiatric disorder, code the disorder.

Excludes: alcohol dependence syndrome (303)
drug dependence (304)
drug withdrawal syndrome (292.0)
poisoning by drugs or medicaments (960-979)

309 Adjustment reaction

Mild or transient disorders lasting longer than acute stress reactions (308.-) which occur in individuals of any age without any apparent pre-existing mental disorder. Such disorders are often relatively circumscribed or situation-specific, are generally reversible, and usually last only a few months. They are usually closely related in time and content to stresses such as bereavement, migration or separation experiences. Reactions to major stress that last longer than a few days are also included here. In children such disorders are associated with no significant distortion of development.

Excludes: acute reaction to major stress (308.-)
neurotic disorders (300.-)

312 Disturbance of conduct not elsewhere classified

Disorders mainly involving aggressive and destructive behaviour and disorders involving delinquency. It should be used for abnormal behaviour, in individuals of any age, which gives rise to social disapproval but which is not part of any other psychiatric condition. Minor emotional disturbances may also be present. To be included, the behaviour - as judged by its frequency, severity and type of associations with other symptoms - must be abnormal in its context. Disturbances of conduct are distinguished from an adjustment reaction by a longer duration and by a lack of close relationship in time and content to some stress. They differ from a personality disorder by the absence of deeply ingrained maladaptive patterns of behaviour present from adolescence or earlier.

Excludes: adjustment reaction with disturbance of conduct (309.3)

drug dependence (304.-)

dyssocial behaviour without manifest psychiatric disorder (V71.0)

personality disorder with predominantly sociopathic or associal manifestations (301.7)

sexual deviations (302.-)

ON the Essential Difference Between Diagnostic Understanding and Therapeutic Understahding

-- starting point of TAT "Kakawari" Analysis

Kazuo Yamamoto

The most important service activities in the field of clinical psychology are psychodiagnosis and psychotherapy. I have been doing these two activities as a clinician. However, these two activities involve contradictory feelings toward the client. The basic attitude included in psychodiagnostic activity is different from the one included in psychotherapeutic activity. The process of diagnostic understanding is different from the process of therapeutic understanding. If we take two different attitudes or two different approaches toward a client, what kinds of attitudes or approaches are we taking? What is the difference? And then if this difference is present, how should we overcome the difference to have a more consistent approach to a client during the processes of psychodiagnosis and psychotherapy?

This paper will discuss the basic question and, after that I would like to try to present a more consistent approach for combining psychodiagnosis and psychotherapy. This is a starting point in the development of a new diagnostic method, TAT "Kakawari" analysis.

I. Basic Premise

Clinicians take the place of a perceiver or observer when participating in the actual clinical situation; and as observers they must give their attention to the total phenomena related to the client. It is the essence of clinical activities to give direct attention to all that the client says or does. In this context clinicians take the phenomenological approach as a starting point.

II. Phenomenological Approach

First of all it is necessary to clarify the meaning of the phenomenological approach as it is used in this paper. The phenomenological approach means an approach or method having the following conditions:

1. It is the primary condition of the phenomenological approach that the clinician should grasp the nature of the person given to him through the medium of his own experiencing of the person. The experiencing process in which the clinician registers the events concerning his client (client's body characteristics, behaviorial characteristics, face or body expression, the individual experience reported from the client, etc.) is the primary condition.

2. The second condition is the process in which a clinician should listen to the client's experiences as though they were his own experiences, and to the referents of these experiences. He can grasp the nature of the given person through this process.

3. The third condition is that traditional theoretical frameworks of interpretation, subjective values and judgment should not be brought into these above-mentioned processes; insofar as possible the clinician should directly feel and experience the experiences communicated from this client's inner world without preconception and should grasp the experienced things as it is in the client's phenomenal world.

4. When a clinician grasps and describes the experienced things in his client's phenomenal world, he should seek to ask himself "What is it?" and should not ask himself "Why?" or "How?". The necessary condition is to grasp and describe the experienced things as it is (Zu den Sachen selbst). That is, the clinician should strive for a direct intuition, rather than having an analytic attitude.

The phenomenological approach undertaken on the above-mentioned conditions has an important influence on the processes through which the clinician comes to understand his client phenomenologically. At the same time the approach requires the clinician to have an understanding uninfluenced by any distortions and preconceptions. In consequence of the application of this phenomenological approach what a clinician grasps is the nature of the

client's existence through his own experiencing processes. What he should grasp and seek is the appearance of the nature of the object as it is, not things which he infers or deduces in rational interpretation.

This phenomenological approach is common to philosophical phenomenology as a method of approach toward phenomena. Edmund Husserl used in his earlier works the term "phenomenology", in the context of a "descriptive" approach to conscious phenomena. The phenomenological approach in psychology has been borrowed historically from philosophy. The method remains the same -- i.e., description of phenomena as they appear to the perceiver -- but the purpose of the phenomenological approach differs. In philosophy, phenomenology is a system for understanding all existence; in psychology, phenomenology is a system for understanding human beings. (MacLeod, R.B., 1947)

One more point that should be clarified is that the meaning of the term "phenomenological" is not derived exclusively from the subjective and individual experiences of the client's inner world. The phenomenological approach also includes the objective materials; overt behavioral characteristics, expressions of face and body, brain waves, the results of psychological testings, etc., as well as the subjective materials of the individual experiences of the client. The basic use of the term "phenomenological" designates an approach to the client through the medium of the experiencing process of the clinician. Therefore this phenomenological approach makes it possible to grasp the nature of the client so as to transcend objectivity and subjectivity. (Bohenski, J.M., 1957)

III. The Difference between the Diagnostic and the Therapeutic Understanding of Human Beings

There are two persons, the perceiver (diagnostician, therapist) and the perceivee (subject, client, or patient) in the

situation where a person is trying to understand another one. Each of these persons has his own independent and unique inner world which the persons outside of himself cannot experience. No matter how much difference there is between the diagnostic and the therapeutic understanding, when the perceiver starts to understand about the perceivee, I would argue that the perceiver applied the phenomenological approach for understanding the perceivee.

Given the above-mentioned premise, we will try to examine the essential difference between the processes of diagnostic and therapeutic understanding. Aspects of this difference are: 1) the viewpoint the perceiver takes, 2) perceiving the client as a separate entity, 3) the process of understanding about the phenomenal appearance, 4) the clinical picture as the consequence of the application, 5) perceiver, perceivee and their relationship as a consequence of the application of both types of understanding.

1. The viewpoint the perceiver takes.

The first aspect of the difference between diagnostic and therapeutic understanding is the viewpoint that the perceiver takes -- i.e., from the side of the perceiver's inner world or from the client's.

In the process of diagnostic understanding the perceiver takes his viewpoint on the side of the perceiver's own inner world and applies the phenomenological approach to see the client as an object. In the process of therapeutic understanding, on the contrary, the perceiver makes his viewpoint the perceivee's inner world and applies the phenomenological approach to perceive the world vicariously, through the perceptual apparatus of the client. This latter (therapeutic) understanding involves a mutual endeavor in which the client describes his world so fully that the therapist can begin to participate vicariously in his client's reactions -- i.e., to begin to "know" the client.

2. Perceiving the client as a separate entity.

In "therapeutic" understanding, one's goal is to minimize the difference between the phenomenal worlds of the therapist and the client; the therapist and client talk with each other so that the therapist may be as one with the client; the client's experiences become the therapist's. At a cognitive level there is empathy between client and therapist; and at an affective level there is identification.

In "diagnostic" understanding there is no such effort to fuse the phenomenal worlds of the client and the clinician. The aim of the clinician when functioning as a diagnostician is to "understand" the client evaluatively and judgmentally as a totally separate person. In this case, the client is the object of scientific scrutiny -- not with a goal of obtaining an empathic understanding of the client's world as he experiences it -- but with a goal of rationally categorizing and classifying what he observes in the client. An example of this is the psychiatric diagnosis of Karl Jaspers (1956). In his diagnostic pattern, he treats two kinds of phenomenal appearance as if they were on the same dimensions; the one is the phenomenal appearance (subjective fact) which we can construct in our mind with empathy by experiencing the other person's consciousness, and the other is the one (objective fact) which we can grasp through our perception about the other person's recordable behavior or action, measurable effect of work, ability, memory, etc.

In the process of therapeutic understanding, the phenomenal appearance is treated independently and differentiated from the one appearing just to the perceiver and not to the perceivee. The former is not treated the same as the latter or on the same dimension. The phenomenal appearance of the latter is not necessarily neglected by the perceiver (therapist) but will be useful to promote therapeutic understanding as cues or side information. However it is not the object of therapeutic understanding. It is

by the fact that the perceiver confines his concern to the phenomenal world of the client that this phenomenal appearance as object can keep its independence and uniqueness, and can be understood as "only for this person".

3. The process of understanding about phenomenal appearance.

An essential difference between diagnostic and therapeutic understanding is shown in the process of understanding about phenomenal appearance.

In the process of diagnostic understanding, the perceiver performs from the phenomenological approach alone. The perceiver tries to grasp things from the phenomenal appearance and formalize or categorize it. This process is done only on the side of the perceiver and separated from the perceivee. The final goal of the perceiver is to elicit the nature clearly and limit it, and also to formalize or categorize the nature with the form. This form should be acceptable and shared by everyone. The validity in application of diagnostic understanding is established on the bases of the standard frame-work which everyone can accept or permit. (Generally this "everyone" means professional group members, such as a group of Rorschach testers, a school of psychiatry, etc.) When the result of this checking up is adjustable to the standard frame-work, the process of diagnostic understanding which the perceiver (as diagnostician) takes will be accepted as an objective one. This checking up process is called Objective Validation.

The process of therapeutic understanding is one in which the perceiver participates cooperatively to comprehend the client's phenomenal world. We can say that the process of therapeutic understanding takes the Interpersonal Phenomenological approach. And also, the perceiver taking a therapeutic approach to understanding does not aim to grasp a limited manifestation of the perceivee's phenomenal appearance nor to formalize the nature

of it. But the perceiver strives to clarify the nature of the perceivee's phenomenological appearance and at the same time he strives with the perceivee's cooperation to seek another new nature beyond the nature he has just clarified. In this process there is an endless, continuous seeking process with the cooperation of the perceiver and the perceivee. The validity of the process of therapeutic understanding is established on the basis of continuously comparing the manner of the perceiver himself to the one of the perceivee by asking if the perceiver is grasping the nature on the same dimension of the perceivee or not. This checking process is called Consensual Validation. (Rogers, C.R., 1963)

4. Clinical picture as the consequence of application.

Each process of understanding makes a different clinical picture, even though based the same observable events.

The clinical picture as the result of application of diagnostic understanding is made of the formalized content aspects of the phenomenal appearance. That is, it is the consequence of Content Orientation (Gendlin, E.T., 1962). The clinical picture has finally a confined and closed human picture as "no more than".

On the contrary, the clinical picture as the result of application of therapeutic understanding is made of continuous reflection concerning how we could clarify the nature of the phenomenal appearance or how we could confront our experiencing. That is, it is the consequence of Process Orientation (Gendlin, E.T., 1962). The clinical picture has an opened and possible human picture as "to be but does not assert to be", which contains not only limitation but also something unlimited.

5. Perceiver, perceivee, and their relationship as the consequence of application of both understandings.

1) The consequence of the application of diagnostic understanding.

In the process of diagnostic understanding the perceivee is viewed by the perceiver in the perceiver's own terms -- terms which would have little meaning to the perceivee. The perceiver uses this perceptual object as materials out of which he establishes a clinical picture concerning the perceivee. Also, the perceiver grasps the clinical picture alone in his own inner world. Consequently, the clinical picture that the perceiver grasped is established beyond the perceivee's reach. The more the perceiver strikes to check his own clinical picture on the objective standard, the more the clinical picture will be beyond the perceivee's reach.

This consequence isolates the perceiver from the perceivee, so that the perceivee is compelled to confront his own phenomenal appearance in his inner world only by himself. The perceivee will stop and be disturbed, unable to continue his endeavor to confront his own phenomenal appearance, because the perceiver presents a closed and confined clinical picture to the perceivee which forces the living experience of the perceivee into the perceiver's confining categories. The continuous development of seeking will not happen under these circumstances, but will result in a limited and closed conceptualization.

Further, the perceiver strives to validate his manner of diagnostic understanding on the objective standard and to adjust his manner to the objective standard. So that the manner and the result of his own understanding becomes the same as others, and are generalized to reduce his own independence and uniqueness. Thus the perceiver as diagnostician abandons his own independence and uniqueness and becomes an "anonymous" diagnostician like a diagnostic machine.

The perceivee will not feel humanistic contact with such a perceiver. Thus the relationship between the perceiver and the perceivee lacks human contact, and results in an isolated relationship, a relationship with "anybody" for the perceivee.

2) The consequence of the application of therapeutic understanding.

The perceiver undertaking therapeutic understanding strives to confront the phenomenal appearance of the perceivee with the cooperation of the perceivee. If the perceivee feels afraid to confront, tries to distort or wants to grasp some limited and confined nature as "nothing more than", the perceiver continuously strives to increase the breadth of the client's phenomenal world. The perceiver feels together the fear, anxiety, and embarrassment of the perceivee, and continuously seeks another new nature beyond the nature the perceiver and the perceivee have just clarified.

