Anthropophobia (Taijin Kyofusho) beyond the Boundaries of a Culture-Bound Syndrome: A Case Series from India

Tanuja Bhardwaj¹, Lokesh Shekhawat² and Viju P.D.¹

All persons who meet authorship criteria are listed as authors, and all authors certify that they have participated sufficiently in the work to take public responsibility for the content, including participation in the concept, design, analysis, writing, or revision of the manuscript. Furthermore, each author certifies that this material or similar material has not been and will not be submitted to or published in any other publication before its appearance in the Indian Journal of Psychological Medicine.

Anthropophobia, a disorder similar to social anxiety disorder, involves social anxiety induced by fear of offending or embarrassing others through perceived personal flaws or shortcomings.¹ In Japanese culture, it is conceptualized as taijin kyofusho (TK) (in Japanese words, taijin: in relation to others, kyofusho: fear or phobia; i.e., fear of others).² The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) described it as characterized by intense fear of displeasing, embarrassing, or offending others due to one's body parts or functions.³ The individuals believe that they may be a threat to the group cohesiveness by causing them discomfort.⁴ Males are at higher risk of this condition than females and the onset is usually during early adulthood.¹ Anthropophobia is often compared and contrasted with social phobia. Social phobia is limited to the fear of performance in unfamiliar social situations while anthropophobia can trouble even in familiar situations and, intimacy and connection can have an insignificant effect on people with anthropophobia.⁶ Symptoms of anthropophobia center around interpersonal relationships and perceiving self-image through others' eyes.² It has different variants such as erythrophobia, scopophobia (fear of one's own gaze and of other's gaze), dysmorphophobia, and autodysomophobia.⁵ Autodysomophobia, also termed as jiko-shu-kyofu, is described as a fear of annoying other people with one's bad smell.⁷ Pryse-Phillips (1971) described this disorder as olfactory reference syndrome (ORS)⁸ and postulated that ORS involved a “contrite” reaction, such as repeated hand-washing, excessive use of perfumes and deodorants, frequently changing clothes, and restricting social contact.⁷ The International Classification of Diseases (ICD-10) characterizes anthropophobia as a subcategory of social phobias.¹⁰ As per DSM-5, ORS is classified under “Other Specified Obsessive Compulsive Disorders” a variant of TK.¹¹,¹² Similarly ICD-11 has considered ORS under obsessive compulsive and related disorders (OCRDs).¹³,¹⁴ Majority of these cases might have been diagnosed as phobias; hence, there is a lack of literature on this condition. The absence of sufficient reports on the distinct psychopathological profile of anthropophobia,² limited data on its prevalence,¹ and the ongoing debate over its classification in the diagnostic systems¹⁵ make this disorder inimitable and worthy of research. To the authors' knowledge, no case has been reported so far in the Indian context. This case series illustrates two cases, highlighting the challenges in assessment and the treatment outcomes.

HOW TO CITE THIS ARTICLE: Bhardwaj T, Shekhawat L and Viju P.D. Anthropophobia (Taijin Kyofusho) beyond the Boundaries of a Culture-Bound Syndrome: A Case Series from India. Indian J Psychol Med. 2022;44(6):615–617.

Address for correspondence: Lokesh Shekhawat, Dept. of Psychiatry, PGIMER, Dr Ram Manohar Lohia Hospital, Connaught Place, New Delhi, Delhi, India.

Submitted: 21 Jul. 2021
Accepted: 27 Sep. 2021
Published Online: 01 Dec. 2021

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ACCESS THIS ARTICLE ONLINE
Website: journals.sagepub.com/home/szj
DOI: 10.1177/02537176211053223

Indian Journal of Psychological Medicine | Volume 44 | Issue 6 | November 2022
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Case 1

Mr N, a 28-year-old graduate unmarried male resident of Delhi, belonging to middle socioeconomic status (MSES), premorbidly well adjusted, was referred to our hospital with the chief complaints of excessive fear of having face-to-face contact with other people and difficulty in maintaining eye contact, sudden speech impediments, and physiological arousal in social situations for two and half years. It began with the fear of annoying others with his gaze. He reported unreasonably high levels of anxiety and mental pressure in interpersonal situations. He would not look at anyone passing by him because of the fear that others might perceive his gaze to be offensive and harmful. He mentioned that he had no intention to hurt anyone but was preoccupied with the idea that his gaze would be distressing to others and would make them feel uncomfortable. He interpreted others' nonverbal gestures and actions during conversations as signs that they were offended or annoyed. On probing, it was found that no one ever reported being offended because of him. He remained distressed with this idea and to relieve himself, he engaged in various avoidance behaviors such as wearing a cap, avoiding eye contact, and completely avoiding social invitations and gatherings at times. He ignored the symptoms initially and was trying to manage them by avoidance. After a few months, his symptoms had worsened and were noticeable to the family members. He stopped going to work and was brought to the obsessive compulsive disorder (OCD) clinic, department of psychiatry, by his family. The possible comorbid psychiatric or neurological conditions were ruled out. He was diagnosed with anthropophobia and was started on Paroxetine CR 12.5 mg which was gradually built to 50 mg over a period of three weeks. After three months, the client reported partial improvement, so Aripiprazole 5 mg was added to augment the response. Cognitive behavioural therapy (CBT) along with social skills training was initiated. The client showed marked improvement in symptoms after five months in response to the treatment as measured on Hamilton Anxiety Rating Scale (HAM-A) (initial score—25, final score—5), Liebowitz Social Anxiety Scale (LSAS-SR) (initial score—92, final score—20), and the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) (initial score—14, final score—4). The patient joined his work and has been maintaining well on these medications for the last one year.

