Title:

Taijin kyofusho: a culture-bound diagnosis discussed by Japanese and international early career psychiatrists

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A 23-year-old male complains about nervousness, stiffness in the face, and inability to act as he wishes when among other people. The patient is concerned that he might make other people feel uncomfortable. He has no apparent symptoms of depression or psychosis.¹

Since the 1930s, Japanese psychiatrist Morita characterized *Taijin kyofusho* (TKS) as phobia of blushing and being ashamed. Kasahara redefined TKS as a type of neurosis that includes excessive anxiety and tension in social situations and withdrawing from interpersonal relationships.^{2,3} He also reported that there can be severe, almost delusional cases.^{2,3} Nagata later developed diagnostic criteria for TKS differentiating tension (fear of being looked at by others) and offensive (fear of offending or embarrassing others) subtypes.² In 1980, the Diagnostic and Statistical Manual of Mental Disorders (DSM)-III adopted social phobia encompassing fear of scrutiny by others, humiliation and embarrassment, not offending others. The criteria were close to the classification of TKS, since social phobia is diagnosed in 66% of TKS cases.³ In 1994, under DSM-IV, social anxiety disorder (SAD) was listed as equivalent

to social phobia, and TKS was added in “culture-bound syndromes.” Fears of offending others in certain cultures (e.g., Japan and Korea) were first mentioned as associated features of SAD. DSM-5 recently included offending others as one of the main fears in SAD,⁴ although differences remain between TKS and SAD, since some symptoms of TKS, *shubo-kyofu* (similar to body dysmorphic disorder) and *jikoshu-kyofu* (similar to olfactory reference syndrome), are categorized as other specified obsessive-compulsive disorder and related disorders.⁴ Still, TKS appears changing under cross-border cultural influences.⁵

In Fellowship Award Symposium at 112th annual meeting of the Japanese Society of Psychiatry and Neurology (JSPN), a TKS case vignette¹ was discussed. Awardees (including some of the co-authors of this letter) chose SAD as a diagnosis, while others suggested body dysmorphic disorder or delusional disorder. In the discussion, we were reminded that diagnostic practices may be culture-bound and evolve over time, even though DSM is an internationally accepted diagnostic standard. Professor Malcolm John Hopwood of the Royal Australian and New Zealand College of Psychiatrists pointed out

the importance of thinking about the purpose of diagnostics and the differences of prognosis and intervention for SAD, TKS and other diagnoses.

Reflection on the diagnostic principles and purposes is crucial for early career psychiatrists. The discussion among international colleagues at the JSPN fellowship award symposium was extremely valuable.

Disclosure Statement

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