The consequence of this is that the perceivee stays in the situation where he can increasingly confront his own phenomenal appearance and also keep the possibility of seeking another new nature beyond the nature the perceivee has just clarified. The continuous development in this process is the meaning of psychotherapy, and also the characteristic of the interpersonal phenomenological approach. The perceiver is concerned about the phenomenal world of the perceivee and the continuous seeking of his nature without confinement, which results in keeping a respect for the independence and uniqueness and endless possibilities of the perceivee.

Further, the independence and uniqueness of the perceiver is not reduced, because he seeks not only a direct, emphatic understanding of the perceivee, but he also actively inspects his own internal reactions to the perceivee and the relationship between the perceiver and perceivee, itself. He alternates in his attitude between a passive, "floating" acceptance of all he hears and sees, and an active, introspective analysis of his own reactions, especially his cognitive implicit, preconscious somatic reactions. In order for the perceiver's reactions to be harmonic with the perceivee, the perceiver's attitude must be truly

receptive; it cannot be contaminated with preconceptions or stereotypes. When such contaminants do exist, we speak of "countertransference" distortions. The therapist is never more than a temporary guest in the client's world; he must remain only a visitor; and in order for this to be in fact true, the therapist's world boundaries must be clearly established in his own mind. But he must be a very special guest -- one who helps his host view his world in a new ways.*

*Yamamoto, K. and Ochi, K. (1963, 1965) made the Psychotherapeutic Relationship Scale, which is an example of a description of the process of the interpersonal phenomenological approach.

The above-mentioned discussion has presented the essential difference between both the processes of diagnostic and therapeutic understanding. Diagnostic and therapeutic activities in actual practice contain both types of understanding. However, in general, when the clinician is doing diagnosis, he actually uses primarily diagnostic understanding, and then shifts this understanding to the therapeutic one in psychotherapy. This combination or shifting process is not really clear. Also, many problems arise in psychotherapy when the clinician starts with the information from diagnostic understanding. Because of this, some clinicians do not use diagnostic understanding and then later try to understand and make sure about the client while continuing psychotherapy.

We will discuss in the following sections the two orientations: therapy based on diagnostic understanding and diagnosis based on therapeutic understanding. The latter orientation is the starting point of "Kakawari" analysis of the TAT.

IV. Therapy Based on the Process of Diagnostic Understanding

1. Uncontradictory case.

In the case of therapeutic activity using the clinical

picture derived from diagnostic understanding, the requirement, in which the clinical picture relates to therapeutic activity without contradiction, is that this therapeutic activity does not require the perceivee (client) to face or confront his own appearance in his own inner world, and the whole responsibility of the therapeutic activity is on the side of the perceiver (therapist). The biological and physiological therapies, drug treatment, electric shock, Insulin shock, and therapy having the intention of changing the environmental situation of the client satisfy this requirement.

The basic thought of these therapeutic activities is not to require the perceivee (patient) to confront his own experiencing in his inner world, but to control the perceivee (patient) from the side of the perceiver (therapist). The purpose is to remove some symptoms and the causes of a disease which are conceptualized as isolated from the ego of the subject. As far as this treatment process continues, there is a consistent process from diagnosis to therapy both on the side of the perceivee and on the side of the perceiver. This is because the perceiver (therapist) has a complete responsibility for the perceivee (patient) and the perceivee (patient) leaves his own responsibility to the perceiver (therapist). This means that the treatment of psychological problems is based on a medical-surgical model.

2. Contradictory case.

However, when we step into psychiatric and psychological therapies concerning the psychology and mentality of a human being, we require the patient (perceivee) to confront and resolve his own problem by himself. The perceivee (patient) is not permitted to leave his own responsibility to the perceiver (therapist) in psychotherapy. If the perceiver continues a diagnostic understanding in this psychotherapy, the following contradictions will happen.

The first contradiction is concerning the difference

between the perceiver and the perceivee. The object with which the perceiver (diagnostician and psychotherapist after diagnosis) has been concerned in diagnostic understanding is not necessarily one which has significant meaning for the perceivee (patient). This is because the material with which the perceiver has been concerned includes the material which the perceivee does not face and feel. That is, there is a gap between targets of the perceiver (therapist) and the perceivee (patient). The endeavor of the psychotherapist should be to make the concealed material, which the perceivee does not yet face and of which he is not aware, the significant one to the perceivee (patient), thus reducing the gap. This endeavor is contained in many kinds of techniques, such as free association during psychoanalysis and counseling.

The second contradiction is found in the different methods of understanding used by the perceiver and the perceivee. The perceivee (patient) has understood his own problem in a limited way as "no more than" to perceive his inner phenomenal world as having some limited nature. After the first contradiction has been resolved to reduce the gap between material which the perceiver and perceivee can confront and face, in the next step, the perceiver should change the perceivee's way of understanding and the perceivee should learn a new way of understanding from the perceiver and face his own problem beyond the old and limited ways of understanding. Then the endeavor of psychotherapy is presented in the techniques of interpretation, education, training or persuation. However, such techniques had sometimes the goal of requiring the perceivee to have another limited way of understanding, to exchange one limitation for another limitation.

The third contradiction is on the side of the perceiver (therapist) himself. When the perceiver has taken a diagnostic attitude, the perceiver has grasped and formalized the nature of his concept of the perceivee in abstract terms and has checked the

validity of his own understanding by the objective standard and in so doing has reduced his independence and uniqueness as a human being, having his own judgment. However, when the perceiver (as therapist) participates in the psychotherapeutic relationship he is required to participate in it with his own independence and uniqueness as a human being. Thus the requirement for the perceiver (therapist) is to recover his own independence and uniqueness as a human being. There is a contradiction in that point. Two methods to resolve this contradiction are: one method is that the perceiver stops checking his own understanding by the objective standard and enters the psychotherapeutic relationship only with his own independent and unique way of understanding. Another method is that the perceiver (therapist) prepares to make a theory or frame-work validating by objective standards his own experience. He then can feel as if he faces his phenomenal world by his own independent ways of understanding. The former method permitted the contradiction between the diagnostic and therapeutic processes of understanding to exist. However, in general practice, many clinicians do not make such a contradiction clear in the performance of their clinical activities. The latter method tries to integrate the gap between two forms of understanding with clear practice and theory. Formal training helps integrate the gap. This training means that the perceiver (therapist) will able to understand independently the phenomenal appearance of his own inner world. The perceiver will get his own independent and unique way of understanding and can recover his own independence or uniqueness through self analysis having the qualification for participating in the psychotherapeutic relationship.

The fourth contradiction happens in the relationship between the perceiver and the perceivee. This contradiction will not be overcome if the perceiver (therapist) continues to take a diagnostic attitude. The perceivee (client) will have to confront his

own phenomenal appearance alone if the perceiver (therapist) continues in a diagnostic attitude. And also the relationship will be isolated and have distance. More effect is needed to resolve the isolated relationship. This effort is shown in the techniques of support, encouragement, affirmation, or acceptance. However, for a really integrated relationship between the perceiver and the perceivee it is necessary that the perceiver's concern should stand on the same dimension as that of the perceivee, confronting the phenomenal appearance together. If the perceiver continues to take the diagnostic attitude, he cannot overcome this contradiction because the object and the way of understanding of the perceiver are on a different dimension from those of the perceivee. Then, whenever the perceiver strives to have a closely integrated relationship with the perceivee, the perceiver is compelled to give up diagnostic understanding. This contradiction will not be resolved essentially if the perceiver brings diagnostic understanding into the psychotherapeutic relationship.

The fifth contradiction is concerned with the difference between both clinical pictures as a result of application of diagnostic and therapeutic understanding. This is essentially a contradiction which we cannot overcome. The perceiver will require the perceivee to learn the limited "no more than" understanding when the perceivee starts and continues psychotherapy with the diagnostic attitude. This results in the limited, "no more than" clinical picture which the perceivee will find out as the final stage of psychotherapy. This result is without doubt because the new clinical picture does not contain the continuous process in which the perceivee (client) seeks a new nature beyond his old nature in his experiencing his inner world. The new clinical picture derived from psychotherapy with the diagnostic understanding will confine the perceivee to a "no more than" person. On the contray, psychotherapy with psychotherapeutic understanding will be orientated to release the perceivee (client) from being a limited,

"no more than" person and will establish an open person having the possibility of continuously seeking a nature beyond the old one.

V. Diagnosis Based on the Process of Psychotherapeutic Understanding.

In the process of psychotherapy using psychotherapeutic understanding, the perceiver (therapist) needs the description of a clinical picture of the perceivee (client). When the perceiver describes and discusses the clinical picture of the client, he should detach the process of psychotherapy temporarily. However, this means that the perceiver does not stop focusing on the appearance of the client's world altogether, but interrupts the focusing process and reflects on his own experiences about the interview processes at the interrupted point. This reflection and description include the limitation of "it has been such and such till now" in terms of the things which the perceiver and the perceivee have been checking together. However, this limitation is the one that "we have understood to this point" together and also the one which includes the possibility of "another nature beyond the nature we have understood". This way of grasping the clinical picture is different from diagnostic understanding because the limitations are not included in this way of understanding.

The characteristic of the clinical picture derived from the process of the psychotherapeutic understanding is the following: The process of psychotherapeutic understanding is a continuous process in which we grasp the nature of the world of the client, viewing it as he views it; but we seek another vision of the client beyond the nature we have grasped from his presentation. The most important point when we discuss or describe the clinical picture is how we can reach this vision. This means the reflection and examination of the process of interpersonal phenomeno-

logy. That is, this reflection means that we ask ourselves how we could confront the client's world within the therapeutic relationship with our understanding of his view of reality and the discrepancy between his view and our view. The core of the clinical picture is constructed on the dimension of confrontation with reality in the process of the interpersonal phenomenological approach. We call this core "kakawari" in Japanese. An example of such a description about the clinical picture is presented in the Process Scale (Rogers, C.R. and Rablen, R.A., 1958) and the Psychotherapeutic Relationship Scale (Yamamoto, K. and Ochi, K., 1963, 1966) which includes the process of confrontation (kakawari) on the therapist's side.

It is important that diagnosis based on the psychotherapeutic process includes questions on the way in which confrontations might be reached. The questions are not only about the way the (client) views his world but also about the way the perceiver (therapist) views it. If the perceiver questions about only the view of the perceivee, the perceivee will be treated as an object and the therapeutic relationship will be broken and isolated from the perceiver. An example of this is the Existential Analysis of Binswanger, L. (1957). He tried to grasp the unique appearance of the subject as the perceivee. However, his application resulted in isolated relationship between the perceiver and the perceiveee because he limited or neglected to examine the way confrontation was reached on the side of the perceiver.

VI. The Basic Idea of "Kakawari" Analysis.

The basic idea of "kakawari" analysis is introduced by psychodiagnosis based on psychotherapeutic understanding. In this section we will mention briefly this basic idea of "kakawari" Analysis.*

The clinical picture, which the psychotherapist grasps in the process of psychotherapy, is not on the level of need - press

*The original idea of "kakawari" analysis comes from the process of the client centered experiential therapy which the writer has been doing (Yamamoto, K. and Ochi, K., 1963). A more detailed discussion, especially related in the practical method, is presented in a publication (Yamamoto, K., 1966).

theory and psychodynamic orientation; i.e., this client has a strong need dependency or a lack of need achievement. Of course, we can grasp or describe a clinical picture in terms of the need-press theory and psychodynamic orientation. However, the clinical picture, which a psychotherapist grasps actually in the process of psychotherapy, is different from the clinical picture related in need-press theory and psychodynamic orientation.

The clinical picture derived from psychotherapists contains: how the client is trying to confront his reality, what degree of broadness and richness he has as his own phenomenal world, and how he is at the present in a situation where he can not move in the real world. Especially important is the delineation of subtle aspects of his disability of movement. A client may fear a close relationship with the therapist; "What are the nuances of the feelings which the client has about this?" or "I wonder if this client would have his own different way of getting close to another person?" These are questions from the clinical picture as grasped by the therapist. One asks also what is his own therapeutic effort which he might not understand completely. That is, these characteristics of content in the clinical picture come from the answers to the questions derived from the situation in which both the therapist and client are cooperating to confront the client's problem.

The most important dimension in the above-mentioned clinical picture is how the client is trying to confront his reality. That is, how his own subject is relating or confronting his phenomenal situation (What is his "kakawari"?). The psychotherapist grasps the clinical picture along this dimension during psychotherapeutic activities in the interview.

This clinical picture derived from the psychotherapeutic relationship in the interview has an essential difference from the clinical picture derived from a psychodynamic orientation such as Murray, H.A.'s (1938) need-press theory, or the formal analysis of Rappaport, D. (1946) in terms of a symptom-categorizing typology.

The results of psychodynamic analysis and formal analysis are useful but indirect for participating in and promoting the actual process and action of psychotherapy. The important process of "kakawari" analysis is to relate the clinical picture derived from TAT materials and the clinical picture from the real therapeutic process directly on the same dimension of psychotherapeutic understanding.

It is necessary to compare the need-press analysis to "kakawari" analysis for realizing the characteristics of "kakawari".

The concept of "need" is based on the dynamic reaction of the organism. This reaction is the original source of some overt behavior. This concept of need is a hypothetical concept for the interpretation of behavior and outlining variables of the personality structure. Murray, H.A. (1938), in "Explorations of Personality", determined forty-four factors including needs and press, making personality structure without unification among these factors. Murray's description in terms of many kinds of "need" is very beautiful and detailed. However, the characteristics of these descriptions raise the following questions from the viewpoint of "kakawari" analysis.

