

S0022-3999(98)00113-5

EDITORIAL

UNDERSTANDING *TAIJIN KYOFUSHO* THROUGH ITS TREATMENT, MORITA THERAPY

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Abstract—This article presents a brief review of the definition, nosology, history, clinical features, and etiology of *taijin kyofusho*. Special attention is also given to Morita therapy for *taijin kyofusho*. The term *taijin kyofusho* literally means the disorder (*sho*) of fear (*kyofu*) of interpersonal relations (*taijin*). Morita therapy was developed by Masatake Morita in the 1910s to treat the Japanese mental disorders called *shinkeishitsu* and *taijin kyofusho*. It is suggested that *taijin kyofusho* is an excellent example of a mental disorder in which understanding its treatment is an integral part of its conceptualization. © 1999 Elsevier Science Inc.

Keywords: Anthropophobia; Morita therapy; Psychotherapy; *Taijin kyofusho*.

INTRODUCTION

Taijin kyofusho (anthropophobia; included in social phobia in ICD-10 [1]) is a mental disorder, which has been frequently considered from a cultural perspective. However, in this study, *taijin kyofusho* is used as an example of understanding mental disorders from the way in which they are treated. By discussing the Morita therapy treatment of *taijin kyofusho*, it will be seen that the treatment of a mental disorder is integral to its conceptualization.

DEFINITION, NOSOLOGY AND HISTORY OF *TAIJIN KYOFUSHO*

The term *taijin kyofusho* literally means the disorder (*sho*) of fear (*kyofu*) of interpersonal relations (*taijin*) [2]. *Taijin kyofusho* was originally described by Masatake Morita (also known as Shoma Morita) in the 1930s as a manifestation of *shinkeishitsu* (nervous character or temperament) [2]. *Taijin kyofusho* is considered to be the core type of *shinkeishitsu* and it has, to some extent, come to be used synonymously with the term *shinkeishitsu*. It is now so widely known in Japan that patients sometimes come to mental health professionals with comments such as, “I have *taijin kyofusho*. I want to do something about it.”

The diagnostic term, *taijin kyofusho*, has been used for more than half a century and there has been much discussion about its etiology, subtype, and relation to Japanese cultural, social, and religious phenomena [3]. Nevertheless, diagnostic criteria

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Table I.—Diagnostic criteria of *taijin kyofusho* [4]

All of the following criteria should be met:

1. The feeling that his/her own attitudes, behavior, and physical characteristics are inadequate in social situations.
2. The persistent suffering (caused by condition 1) from emotional reactions such as shame, embarrassment, anxiety, fear, and tense feelings in social situations.
3. Worrying that he/she is unable to maintain healthy relationships with others (feeling unaccepted, despised, and avoided) due to conditions 1 and 2.
4. Avoids painful social and interpersonal situations, while reluctant to do so.

Supplementary items:

A diagnosis of delusional *taijin kyofusho* should be made when the following criteria are met:

1. Certainty that he/she has a defect in a particular part of body or physical sensations, such as eyes, body odor, and appearance.
 2. Delusional conviction that he/she harms other people or gives others unpleasant feelings because of condition 1.
 3. Delusional conviction that others always avoid him/her due to conditions 1 and 2.
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have not been established until recently: provisional diagnostic criteria were drawn up in 1995 [4] (see Table I). These criteria will be helpful for future epidemiological and statistical studies.

CLINICAL FEATURES OF *TAIJIN KYOFUSHO*

Taijin kyofusho is an obsession of shame and anxiety. It is characterized by fears of offending others by blushing, stuttering, emitting offensive odors, staring inappropriately, presenting improper facial expressions, blemishes, and/or physical deformity [5, 6]. Strong anxiety is usually not experienced in the presence of very closely related people, or, conversely, complete strangers. Rather, it is in settings where other people are to a certain degree familiar, but not intimate, that individuals with *taijin kyofusho* suffer the most anxiety. Such settings include the places most frequented by sufferers (e.g., school, work, commuter trains, etc.). Males predominate in clinical presentation by a ratio of approximately 3:2 [5]. The course may be transient, but is more often chronic. It is rare, however, for *taijin kyofusho* to continue into middle age.

Japanese mental health professionals conceptualize *taijin kyofusho* as varying on a continuum of severity ranging from (a) the highly prevalent but transient adolescent social anxiety to (b) delusional disorders. Kasahara [7] has described four types of *taijin kyofusho* by the topography of clinical presentation: (a) transient type; (b) phobic type (most typical); (c) delusional type (most severe); and (d) phobic disorder, accompanied by schizophrenia, arising as a prodrome of schizophrenia or as a postpsychotic syndrome. For simplicity, *taijin kyofusho* has been divided into two types: (a) mild/neurotic; and (b) severe/delusional [8].

