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# Redefining Mental Illness: Medicalization, Mental Healthcare, and Morita Therapy, 1868-1938

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# Redefining Mental Illness: Medicalization, Mental Healthcare, and Morita Therapy, 1868-1938

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*For H-san*

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# Abstract

## Redefining Mental Illness: Medicalization, Mental Healthcare, and Morita Therapy, 1868-1938

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In 1919, Morita Shōma first published his theories on the nature of a disorder he called *shinkeishitsu*. While it was often translated as "neurasthenia" after the definition of George Miller Beard (1869), Morita himself maintained that it was a nervous disorder with symptoms that included a range of ailments. Anything from physical and mental fatigue, headaches, heart palpitations, insomnia, nausea, or even dizziness could be a symptom of shinkeishitsu. The treatment that Morita recommended for this disorder was a combination of what is now considered behavior modification therapy, self-assessment, and meditation. After his death, this treatment came to be known as Morita Therapy, and it has persisted as a form of therapy for a variety of nervous disorders to the present day.

In this thesis, I will demonstrate how Morita, through his education and connection with western psychiatrics, adapted Western mental health concepts to the Japanese context. At the same time, however, Morita attempted to extend concepts of mental illness that he considered to be Japanese culture-bound syndromes--specifically

*shinkeishitsu*, which in addition to symptoms of neurasthenia caused patients to exhibit signs of obsessive-compulsive or perfectionist tendencies and a social phobia known as *taijin kyōfushō*. Morita Therapy exemplifies the general trends of psychiatric healthcare in the prewar period; the medicalization of nervous disorders and his interaction with the larger psychiatric community demonstrates how Japanese psychiatrists attempted to take part in the international discourse on mental health and wellness.

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# Introduction: Mental Healthcare in Japan

In 2007, I was studying abroad at Sophia University in Tokyo when I met a woman I will refer to as H-san. At the time, H-san worked in the international office at the university helping the visiting students from other countries that were studying at Sophia. She was very passionate about her job and had an infectious laugh, and through the many afternoons spent in her office, she and I became close. Despite her generally sunny disposition, sometimes H-san became distant and sad, moods I learned to interpret as a sign that she was struggling with something. She confided in me one day that she had been seeing a psychiatrist who was treating her for depression and anxiety. H-san was not satisfied with her diagnosis, nor with her experience at the hospital, but she didn't know what to do about it. She told me that she felt as though her options were very limited "because it is bad to have depression in Japan (*nihon de utsubyō ga aru no wa yokunai da kara*)." In her mind, H-san's access to different forms of treatment, the support available from both her family and the national government, and her attitude towards her diagnosis were all determined by factors of her identity—as a Japanese person, as a middle-class urbanite, and as a woman. I have watched my friend change doctors, change medication, and even change jobs to attempt to alleviate her symptoms of suffering. Today she is by her own admission much happier than she was when I first met her, but her story and the things she told me about the mental healthcare system in Japan have remained.

It was with H-san in mind that I began studying the subject of mental health and healthcare in Japan. Having first approached the topic through an interest in suicide and public policy, I soon realized that what was missing from the scholarship on the subject was an actual history of how mental healthcare systems have developed in Japan thus far.

How has the subject of mental illness been described in Japan before now? What does it mean to be mentally ill or mentally healthy to a Japanese person? How has that definition changed or been changed by major events in Japanese history?

While there is no easy way to answer these questions (least of all in a paper of this size), I have shaped my research to try and come to a better understanding of these issues. It is with these questions in mind that I have come to Morita Therapy—a therapy which I believe is exceptional for the fact that it exemplifies so many of the trends that mark the formation of the mental healthcare system in Japan. In 1919, Morita Shōma first published his theories on the nature of a disorder he called *shinkeishitsu*. While it was often translated as "neurasthenia" after the definition of George Miller Beard (1869), Morita himself maintained that it was a nervous disorder with symptoms that included a range of ailments. Anything from physical and mental fatigue, headaches, heart palpitations, insomnia, nausea, or even dizziness could be a symptom of *shinkeishitsu*. The treatment that Morita recommended for this disorder was a combination of what is now considered behavior modification therapy, self-assessment, and meditation. After his death, this treatment came to be known as Morita Therapy, and it has persisted as a form of therapy for a variety of nervous disorders to the present day.

In addition to this longevity, Morita Therapy was founded during a period of great transition for Japan as a nation. Morita grew up in a small town located away from Tokyo, a place where ritual shamanism and spirit possession were still commonly accepted explanations for what Western medical doctors were calling "mental illness." He received his education and much of his training with the help of government funding that had been earmarked for the purpose of spreading Western medical knowledge to the general healthcare system. As a psychiatrist during the Taishō and early Shōwa periods, he was part of a movement that sought to provide modern terminology to illnesses that

had existed for hundreds of years so that ordinary people could understand the biomedical explanations for mental disorders that had existed for centuries. As an academic, Morita and his peers strove to contribute to the international discourse on the assessment and treatment of mental illnesses.

In this thesis, I will demonstrate how Morita, through his education and connection with western psychiatrics, adapted Western mental health concepts to the Japanese context. At the same time, however, Morita attempted to extend concepts of mental illness that he considered to be Japanese culture-bound syndromes--specifically *shinkeishitsu*, which in addition to symptoms of neurasthenia caused patients to exhibit signs of obsessive-compulsive or perfectionist tendencies and a social phobia known as *taijin kyōfushō*. Morita Therapy exemplifies the general trends of psychiatric healthcare in the prewar period; the medicalization of nervous disorders and his interaction with the larger psychiatric community demonstrates how Japanese psychiatrists attempted to take part in the international discourse on mental health and wellness.

## MODERNIZATION VERSUS MEDICALIZATION

There are several themes that are important to understanding how Morita and Morita Therapy fit into existing scholarship on the time period in which Morita lived. The Meiji period, when Morita was born and went to school, is often referred to in terms of the great transitions that were made in Japanese society. The abolishment of the class system, the industrial development and economic diversification, and the increased international involvement in trade and conflict were all products of this era.

Like many of the works written on the subject of healthcare and illness, the development of mental healthcare between 1868 and 1912 was not so much a process of

modernization as it was a process of medicalization. Diseases and illnesses were reinterpreted through the framework of Western biomedical understandings about the workings of the body. Through the advancement of scientific medicine, the Meiji period goals of civilization and enlightenment were extended to the project of nation-building as the bodies of citizens came under the control of the state in a way that had not been possible under the previous Tokugawa rule. For example, Alexander Bay has written on how the treatment of beriberi, classified as a national disease, was presided over by elite doctors who wielded a considerable amount of control over the discourse on health during the Meiji period.[1] Over the course of the Meiji period, doctors went from knowing nothing about the cause or treatment for beriberi to creating propaganda on the benefits of vitamins for the wellbeing of the nation.

This process was not solely linked to somatic illness, but was also present in the construction of Japan's mental healthcare system. The classification and treatment of mental illness also went through a process by which native forms of knowledge about the source of these ailments was replaced by new, modern forms of knowledge that were based in medical discourse from the West. Psychiatrists during this time were able to wield great influence over the perceptions of medical conditions and the course of treatment that should be taken. This influence resulted in the formation of a medicalized discourse on the nature of mental illness, which in some places existed in cooperation with other methods of treatment that had existed for centuries prior to the Meiji Restoration.

Morita himself felt the force of this conflict between modern and "native" knowledge, and his therapy came as the result of compromise between his training as a

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[1] Alexander R. Bay, *Beriberi in Modern Japan: The Making of Modern Disease* (Woodbridge: Boydell & Brewer, 2012).

western psychiatrist and his experiences as a citizen experiencing this great transition. Elements of Morita's therapy, such as the environment in which it was conducted and the type of reflection that the patient is supposed to engage in while undergoing therapy, harken back to some of the native techniques for treating mental illness. Yet his theories on the nature of illness and his defense of his techniques to both a Western and Japanese audience were made in terms of biomedical knowledge that had been adapted from the Western model of mental healthcare. For this reason, though the source of Morita's education and knowledge come from educational advancement in the policies of modernization, it was medicalization that had a greater effect on his theories of mental health and illness.

