

# Anthropophobia: An Old and Typical Japanese Neurosis, its Conceptual Transition and Clinical Disappearance

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## 1. What is anthropophobia in Japan in contrast with social phobia?

Anthropophobia has been described as a peculiar neurosis in Japan and regarded as a clinical state that occurs frequently during puberty and adolescence. In addition, in the 1960' s and 1970' s, many researchers pointed out that the style of Japanese interpersonal relationships was well-reflected by this clinical state (Tanaka, 1992).

We can generally define anthropophobia as a form of neurosis, where one backs away from interpersonal relationships as much as possible, because such patients have unreasonably high levels of anxiety and mental strain in their interpersonal situations, and they worry about being looked down upon by others, causing discomfort to others and being disliked by others. Based upon the variety of their main symptoms, anthropophobia also has several sub-categories, i.e., *erythrophobia*, *scopophobia* (including both a fear of their own gaze and of other' s gaze), *dysmorphophobia*, and *autodysmophobia*.

In the 1990' s, the commonalities and differences between anthropophobia and social phobia became the focus of attention. Essentially, the basic concept of social phobia implies anxiety and fear that occur under specific interpersonal situations. The fear is not of human beings or crowds, but rather of being looked or being evaluated by others. From this description, it might be considered that social phobia, or Social Anxiety Disorder, is

not the same clinical entity as anthropophobia, but is a more narrowly defined disorder than anthropophobia in Japan.

In this manner, we can clarify the points of difference between these two *Phobias* as follows: 1) Social phobia is a diagnosis that is limited to patients who mainly have a fear of acting in front of people, or a fear of general social situations. On the other hand, since it includes every fear of social or interpersonal situations, anthropophobia is a broader concept than social phobia, which also covers so-called delusional ideation in *autodysomophobia*, i.e., “My bad smell annoys other people.” 2) Social phobic fear tends to occur in front of people in general, but other conditions are not necessarily specified, whereas anthropophobic fear is evoked when the patients are among people who have some sort of relationship with them or with whom they need to have an ongoing relationship. 3) Many Japanese researchers have described their structural and psychological conflict, “weak versus strong,” *they want to be strong as a person but actually they are not so, or they do not have to be so strong, or adequately weak, as a person to not be outstanding in their group and community*, which is in common with the above-mentioned varied symptoms of anthropophobia. 4) In anthropophobic patients, their intense narcissistic tendency is more remarkable than in social phobic patients, especially in its generalized type. In this type, their phobic situation includes most social situations, for which we should also consider the additional diagnosis of Avoidant Personality Disorder in DSM-IV and -5.

## **2. Negative self-consciousness in anthropophobia**

As described above, anthropophobia was, or became, not only a neurosis but also a broader clinical entity, partly including a so-called psychotic delusional state, seen particularly in the sub-categories of *dysmorphophobia* and *autodysomophobia*.

Coupled with this feature, after a discussion of the commonalities and differences between anthropophobia and social phobia in the 1990' s, anthropophobia was gradually absorbed in discussions of borderline cases or schizophrenia; it is less often discussed as a clinical entity. Conceptually speaking, anthropophobia has vanished from our sight.

Of course, this tendency has occurred due to the popularization of Social Anxiety Disorder (Social Phobia) in Japan. However, as noted above, these two phobias have only

the *superficial* features in common, but are quite different in their basic psychological structure. Also based upon my clinical experience, it is difficult for us clinicians to elucidate the so-called neurotic structure, or conflict, as seen in anthropophobia, in patients with Social Anxiety Disorder (Social Phobia). Certainly, they cannot help withdrawing from social situations, but in many cases they do not have as much psychological conflict as those with anthropophobia; “weak versus strong,” as I said before. In other words, *they actually do not want to be strong as a person or to be outstanding in their group and community*, unlike anthropophobic patients.

