

## Assessing Social Anxiety in Japanese and Japanese-Americans in the United States

Mikako Moriyasu\* and Rhoda Olkin

California School of Professional Psychology, Alliant International University, USA

### ABSTRACT

A Social Anxiety Scale designed to assess culture-specific symptoms in Japanese clients was assessed for face validity data. *Taijin-Kyofusho* is a culture-bound syndrome specific to Japanese culture in the DSM-5. A Social Anxiety Scale (SAS) was designed by the first author from existing Western social anxiety scales and a *Taijin-Kyofusho* scale. A demographic form yielded information about culturally knowledgeable clinician respondents, and a questionnaire was used to get feedback on the SAS. Responses were obtained from 27 mental health professionals who worked clinically with Japanese legal residents in the United States and Japanese Americans, regarding culturally appropriate social anxiety assessment. Participants perceived the SAS as comprehensive and applicable to Japanese residents and Japanese Americans. Regarding *Taijin-Kyofusho*, most agreed that it should be assessed in Japanese residents but were undecided about its clarity and applicability to Japanese Americans. Several concerns were expressed about the validity of Western social anxiety scales for these populations. Most stressed the need for contextualization of social anxiety scales, differences in stigma against mental disorders across ethnicities, and the need for sensitivity of mental health professions to LGBTQ members in these populations. This is the first study on the views of clinicians working with these populations about *Taijin-Kyofusho* and how to assess anxiety. Nuances between Japanese residents and Japanese Americans were noted. We urge incorporation of cultural differences in manifestations of distress and specifically on *Taijin-Kyofusho* in training for mental health professionals.

The purpose of this paper is to report on the first step in development of a culturally appropriate social anxiety scale for Japanese and Japanese-Americans living in the United States (U.S.). We first review the literature on differences in anxiety presentation across U.S. and Japanese cultures. We then report on feedback from culturally knowledgeable clinicians of the new scale, and specifically on the question of whether *Taijin-Kyofusho* symptoms should be included.

**Keywords:** Japanese; Assessment; Social anxiety; *Taijin-Kyofusho*; Cultural context

## INTRODUCTION

### Psychopathology and culture

Scholars have increasingly directed research efforts toward clarifying cultural influences on manifestations of psychopathology and diagnostic assessment, both of which vary based on race, ethnicity, and culture [1-5]. Social anxiety is a disorder that is highly subject to cultural differences [6-13]. For instance, Asian Americans tend to describe more somatic symptoms related to anxiety compared with European

Americans [1,2]. In a study conducted in China, approximately 60% of all cases of DSM-IV anxiety disorders were diagnosed as belonging to the “Not Otherwise Specified” category based on the use of clinician-administered diagnostic instruments. Although instrument issues could account for this finding, “the DSM criteria embedded in the diagnostic instrument do not capture key aspects of Chinese pathological anxiety” [3]. In fact, in a study that applied the Composite International Diagnostic Interview (CIDI) in Beijing and Shanghai, researchers discovered that the CIDI, which is based on the concept of psychopathology

\*Correspondence to: Mikako Moriyasu, California School of Professional Psychology, Alliant International University, USA, Present Address: 463 Hoyacho, Garden Terrace Seibu Yagisawa #109, Nishi Tokyo-shi, Japan, Tel: +8170-4033-3504; E-mail: mimoriyasu@gmail.com

Received: July 15, 2019; Accepted: August 12, 2019; Published: August 19, 2019

Citation: Moriyasu M, Olkin R (2019) Assessing Social Anxiety in Japanese and Japanese-Americans in the United States. J Dep Anxiety 8:340. doi:10.35248/2167-1044.19.8.340

Copyright: © 2019 Moriyasu M, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

in the DSM-IV, could not match the criteria of Chinese pathological symptoms of anxiety. The DSM-IV's definition of anxiety has placed emphasis on psychological symptoms more than somatic symptoms [3], which partially accounts for this discrepancy. The DSM-5 applies greater cultural sensitivity to its updated diagnostic criteria to reflect aspects of culture as "dynamic systems that undergo continuous changes over time" [14]. Furthermore, the DSM-5 modified culturally determined criteria and made them more inclusive and applicable across diverse cultures in the United States. For instance, the criteria for social anxiety disorder include the fear of "offending others," so as to reflect clinical manifestations that are seen in a Japanese cultural context [14].

Since expression of social anxiety is highly influenced by cultural norms and clients' cultural backgrounds, these are important considerations when conducting psychological assessments. Some research on social anxiety has reported its association with self-construal (i.e., independence vs. interdependence) and/or cultural factors (i.e., individualistic vs. collectivistic). There are positive correlations between higher levels of social anxiety and interdependence self-construal, and between higher levels of social anxiety and coming from a collectivistic culture [3,6,7,15-19].

The threshold for typical behaviors versus pathological symptoms also is influenced by culture. A higher threshold exists for social anxiety symptoms as psychopathology in collectivistic societies, and a lower threshold in individualistic societies. In individualistic countries, social withdrawal and shyness are regarded as interfering with quality of life and are labeled as problematic. As a result, children in these countries are more likely to learn to modify their shyness. On the other hand, social reticence can be interpreted positively in collectivistic countries; therefore, introverted behavior may be understood and supported during development. As a byproduct of these different developmental trajectories, people in collectivistic countries are likely to manifest more social anxiety symptoms compared to people in individualistic countries. However, there is a lower prevalence of social phobia diagnoses in collectivistic countries, despite having higher levels of symptomatology. This may not be due to underdiagnosis, but rather because social withdrawal does not result in interpersonal difficulties (e.g., criticism or dislike) and thus is not labeled as pathological [7].

