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ANXIETY DISORDERS IN JAPAN: A REVIEW OF THE JAPANESE LITERATURE ON SHINKEISHITSU AND TAIJINKYŌFUSHŌ[1]

ABSTRACT. As culture-bound syndromes, Japanese *shinkeishitsu* ("constitutional neurasthenia") and *taijinkyōfushō* ("anthropophobia") have received considerable attention in the Japanese literature. While these disorders are viewed as diagnostically distinct from Western psychiatric categories, recent studies by the Japanese suggest some affinity with Western social phobias, depression, and schizophrenia. The paper reviews this literature and offers suggestions for further cross-cultural research.

INTRODUCTION

Shinkeishitsu (constitutional neurasthenia) is a widely used diagnostic term in Japan applying to a condition which would be diagnosed as an anxiety disorder in the West. It is considered a specific type of neurasthenia, itself a concept which has fallen into disuse in the West. In Japan, the diagnostic term neurasthenia is heavily utilized as both a legitimate psychiatric diagnostic category and a popular term used by lay persons to describe certain – largely somatic – illness experiences. A subcategory of *shinkeishitsu*, *taijinkyōfushō* (usually glossed as "social phobia" or "anthropophobia", though it is perhaps more accurately translated as "fear of interpersonal relationships" or "fear of interpersonal situations"), has received considerable scholarly attention in Japan as a culture-bound syndrome, and every year several popular and scholarly publications treating the subject are published, some aimed at those who suffer from the disorder. As culture-bound disorders *shinkeishitsu* and *taijinkyōfushō* have also attracted the interest of Western anthropologists and psychiatrists (Lebra 1976; Lock 1980; Reynolds 1976, 1980). Reynolds' work in particular has aroused Western interest in the disorders and their treatment, as well as in the prospect of adapting these therapies to treat ostensibly similar disorders (e.g., social phobia, anxiety neurosis, stress) in the West. However, despite Western interest in *shinkeishitsu*, reference to the disorder in Western publications usually occur in association with Morita psychotherapy, and the perspectives offered reveal the influence of the Moritist school, which, while undeniably important to any understanding of the disorder, represents only one of many perspectives currently in circulation among Japanese psychiatrists.

In light of the growing interest in *shinkeishitsu* among Western scholars, the present paper examines current theories of the disorder through the use of selected Japanese materials, many of which have not been translated into English and have thus remained inaccessible to Western scholars. In selecting these materials, I have chosen those that offer various perspectives on the etiology of the disorder and which, by discussing its possible affinity to psychiatric disorders more frequently diagnosed in the West, raise important questions about its diagnostic utilization and its status as a syndrome specific to Japan.

POPULAR AND PSYCHIATRIC VIEWS OF SHINKEISHITSU

The term *shinkeishitsu* has both popular and psychiatric meanings. Generally, when used popularly, *shinkeishitsu* describes a person who is overly sensitive *(binkanshisugiru)* to certain features of his or her immediate environment, "nervous," "worrisome," "easily agitated," and "anxious." Japanese may describe themselves as *shinkeishitsu* or be so described by others when, for example, they complain of certain body ailments, oversensitivity to noise, colds or chills, dirt, or facial or body appearance, or where they demonstrate an extreme sensitivity to the words, gestures, and presence of others. Sufferers are believed to be "nervous" by temperament, individuals being predisposed at birth to the disorder (the term *shinkeishitsu* itself means "of nervous temperament"). Sophisticated persons may substitute the expression *noiroze-gimi* ("neurotic", "prone to neurosis") in place of *shinkeishitsu*, or use the two terms interchangeably. Generally, the disorder is seen as not particularly serious and as physical rather than mental in nature.

