

Psychotherapy and Culture. Morita Therapy: An illustration

Suk Choo Chang

Abstract. *Morita Therapy (MT), or psychotherapy, is a healing approach developed by Morita Shoma in Japan at the turn of the 20th century. Effective for a wide range of neuroses and personality disorders where anxiety is dominant, it is based on the following rationales: (1) Human nature is part of Nature and both are rational, and therefore self-healing; (2) Today, more than ever, material and mental artifacts saturate the world and one's consciousness. These internalized artifacts (further elaborated by personal circumstances) pattern one's perceptions of life and the world and thus distort reality (including our self-healing nature). From the above derive the following therapeutic approaches: (i) Artifacts are identified and selectively culled so as to re-expose one to the pulsating rhythm of life; (ii) This involves a reversal of the mental process, from one which generates and sustains neuroses, to one that dissolves them. Such a reversal is possible only if the conflict is "befriended," i.e., accepted rather than denied. This requires acknowledging that the conflict is an inescapable consequence of the past. (iii) A sense of emptiness usually follows the dissolution of artifacts, followed by an upwelling of a sense of universal relatedness. To the artifacts filled consciousness all beings and phenomena are separate but to the emptied consciousness life is inexorably interrelated. Upon a realization of such conditioning of life can one begin to heal and free.*

Keywords: human nature, healing, anxiety, consciousness, Morita therapy.

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INTRODUCTION This essay describes a number of clinical vignettes illustrating the flavors of Morita Therapy (MT), cultural issues basic and relevant to the practice of psychotherapy including MT, and a suggested workings of the therapy. The vignettes are in this writer's excerption, translation and paraphrasing where needed to be more idiomatic, except for Kora's case, which is originally in English, 1965. My comments and explanations are reported in brackets.

FRAGMENTS OF CLINICAL VIGNETTES

a) Autobiographical note of Morita Shoma's struggle with his own emotional difficulties during his late adolescence

"When I came to Tokyo at age 18 [in 1892], I was afflicted with '*paralytic beri-beri*'. Soon after matriculation in the medical school I was diagnosed as having both *beri-beri* and *neurasthenia*, after which my life became inseparable from medications, and I had difficulties with my studies. Further, at one point my living expenses from home stopped inexplicably. I was frustrated, angry and desperate [the late 19th century *ethos* in Japan was such that there was little possibility for college students to self-support if the funding stops]. At the moment of desperation, I decided to 'go for broke'. I abandoned all the medications and regimens and

Correspondence to: Suk Choo Chang, MD, FAPA
Seattle, Washington

mailto: changsc@comcast.net

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plunged into studying day and night. Incredibly, all the symptoms of *beri-beri* and *neurasthenia* vanished. Today I often see patients with similar complaints” (Suzuki T, 1969).

His experience is considered by now a familiar psychological process observed in various life situations including creative (Hutchinson, 1949a; 1949b), developmental, psychotherapeutic, as well as Zen experiences (Suzuki DT, 1969; Chang, 1974; 2005).

b) An autobiographical vignette by Suzuki Tomonori

A well-known follower of Morita, Suzuki had suffered from *neurasthenia* for three years by age 17 (in 1927) and had tried various treatments without avail. His symptoms included insomnia, gastrointestinal symptoms, a fear of stuttering, and nocturnal emission. One day his father took him to Tokyo to see Dr Morita. The young patient was skeptical about being taken by his father because whenever they visited doctors his father always did all the talking often embarrassing the young patient listening in the room. On this visit, however, the doctor talked directly with the patient.

