OBSERVATIONS ON MORITA THERAPY AND CULTURE-SPECIFIC INTERPRETATIONS

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Morita therapy appeared around the turn of the century in Japan where it has become a major form of treatment for neurosis since it was first developed by Dr. Shomo Morita, a Japanese psychiatrist. It became known in the United States through American psychologists and psychiatrists stationed in Japan after the Second World War. Also, Karen Horney, the American psychoanalyst, studied Morita therapy in Japan in 1952 at the suggestion of the Zen Philosopher, D. T. Suzuki (Miura & Usa, 1970). I intend to focus on it, not primarily because Western interest in it is growing, but because it can show us, by contrast, how culture-specific are the ideas that undergird our interpretations of behavior.

MORITA THERAPY

The following description is a composite of some observations made in Japan, readings in the professional literature, and conversations with clients and therapists. A comprehensive study can be found in David K. Reynolds' book (1976) Morita Therapy.

In 1977, I met a professor in Kyoto whose brother had been successfully cured through Morita therapy after a "nervous collapse." The psychiatrist, Dr. Shin-ichi Usa, had his hospital in Kyoto. Having read a number of articles and Reynolds' book (the first to be published in English on this therapy), I begged the professor to arrange a visit to the hospital. On our way in a taxi my guide told me that Dr. Usa calls his therapy "Zen therapy," although he regards himself, and is regarded, as one of the heirs to Dr. Morita. The professor told me that
Dr. Usa's father had been a promising Zen student whose roshi, or master, had advised him to become a psychiatrist instead of a roshi, and subsequently he studied under Dr. Morita. Dr. Usa had grown up in the atmosphere of a Zen Buddhist temple compound, where he directed the "hospital" founded by his father.

We had been driving along a thoroughfare in downtown Kyoto, and it was startling to turn suddenly from modern commerce and traffic and pass through the great gates of high tile-roofed walls that enclose this Zen Buddhist monastery. It was night, and the curving wood and tile roofs of the temple buildings and meditation halls hovered over us in the dim light. Before us the harmonious rectilinear composition of gravel paths and buildings was softened by the dark and shaggy thrust of giant pines and low clumps of bushes. A deep stillness resonated with the thwack of wooden blocks, rousing meditators in one of the buildings to alertness and the beginning of an evening meditation session.

We entered a lit and bustling "hospital," a one-story building, sprawling and modest, not unlike an enlarged Japanese home. Dr. Morita had cared for patients in his own home and had emphasized the importance of home-like surroundings. We left our shoes with a jumble of others'—some, with a military polish, were precisely aligned, some muddy, their toes splayed upward, some masculine, some feminine—it seemed that "all conditions and manner of persons" were here. A nurse with a bright and cheerful manner directed us through an open shoji screen into Dr. Usa's office. It was more like a casual living room, with a vase of garden flowers and a clutter of journals on a table.

In a moment Dr. Usa, a tall, well-built man in a white coat, entered and called out to one of the young women in the hall to bring us some bean paste jellies and, appropriate for a therapeutic setting, the tea that begins by tasting bitter but ends by leaving a sweet taste in one's mouth. Because of the Japanese liking for uniforms that indicate occupational or group identity, I was surprised that his was the only uniform in sight. Several times during our visit an aide or nurse interrupted to ask Dr. Usa a question or give him information. Although there was affectionate respect in their manner, I was struck by the good-humored informality of these exchanges.

The doctor's face was smooth, serene like the Buddha, and I felt that I had his full attention. Answers to my questions were simple and direct. Shinkeishitsu is the Japanese term for the
form of neurosis being treated. Dr. Morita further classified *shinkeishitsu* into three clinical subcategories: neurasthenia; anxiety state; and obsessive-phobic. The first is characterized by somatic symptoms that tend to be related to interpersonal difficulties. These include a fear of blushing, of meeting another person's eyes, or of having an offensive body odor. For this group of symptoms, by far the most common syndrome, the term "homophobia" is used. Anxiety state is typically a fear reaction to rather specific problems or anticipated problems rather than generalized anxiety, and often involves a physical dysfunction such as dizziness or difficulty in breathing (Miura and Usa, 1970; Reynolds, 1976). Preliminary diagnosis of *shinkeishitsu* is emphasized as patients in other diagnostic categories may be harmed by the therapy, or disrupt the treatment program (Reynolds, 1976).