1) Need as source of reaction. This concept of motivation is not concerned with the relationship between source of reaction and the subject who has this source of reaction in his personality. That is, need is just like an impulsive movement of an object separated from the subject. It is impersonal and abstract.

2) Thus, Murray's description of need describes the content aspect of these impulsive motivating movements. The manner of

this description results in a content orientation, not a process orientation.

On the contrary, "kakawari" is related to the process of confrontation of subject and interview, and does not separate the motivation from the subject. That is, if a subject has N. aggression "kakawari" analysis is trying to grasp in an integrated way both N. aggression and the manner of confrontation of the subject to N. aggression: i.e., to what degree he can feel actually deal with this N. aggression, how he can treat or control his own aggression and also how he relates this N. aggression to his own real situation. Is this manner of relating to his situation the one of nihilistic aggression from resignation of his responsibility, or one of striving aggressively to overcome obstacles.

The focus of "kakawari" analysis is not only what kind of need he has but also how he treats or confronts (internalizes in his self system) these needs with reaction to his real situation. This means "kakawari" analysis has a process orientation.

Murray also presented an idea of the concept of vector. Tomkins, S.S. (1952) developed this vector analysis later. However, the concept of vector is basically similar to the concept of need. Vector is the formal aspect of the content of need.

The concept of vector is also the formal aspect of movement separated from the subject. Thus, many kinds of new aspects can be derived from the viewpoint of "kakawari" in which the diagnostician participates in the phenomenal world of the client. For example, we will take a vector of aggression (the movement of going out of the bound area or closed system).

When a subject moves from a closed system, does he just feel the hope of going out without actual action (the feeling to be discharged from the bound situation)? Does he feel only that he should go out of the bound situation ("should" activity)? Is he indulging in going out without any clear goal in reality (aimless movement toward his future)? Did he make his decision to go

out with trial and error in a real situation (trial movement)? Does he go out with the clear aim and cognition of the real situation when he starts to go out from the closed system (concrete future orientation with aim)? Did he make his decision to go out on his own independent belief (Independent and spontaneous movement)? -- and so on.

There is also a difference between the concept of "press" of Murray's need-press theory and the "situation" of "kakawari" analysis. Press is the dynamic reaction which motivates a person from the outside, usually having the forms of fear of hurt or the expectation of benefits. This press is the same motivating movement from the outside, separated from the subject who gets this motivating movement as need. The situation in "kakawari" analysis belongs to the subject. Situation is the one which appears to the subject phenomenologically and which has meaning just to the subject. Situation is the object or field which the subject is actually facing and confronting in several ways. Situation is the world of meaningful conscious experience just to the subject, who has his own situation just as the others have theirs.

Tomkins, S.S. (1952) introduced the concept of level, by which he means the level of psychological functioning in TAT stories and also principally he means the degree of reality in the modality of behavior, however including another dimension. Stein, M.I. (1954) introduced more clearly the concept of level as the degree of reality in terms of categories of behavior. Togawa, Yukio (1953) also introduced the modality of problem-solving in behavior which has a similar meaning to the concept of level.

These concepts of level and problem-solving have meanings close to "kakawari". However, these concepts seem to be introduced as supplementary for the need-press concepts. And also the categories of these concepts, real or unreal, positive or negative, active or passive, extrovert or introvert, and direct or indirect, will not be useful in drawing a vivid human picture

for clinical purposes because these categories are too simple and stereotyped.

As the above-mentioned discussion demonstrated, need-press theory is trying to grasp the human being as a construct of dynamic powers. This attempt to grasp a human being resulted in presenting only the togetherness of dynamic powers and the anonymous human figure without the subject. This attempt is based on the process of diagnostic understanding. On the contrary, "kakawari" analysis is based on the process of psychotherapeutic understanding which focuses the manner of confrontation on the side of the subject toward his own situation.

VII. Final Comment

This discussion is an effort to realize in so far as possible the essential difference between the processes of diagnostic understanding and psychotherapeutic understanding. If the criticism of this discussion is in terms of a belief that this difference does not occur in the actual practice of diagnosis and therapy, this criticism is a problem on another dimension, because this discussion tried to present the essential difference between the processes of diagnostic and psychotherapeutic understanding as a clear model to make the different structures clear. We believe this model is necessary for putting in order the present vagueness in practical activities in clinical psychology. Clinical psychology is too accustomed to vagueness. "Chaos" or vagueness in the practical field is a wonderful big mineral vein from which we can find out rich things. However, we think that when we discover rich things we must draw them out clearly, so that others may also be able to find them.

We mentioned that the process of diagnostic understanding brings on a limited and closed clinical picture, and also that the process of psychotherapeutic understanding brings on an unlimited and open clinical picture. Both processes are ways of

understanding human beings, but in the writer's opinion, interpersonal phenomenology or psychotherapeutic understanding is a broader and more complete way of grasping human nature -- not only the human nature of patients, but also of all human beings.

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Group Psychotherapy in Japan

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After World War II, a number of young psychiatrists had the opportunity to study dynamic psychiatry at first hand abroad. After experiencing the shock of cultural difference between the East and the West themselves, they were able to get a clearer view of psychotherapy based on dynamic psychiatry. And the confused state of Japan in the post-war years also prepared Japan to accept these new ideas.

In 1956, Japanese Ministry of Health and Welfare gave a two year research grant to our National Institute of Mental Health, in order to study group psychotherapy with various types of mental patients. It was the first experimental group in the field of psychiatry. The research team did it through "trial and error" experience, but the results seemed unexpectedly encouraging. Psychiatrists' interest for dynamic psychiatry and the deepening of their understanding for individual psychotherapy became the base for cultivating group psychotherapy. By that time, Slavson's book, "Introduction to Group Therapy" was translated into Japanese.

In 1958, the author who was a member of the research team above described, had the chance to study group psychotherapy, at first hand in U.S.A. After returning, the author formed "play group therapy" in a public child guidance clinic. The subjects were children aged 4~6, sent from Kindergartens, because of excessive shyness or aggressive behaviors. The clinic provided a free discussion group for mothers of problem children and held a therapy camp during summer. These new methods were introduced into many child guidance clinics and educational counseling centers without much difficulty.

In 1960, group psychotherapy was introduced into relatively large mental hospitals, public or university affiliated. In some hospitals with younger staff members and modern administration, new ideas were adopted more easily.

In some hospitals with long tradition and elderly staff members,

group psychotherapy was accepted only in limited wards for chronic patients. Group psychotherapy was also introduced to small private mental hospitals where individual psychotherapy was favored.

Since deep and meaningful interaction became possible not only between patients and therapist but between patients themselves, group psychotherapy gradually gained a legitimate position, together with individual psychotherapy.

In the early part of 1960, the author with three other social workers, started a therapeutic social club at the YWCA, an easily accessible place for young discharged patients. This type of group later became prevalent in many rehabilitation centers for discharged mental patients.

Group was utilized in 1966 for preventive purposes, such as groups for mothers of twins and premature babies. These mothers discussed their mutual problems, shared feelings and gained confidence.

Group psychotherapy program for the physically handicapped, both inborn and acquired in later life started in 1970 at a public rehabilitation center. It helped patients to realize the fact that they not only resented prejudices shown against them by the public but they, in their turn, had prejudices against others who had different kind of handicaps.

As several anthropologists mentioned, group psychotherapy in different cultures is inclined to reflect the conditions that exist in the family and social life of individuals, outside of psychotherapy. The interaction is influenced by these conditions.

In the beginning phase of use of group psychotherapy, the author observed the following problems on the parts of patients, therapists and administrators.

Patients tended to modify group psychotherapy into a family or an alumini-type of gathering in which their roles and functions were definite. They were inclined to seek for advice from the

therapist. They avoided interrupting others during the session.

Each waited for his turn and remained "a good listener" acting as though silence meant respect. When they had objections, they did not express them outright. They expressed their feelings in very indirect ways and generalized them and let others guess their underlying feelings. Some of them expressed their positive attachment to the therapist only by letters, because of their dependency needs and their fear of being rejected.

However, nowadays patients speak more directly and freely of their individual problems.

They do more than just listen and interrupt each other. Communication by letters has become rare. Peer relationship and power struggle have become more apparent.

In the beginning, Japanese therapists had to use much time for orientation, before actual group session could be started. Both the therapists and patients, at later session, had to review purposes and principles. Inexperienced therapists were preoccupied with such expressions, as free-interaction, patient-centered, non-directive, democratic, non-authoritative, etc. Consequently, they were afraid of taking leadership and were unable to give an appropriate orientation suitable to the type of patients.

Therapists preferred to work with a co-therapist which at times resulted in serious competition between two therapists in group supervision. Because of difference in age, sex and profession, it was difficult to hold equal position in the therapy group.

Some therapists had problems with the authorities. They identified themselves too much with their patients and could not remain neutral and fair.

These days, the problems of co-therapist have become less serious.

There is less objection from administrators, when group psychotherapy is introduced.

In general, therapists have become more relaxed with patients and learn much from each other, feeling a sense of mutuality.

The author feels after 20 years experience that the future prospect of Japanese group psychotherapy can be considered hopeful. This is because dynamic psychiatry and psychotherapy in general have found their rightful places and come to be properly understood and evaluated both by professionals and the general public.

With the changing of times, the traditional figure of the Japanese family and the role expectations of each member have become rather vague and more and more people have begun to take interest in group psychotherapy.

They try to supplement what they lack in their family life in the group and through it they learn dependency on others, at the same time, the necessity of standing on their own legs, as independent and mature individuals.

Social Phobia as a Clinical Syndrome

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I) Introduction

Mild social anxiety is perfectly normal. But when intense, anxiety severely impedes the subject conducting himself in the presence of others; he feels an intense feeling of uneasiness accompanied with psychophysiological symptoms of autonomic nature such as blushing, stiffening, trembling, or sweating. While in a small group meeting, he is seized with a morbid fear of disturbing others by manifesting these symptoms. He may become unable to talk with his colleagues, to take meals together in a restaurant, to sit opposite passengers in a bus or in a train, or even unable to open his eyes to glance at them.

The author has seen many cases of this type of phobic disorder, or so-called social phobia, and has been impressed that the central cluster of this phobia is similar in most cases and forms a coherent clinical syndrome. Though a kind of phobic disorder, this syndrome has a certain paranoid feature with ideas of reference. The distinction between this syndrome and other sensitive paranoid states, especially those of delusional disorders, is delicate but important in clinical practice.

Social phobias are not frequently seen in psychiatric clinic, but there exist many patients with this type of phobia. The majority of them ask for treatments by non-physicians such as hypnosis, Yoga training, starvation cure, or group therapeutic training. To make a compendium of the social phobia syndrome, the aim of this paper, the author has made use of his series of plain social phobic cases. Most of them were seen in a group therapeutic training center carried out by non-medical staff.

II) Historical remarks.

It is indispensable to begin papers such as this which deal with a clinical conception of psychiatric disorder, by paying tribute to the first author who described it.

The term "phobies sociales" (social phobias) was first used

by P. Janet in his monograph on psychasthenia (1903)[1] to group a wide variety of morbid fears arising from social contacts, such as an intense fear of blushing in the presence of others (ereuthophobia), or a persisting fear of trivial or imaginary physical deformities being noticed (dysmorphophobia). Janet pointed out that "the essentials of these phobic disorders consist in a feeling of being in the presence of others and the fact of behaving in public."

The first case report of this type of phobic disorder was published by J.L. Casper[2] as early as in 1846. This was a case of 21 year-old male patient with obsessional fear of blushing. Toward the end of the last century, ereuthophobia and allied conditions had attracted the attention of many European psychiatrists and become one of the topics of neuropsychiatry. Some authors[3][4] considered ereuthophobia as obsessional disorder, while others[5] interpreted ereuthophobic symptoms as a somatic displacement of libido in hysteria.

This vogue, however, did not last long, and articles on ereuthophobia have almost disappeared from psychiatric litteratures of succeeding decades.

But the patients with ereuthophobia or allied conditions did not disappear with the vogue of the fin du sciecle. Afterward, a few clinicians reconsidered ereuthophobia and its analogical conditions and revised their clinical conception from a somewhat different view point. Then, several new labels have been given by them; these include Kontaktneurosen (F.G.v. Stockert, 1929)[6], social neurosis (P. Schilder, 1938)[7], or social anxiety neurosis (A. Meyerson, 1949)[8]. Recently, I. Marks also treats social phobia as a clinical syndrome and details its clinical features in his monograph on phobias (1969)[9].

Apart from this Western trend, Japanese psychiatrists have paid particular attention to social phobias, since the series of leading works of M. Morita on "shinkei shitsu" (nervous

character) published in the 1920's and 30's. Morita treated many neurotic patients with obsessional fears, especially those of social contacts, formulated his theory of "shinkei shitsu", and established a method of psychotherapy for "shinkei shitsu" patients (Morita Therapy)[10].

According to Morita, "shinkei shitsu" partly derives from a certain temperament. The person with this temperament falls inevitably into the state of being preoccupied with trivial disfunctions of physical or mental activities. Then, he entangles himself with this preoccupation which envolves various obsessional fears, insistent hypochondriasis, or neurasthenic states.

Morita added that "shinkei shitsu" patients have a certain avidity for predominance over others and a strong desire to live. He interpreted that phobias of death or of illness represent an adverse effect of such an avid clining to life, while social phobias or phobias of shame represent an adverse effect of an avid need to predominate over others.