Despite his anticipatory fear of rejection he was accepted and admitted to what looked like a make-shift room adjacent to the doctor’s house. It was small, dank and dark. A spider net was hanging from the sooty ceiling. The misery of the room made him wonder if being placed in such a room was in itself some kind of test. During seven days on the *futon* he had little chance to see, let alone talk with, the doctor. It was understood that he would not have visitors from outside during the treatment. The only human contact was with another patient who brought food to Suzuki. During the bed rest he was told not to do anything unessential, that is, not to distract himself. For the first three or four days his mind aimlessly wandered. He spent much time looking at the spider web, the knothole on the ceiling, and the broken window glass. But for whatever reasons he felt at ease, less anxious and restless, and by the end of his admission all the symptoms were gone. He was overjoyed when discharged with a doctor’s autographed book (Suzuki T, 1969).

c) This writer’s own experience of MT

In Seoul, Korea, in mid-teens in early 1940s, I was experiencing severe depression with anxiety [a retrospective self-diagnosis] already for several months by then, which drove me to go to the home room teacher for permission for me to take a leave for a semester or a year. However, his pleading in such a sad expression swayed me into continuing the school but instead seeking a psychiatric help and I asked my father to find one.

I don’t remember how I got such an idea because the field of “psychiatry” was hardly known to most, I had no idea what it does, and my retrospective research years later (Chang & Kim, 1973) suggested that there were at most several psychiatrist for the population of over 1.1 million people in Seoul in early 1940s. There was no directory, yellow pages, and I never heard anyone ever mentioning “psychiatry”. It is possible, however, that I chanced a reference to it in an ad or article in daily newspaper, and my intuition told me that it might be what I needed — even though I didn’t know what is exactly my problem. In any case my father found one and a few days later I was taken to see him. By the end of the interview that may have lasted perhaps for half an hour he gave me a prescription not for medicine but for a book but no further appointment. On the way back home I bought the book. I still remember his office and him well--quiet, airy and calming room, and his humanity.

The book was in Japanese [remember Korea was a Japanese colony], titled, if I remember correctly, *Shinkeishtsu no rhyoho* [*Treatment of Neuroses*] by a Kora Takehisa, the name that meant little to me. It was an absorbing reading and I finished in a few sittings. The book had many quotations from the famous and the wise from the world over mostly from the past but also some from the present. The nature of the quotes was inspiring, affirming or exhorting. It also frequently referred to Zen literature of which I had neither knowledge nor interest but a vague sense of archaism and anachronism. The *ethos* of the time was such that there prevailed a sense

that what is Eastern is superstitious, archaic, anachronistic and hick, whereas what is Western is scientific, modern, sophisticated and hip.

How did the book help me? How deeply and durably? It is hard to delineate in a linear fashion having gone through the historical period with the unprecedented social, cultural, economic, political turmoil and consequent material and mental deprivation — the WW2, Korean liberation and an imposed division of the country followed by the Korean War (1950-1953) that razed the Korean peninsula from one end to the other repeatedly during which so many innocent perished. And, what was the effect of the book? It changed my personality from amorphous to more obsessive-compulsive one seeing the world in good and bad. More importantly I saw the light at the end of the long tunnel. It made me to believe one can change for better to the extent of one's effort. The choice of the doctor was wise one. He became the first chair of the psychiatric department and then the dean of the medical school of which by then I was a student after the Korean liberation in 1945. And I attended his lecture on psychiatry which was entirely organic and Kraepelinian. I don't remember him ever mentioning "psychotherapy" or "culture." It is interesting to note, in retrospect, that his lecture was wholly along an imported Western line whereas his therapeutic approach to neuroses was along the indigenous Eastern line. The two were yet to be integrated.

Since the Korean liberation there has been a great influx of American culture one of which was its modest library in Seoul from which I took out two types of books - American literature and psychology. The literary works were good way to know the language and culture. As to the psychology, the library seemed to carry disproportionately larger number of psychological works not a rat-in-maze but a man-in-society kind and mostly from Freudian perspective about which I had no idea about its place in a larger scheme of things. In any case I read them with a great interest because, in retrospect, it not only gave a systematic explanation of neuroses, but also in relation to culture and history. As a result, by the time I took up psychiatric training at a large and very analytically oriented psychiatric department at a New York hospital, I was a self-professed expert on psychoanalysis. However, my armchair psychoanalysis was yet to meet the reality. One's sense of a theory, especially about the individual and society, such as psychoanalytic, can change remarkably depending on the circumstances in which one is. One's sense is a variable of time and place.