The psychiatric view of *shinkeishitsu* is far more complex and convoluted, largely owing to the number of psychiatric and psychotherapeutic theories which attempt to explain the disorder according to the tenets of their respective schools. Indeed, one of the major ambiguities surrounds the distinction between the concept of *shinkeishitsu* as defined by Morita therapists and the psychiatric concept of *shinkeisuijaku* ("weak nerves", "neurasthenia"). Kawai (1982) suggests that Shoma Morita, the founder of Morita psychotherapy, substituted the term *shinkeishitsu* for *shinkeisuijaku* in order to reduce the association of the disorder with psychopathology. Morita himself did not view the disorder as pathological but as a condition more or less present in all individuals, though more highly developed in some than in others. In fact, he viewed the labelling of the condition as pathological as counterproductive since it served only to reinforce the hypochondriacal tendencies of sufferers.

Moritists divide *shinkeishitsu* into three categories, of which *shinkeisuijaku* is considered a sub-type. The categories run as follows:

Type 1: *shinkeisuijaku* ("neurasthenia") or *futsū shinkeishitsu* ("ordinary" *shinkeishitsu*). Typical symptoms include: headache, fatigue, gastro-intestinal complaints, irritability, inability to concentrate, memory impairment, and insomnia.

Type 2: *kyōhaku shinkeishō* ("obsessive or phobic neurosis"). Typical symptoms include several phobic disorders such as acrophobia, pathophobia, mysophobia, and symptoms grouped under the category *taijinkyōfushō* ("fear of interpersonal relations"), which include fear of blushing, fear of eye-to-eye confrontation, fear of personal body odor, dysmorphophobia, and the fear of making mistakes.

Type 3: *fuan shinkeishō* ("anxiety neurosis") or *hossa-sei shinkeishō* ("paroxysmal neurosis"), principal symptoms of which include palpitations, seizures, and anxiety attacks.

By far the most prevalent type of *shinkeishitsu* disorder is Type 2, of which *taijinkyōfushō* is the most frequently clinically encountered, with fear of blushing, fear of eye-to-eye confrontation, and fear of personal body odor the most frequently reported complaints.

TAIJINKYŌFUSHŌ

Taijinkyōfushō is an indigenous diagnostic label applied by Japanese psychiatrists to a constellation of usually mild, but occasionally severe, phobic reactions to interpersonal situations (for an exhaustive list of symptoms, see Tanaka-Matsumi 1979:232). The disorder predominantly afflicts young males, symptoms typically occurring during mid-adolescence and early adulthood, that is, between the ages of 14 and 29 (Kondo 1981:302). The disorder is treated by a number of psychiatric interventions, chief among them Morita psychotherapy, though the use of anti-anxiety medications and psychoanalysis may also be involved to a lesser extent. Prognosis is uncertain, though generally symptoms are said to lighten or disappear once the individual reaches his 30s. However, symptoms may just as easily worsen, become chronic, and, in some cases, take on the characteristics of paranoia and schizophrenia. Uchinuma (1981, 1983) has commented on the fluidity of *taijinkyōfushō* symptoms, noting, for example, that in some patients the fear of blushing may gradually develop into the fear of self-expression, which itself may later develop into the fear of eye-to-eye confrontation. He suggests that the various phobic symptoms of the disorder be treated as stages which – ranging from normal *hitomishiri* ("shyness") to neurosis and psychosis – may occur in sequence (e.g., from *hitomishiri* to erythrophobia, the fear of eye-to-eye confrontation and fear of personal body odor – the last two disorders shading into the area of psychosis); it may be arrested at one stage or another (either naturally or with therapy); or it may skip stages (Uchinuma 1981:66).