Among the above-mentioned investigations of anthropophobia in Japan, the investigation by Ogawa *et al.* should be noted as an empirical and quantitative approach to studying “consciousness of interpersonal anxiety” among these patients. Ogawa (1974) first clarified “consciousness of interpersonal anxiety” based on the actual “worries” of patients with anthropophobia and then designed the “Interpersonal Anxiety Questionnaire.” However, as there were problems with the number of items and their placement, Hayashi *et al.* (1981) revised it and developed the “Interpersonal Relationship Questionnaire.” It was “negative self-consciousness” upon which they attempted to focus as the quintessence of anthropophobic mentality in a series of investigations.

In 1994, as a student of Prof. Ogawa, I published an article, “Longitudinal changes of characteristics and structure of anthropophobic tendency in adolescence” (Tanaka, 1994), with my colleagues. In it, the university students’ data from the “Interpersonal Relationship Questionnaire” collected in 1981 and 1991 were compared quantitatively using multivariate analytical methods, and I obtained the following interesting results; in the data from 1991, 1) “consciousness of interpersonal anxiety” itself was quantitatively very much reduced, 2) their worry <*feeling strain in interpersonal relationships*> was no longer extracted as an independent factor, although it was extracted as the first factor that formed “consciousness of interpersonal anxiety” in the data of 1981, 3) instead, their worries <*being unable to fit in with a group*> and <*concerns about others*> were extracted as the first and the second factors, respectively.

Based on these findings, it is obvious that among university students the “consciousness of interpersonal anxiety” exhibited remarkable quantitative and

structural changes over the course of one decade (between 1981 and 1991). How can we interpret these changes?

First, it should be pointed out that what composes the major portion of “consciousness of interpersonal anxiety” is no longer “strain” that one feels *inside*, but rather a consciousness toward the *outside*, such as “group” or “others,” has appeared. The major items consisting of their worry <*being unable to fit in with a group*> are as follows: “being unable to fit into a group” and “not being good at getting along in a group.” In contrast, the major items consisting of their worry <*concerns about others*> are: “concerns about how others regard me” and “concerns about how colleagues in the workplace, classmates, and neighbors regard me.” From these findings, it is presumed that the subjects tend to have a “biased view” that is related to other peoples’ perception of themselves, rather than to their own “self.” Furthermore, it could be said that many university students have difficulty in taking part in gatherings or groups due to this “biased view.”

In addition, the worry <*being regarded as a strange person*> was not extracted as an independent factor in 1991, although it was extracted as the twelfth factor in 1981. This factor showed such a degree of anxiety that “one single-mindedly wants to conceal his or her own pathology and thus worries over whether or not his or her *timid* attitude will be known to his or her friends or acquaintances.” When Ogawa developed the “Interpersonal Anxiety Questionnaire” (1974), this factor was considered as “a particular worry of patients with anthropophobia from its contents.” In other words, we could imagine that, although this factor expressed the essence of their worries, based on the “negative self-consciousness,” such “self-consciousness,” or psychological structure, could no longer be formed *naturally*, as of 1991.

### 3. Psychology and self-consciousness

As seen above, the appearance of “others” or “anyone else” among the worries of patients with anthropophobia, based on the “negative self-consciousness” , is neither objective nor real at all, but simply “others locked in their subjectivity.” Also in this sense, we can say that the problem of “self-consciousness” always intervenes in their worries.

In its dawn, namely, in the second half of the nineteenth century, psychology adopted self-observation or introspection as its main methodology. This well reflects that psychology was originally a discipline of self-consciousness, or self-relation, moreover of the soul as such. In other words, “self-consciousness” was both the subject and methodology of psychology.

This is well expressed in the development of psychotherapy throughout the twentieth century, also known as “the century of psychology.” Freudian psychoanalysis first paid attention to the psychical mechanism of “repression” in patients with conversion hysteria as the main *object* of its treatment. Freud had the idea that hysteric patients should *repress* their own negative emotions that they could not accept by themselves. This was mainly related to the problems of self-relation in neurotics. The same could be said for the various “defense mechanisms” that the school of ego-psychology developed conceptually thereafter.