There are a number of foundational concepts in psychoanalysis (PA) that are so basic to be taken for granted as self-evident. To me they were not so self-evident, however. Questioning was difficult because I could not formulate my feeling and sense and the *ethos* of the time said that anyone not seeing things in American way will do so only if he or she sees the light. And I was from a small country that was ravaged by the just concluded Korean War. However, I had to adjust the 'dissociation' between my sense and what was being taught. What are the basis and origin of my sensibility? And what are the rationales for the foundational concepts of PA? My travel began in search.

That was the time I met Dr. Kora Takehisa whose book I remember reading more than a decade earlier. I met him not in person but through his article on Morita therapy in English (Kora, 1965). It was like a meeting an old friend. I could read between his lines and felt I knew exactly what he meant so much so that I wrote an expository article based on his (Chang, 1974), which received a surprisingly warm reception. The reception told me there is a need for such work.

d) A contemporary case vignette by Shioji Rieko (Shioji, 2005)

A 19-years-old college male student, B, was admitted with disabling anxiety over "gaze" of his and other's who come into his visual field. He became anxious for fear if his gaze was making the other uncomfortable.

History A few relevant points out of scant information available suggest that his parents have been very much involved in the children's education, the patient and his seven years older brother. At one point in high school he had to take a leave from the high school possibly in

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rebellion against the parental pressure for his school performance. When he returned back to school he felt being stared at by his classmates and then the fear extended to other people in daily life. The problem became disabling enough, when he happened to read a book on MT and came for treatment.

After a number of initial interviews he was considered appropriate for inpatient treatment and was admitted. He was motivated, had a strong wish to be recognized and socialize beneath his fear and social withdrawal, and he was trapped in a vicious circle of *wanting to flee from and wanting to conquer* the anxiety. And his admission was agreed upon both by the therapist and the patient. The patient got a diagnosis of '*jiko shisen kyo-fu*,' literally a fear of one's own gaze, which we might give a Greek name, an '*autoscopie phobia*'. The therapist did not consider it a delusional psychosis but a form of obsessive compulsive disorder in which "the less he want to think about his gaze the more obsessed he becomes". And in the doctor's view the patient's personality had consonant traits: pride and wish for recognition behind his social sensitivity and withdrawal.

Hospital course An Absolute Bed Rest (ABR) was prescribed, and all unessential activities and communication proscribed. He was encouraged, however, to be with whatever thoughts, feeling and sensations that come to mind *without deliberate control* — neither avoiding nor pursuing. The second day was uneventful. On the third day he had an anxiety attack from which he could not flee but to accept, and at the same time he began to feel an increasing urge to get up, be out and talk to someone--anyone. A day before the end of the ABR he was anxious but also expectant.

Light work period After he got out of bed he was given light manual work, and observed how others are faring. And he began entering diary. On the third day, he was struck with such a fear that he may not be able to mingle with others so much so that he thought about leaving the hospital but decided to stay hoping that it could be the last hurdle he has to overcome. Following the decision, however, he became a little excited chattering, supercilious (hypomanic?) and even approached others for socialization. He also asked for an appointment with his doctor to tell that "It looks like I'm getting better," to which she responded, "Yes, you will experience not only ups but also downs. In either situation it will be best to engage with the life in steady manner".

Heavier work period During this period the patient learnt to do what is needed to be done despite anxiety. The advices given and being practiced by patients in this period include a plunging into the assigned or necessary work despite anticipatory anxiety.

