Brief Morita Therapy for Social Anxiety:
A Single-Case Study of Therapeutic Changes

F. Ishu Ishiyama

University of Victoria

Abstract

Morita therapy is a Japanese therapy for anxiety-related problems developed by Shoma
Morita (1874-1938) in the 1910's. Through didactic discussion and confrontation, it modifies
anxious clients' self-critical thinking and unproductive self-preoccupation. Clients in Morita
therapy are encouraged to appreciate the existential and self-actualizing meaning of anxiety
and to translate it into constructive action instead of resisting and becoming preoccupied with
anxiety symptoms in a self-defeating manner.

Using a multiple baseline design across two target problems (fear of speaking in groups and
fear of approaching strangers), the present study examined therapeutic changes associated
with brief (3-session) Morita intervention in a socially anxious client. Notable changes
regarding both problems were observed immediately after intervention and in the follow-up
phase in the client's ratings on (1) acceptance of anxiety, (2) problem severity, and (3)
effectiveness in coping with anxiety problems. Qualitative information provided by the client
suggested the lasting therapeutic impact of Morita-based interpretation of anxiety and
confrontation. Suggestions are given for future single-case experimental research on Morita
therapy.

Résumé

La thérapie Morita est une thérapie japonaise traitant les problèmes reliés à l'anxiété. Cette
thérapie fut développée par Shoma Morita (1874-1938) en 1910. A travers des confrontations
et des discussions didactiques, cette forme de thérapie vise à modifier le raisonnement auto-
critique et les préoccupations morbides des clients. Pendant la période de thérapie les clients
sont encouragés à apprécier la signification existentielle de leur anxiété et à essayer de
transformer cette anxiété en actions constructives au lieu de résister et devenir préoccupés
d'une manière auto-déceptive par les symptômes de leur anxiété.

Utilisant un modèle à base multiple avec 2 problèmes cibles (peur de s'exprimer en groupe
et peur d'entrer en contact avec des personnes inconnues), cette étude examine les changements
d'ordre thérapeutiques chez un client souffrant d'anxiété sociale. Immédiatement après
l'intervention ainsi que pendant la période suivante des changements notoires furent observés
au niveau de l'acceptation de l'anxiété, de la perception par le client de la sévérité de son
problème et aussi au niveau de l'efficacité à affronter ses problèmes d'anxiété. Des informa-
tions d'ordre qualitatives fournies par le client suggèrent un impact à long terme au niveau de
l'interprètation de l'anxiété et de la confrontation. Des suggestions sont données pour des
futures études expérimentales de la thérapie Morita.

INTRODUCTION

Morita therapy, developed by Shoma Morita (1874-1938), is a Japanese
cognitive behavioural therapy with a unique philosophical orientation
for anxiety-related problems (Kawai & Kondo, 1960; Morita, 1960;
Miura & Usa, 1970; Reynolds, 1976; Suzuki & Suzuki, 1977). It is
currently practised in a variety of modalities including residential, out-

patient, group, and correspondence approaches in Japan. In contrast to wide recognition and popular practice of the therapy in Japan, Morita therapy is still new to westerners and only a small number of case studies of western clients have been published (Ishiyama, 1983; Reynolds, 1981).

Morita therapy aims at changing dysfunctional cognitive and behavioural patterns by providing clients with a seemingly paradoxical instruction of accepting and not fighting anxiety symptoms. Clients are encouraged to accept their anxious and sensitive nature and to use it for constructive purposes. Using the positive reinterpretation technique (Ishiyama, 1985; in press), the Morita therapist helps clients appreciate the existential and self-actualizing meaning of anxiety and redirect their energy from excessive self-preoccupation toward practical goal-directed behaviours. The primary aim of therapeutic intervention is to mobilize clients' self-actualizing desire and facilitate self-acceptance and increased productivity and constructiveness in living.

