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The authors' disclosures accompany the original article.

This reply was accepted for publication in February 2018.

Am J Psychiatry 2018; 175:482–483; doi: 10.1176/appi.ajp.2018.17111240r

Concerns Regarding the Proposed New Diagnosis of "Modern-Type Depression" in Japan

TO THE EDITOR: The Perspectives in Global Mental Health article by Kato and Kanba (1), published in the November 2017 issue of the *Journal*, proposes a new diagnosis called "modern-type depression" (MTD). I believe there is no need for MTD as a new diagnosis. I have encountered many similar cases in Japan in my work. As an APA member for more than 25 years and as a clinical psychiatrist specializing in anxiety and depressive disorders, I have treated patients using DSM-5 without any need for a new diagnosis.

The case of Mr. A described in the article could be diagnosed, per DSM-5, as unspecified depressive disorder with atypical features comorbid with social anxiety disorder. The likelihood of social anxiety disorder is supported by the patient's indulgence in video games (he may be prone to *hikikomori*), lack of desire for social life, and inability to express his opinion in the workplace. The diagnosis of atypical depression comes from the patient's withdrawal from work in response to a perceived insult by his supervisor (rejection sensitivity) and from the enjoyment of attending parties despite requiring absence from work because of sickness (mood reactivity). In the second episode, a feeling of heaviness (leaden paralysis) was exhibited. This notion is supported by a clinical study reporting that 76.1% of patients with social anxiety disorder also had major depression, 77.1% of which were atypical cases (2). It is assumed that the evasion of work or duty ("slacking off") seen in Mr. A is due to sudden leaden paralysis or phobic feeling (rejection sensitivity) in response to unfavorable events and/or an anxious-depressive attack (3), which is often seen in atypical depression. Slacking off appears to result entirely from pathological symptoms, not from patients' laziness (4).

A major shortcoming of Kato and Kanba's article is the absence of either structured diagnostic interviews or clinical psychological batteries (1). Social anxiety disorder in major depression is typically recognized using semistructured interviews at a rate 15.5 times higher than that of unstructured interviews (5).

The authors' suggestion that generational changes in education and culture have resulted in the appearance of depression requiring a new diagnosis appears to be overly speculative and without clear evidence. I believe that the ongoing examination of patients using DSM should be the first step for accurate diagnosis, increasing the likelihood of positive outcomes for patients' well-being.

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The author reports no financial relationships with commercial interests.

This letter was accepted for publication in March 2018.

Am J Psychiatry 2018; 175:483; doi: 10.1176/appi.ajp.2018.17121404

Is a Socio-Cultural Analysis of Depressive Disorders a Matter of Concern? Response to Kaiya

TO THE EDITOR: As Kaiya has suggested, there is abundant room for the consideration of differential diagnoses for clinical cases similar to Mr. A's using structured diagnostic interviews, such as the Structured Clinical Interview for DSM (SCID) (1). We agree with his assertion. We have already advocated for the importance of diagnosis using the SCID for such cases and proposed a system for the strict diagnosis and multidimensional evaluation of patients with a variety of depressive symptoms (2).

Consequently, for cases similar to Mr. A's, what we have termed modern-type depression (MTD) may be diagnosed with adjustment disorder, mild major depression, other specified depressive disorder, or "unspecified" depressive disorder (as Kaiya suggested), according to the descriptive symptom profile of each patient. However, psychopathological, psychodynamic, and psychosocial assessments indicate commonality among these cases, beyond the boundaries of DSM depressive categories, in terms of premorbid personality, precipitating life events (mostly stress in workplaces), clinical courses, and treatment responses. Although there are no statistics available, Japanese mental health care professionals have seen an increasing number of cases like that of Mr. A in the last couple of decades, as Japan has faced rapid sociocultural changes as described in our work (1, 3). Under these conditions, we introduced the concept of MTD to further specify not yet well-studied depressive disorders within DSM and to suggest more specific treatment approaches.

While Kaiya may be undervaluing the socio-cultural influence on the present era of mental health, we believe psychological and behavioral symptoms always emerge in the socio-cultural (and subcultural) environment. Thus,

appropriate evaluations and treatments are not realized without considering socio-cultural realities. To this end, the establishment of the Perspectives in Global Mental Health section within the *Journal* is an important attempt to accumulate wisdom from transcultural psychiatry.

Indeed, we believe that psychiatrists should be experts who are able to read changes in evolving social periods and to make multidirectional considerations of the psychiatric problems that face their patients.

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The authors' disclosures accompany the original article.

This reply was accepted for publication in March 2018.

Am J Psychiatry 2018; 175:483–484; doi: 10.1176/appi.ajp.2018.17121404r

CORRECTION

In the April 2018 letter to the editor "Increasing Male Preponderance in Suicide Coinciding With a Reduction by Half in Total Suicides in the Danish Population Should Raise Awareness of Male Depression" by Soren D. Ostergaard, M.D., Ph.D. (Am J Psychiatry 2018; 175:381-382), there was an error in the left side of Figure 1. On April 11, 2018, the figure was corrected online to show that the number of suicides among men (depicted in blue) fluctuated from 1981 to 1994 rather than staying constant at just under 700.