### **Cultural considerations in the diagnostic criteria for social anxiety**

The diagnostic criteria for social anxiety were constructed based on Western cultural norms, and these norms are codified in social anxiety scales. Yet there are ethnic differences in individuals' experiencing of social anxiety, such as East Asian Americans and immigrants exhibiting higher levels of social anxiety in assessments compared to their White counterparts [9,10,12,17,20]. However, it is debatable whether this means East Asian Americans actually experience more distress in social situations or if some of their behaviors encouraged by their cultural norms are misconstrued as social anxiety symptoms in Western cultural norms. In fact, higher levels of social anxiety in

East Asian populations (in Canada) might not reflect their "functional impairment or distress" [17]. The researchers delineated differences of personality traits that are encouraged in Western versus Eastern cultures [17]. Specifically, they determined that individualistic cultural norms encourage an independent view of the self, (i.e., an independent self-construal), the consistency of personal attributes across situations, and self-confidence. In contrast, collectivistic cultural norms enhance an interdependent view of the self (i.e., an interdependent self-construal), reflective identity of social situations and self-criticism [17]. In a collectivistic society, adjusting to one's environment and integrating situational attributes into one's own thoughts and actions are important skills necessary to thrive. Therefore, a changeable self-image that functions across social situations and self-criticism that is applied "to identify and adjust negative personal attributes that threaten the success of a group interaction" [17] are strengths and virtues in East Asian cultures, while these personality traits can be perceived as weaknesses and a feature of psychopathology in Western cultures. From the perspective of evolutionary psychology, the behaviors that manifest as social anxiety reflect "naturally occurring reactions that can be adaptive under certain circumstances" [12]. The concept of social anxiety was developed based on these perspectives of individualism and is ingrained in Western social anxiety scales, which perceive and detect some traits of collectivism as social anxiety symptomatology in East Asians [17].

There are arguments in favor of the need to contextualize social relationship variables in social anxiety assessments of Asian Americans and immigrants. Rapee and Spence [12] delineated biological/genetic, psychological and environmental factors that can cause social anxiety in individuals. For instance, social contextual issues (such as racial discrimination and microaggressions) which Asian Americans and immigrants of Asian descent are exposed to can cause distress in social situations and lead to social anxiety [12]. Another study investigated the social anxiety of first-generation Chinese immigrants across different social contexts [20]. They focused on the social situations in which these Chinese immigrants interacted with European Americans and with other Chinese from a perspective of social anxiety levels. Context included three cultural factors (acculturation, enculturation, and English proficiency), one environmental stressor (perceived racial discrimination), and two personality traits (neuroticism and extraversion). They found that less extraversion and the experiencing of more discrimination were significant, unique predictors for social anxiety when interacting with other Chinese as well as with European Americans. In addition, more neuroticism and less acculturation significantly contributed to social anxiety levels in a European American context [20]. Their findings suggested that the racial discrimination people perceived influenced their social anxiety across contexts.

More attention has recently been directed toward the heterogeneity of the Asian American population in terms of differences concerning race/ethnicity, culture, socioeconomic status, nativity status, immigration history, educational attainment, English proficiency level, and regional variability. Whereas "Asian cultures" have the cultural values of Buddhism

and Confucian philosophy in common, some studies found empirical evidence of racial/ethnic differences among Asian races/ethnicities [4,21]. For instance, one study showed different levels of adherence to six values—collectivism, conformity to norms, emotional self-control, family recognition through achievement, filial piety, and humility—among Chinese American, Filipino-American, Japanese-American, and Korean-American students [22]. Filipino culture, which is influenced by Catholicism and American language and culture (due to Spanish colonization) in addition to Buddhism and Confucian philosophy demonstrated lower adherence to these six values [21]. Moreover, Chinese, Japanese, and Korean American students demonstrated various levels of adherence to values (e.g., Japanese showed significantly higher adherence to self-control dimension compared to others) and held a unique configuration for Asian cultural values. Thus Kim [21] identified “the need to understand within-ethnic-group differences to provide the most culturally sensitive psychological services to ethnic minorities” (p. 358), as do the new APA Multicultural Guidelines [23,24].

### Cultural idioms of distress – *Taijin-Kyofusho*

The DSM-5 replaced the DSM-IV term culture-bound syndromes with “cultural concepts of distress” [14], and it has been defined as “ways cultural groups experience, understand, communicate suffering behavioral problems, or troubling thoughts and emotions” [13]. These cultural concepts also have been called “idioms of distress,” which may be manifested differently than Western expressions.

Ethnopsychology/ethnophysiology factors have a cultural influence on individuals’ conceptualizations of how the mind and body function and relate and the ways in which distress is manifest. Cultural idioms of distress are unique manifestation of distress that results from individuals’ cultural perceptions of psychological/physiological functions and their cultural norms [24].

*Taijin-Kyofusho* is a phobia that is culturally specific to East Asia countries such as Japan and Korea. In the DSM-5, *taein kong po* in Korea is considered similar to the condition of *Taijin-Kyofusho* [14]. *Taijin-kyofusho* refers to the “fear of interpersonal relations” [25]. Masatake Morita, who invented Morita therapy in 1919, first delineated it in the 1930s as the core manifestation of *shinkeishitsu*, which resembles neurasthenia, described as a combination of anxious, depressive, and somatic symptoms [26]. Later, *Taijin-Kyofusho* became “synonymous with the term *shinkeishitsu*” [27].

### Etiology of *Taijin-Kyofusho* in Morita therapy

Morita found the shared mechanism of symptom formation across the various *shinkeishitsu* types of neurosis, which is called “*toraware*” and means “to be bound as by some intense preoccupation” [28]. Morita also described *shinkeishitsu* as “a nervous-prone personality with a hypochondriacal base” [28]. Based on Morita’s theory, individuals who have a hypochondriacal temperament will develop *Taijin-Kyofusho* after experiencing an accidental event and becoming highly sensitized [27]. Reinforced by their tendency to partake in an oversensitive

interpretation of such an event, they become more affected by sensations and more focused on these sensations and fears of interpersonal situations, which Morita called “psychic interaction” and described as causing a “vicious circle of attention and sensation” [27]. In Morita therapy, the unfolding of *toraware* and the alleviating of *shinkeishitsu* are fundamentally associated; clients with *shinkeishitsu* or *Taijin-Kyofusho* need to go through the recovery process *arugamama*, which means to “accept reality as it is and lead a constructive life” [28].

