The Offensive Subtype of Taijin-Kyofu-Sho in New York City: The Phenomenology and Treatment of a Social Anxiety Disorder

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Background: Taijin-kyofu-sho (TKS) is thought to be a common, culture-bound disorder of social anxiety in Japan and Korea. Its phenomenology has been noted to overlap with that of social phobia. The "offensive type" of TKS, which has no direct parallel in Western classification, is characterized by a fear of offending others in social situations, which leads to social avoidance. There has been only one case of offensive-type TKS reported in the United States, and this case was not regarded as a variant of social phobia.

Method: The phenomenology and treatment of six patients who presented to New York City anxiety disorders research clinic psychiatrists with the offensive type of TKS are described. Features of TKS are compared with those of social phobia, as described in Western countries. Treatment outcomes for four patients are discussed and compared with TKS treatment experience in Japan and Korea and with treatment outcome in social phobia.

Results: In this anxiety clinic sample, features of the offensive type of TKS showed much overlap with symptoms of social phobia. Only two of four treated patients in this TKS sample received adequate trials of medication known to be effective for social phobia, and one of the two improved significantly.

Conclusion: The offensive type of TKS may not be as culture-bound as previously thought. Further study is needed to determine whether such cases respond to medications and to cognitive-behavioral approaches that are effective for social phobia. How to classify the offensive type of TKS is uncertain, but social phobia should be considered in the differential diagnosis.

(J Clin Psychiatry 1996;57:523–527)

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Taijin-kyofu-sho (TKS) has long been considered a common, culture-bound syndrome in Japan. In Japan and Korea, TKS is conceptualized as varying on a continuum of severity from (1) the very common but short-lived "adolescent social anxiety" to (2) "pure" social phobia that fulfills criteria for social phobia in DSM-IV to (3) "quasi-delusional" or "offensive type" TKS that can, at times, take on the quality of a delusion to (4) social phobia accompanied by schizophrenia (arising as a prodrome of schizophrenia or as a postpsychotic symptom during remission).[1,2] For TKS as a whole, males predominate in clinical samples by 3:2.[1] TKS usually begins between the ages of 15 and 25 years, and symptoms tend to remit after the age of 30 years.[3]

The "quasi-delusional" or "offensive type" of TKS is characterized by fear of hurting the feelings of others by the expression of certain imagined shortcomings within oneself. Offending or hurting others may occur in many ways, including embarrassing others by blushing; making others uncomfortable by the nature or intensity of one's gaze or by one's facial expression; causing offense via emitting bodily odors; subjecting others to the sight of a blemish or physical deformity; or irritating others by shakiness of the voice. The majority of those afflicted experience a single, circumscribed fear, although this particular focus may change over the course of the disorder. This type of TKS has no direct parallel in Western classification.

Recent literature suggests that TKS is perhaps not as culture-bound as was thought in the past; it is reported as being common in China and Korea.[4] Moreover, a 1994 study[5] compared symptoms (but not diagnoses) of TKS and social phobia in two community samples in Hawaii: one of people who come from Japanese and other Asian ancestry and one of people from a non-Asian background. Although the study referred to TKS in general, it focused on the offensive subtype of TKS. Volunteers filled out questionnaires that assessed symptoms of social phobia by using an 8-item social phobia symptom scale, while offensive-type TKS was assessed by using a 10-item scale. Contrary to expectations, the researchers found no differences between participants of Asian and Western

backgrounds on the mean scores of the TKS and social phobia scales they employed.

The body of literature written in English on TKS research is scant and confused. There are no reports of controlled studies of TKS and none in which operationalized criteria are used. Also, in the American literature, the term *TKS* has been used to designate what the Japanese and Koreans call the "quasi-delusional" or "offensive type." Only a single case of TKS that occurred in the United States has been reported in the literature; the report[6] describes an African-American woman whose fear of staring at the genitals of those around her and consequently offending them led to social avoidance. Interestingly, this patient was referred for treatment of obsessive-compulsive disorder (OCD), although her primary complaint was social avoidance. It is inferred that the referring clinician viewed her symptoms in the familiar context of OCD, rather than as the more salient but unfamiliar TKS syndrome.

Other English-language reports on TKS include a 1991 article by Kirmayer[2] that emphasizes the role of culture in psychiatric nosology; TKS is seen as a pathologic expansion of culture-specific concerns about the social presentation of the self and the effect of improper behavior on the well-being of others.[2] Again, what is termed "TKS" in the article is, more specifically, the offensive type of TKS.