## INTERNATIONAL TRENDS IN PSYCHIATRY: WHAT IS MENTAL ILLNESS?

Another important aspect to consider is the effect that international trends in psychiatry had on the development of mental healthcare in Japan. Aspiring psychiatrists were sent to the United States, Great Britain, Germany, and other parts of Europe to bring back information, technology, and techniques for the assessment and treatment of known mental illnesses. It should be unsurprising, therefore, that the Japanese mental healthcare system developed under the influence of many of the same trends that were affecting the international community of psychiatrists during the period.

One example of these kinds of trends was the question on how to diagnose and treat mental illness. There were some psychiatrists, such as George Miller Beard, the American neurologist that popularized the term 'neurasthenia', who believed that mental illness was another kind of somatic illness.[2] At the same time, other psychiatrists (such

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[2] Charles E. Rosenburg, "The Place of George Miller Beard in Nineteenth Century Psychiatry," *Bulletin of the History of Medicine*, no. 36 (1962): 245-259.

as Sigmund Freud) were arguing that mental illness had a basis in experienced trauma or some other physiological etiology that manifested itself in somatic symptoms.[3] These two perspectives vied for authority on the definition of mental illness through the research of psychiatrists, neurologists, and even philosophers who contributed to the discourse.

In Japan as elsewhere, the debate between these perspectives on the nature of mental illness was conducted between schools of psychiatrists who held differing beliefs on the subject. Some believed, as Beard did, that providing evidence of a physical basis for mental illness would allow patients to accept a biomedical basis for treatment. Others believed that making the themes of mental illness and the basis for treatment as easy to understand as possible would help patients gain confidence in the new system of treatment. Morita and his contemporaries engaged in international scholarship on the subject over the years and presented their own cases for the differing perspectives, entrenching themselves in this international issue.

#### THE CENTER VERSUS THE PERIPHERY

Finally, like many of the trends of modernization that occurred during this period, change did not occur evenly throughout Japan. Rural areas with no particular value in terms of commerce or industry sometimes felt the effects of the Meiji period much later or much less significantly than did the urban areas of the country. Despite the state's attempts to put an end to the backward practices of shamanism or Chinese medical practitioners, these methods of treatment survived into recent Japanese history and can still be found in parts of Japan today. Part of the reason for the survival of these forms

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[3] Eduard Hitschmann, *Freud's theories of the neuroses*, trans. Charles Rockwell Payne (New York: Moffat, Yard and company, 1917).

of healing is due to the location of the regions in which these practices remained. The effects of modernization were in many ways focused on main city centers and places with political and economic importance. Thus, areas that did not hold a strategic value to the goals of the Meiji period were often slower in experiencing the new forms of mental healthcare that the state endorsed for the treatment of mental illnesses.

This is not to suggest that existing forms of treatment for mental illness ceased to exist in urban centers, nor to suggest that psychiatry did not make its presence felt in rural Japan between the years of 1868-1938. Morita and many of his contemporaries operated their clinics in Tokyo, Osaka, Kyoto, or other large cities, and their own direct connection with those suffering from mental illness in places far away from these cities was limited. Distribution of access to medicalized mental healthcare was uneven at best. This prompted rural-dwellers to seek alternative forms of care for mental illness, such as the shamanism and Chinese medicine, in much the same way they would for diseases and somatic illnesses.

Though many psychiatrists during this period attempted to make mental healthcare accessible to anyone who needed it, there were limits on their ability to accomplish this goal in terms of both the size and distribution of people in the country, and the terminology with which they presented their research. For people who were used to hearing symptoms of mental illness described as the effects of a maleficent spirit, Western biomedical terms were often alien.

### ARGUMENT AND STRUCTURE

In the first chapter, I will introduce the reader to Morita Shōma and Morita Therapy. I will begin by giving a brief biography of Morita, focusing on his

experiences and education that are believed to have impacted his theories on the nature of mental illness and suffering. I will then describe the process of Morita Therapy and the goals that each stage of the therapy is designed to achieve. In the second chapter, I will describe the existing forms of mental healthcare that were available to Japanese before the adaptation of Western medical knowledge. I will show how both spirit possession and ki stagnation were available explanations for a variety of mental illnesses, as well as how these explanations relate to Morita's theories about mental illness assessment and treatment. In the third chapter, I will discuss the basic trends in the development of psychiatric mental healthcare. In the Meiji period, this was characterized by the importation and adaptation of Western medical knowledge on the subject of mental illness, but in the Taishō and early Shōwa eras, Japanese psychiatrists became increasingly more independent. This resulted in the development of many different branches of psychiatry and psychology that were fractionalized from one another and did not communicate on the basis of their findings. I will also briefly discuss Morita's engagement with two different psychiatrists who were interested in the topic of neurasthenia—George Miller Beard and Sigmund Freud. Finally, in the fourth chapter, I will describe some of the major changes to Morita Therapy that have occurred in the postwar period and the state of the therapy today.

Figure 1: Morita Shōma, (1874-1938)

# Chapter One: Morita Shōma and Morita Therapy

Before exploring the relationship between Morita and his contemporaries, it is necessary to understand how Morita himself came to his theories about the nature of mental illness. Morita's personal life as well as his education and medical training contributed to his theories about neurosis, and as such they had a particular influence on how he believed they could be treated in patients.

## Morita Shōma and Morita Therapy

Morita Shōma, (森田正馬, sometimes read as Morita Masatake), was a Japanese psychiatrist whose most well-known contribution to psychology was the development of a meditative therapy (named after Morita) that is still used in the treatment of nervous and anxiety disorders. Morita was born on January 18th, 1874, in Kochi prefecture. Not much has been published about his life or his family, but Fujita Chihiro, a psychiatrist who has written extensively on Morita and his theories, has provided a brief biography of his early life. At the age of ten, Morita was visiting a Buddhist temple near his hometown when he found a particularly graphic and violent painting of hell. The pools of blood and mountains of sharpened needles, in addition to the sharp aroma of incense that permeated the room, shocked the young Morita and filled his head with questions about life and death.[4] Fujita has asserted that it was this formative experience that led to an interest in philosophy and logic, as well as his related inquiries into religious practices in Buddhism and Christianity.[5] This subject of study continued

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[4] Shōma Morita, "Shinkeishitsu no ryōhō (The treatment of shinkeishitsu)," in *Morita shōma zenshū*, Vol. 1, ed. T. Kora, (Tokyo: Hakuyosha, 1974) 96.
[5] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis* (Tokyo: Igaku-Shoin, 1986), 79.

through his middle school and high school years, but when Morita entered Tokyo Imperial University, his focus shifted to medicine. According to Fujita, this signified a rejection of the "ideological mind" and the acknowledgement of the importance of the practical concerns of the body, since Morita chose to focus on somatic illness rather than questions of spiritual or religious importance.[6] Given his ultimate interest in mental illness rather than disease, however, it seems clear that Morita continued to find meaning in the mind.

Morita's own physical state may have also contributed to the subjects of his study. From the time that he was twelve, Morita suffered from a range of physical ailments including chronic fatigue, severe headaches, and heart palpitations. In middle school he contracted typhoid fever, which resulted in convulsive fits that continued through his youth into adulthood. Despite seeing a number of medical professionals seeking treatment, the symptoms persisted through his university studies with most medical professionals of the time suggesting that Morita's condition resulted from "a heart problem" without any specific empirical evidence to support the diagnosis.[7] The University Hospital finally diagnosed the condition as neurasthenia and placed Morita on medication, but he reported that he found his anxiety over his condition persisted through medication and made it impossible for him to concentrate on his studies. He finally stopped taking the medication and began studying intensely whenever his symptoms became an issue. Morita soon realized that as he stopped concentrating on his symptoms, they became less debilitating, and so he continued to work himself at his studies day and night. As a result, he passed his examinations with exceptionally high scores, and his mysterious medical conditions vanished almost at once. Fujita has

[6] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis*, 80.
[7] Shōma Morita, "Shinkeishitsu no ryōhō (The treatment of shinkeishitsu)," 103.

theorized that this experience was the basis upon which Morita developed his ideas about the relationship between the mind and the body.