In the Japanese cultural context, shame has been associated with the symptomatology of *Taijin-Kyofusho*, and it has been called “an obsession of shame and anxiety” [27] and a “phobia of being ashamed” [29]. Clinical manifestations are “an excessive sensitivity to interpersonal relations” [30] and include symptoms such as feeling anxious in the presence of others, blushing, subjective disfigurement, the fear of eye contact, and the fear of emitting unpleasant body odors.

People with *Taijin-Kyofusho* suffer from certain fears, including being embarrassed in the presence of others, offending others, and/or making others feel uncomfortable, which causes them to avoid social situations and interactions. Despite a dearth of epidemiological studies regarding the prevalence of social phobia in Japan or *taijin-kyofusho* in the general population in Japan [31], initial research indicates that up to 38% of patients have been diagnosed with *Taijin-Kyofusho* in Japanese clinical settings [32].

### *Taijin-Kyofusho* diagnostic criteria

Although it has been more than several decades since Morita coined *Taijin-Kyofusho* in Japan, Maeda and Nathan’s formal diagnostic criteria were not established until 1995 [26]. Each researcher formed his/her own nomenclature of *Taijin-Kyofusho* and its classification [32]. Based on its symptomatology, *shinkeishitsu* was sub-grouped into obsession (being obsessed with ideas), ordinary *shinkeishitsu* (being obsessed with somatic symptoms), and paroxysmal neurosis (being obsessed with anxiety attacks and anxiety) [28]. Kasahara redefined *Taijin-Kyofusho* as a type of neurosis that includes excessive anxiety and tension in social situations and withdrawing from interactions with others [33]. Nagata later developed diagnostic criteria for *Taijin-Kyofusho*, which consist of the tension (fear of being looked at by others) and offensive (fear of offending or embarrassing others) subtypes [34]. Two sets of diagnostic criteria [27,34] are listed in Table 1.

### *Taijin-Kyofusho* and western psychopathology

Although some research has demonstrated similarities between the subtypes of *Taijin-Kyofusho* and Western psychopathological entities (e.g., *sekimen-kyofu* and social anxiety, *shubo-kyofu* and body dysmorphic disorder, *jikoshu-kyofu* and olfactory reference syndrome), the offensive subtype of *Taijin-Kyofusho* is thought to be foreign to Western social anxiety. Even in DSM-5, which includes *taijin-kyofusho*’s offensive symptoms in the definition of social anxiety [14], *Taijin-Kyofusho* remains one of the cultural idioms of distress syndromes in the DSM-5. On the other hand, research findings have thus far indicated that the offensive

subtype may not be as specific to Japanese culture as was previously thought [16,29,35-37]. Nonetheless, it is notable that *Taijin-Kyofusho* exhibits some characteristics of Japanese thought processes pertaining to social anxiety. We believe, therefore, that *Taijin-Kyofusho* symptomatology should be considered in assessments for populations in which Japanese cultural and social values are prevalent.

Social anxiety assessment should involve examinations of cultures, individuals' cultural background, and the cultural

norms of their environment. In particular, immigrants require specific assessments that are tailored to examine their own issues. The purpose of this study was to create a culturally-appropriate social anxiety scale for Japanese and Japanese Americans in the United States. The first step in the development of a new scale was to have it assessed for face validity by mental health professionals knowledgeable about Japanese and/or Japanese American clients with anxiety.

**Table 1:** Comparison of two sets of diagnostic criteria for *Taijin-Kyofusho*.

Maeda & Nathan [27]	Nagata et al. [34]
<p><b>A. All of the following criteria should be met:</b></p> <p>(A1) The feeling that his/her own attitudes, behavior, and physical characteristics are inadequate in social situations.</p> <p>(A2) The persistent suffering (caused by condition 1) from emotional reactions such as shame, embarrassment, anxiety, fear, and tense feelings in social situations. (A3) Worrying that he/she is unable to maintain healthy relationships with others (feeling unaccepted, despised, and avoided) due to conditions 1 and 2.</p> <p>(A4) Avoiding painful social and interpersonal situations, while reluctant to do so.</p> <p><b>B. Supplementary items:</b></p> <p>(B1) Certainty that he/she has a defect or issue related to a particular part of the body, such as the eyes, body odor, and his/her general appearance.</p> <p>(B2) Delusional conviction that he/she harms other people or gives others unpleasant feelings because of condition 1.</p> <p>(B3) Delusional conviction that others always avoid him/her due to conditions 1 and 2.</p>	<p><b>A. At least one of the following features:</b></p> <p>(A1) Fear of blushing in the presence of others.</p> <p>(A2) Fear of the stiffening of one's facial expressions, of trembling of the head, hands, feet, or voice, and/or of sweating in front of others.</p> <p>(A3) Fear of physical deformities being noticed.</p> <p>(A4) Fear of emitting body odors. (A5) Fear of line-of-sight becoming uncontrollable.</p> <p>(A6) Fear of uncontrollable flatus in the presence of others.</p> <p><b>B. Either of the following two because of the above fear(s):</b></p> <p>(B1) Tension subtype: fear of being looked at (noticed) by others.</p> <p>(B2) Offensive subtype: fear of offending or embarrassing others.</p> <p><b>C. At most points during the course of the disorder, the person recognizes that the fear is excessive and/or unreasonable.</b></p> <p><b>D. The fear or fears significantly interfere with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress associated with having the fear(s).</b></p> <p><b>E. The symptoms must have been present for at least one year. For individuals under the age of 18, the duration should be at least 6 months.</b></p>

## METHODS

### Research questions

- To what degree do culturally-knowledgeable clinicians perceive this social anxiety scale as effective for assessing social anxiety in Japanese and Japanese Americans in the U.S.?
- How clear and applicable is each item of the social anxiety scale?
- Should symptoms be included when assessing social anxiety in these populations?
- How might the social anxiety scale be improved?
- Which social anxiety scales are professionals currently using for these target populations?