Here are summarised Kitanishi's supervisory comments: The admission was appropriate for this patient because he had been disabled with severe social anxiety and fear, but was motivated. During the ABR, away from the social conflict and usual demands of daily life he is enabled to face his anxiety, and then experience an urge for social life welling up from within. And such learning experiences are further applied and consolidated during the subsequent period of light and heavy work and the regular social life period before the discharge.

Kitanishi reinforces the therapist's view of a need for patience, and plunging into the necessary work despite anticipatory anxiety and changing mood (Kitanishi & Nakamura, 2005).

e) A case from Kora Takehisa (Kora, 1965)

A 33-year-old man was admitted after suffering from severe social anxiety for several years by then and the condition was reaching the point where it became difficult even to talk with his own family members. He also had severe insomnia, headache, and other somatic complaints. And after a little over a month of the inpatient treatment he was discharged much improved. The following is excerpts from his diary with the doctor's feedback on the margin of the diary page, quoted in parenthesis.

Day 1: Having traveled to Tokyo from Sado Island (Northwest coast) for 17 hours he was sent to bed after brief preliminaries, even though he doesn't feel tired. Rather, he feels relieved, having come, he thinks, to where he can get help.

Day 2 : He is anxious and feels frustrated and wonders if he made a wrong choice to come here. (Kora's comments: "it is good sign that you feel anxious and frustrated because it means you are engaged with your neurosis").

Day 7: Overjoyed to be told that he can get up tomorrow; but fleeting doubts go through his mind.

Day 8-10: He feels refreshed in the morning although he had a restless night and fleeting anxiety but decide to trust everything to the doctor.

Day 14: Tired but did the work. During the day he had a conversation with a carpenter but to his surprise he was not anxious.

Day 17: Ventured into the bustling downtown Tokyo for the first time and had anxiety attacks. He was anxious, he later reflects, because he wanted to be like others, that is, he was trying to be someone other than himself.

Day 26: He completes a number of woodworks, and is encouraged to do more useful work if he can find such. He feels he can do "any work."

Day 28: A former patient of the Clinic came and gave a talk. It is hard to believe that he was only recently discharged. He said he thought he would be so happy when he get discharged improved but when he was actually discharged he didn't feel unusually happy but simply felt that the thing is just as it should be (He is becoming more natural). In the evening K and other patients together with the doctor's family went to a temple festival. When he was told they are going by streetcar he became anxious and wondered if there is any other way of getting there. But once on the streetcar it no longer bothered him. He was surprised that he could pay attention to whatever he saw through the car windows. He was so perceptive and noticed things he would not have noticed before. [He has become less self-centered and preoccupied but is able to pay attention to the world outside].

The patient reflects upon his past at this point: "...the picture of me beside myself, gripped with uncertainty, seems decades away now. I will take my children to festivals after I got back home. I am sure even my children, young as they are, notice the change in me. Until now, I refused to take my children out when they asked me, giving all sorts of pretexts as reasons....I look like a fool to myself now.Walking from the streetcar stop to the hospital, I thought about what I would do when I go home. I'm sure both my wife and children will really be surprised at my miraculous recovery." (The time will come when you will realize that all you are experiencing now is something that is only natural).

Day 31: "It was stormy last night and the rain came into the room through a hole...Plugging the hole with a towel, I sat down to read a book written by the doctor and to bed by midnight. About 3 a.m. I was awakened by the doctor's making night rounds. Meantime the wind direction has changed and the rain water is now coming through a crack on the window facing the west. Since I did not want the *tatami* [straw mat] to be wet I lifted it up and kept on mopping up the incoming rainwater. By 5:30 AM the rain stopped and I was tired and went to bed until about an hour and half later when the bell rang announcing breakfast."

Day 32: "I was exhausted but went out to the yard when the doctor called. What a mess the storm made. There was more work to be done that I can ever do but without thinking further I got to work." By the time he finished the work it was 1 PM, although he thought it about 11 AM. In the evening there was a group meeting in which the doctor said the amount of work you have done is tremendous...this proves a person can work quite freely by adapting himself to changing environment.

