JAPANESE CULTURE-BOUND DISORDERS: THE RELATIONSHIP BETWEEN *TAIJIN KYOFUSHO*, *HIKIKOMORI*, AND SHAME

by

Levi Edward Cole

APPROVED:

Armida Bustamante-Millán, PsyD Date 4/2/13

Nancy A. Crawford, PsyD Date April 2, 2013

APPROVED:

Clark D. Campbell, PhD, ABPP, Dean

4/2/13
Date

JAPANESE CULTURE-BOUND DISORDERS: THE RELATIONSHIP BETWEEN *TAIJIN KYOFUSHO*, *HIKIKOMORI*, AND SHAME

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

---

by

Levi Edward Cole

August, 2013

ABSTRACT

JAPANESE CULTURE-BOUND DISORDERS: THE RELATIONSHIP BETWEEN *TAIJIN KYOFUSHO*, *HIKIKOMORI*, AND SHAME

by

Levi Edward Cole

First conceptualized in the 1960s, the term culture-bound disorders refers to a classification of mental disorders or syndromes that are considered specific or closely related to cultural factors and or particular ethnocultural groups. In Japan, two culture-bound disorders, *taijin kyofusho* and *hikikomori*, have seized the interest of researchers and professionals due to their prevalence in Japanese society.

The first disorder, *taijin kyofusho*, is a culture-bound social anxiety disorder that has been documented in Japan since the 1930s. It is characterized by the experience of anxiety in, and often avoidance of, social and interpersonal situations for fear of offending others through blushing, eye-to-eye contact, body deformity, and/or emitting body odor. The second disorder, *hikikomori*, has only emerged in the last 30 years, but afflicts a substantial portion of the Japanese population. It is clinically distinguished by symptoms of social withdrawal, self-confinement in one's home, no intimate relationships with family members, and the absence of engagement in social activities. Because the symptomatology of both disorders closely resemble several of the

Diagnostic and Statistical Manual of Mental Disorders' (*DSM-IV-TR*, American Psychiatric Association, 2000) diagnoses, research on the prevalence and culture-bound specificity of the disorders are investigated, as well as the efficacy of pharmacotherapy, individual and group psychotherapy, and psychosocial rehabilitation treatments.

Finally, drawing upon research describing the relationship between mental illness and shame, and shame's inextricable relationship to Japanese history and culture, the author of this text hypothesizes that *taijin kyofusho* and *hikikomori* are sequelae of shame in Japanese society.

TABLE OF CONTENTS

PAGE

PAGE

LIST OF TABLES

PAGE

JAPANESE CULTURE-BOUND DISORDERS: THE RELATIONSHIP BETWEEN *TAIJIN KYOFUSHO*, *HIKIKOMORI*, AND SHAME

Introduction to Culture-bound Disorders

Culture-bound disorders, or culture-bound mental disorders, are psychological disorders or syndromes that are considered specific or closely related to cultural factors and or particular ethnocultural groups (Marsella, 2000; Miranda & Fraser, 2002; Tseng, 2006). The concept of culture-bound disorders was first classified in the 1960s by Pow Meng Yap as "forms of psychopathology produced by certain systems of implicit values, social structure and obviously shared beliefs indigenous to certain areas" (1969, as cited in Guarnaccia & Pincay, 2008, p. 33). Since its early discovery and study, an array of nomenclature has been used to describe culture-bound disorders, including *culture-bound reactive syndromes*/*disorders*, *culture-specific mental disorders*, *exotic mental disorders/illnesses* (Choi & Yeom, 2011; Yap, 1966), and *exotic psychosis* (Yap, 1969).

In its *Diagnostic and Statistical Manual of Mental Disorders* (*DSM,* American Psychiatric Association [APA], 1980, 1987, 2000), the APA in *DSM-IV-TR* (2000) defined culture-bound disorders as follows:

> The term culture-bound syndrome denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience … generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations. (p. 898)

These disorders, ranging from common to obscure, may be common in one society or period of time, and completely absent in another (Kanayama & Pope Jr., 2011). Marsella (2000) listed many of the commonly known culture-bound disorders found in the *DSM-IV-TR* (2000), along with their respective locations and populations at risk in Table 1. Some less well-known culture-bound disorders include, but are not limited to, *baridi*, emotional coldness and mental and physical fatigue found in the *Bena* tribe in Tanzania (Juntunen, 2005); *bouffée délirante*, "chronic interpretative delusional psychosis" found in France (Sumathipala, Siribaddana, & Bhugra, 2004, p. 201); *dhat*, semen-loss anxiety found in several Asian countries (Sumathipala et al., 2004) *jeong-han*, "neurotic sufferings of narcissism and meloncholia" found in Korea (Ka, 2010, p. 225); and *shenjing shuairuo*, a Chinese "neurasthenia" characterized by weakness and fatigue (Chang et al., 2005).

On the other hand, inasmuch as the concept of culture-bound disorders largely stems from a Western nosology of psychiatric illnesses (Marsella, 2000), some researchers have contended that certain disorders that are common in the West, yet which may be non-existent in non-Western societies, should also be classified as culture-bound disorders (Kanayama & Pope, 2011; Tseng, 2006). Some examples of Western mental disorders argued to be culture-bound disorders include body dysmorphic disorder (Kanayama & Pope), eating disorders (Keel & Klump, 2003), obesity (Tseng), and dissociative amnesia (Pope, Poliakoff, Parker, Boynes, & Hudson, 2007).

The distinguishing and classification of culture-bound disorders has not been unaccompanied by criticism. Guarnaccia and Pincay (2008) contend that some labels

used in the past sound perjorative, such as *exotic psychosis* or irrational behavioral and thought patterns of "exotic" people, and that the "relegation of the culture-bound syndromes to the next-to-last appendix of the *DSM-IV* reinforces the notion that the glossary is in some sense a 'museum of exotica'" (p. 33). Furthermore, they suggest the utility of the term "boundedness" has lost its robustness as societies have become less geographically fixed and increasingly interconnected through globalization. The most heavy criticism directed toward culture-bound disorders is that it "practically always refers to forms of distress among persons in societies other than the United States or Europe" (p. 33).

Nevertheless, there remains a resounding and dominant consensus within the professional community that unique forms of mental illness, or "idioms of distress," which "may or may not be linked to a specific *DSM-IV-TR* diagnostic category" (2000, p. 898) are manifested in specific societies and cultures across the globe. Moreover, when trying to determine if a particular constellation of symptoms are culture-bound or of a formal *DSM-IV-TR* (2000) diagnostic category, the complexity of the issue is reflected in the fact that no definitive answer can be given, and that each disorder must be evaluated on an individual basis. Guarnaccia and Pincay (2008) propose, however, that many of the culture-bound disorders have been "labeled and elaborated in accord with cultural ideas and norms" (p. 34) of the respective society or culture within which they are manifested.

Table 1

Culture-Bound Disorders: Examples of culture-bound disorders (Marsella

Name	Definition and Location
amok	A sudden outburst of explosive and assaultive violence preceded by period of social withdrawal and apathy (Southeast Asia, Philippines).
ataque de nervios	Uncontrollable shouting and/or crying. Verbal and physical aggression. Heat in chest rising to head. Feeling of losing control. Occasional amnesia for experience (Caribbean Latinos and South American Latinos).
hwa-byung	Acute panic, fear of death, fatigue, anorexia, dyspnea, palpitations, lump in upper stomach (Korea).
latah	Startle reaction followed by echolalia and echopraxia, and sometimes coprolalia and altered consciousness (Malaysia and Indonesia).
koro (shook yong)	Intense fear following perception that one's genitalia (men/women) or breasts (women) are withdrawing into one's body. Shame may also be present if perception is associated in time with immoral sexual activity (Chinese populations in Hong Kong and Southeast Asia).
phii pob	Belief that one is possessed by a spirit. Numbness of limbs, shouting, weeping, confused speech, shyness (Thailand).
pissu	Burning sensations in stomach, coldness in body, hallucinations, dissociation (Ceylon).
suchi-bai	Excessive concerns for cleanliness (changes street clothes, washes money, hops while walking to avoid dirt, washes furniture, re- mains immersed in holy river (Bengal, India—especially Hindu widows).
susto (espanto)	Strong sense of fear that one has lost one's soul. Accompanied by anorexia, weight loss, skin pallor, fatigue, lethargy, extensive thirst, untidiness, tachycardia, and withdrawal (Latinos in South and Central America, Mexico, and Latino migrants to North America).
taijin kyofusho	Intense fear of interpersonal relations. Belief that parts of the body give off offensive odors or displease others (Japan).
tawatl ye sni	Total discouragement. Preoccupation with death, ghosts, spirits. Excessive drinking, suicide thoughts and attempts (Sioux Indians).
uquamairineq	Hypnotic states, disturbed sleep, sleep paralysis, dissociative episodes and occasional hallucinations (Native Alaskans: Inuit, Yuit).

Note. Adapted from Marsella, 2000, p. 408.

Taijin Kyofusho in Japan

Introduction to *Taijin Kyofusho*

Taijin kyofusho, meaning "fear of interpersonal relations" (Tarumi, Ichimiya, Yamada, Umesue, & Kuroki, 2004, p. 534), is a culture-bound disorder and a "distinct form of social anxiety disorder" (Nagata et al., 2003, p. 107), or social phobia, endemic to Japan. Moreover, given the historical and cultural backdrop of shame in Japan, *taijin kyofusho* has been called "an obsession of shame and anxiety" (Maeda & Nathan, 1999, p. 526) and a "phobia of being ashamed" (Nakamura, Kitanishi, Miyake, Hashimoto, & Kubota, 2002, p. 595). *Taijin kyofusho* has also been classified as anthropophobia, which is found within the diagnostic code of social phobia in the ICD-10 (Maeda & Nathan, 1999). The disorder is characterized by "an excessive sensitivity to interpersonal relations" (Ono et al., 2001, p. 507), which includes symptoms of feeling anxious in the presence of others, the fear of eye-to-eye contact, fear of blushing, fear of imagined ugliness, and fear of emitting offensive body odors. Individuals suffering from *taijin kyofusho* will often withdraw themselves from social situations for fear of being looked down upon, offending others, or making others feel uncomfortable because of these symptoms.

Although *taijin kyofusho* has been the subject of research, discussion, and treatment since the 1920s, diagnostic criteria were not established until 1995 (Maeda & Nathan, 1999). Nagata et al. (2006) have presented the current set of diagnostic criteria for *taijin kyofusho*, which are as follows:

> [First,] at least one of the following features [must be present]:
> (1) fear of blushing in the presence of others;

> (2) fear of stiffening of facial expression, of trembling of the head, hands, feet, or voice, of sweating while facing with others;
> (3) fear of physical deformities being noticed;
> (4) fear of emitting body odors;
> (5) fear of line-of-sight becoming uncontrollable;
> (6) fear of uncontrollable flatus in the presence of others.
>
> [Second,] either of the following two [must be present], because of the above fear(s):
> (1) Fear of being looked at (noticed) by others;
> (2) Fear of offending or embarrassing others.
>
> [Third,] at most points during the course of the disorder, the person recognizes that the fear is excessive or unreasonable.
>
> [Fourth,] the fear(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the fear(s).
>
> [Finally,] the symptoms must have been present for at least one year. In individuals under age 18 years, the duration should have been at least 6 months. (p. 170)

There is a dearth of epidemiological studies showing the prevalence of social phobia in Japan (Essau, Sasagawa, Chen, & Sakano, 2012). Moreover, to date, there is no known data on the prevalence of *taijin kyofusho* in the general population in Japan, although it appears to affect more males than females. One study has identified the lifetime prevalence of social phobia in Japan to be 1.2% (Tsuchiya et al., 2009; in Essau et al., 2012, p. 221). However, research has identified that up to 38% of patients had been diagnosed with *taijin kyofusho* in clinical settings (Matsunaga, Kiriike, Matsui, Iwasaki, Nagata, & Stein, 2001; in Essau et al., 2012, p. 221).

Subtypes of *Taijin Kyofusho*

Mental health professionals in Japan consider *taijin kyofusho* to vary on a spectrum of severity, "ranging from the highly prevalent but transient adolescent social

anxiety to delusional disorders" (Maeda & Nathan, 1999, p. 526). Some mental health professionals, for the sake of simplicity, have classified *taijin kyofusho* into two subtypes: "mild/neurotic and severe/delusional" (p. 526).

Others, such as Iwase et al. (2000), have classified *taijin kyofusho* into three subtypes: "the classical type (Morita type), offensive or severe type (quasi-delusional type), and avoidant type" (p. 68). "Typical" type is another common term used to describe the classical or Morita type, which tends to closely resemble the Western social anxiety disorder (Nagata et al., 2003).

Individuals with the Morita type fear being looked down upon as a result of manifesting physical symptoms of embarrassment or anxiety, such as blushing, in social situations. They also feel shame for experiencing these anxieties and fears, and therefore avoid social situations where the anxiety might be provoked. The offensive type, which is considered the more severe form of *taijin kyofusho*, pertains to the fear of offending or disgusting others vis-à-vis eye contact or body odor (Iwase et al., 2000; Nakamura et al., 2002). Because the individual possesses the awareness that the "fear is excessive and unreasonable" (Iwase et al., 2000, p. 68), and because the fear is solely limited to interpersonal contexts, it is only considered quasi-delusional and not a true delusion.

Finally, the avoidant type has been identified as a new subtype of *taijin kyofusho*, wherein the patient retains "deep-rooted feelings of inadequacy and low self-esteem …[and are] afraid of being scrutinized and evaluated" (Iwase et al., 2000, p. 68). They also possess a longing for interpersonal connection, but refrain from interpersonal engagement due to the fear of rejection.

Taijin Kyofusho, Culture-bound Specificity, and Social Phobia

Taijin kyofusho has been commonly regarded as a culture-bound disorder for much of its known history, largely due to the fact that reports of similar cases in the West have been historically quite scarce. And yet, *taijin kyofusho* has long been the subject of clinical attention since 1920 (Iwase et al., 2000; Nakamura et al., 2002; Ono et al., 2001). Not until social phobia was introduced in 1980 as a disorder in the *DSM-III* (1980), and symptoms resembling *taijin kyofusho* were noted in other parts of the world, was the "culture-bound specificity of *taijin kyofusho*" (Nakamura et al., 2002, p. 596) called into question. Both *taijin kyofusho* and social phobia share, for example, similar symptoms of experiencing fear of acting or appearing a certain way in social situations, avoiding social situations because of the anxiety and fear, and recognizing that these fears are "excessive and unreasonable" (*DSM-IV-TR*, 2000, p. 456; Ono et al., 2001).

Suzuki, Takei, Kawai, Minabe, and Mori (2003) questioned the assertion of *taijin kyofusho*'s culture-boundedness by arguing that major symptoms of *taijin kyofusho*, such as the fear of imagined ugliness and fear of emitting offensive body odor, can be subsumed under the disorders body dysmorphic disorder and olfactory reference syndrome, respectively. In his research on olfactory reference syndrome, Lochner (2003) also identified major similarities between olfactory reference syndrome and the symptom of fear of emitting offensive body odor in *taijin kyofusho*. Based on some of these reasons and arguments, Suzuki et al. (2003) claimed that research is inconclusive in being able to identify *taijin kyofusho* as a culture-bound disorder.

