

Entry

Schema Therapy in Collectivist Societies: Understanding Japanese Narcissism, Armor Mode, and the Demanding Community Mode

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Definition

Japanese narcissism refers to a culturally embedded form of narcissistic personality that emerges within collectivist societies, particularly in Japan, where self-worth is maintained through emotional over-adaptation, perfectionism, self-sacrifice, and conformity to internalized moral obligations. Within the framework of Schema Therapy, this construct is characterized by dominant coping modes, such as Armor mode and Demanding Community mode, that suppress vulnerable emotional states and promote socially sanctioned compliance. Although narcissistic personality disorder (NPD) has been extensively studied in individualistic Western cultures, its manifestation in collectivist cultures remains underexplored. Japanese narcissism offers a culturally contextualized model that integrates psychoanalytic and Schema Therapy perspectives to explain thin-skinned narcissistic vulnerability, disguised as adaptive functioning. Clinical observations and case analyses indicate that patients often develop Armor mode (fusing Detached Protector and Perfectionistic Overcontroller functions) and Demanding Community mode (internalizing collective moral expectations). These adaptive-appearing modes mask core maladaptive schemas—Emotional Deprivation, Defectiveness/Shame, Enmeshment, and Self-Sacrifice—while being mistaken for mature or healthy functioning. Historically, such patterns have been reinforced by moral-collectivist ideals, exemplified by the Imperial Rescript on Education, which valorized loyalty, endurance, and self-denial. Japanese narcissism may therefore represent a culturally specific clinical configuration, suggesting the need for contextually adapted Schema Therapy interventions that recognize both the harmony-preserving and narcissism-reinforcing functions of adaptive behavior. This framework contributes to the cross-cultural extension of Schema Therapy by theorizing how narcissistic structures manifest in collectivist societies, and highlights the need for empirical validation of culturally sensitive treatment protocols.



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1. History

Schema Therapy, developed by Young in the 1990s, represents a significant advancement in treating narcissistic personality disorder (NPD), particularly through its integration of cognitive-behavioral therapy, attachment theory, and object relations approaches [1,2]. It provides a coherent model for understanding how culturally reinforced coping patterns—such as emotional over-adaptation and self-sacrifice—are formed and maintained.

However, most theoretical frameworks and treatment protocols in Schema Therapy have been developed within Western individualistic societies, limiting their relevance for collectivist cultures where narcissistic presentations may take fundamentally different forms. This gap is especially evident in the scarcity of cross-cultural formulations that address communal norms, emotional restraint, and conformity-based self-worth. The present entry addresses this gap by introducing “Japanese narcissism”—a culturally specific variant of narcissistic personality structure that has been overlooked in existing Schema Therapy literature. Unlike the overt grandiosity typically associated with Western NPD presentations, Japanese narcissism manifests through culturally sanctioned self-sacrifice and emotional over-adaptation behaviors that appear prosocial yet paradoxically serve grandiose and perfectionistic needs.

Clinical observations of Japanese clients with narcissistic personality traits have identified two culturally salient coping modes:

- (1) The Demanding Community mode [3], which reflects the internalized pressure to meet the implicit and unspoken expectations of one’s social group; and
- (2) The Armor mode [4], which fuses characteristics of the Detached Protector and Perfectionistic Over-controller.

In such cases, the Healthy Adult mode often remains underdeveloped or merged with these coping modes, resulting in diminished functional differentiation and limited emotional flexibility. In collectivist societies, self-assertion is rarely considered a virtue; instead, behavior is evaluated according to its alignment with the collective mood or atmosphere [5]. Even outstanding individual contributions may be criticized if they appear to disturb group harmony. This creates an implicit moral code, widely internalized but seldom articulated, dictating that one should restrain personal desires and contribute quietly to the group. From a psychoanalytic perspective, the development of the ego ideal in childhood is shaped by community norms and collective values [5,6]. In capitalist societies, ego ideals may be organized around success and wealth, fostering narcissistic traits when identification with such ideals becomes excessive. Analogously, in collectivist societies like Japan, over-identification with communal norms—such as emotional suppression and avoidance of self-assertion—can result in a culturally specific form of narcissistic personality organization, here termed Japanese narcissism [5,6].

Although defined within the Japanese context, similar dynamics may also emerge in other collectivist or communitarian cultures where implicit communal expectations override explicit individual rights.

The following sections review key psychoanalytic and psychiatric concepts that anticipated or parallel the structure of Japanese narcissism.

1.1. Cross-Cultural Perspectives on Narcissism

Cross-cultural research has increasingly challenged the assumption that narcissism is primarily a Western phenomenon rooted in individualism. In a large-scale study across five world regions, Fatfouta et al. [7] found that individuals from collectivistic cultures (Asia and Africa) reported higher levels of leadership/authority and grandiose exhibitionism facets compared to those from individualistic cultures (USA, Europe, Australia/Oceania). This counterintuitive finding suggests that narcissistic traits may manifest differently across cultural contexts rather than simply varying in prevalence.

Further supporting cultural variation in narcissistic presentations, Leckelt et al. [8] demonstrated that vulnerable narcissism—characterized by hypersensitivity, withdrawal, and anxiety rather than overt grandiosity—was significantly more prevalent in Japan than in Germany and was strongly associated with interdependent self-construal. This suggests

that collectivistic societies may foster distinct forms of narcissistic vulnerability that differ structurally from Western presentations centered on grandiose self-enhancement.