Although *taijin kyofusho* is included in social phobia in ICD-10, many professionals believe it to be separate from social phobia. The primary difference between *taijin kyofusho* and social phobia involves symptom topography and situations in which the disorder is expressed. In *taijin kyofusho*, the symptoms often involve a hypersensitivity to certain body parts such as the eyes or a body deformity. This is not as prominent in social phobia. Additionally, the symptoms of *taijin kyofusho*

Table II.—Morita's theory of *taijin kyofusho* [12, 13]

[Occurrence of <i>taijin kyofusho</i>] = [Temperament] × [Chance Event] × [Pathogenic Factor]
Temperament: Hypochondriacal Basic Tone
A personality characteristic relating to the <i>taijin kyofusho</i> condition
<i>Introversion</i> : introspective, self-punitive, vigilant, prudent, shy, wavering
<i>Extroversion</i> : positive, self-centered, aggressive, stubborn, ambitious
Pathogenic Factor: Psychic Interaction
“A mental process in which attention is concentrated on a certain sensation; this sensation becomes hypersensitized; this condition of hypersensitivity fixates attention; the hypersensitized sensation and the fixation of attention mutually interact to increasingly intensify the sensitivity of the sensation.” (Morita)

become the most exacerbated in social situations with acquaintances. In social situations with strangers or intimate friends and family, the symptoms tend to be less. This is not the case in social phobia.

Recent studies have revealed that the clinical features of *taijin kyofusho* may be changing. Findings indicate that: (a) the percentage of female patients is increasing [9]; (b) the exemplary fear of blushing has been decreasing while the more severe types of fears, such as fears of eye-to-eye confrontation, body odor, and body deformity, are increasing [10]; (c) avoidant and withdrawal tendencies are increasing [9]; (d) a change from “feeling shame toward others” to “fear occurring from being with others” [11]; and (e) complaints of anxiety and fear are becoming more vague [12].

ETIOLOGY OF *TAIJIN KYOFUSHO* ACCORDING TO MORITA THERAPY

The psychopathology of *taijin kyofusho* was first explained by Morita utilizing the terms “hypochondriacal temperament” and “psychic interaction” [12]. Hypochondriacal temperament is a temperamental characteristic, which, according to Morita [12], needs to be given the highest priority in understanding of the process of the onset of *taijin kyofusho* (see Table II). That is, individuals who are prone to develop *taijin kyofusho* have a temperamental characteristic of being hypochondriacal. Furthermore, the balance between introversion and extroversion in hypochondriacal temperament is inclined toward introversion. In Morita's understanding, those with an introverted attitude have a tendency to fixate on their weak points and become anxious and depressed [13]. The specific weak points can include their own staring, blushing, facial expression, stuttering, bodily odors, blemishes, and/or body deformity.

Morita explained the mental mechanisms that trigger the onset of *taijin kyofusho* with an equation (see Table II). In the development of *taijin kyofusho*, an individual starts with a hypochondriacal temperament. An accidental experience results in the individual becoming highly sensitized. The tendency to impose an oversensitive interpretation of the events in the individual's internal and interpersonal life is reinforced. This leads to a further intensification of sensations, and attention becomes more and more focused on these sensations and fears of interpersonal situations. This process of increased attention and sensation is what Morita called psychic interaction and this ultimately sets up a “vicious circle of attention and sensation” [13, 14] (see Fig. 1). The feelings of fear of interpersonal situations and sensitivity to bodily sensations and weak points are intensified, and the criteria for the disorder of *taijin kyofusho* are met.

Schema of Development of Symptoms [13]

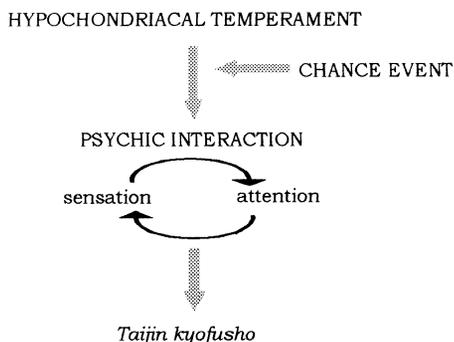


Fig. 1. With an accidental experience, an individual with a hypochondriacal temperament becomes highly sensitized, and a vicious circle of attention and sensation is created. This is how it develops to *taijin kyofusho*.

MORITA THERAPY OF TAIJIN KYOFUSHO

Morita therapy was developed by Morita in the 1910s [5]. The goal of Morita therapy is to restore the patient’s mind to its condition before it was caught up in psychic interaction. In Moritist terms, the goal is to restore the mind to an *arugamama* (things as they are) condition [15, 16]. In the *arugamama* mind, sensations are experienced in a flow, and the patient’s actual living situation is accepted as they are.