When seeking to establish if *taijin kyofusho* and social phobia are qualitatively identical, research has yielded unclear results. It has, however, demonstrated subtle, yet significant qualitative distinctions (Nakamura et al., 2002). Based on clinical research that was conducted on cases of social phobia in Canada to identify if the diagnosis of *taijin kyofusho* could be designated, the assertion was made that while *taijin kyofusho* and social phobia share similar diagnostic concepts, "social phobia, compared to *taijin kyofusho*, is more similar to panic disorder or agoraphobia, and *taijin kyofusho* is closer to obsessive-compulsive disorder" (p. 596). Similarly, Ono et al. (2001) identified *taijin kyofusho* as a much broader concept than social phobia, with symptoms that overlap with body dysmorphic disorder, hypochondriasis, and undifferentiated somatoform disorder.

Matsunaga et al. (2001) has also acknowledged that *taijin kyofusho* and social phobia appear quite similar in their manifestation, as both disorders share the fear that "some action or appearance will be judged inappropriate by observers and associated avoidance of social interactions and performances" (p. 234). However, one of the key differences between *taijin kyofusho* and social anxiety disorder is that "whereas patients with [social anxiety disorder] typically worry about embarrassing themselves, patients with *taijin kyofusho* often worry about offending or embarrassing others" (p. 234).

Nakamura et al. (2002) conducted a study where the similarities and differences between the clinical diagnosis of *taijin kyofusho* and social phobia were compared and contrasted. Three psychiatrists evaluated participants for a *taijin kyofusho* diagnosis, and three *other* evaluators (one psychiatrist and two clinical psychologists) evaluated the participants separately using the Structured Clinical Interview for DSM Disorders (SCID,

Japanese version) for the *DSM-III-R* (1987). Participants were composed of 38 cases of *taijin kyofusho* (29 male, 9 female), 27 of which met criteria for the neurotic type and 11 for the delusional type.

Results showed that 65.8% (25) of all the *taijin kyofusho* cases also met criteria for social phobia. Specifically, 22 of the neurotic type cases and three of the delusional type cases were found to meet diagnostic symptoms for social phobia. Thirteen cases of *taijin kyofusho*, therefore, did not meet criteria for social phobia, but were found instead to have comorbid hypochondriasis (1 case), major depression and obsessive-compulsive disorder (1 case), panic disorder (2 cases), major depression and panic disorder (2 cases), dysthymic disorder and panic disorder (1 case), psychotic disorder (1 case), major depressive disorder with psychotic features (1 case), major depression (2 cases), agoraphobia (1 case), and one case showing no other Axis I disorder.

Nakamura et al. (2002) claimed that social phobia and *taijin kyofusho* possess "differences in the orientation of symptoms" (p. 596). Namely, the primary fear in social phobia is characterized by self-centered fear of being "negatively evaluated by others" (p. 597); whereas the primary fear in *taijin kyofusho* is an "other-oriented fear that [the individual] may adversely affect others" (p. 597). This distinction lends further support to the view that *taijin kyofusho* is a culture-bound disorder, as the "self-centered" and "other-oriented" differences may be reflective of the differences between an individualistic society and a collectivistic society, respectively. Ono et al. (2001) similarly have stated that *taijin kyofusho* differs from social phobia based on an "emphasis placed on specific symptoms in the definition" (p. 507). Specifically, with

social phobia the "fear of embarrassment in social situations" (p. 507) is emphasized in the *DSM*, whereas *taijin kyofusho* is marked by the fear of disturbing others in social situations. In a collectivistic society where the group is placed above the individual, Ono et al. claimed that the patient's fear of offending others, and not primarily because of the fear of embarrassment, is evidence of the manifestation of socio-cultural factors in *taijin kyofusho*.

Dinnel, Kleinknecht, and Tanaka-Matsumi (2002) conducted a cross-cultural comparison of *taijin kyofusho* and social phobia by researching symptoms presented by Japanese and U.S. university students. To put their research in context, it was discussed that while the experience of fear or anxiety in social situations is a universal experience, how an individual defines him/herself on the "individualism–collectivism dimension" (p. 75) is of particular importance to the comparison of *taijin kyofusho* and social phobia. An individual's construal of self as interdependent or independent "may be a function of how a given culture shapes the way in which its members define or construe the self as the object of social threat" (p. 75).

In collectivistic cultures, such as Japan, an individual is and functions as a part of the greater collective, and an individual's behavior, prosocial or antisocial, is directly reflective on the group. As such, "deviation from the group, such as expressed in individualism or self-aggrandizement, is not tolerated" (Dinnel et al., 2002, p. 75), and an interdependent construal of self is fostered. In contrast, individualistic cultures, such as the U.S., foster an independent construal of the self. Novelty, autonomy from others, self-

reliance, and pioneer mentalities are praised, while conformity and conventionality can often be met with judgment and scrutiny.

Given these differences in cultural paradigms, Dinnel et al. (2002) sought to investigate "similarities and differences in cultural conceptualizations of social anxiety and fear, and how various aspects of culture mediate these similarities and differences" (p. 76) as it relates to *taijin kyofusho* and social phobia. A group of students from universities in Japan (N = 124; 68 women, 56 men) and a group of students from a university in the Pacific Northwest of the United States (N = 123; 82 women, 41 men) were measured in separate groups using the *Taijin Kyofusho* Scale, the Social Phobia Scale, the Social Interaction Anxiety Scale, and the Self-Construal Scale. The average age of the Japanese participants was 20.68, while the average age of the American participants was 22.31.

The *Taijin Kyofusho* Scale is a 31-item instrument that measures the "allocentric component of social anxiety" (Dinnel et al., 2002, p. 78) whereby an individual feels anxious to the degree that their personal shortcomings are distressing or offensive to others. The instrument uses a 7-point rating scale (1 = *totally false*, 7 = *totally true*). The Social Phobia Scale is a 20-item instrument that measures anxiety in situations where the individual may be observed by others. The instrument uses a 5-point rating scale (0 = *not at all characteristic or true of me*, 4 = *extremely characteristic or true of me*). The Social Interaction Anxiety Scale is also a 20-item instrument that measures anxiety in social situations, and also uses a 5-point rating scale (0 = *not at all characteristic or true of me*, 4 = *extremely characteristic or true of me*). Lastly, the Self-Construal Scale is a 24-item

instrument that measures "participants' beliefs about the relationship between the self and others and the degree to which they see them- selves as connected with others or separate from others" (p. 78). The items are further broken down into two 12-item subscales, Self-Construal as Interdependent and Self-Construal as Independent. The Self-Construal as Interdependent subscale measures "the degree to which self emphasizes involvement with the social context" (p. 78), while the Self-Construal as Independent subscale measures "the degree to which self emphasizes separateness from social context" (p. 78). No rating scales were delineated by the authors.

The results established that *taijin kyofusho* symptoms were expressed strongest among individuals from Japan and individuals who scored high on interdependence and low on independence. Social phobia symptoms were expressed strongest, irrespective of culture, among individuals who scored high on interdependence and low on independence. The researchers concluded that *taijin kyofusho* possesses a "culturally-determined expression of social anxiety" (Dinnel et al., 2002, p. 82), while social phobia may "represent a more culture-general expression of social anxiety" (p. 82), lending further support to the assertion that *taijin kyofusho* is culture-bound.

In a similar study, Kim, Rapee, and Gaston, (2008) sought to investigating the cultural specificity of *taijin kyofusho* by assessing for the presence of *taijin kyofusho* symptoms among a group of individuals with social phobia living in Australia. Participants included 94 people meeting diagnostic criteria for social phobia and 39 participants who did not meet criteria for any mental disorder. Participants were only included in the study if they had been born and raised in Western countries and were

currently residing in Australia. The majority of the social phobic participants (*n* = 72; 76.6%) and non-clinical participants (*n* = 31; 79.5%) were born and raised in Australia, while the remaining were born in Europe (social phobia: n 5 12, 12.8%; nonclinical: n 5 4, 10.3%) and New Zealand (social phobia: n 5 4, 4.3%; nonclinical: n 5 2, 5.2%). Eighty-nine (94.7%) of 94 social phobic participants and 37 (94.9%) of the non-clinical participants identified as Anglo Saxon, and the remaining, European. Finally, the social phobic group contained 36 males and 58 females (mean age = 34.65, *SD* = 11.64) and the non-clinical group contained 16 males and 23 females (mean age = 37.87, *SD* = 17.53).

The results from this study were similar to some of the conclusions from other studies (Dinnel et al., 2002; Nakamura et al., 2002; Ono et al., 2001), in that, though significant overlap in symptoms were found between *taijin kyofusho* and social phobia, only an insignificant portion of the Australian sample (8.6%) met criteria for the offensive type *taijin kyofusho*.

In another study, Ono et al. (2001) sought to gain a deeper understanding of the role of socio-cultural factors in the presentation of *taijin kyofusho* by conducting an epidemiological study of *taijin kyofusho* utilizing participants from the general population. While previous research on *taijin kyofusho* has been conducted almost exclusively in medical settings utilizing clinical populations, this research is the first known study of *taijin kyofusho* conducted on the general population, allowing for sub-clinical manifestations of *taijin kyofusho* to be investigated.

The researchers (Ono et al., 2001) utilized participants (*N* = 132) from the City of Kofu, in Yamanashi Prefecture, Japan. Participants completed a self-report questionnaire.

They were also administered semi-structured interviews by trained psychologists and psychiatrists using the Time-Ordered Stress and Health Interview. In addition to questions assessing for general mood and psychiatric symptoms, the semi-structured interview also asked questions specifically assessing for symptoms related to *taijin kyofusho*. Two questions assessed for "sensitivity to personal body odor" (p. 509); two questions assessed for "preoccupation with an imagined defect in the person's appearance" (p. 509); and one question assessed for concerns related to eye contact.

Of the 132 participants, nine participants (6.8%), seven females and two males, endorsed symptoms associated with *taijin kyofusho*. Of the nine participants, two were diagnosed with mental illness – one with a simple phobia, and the second with a "combination of obsessive-compulsive disorder, panic disorder, and simple phobia" (Ono et al., 2001, p. 509). None of the participants met full diagnostic criteria for *taijin kyofusho*. Nevertheless, the nine were found to manifest subclinical *taijin kyofusho* symptoms. Two participants expressed concerns about eye-to-eye contact, and two others endorsed imagined defects in their physical appearance or bodies. Of particular note, the results indicated that eight of the nine participants reported fears related to emitting offensive body odor from either the mouth, axilla (armpit), legs, or the entire body. Two participants reported that others noticed these odors.

Ono et al. (2001) expressed their belief that the results from this study offer credence to previous research that has posited that *taijin kyofusho* is a culture-bound disorder, while also broadening the current understanding of *taijin kyofusho*. First, the results indicated fear of emitting offensive odor as being the most frequently reported

taijin kyofusho symptom. The researchers proposed that this result is reflective of the "socio-cultural context and interpersonal schema" (p. 510) of the individual because the majority of the participants appeared more concerned with their own awareness of their body odor "than with an actual perception of any odor by others" (p. 510), suggesting that there is a stronger regard for the "internal image of their representation of interpersonal relationships than their actual external experiences" (p. 510).

Secondly, the Japanese medical community has traditionally conceived *taijin kyofusho* as a disorder primarily affecting adolescents and young adults (ages 14-29), however the nine participants from this study were much older. Thirdly, *taijin kyofusho* has traditionally been regarded as a disorder primarily affecting men. Yet seven of the nine participants who endorsed symptoms of *taijin kyofusho* were women. A possible explanation for this was that women, being middle or old aged, would be more self-conscious of "appearance and appropriate social behavior" (Ono et al., 2001, p. 511) as a result of their traditional societal role of "staying at home and being less assertive in society" (p. 511). Because Japanese culture belabors the value of never offending others, much like how hypochondriacs scrutinize or amplify normal bodily sensations, women may scrutinize and amplify their physical appearance and sensations for fear of offending others.

Although the use of a small sample size was noted as a limitation to the study (Ono et al., 2001), other research (Maeda & Nathan, 1999) has identified similar and additional trends. A rise in female *taijin kyofusho* cases have been observed. The "exemplary fear of blushing" (Maeda & Nathan, 1999, p. 527) has been declining, while

the "more severe types of of fears, such as fears of eye-to-eye confrontation, body odor, and body deformities have been increasing" (p. 527). Social avoidance and withdrawal have been rising as well. Finally, studies have noted a "change from 'feeling shame toward others' to "fear occurring from being with others'" (p. 527). The researchers did not assess for trends over time, and a low rate of participation and a non-randomised sample are additional limitations to the study.

Treatment of *Taijin Kyofusho*

Shoma Morita is one of the earliest known mental health professionals to have extensively studied *taijin kyofusho* (Maeda & Nathan, 1999). Morita conceptualized the etiology of *taijin kyofusho* as being intimately related to a "hypchondriaical temperament" (p. 527). Moreover, he claimed that a proneness to introversion has been observed among individuals with a hypchondriaical temperament, and accordingly, a self-reflective tendency to become fixated with one's faults, weaknesses, and physical appearance or sensations.

According to Morita, *taijin kyofusho* is triggered when an individual with a hypochondriaical temperament encounters a random experience that is intrapsychically and interpersonally sensitizing. Future internal and interpersonal experiences are then interpreted oversensitivitely, leading to an intensification of physical sensations, fears and anxieties, and other cognitive distortions. Ultimately, this vicious cycle becomes embedded physiologically and psychologically, resulting in *taijin kyofusho*. Morita's treatment approach resembles modern day Cognitive-Behavioral Therapy, where the therapist challenges the patient's cognitive distortions and oversensitive interpretations of

physical sensations, and then facilitates a process of transforming them into thoughts and interpretations that more closely align with reality.

Pharmacotherapy for Social Anxiety Disorder

Due to *taijin kyofusho*'s close resemblance of social phobia, reviewing and understanding the body of research on pharmacotherapy for social phobia is essential to comprehending research on pharmacotherapy for *taijin kyofusho*. Selective serotonin reuptake inhibitors (SSRIs) have been well researched and widely supported as the "first-line of choice treatment" for treating social phobia with medication (Davidson, 2003, p. 65). In a review of seven double-blind placebo-controlled studies of serotonergic drugs, including fluvoxamine, sertraline, and paraxetine, all drug trials showed significant and very high success rates compared to placebo groups. In the studies on fluvoxamine, 46% and 43% of the two drug groups responded to the medication, compared to 7 and 23%, respectively, in the placebo groups. For sertraline, the drug groups had response rates of 50 and 55%, compared to 9 and 29% in the placebo group, respectively. And for paraxetine, the drug therapy groups yielded response rates of 55, 66 and 70%, compared to the placebo groups' respective 24, 32 and 8% (Davidson, 2003).

In addition to serotonin, low levels of noradrenaline has also been linked with social phobia (Nagata et al., 2003). Therefore, a small, but growing, body of research on serotonin and noradrenaline reuptake inhibitors (SNRIs), particularly venlafaxine, have produced results suggestive of the value of its use in treating social phobia, with efficacy comparable to, and possibly greater than, SSRIs. In two studies of venlafaxine, the treatment groups of two studies yielded a 44% (Liebowitz, Mangano, Bradwejn, & Asnis,

2005) and 58% (Stein, Pollack, Bystritsky, Kelsey, & Mangano, 2005) response rate compared to 33% in both placebo groups. SNRIs have the added benefit of being safe and well tolerated.