Parallel culture-specific constructs have been identified in other East Asian contexts. In Korea, the emotion *jeong-han* shares features with narcissism and depression, involving deep-seated resentment from chronically unmet relational needs within hierarchical social structures [9]. In China, Cai et al. [10] documented that despite rapid modernization and increasing individualistic values, narcissism among youth showed complex nonlinear patterns, suggesting that the relationship between cultural change and narcissistic traits is more nuanced than previously theorized.

These findings establish that narcissistic pathology requires culturally informed frameworks that account for how communal values, emotional restraint norms, and relational obligations shape personality development. The Japanese-specific conceptualizations discussed below must be understood within this broader context of cultural variation.

1.1.1. Japanese-Specific Conceptualizations

Within this broader cross-cultural context, Japanese scholars have developed indigenous concepts that illuminate culturally specific manifestations of narcissistic vulnerability, particularly those related to self-sacrifice, emotional restraint, and group conformity.

Masochistic Caretaker

Japanese psychoanalyst Kitayama introduced the term *masochistic caretaker* to describe individuals who prioritized the care of others to the point of self-harm [11]. This behavioral pattern reflects a double structure: it serves as a strategy of social adaptation for the individual; conversely, it is culturally reinforced by a society that praises self-sacrificing behavior, which leads to encouraging individuals to adopt and internalize it.

Kitayama traced this pattern to figures in Japanese myth and literature, notably the maternal deity Izanami and the protagonist of the play *Yuzuru* (The Twilight Crane). Izanami, after giving birth to many deities with the paternal god Izanagi, ultimately dies while delivering the fire god. In *Yuzuru*, a crane saved by a man transforms into a human woman and becomes his wife, who secretly weaves expensive cloth by plucking feathers from her own body. These figures, while primarily framed as female, represent a psychological structure not limited to women. Individuals of any gender may exhibit this tendency and become incapable of caring for themselves even when possible or necessary, while compulsively attending to others' needs. Kitayama identified a masochistic and self-destructive dimension.

Developmentally, two main factors contribute to the formation of this caretaker mode. First, the mother figure is often either physically or psychologically unavailable, either due to physical illness or emotional fragility (the mother's narcissistic tendencies), which leaves the child without stable dependency. In such cases, the child internalizes a habitual inhibition of their own aggressive or spontaneous impulses and preemptively restrains them out of fear of rejection. Second, the paternal function is typically weak or absent. No third party mediates or adjudicates the tension that arises from mother and child conflicts. Consequently, these conflicts are repeatedly resolved through the child's internalization of guilt, which can lead to a pattern in which the child assumes responsibility and suppresses their own needs. This dynamic also increases the likelihood that the mother's expectations of the child will align closely with those of the community in the future. When the community directs excessive demands toward the child, the mother may merge with the community and jointly impose these excessive demands, rather than shielding the child from such pressure.

Melancholic Personality Type

German psychiatrist Tellenbach proposed the melancholic personality type, or *Typus Melancholicus*, as a premorbid personality structure associated with endogenous depression [12]. In Japan, this concept gained significant influence before operational diagnostic systems became dominant. During this period, the concept of a characteristic personality preceding depression played an important role in psychiatric practice. Melancholic personality, marked by meticulousness, a strong sense of duty, and concern for others, was considered as a predisposition to “true” biological depression, which merited medical protection and intervention.

Tellenbach identified two main structural components of this personality type: *Inkludenz* and *Remanenz*. *Inkludenz* refers to a close emotional attachment to one’s immediate environment and social relationships, such that any behavior deviating from others’ expectations provokes intense guilt. *Remanenz* involves a persistent self-perception of inferiority or insufficiency, accompanied by an internalized imperative toward constant self-improvement. These dual pressures form a psychological structure in which the individual is caught between a fear of disappointing others and a relentless sense of personal inadequacy.

Scholars have argued that the melancholic personality type emerged in societies, such as Germany and Japan, that modernized relatively late compared with Western Europe, and did so under intense internal pressure, although they still retained strong premodern cultural structures [5,6]. Such individuals often achieve remarkable accomplishments in professional settings owing to their dedication and discipline. However, their identity can be overwhelmed by over-identification with social roles. They may undergo a deep existential crisis when faced with situations in which no clear behavioral norms from their professional code of conduct are available.

Tellenbach critically noted that such individuals lacked what he called a “duty to affirm the self” and displayed an unusual tendency to relinquish moral judgment to others: “They delegate the standard of justice to others in a strangely unquestioning way”.

In his analysis, Hori drew on the Kleinian psychoanalytic theory to describe the developmental background of this personality structure [5,6]. A key feature is the extended fusion between the mother and child during early development [13,14], partly due to a weak or absent paternal function. Consequently, the child’s identification with the mother is preserved for an unusually long time and gradually slides into identification with successive social groups: first the family, followed by the school, workplace, and nation. In this progression, ethical values tend to lack legalistic or logical form and are instead based on imitation and emotional resonance with those nearby. Within such a structure, individuals are socially evaluated based on how they internalize and conform to the group’s expectations of their role.