A 1992 article by Nakamura[7] examines the relationship between social phobia in the West and TKS in Japan and discusses Morita therapy as a comprehensive treatment for patients with all types of social anxieties. Morita psychotherapy has been used in Japan to treat TKS for many years. Important principles of Morita therapy include not laboring to discover the cause of the illness and accepting one's symptoms. The actual therapeutic program usually consists of two phases; it starts with intensive psychotherapy for several months in a psychiatric ward, which is then followed by a "working through" process at an outpatient clinic. It is also broken down into periods of "absolute bed rest, light group therapy work and adaptive activities to actual life."[3,8] A 1975 report by Takahashi[9] describes the formation of a social club in Japan by TKS expatients. The Proceedings of two symposia, one held in 1987 (First Cultural Psychiatry Symposium Between Japan and Korea) and the other in 1995 (Social Phobia in America and Asia), describe forms of social phobia found in Japan, Korea, and the West. While diagnostic criteria for TKS are offered, no controlled studies are presented. Essential clinical features of TKS in both Korea and Japan described during these symposia include: (1) in social situations, the individual feels that his/her behavior or attitude is inadequate and that he/she has some sort of physical defect; (2) due to this inadequacy or defect, the individual feels embarrassed and ashamed; (3) the individual is afraid that others will notice his/her problems; and (4) the individual tries to avoid situations in which this anxiety is produced or he/she endures such situations with extreme anxiety. Both Korean and Japanese literature distinguish between TKS patients who meet only the criteria listed above ("simple type" in Korea and "Morita type" in Japan) and a second type, in which the individual is certain that he/she is making others uncomfortable, and hence, the individual feels that others are avoiding him/her ("offensive type" in Korea and "quasi-delusional type" in Japan.)[10,11] Up to now, however, this distinction has had no parallel in the Western classification of social anxiety or social phobia.

Below, we will discuss the descriptive literature on the pharmacotherapy of TKS.

CASE REPORTS

Case 1

Mr. A was a 43-year-old man who emigrated from the Philippines at age 32 years. Since about age 20 years, he suffered from the fear that in his presence, others would sneeze, get watery eyes, or become sleepy, and he was thereby causing others discomfort. When he feared that he was causing discomfort to others, he would sweat, feel short of breath, feel his heart racing, and be unable to concentrate. His fears were never of a delusional nature; he could hypothesize a number of reasons why others seemed to be sneezing and sleepy in his presence, including the possibility that his presence was a coincidence. Nevertheless, he worked an evening shift to avoid people and repeatedly turned down promotions because these would involve working more closely with others. Mr. A also gave a lifelong history of feeling shy and self-conscious, and being afraid of embarrassing himself in social situations. He had been treated unsuccessfully in the past, once with psychotherapy, and more recently with imipramine and diazepam. Mr. A met criteria for social phobia, without comorbid diagnoses as assessed by the Structured Clinical Interview for DSM-III-R[12] (SCID). He was treated openly with up to 60 mg/day of phenelzine for 13 weeks. He initially reported some increased friendliness and talkativeness, but ultimately continued to complain of severe sweating in anticipation of meeting people. He was tapered off phenelzine and was lost to follow-up after being assigned a new physician when his treating physician left the clinic.

Case 2

Ms. B was a 37-year-old white woman who had been born in New York City. Since age 9 years, she worried that her breath had a foul odor and was offending others. She also had a history since elementary school of performance anxiety, both at school and later at work; she feared that she would make a fool of herself and feel humiliated. Previous treatment consisted of 1 year of psychoanalysis; she never told the analyst about her social anxieties. Ms. B was diagnosed as having social phobia

(no fixed delusions), without comorbid diagnoses, as assessed by the SCID,[12] and she was treated in a double-blind, placebo-controlled study of the reversible monoamine oxidase inhibitor, moclobemide, for social phobia. She improved slightly while taking 800 mg/day of moclobemide for 8 weeks. In open treatment, Ms. B was given fluoxetine, but discontinued it because of side effects at 5 mg/day. She then declined further pharmacotherapy.