Although not widely utilized due to their potential for dependency and withdrawal symptoms, benzodiazapines have also been found to be an effective second-line treatment after SSRIs, particularly for individuals who are unable to tolerate them. Three separate placebo-controlled studies on alprozolam, clonazepam, and bromazepam collectively produced greater efficacy than placebos. In a study of alprozalam, 38% of the drug therapy group responded to treatment compared to 20% of the placebo group. However, due to its heavy withdrawal symptoms, there is little evidence to support the use alprozalam as a first-line treatment for social phobia. A large double-blind, placebo-controlled study of clonazapim produced very effective results in 78% of the treatment group, compared to a 20% response rate from the placebo group. Moreover, although withdrawal symptoms were present in the treatment group, some participants from the placebo group also exhibited withdrawal symptoms, suggesting the involvement of extra-pharmacologic factors are also present in relapse. In a third controlled study of bromazepam, the drug group yielded a response rate of 82%, compared to 20% for the placebo group. Benzodiazapines have also been shown to be effective in treating symptoms of social phobia when given in conjunction with anti-depressants. By themselves, however, benzodiazapines are limited in their "spectrum of action" (Stein et al., 2005, p. 67), as they do not significantly ameliorate the symptoms of disorders frequently associated with social phobia, such as depression, obsessive-compulsive

disorder, post-traumatic stress disorder, and generalized anxiety disorder (Davidson, 2003).

Monoamine oxidase inhibitors (MAOIs) are another line of pharmacotherapy for social phobia. In particular, the drug phenelzine has yielded superior results across several studies, with response rates ranging from 64 to 85% in treatment groups, compared to response rates of 15 to 33% in placeo groups. However, due to poor tolerance and hazardous risk potential associated with MAOIs, its use is typically withheld until other forms of treatment have been unsuccesful. Compared to MAOIs, reversible inhibitors of monoamine oxidase (RIMAs), in addition to be relatively effective in treating the symptoms of social phobia, carry the advantages of safety and tolerance, but is not a widely established and accepted alternative drug of choice (Davidson, 2003).

Pharmacotherapy for *Taijin Kyofusho*

Prior to the year 2001, the number of rigorous studies of pharmacotherapy for *taijin kyofusho* was scarce (Matsunaga et al., 2001). Noting the apparent underlying "psychobiological mechanisms" (p. 232) between *taijin kyofusho* and social anxiety disorder, and also learning of documented cases of patients with *taijin kyofusho* responding to serotonin reuptake inhibitors (SRIs), Matsunaga et al. conducted one of the earliest empirical studies on pharmacotherapy for *taijin kyofusho*.

In their study, Matsunaga et al. (2001) conducted a chart review on patients diagnosed with *taijin kyofusho* from the outpatient clinic of the Department of Neuropsychiatry, Osaka City University Hospital, and whose treatment initially

comprised of SRI pharmacotherapy. The charts of 48 qualifying patients (19 males and 29 females; ages 25.5±6.3) were collected for the study and collated by the patients'demographic profiles and clinical features. Pretreatment assessments of patients were conducted using the Global Assessment of Functioning Scale (GAFS), the Japanese version of the Stuctured Clinical Interview for *DSM-IV-TR* (2000) Axis II Personality Disorders (SCID-II), and the State-Trait Anxiety Inventory (STAI) and Zung's Self-rating Depression Scale (SDS) to assess for anxiety and depression symptoms, respectively. The researchers did not expound on the description of the two measures.

Once pretreatment assessments had been conducted, patients were intiated on treatment with medication. Thirty of the 48 patients (63%) were initiated on the tricyclic antidepressant clomipramine, while 16 were started on the SSRI fluvoxamine. Patients prescribed clomipramine were all started on a daily dosage of 25 mg per day, and increased to a maximum daily dosage of 200 mg per day (mean maximum dosage = 153 mg per day). Patients prescribed fluvoxamine were all started on a daily dosage of 50 mg per day, and increased to a maximum daily dosage of 250 mg per day (mean maximum dosage = 180 mg per day). Of all the patients, 33 (21 of clomipramine patients and 12 of fluvoxamine patients) completed 6 months of medication treatment. Additionally, over the course of treatment, the majority of the patients (94%) were also prescribed benzodiazapines to control anxiety and insomnia, and 10 of the 33 patients who exhibited no to partial response to the SRI treatment received adjunctive pharmacotherapy with antipsychotic medication.

The patients' responses to treatment were assessed using the Clinical Global Impression (CGI) scale. Overall, the findings showed at the end of the six months of treatment, 16 (48%) of the patients treated with either comipramine or fluvoxamine responded favorably to their medication treatment. Of the patients treated with clomipramine, 48% (n = 10) responded to treatment, and the patients treated with fluvoxamine produced a 50% response rate. Interestingly, patients who responded favorably to treatment were more likely to experience major depressive episodes, and less likely to experience cluster A personality disorders, especially schizotypal personality disorder. This is consistent with other research that has found a link between dopaminergic dysfunction and cluster A personality disorders, and may explain these patients' non-responsiveness to SRI treatment, which targets serotonin receptors.

Limitations to the study were noted as two-fold – that their design was uncontrolled and their assessments were retrospective in nature. Therefore, Matsunaga et al. (2001) urged caution in interpreting the results and suggest their study would benefit from future research that might also find similar results.

Drawing largely upon the efficacious results of SRIs in Matsunaga et al.'s (2001) study, Kobayashi, Yoshida, Noguchi, Tsuchiya, and Ito (2003), conducted a case study on three individuals diagnosed with *taijin kyofusho* who were treated with the SSRI paroxetine. The first case was a 19-year-old Japanese male who experienced fears and obsessions about offending others through direct eye contact. The second case was a 45-year-old Japanese female who experienced intense anxiety and obsessions about offending others by her bad odor emitting from her body. And the third case was a 21-

year-old Japanese male who, similar to Case 1, experienced fear of direct eye contact, but with more severe intensity and some other symptoms shared with Body Dysmorphic Disorder.

Treatment was initiated with all three patients at 10 mg per day and increased over several weeks to 40 mg per day. Cases 1 and 2 started experiencing improvement in their obsessive symptoms, self-esteem, and social relationships, while Case 3 showed no improvement over 12 weeks of treatment. The improvement reported in cases 1 and 2 were established through the subjective reports of the patients who reported "feeling calmer" (Kobayashi et al., 2003, p. 264), decreased self-consciousness, increased activity, and decreased depression. However, no objective measures were utilized to quantify the degree of reported improvement. The researchers hypothesized that paroxetine was effective in the first two cases due to the obsessive nature of their symptoms, which were targeted and ameliorated by the medication, while the third case was more severe due to the more delusional quality of his fears. The researchers also noted the need for large, controlled studies on treating *taijin kyofusho* with SSRIs. Limitations to the study include a very small sample size and not a randomized, double-blind, controlled trial, leaving the generalizability of the results limited. Additionally, the participants' reported improvement is signficantly limited by the study's failure to implement objective measures to quantify the improvement.

As previously noted, one subtype of *taijin kyofusho* is called the "offensive" subtype, which involves the fear and anxiety of offending or embarrassing others through eye contact or body odors (Nakamura et al., 2002). Based on research establishing SSRIs

as the first line of choice in pharmacotherapy for social anxiety disorder, obsessive-compulsive disorder, and body dysmorphic disorder, Nagata et al. (2006) sought to investigate the efficacy of treating the offensive subtype of *taijin kyofusho* with paroxetine in a 12-week open trial.

Twenty-two participants were selected for the study based on their meeting criteria for the offensive subtype of *taijin kyofusho*. Those with serious medical conditions, taking psychotropic medication, being treated in psychotherapy, experiencing severe suicidality, and or having concurrent *DSM-IV-TR* (2000) psychological disorders were excluded from the study. Depending on the individual's sensitivity to medication, participants were started on either 10 mg or 20 mg per day, and increased to 40 mg a day over the course of four weeks.

Participants were administered psychiatric assessments at pre-test (week 0), week 4, 8, and 12 to track their response to treatment. Instruments for tracking their response to treatment included the Clinical Global Impression (CGI) scale, a 7-point Likert scale (1 = *very much improved*, 7 = *very much deteriorated*) that rated participants on their degree of improvement or deterioration based on symptoms associated with *taijin kyofusho* diagnostic criteria. To measure participants' insight to their obsessive and compulsive symptoms, the authors used the Insight into Obsessions and Compulsions subscale of the Yale–Brown Obsessive Compulsive Scale (Y-BOCS), for which the authors did not offer a description. Finally, to measure the degree of psychosocial impairment in the patients' lives, the authors adminstered the Japanese versions of the Liebowitz Social Anxiety Scale (LSAS), the Social Phobia Scale (SPS), the Social Interaction and Anxiety Scale

(SIAS), the Social Phobia Inventory (SPI), the Beck Depression Inventory (BDI), the State–Trait Anxiety Inventory (STAI), the Interpersonal Distrust scale of the Eating Disorder Inventory; and the Sheehan Disability Scale (SDS) . Descriptions for these instruments were not supplied by the researchers.

Results from the study showed that 41% of the participants (9 out of 22) responded positively to treatment. Moreover, the results found a significant improvement in the patients' insight to their fears of offending others, as well as with their low self-esteem. No signficant improvements were found, however, in levels of interpersonal distrust. The study is limited by its small sample size and the fact that it was an open trial, and was not randomized, controlled, or double-blind. Nevertheless, their results lend further support to the efficacy of pharmacotherapy for *taijin kyofusho* with SSRIs.

Considering that noradrenaline, in addition to serotonin, had been implicated in social anxiety disorder, and possibly *taijin kyofusho*, Nagata et al. (2003) investigated the effects of the SNRI milnacipran on patients with *taijin kyofusho* in a 12-week open trial study. The sample for the study was composed of 12 self-referred patients with the diagnosis of the offensive type of *taijin kyofusho* and social anxiety disorder. Participants were assessed according to the Japanese version of the Stuctured Clinical Interview for DSM-IV-TR Axis II Personality Disorders (SCID-II) to ensure they met criteria for *taijin kyofusho*. Eligible participants were required to be between age 18 and 65 years of age, and any patients with serious medical conditions, taking psychotropic medication, being treated in psychotherapy, and or experiencing severe suicidality were excluded from the study. Five of the participants were male, while the mean age of the participants was 27.0

years (*SD* = 7.4, range = 18-39). The average age of onset for the disorder was 10.7 years (*SD* = 3.8, range = 6-17), and average duration was 16.3 years (*SD* = 9.8, range = 2-33).

Patients in the study were adminstered 50 mg per day on a flexible dosage schedule and increased to a target dosage of 150 mg per day. They were also administered psychiatric assessments at pre-test (week 0), week 4, 8, and 12 to track their response to treatment. Instruments for tracking their response to treatment included the Clinical Global Impression (CGI) scale, which rated participants on their degree of improvement or deterioration based on symptoms associated with *taijin kyofusho* diagnostic criteria; the Insight into Obsessions and Compulsions of the Yale–Brown Obsessive Compulsive Scale (Y-BOCS); the Japanese versions of the Liebowitz Social Anxiety Scale (LSAS), the Social Phobia Scale (SPS), the Social Interaction and Anxiety Scale (SIAS), the Social Phobia Inventory (SPI), the Beck Depression Inventory (BDI), the State–Trait Anxiety Inventory (STAI), the Interpersonal Distrust scale of the Eating Disorder Inventory; and three subscales (work, social, and home/family life) from the Sheehan Disability Scale (SDS) to measure the impairment in the patients' lives. The researchers did not supply descriptions of these instruments.

Being the first known study to suggest the efficacy of milnacipran in treating *taijin kyofusho*, the results showed that pharmacotherapy with milacipran was effective in reducing the social anxiety symptoms and offensive type symptoms of the fear of offending others. Moreover, the drug yielded a response rate of 55% among the treated patients, which is comparable to response rates found among patients treated for social anxiety disorder with SSRIs. A limitation to the study is its small sample size, as well as

that it was not a randomized, double-blind study, rendering the results limited in their generalizability. Nevertheless, the researchers asserted that the results suggest that the SNRI milnacipran is an effective option for the pharmacotherapy of *taijin kyofusho*.

Two years later, the same research team (Nagata, Wada, Yamada, Iketani, & Kiriike, 2005) conducted a similar open trial study of the efficacy of milnacipran in treating the offensive type of *taijin kyofusho*, with the specific purpose of assessing its effect on insight and strategies for coping with stress. Individuals with *taijin kyofusho* range in the degree of severity of their delusionality, as well as with their insight, which ranges "from good to absent" (p. 196). It was hypothesized that insight would improve with SNRI treatment. Additionally, strategies for coping with stress have been found to improve in the pharmacotherapy for various disorders. In particular, avoidance-oriented strategies, where stressful situations are avoided "by seeking out other people (social diversion) or by engaging in a substitute task (distraction)" (p. 194) have been found to develop in patients being treated for social anxiety disorder. Nagata et al. hypothesized that patients treated with milnacipran experience similar benefits.

Structuring the method of their study in the same way as their previous one (Nagata et al., 2003), 16 patients with the diagnosis of the offensive type of *taijin kyofusho* were treated with milnacipran over 12 weeks. Six patients dropped out in the first week, and these were noted as being significantly more anxious than the non-dropout participants (STAI state 65.8 (SD = 5.7) vs. 53.9 (SD = 9.4), t = 2.8, p = 0.02; STAI trait 69.8 (SD = 2.4) vs. 56.6 (SD = 11.5) t = 3.5, p = 0.005). The mean age of the remaining participants was 31.5 years (SD = 10.4, range 20-49). Seventy percent of the participants

were male (7 males, 3 females) and the average age of onset of *taijin kyofusho* was 13.6 years (*SD* = 4.6, range = 6-19).

Again, the results showed significant improvement in the patients' *taijin kyofusho* symptoms, with 44% of the participants responding to treatment. Signficant improvement in insight was also obtained, as measured by the Yale–Brown Obsessive Compulsive Scale . Moreover, the researchers were surprised to find that emotionally-oriented coping strategies, such as emotional expression and self-assertiveness, and *not* avoidance-oriented strategies as hypothesized, significantly improved after pharmacotherapy with milnacipran. Much like their previous study, the results from this current study are limited in their generalizability due to a small sample size, a substantial dropout rate, and non-randomized.

Although the studies examining the efficacy of pharmacotherapy for *taijin kyofusho* with SSRIs and SNRIs are limited by their size and structure, the overall results point to their efficacy and usefulness in treating patients with *taijin kyofusho*. It would be advantageous for future research to investigate the efficacy of pharmacotherapy for *taijin kyofusho* with larger samples in randomized and double-blind trials. Additionally, since the present studies reviewed only examined a limited number of drugs, it would be beneficial other lines and types of drugs to be studied for their effectiveness. Overall, the findings from these studies on pharmacotherapy for *taijin kyofusho* with SSRI and SNRI medications support their role as an essential part of the treatment of *taijin kyofusho*.

Taijin Kyofusho and Future Research

Despite some objections or questions concerning *taijin kyofusho* being a culture-bound disorder, a large sum of research suggests that ample distinctions sufficiently exist to qualify *taijin kyofusho* as a culture-bound disorder. The current volume of research on the subject is small, but seem sufficient to acquire a general understanding of the disorder's nosology and etiology. The subject would greatly benefit from future research drawn from larger and broader samples, to operationalize and standardize the current understanding of *taijin kyofusho*, and to establish a more nuanced reservoir of information concerning socio-cultural factors and emperically based treatment methods.

Hikikomori in Japan

Introduction to *Hikikomori*

Hikikomori, which literally means "pulling away and confining," is a psychological disorder unique to Japan with rare occurrences in other countries (Sakamoto, Rodger, Kumano, Kuboki, & Al-Adawai, 2005). Widespread particularly among Japanese youth and young adults (Kato, Shinfuku, Sartorius, & Kanba, 2011), *hikikomori* is a disorder that is seemingly inextricable from the shame-based culture of Japan. Although *hikikomori* has only burgeoned conspicuously in the last few decades (Teo & Gaw, 2010), its seeds can be traced back to the influence of Confucian thought on Japanese philosophy and culture, and its tuber to Japan's pre-modern era of the 15th century (Japanese Philosophy, 2010).