Day 35: This is his last day and he did much work in the morning. After breakfast his doctor gave him advice how to lead his life after the discharge, but before he leaves he wanted to finish the cabinet he was making. Before he could finish the cabinet, however, the doctor

took him to a dinner at a Shinjuku restaurant. And he reflects: “Come to think of it, I really had the courage to mingle with the crowd in the hustle and bustle of Shinjuku in my shabby clothes... And at the restaurant I was treated to a splendid dinner. The many guests in the restaurants did not bother me. They appeared to me as just that many guests and nothing more. Had it been a month ago, I would have run out of the restaurant. But today I experienced no embarrassment... During the dinner, the doctor spoke on different subjects but I could remember everything. I felt so relaxed that it seemed as if I was at home with my family... If I were to be asked to write an impression of what happened tonight I would write that I felt as if the world has changed completely during the past month. It is as if ‘a mulberry plantation has changed into a deep blue sea’”. “Now I cannot recall very well how I was when I was still sick, but I recalled the condition in detail during my conversation with the doctor at dinner tonight... Now I feel as if my whole heart is a void, entirely empty. Although I hate to say it, I must confess that I feel something is lacking in me. I feel as if I have chopped off a part of my mind and left it somewhere.”

CULTURE AND PSYCHOTHERAPY The principle of healing is universal but practical approach to healing is necessarily local and temporal in rationale and methods. And understanding the nature of the rationale and method will lead us closer to the principle. It has been shown, for instance, a raising of the patient’s “morale” to be a common therapeutic denominator among a number of different schools of psychotherapy in America (Frank & Frank, 1993; de Figueiredo, 2007).

Reviewing a long history of Chinese approach to healing including shamanism (which is believed to have risen in the Eurasian heartland and spread into south and east and into the Americas), divination, fortune-telling, *feng-sui* (geomancy), *qi-gong* (a “meditation” analog), and through the period of unprecedented socio-political turmoil during the past century, Tseng *et al* (2005) find certain recurrent themes characterizing the Chinese pattern, a belief in *balance and harmony* as the source of health and imbalance and disharmony as the source of sickness. As China enters into the 21st century with an improving livelihood and stabilizing society there has been a sharply rising interest in psychotherapy including Morita therapy, which is ironical to realize psychotherapeutic approaches being supplanted by biological ones in America. In this crosscultural context one of the relevant questions involves the prevailing view that Chinese people tend to “somatize.” This, they suggest, is an iatrogenic myth: First, as noted already, interest in psychotherapy has been sharply rising as livelihood improves and society stabilizes. Second, more importantly, Chinese culture and mentality, especially on educated level, is fundamentally introspective and reflective and can be as verbal as any — if the interviewer can connect and enter into their inner world. It is a folly to expect the patient in a culturally and political turbulent environment to “bare the soul” to the interviewer who comes armed with untenable ideology in the name of science. The first commandment of interview is not a *‘hubris’* but empathy. These are the basis on which the authors urge for cultural sensitivity in psychiatric interactions.

In Korea popular understanding of and remedies for mental health problem, during its long history, have been associated, especially on popular folk level, with shamanistic, folk medicine including herbal, acupuncture, moxa as well as divination and geomancy. For the more educated Confucian teaching was a social guideline, and the teachings of Daoism and Buddhism provided, respectively, cosmological and psychological framework. And the then fledgling psychiatry from the West was little known to and the last resort for most. Since the end of the WW2 there has been an increasing need for mental health and corresponding increase in manpower and facilities (Chang & Kim, 1973).