### Participants and recruitment

Participants were 27 licensed mental health professionals with clinical experience in treating Japanese and/or Japanese Americans in the U.S. All were licensed psychologists (n=10), marriage and family therapists (9), clinical social workers (5), or licensed mental health counselors (3) who had either work experience with at least three Japanese and/or Japanese

American clients, or at least 600 hours of clinical experience with these populations. Their primary language was either Japanese or English, but all had sufficient levels of English proficiency to participate in this survey since they had professional degrees and licenses from the U.S. Clinicians were recruited through a directory of Japanese mental health professionals and mental health professional organizations of California, Hawaii, New York, Colorado, Arizona, Oregon, Nevada, and Utah (e.g., Japanese Medical Support Network in New York and NichiBei Care and Asian American Psychological Association in San Francisco). Recruitment materials contained a link to the website for the survey. Additionally, individual invitations were made via phone calls or email from the first author, and through snowballing.

The 27 participants had a mean of 7.56 years since licensure (SD=6.59), had worked with a mean of 18.37 clients in these populations (SD=11.99), and spent a mean number of over 500 hours working with clients in these populations (SD=312.30). Most (18) worked with both Japanese residents and Japanese Americans (and seven with Japanese residents only and two with Japanese Americans only). Most were native Japanese speakers



(70.4%), and 22.2% were native English speakers (and 7.4% were neither but had formal education in English in their home countries). All but one rated their English proficiency as ‘good’ or ‘primary language,’ and 23 rated their Japanese proficiency as ‘good’ or ‘primary language.’

## MEASURES

### Social Anxiety Scale (SAS)

Social Anxiety Scale is a 43-question self-report scale, with five-level Likert multiple-choice items, that was created for this study by the first author.

**Table 2:** Social Anxiety Scale (English).

Social Situation	Symptom List	Thought list
1. Speaking in front of an audience 2. Speaking up at meetings to share opinions 3. Expressing disagreement with someone 4. Talking to people with more authority 5. Talking to people of the opposite sex 6. Inviting people out 7. Making eye contact when talking to someone 8. Attending social gatherings with many unfamiliar people 9. Participating in small group activities or events 10. Entering a room in which other people are gathered 11. Being watched while working or studying 12. Being watched while writing something 13. Eating or drinking in a public place 14. Making phone calls to unfamiliar persons 15. Answering telephone calls 16. Being the center of attention 17. Using public transportation with other passengers on board 18. Going to a party 19. Giving a party 20. Returning goods to a store 21. Making an important judgment for a group in which you are involved	1. You have a fast pulse, an irregular pulse, heart pounding, chest pressure, and/or chest pain 2. You have difficulty breathing, an uncomfortable throat, a failed voice, and/or frequently sigh 3. You have dry mouth, dizziness, ear ringing, blurred sight, blushing, hot or cold flushing, feel itchy, experience numbness, have a headache, sweat excessively, going to the toilet frequently, and/or menstrual irregularity 4. You have difficulty swallowing, gastric discomfort, nausea, constipation, loose bowels, and/or abdominal bloating 5. You experience tenseness, restlessness, tremors, a stiff shoulder, stiff facial expressions, fatigue, and/or twitching 6. You have difficulty sleeping and/or nightmares 7. You have odd feelings about people and scenes surrounding you, feel out of place, and/or feel that you are not yourself 8. You feel anxious, irritated, and/or anticipate the worst	1. I believe my body odor offends others 2. I notice it due to others' attitudes and/or demeanors 3. I believe my gaze offends others 4. I notice it due to others' attitudes and/or demeanors 5. I believe my appearance offends others 6. I notice it due to others' attitudes and/or demeanors 7. I believe my facial expression offends others 8. I notice it due to others' attitudes and/or demeanors 9. I believe I am a wet blanket 10. I notice it due to others' attitudes and/or demeanors 11. I believe my comments offend others 12. I notice it due to others' attitudes and/or demeanors 13. I believe my abilities offend others 14. I notice it due to others' attitudes and/or demeanors

How much anxiety do you feel when you anticipate doing these things and/or imagine doing these things?  
 SCALE: 1=No anxiety at all  
 2=Minimal anxiety  
 3=Moderate anxiety  
 4=Very anxious  
 5=Could not do this activity due to anxiety

Please indicate how often you have each symptom:  
 SCALE: 1=Never  
 2=Rarely  
 3=Every once in a while  
 4=Fairly often  
 5=Almost daily

Please indicate how much each thought bothers you: SCALE:  
 0=I never or rarely have this thought  
 1=Does not bother me at all  
 2=Bothers me somewhat  
 3=Bothers me a fair amount  
 4=Bothers me very much  
 5=Bothers me so much that I think about it daily

The SAS comprises three parts: (a) 21 items assessing social situations that provoke anxiety, (b) 8 items assessing physical

symptoms of anxiety, and (c) 14 items assessing thoughts that provoke distress in social situations. For each part the scale is

one to five, with one meaning absence of a symptom, and two to five meaning increasing levels or frequency of a symptom (Table 2) [For the Japanese version please contact the first author].

The content of the scale was designed with reference to prevalent social anxiety scales used in the United States (e.g., the Liebowitz Social Anxiety Scale, the Social Avoidance and Distress Scale, the Social Interaction Anxiety Scale, and the Social Phobia Inventory), as well as items assessing *Taijin-Kyofusho* symptoms (from the Social Anxiety/*Taijin-Kyofusho* Scale; SATS). One item (“I believe my abilities offend others”) was not originally from the SATS but created to modify the scale for the situations of Japanese and Japanese Americans in the U.S. Because some users of the scale might have concerns about their English proficiency and/or accents, the definition of *taijin kyofusho*'s was expanded (“fears of offending others by blushing, stuttering, emitting offensive odors, staring inappropriately, presenting improper facial expressions, blemishes, and/or physical deformity”) and included “abilities” in general.

### Demographic questionnaire

The demographic questionnaire was designed for this study and was used to gain descriptive information about the respondents. The first six questions pertained to licensure and clinical experience. The next two questions were for participants' self-assessment of English proficiency, rated using four-levels (1=Poor; 2=Fair; 3=Good; 4=Primary language), and Japanese language proficiency rated using five levels (1=N/A; 2=Poor; 3=Fair; 4=Good; 5=Primary language).