Moreover, as is observed more clearly in the concepts of “transference” and “archetype,” analytical psychotherapy always deals with “the others as self” or “self as the others.” In that sense, we can say that *simple* “others” do not exist in therapeutic psychology, i.e., psychoanalysis or analytical psychology.

In this context, the prominent feature of what is called “modern consciousness” is that it is consciousness reflecting on itself, or being “self-conscious.” It cannot avoid creating a *dissociation* between the reflecting self and the reflected self without interruption (Tanaka, 2008). It is, therefore, not a coincidence that psychology was born in the second half of the nineteenth century, and this is clearly shown in the fact that the classical methodology of psychology was self-observation or introspection, as noted above. The dissociative nature of the modern consciousness acutely needed psychology for studies of such self-relation.

Concerning this simultaneity, or oneness, of becoming conscious and being planted dissociation, Jung mentioned in his paper “The Meaning of Psychology for Modern Man” (1933), “When man became conscious, the germ of the sickness of dissociation was planted in his soul, for conscious at once the highest good and the greatest evil” (*CW* 10, par. 291).

This is the reason why anthropophobia as a type of neurosis had its own psychological structure, based on its psychic peculiarity of “negative self-consciousness.” However, it is now rather difficult for us to see patients with this kind of psychological structure in our practice. As will be seen later, anthropophobia has already disappeared clinically, also.

#### 4. Loss of psychological infra-structure in post-modern times

Today, more than twenty years have already passed since 1991, at which time, as I noted before, anthropophobic “self-consciousness,” or psychological structure, itself could no longer be formed naturally.

Of course, many patients come to us to deal with their worries regarding interpersonal relationships, but it is relatively rare that they complain about so-called “interpersonal strain.” Their chief complaint has become more *concrete*, like a problem in their extremely “narrow” interpersonal relationship, as Keiko Iwamiya, a Japanese clinical psychologist who specialized in psychology of puberty and school counseling, described (Iwamiya, 2009): “How can I be accepted in my class? What kind of position, or role, should I take therein?” “How can I manage to fit in with this or that group of classmates?” Among their concretized complaints, it is difficult for us to see their abstract or psychological themes, i.e., “the others locked in their subjectivity” and “self-consciousness” . In other words, “others” and “groups” were always *not specified but general*, namely, abstract and psychological.

I will present another example. Today, there are many *Bocchi*-s who do not fit in with any peer-groups at Japanese universities. *Bocchi* is an abbreviated form of “*Hitori-bocchi*” in Japanese that means “all on one’ s own.” *Bocchi* students *act by themselves* at universities (in many cases, students act as a group); quickly and separately moving throughout their university campus, sitting in the front row of the lecture halls, all on their own, having lunch alone, and not having conversations with any other students. You might associate only with their loneliness or sadness from these descriptions, but in actuality, it seems to



Fig. 1 Special seats for *Bocchi*-s (*Bocchi-seki*)

me, they have already obtained so-called *citizenship* at Japanese universities or culture. As Chihiro Hatanaka, one of my colleagues at Kyoto University, pointed out, there are special seats for *Bocchi-s* (*Bocchi-seki*) in student cafeterias, and they have a kind of “meal code” for themselves, i.e., they should not eat alone at McDonald’s, but rather should buy a *Bento* (Japanese lunch box) at a convenience store and then take it to eat at a nearby park (Hatanaka, 2013).

Of course, *Bocchi-s* have problems with interpersonal relationships, but among them we cannot imagine the intervention of “the others as self” or “self as the others” which is the premise of therapeutic psychology, as noted above. In contrast with anthropophobic patients, the others, or the others’ gaze, for *Bocchi-s* are always concrete and objective, but not at all abstract or subjective; the others for them are never locked in their subjectivity. Therefore, the screens in *Bocchi-seki* function substantially as a boundary from the others and as a shield from the others’ gaze.