Japanese Morita therapy researchers have reported in their long-term follow-up studies high improvement rates of 80-90% using a simple 4-point rating scale (e.g., Suzuki, Kataoka, & Karasawa, 1982; Suzuki & Suzuki, 1981). Positive changes in clients' attitudes toward anxiety and the self have been documented using qualitative data such as clients' diaries and retrospective comments, and therapists' observations (Ohara & Aizawa, 1970: Morita, 1960; Uchimura, 1970).

Efficacy research on Morita therapy is somewhat limited to primarily qualitative documentation of therapeutic improvements without systematic experimental investigation. Measurement of therapeutic changes has been based on a crude 4-point self-rating scale completed often at a long-term follow-up stage. Lack of more specific diagnostic criteria has been pointed out by Ohara, Maruyama, and Sugita (1973). Thus, there is much need for increased diversity and specificity in assessment criteria, increased immediacy and continuity in measurement, and additional quantitative data in efficacy assessment in Morita therapy research.

The present case study is a first attempt to consider these methodological points in examining cognitive changes using repeated measurements on two target problems. The case study followed the format of a multiple baseline design of single-case research (Hayes, 1981; Hersen & Barlow, 1976; McCullough, 1984a, 1984b).

METHODOLOGY

1. Client

The client, Mary (pseudonym), was a 42-year-old unmarried female who had suffered from social anxiety for over 30 years. She grew up in a punitive and inhibitive family where she was often criticized, ridiculed, and scapegoated. Her intellectual and emotional self-expression often

met the parents' disapproval, criticism, and physical abuse. Mary had had difficulties in dealing with men and people in authority throughout her life. In addition, Mary had been suffering from learning disabilities including difficulties in retaining short-term memory.

The client visited the author as therapist with a complaint about her fear of speaking up in groups (Problem #1) when she started auditing his undergraduate counselling course one summer. She was concurrently enrolled in another course for credit where she had to interact with others in a group on a daily basis. Mary's fear of speaking up in groups was posing a major threat to her academic and occupational aspiration. After Session 1, she presented another life-long fear of approaching strangers (Problem #2).

2. Design and Measurement

(1) Design

The present study followed the format of a multiple-baseline design of single-case experimental inquiry (Hayes, 1981; Hersen & Barlow, 1976) to observe changes in the client's problem-related ratings before and after implementation of an intervention. A causal inference can be made by comparing the repeatedly measured ratings before and after each intervention. Provided that the client's problem-related ratings show relative stability and little sign of voluntary improvement during the baseline phase, the cause of improvements observed whenever an inter-vention is made can be attributed to the intervention itself. If this phenomenon is repeatedly observed across different problems (as in this case study) or across different clients, the validity of the causal inference can be increased (Campbell & Stanley, 1963; Hersen & Barlow, 1976; Kazdin, 1981). Furthermore, measures taken immediately before and immediately after the target-specific intervention can provide additional information on immediate changes associated with the intervention.

(2) Measurement

Repeated measurements were taken on the two target problems (Prob-lems #1 & #2). The client filled out the measures once or twice a week for seven weeks as well as immediately before and after each counselling session. Since Problem #2 was presented after the first session, its base-line period started in the second week. Follow-up measures were taken during the 18th and 28th weeks from the beginning of the baseline period.

Due to the client's urgent request for treatment, the first treatment session was given after two baseline measures for Problem #1. Although three or more baseline data are desirable in clinical single-case research, two are logically acceptable according to Hayes (1981) provided that

the client has a known history of problem persistence and that baseline data show high stability. The present case met both provisions.

The following three scales were comprised of pairs of bipolar adjectives or adjective phrases. They were presented in the following order with seven empty spaces in-between in the manner of semantic differential (Osgood, Suci, & Tannenbaum, 1957) accompanied by a sentence stem for each scale:

(1) Anxiety Acceptance Scale ("My anxious nature is..."): acceptable—unacceptable, useless—useful, desirable—undesirable.

(2) Problem Severity Scale ("My anxiety problem is..."): unmanageable—manageable, easy to solve—hard to solve, unbearable—bearable.