He also desctibed various types of social phobias such as phobias of flatus, of giving off improper facial expressions, or of looking at others. Japanese psychiatrists have elaborated and renewed Morita's concept of social phobias. Their recent studies on social phobias will be mentioned later in this paper.

III) Incidence of social phobias.

Usually, social phobics succeed in keeping their disorder from another person's sight, and because the majority of them are treated in secret by non-physicians in a wide variety of private therapeutic centers, it is difficult to estimate the prevalence of social phobias in the general community. In the author's series of 179 cases, 163 cases (91%) were seen in one such private therapeutic center in Tokyo. Out of these 163 cases, only 12 cases (7.4%) were treated previously in psychiatric clinics.

Y. Uchinuma (1977)[11] found the incidence of social phobias in

psychiatric practice to be 2.5% in psychiatric outpatients who were seen in the psychiatric clinic of Teikyo Medical School in Tokyo. In general social phobias are included in neurotic disorders, the incidence rate of social phobias in neuroses, if available, would be very interesting. I. Yamashita (1977) found 21 cases of social phobias in 269 patients with neuroses, or 7.8%, who were seen in the clinic of the department of neuropsychiatry of Hokkaido University during 1975[12].

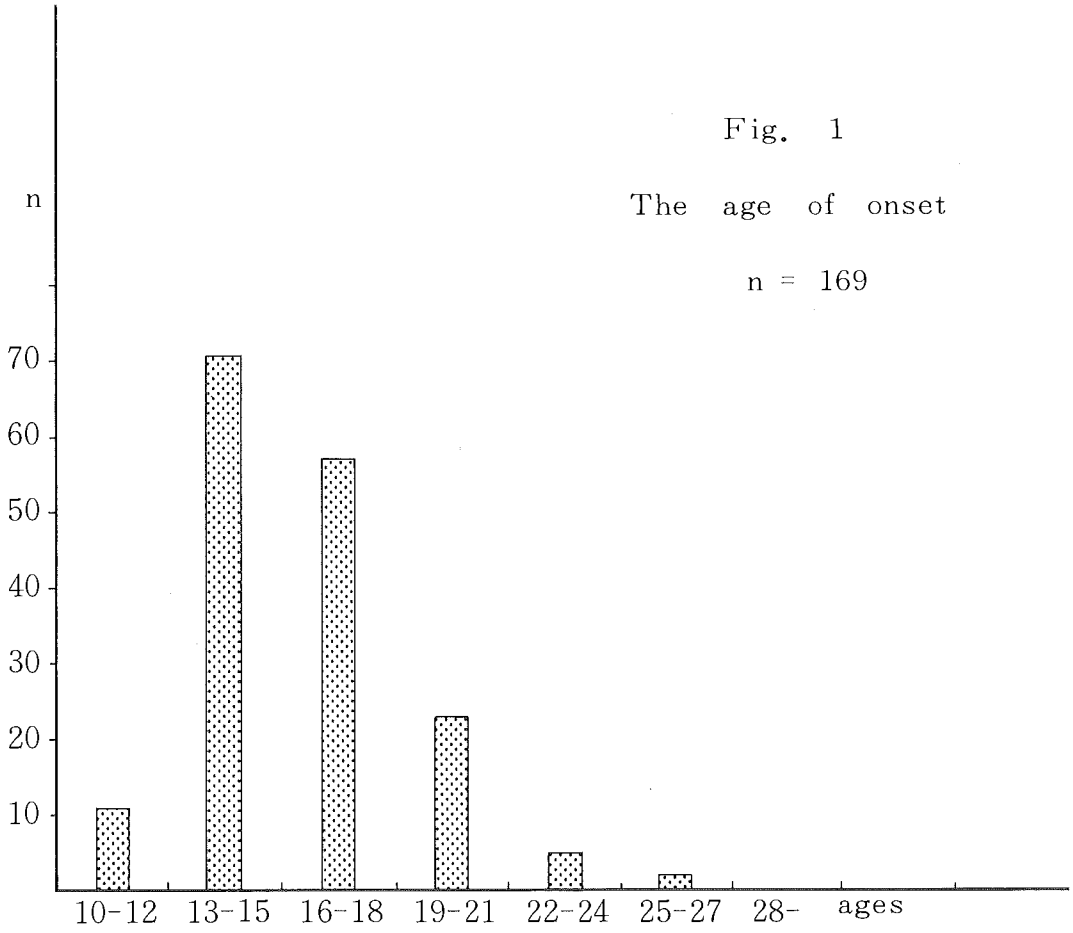
While, relatively large number of social phobics are treated in the psychiatric clinics where Morita Therapy is performed. K. Ohara (1968)[13] reported that the incidence of social phobias amounted to 45.5% in neuroses seen in the Korakosei Hospital where intensive Morita Therapy has been practiced since 1944.

Regarding sex incidence, nearly all descriptions by Japanese authors show a preponderance of men. Both Uchinuma and Ohara, for example, found that the male/female ratio was about 3:2. In the author's series, it was about 5:4, while Marks reported that the sex incidence of social phobias seen in the Maudsley Hospital in London was 60% women.

IV) Onset of Social Phobias.

Social phobias begin in early adolescence. Figure 1 shows the distribution of ages of onset in the author's series.

A substantial number of patients regarded some trivial events that had occurred during certain social contacts as the precipitants of their disorder. For example, an incidental blushing while being confronted with persons of the opposite sex, or minor stage fright while facing class mates in a class meeting, are among the events repeatedly related by the patients. On the other hand, gross traumatic events, or major changes in the patient's life situation, were rarely reported as a trigger. In the author's series, only four cases (2.2%) acknowledged that their disorder started with an obviously traumatic event.



The trigger, though a trivial one, gives rise to a somewhat persisting anxiety, and the subject becomes very sensitive to social situations similar to the circumstances of the initial event. Sooner or later, he begins to fear the very manifestation of various symptoms of social anxiety, as well as social situations involging these symptoms.

V) Symptoms Social Phobics Fear.

Usually, social phobics fear that their symptoms will manifest in certain circumstances. They are afraid of blushing in the presence of others, of stiffening of their facial expressions, of trembles of the head, hands, feet or voices, of sweating while

facing with others, of being seen their physical deformaties, of emitting unpleasant body odours, of their line-of-sight becoming uncontrollable, or of uncontrollable flatus in the presence of others.

Among these symptoms, blushing in the presence of others is the commonest one; 53% of the patients in the author's series chose this symptom as their principal feared symptom. But the symptoms they fear often vary in the course of illness. One who starts with ereuthophobia may become dysmorphophobiac, or may begin to fear that he cannot help staring at others and making them feel uncomfortable.

Those who had shifted their feared symptoms during the course of illness amounted to 27% in the author's series. In this respect, it may be worthy to note that fear of blushing occurred frequently in the beginning of their illness, while fears of stiffening of one's facial expressions, or one's line-of-sight becoming uncontrollable, often appeared later.

Y. Kasahara[14] distinguished two groups of fears of social contacts. One includes those fears featured by a component of "being looked at by others." Fear of blushing in the presence of others represents this group of fears. The other includes those characterized by the predominance-of-the-opponent component, that of "looking at and thus disturbing others." Fear of one's line-of-sight becoming uncontrollable is an example of this latter group of fears.

Although it may be difficult to classify the fears of many cases into either of these two groups, this classification has certain importance. For the patients with fears classified appropriately into the latter group are more seclusive and laden with guilt rather than shyness.

In fact, fear of one's line-of-sight becoming uncontrollable and thus disturbing others often attains to delusional conviction. The patient cannot help feeling that others are actually disturbed

by his uncontrollable stare.

In the extreme case, the patient complains that, even keeping his eyes shut, a kind of magic power radiates from his orbits in all directions and disturbs people around him. He especially feels that the people immediately beside him are intensely influenced by and shrink back from his stare.

Such a delusional type of social phobia occurs as part of so-called border-line state, waxing and waning at the same time as the more prominent delusional symptoms. Kasahara named these delusional cases social phobia gravis. A certain case of body odour may also be labeled gravis type. A patient believes that his body odour so intensely stinks as to make people around him sneeze or cough!

VI) Reactions to Feared Symptoms.

Social phobias are more or less disabling, because feared symptoms are often provoked by social contacts of common everyday occurrence. The patients are driven to avoid social contacts. But they cannot live in complete seclusion. When they attempt to overcome their phobias, they may try to suppress the manifestation of feared symptoms by force of mind. But they soon realized the adverse effect of this volitional suppression. They may then resort to palliative devices to alleviate fears when in the critical situation. The application of face cream to the blushing face may moderate fear of being looked at by others. Some contrive even more astute devices. In a bouncing bus, for example, a patient may begin to pretend to read a newspaper so as to keep his stiffened countenance from the view of other passengers. But being unable to put up with the oppressed atmosphere in the bus even by this feigning performance, he may get off at a bus stop on the way, making it seem as if he has arranged beforehand to stop there.

In fact, a substantial number of patients succeed in keeping

their phobias in secret to such an extent that they themselves acknowledge that nobody penetrates their intentions behind the facade of palliative or feigning performances.

However, few patients are completely satisfied with these palliative devices, because they finally realize that palliatives are palliative and all but ineffective in overcoming their phobias. It is well noted that social phobics seek treatment specially designed for personality change and for improvement of ego-strength, for example, hypnosis, Yoga training, starvation cure, or group therapeutic training. They have a tendency to respond well to the ascetic aspects of such treatments. Often they show a certain stoical will to conquer their phobias.

VII) Phobia Stimulating Situations.

In spite of the diversity of feared symptoms, as well as of palliative devices to alleviate them, social phobias have a common feature with respect to phobia stimulating situations.

One of the most important points in differentiating the social phobia syndrome from other delusional disorders is the fact that, except when in phobia provoking circumstances, social phobics become sane and bright, just as agoraphobics are free from anxiety while at home. In other words, social phobias are strictly bounded with, as well as circumscribed in, a certain social situation.

The majority of the patients believe that they feel anxious wherever they are in the presence of others. But this is a false belief.

In fact, few patients show signs of morbid social anxiety while facing their therapists. On the other hand, there are some who become tense, even when surrounded by familiar friends. Moreover, the impressions of "others" vary greatly with circumstances. A fashion model with ereuthophobia related that she felt better on the stage than when facing and talking with people,

even friends, in a small group.

Based on clinical observations as well as analyses of the patient's comments on phobia provoking circumstances from the communication point of view, T. Takahashi[15] pointed out that the critical situation where social phobic symptoms are engendered consists in a certain modulation of the communicational mode of affinity. Social phobics are very sensitive to the slightest modulation of familiarity with other persons and too ready to conceive ideas of reference.

Passengers in a bus may remain utter strangers to the patient. But an incidental exchange of looks often provokes intense dismay in the patient. According to explanations given by him, he cannot at the time help feeling as if the distance of familiarity with the passengers who he feels are looking at him becomes too close to regulate immediately with appropriate communicational performances.

From the communication point of view, the patient, when in the bus, expresses himself both consciously and unconsciously to the other passengers. On the other hand, he makes inferences about them through their expressions. The security that he justifiably feels in consciously expressing himself to as well as in making inferences about them depends upon his adaptability to the actual communicational mode of affinity in that circumstance.

An exchange of looks may precipitate in the mind of sensitive patient an illusional shift of the communicational mode of affinity, from that of affinity with totally strangers, to that of affinity with more familiar persons. Normal persons may correct this illusional shift almost without awareness, but the patient entangles himself with this illusion because he is so sensitive to the slightest change of familiarity that he deludes himself with appearent familiarity of mere exchange of looks. What is more, he soon realizes this illusion by inferring that expression he gave in accordance with this shifted communicational mode is making an

improper impression on the other passengers, but he cannot control his expression to restore the already disrupted communication distance with the other passengers.

Social phobics may feel tense atmosphere while taking part in the talk with their colleagues. The critical situation often emerges with no one saying anything. Such a pause in the conversation causes them to impulsively shift from the communicational mode of affinity with familiar people to that with less familiar people. They cannot help feeling as if the people surrounding him turn suddenly to be distant.

This hypothetical conceptualization of the phobia stimulating situation is greatly supported by clinical findings, and is well interpreted by the symptom of ideas of reference characteristic of this syndrome.

From the communication point of view, symptoms the patient fear will be considered as manifestations of the disruption of natural communication which involves at the same time the critical situation.

VIII) Social Phobia Syndrome and Delusional Disorder

In general, social phobias are classified under the heading of phobic disorders. However, symptoms of overconcern about social contacts or ideas of reference are characteristic of social phobias, and the distinction between social phobic ideas of reference and delusions of reference seen in delusional disorders is of importance in clinical practice as well as in theoretical considerations.

Social phobic ideas of reference are, firstly, characterized by a feature of self-reference. The social phobic patient cannot help feeling that others take notice of him. But, at the same time, he acknowledges that his feeling originates within himself. Even he conceives the ideas of resorting to palliative devices to conceal manifestations of social anxiety lest he should attract the

attention of others.

This structural characteristic of self-reference is an important point to distinguish social phobic ideas of reference from delusions of reference, especially those of paranoid conditions in which the paranoid patient feels as if he were being spied upon, tested, or controlled by others.

Secondly, social phobic ideas of reference are well circumscribed. Indeed, social phobics become sane and bright when out of the critical situation. Their ideas of reference are strictly bounded with and circumscribed in the situations where their feared symptoms are provoked.