Oral Narcissism and Amai

Doi, a key figure in the first generation of Japanese psychoanalysts, introduced the concept of *amae* in his seminal work “The Anatomy of Dependence” [15]. Based on clinical experience with Japanese patients, Doi argued that a deep fixation on oral stage dynamics, particularly the mother–child relationship, persisted well into adulthood in Japanese personality structures. This enduring attachment was not viewed as pathological within Japanese cultural norms; rather, it was a foundational mode of interpersonal behavior. Doi’s work highlighted how this oral narcissism functioned as a culturally sanctioned emotional pattern, one that in contrast with Western ideals of autonomy and individuation.

1.2. Psychoanalytic Foundations for Understanding Japanese Narcissism

This section discusses psychoanalytic models that illuminate the inner conflict between dependence and autonomy, which forms the structural base for narcissism in collectivist contexts.

Psychoanalytic theory provides essential conceptual tools for understanding Japanese narcissism within collectivist cultural contexts. Several key theoretical concepts establish its foundation and offer insights into the structural and developmental aspects that markedly differ from those in Western individualistic models.

1.2.1. Kleinian Foundations: Internal Objects and Manic Defense

Klein's theory of internal objects, internalized representations of early caregiving relationships that become active psychological structures, offers fundamental insights into narcissistic structures and their formation [13,14]. It has striking parallels with Schema Therapy's mode concept. Both frameworks recognize that early relational experiences become internalized as distinct psychological entities that can be activated in response to environmental triggers.

Kleinian theory posits that narcissism emerges from the deployment of manic defenses designed to avoid the psychic pain associated with the depressive position. These defenses operate through assertions of omnipotence and systematic devaluation of objects, which allow the individual to maintain an illusion of self-sufficiency and avoid the recognition of dependency and vulnerability. Manic defense serves as regression and active resistance to psychic integration and acknowledgment of loss.

1.2.2. Identity Diffusion and Structural Fusion

Kernberg's concept of identity diffusion describes the fundamental failure to integrate self- and object-representations in narcissistic pathology [16]. This structural vulnerability involves a persistent reliance on primitive defenses, such as splitting, idealization, and devaluation, which prevent the development of an integrated self-concept. Kernberg's model emphasizes the role of internalized aggression and the absence of affective differentiation in maintaining these fragmented internal structures.

In collectivist contexts, this identity diffusion manifests as a fusion of different psychological functions, which creates pseudo-integrated structures that appear functional but lack authentic flexibility. This becomes particularly problematic when cultural expectations reinforce defensive patterns otherwise recognized as pathological.

1.2.3. Vertical Splitting and Parallel Self-States

Kohut's notion of vertical splitting explains how incompatible self-representations can exist without integration or conscious conflict [17]. Unlike horizontal repression, which pushes unacceptable content out of one's consciousness, vertical splitting allows contradictory self-states to coexist simultaneously. This enables individuals to maintain fundamentally incompatible self-images without experiencing the normally resulting anxiety from such contradiction.

Kohut's developmental perspective emphasizes the self's need for self-objects, others who provide essential mirroring, idealization, and twinship functions [17]. Compensatory grandiose structures develop to maintain psychological coherence when these needs are frustrated or inadequately met.

1.2.4. Destructive Narcissism and Learning Resistance

Rosenfeld's concept of destructive narcissism describes configurations in which the ego allies with an idealized false self, and systematically directs aggression toward the

life-giving parts of one's psyche that seek genuine connection and growth [18,19]. This destructive dynamic systematically undermines authentic emotional development and maintains an illusion of omnipotent control.

Bion's concept of $-K$ (minus K) represents active resistance to knowledge, understanding, and emotional truth that threaten the false self [20,21]. This goes beyond simple ignorance or denial; it constitutes an active attack on one's capacity for learning and emotional growth. This function destroys the links between thoughts, feelings, and experiences that may lead to insight or change.

1.2.5. Thin-Skinned vs. Thick-Skinned Narcissism

Gabbard's clinical distinction differentiates between two primary narcissistic presentations: thin-skinned, who are hypersensitive to criticism and prone to shame and withdrawal, and thick-skinned, who appear invulnerable and grandiose but are often interpersonally exploitative and emotionally disengaged [22]. This typology is essential for understanding how narcissistic pathology manifests differently across cultural contexts and individual temperaments.

These theoretical foundations provide the conceptual framework for understanding how narcissistic structures manifest within Japanese collectivist culture. Furthermore, they set the stage for examining specific expression through culturally embedded defensive patterns and relational dynamics.

1.3. Schema Therapy Approaches to Narcissistic Personality Disorder

This section integrates these perspectives into the Schema Therapy framework, explaining why it offers a particularly suitable model for understanding Japanese narcissism.

Schema Therapy, developed by Young in the 1990s, is an integrative psychotherapy model designed to treat complex and chronic psychological disorders, particularly personality disorders resistant to standard cognitive-behavioral interventions [1,2]. Schema Therapy offers a structured yet emotionally attuned framework based on cognitive-behavioral therapy (CBT), the attachment and object relations theories, and Gestalt techniques. Notably, it focuses on the developmental origins of maladaptive schemas and therapeutic relationship, especially through limited reparenting.