Hikikomori is clinically distinguished by symptoms of social withdrawal, self-confinement in one's home, lack of intimate relationships with family members, and the absence of engagement in social activities, such as school or work (Hattori, 2006). The Japanese Ministry of Health, Labour and Welfare designate the following criteria for *hikikomori* (Ministry of Health Labour and Welfare; in Teo & Gaw, 2010, p. 445):

> (1) a lifestyle centered at home; (2) no interest or willingness to attend school or work; (3) symptom duration of at least 6 months; (4) schizophrenia, mental retardation, or other mental disorders have been excluded; (5) among those with no interest or willingness to attend school or work, those who maintain personal relationships (e.g., friendships) have been excluded.

This definition was further condensed by Japanese task force on *hikikomori* to define *hikikomori* as "the state of avoiding social engagement (e.g., education, employment, and friendships) with generally persistent withdrawal into one's residence for at least 6 months as a result of various factors" (Saito, 1998; in Teo & Gaw, 2010, p. 445).

History, Etiology, and Prevalence of *Hikikomori*

Hikikomori has increasingly attracted the attention and concern of health professionals in Japan, as there has appeared to be a significant increase in reported cases of *hikikomori* over the past few decades. In the late 1970s, cases of *taikyaku shinkeishou*, or "withdrawal neurosis" (Kasahara, 1978; in Teo & Gaw, 2010, p. 444) were reported, and now appear to closely resemble *hikikomori*. Likewise, in the 1980s, several cases of "school refusal syndrome" were identified and appear to share common features with *hikikomori* (Lock, 1986; in Teo & Gaw, 2010, p. 444). In 1985, there were only four

reported cases of *hikikomori* between the two main newspapers in Japan. By 2005, the number of mentions of *hikikomori* cases had increased to 794 (Furlong, 2008).

Data supplying reliable estimates of *hikikomori*'s current prevalence is "frustratingly limited" (Teo, 2009, p. 180). Depending on the study, estimates range from 400,000 (Furlong, 2008) to speculations as high as 1,400,000 (Hattori, 2006). Hattori, a Japanese psychologist who specializes in the treatment of *hikikomori* believes that about 60% (approximately 76 million) of the entire population of Japan suffers from a covert and sub-clinical form of *hikikomori*. Moreover, despite its near epidemic-proportions, mainstream Japanese health professionals have largely ignored this phenomenon as a mental disorder until recent years. Finally in 2003, the Ministry of Health and Welfare, under pressure from concerned parents, released an official report acknowledging its prevalence and outlining features that characterize *hikikomori* (Hattori, 2006).

Teo (2009) identifies three sociocultural factors that may have contributed to the rise of *hikikomori* in Japan, including decreased desire and lack of motivation among recent generations of Japanese youth and young adults; increased rates of overly-permissive, doting, and less strict child-rearing methods, called *amae*; and following the increased economic comfort experienced by many Japanese families after the 1970s, a diminished sense of value in work among adolescents and young adults. Hattori (2006) similarly identifies the rise in economic wealth, comfort, and stability as a likely cause for the rise in cases of *hikikomori*. Additionally, a study by Kaneko (2006) found that the majority of parents of individuals with *hikikomori* fall into the middle to upper

socioeconomic strata, rendering *hikikomori* a "middle-class phenomenon" because of the financial and economic resources required to support a *hikikomori* in one's home.

One population-based study (Kim et al., 2002; in Koyama et al., 2010, p. 69) found that 1.27% of young adults in their sample population experienced *hikikomori*, and that 2.50% had experienced *hikikomori* in the past. Teo and Gaw's (2010) review of the literature on *hikikomori* found the lifetime prevalence of *hikikomori* to range from 0.9% to 3.8%. A study conducted by Koyama et al. (2010) garnered similar results in their effort to identify the lifetime prevalence of *hikikomori* in Japan.

Working in concert with the World Mental Health Japan, an in-person household survey conducted between 2002 and 2006, Koyama et al.'s (2010) trained interviewers obtained 4,134 participant interviews evaluating for the presence of *hikikomori*, as well as other comorbid psychiatric disorders. The survey sites included one metropolitan city, two urban cities, and eight rural municipalities. Results from their study indicated the lifetime prevalence of *hikikomori* was 1.2% among 20- to 49-year-old residents. Moreover, for participants in their 20s, the lifetime prevalence was even higher at 2%, adding to the body of research (Kim et al., 2008; Kasahara, 1978; Lock, 1986; Teo & Gaw, 2010) showing *hikikomori*'s high prevalence among adolescents and young adults.

Additionally, Koyama et al. (2010) found the onset of *hikikomori* to be highest between the ages of 15 and 19, and that the average duration of *hikikomori* is one year, which is much shorter than other studies that have found the average duration to be about four years (Kobayashi et al., 2003; Takahata, 2003; in Koyama et al., 2010, p. 72).

One important limitation to this study identified by the researchers was that there was only a 55.1% response rate among individuals who were solicited to participate in the study. Furthermore, men and "younger people" (Koyama et al., 2010, p. 73) were less likely to respond, yielding potentially inaccurate results, as most research has found the highest prevalence of *hikikomori* to be among adolescent and young adult males (Teo & Gaw, 2010). Therefore, the population among whom *hikikomori* is most concentrated appears to have been most underrepresented in the study.

Hikikomori: Differential Diagnosis and Culture-boundedness

Although on the surface *hikikomori* appears to resemble the Western diagnosis of Agoraphobia or Social Anxiety Disorder, there are distinct features that many researchers and clinicians claim uniquely differentiates *hikikomori* from its *DSM-IV-TR* (2000) counterparts. Hattori (2006) identifies dissociation, phobia of interpersonal relationships, and emotional numbness as unique features that are symptoms not associated with Agoraphobia, Social Phobia, or Social Anxiety Disorder (Perugi, Frare, & Toni, 2007; Veale, 2003). Additionally, *hikikomori* has predominantly affected generations of adolescent and young adult males born after the 1970s, a time of strong economic growth for Japan and the emergence of video games in people's homes (Kato et al., 2011; Hattori, 2006).

Teo and Gaw (2010), on the other hand, are more reticent to emphatically assert that *hikikomori* is a new and uniquely classifiable psychiatric disorder. Inasmuch as social withdrawal and isolation are the essential features of *hikikomori*, it has a wide differential diagnosis that could include schizophrenia, PTSD, agoraphobia, major

depressive disorder, avoidant personality disorder and schizoid personality disorder. A 3-month prospective study was conducted by Japanese psychiatrists who studied the symptoms of 463 cases with a current or past history of meeting taskforce criteria for *hikikomori*. Of these cases, 31% met criteria for *DSM-IV-TR* (2000) criteria for pervasive development disorder, 10% for generalized anxiety disorder, 10% for dysthymic disorder, 9% for adjustment disorder, 9% for obsessive-compulsive disorder, and 9% for schizophrenia (Watabe et al., 2008; in Teo & Gaw, 2010, p. 445).

Teo and Gaw consider that *hikikomori* may have "broad appeal as a socially acceptable term" within a "society where it is highly stigmatizing to use words like clinical depression (*utsubyou*), let alone schizophrenia (*tougaou shichoushou*)" (Teo & Gaw, 2010, p. 446). Borovoy (2008), an anthropologist who has extensively studied Japanese culture, asserts that Japanese doctors "avoid diagnosing major psychopathology to the extent that it is possible" (p. 556). Alternatively, Teo and Gaw (2010) hypothesize that the common use of *hikikomori* may not be an attempt to avoid a stigmatizing diagnosis, but "an uneducated substitution for the 'proper' terminology of the mental disorder it is symptomatic of" (p. 446).

In their study of 4,134 community residents assessing for the psychiatric comorbidity and lifetime prevalence of *hikikomori*, Koyama et al. (2008) found that 54.5% of individuals with *hikikomori* had also experienced a comorbid psychiatric diagnosis in their lifetime. Moreover, these same individuals were 6.1 times more likely to experience a mood disorder in their lifetime compared to individuals without *hikikomori*. However, no anxiety disorder, substance-abuse disorder, or intermittent

explosive disorder was significantly correlated with the experience of *hikikomori*. Among individuals with *Hikikomori*, 35% had experienced another psychiatric disorder prior to the onset of their *Hikikomori*, including social phobia and specific phobia. Additionally, 16% percent experienced major depressive disorder at the same time as the onset of *hikikomori*. Conversely, 45.5% of individuals identified as having *hikikomori did not* experience any comorbid psychiatric disorder at any point in their life.

Although differing in their rates of the presence or absence of comorbid psychiatric disorders, the research conducted by Teo and Gaw (2010) and Koyama et al. (2008) both suggest that the majority of *hikikomori* cases suffer from "some form of established Axis I or II disorder" (Teo & Gaw, 2010, p. 446). Likewise, both agree that there exists another group, albeit at a lower rate, that solely experiences *hikikomori*. Cases of *hikikomori* with no other co-occurring psychiatric disorder are referred by some as "primary *hikikomori*" (Kinugasa, 1998; in Koyama et al., 2010, p. 73).

While researchers may assert varying opinions and degrees of stringency related to inclusion criteria for *hikikomori* as a new and distinct mental disorder, there appears to be agreement that *hikikomori*, in some form or another, is a culture-bound mental disorder that is relatively unique to Japan, as only two isolated cases of *hikikomori* have been recorded occurring outside of Japan in Oman and Spain (Hattori, 2006; Sakamoto et al., 2005; Teo & Gaw, 2010;).

Sakamoto et al. (2005) conducted a study investigating *hikikomori* as a culture-bound syndrome isolated to Japan. Worldwide studies have observed varying levels of social withdrawal and avoidant behavior across different ethnic groups, indicating that

sociocultural factors may play a role in instigating social withdrawal and avoidant behavior. Religion, child-rearing practices, and education have been suggested as possible factors contributing to this phenomenon. Therefore, in an effort to shed further light on whether or not *hikikomori* is a culture-bound syndrome or a culture-reactive syndrome, Sakamoto, et al. conducted a case study of a reported case in Oman of a 24-year-old Omani man who exhibited some symptoms of *hikikomori*, involving mainly social isolation and a reclusive lifestyle.

Since the patient did not wish to receive treatment, the clinicians decided to involve the patient's family in treating him with nidotherapy, a treatment method that requires the environment to adjust itself to the patient, rather than a traditional psychotherapeutic model that would require the patient to change. Because most social withdrawal is caused by a fear of social-evaluation, when family members ceased to put conditions on the patient's behavior according to the Nidotherapeutic model, the patient became less antagonistic and more social, which, in turn, reduced his distress and suffering, eventually leading to the abatement of the patient's reclusive lifestyle (Sakamoto et al., 2005).

Sakamoto, et al. (2005) discussed the similarities between Japanese and Omanis cultures that may contribute to *Hikikomori*, namely ideas of shame, language complexity, and moral codes. It was noted that in cultures such as Japan and Oman where shame is regarded as an important emotional experience and an integral part of socialization, syndromes akin to social phobia could develop as a result of the fear of rendering oneself socially unacceptable. Secondly, while language facilitates the expression of emotions,

the presence of complex and ambiguous metaphors and abstractions, as found in both Japanese and Arabic, could exacerbate the fear of being evaluated and misunderstood by others in society. Finally, the researchers hypothesized that the more moral and ethical codes and customs a society carries (both Japan and Oman are heavily laden with such codes and customs), the increased likelihood could exist of people succumbing to the fear of being embarrassed, scrutinized, humiliated, or judged. Therefore, on the basis that culture influences social maladjustment, Sakamoto et al. challenge the belief that *hikikomori* is a culture-bound syndrome.

Psychopathology and Treatment of *Hikikomori*

Teo (2009) highlights how a careful investigation of the history of the individual with *hikikomori* "reveals an aversive or traumatic childhood experience" (p. 181). *Ijime* [bullying] is a common social problem affecting Japan, and interviews of individuals with *hikikomori* frequently reveal histories of *ijime*, involving "taunting, being shunned by social circles, or outright physical abuse" (p. 181). Concurrent with this social problem, school truancy (*futoukou*) has been found to be the "most common diagnosis in child and adolescent psychiatry in Japan" (Honjo, Kasahara, & Ohtaka, 1992; in Teo, 2009, p. 181). Moreover, it is typically regarded as the initial "manifestation of withdrawal behavior and is often a harbinger of full-blown *hikikomori*" (Teo, 2009, p. 181).

"Disrupted family dynamics" (Teo, 2009, p. 181) is another factor frequently associated with the background of individuals with *hikikomori*. Violence perpetrated by the *hikikomori*an toward other family members was a common feature that emerged

among families with a *hikikomori*an (Hattori, 2006; Teo, 2009). Also, a doting, overprotective style of parenting "embodied in the psychological concept of *amae*" (p. 181) has been observed in families with *hikikomori* at higher rates than families in which no *hikikomori*ans live. It is suggested that the *amae*-style of parenting may perpetuate a child's dependency on his mother, as *amae* is associated with mothering in the majority of cases.

Kaneko (2006) conducted field research for one year with a number of support groups for *hikikomori* patients. Given the cultural context of a contemporary Japanese society that is infused with rigid standards and extreme pressures to perform efficiently and punctually, "*hikikomori* brings attention to youths who cannot accommodate to such pressures of time and efficiency" (p. 236). Kaneko discusses in her article how time is perceived, managed, and conceptualized by *hikikomori* patients in the period prior to becoming *hikikomori*, the period during *hikikomori*, and the period of recovering from *hikikomori*. Secondly, Kaneko studied two different support groups for *hikikomori* and discusses their differences in philosophy on how to provide support to *hikikomori* patients.

In the period prior to becoming a *hikikomori*, most *hikikomori* patients discuss their experiences as youth in relation to their family background and school, the immense pressure they experienced to conform to the educational system and society as a whole, and their academic year in which negative experiences occurred. In the actual period of *hikikomori*, the patients frequently discussed the period as feeling like a single phase of life in which they were not expected to fulfill social roles and not constrained by

appointments, time constraints, and rules of punctuality. One patient described his period of *hikikomori* as being a time during which he recharged himself of energy he had lost over the previous 30 years. Finally, in the period of recovering from *hikikomori*, most patients consider reintegrating themselves into the educational system or finding employment as their primary goal of fulfilling their social roles. This recovery period is a slow, pain-staking process of increasing contact with society and achieving social participation (Kaneko, 2006).

Kaneko's (2006) field research led her to examine two *hikikomori* support groups with two different philosophies on how to care for and assist *hikikomori* patients with reintegrating themselves back to society. The first support group, Group A, provided a therapeutic milieu that placed very few restrictions of time and space, opposite that of "real" society, so that the *hikikomori* patients would not feel pressured, but instead feel the freedom to socially reintegrate themselves at their own pace.

On the other hand, the main goal of the second support group, Group B, was to prepare the patients for reentering real society and to help them acquire the basics of every day life by creating an environment with a stricter time arrangement with expectation that members of the group would internalize punctuality and socially defined values. Members of this group are expected to "graduate" after two years and re-involve themselves with education or employment.

