

## BRIEF REPORTS/RAPPORTS SOMMAIRES

### **A Case of Severe Test Anxiety Treated in Morita Therapy: Acceptance of Anxiety and Not Fighting It**

F. Ishu Ishiyama  
*University of Victoria*

#### *Introduction*

Morita therapy (Morita, 1929), developed by Shoma Morita in the 1910's, tries to help clients change their unproductive mood-based life style into an action-based one. It discourages clients' attempts to manipulate their subjective discomfort while encouraging them to redirect attention to practical activities and more objective observations. In Morita therapy, anxiety experience is viewed as part of the living process so long as one lives. Emotion is considered as a subjectively valid experience that goes through changes in quality and quantity. If left unaggravated and unmanipulated, anxiety reaches its peak and subsides eventually. If one proceeds to constructive action, a positive feeling as a by-product of a meaningful activity often replaces the previous emotion.

Active acceptance, one of the fundamental therapeutic factors in Morita therapy, means the recognition and constructive integration of aspects of human nature and the living process without denial. Another factor, the desire for life, is regarded as a self-preserving and self-actualizing motivational force that coexists with the fear of death and social failure. By recognizing the desire for life while accepting fears of death, illness, the unknown, and social rejection and failure, one comes to an experiential understanding that one can still make intelligent and responsible choice of action in spite of a mood one is in.

Then, the Morita therapist's task is to guide clients to the recognition and acceptance of the bilateral nature of human experience (Ishiyama, 1982) and to help them actualize their desire for life concretely within a meaningful social context. Thus, it is not the goal of the therapy to eliminate anxiety and discomfort entirely from their lives. Paradoxically, therapeutic progress and reduction of anxiety are experienced when clients simply accept the nature of emotion without manipulation and proceed to get involved in practical activities. Although the therapeutic approach in a hospital setting has been widely discussed (e.g., Kondo, 1953; Kora & Ohara, 1973; Miura & Usa, 1970; Reynolds, 1976), only a limited number of cases (e.g., of a Japanese client by Usa & Usa, 1958; and of North American clients by Ishiyama, 1982) have been reported in English. The present case was briefly mentioned in the discussion of Morita counselling model by the author elsewhere (Ishiyama, 1982).

#### *Case History, Treatment, and Outcome*

The client was a 40-year old divorced woman who had been back to school for two years and required two more years to finish her university degree. She visited the author for consultation on her test anxiety during the first week of the group processes course she was taking from the author. She had a history of blanking out and walking out on an exam. Her panicky reactions to exams included memory blockage, heightened emotionality and sensitivity, loss of appetite and sleep, stomach cramps, headaches, bodily tension. After each exam she became so exhausted that she had to sleep for hours. She experienced anxiety from the time the exam was first mentioned in class. This anxiety peaked in the night before, and lasted until the following day. She had received help from the university counselling

### *Test Anxiety Case Study*

services such as study skills and exam-writing sessions, and a stress clinic to learn relaxation skills. She had also received both behavioural and family counselling. Such help was minimally effective in helping her to "conquer the fears" according to her brief written description of the problem submitted to the author prior to the session. She had no knowledge of Morita therapy.

The author, as therapist, approached the client with empathic responses during the initial stage of the session reflecting her emotional turmoil, summarizing and reflecting situational factors and cognitive patterns. The therapist-client rapport was high. Confrontation was used to help her recognize some underlying cognitive and behavioural patterns. According to the client's self-report, she usually engaged in self-talk such as "I won't be able to remember all the necessary information and I'll blow the exam." At the onset of her anxiety reactions she often tried to calm herself with autosuggestion and relaxation techniques in the vain hope of eliminating anxiety. As she tried to deny the experience by saying, "I shouldn't be anxious and nervous like this over these foolish fears," the anxiety reactions worsened and the client blamed herself for the lack of self-control.