(3) Coping Effectiveness Scale ("I feel... in dealing with the problem"): competent—incompetent, hopeless—hopeful, patient—impatient, self-critical—self-accepting, emotional—objective, confused—relaxed, self-confident—unsure, tense—relaxed.

Each adjective pair was scored from one to seven in the appropriate direction and the total score was used for each scale. Individual scores on the adjective pairs corresponded very closely to the total score for each scale showing similar patterns of change. The possible highest scores are 21 for Anxiety Acceptance, 21 for Problem Severity, and 56 for Coping Effectiveness.

Treatment

The client received three sessions (50 min. each). Sessions 1 and 2 focused exclusively on Target Problem #1 and Session 3 on Target Problem #2. Each session characteristically started with the therapist's empathic reflections and probing for clarification of patterns of anxiety reactions. The positive reinterpretation technique (Ishiyama, in press; 1985) was used with a focus on the following points:

(1) Anxiety is not an abnormal experience or trait. It is a common and normal human experience in certain threatening social situations. Underneath social anxiety, people desire to be socially acceptable, effective, and constructive. Denial of social anxiety in this sense means denial of one's desire to live constructively.

(2) Anxiety can be accepted as it is and one can still make constructive choice of action. The difference between socially effective and ineffective persons is not whether one feels anxious or not but rather whether one takes actions or not in spite of anxious feelings.

(3) The more one tries to fight or manipulate anxiety symptoms, the more self-preoccupied one gets while neglecting what needs to be done in the given social context.

(4) Anxiety does not have to be a personal weakness. Social anxiety is a reflection of one's social sensitivity. One gets anxious at the thought of not presenting oneself appropriately or relating to others effectively. This is normal. Instead of getting preoccupied with anxiety symptoms and running away from action, what needs to be done is to take advantage of one's sensitivity and redirect it to what is happening and what needs to be done in the given social environment.

The objectives that the therapist set for helping the client during the three sessions were: (1) to recognize the universality of existential concerns such as fear of death and social failure and develop empathy for others suffering from such concerns, (2) to accept and act on the underlying desire to be constructive and productive in life, (3) to come to recognize discrepancies between idealistic or dogmatic self-expectations and genuine experience of the self and to develop more realistic and adaptive expectations, (4) to let anxiety take its own course of rise and fall without avoiding or fleeing from anxiety-provoking social situations, and (5) to change a mood-governed unproductive lifestyle into an action-based purpose-oriented lifestyle without negating or resisting human emotionality.

In each target-specific intervention, the client received the following instructions worded to fit to each target problem: (1) Do not resist anxiety. (2) Consider the intensity of anxiety as a reflection of how important the task is. (3) Persevere through anxious moments, and do not lose sight of the task at hand. (4) Make choice of action and not emotion.

Results

(1) Quantitative Changes

The quantitative results based on the three scales on anxiety acceptance, problem severity, and coping effectiveness are presented in Fig. 1. Baselines showed relatively high stability for both target problems with greatest variability shown for anxiety acceptance of Problem #2. The baseline level of problem severity for Problem #1 showed a worsening trend.

The immediate change after introduction of each intervention is shown in a sudden increase in anxiety acceptance, a drop in problem severity, and a notable increase in coping effectiveness. All these positive changes took place in concert subsequent to each target-specific intervention. These changes, especially in the target problem #1, were maintained throughout the post-intervention phase and in the follow-up phase.

In spite of the impressively high immediate changes in Problem #2, the client's improvement on this problem showed a temporary weakening tendency around the 6th week. This makes an interesting contrast to the high stability of positive changes on Problem #1 throughout the post-