Reflecting on Japanese scene, Nishizono (2005) finds changing landscape of culture, symptoms and personality since the Meiji Restoration in late 19th century, and suggests a need to adjust therapeutic approaches accordingly. To cite a few examples: in anxiety and fear about social relation (called *taijinkyofusho* in Japan, aka TKS), a most common neurosis in Japan for which MT was developed to begin with, there has been a decrease in erythrophobic overlay but a marked increase in paranoid

element. In personality, a more notable change has been among the young, toward more peer-group-orientation than the traditional family-orientation. Therapeutic approaches have been accordingly changing. Currently available approaches include Morita Therapy, Naikan Therapy, Psychoanalysis, Cognitive Behavioral Therapy, among others. An interesting phenomenon is a rise in interest in Morita Therapy among the better educated and functioning. Comparing the pattern of thinking, he observes, Japanese approach is integrative, holistic, aesthetic and deductive, whereas the Western pattern analytical, inductive, and individualistic, which is a view consonant with Northrop's (1960) observation on Eastern tradition and Bodde's (1953) on Chinese. In conclusion, Nishizono urges further study on the nature of culture and nature interaction.

One of the themes that emerges from the foregoing is the form of human suffering (or neurotic symptom) change as the culture does, and therapeutic response therefore must accordingly change. So we will do well to look back at "culture" and associated issues if only to remind ourselves the meaning in which the terms are understood and used in this article concerning Morita Therapy.

Culture The concept has been defined by many and used so much so that the meaning has become broad and blurry. It is used here in a commonly accepted sense connoting the following. It is a coherent whole consisting of all man-made material and mental products, which embed us from the cradle to grave. It sustains our lives, layering and shaping and structuring our consciousness, psyche or personality. And it patterns our way of looking at the world, life, and one's self.

Out of many components and layers of culture let me take out a few threads that are more basic and representative out of the vast and intricately woven tapestry that we call culture. They include the *language*, the way the culture define, by commission as well as by omission, *personhood* (or the *individual*) for whom, by whom and of whom the culture has been built. What is the nature of *person*, and does one relate to each other and the society and still larger scheme of things — the cosmos and history? And the nature of human *sufferings* in particular *neuroses* and the approach to *healing and salvation*. All these are prefigured in the way we define *person* (or the *individual*). Phrased differently, the ideology of the individual ramifies into diverse areas of human endeavor, especially *behavioral scientific*; or the main forces of traditions converge toward the ideology (Dumont (1986 [1992])). A few threads of thoughts out of an enormous and complex tapestry called culture and civilization is noted below.

Language Language is a most comprehensive symbolic system in culture and the principal means of communication in daily life including psychotherapeutic. If so, should we not expect to find the meaning of *person* (or the *individual*) for whom much of human activities are related and oriented to? We do indeed find such in the East Asian languages in the form of the *Honorific-Humble System* (HHS) that is especially well developed in Korean and Japanese. The principle of the HHS is identical between the two in form and spirit, and the HHS in Korean language has been described elsewhere (Chang, 1988). Therefore I shall confine myself to Japanese here.

The HHS in Japanese (Sansom, 1928) involves basically two grammatical components of the language, personal pronouns and verbs in conversing or in writing. It can however be best illustrated in a dyadic situation where two (A and B) are conversing. In essence, the verbs make a strongest conjugation according to the assumed or perceived *virtue* of each other, and since the verb indicates the direction of the dialogue the 1st and 2nd person pronouns become redundant and are normally omitted. Since the HHS is a most characteristic features of the language and changes according to the nature of the dyadic relation. We can have a better perspective if we remember the English "I" is immutable regardless of the social context.

Let us imagine, in illustration, two persons (A and B) happened to meet on the street and begin conversing on something very personal for, say, half an hour. And A begins with "I want to talk to you." If this is a Japanese conversation it will be, normally, like "want to talk," without "I" or "you," because Japanese verbs involved (want and talk, here) conjugate strongly in such a way to clearly show who is addressee and speaker so the Personal Pronouns (PPs) become redundant and are omitted. The criteria for the conjugation are the status of each person in the world, but more importantly, however, the way they regard each other. In other words, an interpersonal psychological gradient guides an