In 1902, Morita graduated from Tokyo Imperial University with a medical degree, whereupon he entered into the graduate school to study under Kure Shūzō (1865-1932). Kure was a psychiatrist who had studied in the Kraepelinian School in Germany and had brought the descriptive techniques and process of brain pathology to the Tokyo Imperial University. The Kraepelinian School, which placed an emphasis on a clinical observation of symptoms over time rather than in the short time, eventually came to replace somatic definitions of mental illness in the twentieth century. Thus Kure's imposition of this manner of research shaped Japanese psychiatric learning to reflect the dominant trends in international psychiatric research, which would prove important to later receptions of Japanese research.[8] Since these schools placed an emphasis on pathology and the hospital and academic practices of psychiatry, Kure developed programs at the university that continued these traditions. As an assistant under Kure, Morita was assigned to work on psychotherapy with the schizophrenic patients admitted to the hospital, focusing on the biological components of mental illness. Though his research under Kure yielded fruitful results, Morita himself was drawn towards research in the neurosis that had plagued his childhood. Coupled with his interest in the difficulties of human existence that had been born of his studies of religion and philosophy, this led his research towards the predisposition and constitution of those suffering from mental disorders.

Upon becoming a licensed psychiatrist, Morita served terms at a number of hospitals across Japan and further observed forms of neurosis in the clinical setting. In

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[8] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis*, 83. This importance will be discussed in greater detail in chapter three, particularly in relation to Morita's own research publications.

1903, he began working on his own at Tokyo Prefecture Sugamo Hospital (*Tōkyō-to Sugamo byōin*, renamed in 1918 as Tokyo Prefecture Matsuzawa Hospital). In the same year, he became a Professor of Psychiatry at Tokyo Jikei-kai Hospital Medical Vocational School (*Tōkyō Jikei-kai Iin Igaku Senmon Gakko*).[9] During this time, he published widely on not only neurasthenia—which heralded his future achievements in the diagnosis and treatment of shinkeishitsu—but also on the fields of invocational psychosisand superstition. His research into this field asserted that psychosis could be induced through prayer and incantation, symptoms of which included character transformation and the delusion of possession by a spirit. These conditions were believed to continue for up to several months. Morita believed that these disorders arose from an emotional experience that combined with a religious mentality common to primitive belief in *kami* and other spirits. In 1906, he began working at the psychiatric clinic of Negishi Hospital. While there, he became interested for a time in the related discipline of developmental psychology and conducted research on children, publishing six articles between 1906 and 1917 on abnormal child psychology. It wasn't until 1919 that he finally began publishing his theories on shinkeishitsu and opened the first treatment center for Morita Therapy in his own home.

## MORITA THERAPY

According to Fujita, Morita's ultimate goal was for patients to be able to achieve self-improvement and reach their full potential.[10] Emotions such as anxiety and suffering prevented self-actualization through the creation of contradiction and internal conflict,

[9] Shōma Morita, "Shinkeishitsu no ryōhō (The treatment of shinkeishitsu)," 96. Jikei Hospital currently is one of the remaining centers for Morita Therapy that still produces research on the subject in Japan. It is also one of the largest Morita Therapy centers in the world.
[10] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis*, 6.

which distracted one from being able to find his or her true path. However, rather than viewing these feelings as foreign or in themselves unnatural, Morita acknowledged that these feelings were a natural phenomena, and as such he sought to devise a therapy that would enable his patients to overcome these feelings rather than avoid them. In so doing, the patient would be able to achieve self-actualization and be able to live a normal life.

In 1919, Morita opened the first center for Morita Therapy out of his own Tokyo home.[11] Morita Therapy is a type of meditative, self-reflection therapy designed to deal with shinkeishitsu, a type of constitutional nervous disorder, as well as other physical and mental ailments. It is one of the therapies that is often called a "non-talking cure," in which silent introspection is necessary for the change of a person's mental condition.[12]Though this therapy was initially designed only to treat shinkeishitsu, it was also found to be effective in the treatment of a number of physiological and mental disorders, including chronic organ disorder and bulimia nervosa. The treatment, as prescribed by Morita, includes four stages: (1) isolation and rest, (2) light occupational labor and therapy, (3) heavy occupational labor and therapy, and (4) complicated activity therapy designed to prepare the patient for reentry into normal life activities.[13] Patients must complete all four stages in order to receive full benefit from the therapy, though often modifications can be made to last two treatment stages in order to address particular needs or concerns of patients.

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[11] Ibid., 56.

[12] Shigeru Iwakabe, "Psychotherapy Integration in Japan," *Journal of Psychotherapy Integration* 18, no. 1 (2008): 118.

[13] Though nearly 100 years have passed since the first publication of the Morita Therapy technique, Japanese facilities still use all four steps in the treatment of nervous disorders. There is some variation among international branches of the Morita Therapy Centers, which will touched upon in the epilogue.

In the first stage of treatment, the patient is placed in an isolated room and instructed to remain in a prone or restive state for up to one week. All outside stimuli, such as sounds and scenery, are restricted as much as possible to place the patient in a truly isolated state. During this stage, the patient is prohibited from engaging in tasks such as smoking, reading, and talking with people. Since these activities are prohibited, the patient is allowed to sleep as much as he or she is able, as well as engage in silent contemplation In this way, patients can recover from physical and mental fatigue, as well as give them an opportunity to evaluate their own physical and mental pain outside of their typical environment. The therapists who oversee the isolation process are also able to make an assessment about further diagnosis and treatment options. Clients who suffer from illnesses other than shinkeishitsu are often unable to complete this stage of the treatment, but those who have the right type of nervous disorder often make it to the end. For instance, Morita's patients who suffered from hysteria were considered to have a "weak-willed disposition" and were not able to conform to the requirements for rest and isolation.[14]

Morita's predicted a reasonable pattern of progress for most patients. For the first few days, patients are able to lie quietly and sleep when they are tired. Additionally, many patients observed an increase in appetite from the beginning of the first day.[15] Within a few days however, many patients experience a wakeful state even at night. This increased attentiveness often results in ruminations over ones suffering and mental condition, which will then ideally result in realizations about the truth of the severity of one's psychical and mental condition. David K. Reynolds, an

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[14] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, trans. Akihisa Kondo (Albany: State University of New York Press, 1998), 36-38.

[15] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis,* 201.

anthropologist whose work centers on meditation and what he terms "constructive living therapies" such as Naikan therapy, underwent Morita therapy as part of his own research in the 1970s. He describes the experience of this stage as follows:

> I began to realize, experientially, that thoughts bubble to the surface of my mind, coming from nowhere, receding into nothingness, replaced by other thoughts. The need to keep some control over the content of my thinking prompted me to begin to review my past from my earliest memories…. I had come to realize that I was the product of concern and kindness of other people in my life…. Every skill, every possession, every idea that I considered "mine" had been created, developed, or given to my by others or by "nothingness." [16]

While Reynolds likens Morita Therapy to Zen Buddhist meditation, it should be noted that Morita himself disavowed such a direct link between the two processes, as the author will discuss further. What is significant about his experience is that his realizations occurred at the same time as most of Morita's patients, usually on the fourth or fifth day. Moreover, Reynolds' account and experience fall perfectly in line with what Morita predicted as a result of this first stage of treatment. Afterwards, patients are usually filled with the desire for activity and a sense of the outside world. As boredom increases, the desire for activity grows until the patient is instructed to clean their room and move on to the second stage.

In the second stage, the patient is allowed to engage in specific activities set to them by the therapist during the day, but they must remain primarily in isolation from social contact. Furthermore, patients are allowed to rest between 9:30 P.M. and 6:00 A.M., but they are not allowed to rest during the day. Even if the patient feels tired, he or she must spend daylight hours outside in exposure to fresh air and sunlight, such as picking up the yard of leaves and reading a predetermined number of pages from

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[16] David K. Reynolds, *The Quiet Therapies: Japanese Pathways to Personal Growth* (Honolulu: The University Press of Hawaii, 1980), 8-9.

historical texts such as the Kojiki. As Morita describes, the purpose of this stage is to "let the client calmly endure his or her distressful symptoms and to stimulate spontaneous activities and desires for action by driving the client to experience mental and physical boredom," and typically lasts from between three days to a week.[17] The patient must therefore refrain from conversations with others, exercising, singing, or any other activity that will distract them from their self-reflection. During this stage, the patient is also instructed to keep a diary of his or her thoughts, which is read each day by the therapist to aid in further diagnosis.