Aoki (1981) distinguishes between what he terms "pure" (*tanjunkei*) and "serious" (*jūshō*) *taijinkyōfushō*. "Pure" *taijinkyōfushō* (of which erythrophobia is considered representative) occurs only in the actual presence of others and is limited to "intermediate-level persons", i.e., persons within the individual's circle of social relationships who are neither intimate relations (such as parents, close relatives or friends) nor complete strangers (1981:35–37). Examples of intermediate-level persons include classmates, co-workers, teachers, neighbors, and even fellow passengers on public conveyances. Viewed in terms of the binary opposition that structures Japanese interpersonal relations, these personages occupy an intermediate or ambivalent position between *uchi* (the family, one's inner circle of social relationships) and *soto* (the outside world, the world of strangers to whom one owes no obligation). However, in the case of "serious" *taijinkyōfushō* these boundaries are blurred; thought content is delusional, often involving individuals not actually present. Sufferers of the fear of personal body odor, for example, may be convinced not only that they are malodorous but that their "stench" permeates the neighborhood or even the entire prefecture. The occurrence of symptoms is not limited to encounters with intermediate-level persons, but also includes family members and close friends. Delusions of reference, avoidance, and persecution are not uncommon. Finally, Aoki notes that those afflicted with "serious" *taijinkyōfushō* lack the insights into their condition possessed by their less disturbed brethren (1981:40). While "pure" *taijinkyōfushō* sufferers attribute their condition to some kind of personal or character weakness involving their inability to cope with interpersonal situations and eventually seek some form of psychiatric help, "serious" *taijinkyōfushō* sufferers lack such insights, perceive their problems as real, and attempt to deal with them accordingly. For example, an individual suffering from the fear of eye-to-eye confrontation may attribute his condition to an actual malformation of the eyeball; the dysmorphophobic is convinced that he is physically malformed. Such individuals are more likely to turn to cosmetic surgeons for solutions to their problems than psychiatrists or psychotherapists (1981:37–40).

Uchinuma (1974, 1977, 1981, 1983) suggests that the transition from mild *taijinkyōfushō* to more severe conditions marks a parallel transition from phobic reactions based on feelings of shame (*chijoku*) to those based on feelings of guilt (*tsumi*) and argues that the more serious cases of the disorder, especially the fear of personal body odor, are best regarded as manifestations of hysteria, obsessive neurosis, or borderline or psychotic disorders distinct from *taijinkyōfushō* proper.

There is a consensus among Japanese psychiatrists that *taijinkyōfushō* is a culture-bound disorder. Virtually all studies of the disorder note that reports of *taijinkyōfushō*-like disorders are rare in the West, and that although social phobias and anxiety disorders show similarities to the disorder, these

resemblances are usually seen as superficial at best. Uchinuma (1983) notes that although the disorder shows some clinical similarities to the DSM-III classifications of social phobia and avoidant personality disorder, the complaints associated with Western social phobias, such as the fear of eating in public, fear of meeting members of the opposite sex, fear of attending social functions, and the fear of excessive sweating are peripheral to *taijinkyōfushō* (1983:30). Kasahara observes that "[e]reuthrophobia and allied conditions as a whole seem not to have been in the limelight in Western psychiatry" and quotes Dietrich as saying that erythrophobia is very rare in Germany (1970:384). In summarizing the Western literature, Kasahara points to the lack of references to body odor fears or fears of eye-to-eye confrontation, concluding that although "the fear of eye-to-eye confrontation no doubt exists in other cultures ... it may fail to attract doctors' attention" (1970:384). Satomura (1979) reaches a similar conclusion concerning erythrophobia, noting that while there is some evidence of the disorder in West Germany, there is little apparent interest in the phenomenon on the part of German psychiatrists.

The notion that certain phobic reactions may exist in other cultures but are unrecognized by its healers is an intriguing one, for it implies that practitioners take their cues from culture in recognizing and constructing illness experiences. On the other hand, adherence to the nosological categories of one's own culture may result in procrustean mislabelling. For example, Tanaka-Matsumi (1979) has shown that in one study American psychiatrists presented with Japanese cases of *taijinkyōfushō* tended to group these cases into a number of heterogeneous categories, ranging from paranoid schizophrenia, to paranoid personality disorder, to phobic and anxiety neurosis.