### Survey questionnaire

The survey questionnaire was designed for this study and was used to gain opinions about the SAS. Six levels were available for responses (0=N/A; 1=Strongly disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly agree). The first question sought to examine the overall social anxiety scale:

- (a) Can it assess social anxiety in Japanese clients?
- (b) Can it assess social anxiety in Japanese American clients?

The clarity and applicability of each of the 43 items also were assessed. One question was included to gather opinions of whether items regarding *Taijin-Kyofusho* symptoms should be assessed in these populations. The last four items were open-ended questions, which were asked to obtain participants' clinical experience with these populations, the existing social anxiety scales they presently use, and general opinions about how to improve the proposed social anxiety scale.

**Table 3:** Participants' comments about the scale items.

---

“The contents of some of the questions are culturally appropriate behaviors for Japanese to some extent, such as not keeping the eye contact, and feeling uncomfortable disagreeing with others, etc.”

---

“I think many items are right on. However, some items are not clear whether they describe social anxiety symptomatology or behaviors that are against Japanese cultural norms” (translated into English by the author).

---

### Procedures

The survey website provided information about the purpose of the study and the procedures to complete the evaluation survey. The following were included:

- (a) A self-report of English proficiency,
- (b) The Social Anxiety Scale,
- (c) An evaluation surveys.

After including a check mark in the designated box to indicate having read the consent form, participants were shown the SAS and asked to complete an evaluation questionnaire. Participants were able to choose the language version (i.e., English or Japanese) they examined based on the primary language of their clients. When participants were bilingual in English and Japanese, they were encouraged to examine both versions. The anxiety scale items were repeated on the questionnaire so that respondents did not have to scroll back to the anxiety scale items. All answers were anonymous, and participants were taken to a separate page to enter a lottery for three \$50 gift-cards. They had the option of requesting the study results and/or some of the literature review.

## RESULTS

### Research questions

The scale for responses to each research question was 1=Strongly disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly agree. Also included was 0=not applicable.

**Research question 1:** To what degree do professionals perceive this social anxiety scale as effective for assessing social anxiety in Japanese residents and Japanese Americans?

For the three versions of the scale (English version for Japanese; English version for Japanese Americans, and Japanese version for Japanese) the mean of responses were 3.76 (SD=.70), 3.54 (SD=.81) and 3.80 (SD=.63), respectively.

For the English version of the scale, nine participants wrote comments. Four participants explained the reasons of their endorsements of “Agree” or “Strongly agree,” such as “It covers most social scenarios.” For those who endorsed ‘Neutral’ or ‘Disagree,’ there were four comments. For example, one comment read as “I think many items are right on. However, some items are not clear whether they describe social anxiety symptomatology or behaviors that are against Japanese cultural norms” (translated into English by the first author) (Table 3).

“People with social anxiety are typically observed to have issues in a middle distance of relational proximity such as a relationship with acquaintances wherein they are neither friends nor strangers. In this social anxiety scale, there are not many items that describe situations in such a middle distance of relational proximity” (translated into English by the author).

Regarding “Speaking in front of an audience,” “Expressing disagreement with someone,” “Talking to people with more authority,” “Making eye contact when talking to someone,” “Making phone calls to persons with whom one is not very well acquainted,” “Being in the center of attention,” “Returning goods to a store,” “Make an important judgment for a group you are involved in”) “In Japanese culture, one is expected to not stand out, to be considerate of others/worry about what others would think of you, and to avoid conflicts/obvious disagreement with others. Those items (...) wouldn’t be appropriate to assess social anxiety Japanese clients/some Japanese Americans because those behaviors are overall discouraged or not valued in Japanese culture.”

“Some second-generation of Japanese Americans with both Japanese parents may have held more Japanese cultural values, while third-generation of Japanese Americans or even second-generation of Japanese Americans whose one of parents are not Japanese are likely to hold more American cultural values.” (translated into English by the author).

(Regarding “Talking to people of the opposite sex”) “If you mean ‘people of sexual attraction’ by ‘people of the opposite sex’, the wording should be thoughtfully considered in terms of LGBTQ inclusion.” (translated into English by the author).

(Regarding “Returning goods to a store”) “I am wondering this is not applicable to Japanese Americans since this custom is the norm in this country.”

(Regarding “Returning goods to a store”) It doesn’t refer to social anxiety symptoms in Japanese cultural context.”

(Regarding “Going to a party”) “Japanese do not have many parties in Japan. If there is, there is usually “kanji” type people who is good at doing it take care of it, so not too many Japanese experience giving a party. Also, those questions are kind of overlapping with (A)-6, 8, 9, 10, 13 that are more specific in nature. I wonder why party situation is singled out.”

(Regarding “Giving a party”) “(It is) culturally acceptable (if Japanese get anxious throwing a party). Also, other reasons can be concerned.”

**Research question 2:** Should *Taijin-Kyofusho* symptoms be assessed to capture social anxiety in these populations?

This research question had two parts: *Taijin-Kyofusho* symptoms

- (a) For Japanese residents and
- (b) For Japanese Americans.

### ***Taijin-Kyofusho* for Japanese residents**

Some participants’ comments focused on how its cultural specificity can have an influence on this population and thus can factor into the reason for selecting “Agree.” For instance, “This is a very culturally-specific issue and it is important that any therapist working with this population be versed in the subject.” One participant, who indicated “Disagree,” stated the following:

“In my experience, I have rarely seen people with *Taijin-Kyofusho*, nor have I diagnosed anybody with it. As for anxiety disorders, I have only had clients with general anxiety and PTSD” (translated into English by the first author). Only two participants reported clinical experiences in working with clients with *Taijin-Kyofusho*.

### ***Taijin-Kyofusho* for Japanese Americans**

Some participants agreed that *taijin-kyofusho* should be assessed in Japanese Americans due to Japanese cultural influences. An

example was “Japanese Americans who hold Japanese cultural values need to be assessed.”

In comparison, participants who disagreed or were undecided expressed concerns about its applicability to Japanese Americans. As one participant noted, “*Taijin-Kyofusho* symptoms are developed in the Japanese cultural environment. I think that Japanese Americans who live in this country are unlikely to manifest its symptoms” (translated into English by the first author).