According to Morita, the purpose of the second stage of the therapy is to "let the client calmly endure his or her distressful symptoms and to stimulate spontaneous activities and desires for action" so that he or she will experience the pains of physical boredom.[18] Coming out of a period of isolated rest, the opportunity to perform some functions will initially satiate the desire for action in most patients, but since the range of activity is still strictly limited, the patient will soon return to feelings of boredom. Though the patient will also experience a return to feelings of anxiety or suffering during this time, Morita believed that the desire for action as a relief of boredom would be greater than the feelings of suffering on the part of the patient. Additionally, the tasks assigned were designed to be small tasks (such as picking up fallen leaves in a section of the garden) rather than large ones (such as cleaning the entire yard). This is because of the tendency towards perfectionism in patients suffering from shinkeishitsu. Morita believed that if patients were allowed to perform complicated or intensive tasks during this stage of the therapy, they would be unable to get beyond their fear of failure and desire to do the task perfectly. This would disrupt their potential progress and bring

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[17] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, 44.
[18] Shōma Morita, "Shinkeishitsu no ryōhō (The treatment of shinkeishitsu)," 104.

them into contact with their neurosis in a troubling manner. The importance is to allow patients to resume activity while also discouraging them from evaluating their own thoughts or behaviors.

Despite the fact that the patients during this stage are encouraged to record their thoughts or activities in a journal, the therapists who read them are instructed not to respond to patients' complaints of ailments or symptoms of their disorders. Most shinkeishitsu patients in time stop reporting feelings such as fatigue or lightheadedness either because they have stopped noticing their effects or because they have realized that they therapists are not going to respond to these observations. In some cases, however, when a patient notices a lack of symptoms (such as the absence of a chronic headache) the therapist is instructed to relate this observation back to the development of self-awareness so that the patient can be observant of the changes in his or herperceptions.

The third stage centers on a return to labor-intensive activities and the promotion of physical endurance for labor. Typical tasks during this stage include chopping wood, digging holes, and working in the fields tending to crops. There are three goals inherent in this type of activity: (1) to gain the patience and ability to endure physical labor, (2) to inspire confidence in the value of labor and to encourage subjective experiences, and (3) to feel successful in performing labor and to receive encouragement for one's accomplishments. The focus of this stage is on getting patients past their anxieties about the work they are being asked to perform and the values that they might normally attach to that work. Patients are encouraged to perform activities that they think normal people do and are encouraged to do work that he or she might typically consider unsuitable for their level of personal or professional achievement. Examples of this might be a company CEO cleaning out toilets or a university student changing straps on

clogs.[19] This helps patients break down preconceived notions about the value of certain tasks and the accompanying anticipatory feelings that a patient might have for needing a high evaluation of his or her work.

Despite the increased physical labor, patients during this stage are also encouraged to foster their own natural interests in activities. In this way, patients are often able to achieve extraordinary results despite their initial condition. Morita relayed the story of one patient who succeeded in crafting a violin using candy boxes and other wood scraps. "The joy of this client, felt at the moment he heard the instrument's sound, can be compared with the experience of Thomas Edison the moment he found a dim light emanating from his electric lamp."[20] This period of labor can be either short or long in duration, depending on how the patient progresses according to the three goals of this stage, but typically this stage also lasts between three days and one week, with some patients remaining for up to a month. According to the therapist's evaluation of the patient's improvement in each of these three areas, an individual may then move on to the fourth and final stage of the therapy.[21]

In this final stage, patients are encouraged to engage in what might be called a "life-training" period, in which they continue labor at the facility or hospital but are also permitted to continue other activities such as reading and doing errands outside the facility. Patients are also allowed to resume communication with their family members and conduct personal business, such as banking and shopping for groceries. Additionally, sports and activities with other patients help increase socialization opportunities and create an atmosphere of purposeful enjoyment.

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[19] David K. Reynolds, *The Quiet Therapies: Japanese Pathways to Personal Growth*, 13.
[20] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, 50.
[21] Ibid., 48.

One of the common complaints of those suffering from shinkeishitsu is a lack of concentration or memory when it comes to retaining information through reading. As such, one of the most common activities during the fourth stage revolves around building the reading concentration of patients. Books on the subject of history, biographies, or astronomy are presented to individuals, and they are instructed to read whenever they have spare minutes between activities (such as finishing meals, getting ready for bed, and so on). Patients are instructed to open their books to a random page and begin reading for as long as it holds their interest, whether for only a few minutes or a few hours. Most patients found that as their time in the fourth stage went on, they were able to read for longer durations of time and with more clarity about the subject matter they were pursuing, even if they had previously no knowledge of the subject of the book.

As opposed to the third stage, when activity is designed to reflect the interests of the patient, during this stage the patient is supposed to ignore their own interest in favor of accomplishing necessary tasks, such as those surrounding work and life activities. It is important during this stage that the patient is attentively aware of the intent to all activities and that nothing is done without a specific, practical purpose.[22] This enables the patient to focus on tasks rather than the feelings of anxiety or fear related to the anticipation of completing the activity. In time, the patient may be released to return home, though they continue to attend ex-patient meetings and socialize with other ex-patients, as well as receive hospital newsletters. A relationship is maintained between the treatment center and the patient for as long as the symptoms of shinkeishitsu persist.[23]

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[22] David K. Reynolds, *The Quiet Therapies: Japanese Pathways to Personal Growth*, 23.

[23] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, 52.

**THE MEANING OF ILLNESS AND SHINKEISHITSU**

At the time of the opening of the first Morita Therapy Center, Morita also published his first complete set of theories about the nature of mental illness that he believed could be treated using his therapy. Through his experiences working with patients at the Jikei Hospital as well as those at the Negishi clinic, Morita had already come to some assumptions about the nature of anxiety disorders and their relationship to physical symptoms. This relationship was predicated on a relationship between the mind and body that asserted a natural connection between the two—psychic trauma as well as physical trauma could lead to the development of anxiety disorders, which manifested themselves through the basis of physical and mental symptoms of distress.[24]

Since the ultimate goal of Morita therapy is the self-actualization of the individual, which includes internal harmony with ones thoughts and feelings as well as external harmony in ones social relationships and with ones environment, many western psychologists have mistakenly classified Morita Therapy as being closely related to Zen Buddhism.[25] However, Morita founded his therapy based on his own observations on the nature of suffering and neurasthenia-related illnesses, which were based on the psychoanalytic theories devised by his early twentieth century Western contemporaries.[26] The relationship between Morita Therapy and the Zen philosophies that it so closely mirrors were not considered by Morita to be necessarily religious. Rather, he saw this relationship as confirmation that the goals of Buddhism were among those most closely

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24 Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, trans. Akihisa Kondo (Albany: State University of New York Press, 1998), 45.

25 H.B. Gibson, "Morita Therapy and Behavior Therapy," *Behaviour Research and Therapy* 12 (1974): 353.

26 This relationship will be explored in chapter three.

related to the psychotherapeutic techniques being developed in Europe during this period.[27]

Morita's work at the clinic of Negishi Hospital was the ground upon which he based his theories about the nature of neurosis and treatment methods, yet his personal experience as a sufferer of acute anxiety attacks were doubtlessly influential on his ideas about the condition. Although he continued researching many different subjects during this time, Morita was most concerned with patients who suffered from what he called shinkeishitsu, commonly translated as "neurasthenia." Morita, however, explicitly rejected the term and instead insisted on the nature of "anxiety-based disorders" emerging as a result to a person's "over sensitivity to felt sensation or hypochondriasis".[28] He believed shinkeishitsu was at its base a form of hypochondria, in which concerns about a person's body or fear of contracting an illness would preoccupy that person's thoughts. These thoughts of illness centered on a fear of death, as had Morita's own thoughts from his childhood. This in turn would produce a number of symptoms, ranging from a sense of dizziness, a sense of headache, a feeling of fatigue, or the inability to concentrate.[29] Once the person was convinced that these symptoms were the result of some underlying condition, they would invariably attempt to root out the cause of the illness, which would in turn lead to further suffering and negative emotions until the person was depressed about his or her condition. Treating the symptoms, Morita wrote, would not resolve the condition. One must concentrate on treating the hypochondrias base in order to resolve the condition. For most patients suffering from shinkeishitsu, these symptoms are

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[27] Shōma Morita, "Shinkeishitsu no hontai to ryoho (Nature and treatment of nervosity)," in *Morita shōma zenshū* Vol. 2, ed. T. Kora, (Tokyo: Hakuyosha, 1974), 183.
[28] Ibid., 106.
[29] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis* (Tokyo: Igaku-Shoin, 1986) 63.

subjectively judged to be greater than they really are, hence differentiation Morita makes between “a headache” and “a sense of a headache.” Through the course of Morita Therapy, these feelings would eventually be revealed to the patient as subjective indications of discomfort rather than real ailments, and the patient would learn to treat them as a symptom of their hypochondria rather than another illness.