Professionals in the *hikikomori* field are not in agreement over whether recovering *hikikomori* patients should be freed from time constraints and social expectations, or if they should be assisted with internalizing punctuality and social expectations (Kaneko,

2006). Moreover, the author did not offer any hypotheses or concluding thoughts when comparing the two groups, which may leave readers confused in knowing how to integrate and put into context the two different group formats. The author did, however, make a general conclusion that *hikikomori* may be partially seen as an "act of rejection of maturity, as sufferers cannot cope with the social expectations as mature adults" (p. 246). Yet even more broadly, the author suggests that *hikikomori* represents the acute "pressures of time and role performance" (p. 246) under which members of Japanese society live on daily basis.

In another study on support groups for *hikikomori* patients, Ogino (2004) conducted a participant observation of *hikikomori* patients, individuals he calls, "*hikikomori*ans," in the setting of a private support group for *hikikomori*ans. Ogino observed and studied how the dynamics within the support groups facilitated healing and recovery for *hikikomori*ans. Ogino stated the ultimate goal of the support group is to help *hikikomori*ans with "managing categorization," a label he gives to the therapeutic philosophy underlying the milieu of the support group. The roles and responsibilities of members within the support group are kept intentionally vague. This therapeutic philosophy sees disease labels, social roles and hierarchies, rigid functions of space, and time constraints as being major causal factors of *hikikomori*. The therapeutic milieu of the support group, therefore, is uniquely constructed to avoid such social constructs and obligations, but instead offers a milieu free of such categories.

For example, new members of the support group are not asked to report on past treatments or diagnoses, seeing as they are irrelevant to what they hope to accomplish for

themselves in the present. Secondly, any non-member who would have contact with the *hikikomori*an cannot "smell" like a professional. Whether he or she is a therapist, teacher, or psychiatrist, if they cannot set aside their professional demeanor, they are not allowed to help out with the support group because the fear exists that the member would be forced to take a student or patient role, causing them to feel inferior or experience certain expectations, which may ultimately lead them to stop attending the support group. Thirdly, part of the managing categorization philosophy involves the importance of staff being indistinguishable from the members, for similar reasons set forth in the previous example. Fourthly, the actual space of the support group, with its different rooms and spaces, is not to have any specific purpose. This further deconstructs rigid, socially imposed functions of rooms and spaces. Finally, in an effort to eliminate socially imposed time constraints and rigid punctuality, schedules are constructed very loosely and spontaneously (Ogino, 2004).

With such a milieu in place, it is believed that *hikikomori*ans experience freedom from socially imposed roles and responsibilities and can freely explore and develop who they wish to become in the process of reintegrating themselves back into society (Ogino, 2004). Categorization functions as "status and ability symbols" (p. 132), whereby status "determines possibilities of explaining the self and then appearing in social settings" (p. 132), while ability "determines expectations of others in the ability of the self to perform the roles corresponding to the self's category" (p. 132). Moreover, Ogino concludes that categorization in Japanese society is responsible for pressure individuals with *hikikomori* experience and with which they are unable to adaptively cope, and that individuals with

hikikomori are drawn deeper into isolation as they struggle, and often fail, to understand, adapt to, and function in their perceived role, or categorization in society.

Where many studies speak to the rigid social obligations as being a possible cause for *hikikomori*, Japanese psychologist Yuichi Hattori noticed in his private practice and treatment of *hikikomori* patients a common trend of trauma-related symptoms, such as dissociative symptoms and attachment problems (Hattori, 2006). Hattori conducted a study on *hikikomori* with 35 participants, 25 male and 10 female, with an average age of 21.5 (range = 11-35). The sample for the study was a convenience sample obtained between 2000 and 2002 from the author's private counseling practice. The participants engaged in fifteen 50-minute sessions, during which time they were examined for common features associated with childhood experiences, personal and family history, and treatment methods. In addition, participants were administered the Dissociative Experience Scale (DES), a 28-item self-report screener with a frequency percentage ranging from 0 to 100% to measure levels of dissociative symptoms.

According to the results from the study, parents of the subjects indicated a range of 6 months to 16 years for the period of time of social withdrawal experienced by the subject. Other results revealed many common features, symptoms, and family backgrounds; the most common of which was a cognitive schema of distrust for human beings, which was experienced by 100% of participants. Other common features were high levels of dissociative symptoms (71%), phobias of humans (71%), depersonalization (26%), and amnesia (23%). Ninety-one percent of participants reported a history of emotional neglect, which included their parents not talking to them when they were

children; avoiding eye contact with and being emotionally unavailable for soothing; and ignoring them whenever they as children made emotional demands. Fifty-four percent reported being bullied in school; 54% reported being emotionally abused as children; 11% reported being physically abused; and 0% reported sexual abuse (Hattori, 2006).

All participants reported a distrust of their parents as children, and all participants exhibited the loss of and or absence of a secure attachment as a child. Large percentages of the participants reported a fear of self-expression to parents (89%), fear of parents when young (80%), rage against parents (69%), that they destroyed family properties (49%), that they wished to kill their parents (46%), and that they physically attacked their parents (29%; Hattori, 2006). Violence against family members was not only reported in this study, but also in a study that assessed differences between Japanese youth and American youth in who they seek out for help in various times of need (Crystal, Kakinuma, DeBell, Azuma, & Miyashita, 2008). They observed a surprisingly high prevalence of American youth who possess very positive relationships with their parents. However, this was contrasted with trends among Japanese youth, which has seen increased accounts of violence against family members and an extremely high prevalence of *hikikomor*.

Finally, all participants came from similar socioeconomic backgrounds of middle to upper-middle class families (Hattori, 2006). As detailed earlier, a study conducted by Kaneko (2006) found that *hikikomori* is predominantly a phenomenon and problem isolated to the middle class due to the financial and economic resources necessary to support a *hikikomori* in the home.

Hattori (2006) utilized individual psychotherapy for treating participants in his study with the goal of assisting the participant in recovering emotions, recovering their original identity, forming a new attachment to the original identity, and rehabilitation. Hattori noted positive outcomes to the psychotherapy treatment, however the degree to which the participants recovered from *hikikomori* was not quantified. Further limitations include the absence of a control group with which to compare outcome data; no formal and standardized method of treatment was delineated; and finally, the research was conducted upon a convenience sample of individuals seen in the author's counseling practice.

Finally, in the context of how to effectively treat *hikikomori*, Suwa & Hara (2007) claim that there is an important distinction between primary *hikikomori* and *hikikomori* with High-Functioning Pervasive Developmental Disorder (HPDD). Suwa and Hara define primary *hikikomori* as, "the state of social withdrawal [that] is not derived from any mental disorder" (p. 98). As children and adolescents, primary *hikikomori*ans are very similar to their peers, and can interact with others and make friends, albeit with some difficulty. Children with HPDD, on the other hand, have slower language acquisition. They also experience difficulties with comprehending directions and complex tasks, while also having difficulty engaging in physical activities. Children with HPDD exhibit peculiar behaviors and patterns that stem from their indifference toward others. As adolescents, those with HPDD have great difficulty making friends, which leads them to awareness that they are different from other people. This awareness about themselves often leads to them to try to compensate for their impairments, however this

compensation is often executed in socially inappropriate ways. By the time they enter into the latter years of their education or early stages of employment, the pressures of being different and impaired can seem to cause these individuals to socially withdraw and become *hikikomori* (Suwa & Hara, 2007).

The difference between these two types of *hikikomori* becomes important in the context of treatment. While in the case of primary *hikikomori* the psychoanalytic approach can be utilized in intervening with the family dynamics. However with *hikikomori*ans with HPDD, the psychoanalytic approach appears to be ineffective because of their lack of understanding of interpersonal relationships. Therefore with *hikikomori*ans with HPDD, group therapy that facilitates social interaction and peer-group experiences seem to be more effective (Suwa & Hara, 2007).

Given the staggering number of cases of *hikikomori* that exist and quickly continue to increase, it seems to be of the highest importance that mental health professionals be informed and educated on this illness and that effective treatment be offered to the patients of this disorder. There appears to be a general consensus across the board as to how sociocultural factors may contribute to this increasing epidemic, however Hattori's (2006) research and conclusion that *hikikomori* is a trauma-based disorder raises some very important questions regarding proper methods for treating *hikikomori*. Due to the only recent awareness of the high prevalence of this illness, research on this subject is lacking in almost every way. No empirical data exists regarding treatment methods for *hikikomori*. Research ought to be conducted to investigate possible covert forms of this disorder as well.

What is of vital importance for the future is to determine the most effective method for treating *hikikomori*; and the results of this review suggest that a combination of psychotherapy and involvement in a *hikikomori* support group would prove to be the most effective method of treatment. Furthermore, the results of this review indicate that a support group that utilizes a role-free, time-free, obligation-free philosophy will prove to be more effective than a support group that attempts to assist members with internalizing social expectations and punctuality. The secondary purpose to this paper would be to encourage more research on this subject so more accurate, empirically verified information could be made available on this illness. Finally, while effective treatment methods for *hikikomori* is vital for the health of its patients, due to the cultural implications of the disorder, there would be much value in researching the systemic nature of the disorder and how the broader culture of Japan can take responsibility for its contributions to this disorder.

Shame in Japan

Introduction to Shame

Shame has been labeled a "self-conscious emotion" in psychological literature (Rizvi, 2010). It is a "powerful and ubiquitous human experience … that can have a profound effect on psychological adjustment and relationship" (Tangney, 2000). With shame, there is the "awareness of inadequacy or failure to achieve a wished-for self-image which is accompanied by, or originally arises from, the fear of separation or abandonment" (Creighton, 1990, p. 285). Shame is strongly characterized by the view of

oneself as "fundamentally flawed and bad" (Paivio & Pascual-Leone, 2010, p. 206) or "lacking in dignity or worth" (p. 206). Concurrently, it is "an interpersonal affect [that] requires the presence of another, in fact or in imagination, for its blow to be felt" (Allender, 1995, p. 64). Moreover, shame, "unlike other feelings that relinquish some of their power by putting words to their inner sensation … has the propensity to increase in intensity when it is first acknowledged" (p. 63). Conversely, shame possesses the adaptive capacity to organize an individual to hide himself from the scrutiny and criticism of others "so that personal flaws are not exposed" (Paivio & Pascual-Leone, 2010, p. 206).

Shame versus Guilt

Shame and guilt are often improperly distinguished and are frequently referenced synonymously or used interchangeably, particularly in Western culture (Parker & Thomas, 2009). Failure to properly distinguish the psychological differences of one from the other has significant implications, especially in clinical settings, in light of a growing body of research that highlights critical differences between the two. In clinical settings, for example, treatment could be rendered ineffective or even exacerbate a client's distress if his/her shame is mistaken, and subsequently treated, for guilt. It is therefore essential to adequately differentiate shame and guilt in order to gain a proper understanding of their psychological dynamics and impact.

An "individual's interpretation of the role of the self" (Parker & Thomas, 2009, p. 215) has a different impact in their experience of shame or guilt. In guilt, the self pronounces judgment on its *activity*; while in shame, the self pronounces "a more

summary judgment on the inadequacy of the *self* itself" (p. 215). Shame is exceedingly self-conscious and self-aware compared to guilt. Likewise, individuals "experiencing shame seem less able to cognitively sort out their actions from the more fundamental sense of self" (p. 215). The perception of the self as worthless and powerless is also more fundamentally tied to shame, while the belief that corrective action can be taken to address the consequences of their present or future behavior tends to be more present with guilt.

Shame and guilt possess a form of consciousness and concern for others, in that there is an acute awareness of others in their experience. Subsequently, differences exist between shame and guilt in how an individual perceives the role of the "other" or others, who "may be human or supernatural, specific or generalized, alive or dead" (Lebra, 1983, p. 193). With shame, others are viewed as audience and spectators to one's actual or perceived transgression. Whereas with guilt, others are viewed as "patient's of or sufferers from one's action" (p. 193).

Drawing from psychoanalytic literature, Creighton (1990) asserts that shame develops earliest in infancy, and that guilt is predicated on shame later in development once external values become internalized upon the development of the superego. Shame arises in the failure to develop a sense of autonomy and adequacy gained through attempts to separate and individuate. Guilt, by comparison, initially develops from the fear that a negative act will incur punishment from a parent, which is then internalized, "so that guilt feelings result whether there is an actual threat of punishment or not" (p. 286). Shame is compelled by the fear that the "inadequacy perceived by others is valid,"

while guilt is compelled by the "internal recognition of transgressing" internalized values and the associated punitive consequences (p. 286).

Shame versus Guilt Cultures

Eastern cultures have often been broadly contrasted with Western cultures as being a shame culture versus a guilt culture, respectively. The psychological make-up of Japanese culture in particular has frequently been juxtaposed with American culture in this shame-versus-guilt dichotomy. Although shame and guilt are present in both Japanese and American cultures, non-Japanese and Japanese scholars alike agree "shame sanctions play a greater role in regulating behavior in Japan than guilt sanctions" (Creighton, 1990, p. 282).

One view of the difference between shame cultures and guilt cultures is that shame cultures rely on "external sanctions of control while guilt cultures rely on internal sanctions of control" (p. 282) wherein the collectivistic ethos of shame cultures serve to regulate and control behavior, while the individualism of guilt cultures is far more compelling to control and regulate. In contrast, a view of shame and guilt more endemic to Japanese culture assert that guilt is learned through external punishment, and that a person will then learn to control themselves once they know shame on the inside.

Shame in Japan

Shame is ubiquitous in Japanese society (Lebra, 1983). Its prevalence may be partially attributed to its geography and demographics. In contrast to culturally and ethnically diverse societies such as the United States, the island nation of Japan is an ethnically and culturally homogenous society with well-defined and readily recognizable

cultural norms wherein "the Japanese individual is more surrounded by significant audiences to whom his action is exposed" (p. 193).

Additionally, Lebra (1983) proposes another factor mediating the pervasiveness of shame in what is described as "the exposure sensitivity of the outer self" (p. 193). The author states that Japanese, compared to Westerners, possess a unique sensitivity to a form of embarrassment, or a "surface-level shame affecting the outer self only" (p. 194). Japanese are easily embarrassed, or experience shame of the outer self, when exposed to an audience, irrespective of whether or not they have done anything wrong. The Japanese word *haji* captures the continuum of affect between embarrassment and shame, and it is the "prevalence of embarrassment-*haji*…[which] makes the Japanese all the more vulnerable to shame-*haji*" (p. 194).

Being exposed to others' gaze has been found to cause stress-induced physiological arousal (Mazur et al., 1980, as cited in Lebra, 1983, p. 194), and among Japanese, the stress elicited from an audience's gaze, both real and imagined, is "processed foremost into *haji*" (p. 195). Accordingly, the suppression and inhibition of affect, expressing private thoughts and feelings, and reflexively utilizing certain "gestures, behavioral styles, or speech patterns" (p. 195) are defensive strategies used to avoid exposure and the experience of *haji*. The avoidance of exposure is both a reflexive and spontaneous act and a "culturally desirable and prescribed attitude" (p. 195) reflected in the measures taken to "remain hidden, unexpressed, or inconspicuous" (p. 195).

While Japanese sensitivity to exposure promotes non-exposure, it conversely motivates an individual to display and demonstrate perfectionism to the audience when

exposure is necessary (Lebra, 1983). An intricate matrix of behaviors, styles of speech, courtesies, and customs designed to ensure perfection and propriety in an individual's public persona. The Japanese words *tatemae* (public mask or façade) and *honne* (private, true self) appropriately capture this public persona–private self dichotomy that so common and inextricable in Japanese culture. When a Japanese has acute exposure sensitivity relative to his/her peers, it can serve as a catalyst for the development of the mental disorder known as *taijin kyofusho*, the culture-bound disorder discussed in detail earlier in this paper.