### **Other Questions for Mental Health Professionals**

We asked the professionals what scales they currently used, if any (Table 4). The DSM-5 criteria were the most commonly used. However, seven professionals used no scales with Japanese Americans clients and eight used no scales with Japanese clients.

We asked how the SAS could be improved and received twelve comments. In general, the comments were about needing highly nuanced assessment. One participant made a distinction between the east and west coasts of the U.S. English proficiency, acculturation, and interlocutor were also raised as issues that could affect social anxiety.

For example, a professional wrote that “one thing I notice is anxiety around syntax and accent. Being afraid that someone might misunderstand them and that what they say may have an unintentionally embarrassing meaning.” Changing cut-off scores for anxiety threshold was another suggestion.

	<b>Social Anxiety Scales</b>
	DSM-5 (3)
	Leibowitz Social Anxiety Scale (2)
	Thought List (2)
	Big Five Personality N Scale (1)
	Hopkins Symptom Checklist (1) Beck Anxiety Inventory (1)
	GAD assessment (1)
	Burns Anxiety Inventory (1)
<b>For JP</b>	SCARED (1)
	DSM-5 (3)
	Beck Anxiety Inventory (2)
	GAD assessment (2)
	Leibowitz Social Anxiety Scale (1)
	PHQ-9 (1)
	Hopkins Symptom Checklist (1)
	Burns Anxiety Inventory (1)
<b>For JA</b>	SCARED (1)

## DISCUSSION

Most participants indicated that both the English and Japanese versions of the Social Anxiety Scale would be effective for assessing social anxiety in their Japanese resident and Japanese American clients. Interestingly, there were various levels of awareness about *Taijin-Kyofusho* among participants. Even some participants who were raised in Japan had never seen clients with *Taijin-Kyofusho* nor received any training in it. Given the lack of formal diagnostic criteria for *Taijin-Kyofusho* before 1995 and a history of the use of various operational definitions of the diagnostic subtypes in Japan [26], it is comprehensible that even Japanese clinicians demonstrated varied levels of understanding of *Taijin-Kyofusho*. Also, there was disagreement among participants regarding the necessity of *Taijin-Kyofusho* assessment for Japanese residents. Specifically, one participant pointed out that some Japanese clients with *Taijin-Kyofusho* deteriorated after moved to the United States, while other participants questioned whether Japanese clients who decided to emigrate from Japan on their own develop *taijin-kyofusho* in the United States. Since there is no study about the prevalence of *taijin-kyofusho* and social anxiety in Japanese residents in the United States, we cannot predict the likelihood of working with Japanese clients with *Taijin-Kyofusho*. Nonetheless we believe it is important to

hold knowledge of *Taijin-Kyofusho* for mental health professionals who are working and may work with Japanese residents and Japanese Americans.

A number of participants stated that certain items describe situations and behaviors that are not indicative of social anxiety symptoms in the Japanese cultural context. When a behavior is considered as disrespectful or impolite in Japanese society, it should not necessarily count as a symptom when assessing anxiety. Such behaviors include “speaking up at a meeting,” “expressing disagreement with someone,” and “talking to people with more authority.” For instance, speaking up at a meeting without permission from a person with authority can be regarded as impolite and inappropriate.

This behavior can be considered to be standing out or to be inconsiderate in a group, which is not encouraged in Japanese culture. This point of view is consistent with previous research findings.

Foreign-born East Asians are found to report higher social anxiety than those born in the United States, which can result from Western social anxiety scales that were developed based on Western constructs of social anxiety that regard interdependence and collectivistic attitudes as psychopathology [17]. As Hong and Woody [17] suggested, what Western social anxiety measures detect in East Asians may not be equivalent to subjective distress and the avoidance of social situations in Westerners.

Participants pointed out the need to contextualize social anxiety assessment to consider sociocultural, political, and racial factors that are relevant to Japanese residents and Japanese Americans. Assessing social and environmental stressors should not be underestimated to understand social anxiety symptoms experienced by people of color and people with different cultural backgrounds. Previous research findings also indicated that environmental distress plays an important role in the onset and maintenance of social anxiety [19,20,38]. As diathesis-stress paradigm posits that psychopathology, especially social anxiety, corresponds with environmental, biological/genetic, and psychological factors [20] and should be assessed with scales that are tailored for each population. Cultural specificity that can contribute to the development and maintenance of social anxiety in Japanese residents includes language/communication abilities and collectivistic/interdependent tendency, which reflects individuals’ acculturation processes as well.

Some participants did not view unfamiliar situations or behaviors that can provoke anxiety as indications of social anxiety, while others regarded normal situations or behaviors as ineffective question items to detect social anxiety. For instance, four participants expressed that items such as “returning goods to a store” for Japanese residents are not culturally appropriate since this behavior is not considered to be normal in Japanese society and does not occur regularly. In comparison, two participants regarded the same item for Japanese Americans as not culturally appropriate and thus, ineffective because this behavior is normal and “not referenced as being rude and disrespectful.” These perspectives of adequateness are quite contradictory to each other. This argument reflects a point that requires further investigation in a future study: balance between



contextualization and generalization to tailor the specificity of social anxiety in Japanese residents and Japanese Americans. This incorporation of each individual's cultural background is necessary to avoid over-pathologizing individuals.