This base Morita results from internal tensions present in all human beings, namely the desire for improvement of the self and a desire for the preservation of the body, or rather, a fear of death.[30] The desire for self-improvement, on the one hand, is best expressed through the desire for self-improvement, or *sei no yokubō.* According to Morita, this concept is defined as a “life-force, and a desire for self-development and self-actualization, in any human being who lives with vigor.”[31] While this desire is not always readily visible in modern life, it can become so through the use of silent reflection and contemplation. For most people, the desire for self-improvement is a natural process and occurs through self-motivation. On the other hand, in each person there is also a natural fear of harm or death. Since this trait causes the individual to act in a manner that is inconsistent with the development of the self, it can result in a psychological condition in which the person is afraid of seemingly inconsequential things. He referred to this fear as being rooted in a “hypochondrial mental state”—for example, that a person is afraid of coming across a dog rather than simply being afraid of dogs.[32]

In mentally healthy individuals, there is a balance between the desire for self-improvement and the fear of death. These two opposing forces are together referred to

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[30] Ibid., 103.
[31] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis,* 7.
[32] David K. Reynolds, *The Quiet Therapies: Japanese Pathways to Personal Growth* (Honolulu: The University Press of Hawaii, 1980), 18.

as "the contradiction by ideas (*shisō-no-mujun*)," and when they are in balance there is no stagnation in a person's life.[33] Morita also referred to this balance as a contradiction between one's objectivity and subjectivity, which existed for all people. For instance, one's desire for self-improvement may lead to the acquisition of a new hobby or skill, but the fear of harm or death may prevent someone from attempting to make a living off of that new interest. However, when the hypochondrial state overpowers one's desire for self-improvement, psychological and mental symptoms manifest themselves. These include headaches, palpitations, dizziness, weakness, insomnia, and more complex symptoms such as feeling shame in public.[34] This imbalance can be caused by situational factors, such as the daily stresses in one's life, or they can be caused by underlying constitutional deficiencies that arise as a result of one's childhood and upbringing.[35]

The symptoms of shinkeishitsu are themselves common ailments that mentally healthy people also experience, but because of their underlying hypochondria, people with shinkeishitsu tend to regard these experiences as signs of abnormality because of their underlying hypochondria. Additionally, as Morita describes, "when a person's attention is fixated on a sensation, awareness of that sensation becomes sharper and sensitivity to the sensation increases. The mutual interaction between sensation and attention heightens the person's awareness of the self and the sensation."[36]

Initially, Morita identified three major pathological types of shinkeishitsu: ordinary shinkeishitsu, paroxysmal neurosis, and obsessive ideation or obsessive disorder, all of which could be treated using his therapy. Ordinary shinkeishitsu is the type that is typically diagnosed as neurasthenia. It is diagnosed through by the

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[33] Shōma Morita, "Shinkeishitsu no ryōhō (The treatment of shinkeishitsu)," 105-106.
[34] Ibid., 101.
[35] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, 46.
[36] Ibid., 127.

symptoms of neurasthenia that Morita identified and has at its base a hypochondrial state by which the patient comes to his or her symptoms. Paroxysmal neurosis is characterized by its “pain-like attacks,” which include palpitations, spasms, and fainting. These symptoms are caused by acute fear or agitation, and may often be misdiagnosed as hysteria. Obsessive disorders, meanwhile, is present when the patient focuses excessively on his or her symptoms as evidence of morbid abnormality. The suffering is centered on one or more particular “obsessive foci,” which include fear of omens, fear of theft and murder, fear of making mistakes, and “fear of being thrown off from the earth by its rotation.”[37] The patient must learn to eliminate all resistance to the perceived suffering of their condition in order to be relieved of their fear, and Morita believed that the best method for doing this was through Morita Therapy.

## CULTURE-BOUND ILLNESS: *TAIJIN KYŌFUSHŌ*

When initially outlining his theories about the nature of shinkeishitsu and its occurrences, Morita did not believe that it was a disorder that was unique to the Japanese people. Rather, he engaged in debates with many scholars who were interested in studying neurasthenia and other disorders from a variety of cultural perspectives, including Emil Kraepelin, Otto Binswanger, and Sigmund Freud.[38] This was directly contrary to the original definition of neurasthenia as proposed by George Miller Beard in 1869. Beard believed that neurasthenia was an American culture-bound syndrome that could not occur in any other nation in the world.[39] Morita and his contemporaries who

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[37] Ibid., 129.
[38] This conversation with Freud will be remarked on further in chapter three.
[39] Charles E. Rosenburg, "The Place of George Miller Beard in Nineteenth Century Psychiatry," *Bulletin of the History of Medicine*, no. 36 (1962): 252.

investigated these nervous disorders argued that Beard's definition was not comprehensive enough to describe all of the causes and symptoms of neurasthenia, and it was on this basis that they contributed to furthering the definitions of this disorder. The idea that there could be a culture-bound component to the illness, however, was not completely dismissed.

In the 1930s, Morita expanded on his theories of shinkeishitsu with reference to a specific kind of social phobia. He called this disorder *taijin kyōfushō* (対人恐怖症) literally the disorder (*shō*) of fear (*kyōfu*) of interpersonal relations (*taijin*).[40]A person who possessed strong hypochondrial state underlying their shinkeishitsu was more likely to develop this social phobia than someone who had only a moderately strong hypochondrial base.[41] However, Morita believed that the disorder was a culture-bound syndrome in a way that common shinkeishitsu or neurasthenia were not. This was because of the strong feelings of shame attached to the anxiety of the disorder.[42] In a person with any of the first three types of shinkeishitsu that Morita described was introduced into a social situation that was unfamiliar to them, he or she would experience a fear of blushing, facial expressions, blemishes, body odors, and other body deformities. A person with shinkeishitsu and this culture-bound social phobia, on the other hand, would not simply fear these reactions, but experience shame at both the reaction and at his or her own fear of the reaction.

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[40] Fumiko Maeda and Jeffery H. Nathan, "Understanding Taijin Kyōfushō Through Its Treatment, Morita Therapy," *Journal of Psychosomatic Research* 46, no. 6 (1999): 525.

[41] Neither Morita's writings nor any article I have been able to find has been able to quantify the relative strength of an underlying hypochondrial state.

[42] Fumiko Maeda and Jeffery H. Nathan, "Understanding Taijin Kyōfushō Through Its Treatment, Morita Therapy," 526.

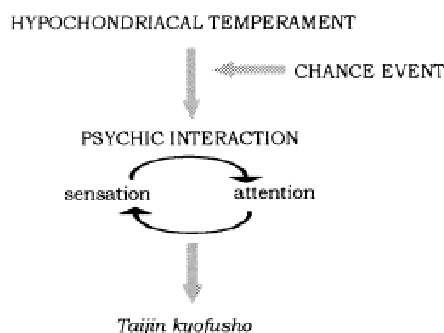


Figure 2: The relationship between shinkeishitsu and*taijin kyōfushō*.[43]

Depictions of Japanese culture as a "shame culture" have been prevalent in both Western and Japanese scholarship. Ruth Benedict (1887-1948), the noted anthropologist, popularized the idea for an American audience in her seminal work *The Chrysanthemum and the Sword*, which inspired a myriad of responses to her use of the concept to differentiate Japanese culture from Western culture.[44] Morita, writing nearly twenty years before Benedict, could have no knowledge of her conclusions, but much like Benedict, he believed that Japanese people were more prone to this characteristic than people from any other culture. Especially significant to the Japanese case was the fear of looking others directly in the eye or making prolonged eye-to-eye contact.[45]

Just as with shinkeishitsu, Morita believed that social phobia could be treated through Morita Therapy. As the patient was instructed to work through his or her discomfort and the sensation of symptoms, he or she would come to a voluntary tolerance of the symptoms, which would in turn lead to acceptance. Sometimes the cyclical

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[43] Ibid., 528.

[44] Ruth Benedict, *The Chrysanthemum and the Sword*, 2nd Edition (Cleveland: Meridian Books, 1967).