Thirdly, the content of their ideas of reference usually has hardly a trace of persecution. The patient with social phobias withdraws and avoids social contacts, but he is not a true misanthrope. Inwardly, he seeks contact with others. Usually, he imagines his acquaintances or neighbours as good-natured people and never conceives of their persecuting plots. He is even afraid of hurting them by giving off improper expressions.

Ideas of reference seen in the central cluster of social phobias have all these characteristics which permit one to defferentiate social phobic ideas of reference from other delusions of reference.

But in a few exceptional cases, especially in the case of social phobia gravis[16], these characteristics are more or less blurred, and further elaboration based on a diffusion of ideas of reference often flavors the patient's ideas with persecutional nuances. For example, the whole neighbourhood may seem to gossiping about his fierce looks or unpleasant body odour.

IX) Course and Prognosis.

Accurate accounts of the course and prognosis of social phobias are precluded by the lack of longitudinal studies of sufficient number of patients over a long period of time. However,

although their numbers of patients are small, nearly all studies by Japanese psychiatrists have reported good results.

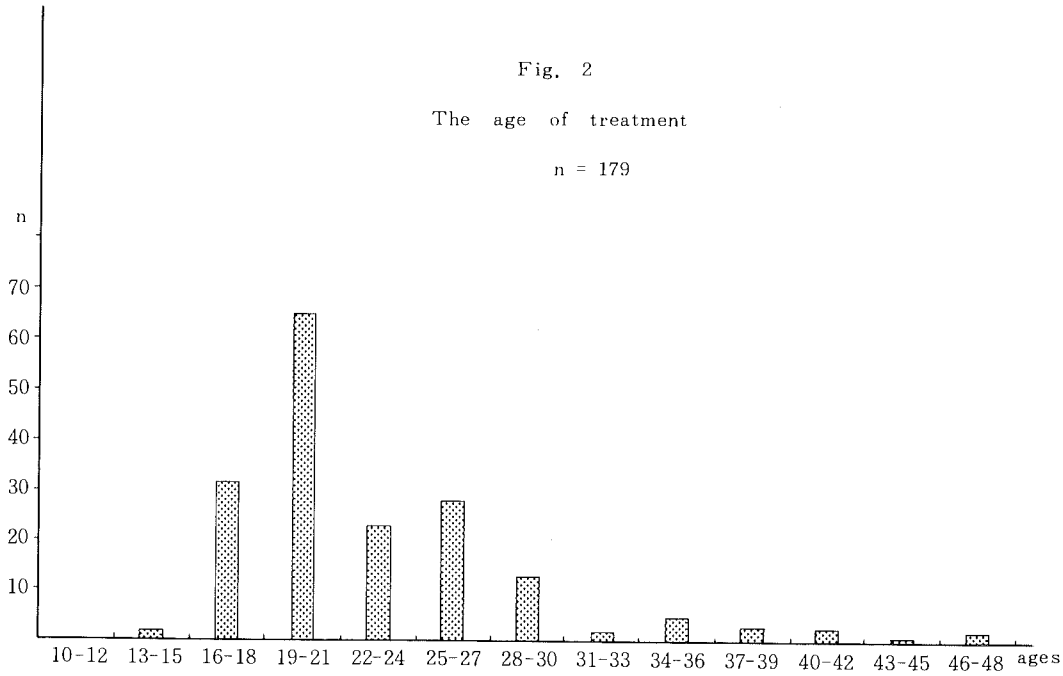
In the author's series, followed up for anywhere from two months to eight years after treatment, some 80% (143) of the patients became well, and their symptoms subsided to a point that they were able to conduct themselves as if they were sociable. The complete remission of symptoms for a certain period was often actualized by the contrivance of more astute devices to alleviate fears of social contacts.

On the other hand, 20% (36) of the patients were unchanged or worse. In addition, 10.5% (19) of the cases became social phobia gravis during the follow up period, and two-thirds (13) of them fell in this unimproved group.

Fig. 2

The age of treatment

n = 179



Patients who seek treatment are most commonly in their teens or twenties. Few patients are over thirty. Figure 2 shows the distribution of ages of patients treated in the author's series.

In consideration of the age of onset (Fig. 1), the mode of onset, the feared symptoms, the nature of sensitivity to other persons well represented in ideas of reference as well as the prognosis, the social phobia syndrome seems to be closely connected with progressive developments of sociability in adolescence.

Adolescence is marked off by important changes in many facets of development which involve more or less the modulation of the formation of basic social relationships.

It has been generally accepted that the maturation of the sociability of a child is characterized by the development of innate potentialities of dependence in an ordered sequence. Developmental symptoms such as the smiling response observed a few months after birth, stranger anxiety at the age of eight months, hyper-suggestibility during the ages from about eight to twelve years, loyality to a gang at preadolescence, and so on, have been considered in the context of dependence phenomena.

After puberty, however, the mode of sociability changes from dependence to inter-dependence. The revolutional change reflects its characteristics in the psychopathological manifestations of adolescent youth.

In line with this, some psychiatric syndromes, such as a certain psychotic episode with schzophrenic features, a certain derealization syndrome, or a certain juvenile depression, have been investigated in connection with adolescent identity crises. It seems justifiable to consider the social phobia syndrome as a manifestation of a certain retardation in progressive developments of sociability in adolescence.

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The "Mentally Disordered" and the Family in japan

—some preliminary remarks from a sociological perspective—

Kunio Ishihara

I

A widely-accepted sociological definition of the family in Japan is a primary and welfare seeking group which is mainly consisted of such closely-related kins as parents and their children. In this paper we will discuss briefly the relations between the family defined as above and "mentally disordered".

From a sociological view point, "mentally disordered", though it is not a proper sociological term, is defined as "a person who showed deviant behaviors that are regarded as insanity by other people". They are not such specific symptoms as hallucinations or delusions, which are the main issues in psychopathology or abnormal-psychology. Mentally disordered is regarded as certain states of personality where the person loses the state of integration and the ability to think and judge or the conditions being extremely deviated from social standards and the resulting deviant behaviors. The actor of such social behavior will be regarded as mentally disordered person.

As long as we view the mentally ill as deviant behaviors, they are socially defined.

In relation to this, the concepts of illness versus caseness which are become to be used in social psychiatry are very interesting. Illness refer to the phenomena viewed from the medical (biological or psycho-pathological) standpoint. On the other hand, mentally ill persons are brought to attention only when they cause problems in daily social life.

The caseness of mentally disordered will be decided when there is probability of hurting himself and others on account of their illness.

The socio-cultural situation is important to define the meaning of caseness. A person may be treated as a case because of his deviant behavior even when no medical symptoms are identifiable.

Though there are several approaches to studies of mentally

disordered in relation to the family they have predominantly been psychiatric.

First approach views the relation between mental "illness" and the family as a eugenic problem. Here the family is treated not as a group but as an agent of hereditary predisposition which causes mental disorder. This is a genetic or eugenic point of view.

At the other end of the pole there is an approach focusing on the intra-family relations which is derived from Freudian psychodynamic theory.

The third view finds the unique pattern of communication or a distorted role relationship in the family of psychotic patients, interpret schizophrenic syndrom not as individual pathology but as a manifestation of family pathology. This point of view may be the leading school of psychiatric family studies today.

This family-pathological viewpoint is closely related to family therapy which is the method to cure the mentally disordered through working on his family members in order to rearrange the family relationship.

These three approaches have emerged from the tradition of psychiatry as a medical science, but since 10 years, a new view which regards psychiatric treatment as a social problem has come into the scene. This has become a type of social movement. Main claim in this faction is that Japanese psychiatry has developed mainly by Kraepelinian school and thus it has regarded mental disorder as a desease, stressing not much importance on the problem of the individual who suffers from the disorder, and without sufficient issues on social environment.

These critiques are advocated by clinical psychiatrists in mental hospitals and psychiatrists who are community-oriented. Some of them have expanded the criticism to claim that psychiatry legitimated non-therapeutic and non-humanistic treatments in the name of science.

In this sense, the families, as well as patients, may be considered as those who are entitled to demand better organizations of medical and social services.

"Relatives' association for mentally disordered", an organization unique to Japan, is highly evaluated as the core of the movement demanding changes in medical and social service systems. Claims against establishments, however, contain another point of view that the family itself might be regarded as one of the social agents which control and exclude psychiatric patients from the community. In fact, there are many examples in which we observe conflicts of interests between the patients and their families.

In the area of social work, the family having a member with mental disorder is looked upon as facing a difficult problem to solve. Social worker takes it as a technical problem of how to support the problem solving behaviors of the families under stress.

In the above brief summarization, we may understand the multiplicity of the approaches to the relations between mental disorder and the family.

How have family sociologists in Japan tried to approach this problem?

Though family sociology is regarded as one of the most productive areas of sociology in Japan, the number of studies in this area is negligible.

Takako Sodei made a leading contribution in 1974.(1) She assumed that having a mentally disordered in family member as the cause of family crisis, and proposed three problematic areas. First was the family situation of the patient, which would include the socio-economic background of the family and interpersonal relationships among its members. It is, in a sence, a socio-genetic approach or a viewpoint inquiring into the dominant causal factor in the onset of mental disorder. The second area, which

was the main point of her argument, was the process of family adaptation. Attention was given to the process of family adjustment to the situation under the impact of the deviant behavior based upon the mental disorder and the process of readjustment. It was viewed as the dynamics of the family role structure. The third area she mentioned was the approach from the view point of family life cycle only as a possibility. At any rate, the presentation of her framework, aided by some research data of her own, is a useful one reflecting the preceding academic achievements in family sociology. This assumption to grasp having "mentally disordered" as the stressor of inducing family stress is very promising and should be tested further by empirical studies. In the course of testing, we may well introduce the theories of family life cycle and of mode and condition of family life.

II

Is there not any more sociological point of view concerning the problems about the "mentally disordered" and the family? The relations between the family and the society may be the new task to be investigated. Generally speaking, this theme has been rather neglected in family sociology after the War. Family sociologists have been interesting rather in intra-familial relations. But recently the extra-familial social relations became to be emphasized.

Three approaches below are the possibilities in attempting to analyze the problem of the "mentally disordered" and the family in the context of "family and the society".

The first one is to study the external social relations of the family with the "disordered" member in the local community setting. One issue here is the conflict between the family and the community which arises on account of the problem behavior of the

disordered person. The process that the family eliminates the ill member by way of hospitalization is often pointed out as the function of intra-familial conflicts and also those between the neighborhood and the family. This is related to the "caseness" which is formerly mentioned. On the other hand this theme is related to the resource theory which pays attention to how the burdened family tries to solve the problem by utilizing the community resources. These two, neighborhood conflict and the use of community resources, may be integrated into the framework which is called the theory of life style or of mode and condition of family life. Then, this first approach may be closely interrelated with Sodei's framework.

The second one is the issue regarding "the relatives' association for the mentally disordered". Within the context of this article, the relatives' associations for the mentally disordered are grasped as a type of social actions agency, appealing social, economic, and psychological burdens they are forced upon as the immediate care-takers of the patients, and acting as spokesmen of the patients who are often unable to make their demands.

The relatives' association for mentally disordered was first organized at Tomobe Mental Hospital in Ibaraki prefecture in early 1960's. It developed through growing participation of families in the patients' activities in the hospital. While other associations were being organized in various places, there was a move forward the revision of the Mental Health Act as a result of the incidence in which a psychiatric patient injured the American ambassador in 1964. In the process of the campaign against that legal revision, the National Federation of the Relatives' Associations for the Mentally Disordered (Zenka-ren) was organized in 1964. Two hundred and eighty three associations joined the federation with a membership of about 10,000. The activities of Federation are reported in a monthly bulletin titled Zenka-ren. It is remarkable that only in Japan, so it is said,

the family of the psychiatric patients organized associations for the purpose of making social actions.

However, the "reratives' association" is not solely social-action oriented. When it first started at Tomobe Mental Hospital, psychiatrists led the way for the purpose of making the family assist in their care for the patients. Those organized at every ward since then are of collaborative nature in the total care system. Most of the family associations at the ward level join to composed an association at the hospital level.

Another type of family association is called the community relatives' association for mentally disordered. This is usually led by public health centers and mental health centers in the course of their community mental health services. As it is more difficult to organize on the local community level than on the hospital level, there were only a few of these associations in the early period. But now the local associations are more numerous in number that the hospital-based associations (about 220 vs. 198). As the former is regarded as more effective and desirable form of social movement, psychiatric social workers and public health nurses at the mental health centers or the public health center have made efforts to lead to organize the associations of this type. However, in the National Federation of the Relatives' Associations for the Mentally Disordered, the community associations are still the minority (67 vs. 108 in number) because not all of associations have gotten part in the Federation. Even in the cases of the local associations, not to speak of hospital-based associations, the members are mostly the families with the patients who have been hospitalized for a long time. There are only a few families with outpatients. There may be some criticism that the relatives' associations have been making actions in order to continue to keep the patients in the mental hospital. When we attempt to understand the relatives' associations, we ought not to neglect the fact that the interests of the patients and their

families may be in conflict.[2)]

Anyhow, the "relatives' association" is an important factor in the analysis of the relations between the "mentally disordered" and the family, and also of psychiatric medicine in contemporary Japan.

The third point, is the approach from the legal system as a core of the social norms and the institutions. As in the sociological viewpoint, "mentally disordered" has been regarded as a person who showed behaviors deviant from the norms, we should treat the problems in terms of norms and institutions which include the view on the control of the deviance from them. This third point is to be discussed in detail in the following section.