CULTURE, SOCIAL CHANGE AND TAIJINKYŌFUSHŌ

Japanese cultural values, socialization practices, and perceptions of interpersonal relations are factors frequently used to explain the etiology, prevalence and dynamics of *taijinkyōfushō*. Shoma Morita attributed the disorder to an introverted, hypochondriacal temperament and to a process he termed "psychic interaction" (*seishin kōgo sayō*), a vicious cycle of sensation and attention whereby attention focused on some sensation results in the elevation of attention on that sensation, which in turn further heightens and sharpens the original sensation. By contrast, current theories of *taijinkyōfushō* emphasize the cultural and psychosocial aspects of the disorder.

Doi (1973) has attributed anxiety disorders involving interpersonal relationships to the frustration of the individual's desire to *amaeru*, "to depend and presume upon another's benevolence." He goes on to argue that social and

valuational changes that have occurred in Japan since the Meiji Restoration (1868–1912) have contributed to the prevalance of such disorders because "social relationships today no longer allow the individual to *amaeru* so easily as in the past," and thus tend to frustrate the ready expression of *amae*-related behaviors (1973:108). The ambiguity which surrounds the transaction of interpersonal relationships creates a sense of insecurity as to the propriety of expressing *amae* needs in certain social situations and an uncertainty concerning with whom these needs may be safely expressed; the fear of rejection serves to circumscribe social encounters beyond the intimate inner circle of *uchi*-centered relations.

Miyoshi (1970) has suggested that the disorder is generated by the conflict between the individual's strong feelings of self-conceit (*unubore*), which convince him that he is essentially different from others, and the value Japanese society places on conformity, which stresses that people are essentially the same. At the same time that the individual attempts to maintain an idealized self-image of himself, he also remains keenly sensitive to, and obsessively concerned with, how others will respond to weaknesses. In a similar vein, Iwai (1982) views the major complaint underlying *taijinkyōfushō* disorders as less an actual "fear of strangers" than a state of anxiety aroused by doubts concerning one's acceptability to others, and suggests that a more appropriate term for the disorder might be "*jikotaimenkyōfushō*", or fear of self-presentation. According to Iwai, the object of fear is not the social situation or other people as much as it is oneself in the context of presenting that self to others (*hito ni taisuru jibun e no osore*"), and how that self will be received by those others ("*taimen suru jibun ga dō uketorareru ka*") (1982:14).

Many of these authors concur that *taijinkyōfushō* is primarily a neurosis of adolescence, a turbulent stage in the life cycle in most societies, marked by a heightened sense of self-consciousness, self-preoccupation, and feelings of insecurity due to natural physiological changes in the adolescent and the pressures on him or her to assume new social responsibilities. Okonogi (1982) argues that the often abrupt transition period during this period from indulgent *uchi*-based relationships to the more demanding and uncertain *soto*-based relationships may account for the high incidence of the disorder within this group (1982:185). This *uchi-soto* dichotomy, however, may be generalized to include any situation where an individual leaves a secure, familiar environment for a new, unfamiliar one. Doi (1973) and Mashino (1981) have noted that *taijinkyōfushō* and allied disorders may occur in adulthood or even in middle-aged individuals who leave a familiar community, change workplaces or schools, or who live or work overseas. Indeed, the reported increased incidence of *taijinkyōfushō* among women has been attributed by Kondo (1981:301) to the changing social position of women in Japan and the expansion of their activities outside the traditional domain of the household (*uchi; ie*) and into community-,

neighborhood-, or employment-related activities where their role performance is evaluated by unfamiliar others.