Case 2

Mr A, 32-year-old graduate unmarried male resident of Delhi, belonging to MSES, premorbidly maintaining well, was referred from the ENT department to our OCD clinic with the complaint of preoccupation with the idea that his breath smelled foul. It had begun three years ago. He worried that people were getting affected by that foul smell and were trying to avoid him. While interacting with others, he would repeatedly check his breath and stated that these thoughts preoccupied most of his waking time. He reported that this thought would repeatedly come to his mind and was recognized as his own thought. He tried to suppress these thoughts and distract himself but could not succeed. As much as he tried to control these thoughts, they became more frequent and distressing. He would repeatedly ask other people at the office about his bad breath and would report feeling relieved after their assurance of not having any problem with his breath. He started feeling shameful and embarrassed because of the idea that his breath smelled foul. He started avoiding people at work and reported that their body language made him think that they were getting disturbed by the foul smell of his mouth. However, he reported that none of his colleagues had ever explicitly stated that his breath smelled bad. To mitigate the bad smell, he started excessively using body perfumes, mouth fresheners, mouth washes, and breath fresheners. As a result, he started completely avoiding interaction with his colleagues at the workplace and isolated himself. He started experiencing great distress during meetings and could not concentrate due to his preoccupation with embarrassing others with his foul smell. His performance worsened and he finally resigned from the job. He visited several physicians, dermatologists, and dentists, and was finally referred to OCD clinic, department of psychiatry. CBT with exposure and response prevention was initiated along with pharmacological treatment. He was started on Fluvoxamine 50 mg, which was gradually built to 300 mg over three weeks, augmented by Aripiprazole 5 mg after three months. The client showed significant improvement during follow-up as indicated by the scores on the HAM-A (initial score—25, final score—5) and Y-BOCS (initial score—31, final score—8). The patient joined his work and continued medications for one year. Aripiprazole was stopped after that, and gradually, fluvoxamine was withdrawn and stopped. After six months of discontinuation of fluvoxamine, he again presented with similar symptoms and was managed in a similar manner. He significantly improved in five months and is trying to find another suitable job.

Discussion

Anthropophobia or TK can affect an individual in many ways, and in an extreme scenario, an individual can become homebound or socially withdrawn. The cases illustrated above, are two different manifestations of this disorder. The first case resembles scopophobia and the second exemplifies autodysomophobia or ORS. Both the cases shared some commonalities in terms of fear and anxiety in social situations and avoidance and safety behaviors in response to them. However, the second case exhibited typical “contrite” reactions, including repeatedly checking his breath, reassurance-seeking behaviors, excessive mouth washing, and use of mouth fresheners.

A combination of pharmacotherapy and psychotherapy was used to treat these conditions. Both the cases responded well to treatment. However, a few challenges were encountered during the treatment. Firstly, there is no distinct diagnostic category for these conditions in any of the classificatory systems. Therefore, a careful differential diagnosis had to be made. The cases were distinguished from social phobia based on the clients’ fear of annoying others due to his gaze in the first case and mouth odor in the second case, and it was not a fear of general social situations. Both cases had a preoccupation with offending others, which had all the characteristics similar to obsession, while the avoidance and safety behaviors in response to these beliefs shared the characteristics of social anxiety. Therefore, both cases seem to fall
in the spectrum between social anxiety disorder and OCD. In addition, beliefs related to perceived physical or psychological flaws may be similar to self-image problems seen in body dysmorphic disorder. Safety and avoidance behaviors were not suggestive of neutralization in response to the beliefs, which differentiate them from compulsion. Another major challenge was faced in terms of assessing these conditions. Though there is a TK Scale (TKS), studies testing its psychometric properties are limited and have mostly been on undergraduate students in Japan. For the second case, we reviewed the literature, and it was stated in one of the articles that there is one questionnaire available online, but the article for citation is missing. Therefore, we relied on Y-BOCS to gauge the progress from the baseline because it has been used in previous studies to assess ORS. Some client-related factors aided the treatment process. For example, both the clients were regular in following the treatment protocol. Secondly, their insights levels made cognitive restructuring easier. Motivation levels and family support acted as protective factors and, therefore, added to the treatment effectiveness. Collectivistic cultures characterized by interdependent, reciprocal, and implicit interpersonal relationships may play a role in shaping anthropophobic symptoms. However, it is found that Asians endorse higher levels of social anxiety symptoms but lower prevalence rates than their white counterparts. This discrepancy may be attributed to cultural differences, measurement errors, diagnostic criteria, or a combination of all three. These factors may result in under-diagnosis or over-diagnosis of these conditions. Moreover, anthropophobia or TK is an aspect of social anxiety, which has been reported in more than one cultural group and thus, it can be inferred that anthropophobia may not be a culture-bound phenomenon. Therefore, future work should focus on developing questionnaires specific to these disorders to accurately measure the phenomenology.

Conclusion

The cases are unique in their phenomenological presentations. Clients’ belief of perceived defects and compulsive behaviors are similar to OCD and body dysmorphic disorder, but the other symptoms of avoidance to social situations and adopting safety behaviors are related to social anxiety disorder. So, it is a diagnostic dilemma for clinicians to place it in the classificatory system. We suggest that it might not be a culture-specific entity; rather, it is beyond the cultural boundaries and needs the attention of researchers to carry out more research for a better understanding of phenomenology. The diagnostic categorization will guide the development of assessment tools and effective management strategies.

Declaration of Conflicting Interests
The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Declaration of Patient Consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patients have given their consent for their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Funding
The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs
Tanuja Bhardwaj https://orcid.org/0000-0001-5920-2764
Lokesh Shekhawat https://orcid.org/0000-0003-3441-7915

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