[45] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis*, 108. Since the fear of one's reaction to these social situations was so strong, Morita also believed that this shame could result in a tendency towards perfectionism or further obsessive behavior.

pattern of anxiety and acceptance would repeat themselves many times over before a patient was cured of the disorder (see Figure 3). Just as with those who suffered from other forms of shinkeishitsu, patients with this social phobia were instructed to maintain a relationship with their treatment center even after they were discharged from the therapy center. This was designed to prevent a relapse in symptoms that might threaten a patient's health.

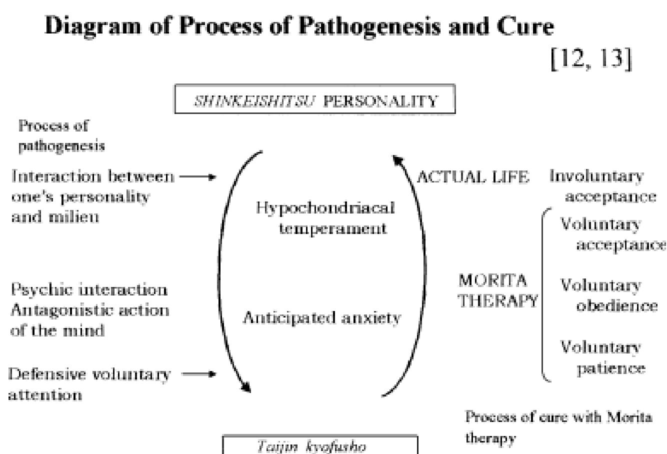


Figure 3: The progression and treatment for *taijin kyōfushō,* including the stages for treatment under Morita Therapy.[46]

**CONCLUSION**

Morita first published the results of his therapy in 1924, the same year in which he moved his practice from the Negishi clinic to Tokyo Imperial University. There he began teaching medical students in his techniques and in the methodology of the Kraepelinian School under which he himself had been taught. In 1925 he became a professor at Jikei-kai Medical College. He also served as an advisor at Negishi hospital, where he taught students that include Kora Takehisa (who later became one of the most

[46] Fumiko Maeda and Jeffery H. Nathan, "Understanding Taijin Kyōfushō Through Its Treatment, Morita Therapy," 528.

celebrated Japanese psychiatrists of the postwar period). In 1937, he retired from Jikei-kai Medical College, becoming the first honorary professor of the school. Morita passed away on April 12, 1938, at the age of 74.[47]

[47] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis*, 76-78.

## Chapter Two: "Native Knowledge" on Mental Illness

Morita's ideas about the nature of mental illness and the relationship between the mind and body were born in an era of transition in the context of Japanese mental healthcare. During the Meiji Era and the process of national modernization and industrialization, the biomedical interpretations of mental disorders adapted from Western systems of mental health came to dominate perceptions about mental illness. This is not to suggest, however, that psychiatrists were the only ones who were able to interpret the symptoms of mental illness, nor were they alone in appropriating the treatment of mental illness as part of their role in institutionalized systems of mental health care. In fact, there were a number of groups whose contact with the phenomena of mental disorders predated the introduction of Western medical science to Japan.

Recent work focusing on the relocation and dispersion of knowledge has made an effort to decode the process by which knowledge, particularly scientific knowledge, is created. Bruno Latour has convincingly argued in his work, *The Pasteurization of France*, that scientific knowledge is not a series of breakthrough discoveries (as commonly depicted), but it is rather a complicated process that involves competing interests, networks of specialists, and various audiences to which the knowledge is presented.[48] Ann Jannetta has made a similar argument with regards to medical history in Japan over the same time period in her work, The Vaccinators: Smallpox, Medical Knowledge, and the 'Opening' of Japan. Through her example of the importation of western medical knowledge that occurred nearly fifty years before Perry forced the opening of Japan, Jannetta demonstrates how influential medical practitioners were in the

[48] Bruno Latour, *The Pasteurization of France*, trans. Alan Sheridan and John Law (Cambridge: Harvard University Press, 1988).

creation of knowledge during this period.[49] Japanese psychiatry, and more specifically Morita Therapy, was formed through a process very similar to that described by Latour and Jannetta. Morita's academic and medical colleagues were instrumental in shaping his process and theories, like Pasteur's, and the marketing of his therapy required an audience who understood the concepts behind the therapy. Most interestingly, the competing interests in the development of Japanese psychiatry were most often those that advocated alternative diagnosis and treatment—proponents of older knowledge that had dominated the discourse on mental health prior to this period. The most common of these were spirit possession, and ki-stagnation.

In Japan in the late 1800s, the existing discourse on mental healthcare was rapidly expanding as scholars went abroad and attempted to imitate Western style psychiatry as another framework for interpreting mental illness. During the Meiji era, rapid modernization and westernization efforts confronted generations of traditions that were considered "backward" or "primitive" by these new standards, such as the alternative methods mentioned previously. Both spiritual possession and ki stagnation theories offer explanations for the same disorders that Morita therapy was designed to treat, and both were still practiced in 1919 when Morita opened the first Morita Therapy institute. Therefore, in order to conceptualize Morita Shōma's theories on the nature of mental illness and its treatment, it is necessary to consider alternative frameworks for understanding mental illness.

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[49] Ann Bowman Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the 'Opening' of Japan* (Stanford: Stanford University Press, 2007).

## SPIRITUAL POSSESSION AND MADNESS

Despite the general theme of modernization and industrialization that marks the Meiji era, many people believed that world was full of creatures such as spirits who stole children (*zashiki warashi*), goblins (*tengu mori*), and strange hermits who were actually *kami* in disguise. Given the combination of these images, it is not surprising that spirit possession was a common explanation for a person who behaved in a manner incongruous to the expectations of a person in public. Irokawa describes in *Culture of the Meiji Period* the tale of an old woman who would frequently visit the site of a factory to stand outside and laugh "in a scary, vulgar way".[50] This experience frightened the factory workers so much that the plant was closed down and relocated rather than face the continued presence of the spirit the presumed to be inside her.

This image of the modern factory, built upon the very premise of the Meiji period, being tormented by an old spirit, is particularly poetic. The modernity represented by the placement of the factory—a space meant to further the development of the nation, of industry and future promise—was being tormented by an old woman whose affliction was an old world spirit. Gerald Figal has theorized that images such as these, particularly those whose images are monstrous in nature, occur during periods of transition as a form of social control—an outlet for the internal tensions of society. Spirit possession was a part of the history of mental health; "a discourse on the supernatural, the mysterious, and the fantastic…was constitutive of Japan's modern transformation."[51] This theory is supported by the fact that Irokawa finds no need to remark on the difference between these images. When considering mental illness,

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[50] Daikichi Irokawa, *The Culture of the Meiji Period,* trans. Marius B. Jenson (Princeton: Princeton University Press, 1985), 20.
[51] Gerald Figal, *Civilization and Monsters: Spirits of Modernity in Meiji Japan* (Durham, NC: Duke University Press, 1999), 7.

modernity existed alongside tradition in a manner that persisted through the imposition of modernization policies by the state.

Spirit possession has a long history in Japanese culture, and it has long been a mainstream explanation for erratic behavior. There were a number of spirits whose inhabitance inside a living person was cause for alarm. In some instances, the spirit was that of an animal, such as the dog or fox spirit. In others, the spirit was believed to be that of a deceased individual whose wrath had been incurred through an action or a failure to act. Both forms of possession could manifest themselves with similar symptoms, and it was often left up to authorities on the subject of possession (such as shaman or priests) to diagnose the ailment. It was animal spirit possession, however, that was most closely associated with mental illness. In particular, a person believed to be possessed by the spirit of a fox was attributed with madness and extremely erratic behavior and was often stigmatized until treated.[52] These spirits were believed to enter the body in spirit form and disrupt normal functioning. *Inari* fox spirits were among the most cunning and manipulative, and as such they were often blamed for any malaise.[53]

The evidence of a spiritual possession or influence could manifest itself through a number of symptoms—some physical and some mental. Medical booklets and pamphlets from the Edo and Meiji period have described the possessed as exhibiting "unusual acts" and speaking in "disordered words," indicating a deviation from a normal pattern of behavior as observed by those close to the individual. A persistent illness such as a lingering cold could be the sign of a maleficent spirit, but a spiritual presence could also be indicated by a persistently gloomy mood, explosive rage, or excessive

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[52] Though foxes were usually considered to be the most maleficent, ailments were also often linked to badgers, dogs, snakes, and weasels.