The therapist asked the client if she could think of any studious college friend who would remain totally unaffected by exams. She said no. After sharing his similar test anxiety experience, the therapist pointed out that anxiety is a normal and acceptable experience. He offered a reinterpretation of anxiety using the concept of the desire for life: "Where there is a desire, there is an anxiety about not fulfilling it. The intensity of your anxiety is an indication of the strength of your desire for a meaningful academic accomplishment. Which would you choose, exhausting your energy trying to conquer anxiety or getting your work done in spite of it?". She agreed to the latter.

At the end of the 30-minute session, the client was given the following instructions to be practiced to the best of her ability: (1) to accept fears and feelings as they came while studying and to abandon any attempts to change them; (2) to acknowledge simply that anxiety was there and to continue studying while experiencing it; and (3) to notice the fine details of her anxiety reactions and acknowledge each as if studying a natural object if she could not get her mind off the anxiety. The client sent a note to the therapist

a few hours after the session saying, "So much of my fear is tied up with my whole evaluation of myself. For the first time I have felt that I am not stupid to feel this way." A few days later she went through minor surgery for the removal of a fibroid lump from her breast. She reported afterwards that she had practiced active acceptance of anxiety and nervousness as instructed, and that to her surprise her typical reactions to medical treatments (such as tearfulness and trembling) had not occurred while waiting for this operation.

One week after the session the client had to take an English exam. A brief follow-up session was held a few days after the exam and the client reported her experience. Due to the distraction by the surgery, her anxiety reactions did not start until the day before the exam. As a panicky feeling started bothering her she said to herself, "Yes, I'm afraid of this exam and I accept it. *And* I must read this page and be productive, too." She proceeded to study, and anxiety did not disturb her work. When a 90-minute delay of the exam was announced in the classroom the next day, she felt very anxious and practiced objective observation of her nervousness. Then for the first time she recognized that other students were nervous and anxious also.

As soon as the exam started, the client became so immersed in writing that she completely forgot her anxiety. For the first time she sat through and wrote a satisfactory exam. In addition to this success, she was also surprised that she did not feel exhausted afterwards. She felt energetic and her mind was clear. Instead of sleeping, she went straight to doing house chores and spent the afternoon productively. No relapse was reported in the follow-up interviews six months and one year later. The woman reported that she had been successful in managing anxiety and being productive by applying "active acceptance" to many exam situations as well as to various aspects of life including interpersonal confrontation that she had much avoided in the past.

### *Discussion*

The treatment was successful in more than helping the client write an exam without being paralyzed by test anxiety. A few by-products (i.e., successful coping with anxiety about the surgery, the post-exam exhaustion and interpersonal confrontation) seem to support the generalizability of certain Morita therapy

principles. The fact that the therapist was the client's course instructor seems to have had a minimal effect on the outcome since the treatment took place during the first week of the course and the case was never discussed outside the session.

The instructions used in this treatment were similar to those used by Usa and Usa (1958) in two respects, i.e., the nonrejection of anxiety and the objective observation of the target symptoms. Obviously, the client's willingness to follow the three instructions to the best of her ability was the essential factor in the successful outcome. Reattribution of the cause of anxiety to the desire of life instead of personal weakness was indicated in her comment on the note she sent after the treatment session. This is similar to the modification technique for erroneous causal attribution discussed by Valins and Nesbitt (1971). The treatment, in this sense, gave her a new cognitive set of a gestalt in viewing her anxiety experience positively. Resultantly, she experienced an emotional relief from self-blame. A shift in the client's attention from subjective self-evaluation to objective observation is clearly indicated in her noticing others' anxiety for the first time. The change from emotional self-preoccupation to preoccupation with writing the exam seems to coincide with Sarason's (1975) model of self-preoccupation. From the client's unsolicited reports, the basic goal of changing her mood-based behavioural pattern to the practical action-

based life style seems inferentially attained. No control was exercised on client selection, therapist variables or treatment conditions. A more systematic approach including the use of a control group will be necessary to study the efficacy of Morita therapy in comparison with other therapies.

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