There are several explanations of the etiology. Some theorists hold that self-centeredness is natural, with some persons innately hypersensitive. Others attribute *shinkeishitsu* to over-protection in childhood and the tendency of parents to discipline by shame and warnings about what others may think. Other theorists point to pervasive elements in Japanese culture, specifically the individual's locus of identity in family and group memberships (Vogel, 1968; Reynolds, 1976). Most, like Morita himself, believed that all of these factors play a part.

The average length of stay for Dr. Usa's patients is forty days, divided into four phases. It begins with a week of bed rest, except for eating, eliminating and bathing. The patient is told that it is important to follow instructions, to avoid talking and other diversions such as reading, writing, smoking, or listening to the radio, but there is no policing of his compliance. He is encouraged to ruminate freely, with no effort to control or escape his thoughts. The regimen may sound like sensory deprivation, but the rooms are not isolated or austere. Reynolds, who undertook a treatment program in another Morita center as part of his research, was pleased to find roses, a gift from the doctor, and a handsome piece of calligraphy in his room. There had been evening visits, not interviews, from the doctor, and daytime sounds of footsteps and a few voices in the hall. He was touched to find that other patients had cleaned his room while he was out bathing, and he was warmed, by the friendly solicitude of the nurses. In general it is not unusual for repeated encounters with either sex in Japan to lead to a friendly, personal relationship, and a quality of cheerful nurturance is especially associated with femininity.

At first a patient feels relieved by the opportunity to escape from coping. After a while, however, preoccupation with his...
supposed inferiority and accumulated fears often leads to intensified anxiety from which he cannot divert himself in customary ways. Most patients then find that, when the attacks of anxiety cannot be escaped, a self-limiting process arises which reduces their fear of fear as boredom sets in. Toward the end of the week of rest, self-preoccupation declines, and ordinary sensations, like washing and going to the toilet, are experienced with pleasure. Interest in the outside world and activity increases, and the patient becomes ready for the next stage of treatment.

Social activities, whether unnecessary conversation or private amusement like novels or TV, continue to be prohibited in the second phase and also in the third. But the patient is permitted to get up, go out into the garden, and to undertake light work as he feels an inner urge to do so. During this second week, although a patient is discouraged from staying in his room reading, he is allowed to read the *Kojiki*, a classic work of early Japanese history, but only if he feels an inner urge. He is advised not to make any particular effort to remember or to understand what he reads.

In this second stage he begins keeping a journal, an important part of the remaining treatment. In it he reflects upon his experiences of the day. Each evening the doctor takes the journal and returns it the next day, often with comments on the previous day’s entry. One of Dr. Usa’s patients, in his first entry, quite typically wrote about his anxiety and feelings of inferiority. In the margin Dr. Usa wrote, “It is not useful to dwell so much on it.” In subsequent weeks the doctor passes over the patient’s preoccupation with symptoms and is more likely to write supportive comments on entries that are objective and task-oriented, or to respond to recorded sense data such as, “How fine a spring day! The cool air on my face was refreshing as I swept leaves from the moss garden.” The doctor’s comments also underscore the idea that work is assigned because it is socially useful, not because it is therapeutic. When a patient wrote in his diary that he had noticed a depression in the path that collected muddy water and had filled the hole, the doctor’s comment was: “Work is undertaken because it needs to be done.” Other comments support the idea that there is intrinsic satisfaction in work, and thinking about whether one likes or dislikes a task, or about one’s capacity for it, are hindrances.