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appropriate form of the HHS. Since deference is a virtue in itself, A and B are likely to use mutually deferential (or humble form of) verbs until the relation becomes closer. The HHS of the Korean and Japanese is a most characteristic feature of the languages and difficult for foreigners to learn let alone master, although for the native speakers the form acquisition is as natural as a child learning to walk. In fact the manner of one's use of the HHS is a common measure of the nature of one's upbringing and socialization. Since language especially in its grammar is amenable neither to personal or political control, and follows its own dynamics, one can suggest the HHS points to something basic and significant in culture and mentality. Only more so if we realize that despite spectacular social and cultural changes including, more notably for our purpose, advance in communication technology, I am aware of little evidence that the use of the HHS is significantly diminishing.

Recall English grammar for a moment for a comparative perspective. English verbs, for example, do not respond to the nature of social context and relation, but strongly to number, mood, especially tense, to all of which Japanese verbs react weakly if at all. And the English personal pronouns are, normally, not omissible and the "I" is always capitalized and immutable.

Social ambience created by such languages is difficult to convey to non-speaker of the language because in the process of translation (or interpretation) of Korean or Japanese, say, into English, all the characteristic grammatical features are automatically deleted or converted to adjust to default position of English grammar. In other words, a most distinct flavor of social ambience is lost in translation, and it becomes an unidentified source of ethnocentrism and misunderstanding.

This psycholinguistic implication of the HHS is neither an accidental nor isolated phenomenon but consonant with and symbolic of other cultural values including aesthetic and psychological ideals. In the mainstream classical *landscape painting* in East Asia (in '*shan shui hui*,' in Chinese, literally meaning 'mountain-water painting'), human figure is generally hardly visible, if it does, however, it is willowy and ephemeral amidst the vastness of Nature. The spirit of the painting is not in showing man's control and dominion but a submission to and identification with the "the essential rhythm of the cosmic process." (Yee, 1949). In this, one may note, there is an identity between the ideals of aesthetics and the metaphysics (Daoism). So is with the psychological ideal of '*mushin muga*' (literally, 'no mind,' 'no self.' Or, in equally misleading and misunderstood words, 'ego-less-ness' and 'self-less-ness.') (Chang, 1988).

A little glimpse into a few aspects of the culture will help to understand why an approach to healing such as Morita Therapy takes the way it does.

When Morita Therapy was developed in early 20th century in response to prevalent psychiatric conditions in neurotic range especially with anxiety symptoms, in particular *taijinkyofusho* (TKS) meaning 'fear of people', or 'social anxiety and phobia' (SAP), there was no diagnostic concept appropriate to TKS in the imported Euro-American nosology. Therefore, TKS was a sole indigenous diagnostic entity amidst the imported and translated diagnostic scheme. The first report of TKS by Tazawa (1907) is yet to be exceeded in his acuity of clinical observation. In 1980, the concept entered into DSM-III (APA, 1980). By then, it has been found that TKS is prevalent in other Asian societies including Korea and China (Kitanishi *et al*, 1998; Chang, 1997; 1998).

After SAP was introduced in DSM-III (1980) it showed an interesting difference between SAP and TKS. In the former the patient is anxious being embarrassed by others, whereas in the latter there is a not uncommon subtype in which the patient is afraid he might embarrass even harm other(s) because of his (imaginary) deficiency or disorder. In other words the direction of aggression, one might say, is reversed between the two types (Chang, 1997).

MT has been often compared to Freudian perspective (psychoanalytic or PA) as a means of explaining, as illustrated by the recent work by Kitanishi and colleagues (2007). The reasons for the comparisons may include: (1) a less well known can be better understood by relating to a better known; (2) PA is a comprehensive framework through which one can relate to various areas of behavioral sciences on one hand and to a broader culture and longer history; (3) it is most "Western" in its premise on the nature of human nature and the place of the individual in the greater scheme of things.