On the other hand, we need to refrain from being so overly attentive to cultural factors that we lose sight of individual distress. Cross-cultural social anxiety assessments involve both cultures; a cultural context of physical place wherein an individual resides and interacts with others, and a cultural context of the individual holds of. As mental health professionals we are required to strike a balance among multiple cultures pertaining to our clients. For instance, a number of participants expressed concerns about the applicability of items such as "going to a party" and "giving a party," as well as "returning goods to a store." Socialization in the United States does not necessarily correspond to that in Japan; social functions at work and at school in the United States play a more important role than in Japan. Thus, Japanese residents are particularly at risk of experiencing distress on social occasions. Additionally, some Japanese residents face challenges on social functions due to language issues and lack of American social skills that are required to function socially in the United States, which can interfere with their socialization. Therefore, we have to detect possible causation of distress leading to social anxiety. Specifically, avoidant behaviors in some situations (e.g., "not participating in a party") can lead to racial labeling and discrimination, which may affect social and/or vocational functioning negatively. For instance, Asian students are viewed as hard workers and good students who do not get the point of talking to strangers at a party and drinking when they could be studying. As previous research findings indicated, sensing the discrepancy between social expectations and one's self-view can cause distress in social situations and can lead to social anxiety [12,17]. Moreover, after a certain period of time, we can expect resilience to allow adjustment to a new environment. If not, we should consider adequate treatment plans for rigidity—a factor that can lead individuals to social anxiety. We should detect anxious behaviors that are provoked by unfamiliar customs to immigrants' cultural background in a new environment and check up on their transformation over time. Otherwise, they may eventually develop social anxiety.

As for *Taijin-Kyofusho*, most participants were undecided as to whether *Taijin-Kyofusho* should be assessed in Japanese Americans. Some participants expressed that Japanese Americans are unlikely to express *Taijin-Kyofusho* symptoms because Japanese Americans who were raised in the United States as Americans are unlikely to express *Taijin-Kyofusho* symptomatology that is a culturally-specific expression of distress. On the other hand, most participants agreed that *Taijin-Kyofusho* should be assessed in Japanese residents (even though only two respondents each reported one case of *taijin-kyofusho*). The findings are congruent with some of the previous research and consensus on *taijin-kyofusho* in the United States [6,30]. However, other research findings have indicated that *Taijin-Kyofusho* might not be as specific to Japanese culture as was previously thought [16,29,39]. Given the variability of responses, we suggest using the DSM-5 cultural formulation interview [14] protocol.

This interview allows clinicians to be more specific and nuanced in their understanding of a client's culture and its role in the client's mental health. Additionally, we need to consider the effects of current globalization which weakens existing boundaries across cultures, geographic locations, and expressions of psychological distress [13,40].

Some participants expressed concerns about prominent stigma against mental health disorders in Japanese residents and Japanese Americans. This point is consistent with previous findings that Asian immigrants and Asian Americans tend to be resistant toward mental health services, which causes a delay in seeking treatments from professionals [41-45].

## CONCLUSION

In particular, this study presented a new perspective about ethnic differences of mental health stigma in a minority community, which requires further investigation in a future study. An important addition to the DSM-5 was a cultural formulation interview protocol. This interview allows clinicians to be more specific and nuanced in their understanding of a client's culture and its role in the client's mental health. A few participants commented on the wording of one item (A-5) from a perspective of LGBTQ inclusion. This item asks about fear of approaching an opposite sex person to whom one is romantically attracted and needs to be reworded to allow for same-sex attractions. This intersectionality would be an important consideration in future work with the current measure.

## REFERENCES

1. Cooley MR, Boyce CA. An introduction to assessing anxiety in child and adolescent multiethnic populations: Challenges and opportunities for enhancing knowledge and practice. *J Clin Child Adolesc.* 2004;33(2):210-215.
2. Gee CB. Assessment of anxiety and depression in Asian American youth. *J Clin Child Adolesc.* 2004;33(2):269-271.
3. Lewis-Fernández R, Hinton DE, Laria AJ, Patterson EH, Hofmann SG, Craske MG, et al. Culture and the anxiety disorders: Recommendations for DSM-V. *Focus.* 2011;9(3):351-368.
4. Pina AA, Silverman WK. Clinical phenomenology, somatic symptoms, and distress in Hispanic/Latino and European American youths with anxiety disorders. *J Clin Child Adolesc.* 2004;33(2):227-236.
5. Varela RE, Vernberg EM, Sanchez-Sosa JJ, Riveros A, Mitchell M, Mashunkashey J. Anxiety reporting and culturally associated interpretation biases and cognitive schemas: A comparison of Mexican, Mexican American, and European American families. *J Clin Child Adolesc.* 2004;33(2):237-247.
6. Dinnel DL, Kleinknecht RA, Tanaka-Matsumi J. A cross-cultural comparison of social phobia symptoms. *J Psychopathol Behav.* 2002;24(2):75-84.
7. Heinrichs N, Rapee RM, Alden LA, Bögels S, Hofmann SG, Oh KJ, et al. Cultural differences in perceived social norms and social anxiety. *Behav Res Ther.* 2006;44(8):1187-1197.
8. Hofmann SG, Heinrichs N, Moscovitch DA. The nature and expression of social phobia: Toward a new classification. *Clin Psychol Rev* 2004;24(7):769-797.
9. Lau AS, Fung J, Wang SW, Kang SM. Explaining elevated social anxiety among Asian Americans: Emotional attunement and a