[53] Karen A. Smyers, "My own inari: Personalization of the Diety in Inari Worship," *Japanese Journal of Religious Studies* 96 (1996): 85-116.

pensiveness, even an inspired or exalted state. Physical symptoms such as seizures were also commonly associated with the influence of a spirit as the ill person often hallucinated during these episodes.[54] However, a person who was experiencing general malaise unassociated with any known diseases or illnesses could also be suffering from spiritual possession. These experiences represent a theme in literature that persists through the modern period, indicating that there was a continuing popular fascination with the concept of spirit possession even as it was difficult to document or prove.

Despite the increase in psychological and medical discourse, methods of treatment for spirit possession varied based on the region and local culture. In some places, spirit possessions were treated through the use of sources with specialized knowledge and training—such as shamans, mediums, or priests, sometimes in tandem with one another. For instance, shamans known as *yuta* in Okinawa were named for their tendency to shake (*yuyung* in Okinawan) during their trance-like state, during which time they made contact with their personal god or ancestor and were able to advise clients on how best to resolve their current issues.[55] In northern Japan, blind or near-blind women called *itako* were also able to enter a trance-state and commune with the spirit inside a particular person. In the Tohoku region, women were recognized as *kami uba* when they were believed to possess a special connection to the spirit realm.[56]

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[54] Seizures were also one of the identifying features of a woman who could be trained to become a medium or shaman, as with training a woman was supposed to learn how to interpret these hallucinations as messages from the spirit world. Particularly in the case of the *yuta* in Okinawa, it is now believed that many of the women who become *yuta* suffer from either epilepsy or schizophrenia.

[55] Matthew Allen, "Therapies of Resistance? Yuta, Help-seeking, and Identity in Okinawa," *Critical Asian Studies* 32, no. 2 (2002): 248. Kunimitsu Kawamura, "A Female Shaman's Mind and Body, and Possession," *Asian Folklore Studies* 62, no. 2 (2003): 257-289.

[56] Kunimitsu Kawamura, "A Female Shaman's Mind and Body, and Possession," *Asian Folklore Studies* 62, no. 2 (2003); Alan L. Miller, "Myth and Gender in Japanese Shamanism: the 'itako' of Tohoku," *History of Religions* 32, no. 4 (1993): 343-367.262.

The titles and rituals of these intercessionary women varied by location, but they all served a similar function within their region to intervene on behalf of those possessed. Many shamans and mediums were believed to be in such close connection with the spirits that they had become hosts for spirits themselves. The spirit possession of a medium was not perceived as a malaise, as mediums were believed to use their close contact with the spirits to help alleviate those who had suffered through a possession. If the woman was believed to be in the possession of an evil spirit, or if the woman was believed to simply be an "abnormal person (*mono tsuki*)," then her claims to be a shaman would not be recognized.[57] Many mediums and shamans had symptoms similar to those they were supposed to be treating, but with the aid of their own resident spirits, they were able to communicate with the spirits living in others. Through this contact, they were able to recommend the best way to remove the spirit, either through an offering or performance of a ritual that would appease its desires.[58]

In addition, both Buddhist and Shinto priests also performed rituals to diagnose and alleviate the symptoms of a spiritual possession, which, given their purview, were usually the vengeful spirits of ancestors whose last wishes had not been observed. Buddhist priests, for example, were often responsible for the management and care of posthumous souls that were entrusted to particular temples and for the parishioners who resided in the community. In addition to dispensing medicines that were marketed as "cure alls" for a variety of diseases, Buddhist priests would also perform chants and burn

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[57] Kunimitsu Kawamura, "A Female Shaman's Mind and Body, and Possession," *Asian Folklore Studies* 62, no. 2 (2003): 257-289.; Karen A. Smyers, "My own inari: Personalization of the Diety in Inari Worship," *Japanese Journal of Religious Studies* 96 (1996): 85-116.

[58] Alan L. Miller, "Myth and Gender in Japanese Shamanism: the 'itako' of Tōhoku," *History of Religions* 32, no. 4 (1993): 352. Susan L. Burns, "Relocating Psychiatric Knowledge: Meiji Psychiatrists, Local Culture(s), and the Problem of Fox Possession," *Historia Scientiarum* 22, no. 2 (2012): 88-109.

incense as part of appeasement rituals for departed souls.[59] In the Meiji period, the New Religions also stepped up to fulfill the role. Nancy Stalker, in her depiction of the New Religious movement of Ōmoto, discusses the roles that spirit possession played in these religions. For example, faith healing practices such as the laying of the hands (*teate*) were part of the major draw for new followers of New Religions such as Ōmoto and Tenrikyō.[60]Successful treatment of one who had been possessed by a spirit, whether animal or human, was when the spirit was successfully expelled from the body. This would result in a disappearance of all related symptoms.

As Susan Burns notes in her work on the formation of psychiatric knowledge and madness in Meiji Japan, by the 1870s the conception of "fox possession" had come under attack from a variety of authorities, ranging from government officials and Enlightenment intellectuals to psychiatrists and psychologists trained and educated in Western Europe.[61] For these individuals, spirit possession was yet another form of backward and primitive practice that made the entire country seem weaker in comparison to the Western nations it was attempting to imitate. For different reasons, however, it was also a source of contestation among medical practitioners who had not been trained in western science, many of whom had already come to doubt the authenticity of spirit possession as a diagnosis for mental disorders before the process of medicalization had begun. In contrast to using spirit possession as the organizing concept for mental illness, these professionals relied on Chinese medical knowledge for the source of their criticism.

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[59] Duncan Ryūken Williams, *The Other Side of Zen: A Social History of Sōtō Zen Buddhism in Tokugawa Japan* (Princeton: Princeton University Press, 2005) 169.
[60] Nancy Stalker, *Prophet Motive: Deguchi Onisaburō, Oomoto, and the Rise of New Religions in Imperial Japan* (Honolulu: University of Hawaii Press, 2008), 80.
[61] Susan L. Burns, "Relocating Psychiatric Knowledge: Meiji Psychiatrists, Local Culture(s), and the Problem of Fox Possession," *Historia Scientiarum* 22, no. 2 (2012): 88-109.89-90

## KI STAGNATION AND TRADITIONAL MEDICINE

Medical practitioners living in early Meiji Japan were often untrained in Western medical science, but they organized experiences of mental illness based on reference to the Chinese concept of *ki*(*qi* in Chinese).[62]Ki was believed to be a living force that existed in all things, felt through the wind in the atmosphere and the breath in the human body. This essential force circulated through objects and gave them life energy, but because of its transient nature, internal and external forces could also alter ki. Inside a human being, ki could become irregular, blocked, or even stagnant, and the resulting emotional and physical discomfort would center itself around the organs, prompting the sufferer to seek medical attention. This condition, ki stagnation or constraint (*ki-utsu* 気鬱), was diagnosed by medical practitioners through the early twentieth century to explain mental illness and madness.[63]

*Ki-utsu* and *ki-utsushō* (signs of ki stagnation) have a long history in Japanese health discourse. The character used to represent *utsu* (鬱) depicts a group of closely clustered trees, signifying a physiological state in which growth in dense areas is stagnated. Kitanaka Junko has attributed the importation of the concept of *utsu* in the sixteenth century to Tashiro Sanki, who brought the term back from China. Tashiro also described different types of *utsu* such as blood-*utsu*, phlegm-*utsu*, and even food-*utsu*, all of which might manifest some of the same symptoms as *ki-utsu*. In both Chinese and Japanese medical texts, a diagnosis featuring this character originally indicated a persistently gloomy mood. Throughout the eighteenth century, *utsushō* and *utsubyō* (stagnation illness) were illness categories whose chief symptoms were a depressed state

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[62] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," *Culture*, *Medicine and Psychiatry* 37 (2013): 61.
[63] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress,* (Woodstock UK: Princeton University Press, 2012), 21.

of mind, lack of energy, and social withdrawal. Diagnosis of *ki-utsu* was widespread enough that several Emperors and shoguns were treated for the condition in the years since. For instance, the Emperor Goyōzei (1571-1617) was diagnosed with utsushō and treated through the use of medicinal herbs. Tokugawa Iemitsu (1604-1651), the third shogun of the Tokugawa dynasty, also suffered from attacks of utsushō through and was treated for his symptoms more than once.[64]

Though at first confined to indicate these narrow symptoms, ki stagnation and other ki disorders were gradually expanded in medical discourse to signify a wide range of emotional ills.[65] For instance, Hiruta Genshirō demonstrated that terms that utilized ki as their defining concept were often used by officials and traditional doctors to describe unusual behavior and emotional states. In Moriyama in the late 1700s, illness categories included terms such as *ranshin* (disordered heart), *kyoki* (deranged ki), *tenkan* (convulsions), and *kichigai* (altered ki).[66] Each diagnosis was attached to a particular condition that was related to a similar Western mental disorder. In the 1870s, when the first Western medical texts were translated to Japanese, *ki-utsu* was the translation used for the category of illness called melancholia.[67] Even as melancholia fell out of use in psychiatric discourse, *ki-utsu* was redefined to include first nervous disorders and then the modern concept of depression.[68]

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[64] Ibid,. 25-26. Today, *utsu* is used colloquially for *utsubyō* or depression, which has been identified as an epidemic in contemporary Japan.
[65] Ibid., 24.
[66] Genshirō Hirutao, "Edo jidai ni okeru seishin igaku byōin ron," *Seishin igakushi kenkyū* 3 (2003): 27-39.
[67] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress*, (Woodstock UK: Princeton University Press, 2012), 34.
[68] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," *Culture*, *Medicine and Psychiatry* 37 (2013): 61.