Early Maladaptive Schemas (EMSs), a core concept of Schema Therapy, refer to broad, pervasive themes or patterns composed of memories, emotions, cognitions, and bodily sensations formed during childhood or adolescence and elaborated throughout life. These are often rooted in unmet emotional needs, such as secure attachment, autonomy, or realistic limits. In response, individuals develop schema modes, moment-to-moment emotional-cognitive states that include Vulnerable Child, Dysfunctional Coping modes (e.g., Detached Protector, Compliant Surrender), and the Healthy Adult.

Schema Therapy's approach to NPD is particularly relevant as it complements psychoanalytic theories by offering a concrete clinical method for working with narcissistic structures previously theorized in abstract terms. The final chapter of *Schema Therapy: A Practitioner's Guide* [1] outlines a prototypical profile of patients with narcissistic pathology who have often "never truly loved or been loved," which results in deeply ingrained patterns of disconnection and overcompensation. Three schema modes were most frequently observed in such patients: Lonely Child, Self-Aggrandizer, and Detached Self-Soother. These modes are not arbitrary; they represent compensatory and avoidant responses to deep-seated EMSs, most notably Emotional Deprivation and Defectiveness/Shame, often accompanied by Entitlement/Grandiosity as schema overcompensation.

Patients with narcissistic traits often have a developmental history that includes an emotionally misattuned caregiving environment. The primary caregiver, usually the

mother, may have paid attention but failed to provide sufficient affective attunement, physical affection, or empathy to the child. Hence, the child is not loved for who they are but rather idealized and controlled as an extension of the caregiver's own unmet needs. The other parent, often the father, tends to be emotionally unavailable, passive, distant, critical, or even abusive.

Consequently, the individual fails to develop a stable and integrated sense of self. The Lonely Child mode emerges from unmet attachment needs and persists beneath the surface of grandiose or self-soothing behaviors. The Self-Aggrandizer compensates for profound feelings of worthlessness by excessively striving for admiration and superiority, while the Detached Self-Soother numbs emotional pain through work, substances, or fantasy.

Therapy aims to cultivate the Healthy Adult mode, which can reparent the Lonely Child and modulate the dysregulated coping modes. This requires the therapist to remain empathically attuned while setting firm limits, a technique known as empathic confrontation. When patients with a narcissistic personality exhibit hostility, contempt, or rage toward the therapist, a common occurrence, these responses are addressed directly yet compassionately to promote insight without reinforcing shame or defensiveness.

Importantly, therapy aims to enable the patient to build authentic, reciprocal relationships, rather than eliminate narcissistic traits. This involves helping them tolerate vulnerability, recognize their needs without overcompensation, and engaging with others without resorting to maladaptive modes.

In contrast to traditional psychoanalytic approaches that often rely on interpretive neutrality, Schema Therapy encourages active, emotionally engaged interventions. While it does not dispense with structural insights—its entire model presupposes deep internal structures akin to psychoanalysis—it translates them into engageable, practical, observable frameworks.

The clinical framework of Schema Therapy thus provides both conceptual precision and emotional accessibility for working with narcissistic structures. However, its standard formulations were largely developed in Western individualistic contexts, where autonomy, assertiveness, and explicit boundary-setting are viewed as hallmarks of psychological health.

In collectivist cultures such as Japan, these same therapeutic principles may evoke different meanings and emotional responses. Patients may value self-restraint, harmony, and relational duty over self-assertion, leading to unique manifestations of narcissistic vulnerability.

Therefore, the next section situates Japanese narcissism within its historical and moral context, illustrating how culturally embedded coping modes—Armor and Demanding Community—mediate between individual schemas and collective expectations.

1.4. Cultural Challenges in Applying Schema Therapy to Collectivist Contexts

Recent qualitative research has documented substantial challenges in applying Schema Therapy to Asian collectivist contexts. Mao et al. [23] conducted interviews with schema therapists in Hong Kong and Singapore, identifying three primary cultural tensions: (1) incongruence between therapeutic expectations of emotional expression and cultural norms favoring emotional restraint; (2) the question of whether schemas and modes deemed “maladaptive” in Western contexts may serve adaptive functions in collectivist societies; and (3) conflicts arising when therapeutic techniques requiring confrontation of Parent/Critic Modes clash with deeply held values of filial piety and respect for authority.

Crucially, therapists reported that guilt-inducing Critic modes are activated more frequently in collectivist cultures when clients attempt to challenge parental expectations. The Parent/Critic mode is experienced not merely as an internalized voice but as a revered

figure whose authority must not be questioned [23]. This parallels the Demanding Community mode identified in Japanese clinical practice, suggesting a common structural feature across collectivist societies.

Hwang [24] proposed a comprehensive Psychotherapy Adaptation and Modification Framework specifically for Asian populations, emphasizing that effective cultural adaptation requires modifications to both therapeutic content (addressing culturally specific concerns such as family conflict and social marginalization) and process (incorporating culturally syntonetic intervention strategies). This framework acknowledges that what appears as “resistance” in therapy may actually reflect valid cultural commitments that therapists must respect while still facilitating psychological growth.

These findings underscore that culturally adapted Schema Therapy must navigate the tension between therapeutic goals of emotional authenticity and autonomy on one hand, and cultural imperatives of relational harmony and collective obligation on the other. The framework of Japanese narcissism proposed in this paper addresses these challenges by theorizing how collectivist modes—particularly Armor and Demanding Community—emerge and function within specific cultural contexts, and how therapeutic interventions can be adapted accordingly.