Historical Context of Shame in Japan

Archeological remains indicate that a Paleolithic culture inhabited Japan in 30,000 BC, and since that time, Japan's culture and practices have been chiefly shaped by Chinese and Korean cultural and political influences. Historians have concluded that Japan became a unified nation under the Yamato court in the 4th century AD, and in the 7th century, a constitution known as the *Seventeen Article Constitution* was implemented as a moral code and philosophy of government for ruling the nation. The philosophical themes embedded within this constitution were heavily influenced by Confucianism and Buddhism and generated an unmitigated impact on the future development of Japanese philosophy and culture (History of Japan, 2010). It is the relationship between Confucianism and Japanese culture that is of particular importance in an analysis of the historical context of *hikikomori*.

Confucius lived his life in China during the "Warring States Period" of 403-221 BC, a period in Chinese history where China was plagued by internecine warfare and

political disunity. Furthermore, he was born on the dying cusp of the powerful Zhou Dynasty, the longest dynasty ever to exist in Chinese history. The historical context out of which Confucian philosophy emerged was on the deathbed of the highly idealized Zhou Dynasty starkly contrasted with the war-torn, disunited political state of his time (Richey, 2003). Thus, a major emphasis in Confucius' philosophy and teachings was a "reliance on and love for the ancients (*Lunyu* 7.1)" as a means of transmitting *Dao* (Way), or the quintessential ways and values of antiquity, of which he claimed the great dynasty of Zhou was an exemplary embodiment (Riegel, 2006).

Due to the social and political disunity that was rampant in his time, a chief concern of Confucius' teachings pertained to the ancient value of "harmonious order" being effectively laid as the foundation for society. Moreover, Confucius defined three interconnected types of order, aesthetic, moral, and social, which are subsumed under harmonious order; and *li*, or ritual propriety, was the vital instrument for the effectuation of all three. As reflected in Confucius' saying, "Do not look at, do not listen to, do not speak of, do not do whatever is contrary to ritual propriety (*Lunyu* 12.1)," the rigorous adherence to ritual propriety, both personally and politically, became the cornerstone of Chinese society thereafter, as it served the common objective of regulating and maintaining order (Richey, 2003).

Of the threefold nature of the harmonious order, the purpose of the aesthetic order was to maintain the "cultural hegemony" of noble traditions, literature, and "conventions of elite good taste," which were considered to reflect the exemplary ways of *Tian*, or heaven. Secondly, moral order encapsulated the virtue of *ren* (humanness or

benevolence), which demonstrated a concern for others, while also displaying an awareness of one's place in the order of society. Finally, and perhaps most importantly, social order concerned the proper observance of rituals and practices to maintain ideal hierarchy of power. The quintessential element of maintaining harmonious social order was regarded by Confucius to be *xiao* (filial piety), of which the element *jing* (reverence) is paramount. Filial piety is first and foremost observed in reverence towards one's father and mother; yet it also encompasses a much broader concept of reverence for one's elders and those who are superior in the social hierarchy. This core tenet is reflected in Confucius' saying,

> In serving your father and mother, you ought to dissuade them from doing wrong in the gentlest way. If you see your advice being ignored, you should not become disobedient but should remain reverent. You should not complain even if you are distressed (*Lunyu* 4.18).

Ultimately, "when persons and things are in their proper places – and here tradition is the measure of propriety – relations are smooth, operations are effortless, and the good is sought and done voluntarily" (Richey, 2003). Personal expression is sacrificed for what is believed to be the greater good of maintaining order in society.

While Confucianism was a guiding force in Japan in the early development as a more unified nation under the Yamato court in the 7th century, it had an even more significant impact during the Tokugawa period (also known as the Edo period) in the early 1600s and thereafter. Similar to how the historical context in China provided fertile soil, within which the seeds of Confucianism were easily sown and able to take root and germinate, so the period prior to the Tokugawa period, the Sengoku period, furnished a

favorable context from which Confucian philosophy could flourish (Neo-Confucianism, 2010).

The Sengoku period, meaning the "Warring States period" (also the same name given to the period of time in China when Confucius lived), was a 100-year period marked by constant and widespread warfare between small states that were ruled by military leaders known as *daimyo*. Prior to this time, military governors known as *shugo* ruled large provinces of land appointed to them by the Ashikaga shogun (hereditary military dictators). However, in what marked the beginning of the Sengoku period, deputies and subordinates of the *shugo* usurped their domains in a phenomenon known as *gekokujō*, a term meaning "the lower overcome the higher." As such, across the country land became divided into small states that were ruled by domain lords known as the Sengoku *daimyo*, and for the next 100 years Japan was plagued by warfare between these small, belligerent states (History of Japan, 2010).

As the *daimyo* fought against each other, a consolidation process transpired where fewer and fewer *daimyo* emerged from the wars controlling more and more territory. In 1568, the powerful Sengoku *daimyo* Oda Nobunaga executed a decisive military conquest to unify the country. His conquest was continued by his most powerful general Toyotomi Hideyoshi, and ultimately completed by his successor Tokugawa Ieyasu in 1603, who gained hegemony of the remaining daimyo and then established the Tokugawa shogunate, the commanding military power for the Imperial Court (Daimyo, 2010). Within this context, the Tokugawa period was established. It was the "final period of traditional Japan, a time of internal peace, political stability, and economic growth" that

lasted for over 250 years under the military dictatorship of Tokugawa Ieyasu (Tokugawa period, 2010).

As a part of Tokugawa's plan for maintaining national stability, the social order (which consisted of four social classes composed of the warriors, farmers, artisans, and merchants) and mobility between social classes was officially frozen. Moreover, the Confucian philosophy that already carried a strong influence in society became the guiding philosophy for the Tokugawa period. Confucianism provided a heavenly sanction for the fixed social order, and the *Samurai* warrior class was equated with the Confucian "perfect gentleman" who would exemplify the "virtues of filial piety, loyalty, obedience, and a sense of indebtedness to one's superiors to the lower classes (Tokugawa period, 2010)."

Tokugawa implemented vast and extreme measures as a means of retaining the social order that played such a vital role for the smooth operations of the government, politics, and the economy. The farmer class, who were predominantly peasants and composed 80% of the population, were restricted from engaging in any non-agricultural activities as a means of insuring a stable and continuous source of income for the warrior class. The possession of weapons was also forbidden as a means of discouraging insurrections. Additionally, Tokugawa effected a complete ban against Christianity, which had been introduced to Japan in the mid-1500s and had been protected and encouraged by Tokugawa's predecessor Oda Nobunaga. Tokugawa perceived Christianity as being particularly threatening to his government, as Christianity directed its followers toward personal ideals and allegiances that opposed or transcended

Tokugawa's philosophy of government and social order. Tokugawa's extreme measures of maintaining stability and social order eventually led to him instituting a policy of total national seclusion from the rest of the world, which lasted until the mid-1800s (Tokugawa period, 2010).

Fearing insurrections from the lower classes and followers of Christianity, Tokugawa instituted neighborhood associations called *gonin-gumi* (five-household groups) whose function was to incentivize "joint responsibility for tax payment, to prevent offenses against the laws of their overlords, to provide one another with mutual assistance, and to keep a general watch on one another" (Gonin-gumi, 2010). Families were held responsible to report to the local authorities any suspicious activities that were contrary to laws instituted under the Tokugawa government. If a member of a *gonin-gumi* was caught engaging in activities that were considered illegal, the entire *gonin-gumi* was held responsible for the offense. This had a two-fold effect on members of the *gonin-gumi*. First, it produced the incentive and a sense of paranoia to be vigilant of others activities, and the motivation to report to the authorities, if anyone should be engaging in anything illegal. For in so doing, with the exception of the offender(s), the *gonin-gumi* was kept safe from punishment. Conversely, it discouraged an individual from engaging in any unlawful activities, such as conversion to Christianity, because one would put the entire *gonin-gumi* at risk of punishment. The institution of *gonin-gumi* was a highly effective means of suppressing personal expression, beliefs, or endeavors over the collectivistic whole and maintaining social order.

There is arguably no other period in the history of Japan that instilled and wove the Confucian values of social order and communal morality into the fabric of Japanese culture more than the Tokugawa period. Many of the social establishments instituted by Tokugawa have remained intact to this very day. The institution of *gonin-gumi* made a strong resurgence during World War II when the will of the Emperor and the objectives of the Japanese empire were mandated for all of society to follow. To oppose the values and the good of the greater whole for personal expression would be at the cost of bringing shame to oneself, one's family, and the surrounding community, as well as to jeopardize social order and harmony.

Such is a brief historical context of shame in Japan. Accordingly, shame might be considered the most powerful force at work in Japanese society. Japanese society is that of a collective, and its cultural roots stretch deep into the Confucian value of harmonious order and ritual propriety, which serves the function of regulating and maintaining order throughout society (Richey, 2003). Confucius stated, "Direct the people with moral force and regulate them with ritual, and they will possess shame, and moreover, they will be righteous" (*Lunyu* 2.3). To be a member of society in Japan is to suppress personal expression, desires, aspirations, and beliefs for the greater purpose of maintaining order and stability in society. The Japanese proverb, "*deru kugi wa utareru*, [the nail that sticks up gets hammered down]," appropriately reflects these cultural mores and values. To make choices or to express oneself in a way that is contrary to social norms is to be met with resistance, at best, but more commonly with shame and hostile opposition. As such,

Japan is a country where nearly 127 million individuals seemingly live in unison to maintain the structure, rituals, and values of their collectivistic culture.

Shame and Mental Illness in Japan

A growing body of research has identified associations between mental health issues and shame. Depression, anxiety, suicidality, and maladjustment to trauma are common symptoms with relationships to shame (Paivio & Pascual-Leone, 2010; Rizvi, 2010). Connections between personality disorders and shame have also been identified (Schoenleber & Berenbaum, 2012). Specifically, the emotional regulation of shame has been implicated in as a significant factor in personality pathology. For example, affect dysregulation and instability is a defining feature of borderline personality disorder, and feelings of inferiority and fear of rejection underlies much of the dysfunction associated with avoidant personality disorder. Mechanisms for shame regulation utilized across personality disorders include prevention, escape, aggression, and self-directed harm and deprication.

With regard to the regulation of shame, individual differences in personality disorders share the common tendency to avoid and actively suppress the impact of shame, albeit with varying preferences and strategies (Paivio & Pascual-Leone, 2010). These preferences are expressed in an individual's proneness to anticipate or "forecast" shame, "experience shame across situations," and propensity to perceive shame as particularly painful and unbearable (p. 434).

Shame has been identified as the impetus for mental illness in Japan as well (Okano, 1994). Japanese psychiatrists have regarded shame to play a significant role in

the pathogenesis of depression, paranoia, dysmorphophobia, and, the "pathological shame reaction," social phobia (Uchinuma, 1983; in Okano, 1994, p. 325). Not surprisingly, avoidant personality is disorder is the most common Axis II disorder reported in Japan, "which may reflect genetic predisposition, environmental factors, a combination of both, or diagnostic favoritism" (Kondo, 1997; in Teo, 2009, p. 179).

Although substantial epidemiological data is lacking, many Japanese professionals allege a high prevalence of social phobia exists in Japan relative to Western countries (Okano, 1994). Moreover, it is believed that a significantly large "sub-clinical" population with social phobia is rife in Japanese society. For example, one report (Fukui, 1984; in Okano, 1994, p. 325), approximately 50% of Japanese university students were identified as exhibiting social phobia tendencies. Furthermore, a high prevalence of social phobia and social-phobia-like symptoms, as well as "hypersensitivity and pervasive hypochondriacal concerns," which has been labeled *"shinkeishitsu"* (Okano, 1994), have garnered the attention of mental health professionals since the 1930's (Maeda & Nathan, 1999).

A pioneer in research on the subject, Shomo Morita, postulated through his research on *shinkeishitsu* that certain individuals possessed a greater innate tendency towards being "overly sensitive, self- reflective, and notice even minimal changes in their mental and physical states" (Morita, 1960; in Okano, 1994, p. 326). According to Morita, the experience of shame is not pathological, but an experience shared by all human beings. However, he claims it is the failure to accept and manage these feelings that results in pathology. Additionally, Okano claims that the seemingly ubiquitous presence

of social phobia-like symptoms in Japan, in addition to an individual's innate predisposition to neurotic shame, can be attributed to and exaccerbated by the active promotion of a "sociophobic-like attitude, with humility and self-deprecating gestures in social relationships and with a resultant proliferation of shame-prone, avoidant, and sensitive demeanor similar to social phobia" (Okano, 1994, p. 328).

In Japan, therefore, shame is not simply a felt emotion, but a culturally prescribed emotion intended to influence behaviors that closely resemble social-phobic tendencies. Consequently, individuals who have a temperamental disposition towards excessive shame, as well as individuals who fail to navigate and manage the societal demands surrounding shame and conforming behavior, are particularly prone to develop clinical syndromes resembling social phobia, such as *taijin kyofusho* and *hikikoromoria*

Conclusions

Culture-bound Mental Disorders

Proceeding from the intersection between culture and mental health, culture-bound disorders compose a unique subset of psychiatric disorders (Marsella, 2000; Miranda & Fraser, 2002; Tseng, 2006). The manifestation of a culture-bound disorder is largely contingent on the interplay of numerous identifiable and unknown factors, including, but not limited to, cultural and religious values, societal norms, economic resources, education, political environment, endemic genetic predispositions, geography, demographics, and so forth. Inasmuch as the reference to a culture-bound disorder is largely based on a Western nosology of psychiatric illness, widely recognized culture-

bound disorders are typically found in non-Western countries and societies, such as societies in Africa and Southeast Asia (Marsella, 2000). Nevertheless, there may be good reason to consider that certain psychiatric disorders commonly seen in Western societies may in fact be culture-bound disorders unique to Western societies (e.g., eating disorders).

In Japan, two culture-bound disorders, *taijin kyofusho* and *hikikomori*, have garnered the attention of mental health professionals, sociologists, and anthropologists. While the recognition of *taijin kyofusho* as a mental disorder is nearing its centennial anniversary (Maeda & Nathan, 1999), *hikikomori* seems to be a relatively new mental disorder to have emerged in Japan in the last few decades (Teo & Gaw, 2010). Irrespective of the timeline of their origins, *taijin kyofusho* and *hikikomori* affect a substantial portion of the population. Although reliable epidemiological studies are scant, *taijin kyofusho* has reportedly accounted for up to 38% of clinical populations (Matsunaga et al., 2001; in Essau et al., 2012, p. 221); and approximately 2-4% of the general population has been affected by *hikikomori* (Teo & Gaw, 2010). As such, these two culture-bound disorders present as a noteworthy source for clinical attention and research.

Taijin Kyofusho

As previously defined, individuals with the diagnosis of *taijin kyofusho* experience a hypersensitivity to interpersonal relations and the excessive fear of being noticed by, embarrassing, and or offending others by their own eye contact, blushing, imagined ugliness, and or offensive body odors (Ono et al., 2001). Researchers have

delineated three basic subtypes of *taijin kyofusho*: the Morita type, offensive type, and avoidant type (Iwase et al., 2000).