Changes in Japanese society and cultural values have also been cited to account for reported changes in the prevalence and distribution of particular phobic symptoms associated with *taijinkyōfushō*. That is, while the overall clinical incidence of the disorder has remained constant over time, reports of erythrophobia (*sekimenkyōfushō*) have decreased while fear of body odor *(taishūkyōfushō)* and fear of eye-to-eye confrontation (*shisenkyōfushō*) – the two more serious conditions – have increased (Iida 1976; Kondo 1981; Nishizono 1970; Uchinuma 1974). Psychiatrists have attributed these changes to the devaluation of shame consciousness in modern, postwar Japanese society, noting that feelings of aggression or antagonism play a larger role in these disorders (Nishizono 1970:163; Uchinuma 1981:67). Rapid social change, industrialization, and the transition of Japanese society from one based on *gemeinschaft* to *gesellschaft* relations are often cited as contributing social factors. Kondo, for example, singles out the competitive principle inherent in modern capitalism as being responsible for the transformation of interpersonal relations and the "suppression" and "obliteration" of feelings of shame in modern Japanese society (1981:304).

The effectiveness of indigenous therapies, particularly Morita psychotherapy, to treat these disorders has also diminished, according to some psychiatrists. Kasahara states that the new generation of *taijinkyōfushō* patients treated by Morita therapy are unable to realize the goal of accepting rather than fighting their symptoms, and few patients remain hospitalized for over a week or so (formal hospitalization usually lasts for 40–60 days). Other patients seem unwilling to accept the authoritarian direction of Morita therapists. It is also possible that, given the apparent increased incidence of the more serious or borderline types of the disorder and the fact that Morita therapy has long been regarded as ineffective in the treatment of psychosis, the effectiveness of Morita therapy has been greatly compromised.

CULTURAL INFLUENCES ON THE EXPERIENCE AND DIAGNOSIS OF TAIJINKYŌFUSHŌ

Previously it was pointed out that Western psychiatrists tend to diagnose Japanese cases of *taijinkyōfushō* as paranoia and paranoid schizophrenia. On the other hand, Moloney, an American psychiatrist, has observed that the percentage of patients diagnosed as suffering from paranoia is considerably lower in Japan than in the United States (Moloney 1954:37–39). This discrepancy may in part be attributed to the difference in value psychiatrists in the two countries assign to feelings of victimization, the Japanese viewing them as a more or less normal

if heightened manifestation of *higai-ishiki* ("victim-consciousness",
"consciousness of being victimized"), while their occidental counterparts, when
confronted with Japanese cases, tend to view such feelings as delusional or
persecutorial without first taking into account the normative nature of idioms of
victimization in Japanese culture. In fact, victim-consciousness is embedded in
the Japanese language itself, as is seen in the so-called suffering passive
inflection of Japanese verbs where something just happens and one is made to
suffer as a consequence. For example, a person caught in a rain storm may
express his dismay that he "has been rained on", the construction implying that
he has in some way been inconvenienced or made to suffer because of it. Doi
suggests that *higai-ishiki* may be one means by which the Japanese gain the
sympathy and indulgence of others (Doi 1973:127–132). Interestingly, while the
taijinkyōfushō sufferer feels victimized by his symptoms, the feeling of vic-
timization is primarily expressed in terms of the embarrassment or unpleasant-
ness the symptoms are thought to arouse in others. Satomura has noted that
while the content of West German erythrophobia revolves around the fear of
being overwhelmed and looked down upon by others, Japanese sufferers
complain that they fear their blushing offends others and makes them feel
embarrassed or unpleasant. Kasahara has described *taijinkyōfushō* as an
"altruistic phobia" for this reason. He cautions, however, that both the fear of
humiliation and the fear of humiliating others are present and sees the central
problem of all phobias as "the threat of public display of inadequacy and
imperfection" (Kasahara 1970:401).

Nonetheless, the fact that *taijinkyōfushō* sufferers tend to express their
complaints in an altruistic idiom (i.e., one that is concerned with the impact of
symptoms on others) rather than an "egoistic" one (i.e., one in which concern is
centered on the individual him- or herself) suggests that the expression of the
disorder, if not the disorder itself, mirrors Japanese normative values that
positively sanction allocentric, or other-oriented, behavior, the denial of self, and
the importance of harmonious interpersonal relations.