1.5. The Proposed Culturally Contextualized Understanding of Narcissistic Pathology and Schema Modes

While the core emotional needs and basic structure of NPD are generally considered universal, schema modes, especially Punitive Parent modes and culturally embedded coping responses, are significantly shaped by sociocultural environment.

One such construct is the Imperial Rescript on Education (Kyōiku Chokugo) [25], issued in 1890 during Japan’s early modernization period and officially rescinded in 1948 after World War II. It articulated a moral code that included: “Be filial to your parents, harmonious with your siblings, affectionate with your spouse and children, faithful to friends, modest in behavior, and benevolent to others.” At first glance, these values appear benign or even virtuous. However, as political theorist Fujita argued, these moral demands were based on direct interpersonal obligations and affective expectations within concrete relationships, rather than philosophical or theological abstractions [5,26]. Thus, ethical subjects were expected to constantly cultivate moral behavior in a socially immersive, emotionally fused context.

The Rescript culminated in the command: “Should emergency arise, offer yourselves courageously to the state, and thus guard and maintain the prosperity of Our Imperial Throne coeval with heaven and earth.” This call for self-sacrifice, without differentiation between public duty and private agency, can be the moral prototype for what this paper conceptualizes as the Demanding Community Mode [3]. Unlike in some Western contexts, where punitive parent modes may be experienced as internalized individual figures (e.g., parents, teachers), in Japan, they often merge with broader communal entities, such as school, workplace, or even the state itself, which blurs the boundary between personal and collective superego structures.

Although Japan has adopted further democratic and individualistic educational frameworks since the post-war era, the ideology embedded in the Rescript remains subtly operative in schools, workplaces, and political discourse. Therefore, examining the cultural construction of schema modes in Japan, particularly how punitive and demanding modes are socially reinforced, offers new theoretical grounds for Schema Therapy in collectivist societies.

This paper proposes a culturally contextualized understanding of narcissistic pathology and schema modes. It contributes to Schema Therapy by highlighting how collective

moral ideologies shape the internal architecture of coping and self-evaluation, and how interventions should address these embedded cultural structures.

2. Applications

This paper presents the clinical applications of Schema Therapy based on the framework of “Japanese narcissism” [5,6]. The following three cases illustrate how culturally embedded coping modes—particularly Armor mode and Demanding Community mode—manifest in clinical practice and influence therapeutic processes.

Case 1 involved a man in his 30s working at a bank. This was a fictionalized composite constructed for illustrative purposes, based on the author’s clinical experience and theoretical reflections. It does not describe a real individual; rather, it integrates features commonly observed in patients with similar personality structures and cultural dynamics. This case was selected as it effectively depicted the interaction between self-sacrificial conformity and covert narcissistic vulnerability, which caricatured the structural features of Japanese narcissism. No identifiable patient data were included, and no ethical approval or consent was required.

Case 2 involved a man in his 40s, who worked for a local government at the time of treatment initiation [4,27].

Case 3 involved a woman in her 40s, who was employed in the private sector when treatment began [3].

Both presented with depressive symptoms and initially consulted the author’s psychiatric clinic in Fukushima Prefecture, which was established after the Great East Japan Earthquake and nuclear disaster in 2011. The author, a psychiatrist, served as both the prescribing physician (primarily antidepressants) and psychotherapist who conducted intensive psychotherapy due to treatment resistance.

Both real cases were diagnosed with disaster-related post-traumatic stress disorder (PTSD). During their treatment, Prolonged Exposure (PE) therapy [28] was used in combination with Schema Therapy. The author understood this integration as follows: core PTSD symptoms, such as flashbacks and nightmares, were physiological responses of the brain, and effectively addressed through targeted exposure-based techniques. However, in Case 2, developmental trauma from early childhood influenced the course of PTSD. Furthermore, pre-existing personality traits functioned as avoidance mechanisms toward trauma memories in Case 3, which necessitated the use of Schema Therapy.

Psychotherapy sessions were conducted weekly or biweekly. Case 2 and 3 received 60 and 36 sessions, respectively. The two real cases have been previously published in peer-reviewed journals, and full informed consent was obtained at the time of the original publication. This manuscript has appropriately cited the sources, and no new identifiable information has been added. Therefore, no additional consent was required. All identifying details were anonymized to ensure confidentiality in accordance with institutional and international ethical standards.

3. Cases

3.1. Case 1: Fictionalized Composite of a Banker in His Thirties

3.1.1. Presentation and Background

This case presented a fictionalized composite drawing of recurring clinical patterns observed across multiple clients treated by the authors. The patient was a man in his 30s who worked as a branch manager at a bank. Despite exceptional performance that led to a headquarters promotion, he developed emotional exhaustion and depressive symptoms.

His career exemplified traditional Japanese banking expectations within lifetime employment frameworks. Success came at the cost of constant vigilance toward reading the

organizational atmosphere and suppressing personal needs for collective goals. Initial pharmacotherapy provided temporary improvement; however, the patient's symptoms recurred repeatedly. He exhibited excessive role compliance, as an ideal "patient" clinically and a "model banker" professionally, yet lacked emotional integration.