FIGURE 1

Changes in Anxiety Acceptance, Problem Severity,
and Coping Effectiveness after Morita Intervention
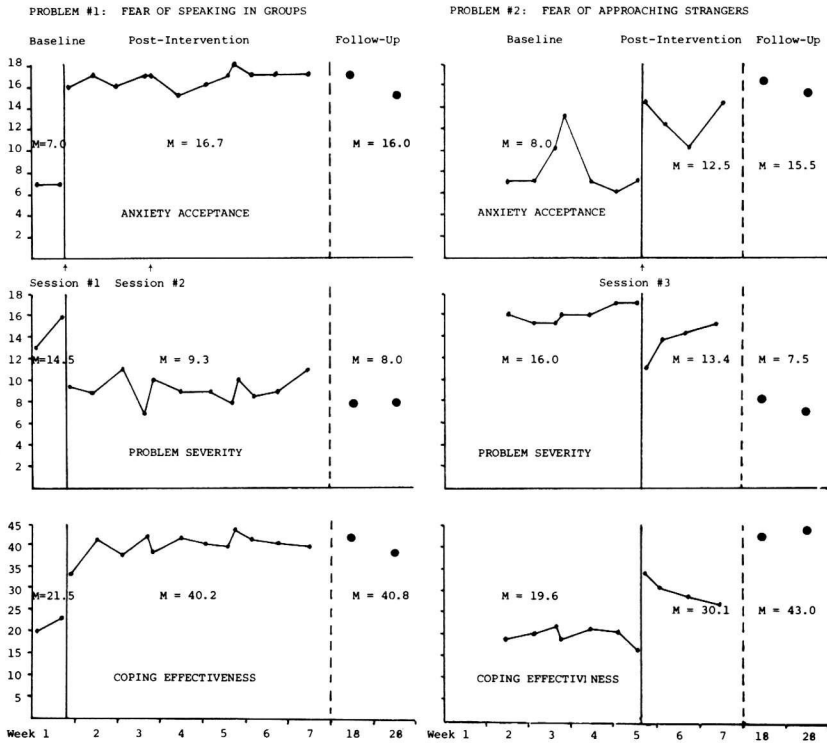
intervention phase. However, the measures on Problem #2 in the follow-up phase showed high improvement rates comparable to those on Problem #1. In the 28th week, the client explained this steady improvement on Problem #2 by saying that she had realized that both problems were coming from the same anxiety-rejecting and self-critical attitudes.

2. Qualitative Changes

In the 14th week, the client was given a brief questionnaire. She was asked to comment on the following three aspects: (1) the current interpretation of her anxious trait, (2) changes in self-statements in the target social situations, and (3) the current coping method. The following are her responses, which are consistent with the objectives of Morita intervention:

(1) [My anxiousness/nervousness means] that I am over-sensitive, and I can use that energy to help me in situations, or I can choose to focus in on the feeling and lose an opportunity to move forward and risk a new encounter.

(2) I used to say, "Keep calm, you'll be okay," "Don't be so uptight," "Don't say or do anything till you've sized up the situation," "Keep smiling and looking interested and people won't put me on the spot." Now, [I say,] "Allow myself to feel what I feel and still approach people. It's okay to be nervous/anxious. That's how much caring and sensitivity I have for myself and others."

(3) [I cope with my anxiety problems by] realizing the strength of my anxiety is in direct proportional strength to my desire to do the task at hand. I can choose to use that anxious energy to give me energy to do something constructive in the anxiety provoking situation.

The client's journal reflecting on her therapy experience confirmed that the meaningful therapy experience was directly related to the Morita-based content. The following are excerpts from the client's journal that she shared with the therapist in the 28th week:

Session 1: "[I became aware that] my focus was on feelings instead of actions. I'd never thought that the strength of my anxiety was a reflection of how strongly I wanted to do a good job, or that I could co-exist with anxiety and use anxiety as my cue to do a good job sensitively and constructively so that I could use my anxious disposition to work for me. I did not need to deny it or try to push it away, which I had done in the past. I could accept it as a natural feeling (an involuntary bodily reaction), and could still make a choice of action."

Session 2: "I had not considered that letting my moods govern me had been stopping me from action and that instead I could let my conscious choice govern my action and accept feelings as they are. By acknowledging the feeling, I could use that energy to work for me, that I had control over my chosen action in spite of feelings. This was scary and challenging. I realized that I [used to] give myself excuses not to act because of my feelings or had rejected anxiety which only made it stronger. Now, the question was: How could I do the task anxiously and sensitively?"