Given that *taijin kyofusho* and social phobia share many traits and features, a great deal of research has been conducted to compare and contrast the two disorders (Matsunaga et al., 2001; Nakamura et al., 2002). The most significant distinction between the two disorders is manifested in the focus and direction of the fear. Where individuals with social phobia suffer from an excessive fear of embarrassing themselves, individuals with *taijin kyofusho* suffer from an excessive fear of embarrassing and offending others. This unique difference reflects the broader and deeply rooted culture of collectivism in Japan, where maintaining harmony and order throughout the larger group is emphasized and valued above individual preferences and comfort (Dinnel et al., 2002; Nakamura et al., 2002; Ono et al., 2001;).

Individual psychotherapy and pharmacotherapy are the two primary methods utilized for treating *taijin kyofusho*. In individual psychotherapy, an individual's cognitive distortions and oversensitive interpretations of physical sensations are targeted and changed to thoughts and interpretations that more closely align with reality (Maeda & Nathan, 1999). With pharmacotherapy, several studies have demonstrated the efficacy of SSRIs and SNRIs to be used as frontline treatment for *taijin kyofusho* (Kobayashi et al., 2003; Matsunaga et al., 2001; Nagata et al., 2006).

Hikikomori

Hikikomori is characterized by a unique miscellany of symptoms that include social withdrawal, self-confinement in one's home, lack of intimate relationships with

family members, and the absence of engagement in social activities, such as school or work (Hattori, 2006). Its recent pathogenesis has largely been attributed to a diminished sense of value in work among adolescents and young adults following the increased economic comfort experienced by many Japanese families after the 1970s (Teo, 2009), as well as the increased economic ability for middle class families to support a *hikikomori* in their home (Hattori, 2006; Kaneko, 2006). Because reliable estimates of the prevalence of *hikikomori* are scant, there is substantial variability in estimations, which range from 400,000 (Furlong, 2008) to 1,400,000 (Hattori, 2006). Consistent throughout the research, however, is that *hikikomori* is a mental disorder that primarily affects adolescent and young adult males from middle class families (Kaneko, 2006; Koyama et al., 2008; Teo & Gaw, 2010).

The widespread notion appraising *hikikomori* as a culture-bound disorder has a multi-faceted explanation. There is a general consensus among researchers that *hikikomori* possesses unique traits and features deserving of recognition as a culture-bound disorder (Teo & Gaw, 2010). However, estimates of its prevalence may be inflated. Because mental illness carries a heavy stigma within Japanese society, *hikikomori* may be a popular and less stigmatizing diagnostic alternative utilized by psychiatrists and physicians who are reticent to diagnose major psychopathology (Borovoy, 2008). *Hikikomori* may also be an uneducated and poorly differentiated label for a more proper diagnosis (Teo & Gaw, 2010). Therefore, further research is needed to clarify and establish more reliable methods of diagnosing *hikikomori*.

Individuals with *hikikomori* tend to have backgrounds of being victims of trauma and bullying, perpetrators of violence in their own family, and having overly permissive and doting mothers (Teo, 2009). Additionally, individuals with *hikikomori* appear to have difficulty navigating and accommodating societal expectations and pressures associated with social roles, productivity, and efficiency (Kaneko, 2006). As such, one theory on the pathogenesis of *hikikomori* sees disease labels, rigid social roles and hierarchies, and high pressure for efficient productivity as being major causal factors of *hikikomori* (Ogino, 2004). Another theory views the presence of a traumatic or insecure attachment with one's primary caregivers as an underlying cause of many cases of *hikikomori* (Hattori, 2006).

A review of the literature indicates that support groups resembling the clubhouse model of psychosocial rehabilitation is the most common method of treating *hikikomori* (Kaneko, 2006; Ogino, 2004). In these psychosocial rehabilitative day treatment programs, *hikikomori*ans are granted opportunities to learn the necessary social and psychological skills to re-integrate themselves back into school, work, and society. However, due to the absence of empirical data measuring the efficacy of this model, no definitive conclusions can be made about its efficacy in treating *hikikomori*. The lone empirical study on the treatment of *hikikomori* with individual psychotherapy (Hattori, 2006) identified unique trends among individuals with *hikikomori*. Of note was the high prevalence of cognitive schemas of distrust for human relationships, including their own parents; histories of emotional neglect and abuse by their primary caregivers; the lack of a secure attachment with their primary caregivers; and high levels of dissociative

symptoms. Additionally, participants in this study received individual psychotherapy to treat their *hikikomori*. The results reported "positive outcomes" from the psychotherapy treatment. Although this is the first known empirical study of the treatment of *hikikomori*, it is replete with unreliable and unquantifiable pre- and post-treatment measures, rendering the results nearly anecdotal in their utility.

Shame, Mental Illness, and Japanese Culture

Finally, this paper has discussed relationship between shame, mental illness, and Japanese culture. Shame is a self-conscious emotion (Rizvi, 2010) that can have a tremendous impact on an individual's relational and psychological adjustment (Tangney, 2000). Shame can be adaptive in its capacity to organize an individual to avoid exposing personal flaws and vulnerabilities to others' criticism or scrutiny (Paivio & Pascual-Leone, 2010). More typically, however, it is strongly characterized by and manifested through acutely painful, and often incapacitating, feelings of profound inadequacy and self-loathing (Creighton, 1990).

In its relation to culture, shame has often been ascribed to the fabric of Eastern or Asian cultures, wherein the external sanction of shame serves to regulate an individual's behavior in the context of the greater collective (Creighton, 1990). In contrast, guilt has been attributed as the more dominant motivation within Western cultures, as it relies on internal sanctions of control. Another persepective, however, suggests that guilt is learned through external punishment and is an external motivator of control, whereas shame is internalized and motivates an individual from within.

Insulated geographically by water, the ethnically and culturally homogenous island nation of Japan has possessed fertile ground for the maturation of a profoundly rich culture. By consequence, with historical roots firmly embedded in the Confucian philosophy and value of harmonious order and ritual propriety, the foundation for maintaining social order, shame is nearly inextricable from Japanese society (Richey, 2003). Japanese, compared to Westerners, therefore, possess a heightened degree of sensitivity to the experience of shame and scrutiny of others (Lebra, 1983) and actively defend against exposure to scrutiny and shame through the inhibition of *honne*, the private self's thoughts, feelings, and opinions (Mazur et al., 1980, as cited in Lebra, 1983). Concurrently, in social contexts where exposure is unavoidable, such as school or work, a Japanese strives to display a flawless and respectable *tatemae*, public persona.

The body of research linking shame and mental illness indicates an individual's predisposition or hypersensitivity to the experience of shame, as well as maladaptive means of coping with and regulating shame, can lead to the development of myriad of psychological problems and disorders (Rizvi, 2010; Paivio & Pascual-Leone, 2010; Schoenleber & Berenbaum, 2012). In Japan, psychologists have implicated shame in many of the prevalent psychological disorders affecting the population (Okano, 1994). Specifically, social phobia and social phobia-like symptoms have been identified as one of the most common psychological disorders afflicting Japanese.

Given this context, *taijin kyofusho* and *hikikomori* may be broadly characterized as culture-bound mental disorders of dysregulated shame. Specifically, *taijin kyofusho* may be conceived as mental disorder distinguished by a pathological hypersensitivity to

shame, or a "phobia of being ashamed" (Nakamura et al., 2002, p. 595). One of the essential features of *taijin kyofusho* is a hypersensitivity to the perception and scrutiny of others, which in turn elicits a neurotic, and in more severe cases, delusional paranoia about one's appearance or body odors. Consequently, the pathology of shame in *taijin kyofusho* seems to be two-fold. First, there exists an intense fear of bringing shame upon oneself by causing others to become uncomfortable, embarrassed, or offended on account of manifesting an offensive or embarrassing appearance or body odor. Secondly, there is the concurrent experience of feeling ashamed and the experiencing a sense of self as shameful for being offensive or manifesting offensive stimuli.

Hikikomori may in a similar fashion be conceived as a mental disorder involving a pathological self-schema of shame. The self-schema of shame is first initiated in early childhood and subsequent years through painful, traumatic, and disempowering experiences that create and reinforce a self-schema of shame. Most individuals with *hikikomori* have a history of verbal and emotional abuse and neglect from their primary caregivers (Hattori, 2006), bullying and abuse from peers in school, and being raised by overly permissive and doting mothers (Teo, 2009).

With respect to abuse and neglect from primary caregivers, many individuals with *hikikomori* experience deep feelings shame early in life as a result of incurring repeated verbal and emotional abuse in the form of personal revilement and or emotional neglect. Therefore, early in life, many individuals with *hikikomori* internalize into their sense of self the explicit and or implicit message that they are a shameful person.

Compounded upon negative experiences at home, many individuals with *hikikomori* fall victim to *ijime*, abusive bullying, throughout their time in school. Not only does *ijime* instill or reinforce the belief that one is loathsome and shameful, but the individual's educational track can become significantly disrupted, leading to academic struggles, delayed or failed progression in educational achievement, and truancy. For such individuals, these disruptions can become severe handicaps in a Japanese educational system where the degree of one's academic success and proficiency essentially determines the quality of high school, college, or career track one may enter. The self-schema of shame is further reinforced in this context as academic struggles and failings lead to an internalization of the self as incompetent, which is then further reinforced by their diminished proficiency and competence compared to their peers, resulting in a vicious cycle. In addition to the academic struggles and deficits they might develop in school, many individuals with *hikikomori* are "cut off at the knees" at home by overly permissive and doting parents, particularly mothers, which impedes the healthy development of confidence, self-initiative and competence.

Experiences from early development, which include delayed or impaired academic, vocational, and social skills, as well as deeply rooted self-schema of shame, culminate in adolescence and early adulthood where individuals with *hikikomori* lack the personality structure, psychological resources, and social skills to navigate the demands of living in Japanese society. As the social, academic, or occupational demands become too much to bear, or as their self-schema of shame is perpetually reinforced by struggles

or failures in these domains, these individuals defend against the overwhelming and painful shame by pulling away and confining themselves in their home.

Limitations and Future Research

A synthesis of the theory and research supports a compelling picture of the inextricable and underlying role shame plays in the two culture-bound disorders of Japan, *taijin kyofusho* and *hikikomori*. However, this picture is not without its problems, gaps, and blemishes. The present body of research on *taijin kyofusho* and *hikikomori* is either scarce or replete with limitations.

With *taijin kyofusho*, there is a very limited quantity of empirical studies on the pathogenesis and prevalence of *taijin kyofusho*, as well as its comorbidity with other mental disorders, leaving conclusions somewhat speculative at times given the lack of reliable data. Likewise, there is a paltry sum of research on effective means of treating this disorder. Pharmacotherapy for *taijin kyofusho* has been most extensively researched and lends some credible empirical data on effective means of treating *taijin kyofusho* with medication. However, there is no known emprical research on psychotherapy for *taijin kyofusho*. In as much as *taijin kyofusho* is a disorder characterized by the fear of interpersonal relations, the utility of identifying and developing empirically supported treatments for *taijin kyofusho* cannot be overstated.

Similarly, the present body of research on *hikikomori* is profoundly lacking. The majority of articles on *hikikomori* are theoretical in nature, while the small body of empirical research is limited by small convenience samples, unreliable methodology, or evidence drawn from isolated case studies. Further research is needed to determine more

reliable estimates of the prevalence of *hikikomori*, as well as differentiating *hikikomori* from other mental disorders. Psychosocial rehabilitation models of treatment (Kaneko, 2006; Ogino, 2004) and individual therapy (Hattori, 2006) were presented as viable means of treating *hikikomori*. However, reliable empirical research with pre-treatment and post-treatment outcome measures need to be conducted to substantiate its efficacy.

Future research on *taijin kyofusho* and *hikikomori* should focus on several factors. First, it should compare, contrast, and differentiate these diagnoses from other psychiatric disorders in order to clarify the specific nature of the diagnosis. Second, once a proper differential diagnosis has been conducted and clearly defined symptoms and characteristics of each disorder are defined, research identifying the lifetime prevalence of the disorders, as well as its comorbidity with other disorders should be conducted. Third, with the rise of globalization and the boundaries delineating societies becoming more diffuse, it is likely that mental health professionals may encounter culture-bound disorders from other countries or cultures. Conversely, globalization may have the *opposite* effect, whereby the prevalence of culture-bound disorders are reduced as cultures themselves become amalgamated with others. As such, further research is necessary to properly differentiate *taijin kyofusho* and *hikikomori* from other psychiatric disorders they closely resemble, as well as the prevalence of these disorders in other countries. Additionally, the body of research on Japanese culture-bound disorders would benefit from future research investigating the prevalence of culture-bound disorders among Japanese immigrants.

Finally, with *taijin kyofusho* and *hikikomori* affecting such a substantial portion of the population in Japan, perhaps the most compelling need for future research is in identifying effective methods of treatment. Specifically, research focusing on the efficacy of cognitive-behavioral or exposure therapies in treating *taijin kyofusho* would be beneficial, given how *taijin kyofusho*'s symptomatology is primarily elicited in social and interpersonal contexts. With *hikikomori*, research on the effectiveness of social skills training, psychosocial rehabilitation, and individual cognitive-behavioral, psychodynamic, or emotion-focused therapies would of particular importance. Also, it would be expedient to research the efficacy of group psychotherapy in treating both disorders.

Notwithstanding the limitations in research, *taijin kyofusho* and *hikikomori* are a unique manifestation of culturally laden psychopathology deserving of greater attention as culture-bound mental disorders. Moreover, given the significant role shame plays in the presentation and mechanics of the disorders, many more questions can be asked about the relationship between Japanese culture and the psychopathology of *taijin kyofusho* and *hikikomori*. In particular, while individual cases can be treated as they emerge, if the source of the psychopathology is generated by certain factors embedded within a culture, such as shame in Japan, how does one begin to extricate and address aspects of a culture that are potentially maladaptive or pathological? Furthermore, if such problems are so widespread within its society, how must the Japanese government and mental health professionals mobilize in such a way to effectively address this widespread problem? With epidemic levels of mental health problems, particularly *hikikomori*, a struggling

economy, and widespread disillusionment and lack of volition among adolescents and young adults, Japan is facing a crisis of health and vibrancy. A greater understanding of *taijin kyofusho* and *hikikomori*, as well as the underlying role of shame, is not simply relevant for its benefit to the mental health field, but relevant because of its deeper significance and reflection of a nation in distress. The nation of Japan is desperately longing to reclaim its future, a future that is sadly hidden away with so many of its youth in the confines of their homes and who are in dire need of help to step back into light of the land of the rising sun.

REFERENCES

Allender, D. B. (1995). *The wounded heart.* Colorado Springs, CO: Navpress.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision). Washington, DC: Author.

Borovoy, A. (2008). Japan's hidden youths: mainstreaming the emotionally distressed in Japan. *Culture, Medicine & Psychiatry, 32*, 552-576.

Chang, D. F., Myers, H. F., Yeung, A., Zhang, Y., Zhao, J., & Yu, S. (2005). Shenjing shuairuo and the DSM-IV: Diagnosis, distress, and disability in a Chinese primary care setting. *Transcultural Psychiatry , 42*(2), 204-218.

Choi, M., & Yeom, H.-A. (2011). Identifying and treating the culture-bound syndrome of Hwa-Byung among older Korean immigrant women: Recommendations for practitioners . *Journal of the American Academy of Nurse Practitioners , 23*, 226-232.

Confucius. (500 BC). *The internet classics archive*. Retrieved from The Internet Classics Archive: http://classics.mit.edu/Confucius/analects.html

Creighton, M. R. (1990). Revisiting shame and guilt cultures: A forty-year pilgrimage. *Ethos , 18*(3), 279-307.

Crystal, D. S., Kakinuma, M., DeBell, M., Azuma, H., & Miyashita, T. (2008). Who helps you? Self and other sources of support among youth in Japan and the USA. *International Journal of Behavioral Development , 32*(6), 498.