Case 3

Mr. C was a 38-year-old man born in Colombia who came to the United States at age 27 years. He reported a 4-year history of a bad bodily odor and bad breath, which he believed caused people to recoil from him and avoid him. He also reported shaking when writing in public. Mr. C believed that he picked up strong odors from the environment. He had had an extensive negative medical workup to find the source of these odors. Mr. C's beliefs were of a fixed and delusional quality; he was certain that he smelled bad and that people avoided him because of it. Mr. C met criteria for delusional disorder, but because of the social content of his fears, he was treated with 0.5 mg b.i.d. of clonazepam, as one might initiate treatment of a social phobic. He consistently felt less anxious and reported a decrease in stomach tightness on clonazepam treatment, but he ultimately reported that he was unsure if the odor problem had improved since he could not trust anyone to be honest with him about it. He was lost to follow-up after 1 month of clonazepam treatment.

Case 4

Ms. D was a 16-year-old white girl born in New York City who complained of a $2^1/_2$-year history of bodily odor despite numerous negative medical workups. She also had a history since early childhood of being very shy and never participating in class unless called on. Ms. D's mother reported that initially there had been some validity to her daughter's complaints of having a bad odor; when the mother would enter her daughter's room in the morning, she did detect an unpleasant odor, but the mother reported that this quickly passed after her daughter changed her bathing and hygiene habits. Her family reported that she had been irritable since the preoccupation with body odor began; there were no other symptoms of depression or dysthymia. Ms. D was diagnosed as having social phobia and TKS, and she was treated with up to 60 mg/day of phenelzine. She reported that on phenelzine treatment she was no longer sitting tensely in classes, and her family found her much more outgoing and without irritability. She was "not sure" if she continued to smell bad, but reported that she rarely thought about it anymore. She decided to discontinue phenelzine 3 months after beginning it because she did not like the idea of being on medication.

Case 5

Mr. E was a Pakistan-born man who had been in the United States for a decade. He presented at age 40 years with fears of offending others because of foul-smelling perspiration. He recognized his fears as being excessive and often irrational. The odor fears were not a preoccupation when he was with his wife or closest friends, but in the presence of colleagues or social acquaintances, the fears were always on his mind, distracting him from conversation and leading him to avoid parties. Two years of psychoanalytically oriented psychotherapy had not resolved his fears. Mr. E was offered treatment for TKS, but decided to pursue treatment elsewhere.

Case 6

Ms. F was a 30-year-old Haitian-born woman who presented with a chief complaint of initial and terminal insomnia, but upon evaluation, reported that since she came to the United States 14 years ago, she had been plagued by bad breath that other people could smell. This caused her to avoid people, especially groups. She reported that she could tell from others' gestures that her breath was bad. She also worried about the odor of her sweat offending others, as well as whether her accent would cause others to misunderstand her if she spoke before a group. Ms. F additionally met DSM-IV criteria for panic disorder without agoraphobia, generalized anxiety disorder, and dysthymia. Ms. F decided not to pursue treatment at this time.

DISCUSSION

Conclusions drawn from these results must be tempered by the very small sample size, the lack of controls, the absence of standardized rating scale assessments, and the fact that three of the four treated patients had responded to recruitment for studies of treatment of social phobia. In addition, the 0.5-mg b.i.d. dose of clonazepam was rather low for treatment of social phobia, and the efficacy of moclobemide for social phobia is not established. With these caveats in mind, the equal sex distribution and early age at onset are not atypical for social phobia patients.[13] The ages of the patients at presentation to the clinic are not representative of TKS, in which symptoms reportedly tend to remit after age 30 years. However, this may reflect a selection bias. Social phobic symptoms also may abate with age; socially phobic patients often present in their 30s precisely because their symptoms are not abating. It is also notable that our cases include several persons who are not of East Asian origin.

In DSM-IV, TKS is acknowledged among the culture-bound syndromes listed in Appendix I. Social phobia and TKS share common features, such as anxiety over being observed and social avoidance. As early as the 1920s, Japanese psychiatrists described the complaints of TKS as including stage fright, fear of writing in the presence of

others, fear of blushing, and fear of eye-to-eye confrontation[2]; these are familiar preoccupations of social phobia.

While the diagnostic criteria for social phobia in DSM-IV clearly include many TKS patients without delusional features, they would exclude the patient with the quasi-delusional type of TKS, as one criterion stipulates that the person must recognize his or her social fear as being excessive or unreasonable. On the other hand, even for some persons with social phobia, the social fear may transiently seem appropriate and reasonable (e.g., the trembling public speaker who fears that others will judge him or her negatively). Patients who visit psychiatric clinics for TKS treatment in Japan belong mostly to the quasi-delusional group.[8] Japanese researchers of TKS do distinguish between "delusions of reference" in the classical sense and TKS delusions, in that the latter are usually transient, becoming manifest only in the presence of another person, and are never persecutory. Japanese researchers prefer to think of TKS delusions as "quasi-delusions" or "phobic delusions" to make this distinction.[3] Another way in which the offensive type or quasi-delusional type of TKS and social phobia differ is that the social phobic is anxious about embarrassing himself or herself, while in TKS, the concern is one of offending or embarrassing others. However, some social phobia patients, when queried, do also have concerns about causing discomfort or embarrassment to others.