III

The Mental Health Act is the fundamental law dealing with mental disorder in Japan today, and is the basis for the governmental administration. Our problem of the family and the mentally disordered is also deeply connected with this law. The Mental Health Act, which was enacted in 1950 and extensively amended in 1965, prescribes the purpose of the Act as follows: "The purpose of this Act is to maintain and promote the mental health of the Japanese people by affording medical treatment and care to the mentally disordered and the like." (§1) Since the meaning of the "mental health of the people" is ambiguous through all provisions, it may be fair to say that it is nothing but a mental disorder countermeasure. And the law states that the mentally disordered is only the object of medical treatment and care.

Though the concept of medical treatment is lucid, the meaning of the care to the mentally disordered is ambiguous in spite of its importance.

The "mentally disordered person" is defined as "the psychotic

patient (including toxic psychosis), the mentally retarded, and psychopathic personality" (§3). In regard to psychopathic personality, it is difficult to define it as a medical concept and the definition is usually identified in terms of social deviance (e.g. crime). Major criticisms on this point in the academic circle of psychiatry have been related to provisions regarding the protection of public peace. As formerly indicated in the section I, the concepts of mental disorder and mentally retarded also cannot be free from socio-cultural environments.

In the Mental Health Act the relations between the psychotic patients and their families and/or relatives are prescribed in terms of "the protector" to the ill. That is, "any one responsible for the patient, be it a guardian, a spouse, a person in parental authority, or a legal sustainer can be the protector of the mentally disordered" (§20(1)), and "the protector must put the mentally disordered under medical care, supervise him not to injure himself or others, and protect patients' proprietary interests" (§22(1)).(3)

To know the nature of the Act, we shall compare the prescriptions with others. One way to compare is the comparison between this Act and the laws in other countries, and the other is the historical comparison between the present law and that in earlier periods.(4)

Here, we shall make a brief historical comparison.

The Care and Custody Act for the Psychotic Patient (enacted in 1901) preceded the present Mental Health Act. The first article of the Care and Custody Act states that the guardian, the relatives within the fourth degree, or the head of the family is responsible for the care and custody of the mentally ill person. In other words, the mentally disordered was regarded as the object of custody, and the kin was first of all in charge of this duty. In this Act, there was no view of medical care and the human rights of the disordered. Moreover, the administrative enforce-

ment of the Act belonged to the Ministry of Home Affairs mainly to be the police power. Thus we understand that this Act was enacted for the purpose to maintain the public peace and order. The "custody" in this Act meant, in fact, the "detention" which meant restraint on person's liberty for the sake of public peace and order. The logic behind it is that the government in pre-war Japan imposes the burden of care and custody of the mentally disordered upon his family in order to maintain the public order. It is important to note that the detention meant, first of all, private restraint of the mentally ill person in his house. The word "zashiki rou" (living room as a prison shell) symbolized the power to restrain person's liberty in the family household ("ie"). Though it has not been emphasized in family sociology in Japan, this is an important function of the family household (the "ie").

As a result of the defeat in the World War II, drastic changes in the legal system were brought about and the new constitution and the revised civil code lead the way for new relations among the family and kin members. In accordance with these changes, the Mental Health Act which was enacted in 1950 gave priority to medical care for the psychiatric patients. The duty of protection of the ill took place of the duty of custody and the private detention in the house was inhibited. It was widely reduced but not thoroughly negated that the state authorizes the power of the family household ("ie") to restrict the liberty of mentally ill members. The provisions concerning "detention for protection" in the new Act may be regarded as traces of the pre-war pattern, since they permitted to restrain the patient in a place other than the mental hospital. Though it must be authorized by the governor on the diagnosis by a licenced psychiatrist, and the term of detention had its limit, the subject of making decisions about this detention of the psychiatric patient was the legal protecter (i.e. family). But these items were eliminated at the time of extensive

revision of the law in 1965.

The preference of public order to the medical care placed the power of the compulsory hospitalization in the hand of the prefectural governor, and the power and duty of the family to restrain the mentally disordered was much reduced. In the legal system after the war in Japan, the administrators of mental hospitals seem to have the power which the family used to hold. This reflects the unwillingness on the part of the state or the local government to cope with the problem which contains conflicting interests between the maintenance of public order or the security and the maintenance of medical care or the welfare of the mentally disordered. The larger part of the duty is still on the shoulder of other systems such as the hospital and the family. This is a major difference from U.S. or Europian countries where due process of court orders is responsible.

The provisions about "commitment with consent" also reflect this characteristic of the mental health system in Japan. Article 33prescribes that the hospital administrator is able to hospitalize a person who is diagnosed as mentally ill and is regarded as in need of hospitalization for the treatment and protection without agreement of the patient himself but with the agreement of his legal protector. In short, the agreement is that of the legal protector (i.e. nearest kin). Incidentially when hospitalization is based on the agreement of the patient himself, it is called the "voluntary commitment". The voluntary commitment and compulsory admission are the two basic systems of hospitalization of the psychiatric patient. Though several countries have the third system of emergent or tentative commitment by mutual consent between the doctor and the nearest kin (or the guardian), it may be fair to say that the two systems, voluntary commitment and compulsory commitment on the governmental power, are the basic systems of hospitalization in many other countries.

The "admission with consent" in Japan resembles the above-

stated third system on the surface, but it is very unique in the sense that it is not emergent or tentative treatment; it is a stable and indefinite if the family would like to continue the patient's stay in mental hospital, and it is regular and most popular pattern of commitment. The pattern in which the public power does not interfere with the admission to retain individual liberty on a long term basis without his own consent seems considerably peculiar in a modern society. Though Article 37 of the Act states that the prefectural governor must give an immediate order to release a patient when he is diagnosed by more than two licenced doctors as not in need of prolonged hospitalization, not much cases have been put to use.

As we have seen above, it does not seem a modern way that the state controls over the psychiatric patient through the family. From the side of an individual (patient), he is under a double control from the family and the state. But no governmental power can function effectively unless it is accepted by the people. Although weakening the ability of supporting its members, the family ("ie") is still considered by many people in Japan as the patron of individuals. The compulsory admission means that the patient is committed to the charge of the government. On the other hand, the fact that the admission with legal protector's consent is made by the autonomy of the family is a relief for the family which has the mentally ill member to support. Every family is not necessary aware of making their decisions autonomously about committing the ill member, but the acceptance of the system is based on the generally accepted notion that the maladjusted member must be cared by the family, and not to become a public burden. From the viewpoint of medical care, it has more merit to give complete medical treatment in the hospital than to take the procedure of compulsory admission before the condition of the patient growing worse and the probable fear of doing injury to himself and others may arise. But it is true that "the admission with legal protector's

consent" introduces severe confrontation against the human right of the patient. This is the problem yet to be solved.

IV

As we have seen above, the family (the "ie") has been expected to a great extent to participate in the care and social treatment of the mentally disordered under the Japanese legal and institutional system. This, of course, was a reflection of the reality of family life.

Let us now review the treatment of the mentally disordered from the point of the changing family structure. It may safely be said that the life of every individual was based and dependent upon the "ie" (Hausgemeinschaft or family household) in the premodern Japan. The majority of the people spent their life as farmers on the land they inherited from their ancestors. The family household was usually continued by the eldest son who lived with and cared for his parents after his marriage, succeeding the family occupation and property. When the family was well-to-do, younger sons received parts of the family property and establish new households upon marriage. This act of branching (establishing branch households) was not the younger-sons' right, it was an act of mercy on the part of the main household (the father or the eldest son). The main family was the master and the protector for the branch family which should in return obey and serve the former.

When the family property was not enough to share among sons, the male offsprings, with the exception of the oldest son—— the successor, had to choose one of the three alternatives. The first alternative was to remain in the main household through life, working for the family business. In this case, he usually remained unmarried. The second alternative was to become a

member of other family which had no family heir (either no child or only girls). He would become an adopted son, eventually becoming the heir of the adopted family. The third alternative was to live in with the family of a big merchant or a land owner serving as an apprentice for a substantial number of years, hoping to become independent as a branch house of the master. In any case, there was no assurance of his secure living without being a member of the "ie" (the family household). For those who were not able to choose one of the above three alternatives, the possible remaining courses to take were either to be affiliated with the Buddhist temple (as monks or as servants) or to live as out-laws such as gangstars and gamblers. The system that operates in the under world was(is) similar to the traditional family system. One has to so through a specific procedure to establish a parent-child relationship with the boss. The relationships within the gang family were(are) much life those in the "ie". The "ie", thus, was fundamental to the traditional life of the Japanese.

The people shared the awareness that the family (the "ie") was the ultimate source of welfare for every individual who would not be able to survive independently. Because of this awareness, they developed a pattern of behavior supporting the maintenance of the family at any cost over generations.

The emergence of Japan as a modern nation since the Meiji era was possible by making use of the people's traditional way of life. The government legitimized the "ie" as the basic unit in the registration system, granting the family head the right to control over his family members with the expectation that the "ie" provided welfare for its members. Thus the government could maintain the burden of social welfare at the low level and shifted their emphasis on rapid industrialization and militarization. Social welfare relief was provided as a favor to only those who did not enjoy the family support. This type of welfare was conceived by the people not as their "right" but as a "disgrace" admitting

the failure from making a normal living. We may now understand that the familistic treatment of the mentally disordered expressed in the law is in accordance with the relation between the "ie" and the government regarding welfare.

Revolutionary changes after the World War II denied the patriarchal privileges of the family head. Family formation became an institution based on the consent of the two parties (both sexes), terminating in one generation. Right to the inheritance of family property is now equally shared by all children. The expanding urban working class had better backgrounds to accept the new ideology. For farmers and merchants, however, the old custom of succeeding the family business by one son necessary for the maintenance of stable living. Even among the working class, the aged parents could not rely on the underdeveloped social welfare system, and they tended to expect their married offsprings to support them. Today, more than 70 percent of the elderly in Japan live with their married offsprings.

Legally speaking, the government in the pre-war time changed to the government for the people after the War, but the development of social welfare system was slow when the priority was placed upon economic reconstruction. Medical treatment of the mentally disordered was formalized in 1950 by the Mental Health Act, but necessary environments were not provided. The nationwide survey of 1954 estimated about 250 thousands patients who might need hospitalization for treatment while only 40 thousands were actually put in the hospital. The rest of the patients were either under home-treatment or left free. We can not say that all of them were socially identified as mentally disordered. We only know that the great majority of those who were socially dependent lived under the protection of their families.

The 1965 amendment of the law and the following development must be understood in line with changing social trends, particu-

larly the changes in the family.

Japan entered the period of rapid economic growth since 1960. Those who were engaged in traditional occupations such as farming and fishery decreased rapidly and those in productions and services increased. This trend was observed in the migration from rural to urban areas, causing rapid urbanization. Occupational and geographical mobility functions against the maintenance of traditional family life. When the family heir tends to seek a new occupation, the traditional family (the "ie") which continued to exist over generations providing security for its members was forced to change. The legal and administrative notion of the nuclear family now became the major existing form of the Japanese family. Being wage-earning, small in size, and nuclear in the structure, Japanese family lost a great deal of its supportive ability. We cannot deny the weakening power of the family in the protection of the mentally disordered. The number of the beds in the mental hospitals increased since the operation of such facilities made a "good business" financially. At the same time, we should not forget that changes in the condition of the family were contributing factors to the above trend.

The increase in the hospitalized patients parallels the increase in the number of patients with compulsory commitment by Mental Health Act, but this should not be interpreted as the increase in the patient with "probability of hurting himself and others". It is true that a highly organized and complex society demands a higher degree of rationality and eliminates the maladjusted members. The increase of the patients with compulsory commitment under the section 29 of Mental Health Act during this period, however, seems to be due to the diminishing function of the family as support system. The national welfare benefit in Japan does not provide enough subsistence and confines the eligibility of the applicants. By the use of compulsory commitment by Mental Health

Act the medical cost becomes a public account. To lessen the economic burden, the families of the patients tended to keep the patients in the hospital even after hospitalization became no longer necessary, and the medical and welfare staff ignored or even encouraged this.

The above type of treatment has become a target of criticism from the standpoint of the patients' human rights, and the patients with compulsory commitment by Mental Health Act is gradually decreasing. The total number of hospitalized patients has not decreased, however, due to the balancing effect by the increase in the number of those admitted with legal protector's consent who receive medical benefits from the national welfare service. On the other hand, the number of those with voluntary commitment has not increased as expected. The structure of emphasizing the involvement of the family in the social treatment of the mentally disordered still remains in our legal and administrative system.

Summary and Conclusion

The main points of discussion on sociological approaches to the problem on the "mentally disordered" and the family are as follows:

1. The predominant methods of research in the area place focus on the interactions or communication patterns between patients and their families, or the problem solving process of the family as a small group.

2. In contrast to the above, we have proposed the view point which considers the relations between "the family, the society, and the individuals" essential in understanding the problem about the mentally disordered and the family. We have indicated three specific view points. The first one is on the relations between

the family and the community, and this is relevant to the theory of mode and condition of family life. The second one is the theme about the Relatives' Associations for the Mentally Disordered which includes the viewpoint that the family (and the patient himself) does not remain as the object of the social welfare services but exists as a subject of social actions. The third one is reference to the legal institutions which socially define the "mentally disordered", and put the relations between the "mentally disordered" and the family in the frame.