External or social factors may play a role in the diagnosis of the disorder.
Given Kasahara's suggestion that both "egoistic" and "altruistic" concerns are
represented in all phobic reactions, it remains to be seen why altruistic concerns
are often expressed by *taijinkyōfushō* sufferers – so much so, in fact, that they
are used to distinguish it from Western social phobias or anxiety disorders where
the egoistic idiom seems preferred. Moreover, given the widely held perception
among Japanese psychiatrists that shame-based *taijinkyōfushō* is declining while
guilt-based or aggressive *taijinkyōfushō* is increasing, one wonders to what
extent, if any, this differential in diagnosis is influenced by the idiom in which
the patient's complaint is expressed in the clinical situation, such that those who
adopt the egoistic idiom are more likely to be diagnosed as suffering from
severe manifestations of the disorder than those who express their complaint in

more altruistic terms, the latter being, I think, the more socially acceptable idiom of complaint.

Recently Munakata (1986) has argued that Japanese attitudes toward mental illness also have an impact on the diagnosis of neurasthenia, which until recently was diagnosed by Japanese psychiatrists and doctors to disguise socially stigmatized mental illnesses such as schizophrenia in order to spare their patients and families the psychological shock and ostracism that would accompany the diagnosis of more severe mental illnesses (Munakata 1986:373–375). If this is indeed the case, the question of "disguised diagnosis" raises a number of questions, chief among them its relationship to the apparent increased incidence of serious or borderline *taijinkyōfushō* disorders, the role psychiatric bias plays in the cross-cultural recognition of the disorder, as well as its legitimacy as a culture-bound disorder.

TAIJINKYŌFUSHŌ AND DEPRESSION

A number of Japanese psychiatrists have suggested that *taijinkyōfushō* may be a form of depression and that depression may play a role in its development. Both Mizukami (1981) and Kimura (1981) have commented on the similarities between the personalities of premorbid *taijinkyōfushō* sufferers and those of melancholics as outlined by Tellenbach. Both groups manifest traits of orderliness in dealing with life and work situations, conscientiousness, perfectionist tendencies, and, in Beck's words, "an overriding need to do right to those close to them" and "... a great sensitivity to the dos and don'ts, the shoulds and should nots" (Beck 1967:251). This last personality trait in particular recalls the Moritist position that *taijinkyōfushō* arises from a conflict within the sufferer between his perception of *kakuarumono* ("things as they are") and *kakuarubeki mono* ("things as they should be"), where "things" refers to the external world and/or aspects of the individual's personality or behavior.

Somatic rather than dysphoric complaints are characteristic of both Japanese depression and *shinkeishitsu*. For example, Tanaka-Matsumi and Marsella (1976) have indicated that Japanese tend to associate depression (*yūutsu*) with somatic states and only rarely with dysphoric affect. This focus on somatic symptomatology is also present in the case of *shinkeishitsu*. Following Kleinman and Kleinman (1985), one might suggest that the physiological complaints typical of *shinkeishitsu* may be interpreted as somatization, *shinkeishitsu* serving as a socially legitimate idiom of distress in Japan not unlike the concept of neurasthenia in China. It might also be suggested, following Munakata, that in some cases the diagnosis of *shinkeishitsu* is used to disguise depression, legitimizing the sufferer's distress by giving it a physical basis, and thereby circumventing stigmatization. Finally, the sense of worthlessness, feelings of

being warped, perverted, no longer human, and criminal expressed by
shinkeishitsu sufferers suggest delusional thought content associated with
depression (see Beck 1967:37).

CONCLUSION

The question of whether *shinkeishitsu* and *taijinkyōfushō* are culture-bound
syndromes unique to Japan requires further study. As indigenous psychiatric
diagnostic categories, while superficially displaying features associated with the
DSM-III classifications for phobic, anxiety and avoidant personality disorders,
they appear to constitute unique clinical syndromes which the Japanese have
attributed variously to temperamental predisposition, early childhood socializa-
tion practices, family dynamics and frustrated dependency needs.