The procedure of Morita therapy consists of experiential guidance in the acceptance of the patient’s specific symptoms. Morita therapy seeks to direct the individual’s energy from their previous concerns, such as somatic symptoms, to the here and now [12] (see Fig. 2).

Diagram of Process of Pathogenesis and Cure [12, 13]

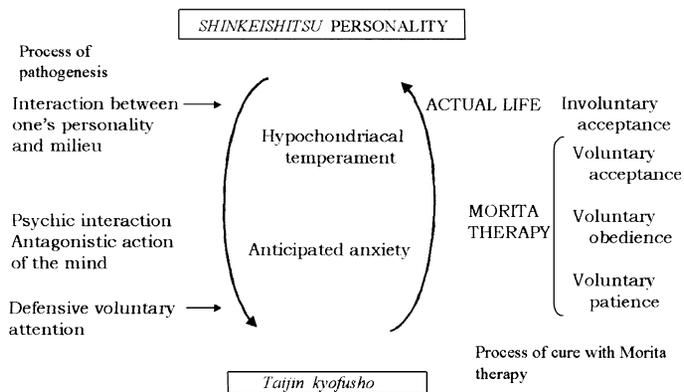


Fig. 2. This process of pathogenesis in this figure is also described in Fig. 1. The process of cure is the voluntary and involuntary acceptance of previous concerns.

Morita therapy originally treated *shinkeishitsu* patients by rest and discipline [17]. An ideal course of therapy begins with hospitalization. The first stage consists of isolated bed-rest. Patients are not allowed to have visitors or to engage in any reading or conversation. They stay in bed all day except when they eat or go to the toilet. They may, at this time, worry and preoccupy themselves with their problems. At this stage they learn that anguish eventually leads to deliverance (*hanmonsokugedatsu*) [18]. The second stage is more active. They are out of bed, engaging in light work, and are assigned single chores. They are still in an isolated environment and are not permitted to speak to others. From the second day of this stage, they write diaries under the therapist's guidance. They engage in reading such things as classical poems out loud in the morning and before sleep. In the third stage, they are assigned heavy work with minimum guidance. They may read light literature but are still prohibited from taking free walks or engaging in other entertainment. In the fourth stage, they attend lectures and meetings and are exposed to persuasive arguments toward accepting themselves and their symptoms and toward engaging in constructive activities. The total period of this treatment was originally 40 days [16, 17]; however, variations were incorporated considering the length of treatment, boundaries of each stage, and content [17, 19].

Since the 1930s, Morita therapy has been modified and is now conducted on an out-patient basis and in groups. The protocol including the modified methods is called neo-Morita therapy. In addition, a greater numbers of patients are now considered candidates for Morita therapy. Although Morita therapy was originally applied only to neurotic disorders (e.g., *shinkeishitsu* and *taijin kyofusho*), it is now administered to a variety of disorders such as depression, schizophrenia, borderline personality disorder, and alcohol dependence [16, 20]. One study found that, in a treatment group with many atypical cases, the positive treatment response was 77.6% [21]. It has also been reported that when treatment protocols are followed more strictly, 93.3% of Morita therapy patients had favorable outcomes [22].

IMPORTANCE OF TREATMENT OF *TAIJIN KYOFUSHO* IN ITS CONCEPTUALIZATION AS MENTAL DISORDER

Taijin kyofusho is an excellent example of a mental disorder in which the conceptualization of its treatment is an important aspect in the understanding of the disorder itself. Historically, the development of the treatment of *taijin kyofusho* proceeded along with the development of ideas in regard to its definition, etiology, and maintenance. Additionally, conceptualization of these ideas and the treatment of *taijin kyofusho* were promoted primarily by one individual, Masatake Morita.

It is quite probable that the formation of ideas about the treatment of *taijin kyofusho* influenced its definition, perception, expression, etiology, maintenance, clinical features, and epidemiology. When Morita therapists defined the problem of *taijin kyofusho* and then focused scientific and nonscientific attention on the symptoms of *taijin kyofusho*, the tendency for those symptoms to be noticed by individuals with a hypochondriacal temperament may have increased. While an individual's hypochondriacal temperament may have an underlying temperamental etiology, the tendency to become caught in the psychic interaction may have been influenced by media coverage of the symptoms of *taijin kyofusho*. An individual may become more aware that the symptoms they experience are part of *taijin kyofusho*, because

of the nature of the disorder is involved in attention. That is, a primary aspect of *taijin kyofusho* is the focusing of attention on bodily parts and sensations. The person's attention becomes fixated on those body parts and sensations. Thus, ideas about the treatment of *taijin kyofusho* probably influence manifestation of the disorder. In the future, as the treatment of the disorder changes, its clinical features may also change.

Acknowledgments—The authors thank Dr. Kenji Kitanishi, Dr. Masahiro Asai, and Dr. Joichiro Shirahase for their helpful comments.

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