3. By taking a glance at the historical pattern of changes in the legal and institutional systems concerning to the social treatment of the psychiatric patient, we have found that the traditional family system ("ie") has been exerting influence not only upon the historical pattern but also upon the contemporary pattern, though it has changed considerably. Even now in Japan, the change of the family is one of the important factors to affect how to deal with the mentally disordered in the society.

Notes:

1) SODEI, Takako, "Mental Disorder as the Family Crisis, <Kazoku Kiki to shite no Seishin Shyogai>" in Contemporary Family in Japan <Gendai Nihon no Kazoku>, ed. by Kazoku Mondai Kenkyu Kai, Tokyo: Baifukan, 1974, pp. 202~216.
2) ENOMOTO, Minoru, "On the Relatives' Association for the Mentally Disordered <Seishin Shyogai-sha Kazoku Kai ni tsuite>" Clinical Psychiatry, Vol. 15, No. 12, 1973, pp. 75~81.
3) The specifics of the law regarding the above as follows:

1. When a government-appointed psychiatrist is to diagnose a person, the prefectural governor must notify in advance his legal protector of the date and the place it will take place

(§28(1)). And, his guardian, the person in his parental authority, his spouse, or the person who is actually protecting him has the right to attend the psychiatric diagnoses.(§28(2))

2. The legal protector must receive the patient when he is discharged by the prefectural governor from the compulsory commitment, and when his treatment is still necessary, the legal protector is obliged to obey the directions of the administrator of the mental hospital (§41).

3. The expenditures necessary for the medical treatment and protection for the patient is to be born by that mentally ill person himself or his legal sustainer (§49).

4. With the consent of the legal protector, the administrator can hospitalize a person without his consent, when he is diagnosed as mentally disordered (§33~34).

4) In regard to the cross national comparison, let us point out two distinctive tendencies. First, in the western countries the protector or the guardian is not imposed so much burden as in Japan where the duration and the nature of rights and duties are left unspecified. Second, by limiting the protective commitment of the disordered to a short term, the patient is treated as an independent personality when the term is over. (URABE, Keiji,"The Cross National Comparison of the Mental Health Act<Kakkoku to Nihon no Seishin Eisei Ho no Hikaku>," Psychiatrica et Neurologica Japonica, Vol. 76, No. 12, 1974, pp. 835~844).

On the Evaluation of

the Factors connected with Adjustment of the Aged

Kazuko Saito
Masaaki Kato

presented at the time of
the 10th International Congress of Gerontology, Israel, 1975

The object of our research was to evaluate the mental and physical changes with aging and to make clear the correlations between these changes and the adjustment of the aged people over 65 years old. In Japan, as in other developed countries, the population of the aged is increasing in number. As indicated on the Table 1, in 1970, the percentage of the people over 65 years old was about 7% and was still smaller than many European countries. It is estimated, however, that this percentage will pass over the 10% line within the next 20 years.

On the other hand, by the end of World War II, the circumstances of the family and the community where they live have drastically changed. For instance, within the family system, registration of the first son as heir has been abolished and value orientation toward the elderly has changed. Urbanization has gone on rapidly all over the country and many communities have become highly industrialized. The aged people of today have met with these drastic changes in the later part of their life cycle. They cannot live in the same way as their parents or their grandparents. They must devise new ways of coping with life on their own.

Nevertheless, the life style of the aged in Japan would be rather different from that in other industrialized countries. As indicated on the Figure 1 we are now viewing, the majority live with their children and their grandchildren. Although the percentage of people who reside with their children will decrease, 45% will continue to live with their children in the 21st century.

Our research program involved four separate operations for each case reviewed. There is the examination of physical changes and intellectual ability of each individual followed by an evaluation of adjustment to present living conditions and of the individual's life history. In examining physical changes, we made inquiry regarding diseases past and present and covered a check list of physical findings, for example, white or gray hair,

visual ability, hearing ability, slowness of speaking, elasticity of skin, sclerosis of the arteries, etc. From the examination of the physical findings, we have assigned rating points to each item.

The sum of these points became an index of physical aging. For the intellectual ability, we used the scale developed by Dr. Hasegawa. It consists of 12 inquiries, for example, the date, how many days there are in a year, the name of the prime minister, successive subtraction 7 from 100 first and then from resulting remainders, memorizing five articles presented momentarily, etc. We used the score obtained as an index of intellectual ability. To evaluate adjustment, we used a free interview to ask about the life history and present living conditions of each individual. The results of the interviews were analyzed by certain events and the phenomena. Finally we employed the life satisfaction questionnaire developed by Dr. Neugarten. Then we adopted the life satisfaction index as the index of evaluation by comparing it with the events and phenomena of the life history and present living conditions.

We carried out this research in three locations in Japan, that is, in Urayasu, Naha, and Tokyo.

Urayasu is situated on the Edo River delta, east of Tokyo, and used be a fishing village. Even though it is situated within 15 km of Tokyo, because of transportation inconvenience it is like a solitary island. The large scale industrialization of the Tokyo bay area was accompanied by reclaiming of former bay area. The people of Urayasu were obliged to completely abandon their fishery rights in 1971. At the same time a new subway was opened in 1969. So that it now takes only a quarter of an hour to reach the center of Tokyo. On the reclaiming land, innumerable apartment houses have been constructed by private developers. Urayasu is becoming one of the most nearer residencial areas to downtown Tokyo.

Naha is the capital city of Okinawa prefecture. Okinawa consists of many islands, Okinawa has been known for its unique family system. Family ties are strong. Usually the families are of three or more generations. Each member of the family receives maintenance through the family. Aged people are respected as the seniors of the families and of the communities. After the war, these traditions are gradually changing but the feeling of respect for the aged still remains.

In Tokyo and Naha, the interviews were done by home visiting. In Urayasu, we interviewed people who were coming to the community welfare center for the aged. The interviewers were medical doctors, public health nurses, social workers and clinical psychologists.

We interviewed each person from two to four times, and each interview took from 30 minutes to 1 hour.

The results were as follows.

The number of the cases were 378, of which 86 in Urayasu, 142 in Tokyo, and 150 in Naha. The classifications of the subjects by sex and age were as indicated on the Table 2. We found that in Urayasu, 87 percent were living with their children, in Tokyo this figure was 80 percent, in Naha 76 percent the average was 80 percent. This percentage is higher than the national average in Japan reported by the Ministry of Health and Welfare in 1973. The average score for each index appears on the Table 3, and Figure 2.

On the physical index a higher score is considered as more advanced aging. On the intellectual index a lower score shows advanced aging. On the life satisfaction index a higher score is considered as having greater satisfaction.

The degree of physical aging was the highest in Naha, the lowest in Tokyo and close to average in Urayasu. The degree of intellectual aging was the highest also in Naha, the lowest in Urayasu and close to average in Tokyo. The degree of life

satisfaction was the highest in Naha, the lowest in Tokyo and close to average in Urayasu. The contrast between Tokyo and Naha was very clear. In Naha, the degree of physical and intellectual aging was high but that of life satisfaction was the highest. On the other hand, in Tokyo, even though the degree of the aging both physical and intellectual was not so high, the degree of satisfaction was the lowest.

The Table 4 and Figures 3, 4, 5 show differences in physical, intellectual and satisfaction indices according to kind of person with whom the aged individual lives. In Urayasu and Naha, the people who lived with their children were more satisfied than the people who lived alone or with their spouse only. On the contrary, in Tokyo, the people who lived alone or with their spouse only were more satisfied than others in spite of higher scores on indices physical and intellectual aging. This is an interesting result. It could be said that the people are more independent in Tokyo, where extended family style is not acceptable for the people any more.

In conclusion, we would like to say that, generally, agings both intellectual and physical parallel chronological age, however, there is some exception like in Tokyo, and that the life satisfaction index is not necessarily related with either physical or intellectual aging. We started with the hypothesis that the people who lived with their children would be more satisfied than those who did not. In Tokyo, this hypothesis did not prove correct. In Urayasu and Naha it was borne out. It is interesting that old people in Japan place a very high value on living with their children in spite of the increasing difficulty with this kind of arrangement. According to a recent inquiry made by the Ministry of Health and Welfare, as indicated on the Table 5, 90 percent of the people who actually live with their children now indicate that they would like to keep it. Furthermore 42 percent of those who do not now live with their children would like to do so.

Our study would seem to indicate that in spite of this still strong traditional feeling, older residents of large cities like Tokyo are experiencing increasing satisfaction with life apart from their children.

Table I. Movement of the Structure of Population

Year	Total Population	Over 65	Age group		
			0～14	15～64	65～
	,000	,000	%	%	%
1900	43,785	2,378	33.89	60.68	5.43
1920	55,391	2,917	36.47	58.26	5.27
1930	63,873	3,034	36.56	58.69	4.75
1935	68,662	3,189	36.86	58.49	4.64
1947	78,101	3,745	35.30	59.90	4.79
1950	83,200	4,109	35.37	59.69	4.94
1955	89,276	4,747	33.38	61.30	5.32
1960	93,419	5,350	30.04	64.23	5.73
1965	98,275	6,181	25.61	68.10	6.29
1970	103,720	7,330	23.93	69.00	7.07
1975	109,925	8,715	23.97	68.10	7.93
1980	115,972	10,279	24.07	67.07	8.86
1985	120,798	11,502	23.35	67.13	9.52
1995	128,344	15,380	21.00	67.02	11.98
2005	134,960	19,440	21.23	64.36	14.41

Institute of Population Problems,
Numbers on and after 1975 are the estimates

Figure 1. International comparison according to kind of people with whom the aged live

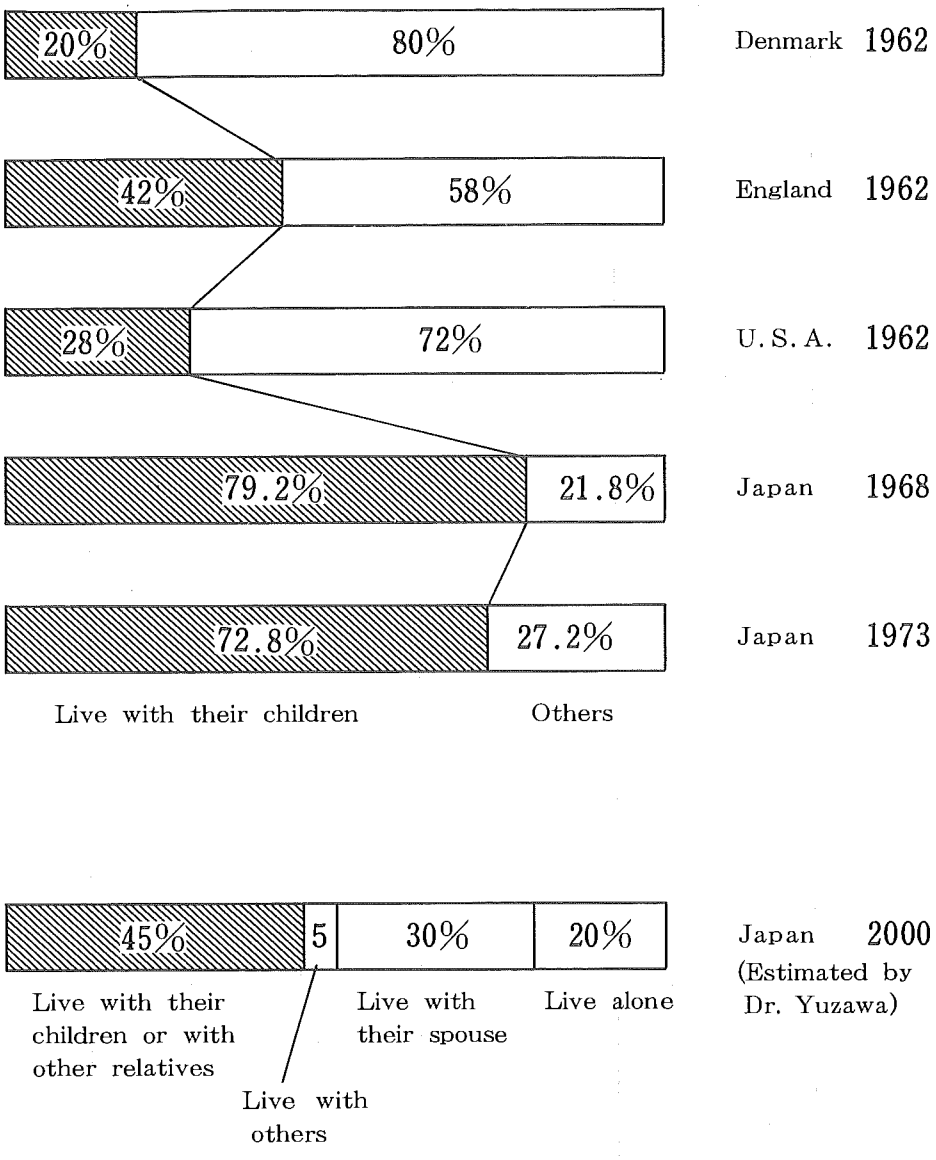

Table 2. The Study Population: Coefficients by Sex and Age

Location	Case	Sex		Age group					
		m.	f.	60～64	65～69	70～74	75～79	80～	Average
Total	378	45.2	54.8	4.0	22.5	28.2	27.8	17.5	73.7
Urayasu	86	74.4	25.6	12.8	31.4	24.4	19.8	11.6	71.2
Tokyo	142	40.1	59.9	0	22.5	26.1	32.4	19.0	75.0
Naha	150	33.3	66.7	2.7	17.3	32.7	28.0	19.3	74.0