Session 3: "We discussed my anxiety in speaking to strangers and where the roots of this fear of rejection came from in my early childhood experiences. Again, a new way of thinking was presented. I could contact people for contact sake, regardless of my anxiety. I didn't need to aim at [developing an instant] friendship, [but] only contact. My anxiety was a reflection of my sensitivity and I could be sensitive and still choose to do what I choose to do. My primary aim was to make contact whether I feel anxious or not."

The client's therapeutic improvement was also externally validated. Positive behavioural changes were reported by others who had a regular contact with her. In the 7th week, her classmate reported to the therapist a notable increase in the client's participation in two summer courses. The client also received feedback from three course instructors in the

summer and the following fall that they had recognized increased effectiveness and initiative in her class participation.

The client reported increased effectiveness in her social and academic participation in the note sent to the therapist in the 29th week. She wrote, "It became clear to me that I didn't need to let my feelings dictate my actions and I could make responsible choices for my actions. I am able to contact strangers and speak in groups without being overcome with anxiety. My marks on exams have improved. In general, I feel more confident in my ability as a person and a student. . . . My sense of inner control and personal power has increased. I can co-exist with my anxious disposition. I can choose the most constructive thing to do and do it anxiously and sensitively."

Discussion

Both the quantitative and qualitative information clearly showed therapeutic changes after Morita therapy. The client became more accepting of her anxiety and perceived herself to be more effective in coping with each target problem. There were also marked reductions in problem severity ratings. Such positive changes were drastic and obvious in the visually represented data implying "the slam-bang effect" of the therapeutic interventions (Gilbert, Light, & Mosteller, 1975).

Qualitative information further substantiated such changes. The client's attempts to accept and integrate anxious sensitivity into a constructive lifestyle are evident in her post-treatment reports. Increased sense of self-confidence and self-acceptance was also reflected in these reports. Improved behavioural performance was validated by her peer and course instructors in addition to her own self-report.

Therapeutic improvement after intervention remained stable for Problem #1 which was dealt with in two sessions while improvement on Problem #2 tended to weaken shortly after the single-session intervention. This temporary weakening tendency may be due to limited therapeutic attention directed to Problem #2. However, remediation observed on this problem in long-term follow-ups seems to suggest a possible process of integration of insights by the client who recognized similarities in the two problems.

A noticeable increase immediately after Session 2 and a subsequent drop in the client's anxiety acceptance related to Problem #2 could be explained as a temporary generalization effect since these two types of anxiety problems were not heterogeneous. However, it is difficult to explain the cause of this phenomenon without further information.

As a first quantitative investigation into cognitive changes with repeated measurements, this study seems to play an important role in pointing to a new direction in Morita therapy research using single-case experimental designs. Future studies need to make further improvements on research design. Direct and systematic replications across a

number of subjects needs to be done to test inter-subject replicability. Longer baseline periods are desirable to observe the trend and stability to examine the effects of spontaneous improvement and treatment expectancy.

Although the present study used cognitive measures and qualitative information, additional measures on behavioural change are also desirable. While the adjective checklist-type scales used in this study showed high sensitivity to change associated with therapeutic interventions, further validation and improvement of these scales need to be done in future studies.

The present study did not specifically isolate the effects of Morita-based treatment variables from other treatment variables such as attention, empathy, catharsis, and treatment expectancy. Therefore, future studies need to partial out the effects of non-Morita variables and examine the specific effects of Morita intervention in the single-case experimental paradigm. Furthermore, researchers may investigate differential effects of variables such as treatment length, anxiety type, and intervention modality (e.g., group vs. individual sessions, interview vs. written communication, residential treatment vs. counselling).

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About the Author

Dr. F. Ishu Ishiyama is a lecturer in the Department of Psychological Foundations at the University of Victoria. His current interests include the study of Morita therapy, shyness, treatment of social anxiety, and fear of success in adolescents.