- cultural double bind. *Cultur Divers Ethnic Minor Psychol.* 2009;15(1):77.
10. Okazaki S. Influences of culture on Asian Americans' sexuality. *J Sex Res.* 2002;39(1):34-41.
  11. Okazaki S, Liu JF, Longworth SL, Minn JY. Asian American-White American differences in expressions of social anxiety: A replication and extension. *Cultur Divers Ethnic Minor Psychol.* 2002;8(3):234.
  12. Rapee RM, Spence SH. The etiology of social phobia: Empirical evidence and an initial model. *Clin Psychol Rev.* 2004;24(7):737-767.
  13. Ventriglio A, Ayonrinde O, Bhugra D. Relevance of culture - bound syndromes in the 21st century. *Psychiat Clin Neuros.* 2016;70(1):3-6.
  14. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders.* 5th ed. Washington, DC: APA. 2013.
  15. Becker M, Vignoles VL, Owe E, Brown R, Smith PB, Easterbrook M, et al. Culture and the distinctiveness motive: Constructing identity in individualistic and collectivistic contexts. *J Pers Soc Psychol.* 2012;102(4):833-835.
  16. Hofmann SG, Anu Asnaani MA, Hinton DE. Cultural aspects in social anxiety and social anxiety disorder. *Depress Anxiety.* 2010;27(12):1117-1127.
  17. Hong JJ, Woody SR. Cultural mediators of self-reported social anxiety. *Behav Res Ther.* 2007;45(8):1779-1789.
  18. Moscovitch DA, Hofmann SG, Litz BT. The impact of self-construals on social anxiety: A gender-specific interaction. *Pers Individ Dif.* 2005;38(3):659-672.
  19. Schreier SS, Heinrichs N, Alden L, Rapee RM, Hofmann SG, Chen J, et al. Social anxiety and social norms in individualistic and collectivistic countries. *Depress Anxiety.* 2010;27(12):1128-34.
  20. Fang K, Friedlander M, Pieterse AL. Contributions of acculturation, enculturation, discrimination, and personality traits to social anxiety among Chinese immigrants: A context-specific assessment. *Cultur Divers Ethnic Minor Psychol.* 2016;22(1):58.
  21. Okazaki S, Okazaki M, Sue S. *Clinical Personality Assessment with Asian.* Oxford handbook of personality assessment. 2009:377.
  22. Kim BS, Yang PH, Atkinson DR, Wolfe MM, Hong S. Cultural value similarities and differences among Asian American ethnic groups. *Cultur Divers Ethnic Minor Psychol.* 2001;7(4):343.
  23. Clauss-Ehlers CS, Chiriboga DA, Hunter SJ, Roysircar G, Tummala-Narra P. *APA Multicultural Guidelines executive summary: Ecological approach to context, identity, and intersectionality.* *Am Psychol.* 2019;74(2):232.
  24. Hofmann SG, Hinton DE. Cross-cultural aspects of anxiety disorders. *Curr Psychiatry Rep.* 2014;16(6):450.
  25. Tarumi S, Ichimiya A, Yamada S, Umesue M, Kuroki T. Taijin Kyofusho in university students: Patterns of fear and predispositions to the offensive variant. *Transcult Psychiatry.* 2004;41(4):533-46.
  26. Sharpless B. *Unusual and rare psychological disorders: A handbook for clinical practice and research.* New York: Oxford University Press. 2017.
  27. Maeda F, Nathan JH. Understanding Taijin Kyofusho through its treatment, Morita therapy. *J Psychosom Res.* 1999;46(6):525-30.
  28. Kitanishi K, Nakamura K, Miyake Y, Hashimoto K, Kubota M. Diagnostic consideration of Morita shinkeishitsu and DSM - III - R. *Psychiat Clin Neuros.* 2002;56(6):603-608.
  29. Nakamura K, Kitanishi K, Miyake Y, Hashimoto K, Kubota M. The neurotic versus delusional subtype of Taijin - Kyofu - Sho: Their DSM diagnoses. *Psychiat Clin Neuros.* 2002;56(6):595-601.
  30. Ono Y, Yoshimura K, Yamauchi K, Asai M, Young J, Fujuhara S, et al. Taijin Kyofusho in a Japanese community population. *Transcult Psychiatry.* 2001;38(4):506-514.
  31. Essau CA, Sasagawa S, Chen J, Sakano Y. Taijin kyofusho and social phobia symptoms in young adults in England and in Japan. *J Cross Cult Psychol.* 2012;43(2):219-232.
  32. Asakura S. *Diagnosis and clinical evaluation of social anxiety disorder.* *Fuanshokenkyu,* 2015;7(1):4-17.
  33. Nakagami Y, Ii T, Russ TC, Marques JG, Riese F, Sönmez E, et al. Taijin kyofusho: A culture - bound diagnosis discussed by Japanese and international early career psychiatrists. *Psychiat Clin Neuros.* 2017;71(2):146.
  34. Nagata T, Van Vliet I, Yamada H, Kataoka K, Iketani T, Kiriike N. An open trial of paroxetine for the "offensive subtype" of taijin kyofusho and social anxiety disorder. *Depress Anxiety.* 2006;23(3):168-174.
  35. Heimberg RG, Hofmann SG, Liebowitz MR, Schneier FR, Smits JA, Stein MB, et al. Social anxiety disorder in DSM - 5. *Depress Anxiety.* 2014;31(6):472-9.
  36. Iwata Y, Suzuki K, Takei N, Touloupoulou T, Tsuchiya KJ, Matsumoto K, et al. Jiko-shisen-kyofu (fear of one's own glance), but not Taijin-Kyofusho (fear of interpersonal relations), is an east Asian culture-related specific syndrome. *Aust Nz J Psychiat.* 2011;45(2):148-52.
  37. Suzuki K, Takei N, Kawai M, Minabe Y, Mori N. Is Taijin-Kyofusho a culture-bound syndrome?. *Am J Psychiatry.* 2003;160(7):1358.
  38. Brook CA, Schmidt LA. Social anxiety disorder: A review of environmental risk factors. *Neuropsych Dis Treat.* 2008;4(1):123-143
  39. Clarvit SR, Schneier FR, Liebowitz MR. The offensive subtype of Taijin-Kyofu-Sho in New York City: The phenomenology and treatment of a social anxiety disorder. *J Clin Psychiat.* 1996.
  40. Kato TA, Kanba S. Boundless syndromes in modern society: An interconnected world producing novel psychopathology in the 21st century *Psychiat Clin Neuros.* 2016;70(1):1-2.
  41. Abe-Kim J, Takeuchi DT, Hong S, Zane N, Sue S, Spencer MS, et al. Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American study. *Am J Public Health.* 2007;97(1):91-8.
  42. Lin KM, Cheung F. Mental health issues for Asian Americans. *Psychiatr Serv.* 1999;50(6):774-80.
  43. Sue D, Sue S. Cultural factors in the clinical assessment of Asian Americans. *J Consult Clin Psych.* 1987;55(4):479.
  44. Leong FT, Ebreo AE, Kinoshita LE, Inman AG, Yang LH, Fu ME. *Handbook of Asian American Psychology.* Sage Publications, Inc; 2007.
  45. Yeung A, Chang D, Gresham Jr RL, Nierenberg AA, Fava M. Illness beliefs of depressed Chinese American patients in primary care. *J Nerv Ment Dis.* 2004;192(4):324-327.