Table 3. Scores of three indices of aging

Location	Age	PAI	IFI	LSI
Total	73.3	11.3	26.7	11.5
Urayasu	71.2	11.1	28.9	11.6
Tokyo	75.0	10.2	26.2	10.2
Naha (Okinawa)	74.0	12.5	24.9	12.8

Figure 2. Scores of three indices of aging

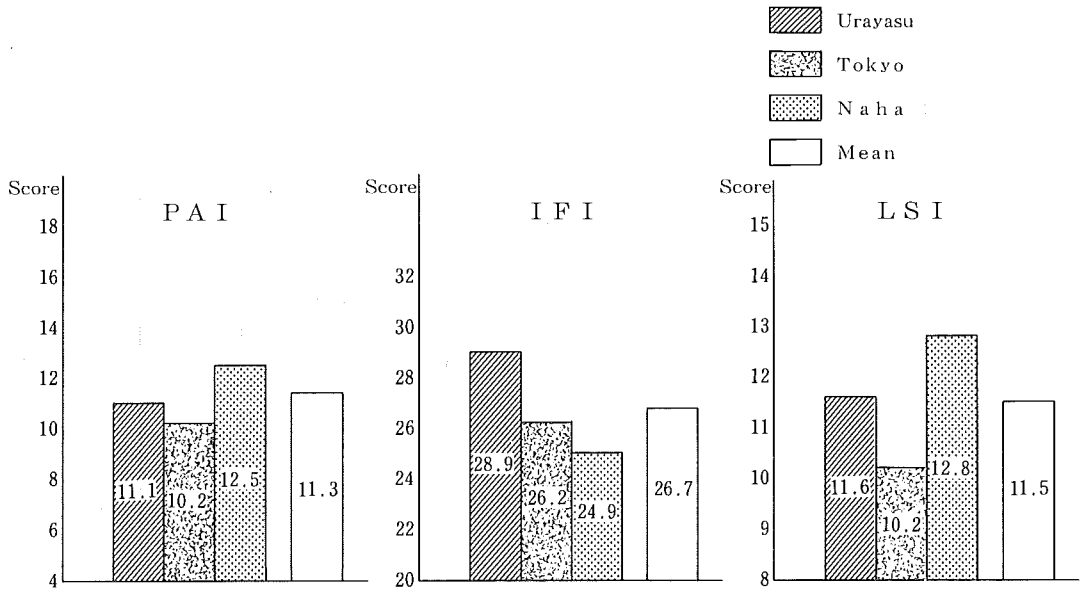

Table 4. Scores of three indices of aging according to kind of people with whom the aged live

Urayasu

Live with	Case (%)	Age	PAI	IFL	LSI
Alone or with their spouse	10.5	74.3	13.1	27.5	9.8
With their children	87.2	70.9	11.0	26.6	12.0
With others	2.3	69.5	8.5	31.0	11.5

Tokyo

Live with	Case (%)	Age	PAI	IFI	LSI
Alone or with their spouse	17.7	74.9	9.6	25.5	12.6
With their childrn	79.9	74.6	10.3	26.2	9.9
With others	2.4	77.0	8.3	29.3	12.1

Naha(Okinawa)

Live with	Case (%)	Age	PAI	IFI	LSI
Alone or with their spouse	23.6	74.8	10.1	26.0	11.9
With their children	75.7	73.7	11.7	24.5	13.4
With others	0.7	75.0	17.0	32.5	10.0

Figure 3. Score of Physical Aging Index according to kind of people with whom the aged live

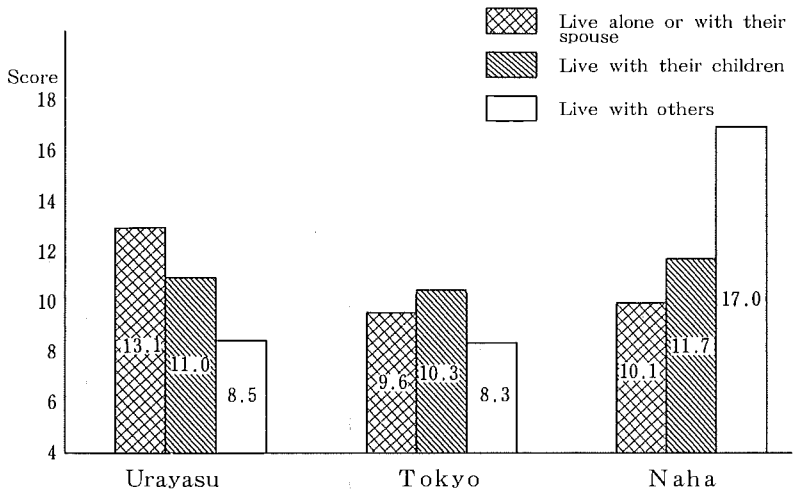

Figure 4. Score of Intellectual Faculty Index according to kind of people with whom the aged live

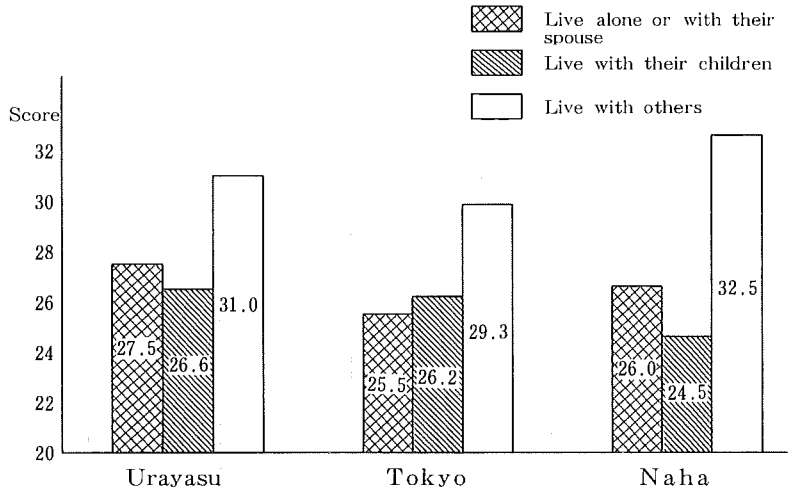

Figure 5. Score of Life Satisfaction Index according to kind of people with whom the aged live

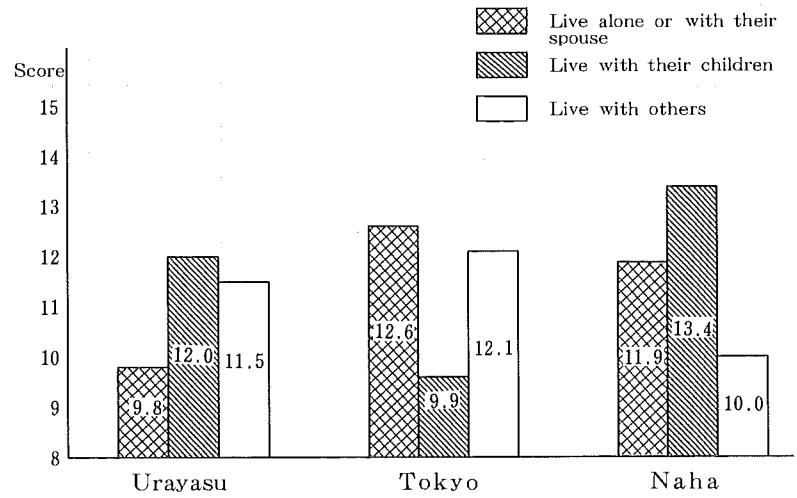

Figure 3. Score of Physical Aging Index according to kind of people with whom the aged live

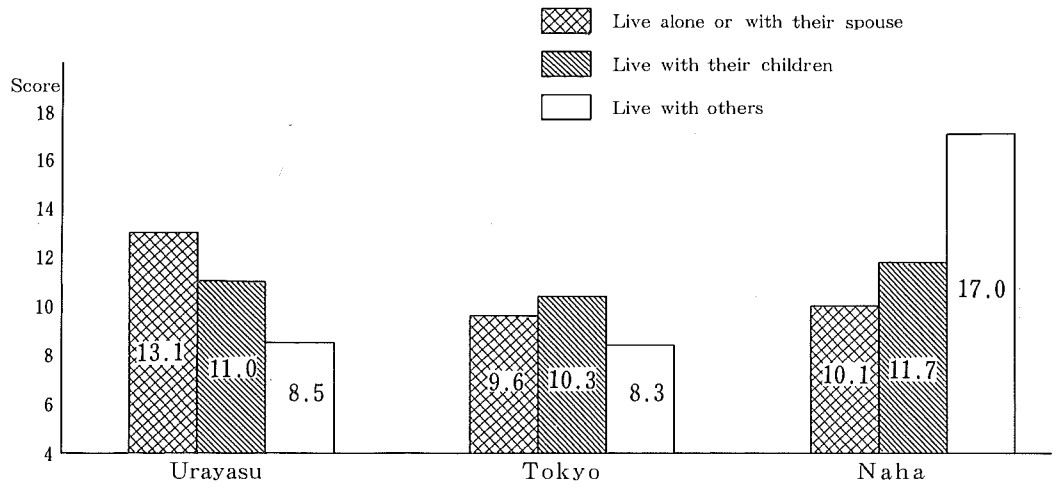

Figure 4. Score of Intellectual Faculty Index according to kind of people with whom the aged live

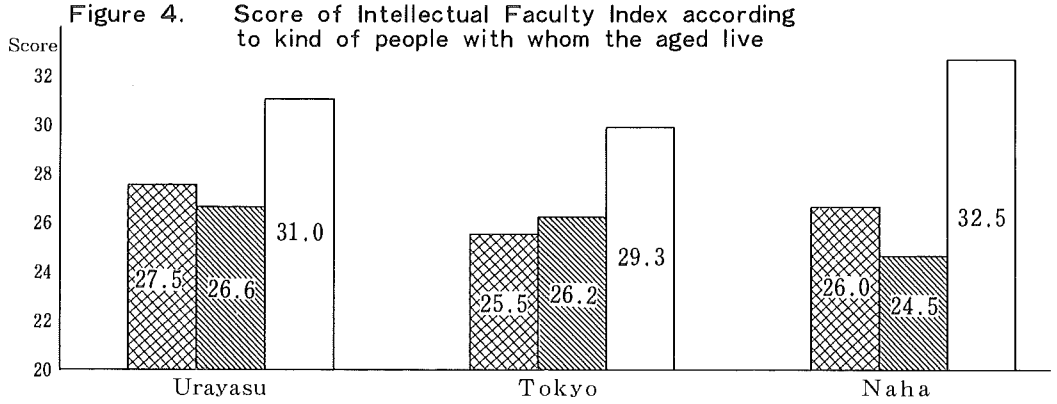

Figure 5. Score of Life Satisfaction Index according to kind of people with whom the aged live

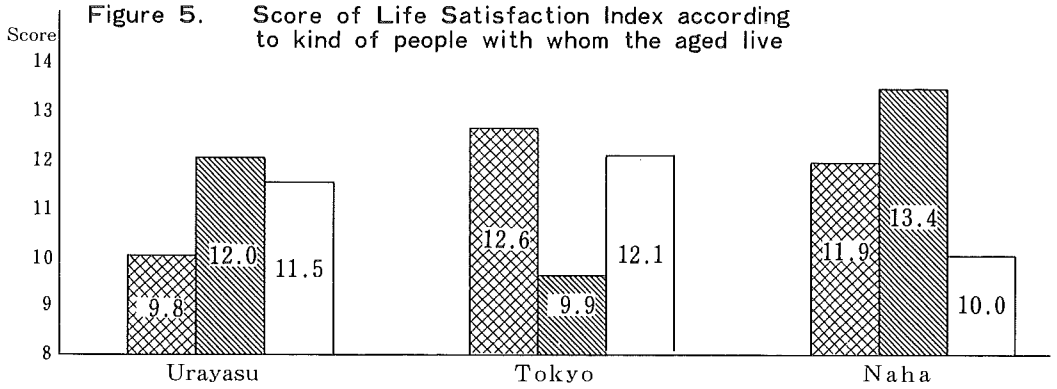

Table 5. Desire to live with their children

(%)

Residence	Desire to live with their children	Desire to live separately	D K
Actually live with their children	90.8	5.8	3.4
Actually live separately	42.2	46.7	11.1

あ と が き

1977年は、わが精神衛生研究所の創立25周年でした。研究所内の機構も、班による研究体制から、新しい部体制のもとでの研究へと歩みつつあります。この機に、班研究の総括をかねて、25年をふり返り、わが研究所の動向と現状をお伝えしようというのが、今回の資料委員の考えでした。

さらに、せっかくの25周年記念誌なら、これを外国の人々にも読んでもらおうということになりました。

しかし、この企画では、各グループの研究項目や概略に紙面がとられ、その研究内容の部分が薄くなりますので、外国向けということを意識して、国際学会等で発表した論文を中心に、研究員の英文による論文を掲載しました。これらが、国内および国外の人々に読まれ、多くの批判を得て、研究のための一助となればと思います。

発刊が大幅に遅れましたこと、お詫びいたします。各国の図書館の蔵書の中に、日本人による論文が増え、世界の人々にわが国の精神衛生の現状を理解してもらうために、今後も積極的に英文等による研究論文が発行できるよう、次回の資料委員に引き継ぎたいと思います。

精神衛生資料
——第 22 号——

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