In the third phase, work assignments are heavier and carry more responsibility. Reading can be expanded beyond the *Kojiki* if the subject is informative and factual rather than speculative or escapist. An innovation made since Dr. Morita’s
original program is added in this third phase, a meeting of patients. They hear accounts from ex-patients who have surmounted their problems and returned to normal living, whether or not entirely free of inner self-doubts, and pay them the respect due to elder brothers and sisters. They also share accounts of their own symptoms and progress, with a certain amount of ridicule and laughter at the absurdity of their own symptoms. From time to time the doctor lectures to these patient groups. He is likely to say it is natural for all persons to seek their full development, and that the patients’ perfectionism and anxiety are rooted in this wish, but that paying attention to fears, desires, and aversions leads to neurotic dysfunction and misery.

Social interaction is kept to a minimum until the fourth and final phase, but it is in this sphere that the neurosis has arisen and where it must be resolved. After the long period of restriction, an urge to reach out toward people gathers enough strength to overcome neurotic fears. If the treatment has followed its usual course, the final ten days serves as a transition to daily life at home, with trips and possibly full-time work outside the hospital. A patient’s readiness to leave the hospital is acknowledged in the group meetings, with farewells and good wishes. In a case history described by Chang (1974), a patient was taken out to dinner by the doctor on the eve of the patient’s departure. The doctor talked about his understanding of life, and the patient absorbed what he said. After a patient has left, there is continuing contact through a newsletter, occasional return visits by “graduates” to the patient groups, and sometimes brief exchanges of letters between the doctor and former patient.

BUDDHIST AND JAPANESE ASPECTS OF MORITA THERAPY

Those familiar with Zen Buddhism will recognize a similarity in attitudes that Moritists foster toward emotions and toward work, and in experiential learning. The Buddhist philosophy is explicit in the following instructions to Morita therapists:

Lead them not to accumulate self-confidence from various experiences. Aiming at attaining a specific mental state, like the feeling of relief, gives rise to an illusion of the reality of one’s feeling, and results in establishing an imaginary self again (Miura & Usa, 1970).

How emotions are “unreal” should, perhaps, be explained. What is ordinarily regarded as emotion is an extension of the self-image. Responding to emotion becomes a substitute for
Morita therapy has been criticized by Westerners who assume that the aim of treatment is to suppress emotion. This is a misunderstanding stemming from a Western belief that emotion must either be suppressed or discharged. Buddhists, and Moritists, believe there is a third option, a re-training of attention. When patients note in their diaries that they became so immersed in a task at hand or some simple pleasure that they forgot their symptoms, the doctor's written comments reinforce the idea that anxiety and feelings of inferiority are not overcome by attention to their problems but by attending to work that needs to be done whether or not they feel comfortable. If the fears are allowed to be in the foreground of attention, with practical concerns sinking into background, fear looms larger and becomes circular, a fear of fear. A Buddhist and Moritist view is different from that of a gestalt therapy which teaches one to flow with the stream of foregrounds that are ever shifting and reflecting transient needs and emotions (Aleksandr, 1975). Buddhists would tend to emphasize the background behind the changing whims and desires.

The Westerner who reads the Buddhist prescription for the way out of suffering, "Give up your attachments," tends to picture a state of passivity bordering on catatonia (Alexander, 1931). But it is attachment to the mental monolithic "I" that fuels fear and craving. Physical pain or hardship, felt as an insult or threat to the I sense, is magnified; and pleasures seen as something for the "I" to collect and possess, become trophies for the ego. To awaken, to be enlightened, is to be liberated from the "I," an illusory entity at the imaginary center of experience. Then there can be an openness to experience and creative expansion that "is appealing beyond all possibility of possession" (Tarthang Tulku, 1979). The first step toward such liberation requires temporary withdrawal from social roles and interactions in order to observe the workings of the mind.