The phenomenology of TKS overlaps not only with that of social phobia but also with that of body dysmorphic disorder (BDD), olfactory reference syndrome, delusional disorder, and the ego-dystonic delusions about bodily odor and defective physical appearance, which sometimes accompany delusional depression. DSM-IV criteria for BDD make no distinction between delusional and nondelusional types, although researchers in this area describe a range of delusionality, accompanied by a range of insight into the delusions, in subjects with either BDD, OCD, or affective disorders with psychotic features.[14]

There are several options for classifying offensive type TKS patients in DSM terms. DSM criteria for social phobia could be expanded to allow for a greater spectrum of delusionality and insight, so that the offensive type of TKS would come under the rubric of social phobia. Alternately, the offensive type of TKS could be defined as a new disorder in the DSM. A third option is for TKS to be left as is, in the DSM Appendix, relying on current diagnoses such as, for example, body dysmorphic disorder or delusional disorder to classify such patients.

Available data do not support a new diagnostic category nor the expansion of criteria for social phobia to include the offensive type of TKS. Our treatment findings are not yet highly informative in terms of either how to classify or how to treat patients with the offensive type of TKS. However, social phobia should be considered in the differential diagnosis of patients with the offensive type of TKS.

In this sample of patients with the offensive type of TKS, only two of four treated patients received adequate trials of a medication known to be effective for social phobia (phenelzine.) One of the two patients improved significantly. This sample is too small to comment on the response rate of patients with TKS to medications that are effective for social phobia. In controlled clinical trials of clonazepam and phenelzine for social phobia, however, there is a $^{2}/_{3}$ to $^{3}/_{4}$ response rate.[15] Further study is needed to determine whether the reluctance of our TKS patients to take medications and their reduction in anxiety symptoms and avoidance despite little change in cognitive features may suggest that TKS is different from and perhaps more medication-resistant than social phobia.

In Japan and Korea, where there is much experience in the treatment of TKS (although an absence of controlled trials), group therapy, Morita therapy, cognitive restructuring, and behavior therapies have been accepted as effective, whereas drug therapy is considered rather ineffective.[4] Lee[4] of Korea has reported on 80 patients with TKS who received drug and supportive group therapy. Medications used were "anxiolytics," propranolol, imipramine, and pimozide, but no dosages or lengths of treatment are reported. There are no reports of adequate trials of medications that have the best established efficacy in social phobia, such as phenelzine, clonazepam, or serotonin selective reuptake inhibitors. Lee found a 38.5% response rate to drug and supportive group therapy, while, according to other self-reports, 83.6% of patients claim improvement after group therapy that mainly employs cognitive restructuring.[11] Interestingly, it seems from the Japanese and Korean reports that most "responders" did not actually give up their beliefs about being offensive to others, but rather, like our patient who responded well, they experienced a decrease in social anxiety while not really changing these beliefs. Cognitive restructuring is said to involve a "cure without being cured"—the symptom still remains, but the patient's attitude toward it is no longer troublesome. Yamashita[8] "roughly estimates" that of 100 TKS patients that he treated in Japan, 27 had symptoms cease completely or almost completely, 55 had symptoms improve considerably, and 18 had no apparent change in symptoms.

In conclusion, the finding of six cases of the offensive type of TKS in the practices of New York City anxiety clinic psychiatrists within a 3-year period suggests a need for reevaluation of the supposed rarity of TKS in Western cultures. Despite its similarity to social phobia phenomenology, further study is required to determine whether TKS responds to medications effective for social phobia. The effectiveness of antipsychotic medication for delusional TKS cases has not been well studied and may be clinically useful for particular cases. East Asian reports suggest that cognitive restructuring in a group setting may be useful in these patients; cognitive-behavioral ap-

proaches that have been shown to be effective for social phobia should be considered. Overall, further studies regarding both the classification and treatment of the offensive type of TKS are needed.

Drug names: clonazepam (Klonopin), diazepam (Valium and others), fluoxetine (Prozac), imipramine (Tofranil and others), phenelzine (Nardil), pimozide (Orap), propranolol (Inderal and others).

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