Daimyo. (2010). In *Encyclopædia Britannica*. Retrieved from Encyclopædia Britannica Online: http://www.britannica.com/EBchecked/topic/ 149919/daimyo

Davidson, J. (2003). Pharmacotherapy of social phobia. *Acta Psychiatrica Scandinavica , 108*, 65-71.

Dinnel, D. L., Kleinknecht, R. A., & Tanaka-Matsumi, J. (2002). A cross-cultural comparison of social phobia symptoms. *Journal of Psychopathology and Behavioral Assessment , 24*(2), 75-84.

Essau, C. A., Sasagawa, S., Chen, J., & Sakano, Y. (2012). Taijin kyofusho and social phobia symptoms in young adults in England and in Japan. *Journal of Cross-Cultural Psychology, 43*(2), 219-232.

Fukui, Y. (1984). *Manazashi no sinrigaku [Psychology of gaze]*. Tokyo, Japan: Sogensha.

Furlong, A. (2008). The Japanese hikikomori phenomenon: Acute social withdrawal among young people. *The Sociological Review , 56*(2), 309-325.

Gonin-gumi**.** (2010). In *Encyclopædia Britannica*. Retrieved from Encyclopædia Britannica Online: http://www.britannica.com/EBchecked/topic/ 238500/gonin-gumi

Guarnaccia, P., & Pincay, I. M. (2008). Culture-Specific diagnoses and their relationship to mood disorders. In S. Loue, & M. Sejatovic (Eds.), *Diversity issues in the diagnosis, treatment and research of mood disorders* (pp. 32-53). New York, NY: Oxford University Press.

Hattori, Y. (2006). Social withdrawal in Japanese youth: A case study of thirty-five hikikomori clients. *Journal of Trauma Practice , 4*(3/4), 181-201.

History of Japan. (2010). *Encyclopædia Britannica*. Retrieved from Encyclopædia Britannica Online: http://www.britannica.com/EBchecked/topic /300531/Japan

Honjo, S., Kasahara, Y. & Ohtaka, K. (1992) School refusal in Japan, *Acta Paedopsychiatrica: International Journal of Child & Adolescent Psychiatry, 55*(1), 29-32.

Iwase, M., Nakao, K., Takaishi, J., Yorifuji, K., Ikezawa, K., & Takeda, M. (2000). An empirical classification of social anxiety: performance, interpersonal and offensive. *Psychiatry and Clinical Neurosciences, 54*, 67-75.

Japanese Philosophy. (2010). In *Encyclopædia Britannica*. Retrieved, from Encyclopædia Britannica Online: http://www.britannica.com/EBchecked/topic/301242/Japanese-philosophy

Juntunen, A. (2005). Baridi: A culture-bound syndrome among the Bena peoples in Tanzania . *Journal of Transcultural Nursing , 16*(1), 15-22.

Ka, Y. (2010). Jeong-han as a Korean culture-bound narcissism: Dealing with Jeong-han through Jeong-Dynamics . *Journal of Pastoral Psychology , 59*, 221-231.

Kanayama, G., & Pope Jr., H. G. (2011). Gods, men, and muscle dysmorphia. *Harvard Review of Psychiatry , 19*, 95-98.

Kaneko, S. (2006). Japan's "socially withdrawn youths" and time constraints in Japanese society. *Time & Society , 15*(2/3), 233-249.

Kasahara Y (1978) Taikyaku shinkeishou withdrawal neurosis to iu shinkategorii no teishou (Proposal for a new category of withdrawal neurosis). In H Nakai, Y Yamanaka (Eds.), *Shishunki no Seishinbyouri to Chiryou (Psychopathology and Treatment in the Adolescent*) (pp 287–319). Tokyo (Japan): Iwasaki Gakujutsu Shuppan.

Kato, T., Shinfuku, N., Sartorius, N., & Kanba, S. (2011). Are Japan's hikikomori and depression in young people spreading abroad? *Perspectives , 378*, 1070.

Keel, P. K., & Klump, K. L. (2003). Are eating disorders culture-bound syndromes? Implications for conceptualizing their etiology . *Psychology Bulletin , 129*(5), 747-769.

Kim, J., Rapee, R. M., & Gaston, J. E. (2008). Symptoms of offensive type Taijin-Kyofusho among Australian social phobics. *Depression and Anxiety , 25*, 601–608.

Kinugasa, T., 1998. Young adults and withdrawing. *Rinsho Seishin Igaku*, 147-152.

Kobayashi, S., Yoshida, K., Noguchi, H., Tuchiya, T., & Ito, J., 2003. Research for parents of children with “social withdrawal”. *Seishin Igaku, 45,* 749–756.

Kondo, N. (1997) Hiseishinbyousei hikikomori no genzai (The present conditions of non-psychotic pyscho-social withdrawal cases). *Rinshou Seishin Igaku (Japanese Journal of Clinical Psychiatry), 26*(9), 1159–1167.

Koyama, A., Miyake, Y., Kawakami, N., Tsuchiya, M., Tachimori, H., & Takeshima, T. (2010). Lifetime prevalence, psychiatric comorbidity and demographic correlates of “hikikomori” in a community population in Japan. *Psychiatry Research*, *176*, 69-74.

Lebra, T. S. (1983). Shame and guilt: A psychocultural view of the Japanese self. *Ethos , 11*(3), 192-209.

Liebowitz, M. R., Mangano, R. M., Bradwejn, J., & Asnis, G. (2005). A randomized control trial of venlafaxine extended release in generalized social anxiety disorder. *66*(2), 238-247.

Lochner, S. (2003). Olfactory reference syndrome: diagnostic criteria and differential diagnosis. *Journal of Postgraduate Medicine , 49*, 328-331.

Lock M (1986) Plea for acceptance: School refusal syndrome in Japan. *Soc Sci Med*. 23:99-112.

Maeda, F., & Nathan, J. H. (1999). Understanding taijin kyofusho though its treatment, Morita Therapy. *Journal of Psychosomatic Research , 46*(6), 525-530.

Marsella, A. J. (2000). Culture-bound disorders. In A. E. Kazdin (Ed.), *Encyclopedia of psychology, Vol. 2* (pp. 407-410). Washington, DC: American Psychological Association.

Matsunaga, H., Kiriike, N., Matsui, T., Iwasaki, Y., & Stein, D. J. (2001). Taijin kyofusho: A form of social anxiety disorder that responds to serotonin reuptake inhibitors? *The International Journal of Neuropsychopharmacology, 4,* 231-237.

Ministry of Health, Labour and Welfare (2003) *10-dai, 20-dai wo chuushin to shita 'Hikikomori' wo meguru chiiki seishin hoken katsudou no gaidorain* (Community mental health intervention guidelines aimed at socially withdrawn teenagers and young adults). Chiyoda-ku (Tokyo): Author.

Miranda, A. O., & Fraser, L. D. (2002). Culture-bound syndromes: initial perspectives from individual psychology. *The Journal of Individual Psychology , 58*(4), 422-433.

Morita, S. (1960). *Shinkeisho no hontai to ryoho [The pathology and treatment of neurosis]* . Tokyo, Japan: Hakuyo-sha.

Nagata, T., Oshima, J., Wada, A., Yamada, H., Iketani, T., & Kiriike, N. (2003). Open trial of milnacipran for taijin-kyofusho in Japanese patients with social anxiety disorder . *International Journal of Psychiatry in Clinical Practice , 7*, 107-112.

Nagata, T., van Vliet, I., Yamada, H., Kataoka, K., Iketani, T., & Kiriike, N. (2006). An open trial of paroxetine for the "offensive subtype" of *taijin kyofusho* and social anxiety disorder. *Depression and Anxiety , 23*, 168-174.

Nagata, T., Wada, A., Yamada, H., Iketani, T., & Kiriike, O. (2005). Effect of milnacipran on insight and stress coping strategy in patients with Taijin Kyofusho . *International Journal of Psychiatry in Clinical Practice , 9* (3), 193-198.

Nakamura, K., Kitanishi, K., Miyake, Y., Hashimoto, K., & Kubota, M. (2002). The neurotic versus delusional subtype of Taijin-Kyofu-sho: Their DSM diagnoses. *Psychiatry and Clinical Neurosciences , 56*, 595-601.

Neo-Confucianism. (2010). In *Encyclopædia Britannica*. Retrieved, from Encyclopædia Britannica Online: http://www.britannica.com/EBchecked/topic/408627/Neo-Confucianism

Ogino, T. (2004). Managing Categorization and Social Withdrawal in Japan: Rehabilitation Process in a Private Support Group for Hikikomorians. *International Journal of Japanese Sociology , 13*(1), 120-133.

Okano, K. (1994). Shame and social phobia: A transcultural viewpoint. *Bulletin of the Menninger Clinic , 58*(3), 323-338.

Ono, Y., Yoshimura, K., Yamauichi, K., Asai, M., Young, J., Fujuhara, S., & Kitamura, T. (2001). *Taijin kyofusho* in a Japanese community population. *Transcultural Psychiatry , 38*(4), 506-514.

Paivio, S. C., & Pascual-Leone, A. (2010). *Emotion-focused therapy for complex trauma.* Washington, DC: American Psychological Association.

Parker, S., & Thomas, R. (2009). Psychological differences in shame vs. guilt: Implications for mental health counselors. *Journal of Mental Health Counseling , 31*(3), 213-224.

Perugi, G., Frare, F., & Toni, C. (2007). Diagnosis and treatment of agoraphobia with panic disorder. *CNS Drugs , 21*(9), 741-764.

Pope Jr., H. G., Poliakoff, M. B., Parker, M. P., Boynes, M., & Hudson, J. I. (2007). Is dissociative amnesia a culture-bound syndrome? Findings from a survey of historical literature . *Psychological Medicine , 37*, 225-233.

Richey, J. (2003, November 12). *Confucius*. Retrieved from Internet Encyclopedia of Philosophy: http://www.iep.utm.edu/confuciu/

Riegel, J. (2006, September 05). *Confucius*. Retrieved from Stanford Encyclopedia of Philosophy: http://plato.stanford.edu/entries/confucius/

Rizvi, S. L. (2010). Development and preliminary validation of a new measure to assess shame: The shame inventory. *Journal of Psychopathology & Behavioral Assessment, 32*, 438–447.

Saito T (1998) *Shakaiteki Hikikomori: Owaranai Shishunki (Social Withdrawal: A never ending adolescence)*. Tokyo, Japan: PHP Kenkyujo.

Sakamoto, N., Rodger, M. G., Kumano, H., Kuboki, T., & Al-Adawai, S. (2005). Hikikomori, is it a culture-reactive or culture-bound syndrome? Nidotherapy and a clinical vignette from Oman. *International Journal of Psychiatry in Medicine , 35*(2), 191-198.

Schoenleber, M., & Berenbaum, H. (2012). Shame regulation in personality pathology. *Journal of Abnormal Psychology , 121*, 433-446.

Stein, M. B., Pollack, M. H., Bystritsky, A., Kelsey, J. E., & Mangano, R. M. (2005). Efficacy of low and higher dose extended-release venlafaxine in generalized social anxiety disorder: A 6-month randomized controlled trial. *Psychopharmacology , 177*(3), 280-288.

Sumathipala, A., Siribaddana, S. H., & Bhugra, D. (2004). Culture-bound syndromes: the story of dhat syndrome. *British Journal of Psychiatry , 184*, 200-209.

Suwa, M., & Hara, K. (2007). Hikikomori among young adults in Japan: The importance of differential diagnosis between primary hikikomori and hikikomori with high-functioning pervasive developmental disorder. *医療福祉研究 , 3*, 94-101.

Suzuki, K., Takei, N., Kawai, M., Minabe, Y., & Mori, N. (2003). Is Taijin-Kyofusho a culture-bound syndrome? *American Journal of Psychiatry, 160*(7), 1358.

Takahata, T., 2003. A survey of withdrawal syndrome in Saitama prefecture. Seishin Igaku 45, 299-310 (in Japanese).

Tangney, J. (2000). Shame. In A. E. Kazdin (Ed.), *Encyclopedia of Psychology* (Vol. 7, pp. 266-269). Washington, DC, New York, NY: American Psychological Association.

Tarumi, S., Ichimiya, A., Yamada, S., Umesue, M., & Kuroki, T. (2004). *Taijin kyofusho* in university students: patterns of fear and predispositions to the offensive variant. *Transcultural Psychiatry, 41*(4), 533-546.

Teo, A. R. (2009). A new form of social withdrawal in Japan: A review of hikikomori. *International Journal of Social Psychiatry, 56*(2), 178–185.

Teo, A. R., & Gaw, A. C. (2010). Hikikomori, a Japanese culture-bound syndrome of social withdrawal? A proposal for DSM-5. *The Journal of Nervous and Mental Disease , 198*(6), 444-449.

Tokugawa period**. (**2010). In *Encyclopædia Britannica*. Retrieved from Encyclopædia Britannica Online: http://www.britannica.com/EBchecked/topic/598326/Tokugawa-period

Tseng, W.-S. (2006). From peculiar psychiatric disorders through culture-bound syndromes to culture-related specific syndromes . *Transcultural Psychiatry , 43*(4), 554-576.

Tsuchiya, M., Kawakami, N., Ono, Y., Nakane, Y., Nakamura, Y., Tachimori, H., ... Kessler, R. C. (2009). Lifetime comorbidities between phobic disorders and major depression in Japan: Results from the World Mental Health Japan 2002-2004 Survey. *Depression and Anxiety, 26*, 949-955.Uchinuma, Y. (1983). *Shuchi no kozo [Structure of shyness]*. Tokyo, Japan: Kinokuniya Shoten.

Veale, D. (2003). Treatment of social phobia. *Advances in Psychiatric Treatment , 9*, 258-264.

Watabe K., Saito K., Kodaira M., Usami M., Taira R., Suzuki Y., … Nakasato Y. (2008) Jidouki zenshishunki no Hikikomori ni taisuru seishin igakuteki chiryou enjo ni kansuru kenkyuu (1) (Research on the psychiatric treatment and support for social withdrawal in childhood and pre-adolescence part one). *Kokoro no Kenkou Kagaku Kenkyuu Jigyou*. 103-109.

Yap, P. M. (1966). The culture-bound reactive syndromes. *Conference on Mental Health in Asia and the Pacific* (pp. 101-103). Honolulu, HI: Transcultural Psychiatry.

Yap, P. M. (1969). The culture-bound reactive syndromes. In W. A. Caudill, T.-Y. Lin, W. A. Caudill, & T.-Y. Lin (Eds.), *Mental Health Research in Asia and the Pacific* (pp. 33-53). Honolulu, HI: East-West Center Press.

VITA

NAME:

Levi Edward Cole

EDUCATION:

Rosemead School of Psychology Clinical Psychology	PsyD		(Cand.)
Rosemead School of Psychology Clinical Psychology	MA		2010
Biola University Psychology	BA		2004

INTERNSHIP:

Wright-Patterson Medical Center Wright-Patterson AFB, OH	2012	–	2013

PRACTICA:

Forensic Assessment Clerkship Tustin, CA	2011	–	2012
Intercommunity Counseling Center Whittier, CA	2010	–	2011
Biola Counseling Center La Mirada, CA	2009	–	2010
Pioneer High School Whittier, CA	2009	–	2010

EMPLOYMENT:

Harrisonburg-Rockingham Community Services Board Mental Health Case Manager	2007	–	2008
Rockingham Memorial Hospital Mental Health Counselor	2005	–	2007