3.1.2. Schema Mode Formulation

This case resembled that of Gabbard's thin-skinned narcissistic personality disorder [22]. The client's competent workplace presentation was supported by a coping mode disconnected from his Vulnerable Child mode, rather than by the Healthy Adult mode. When this failed to elicit validation, intense emotions were triggered and managed through self-sacrificial attachment to social roles.

This coping mode fused with a Demanding Inner Critic that enforced normative expectations. This Armor mode combined elements of Detached Protector (devaluing emotional needs) and Perfectionistic Over-controller (fulfilling implicit "Demanding Community mode" demands). Key schemas included Emotional Deprivation, Enmeshment/Undeveloped Self, Approval-Seeking, Unrelenting Standards, and Subjugation.

3.1.3. Treatment Approach

Treatment required Armor softening and recognition of the coping mode as externalized. Clients often viewed anger and aggression as shameful, and required careful work to access the Vulnerable Child mode while ensuring psychological safety. Through limited reparenting and empathic confrontation, the differentiated Healthy Adult mode emerged to nurture the Vulnerable Child.

3.2. Case 2: Municipal Government Employee with Complex Trauma [4,27]

3.2.1. Background and Trauma

A local government worker who experienced the 2011 Great East Japan Earthquake, witnessed the tsunami, and immediately joined relief efforts to retrieve corpses. He led evacuations, was verbally assaulted by citizens, and later performed distressing duties, which included livestock euthanasia. Although he initially displayed remarkable composure and commitment to communal duty, disaster-related media coverage reactivated intrusive memories and physiological hyperarousal three years later, leading to PTSD symptoms.

3.2.2. Treatment Course

Initial prolonged exposure therapy [28] was partially successful; however, his symptoms remained unstable. After pharmacological treatment proved insufficient following his father's death, Schema Therapy [1,2] was initiated to address deeper developmental and personality-based vulnerabilities.

The therapeutic focus shifted to childhood schemas of fear and submission toward a strict father, which interacted with collectivist demands for duty and self-restraint. Key schemas included Subjugation, Enmeshment, and Abandonment. Armor mode manifested as emotional numbing and excessive role fulfillment, making emotional access difficult.

Gradually, through imagery rescripting and limited reparenting, the client began to recognize that his sense of moral obligation to the community had also served as a defense against grief and helplessness. This re-integration reduced hypervigilance and enabled authentic mourning.

3.3. Case 3: Bereaved Mother with PTSD and Health Comorbidities [3]

3.3.1. Background and Trauma

The client, primarily raised by her grandparents despite material affluence, experienced emotional loneliness with her brother, who was prioritized as the male child. During

the 2011 earthquake, her husband was killed in the tsunami. She developed binge eating, diabetes, and hypertension, and assumed sole child-rearing responsibilities. Her coping pattern reflected a fusion of the Demanding Community mode and Perfectionistic Over-controller, expressed as unrelenting self-sacrifice and inhibition of anger.

3.3.2. Treatment and Outcomes

Eight years post-disaster, she was diagnosed with PTSD; although she initially chose pharmacological treatment over exposure therapy [28]. Her preference reflected both fear of re-experiencing trauma and a culturally reinforced belief that endurance and self-control were virtues.

Ten years later, Schema Therapy was used to address long-standing patterns of over-compliance with parental and community demands. Key schemas included Emotional Deprivation, Enmeshment, Self-sacrifice, and Subjugation. These modes formed a culturally sanctioned coping pattern—an expression of the Demanding Community mode—that appeared adaptive but served as a strategic avoidance of trauma, grief, and anger.

Only after schema-level restructuring could she safely engage in exposure therapy, which was then successfully completed.

Following this integrated treatment, she reported increased emotional differentiation and self-compassion, marking the emergence of the more autonomous Healthy Adult mode.

3.4. Cross-Case Analysis and Common Patterns

3.4.1. Shared Schema Patterns and Cultural Reinforcement

All three cases demonstrated prominent schemas of Self-sacrifice, Subjugation, Enmeshment/Undeveloped Self, and Approval-seeking, which were reminiscent of the “masochistic caretaker” [11] and “melancholic personality type” [12]. These psychological constructs function as internal structures and realistic strategies for securing belonging and evaluation within their respective communities.

Patients typically experienced numerous positive outcomes from receiving praise and recognition through these behaviors, which created significant therapeutic ambivalence. While they often sensed the problematic nature of these socially valued patterns, adaptive benefits within their cultural contexts made it difficult to recognize the negative aspects without therapeutic intervention. These dynamics underscore the necessity of culturally informed formulations that differentiate between socially reinforced adaptation and genuine self-development.

Developmental histories across cases revealed consistent patterns. Material needs were generally met, but emotional attachment was absent. Parents often demonstrated limited emotional awareness toward both their own and their children’s needs, which was strongly influenced by community expectations of emotional restraint. When children expressed emotions, parents frequently criticized these expressions as inappropriate, which was viewed as proper education in self-control. Experience with caregivers who prioritized emotional needs over community expectations was consistently absent, which contributed to Abandonment, Emotional Deprivation, Enmeshment/Undeveloped Self-schemas.

3.4.2. Armor Mode: Behavioral Defense and Over-Control

The Armor mode represents a defensive integration of the Detached Protector and Perfectionistic Over-controller modes [4]. It functions as a behavioral strategy of control and perfectionism that sustains social approval through diligence, restraint, and moral integrity. This adaptive façade allows individuals to meet collective expectations while concealing their unmet emotional needs.