All that has been said here about Buddhism can be glimpsed in Morita therapy. Morita therapy was not deliberately designed to be Buddhist but is coherent with features of Japanese culture, features more or less shared with other Asian cultures where Buddhism has taken root. The first of these features is group-consciousness, a view that individuals have a limited existence apart from a group and that every group is in itself part of a larger whole. A view prevails of "worlds within worlds," in which human life is a grain, a lightning flash, a
drop of dew. All of nature, inanimate and animate alike, engages in an interplay of complementary forces that, like an ocean, buoy the human swimmer if he does not flail about in ignorance. The infant, even before the l-sense is fully formed, is seen to be in relative harmony with Great Nature (a Zen Buddhist term).

Second, Japanese babies are rarely isolated from human sounds and are seldom far from a comforting touch. For much of the first year a Japanese baby is carried close to his mother's body in a velvety carrier and usually breast-fed when hungry, as self-regulation is assumed in the as yet unself-conscious child. Also in Japan, it is considered a deprivation, almost unnatural, for anyone to sleep alone, without the warmth and nearness of another body, though it is no longer uncommon now for adolescents and young adults to have their own rooms (Caudill & Plath, 1966).

From this orientation comes the Japanese term *amae*, meaning "the need to be loved," a concept essential to an understanding of Japanese character (Doi, 1962). Having been so nurtured, the Japanese feel a need to give something back in service and gratitude. Descartes' "Cogito ergo sum" - "I think, therefore I am" - is, for most Westerners, banal truth. For the Japanese and perhaps for many Buddhists, it may be "Amara ergo sum" - "Having been loved, I am" - that is self-evident. The *amae* concept is typically Japanese and not necessarily Buddhist, but Japanese share with other cultures the understanding that gratitude and a desire for others' welfare is cultivated by reflecting on the care that has nourished and sustained them, especially when small and helpless.

**A DEVELOPMENTAL INTERPRETATION**

Western psychiatrists who first observed Morita therapy in Japan tended to dismiss it because it did not fit established psychiatric theory. From the standpoint of traditional psychoanalysis Morita therapy may not seem to make sense and can be fit into a behaviorist model only with difficulty (Reynolds, 1976). The Japanese, who place high value on learning-by-doing and who work from an internalized tradition, offer very little explanatory theory. Nevertheless, a developmental or recapitulatory interpretation may be of some help in understanding Morita therapy.

In its typical course Morita therapy appears to re-enact the stages of childhood. The inactivity of the first week, being cared for by a nurse concerned with the patient's comfort,
within hearing of her voice, footsteps and familiar household sounds, is not unlike infant experience. The doctor's casual evening visit is like a father seeing his children before bedtime, hearing their accounts sympathetically, but not unduly alarmed by their conflicts. When a patient has an inner urge to move into a bigger world despite trepidations, he is encouraged to go outdoors and help with adult tasks, with approval but little pressure, and is introduced to a peer group. As he becomes more able, he is required to contribute to the maintenance of his shared home, and is exposed to more peer pressure as well as support. When at last he is ready to move into the world, he sets forth with parental counsel and blessing and the admiration of juniors, knowing that farewells are not final and that he may return and receive the respect of patients not yet ready for adult challenges. A developmental pattern of childhood taken from a Buddhist perspective might proceed as follows. Infants possess a consciousness with qualities more positive than the simple tabula rasa. Enlightened they are not, but until self-consciousness emerges with differentiation of Self from Other, an open awareness and responsiveness is assumed. An American psychologist (Kaplan, 1978), reflecting this understanding of early development, puts it this way:

"In his first partnership outside the womb, the infant is filled up with the bliss of unconditional love - the bliss of oneness with his mother... All later human love and dialogue is a striving to reconcile our longing to restore the lost bliss of oneness with our equally intense need for separateness and individual self-hood... We spend most of our adult life solving and resolving the dilemma of our second birth."

For the above author the second birth focuses on individuation whereas for the Buddhist it is more radical - an awakening or enlightenment.