As I mentioned before, “self-consciousness” was both the subject and methodology of psychology in modern times; psychology developed as a discipline of such modern consciousness always reflecting on itself. In that sense, we can also say that this “self-consciousness” was the sole “psychological infra-structure” upon which our “psychology” was exclusively based, and that anthropophobic patients still maintained this “self-consciousness” as their “psychological infra-structure”; although it was one-sidedly in negative form, i.e., “negative self-consciousness.”

However, as indicated by their complaints in the school counseling office and their problems in interpersonal relationships that was expressed in *Bocchi* as a cultural phenomenon, among today’s Japanese students during puberty and adolescence, whose mentality used to be regarded as closely connected to anthropophobic tendency, we can no longer find any *trace* of such psychological infra-structure. *They have no psychology* in its former sense any longer.

In this manner, I have the impression that this psychological “base structure,” or infra-structure has already been lost in post-modern times.

##### **5. How do we see, or experience, the loss of psychological infra-structure in our practice?**

To help your understanding of what “psychological infrastructure” means, I will first

present one sandplay and one dream from two patients with anthropophobia whom I saw for psychotherapy in the first half of the 1990' s.

Boy F. was a male high school student who came to see me, complaining about interpersonal strain. Since he could not speak well during sessions, he brought a short report in each session to summarize what he wanted to say; he made me read these reports loudly in every session.

Figure 2 shows his first sandplay expression.

A sheet was spread over the sand as if it would prevent the force from the realm of “under.” In addition, the surrounding area was enclosed by bushes, as if to protect the realm of “inside.” On the boundary, a “grave” and a “shrine” were set, which likely *symbolized* his fear and yearning for the realm of “outside.”

In this manner, we can easily imagine that there is a “base structure” that is shown by this patient’ s expression, which allows us psychotherapists able to read psychological “meaning.” Here we call it “psychological infrastructure.”

Another case, Ms. G, was in her early twenties when she came to see me with her chief complaint of “extreme interpersonal strain.” She soon started to report some dreams in her psychotherapy. The following dream was reported in the second session, as one of her initial dreams.

*Dream: I had an appointment for a date with a man. Our meeting point was in a sewer tunnel (underground passage inside a manhole). I felt uneasy because dirty water was flowing around my feet and was dripping from above. My partner stood leaning against a wall. I spoke a few words with him. Suddenly, he started to speak in language used by women, and before I knew it, his breasts became bigger. I asked her, “Who are you?” She answered, “I am his sister. My brother could not come because of his illness, I came here in his place.”*

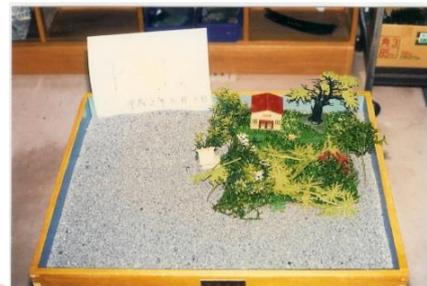


Fig. 2 Sandplay by Boy F.



Fig. 3 Grave and shrine on boundary

Her associations for this dream were as follows; the sewer tunnel was cold and dirty, vague and dark. I felt, “Why am I here in this place!” The sewer tunnel has often appeared in my dream. I have never been exposed to the sun. I feel it is unpleasant, but I think that it is appropriate for me. No place more beautiful than a sewer tunnel would be suitable for me. The man in the dream was my acquaintance and was the same age as me. He was, not unique, just an ordinary person. The person had his face, but when I noticed it, his appearance changed. Until then, I was happy, but then felt disappointed. I asked “who are you?” strongly, meaning *it's awful*. In dreams, I can frankly say what I want to say. I stamped my feet in frustration as if I were a child, or in anger. I had anticipated his transformation. Because I am a pessimist, I generally think the worst. This dream was the most impressive compared with the other dreams in the session.