One of the issues that has not been sufficiently attended to in such relational (or comparative) studies, in my view, is a most basic issue, the premise of the theoretical structure: Is human nature irrational or rational? Has it been buried too deeply to be noticed? Perhaps the premise is too deeply buried to be noticed. To Freud (1930 [1962]) human psyche (read the Unconscious) is malevolent, irrational and destructive, but to Morita Therapy human nature is benevolent, rational and self-healing. With these attributes PA flows down western slope, whereas MT eastern slope in rationale and method. In other words the question (human nature) is a watershed issue that require urgent study because if we have learnt one thing from the 20th century behavioral sciences, if we have not known for thousands of years, is the way we believe human nature to be is a profoundly self-fulfilling psychosocial prophecy (Eisenberg, 1972). Further, the nature of the premise determines the meaning of *person* (the *individual*), their relationships, the cultural causes as well as the therapeutic ideals. The readers are referred to Bodde (1953) for his discussion on relevant philosophical issues in Chinese context, for the question of “self” in comparative cultural context (Chang, 1988), Lukes (1973) and Dumont (1992 [1986]) on the individualism, Montagu (1968) on the nature of human nature.

Morita Therapy was developed in early 20th century when Japanese culture was experiencing a rather exhilarating turmoil because of a flooding in of the Western culture since late 19th century with the official opening of the country with Meiji Restoration. It was the meeting of two cultures that have developed heterogeneously for thousands of years. Like a coming together of the cold and warm streams in the sea, the meeting was fraught with expectant bewilderment. It was in such an environment Morita worked on his approach. Because of the cultural circumstances of the time there were considerable debates on various aspects of the methods and rationale and its relation to the incoming psychiatric sensibilities including psychoanalytic. Amidst the controversies, one day, Morita was asked how much his method derives from Japanese tradition. The answer, attributed to Morita, was: “If I say my method comes from Japanese tradition would there be any patient for me?”

Reviewing the vicissitudes of Morita therapy during 90 years since its inception in 1919, Kitanishi (2009) surveys an extensive literature for domestic readers. And there have been a few for English readers also by Murase & Johnson (1974), Reynolds (1982), and by Morita’s work translated by Kondo and edited by LeVine (1998).

Permeating Morita’s approach, the culture at large and Asian consciousness are the two concepts: *arugamama* and *karma*. *Arugamama*, a Japanese term, is etymologically related to ‘nature’ and ‘naturalness’. *Karma* means, in the context of this paper, ‘the chain of cause and effect in the world of morality.’ Together (*arugamama* and *karma*) they mean that the present suffering (neuroses) is an inescapable consequences of all the past deeds in commission as much as in omission, and the past deeds not only of personal but also collective not only of his but beyond — of the humanity. Positive thoughts and deeds will result in positive reward, and negative ones in negative retribution. Such moral causation and consequences are as exacting, logical, natural and inevitable. This is a belief that is common to all schools of Buddhism (Fung, 1948), which suffuses “Eastern ethos”. Isn’t the neurotic conflict a futile struggle against an inevitable? Would it not be a release from suffering if one can befriend and receive? Morita therapy suggests that all beings and phenomena are interrelated and interdependent, and acknowledging the conditioned nature of life is the beginning of healing and freedom. “Knowing,” Buddhists’ epistemology suggests, is ‘to love’ (in a sense closer to ‘empathy’) (Nishida, 1950) . In this respect, the ideal of Morita therapy is that also of *yoga* (Wood, 1959) and *Zen* (Suzuki DT, 1969).

CONCLUSION Healing is a universal need and follows common principle. But in practice, approaches are local and temporal. Trust in nature and human nature informs the therapy: effective suspension (if not removal) of artifacts from one’s mind so that to allow one’s healing nature to re-emerge. A priority task is to learn from approaches based on different premises to enrich and allow the latent analytical drive and individuality, which have been hindered by integrative mentality and holistic culture. Psychotherapy tells much about culture as the culture informs psychotherapy.

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