As a young being grows, the development of the mind and senses make inevitable an accretion of concepts, solid as cement, imprisoning a person within his own rigid mental constructs. Only when a person sees through the working of his mental apparatus can he see through these tight fortifications. The earliest and most resistant construct is the separative I-sense, the conviction that "I" am in here somewhere and everything else is out there. The nature of mind and the young child's experience with Other gradually sets up a binary system of subject-object, mine and not-mine, and all experience is then assigned to one or the other. There is a mutual identity of subject-object that has been obscured, and attention constantly reacts and scans in ways that strengthen the binary opposition.
The artifact "I" flowers rankly into a self-image petaled like an artichoke, a "good" or a "bad" self, stupid or clever, attractive or plain, strong or weak, developing a mental picture that inadvertently rules one's subtlest behavior. Tarthang Tulku, the Tibetan teacher cited above, in a lecture at Berkeley in 1974, once described the self-image as a protection for ego (here meaning a fundamental sense of identity). Seen as tyrannical, the self-image is not unlike Horney's concept of a pseudo self (Horney, 1950); but from it Buddhist perspective there would be little concern with the origin of self-image in interpersonal relationships, or whether the self-image is positive or negative. In this view, any self-image would tend to capture attention and extinguish naturalness and balance.

Another interpretation of human development, with some elements similar to Morita therapy and Buddhism, is suggested by the theory and clinical work of a little-known British psychiatrist, Ian Suttie (1952). The cornerstone of Suttie's theory is "love," unsentimentally defined as harmonious interplay, a social give-and-take in which neither partner feels "taken." Suttie postulates that the infant, before it can differentiate Self from Other, is solipsistic, not narcissistic as Freud theorized. Suttie asserts an innate thrust toward a social interplay that he names love, and sees self-consciousness emerging, with its differentiation of Self and Other, as an unavoidable seedbed for neurosis. The pain of separation causes, in Suttie's theory, a "repression of tenderness"; in Buddhism it causes a blinder to one's true place in the scheme of things and an impediment to spontaneous, altruistic and joyous response.

Buddhists, Moritists, and Suttie alike regard preoccupation with self, whether in pride or despondency, as a hindrance to the harmonious interactions that sustain life for all. Suttie's notion of allowing neurotics to re-experience childhood, free from adult responsibilities and in the care of benign parent figures, is mirrored in Morita therapy. It would be stretching things to say that this experience can be found in Buddhist practice, although a monastic regimen takes one out of familiar social roles and places one under a teacher who is far more of a parent figure than any teacher in the West. Rest and inactivity, prescribed by both Suttie and Moritists, allow a patient to face the busywork of his mind, leading to an experience that is similar to what beginning Buddhist meditators report. There is a return to immediate awareness, to a way we may have experienced before words and concepts intervened, accompanied by a liberating freshness and spontaneity.

Interpretations of human nature such as Suttie's may strike contemporary Westerners as charmingly naive, like a Victor-
ian valentine. The obstinacy of a two-year-old, the Oedipal wishes of a four-year-old ("I'm going to marry Daddy when I grow up"), so obvious to a Western person, are not so obvious everywhere on earth. In Japan I have had a two-year-old samurai hurl himself against me as I balanced steaming tea while his mother, a truly considerate hostess, gently and ineffectually remonstrated while beaming at his strength and exuberance. When a second onslaught landed the tea on me and the tatami mat, she did not interpret his behavior as rebelliousness, but simply found someone who could attract the boy to another room for play wrestling, commenting that it is the nature of boys this age to be full of mischievous energy. Although we see among Westerners plump parents who translate every cry as a hunger pang, and slim gregarious parents who believe that infant fussiness is a need for sociability, the attitude of the Japanese mother appears to be culture-specific rather than idiosyncratic.

CONCLUSION

In view of the apparent psychological differences within and between cultures, it seems appropriate for therapists and theorists to give some attention to culture-specific interpretations of human development that influence our behavior. In this discussion Morita therapy has served as an example of some of the considerations that may be involved. However, in a larger perspective, the increasing contact between Eastern and Western societies may accelerate the need to examine our psychological assumptions. Perhaps by attending to the cultural similarities and differences in our basic interpretations of behavior, we will be able to better appreciate that deeper human nature that connects us all.

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