Clinically, this mode often emerges in high-functioning professionals who equate moral performance with self-worth. Its apparent maturity and discipline make it easily mistaken for the Healthy Adult functioning by both clients and therapists. However, beneath this veneer lies profound emotional deprivation and fear of inadequacy.

This paradoxical self-aggrandizement through moral purity often sustains social recognition while concealing emotional deprivation. This culturally and morally grounded sense of superiority can also serve as a basis for rejecting, dismissing, or arguing against the therapist's guidance—moments in which the previously hidden grandiosity may become overtly observable. In such moments, patients could be interpreted as exhibiting activation of the latent Entitlement/Grandiosity schema, which temporarily dominates their cognitive-emotional state.

The deeper the adaptation, the more difficult it becomes for patients to access genuine emotional experience. When the Armor mode dominates, the therapeutic challenge is not only to soften excessive control but also to help the patient differentiate authentic self-regulation from culturally reinforced over-adaptation.

3.4.3. Demanding Community Mode: Communal Superego and Emotional Suppression

Complementing the Armor mode, the Demanding Community mode [3] reflects an internalized communal superego that governs emotional life through moralized shame. It originates from deeply ingrained cultural imperatives that prioritize harmony, loyalty, and self-restraint over individual expression.

In this mode, patients experience the collective moral voice as an inner authority that prohibits anger, desire, or sadness as morally inappropriate. When such feelings arise, they are accompanied by intense shame and guilt, leading to suppression rather than expression. What appears as emotional numbing is in fact an active inhibition sustained by fear of moral failure.

This dynamic severely limits access to the Vulnerable Child mode, as authentic emotional expression feels like a transgression against communal norms. It also undermines the development of healthy boundaries: patients often confuse consideration for others with self-sacrificial compliance. This confusion is particularly evident in collectivist societies, where individual needs are routinely subordinated to group harmony.

Therapeutically, it is essential to recognize this mode not as simple resistance but as a culturally sanctioned moral structure. Effective intervention involves externalizing the “voice of the community”, validating its moral intent, and gradually helping the patient reclaim emotional authenticity.

3.4.4. Cultural Value Conflicts and Identity Fragmentation

These patients demonstrated internal conflicts between aspirations toward individual autonomy, values associated with modern societies, and deeply ingrained expectations of collective loyalty and emotional restraint. This would manifest as intense resistance to therapeutic interventions that encourage individual autonomy or emotional authenticity.

This value conflict may create identity fragmentation where patients simultaneously aspire to have modern individual values and also remain embedded in traditional collective expectations. This fragmentation could be experienced by individuals navigating cultural transition in collectivist societies, particularly among those who have received education or are exposed to individualistic values while maintaining strong family and community ties.

This conflict often emerges as confusion regarding the therapeutic goals. Patients intellectually understand the value of emotional awareness and boundary setting while simultaneously experiencing these goals as selfish or inappropriate. The therapeutic process requires careful navigation of these competing value systems, rather than simply

advocating for individualistic approaches. Therapeutic neutrality must be reframed not as detachment, but as a culturally sensitive balance between empathy and differentiation.

3.4.5. Psychoanalytic Annotation on Schema Therapy Formulation

NPD in collectivist societies, such as Japan, typically does not exhibit the characteristics of Gabbard's thick-skinned type [22]; rather, individuals with NPD are thought to demonstrate features of the thin-skinned type. Externally, these individuals appear inhibited and over-adaptive. However, this modesty does not represent integrated ego functioning or the Healthy Adult mode. Rather, it reflects an over-identification with social roles characteristic of the melancholic personality type [12], essentially a coping mode in Schema Therapy terms [1,2]. Self-Aggrandizer mode may manifest in a pattern such as "I am so humble and self-sacrificially contributing to the community." In Kernberg's terms [16], identity remains diffused, and individuals experience discomfort while simultaneously identifying deeply with social roles.

Thin-skinned narcissists externally resemble Cluster C personality disorders, such as the dependent and avoidant types. Schema therapy suggests that identifying the patient's coping modes, bypassing them, and accessing genuine emotions and the Vulnerable Child mode are crucial for Cluster C disorders [2]. However, significant therapeutic difficulties emerge at this juncture when NPD pathology runs deep.

Patients with NPD cannot safely present their vulnerable aspects. They have repeatedly experienced neglect or criticism when exposing these parts. Therefore, as per Kohut's concept of vertical splitting [17], approaching this domain may provoke highly defensive reactions, including dissociation and dangerous acting-out behaviors. This occurs as other integrative psychological elements remain fragile when superficial defensive-coping modes fail, which leaves the patient's psyche vulnerable to disintegration. In collectivist contexts, this fragility is intensified by the absence of symbolic separation from parental and communal figures. The Healthy Adult exists not as an independent, autonomous agent, but remains fused with the punitive parent (community mode), coping modes, or sometimes the angry child mode.

Alternatively, patients remain perpetually enmeshed with their maternal caregivers and surrounding communities, and are driven relentlessly toward contributing to such imagoes [5,6,12,13]. Historical experiences of being constantly regarded as morally indebted result in Defectiveness/Shame schema. There is a paucity of Good Parent/Healthy Adult images that can advocate for the patient's Vulnerable Child mode and protest against excessive demands. Providing such images is a crucial element of Schema Therapy's limited reparenting and imaginary rescripting techniques.