In this manner, any *meaningful* association comes from the patient, which is characteristic of image equipping “psychological infrastructure.” As Jung pointed out, “The division into two was necessary in order to bring the ‘one’ world of the state of potentiality into reality. Reality consists of a multiplicity of things. But one is not a number; *the first number is two, and with it multiplicity and reality begins*” (CW14, par. 659; my italics), the emergence of “two” is essential to psychological differentiation and development. This “two” has already been established in her dream; <above (light) / under (dark)>, <beautiful / dirty>, <uncommon / ordinary>, <joy / disappointment> etc. These divisions and differentiation happen *within* her “anticipation.” In this context, we can say that she lives in the world after the emergence of “two,” in other words, in the world where the “two” forms its *inside*.

By contrast, we psychotherapists in Japan have many opportunities to realize the loss of “psychological infra-structure” in our daily practice. However, in the 1990s, in addition to Boy F. and Ms. G., mentioned above, I also met Ms. H. whose sand play had such a unique image that we psychotherapists were unable to read its psychological “meaning.” In other words, there was no “psychological infrastructure,” as will be shown below.

Ms. H. was in her late thirties, and came to see me saying that she wanted to undergo sandplay therapy, after having undergone four years of treatment with a psychoanalytical-oriented psychotherapist. Her chief complaint was “my interpersonal

relationships are not good. I cannot understand myself.”

In her sandplay sessions, she stood in front of the shelf lined with items and placed whatever attracted her attention each time into the tray. Figures 4 and 5 show her sandplay expressions half a year, and a year and a half after our psychotherapy was started.

This course of action in sandplay was important for Ms. H. to make her “subject” stand up *in every moment* (even if slightly) during the psychotherapy, despite the fact that she was extremely lacking in initiative and subjectivity. On the other hand, it was obvious that as her therapist I experienced difficulty in reading the *meaning* and the *development* of her sandplay. At that time, I had no idea of the concept of “adult pervasive developmental disorder,” therefore I did not see through her state as such. Today, looking back on this case, I think that she was in the category of adult PDD patients.

At the end, I would like to describe one more dream. This dream was reported by a man in his late thirties, who had a tendency towards PDD, when the psychotherapy was initiated.

*Dream: I urinate in the toilet. My urine does not stop and is very yellow. From the toilet bowl, something mixes with the water and the urine pours out. At first, I try to avoid it, but the volume becomes bigger. The water gradually pools, and it becomes a square puddle and finally becomes bigger and bigger, like a pool. My daughter starts to swim in it. I also swim, but say that we should stop swimming because it is dirty. Both of us get out of the pool, but my daughter seems to want to swim some more.*

This dream suggests that the “psychological infrastructure” has not been built.

Endless urination and the sewage disposal system cannot help this. Furthermore, from the toilet bowl, “something mixes with the water and urine pours out,” eventually it



Fig. 4 Sandplay 1 by Ms. H.



Fig. 5 Sandplay 2 by Ms. H.

becomes “*like* a pool.” His daughter started to swim in this “pool that is not a pool” . At first, the dreamer also swims in this pool, but finally says; “we should stop swimming because it is dirty,” and both of them get out of the pool.

Today, we psychotherapists need to be involved with these patients. It is difficult for them to establish a “vessel” inside them, and they live in a world where “oneself” extends endlessly and expands without clear “separation” between “oneself” and “urine,” or between “oneself” and “daughter.” In this context, it is necessary for us to stop dreaming of the “good old days” of psychotherapists that are symbolized in sandplay or dream of anthropophobic patients, as presented herein. We should begin with the fact at hand; the loss of “psychological infrastructure.”

## 6. Conclusion

Analytical psychology, which was also born in the modern age, is based on the premise or “base structure” of self-relationship, i.e., “psychological infrastructure,” in its therapeutic practice. However, this premise has already been broken down. Thus, through our own clinical experiences of psychotherapy for patients whose sandplay and dreams have no “psychological infrastructure,” like adult PDD patients (Tanaka, 2013), we need to learn that even our sense of “oneself,” or construction of our “self-consciousness,” may vary in the tide of the times. Furthermore, it might be inevitable that we psychotherapists must open ourselves to such a *new* modality of “oneself” (otherwise, it might be too *old* for us to fit in), insofar as we want to be *clinical* in its truest sense.

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