By way of conclusion, the paper suggests that research into *shinkeishitsu* be
expanded in the following areas. First, given the emphasis Japanese studies
place on dependence as a major factor in the etiology of *shinkeishitsu*, the
relationship between dependence and psychiatric disorders which demonstrate
similarities to *shinkeishitsu* and its sub-categories in the West should be
explored. For example, Zimbardo (1977) has noted the close relationship
between dependent personality structure, child-rearing practices, and shyness in
the West; Beck (1967) citing increased dependency wishes in depressed
patients, suggests that "accentuated wishes for dependency, ... have been
recognized and assigned a major etiological role in several psychodynamic
explanations of depression", though he cautions against listing increased
dependency as "a specific manifestation of depression" (1967:31).

Second, the cultural domain of cross-cultural comparison should be expanded.
Presently cross-cultural comparisons of *shinkeishitsu* to seemingly allied
disorders in other cultures are too narrowly focused on comparisons between
Japan and the West and need to include comparisons with Chinese and Korean
popular, psychiatric and biomedical conceptions of *shinkeishitsu* or allied
disorders. Kleinman and Kleinman's study of neurasthenia in China suggests
that while Chinese neurasthenia shows a close affinity to its Japanese counter-
part (particularly *futsū shinkeishitsu*, or ordinary neurasthenia) in that both
emphasize somatic complaints, the Chinese apparently lack a sub-category of
the disorder corresponding to *taijinkyōfushō*, the most prevalent form of
taijinkyōfushō experienced by Japanese sufferers. The literature on Korean
manifestations of the disorder is, as far as I know, non-existent. However, with
regard to dependence, O-Young Lee has asserted that "the concept of depen-
dence plays such a crucial role in child-rearing in Korean that one could say
dependence is more inextricably bound up with the Korea psyche than it is with
the Japanese" (Lee 1983:11). He notes that like Japan, Korea has its own store

of *amae*-like concepts – *origwan, unsok,* and *osmal* – which he says "are far more complex than the simple Japanese term *amae*." Given this Korean sensitivity to dependency needs, one might wish to inquire whether syndromes similar to *shinkeishitsu* or *taijinkyōfushō* exist in Korea, and should they be found, whether these indigenous concepts occupy as pivotal an explanatory position in tracing the dynamics and etiology of such disorders as is the case of the *amae*-concept in Japanese psychiatric thinking.

Finally, attention should be focused on the impact of diagnostic bias and cultural bias in the recognition and labelling of anxiety and allied disorders cross-culturally. Not only do nosological and, consequently, diagnostic categories differ across cultures but attentiveness to symptoms and interest in them by psychiatrists also differ, psychiatrists recognizing and assigning meaning to certain symptoms more than others (e.g., the relative lack of interest in erythrophobia in West Germany compared with Japan). The phenomenological experience and expression of that experience also differ across cultures; these, in turn, impact upon the diagnosis and labelling of these types of disorders, which seem to follow culturally prescribed patterns. On the other hand, psychiatrists' recognition of certain features of these disorders also appears culturally patterned. For example, although, as Kasahara suggests, both the fear of self-humiliation and the fear of humiliating others are present in all phobic disorders, Western psychiatrists emphasize the former, Japanese the latter – not surprising given the respective egocentric and allocentric orientations of the two cultures. The diagnostic process may also be influenced by social attitudes toward mental illness and the personal and social consequences of such labelling. The diagnosis of phobic, anxiety or psychosomatic disorders by sympathetic psychiatrists may be a means through which individuals and their families are spared the social stigma that would accompany the diagnosis of socially or politically unacceptable disorders, as can be observed in the disguised diagnosis of Japanese *shinkeishitsu* for schizophrenia and the diagnosis of neurasthenia for depression in China, where depression carries connotations of political dissaffection.

NOTE

[1] This paper was accepted for publication prior to the compilation of Volume 13, No. 2, "Neurasthenia in Asian Cultures." Consequently it does not refer to the papers in that volume, several of which are very relevant to the discussion in this paper.

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