When diffused individuals, whose multiple psychic elements cannot achieve independence and remain fused, lacking developed Healthy ego functioning/Adult modes, develop coping modes to endure their predicament, Kleinian's destructive aspects of NPD may emerge [13,14,16–19]. Envy toward therapists perceived as possessing Healthy ego functioning/Adult modes becomes activated; furthermore, the therapeutic approach itself becomes the target of the patient's unconscious destructive wishes (Bion's -K [20,21]). Therapists must anticipate such possibilities, particularly in early treatment phases, and carefully evaluate whether their intended interventions fall within the patient's window of tolerance before implementation.

3.4.6. Therapeutic Implications and Clinical Considerations

Treatment requires a careful assessment of whether the therapeutic environment adequately supports the temporary vulnerability that emerges when patients leave established Armor modes [4]. When the Healthy Adult mode is insufficiently developed, this

transition can result in marked vulnerability that could be destabilizing without proper therapeutic containment.

These observations converge to highlight several implications for culturally attuned Schema Therapy practice. Success is based on creating a protective therapeutic space and time while navigating tensions between an individual's therapeutic goals and their embedded collective expectations. This represents a fundamental challenge in treating this population: balancing the adaptive value of established coping modes with the therapeutic necessity of accessing further authentic emotional functioning.

The clinical approach requires particular sensitivity to patients' internal value conflicts and recognizing that resistance to individualistic therapeutic interventions often reflects deeper cultural loyalties rather than mere treatment resistance. Therapists should honor cultural values while still facilitating emotional growth and authenticity.

Limited reparenting techniques have been proven particularly valuable for patients who experienced emotional deprivation despite material adequacy. However, their effectiveness requires careful cultural adaptation, as patients often initially experience therapeutic warmth as inappropriate or manipulative due to their unfamiliarity with unconditional emotional support.

Furthermore, the timing of the interventions is crucial. Premature confrontation of Armor modes could damage therapeutic rapport or lead to treatment dropout. Conversely, insufficient challenge could result in intellectualized therapy without emotional change. Successful treatment requires what might be termed "empathic confrontation" [1,2], which is directly addressing maladaptive patterns while maintaining a deep understanding of their cultural origins and adaptive functions.

4. Conclusions and Prospects

This entry explored how narcissistic personality structures in collectivist societies, particularly Japan, manifested unique clinical and cultural features that challenged conventional formulations derived from individualistic contexts.

The cultural specificity of Japanese narcissism must be understood within the broader context of narcissistic variation across collectivist societies. While the specific historical influence of constructs such as the Imperial Rescript on Education is unique to Japan, similar dynamics have been observed in other East Asian contexts where hierarchical social structures and interdependent self-construal predominate [7–10]. The distinction between admiration-seeking and rivalry-based narcissism [29] may manifest differently in collectivist contexts, where self-enhancement often occurs through moral superiority and self-sacrificial contributions rather than overt grandiosity.

Moreover, the challenges identified in adapting Schema Therapy for Japanese clients align closely with those documented by therapists working in Hong Kong, Singapore, and with Asian American populations [23,24]. This suggests that the theoretical constructs proposed here—particularly the Armor and Demanding Community modes—may have broader applicability across collectivist cultures, though specific manifestations will vary according to local historical, religious, and social contexts.

The fusion of punitive parent and coping modes with underdeveloped Healthy Adult functions leads to heightened risks during schema confrontation, particularly when attempting to access the Vulnerable Child mode. Thus, clinical success depends not only on technical competence but also on a nuanced understanding of culturally embedded defenses and values.

Future Research Directions

This theoretical framework provides a foundation for future empirical studies in several key areas.

First, the development of culturally adapted assessment instruments is essential to operationalize the constructs of Japanese narcissism, particularly the Armor [4] and Demanding Community modes [3]. Instruments should be designed to detect the subtle manifestations of thin-skinned narcissistic presentations [22] often overlooked by existing Western-derived measures. Their validation requires rigorous psychometric evaluation and cross-cultural comparison to confirm cultural specificity, while maintaining theoretical coherence with the broader Schema Therapy model.

Second, the creation and validation of Japan-specific Schema Therapy protocols are crucial for clinical application. This will involve systematically adapting existing techniques to address the distinctive challenges posed by collectivist coping modes, especially the risks associated with prematurely confronting identity-diffused patients. Protocol development should emphasize culturally attuned approaches to limited reparenting and empathic confrontation that respect both the individual's therapeutic needs and their embedded cultural collective values.

Finally, comparative effectiveness research across collectivist cultures can establish broader applicability of this framework beyond Japan. Such studies may reveal parallel narcissistic presentations in societies with strong collective identities and internalized moral obligation. This comparative perspective could refine and extend Schema Therapy's theoretical architecture, offering a culturally pluralistic model of narcissistic pathology and its treatment worldwide.

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Abbreviations

The following abbreviations are used in this manuscript:

APA	American Psychiatric Association
CBT	Cognitive Behavioral Therapy
EMS	Early Maladaptive Schema
NPD	Narcissistic Personality Disorder
PE	Prolonged Exposure
PTSD	Post-Traumatic Stress Disorder

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