Part of the value of ki stagnation as a category of mental illness was that it could be used to describe a wide range of symptoms and conditions. Since the stagnation could occur around any major organ within the body, the symptoms and prognosis for the treatment could vary as well. For instance, the Edo period medical practitioner Wada Tōkaku (1744-1803) believed that the liver was the center of the body responsible for producing emotion, and that a blockage of ki in the liver could result in feelings of frustration and resentment, causing idleness and the inability to work.[69]Ki stagnation could be caused by psychological or physical trauma, along with an increase in stress or anxiety. It could manifest itself in any normally healthy person, but it was also thought to occur more often in people whose lifestyles were considered unproductive. Women in particular were in danger of this type of stagnation, and morality tales were used to remind them to put effort into their household labors lest they run the risk of becoming ill.[70]

Unlike issues of spirit possession, ki stagnation was considered a medical issue and were thus treated by a medical practitioner using traditional medical knowledge that was loosely based on Chinese medicine (commonly referred to as kampo).[71] Wada, for instance, believed firmly in the healing power of the Ki health drink—a brew of herbs that opened up blockages with its aromatic smell and bitter taste.[72] Another typical remedy for ki stagnation involved talking therapy (*ronsetsu* 論説), in which a doctor would listen to the complaints of a patient before revealing to them the moral issues

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[69] Ibid., 63-64.

[70] See for example Duncan Ryūken Williams, *The Other Side of Zen: A Social History of Sōtō Zen Buddhism in Tokugawa Japan* (Princeton: Princeton University Press, 2005).

[71] In order to avoid confusing Japanese traditional medicine with other styles of Chinese-influenced medical science, kampo will be used to refer to the Japanese traditional medicine.

[72] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," *Culture*, *Medicine and Psychiatry* 37 (2013): 65.

behind their complaint. In most people, this was typically a lack of strong work ethic, and upon diagnosis of the stagnation, it was common for the patient to receive a doctor-recommended increase in physical labor, much like patients who underwent Morita Therapy. This among of activity was believed to force the movement of ki and to push through blockages, reversing the condition and alleviating symptoms.[73] Many of those who suffered from stagnation symptoms were the sons and daughters of well-off families, who also tended to suffer from ki stagnation because of their unproductive lifestyles. In this case, herbal remedies were common to help circulate the forces in the body, since it was unlikely that a doctor would prescribe work-therapy as a treatment.[74] In combination with therapies such as acupuncture and pressure point massage, these measures were believed to be the most effective method of relieving stagnation, though it was also believed that a person who had once suffered from this affliction was more prone to relapse into their depressive state.[75] A person was considered cured, however, when the symptoms of the ki stagnation were reversed and the ki was believed to be flowing properly once again.

Kampo doctors persisted in their treatment of ki stagnation well into the late eighteenth century, but modern healthcare policies and the national hygienic movement made their involvement in the mental healthcare system less and less significant as time went on. In 1875, the Medical Licensing Act institutionalized academic standards for

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[73] Junko Kitanaka, Depression in Japan: Psychiatric Cures for a Society in Distress, (Woodstock UK: Princeton University Press, 2012), 29.

[74] There was a class-based component to kampo medicine that reflected the societal structure of the Tokugawa period. Those in the samurai class were less likely to be prescribed work therapy because of their elevated status, while merchants and commoners were considered less productive simply by virtue of their lower class.

[75] Nathan Sivin, "Science and Medicine in Imperial China--the state of the field," *The Journal of Asian Studies* 47, no. 1 (1988): 48.

medicine, all of which were based upon Western concepts of health and illness.[76] Kampo practitioners were able to keep their licenses through loopholes in this system, but as more Western medical texts were translated and implemented as teaching tools in universities, even these traditional practitioners began to find their specialties subsumed by biomedical subspecialties in Western healthcare systems. *Ki-utsu* developed new bio-medical meanings in relation to nervous disorders, centered on the involvement of the head rather than the liver or other organs. KureShūzōhimself related stagnation to manic-depressive psychosis rather than to the ki to which it was generally associated.[77] These and other developments resulted in a decline of traditional medical practices, especially in urban areas where access to western-trained doctors was greatest.

In the 1930s, a group of kampo doctors who were also trained in Western medical science attempted a revitalization of traditional medicine, reshaping their practices to reflect the biomedical perspective that patients had come to expect from their healthcare system. Rather than using the traditional categories of illness that had been developed with reference to the Chinese conception of ki, they centered instead around Western medical categories such as neurasthenia and other nervous disorders.[78] For instance, Yumoto Kyūshin, a kampo doctor associated with the Ancient Formula Current school of Kampo, advocated the belief that there was a single bodily poison that was responsible for illnesses ranging from neurasthenia to insomnia, hysteria to neuralgia. This belief was based on a tenet passed down through the Ancient Formula Current school from the Edo-period doctor Yoshimatsu Tōdō, who had believed that poisons were the cause of ki

[76] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," *Culture*, *Medicine and Psychiatry* 37 (2013): 69.
[77] Junko Kitanaka, "*Utsu no byō* (Disease of Constraint)," in *Kindai nihon no shintai kankaku* (*Bodily Experiences in Modern Japan*), (Tokyo: Seikyūsha, 2004), 359.
[78] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," 70-71.

stagnation in patients. Instead of relying on this explanation, Yumoto related his diagnosis to the Western concept of 'autointoxication' developed by Ilya Ilyich Mechnikov in 1927.[79] Water poison (*suidoku*) was thus rebranded as urinary autointoxication (*nyōei jika-chūdokushō*), and though the diagnosis was officially based on the western concept of 'toxins,' the cure for such an illness was still within the same brand of Japanese traditional medicine that had been available for centuries previous: a bupleurum and cinnamon decoction and a three coptis pill.[80]

Attempts to rebrand poisons as toxins were common in the kampo revival during this period. At around the same time, Mori Dōhaku (a kampo doctor in the Later Masters Current), attempted to explain neurasthenia through the organizing mechanism of ki stagnation. Like Yumoto, Mori believed that neurasthenia was caused by poisons in the body, but unlike Yumoto, Mori believed that there were three different poisons in the body which could cause this disease. They were stagnant blood, food poison, and water poison. In addition, Mori shared with Morita the belief that there were different constitutional types that caused people to react differently to each of the poisons. He called these the stagnant blood constitution, the poisoned organ constitution, and the detoxification constitution. Determining each patient's constitutional type and type of poison was of key importance to diagnosing the type of neurasthenia. Treatments would vary then based on both the type of poison and the constitution of the individual. For instance, someone who suffered from detoxification constitution would likely develop symptoms such as insomnia, headaches, stiffness in the back and shoulders, and loss of

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[79] Ibid., 75-76.

[80] Keisetsu Ōtsuka, *Shoko no yoru kanpo chiryo no jissai* (*Practice of traditional Chinese medicine in the treatment of diseases arranged by symptoms*), (Tokyo: Nanzando, 1963), 372. Otsuka The bupleurum and cinnamon decoction (柴胡加桂湯) was used to treat liver ki constraint and disharmony between the liver and stomach. The three coptis pill (三黄丸) was often used to treat constipation.

appetite. Since in Mori's view these symptoms all indicated that the poison was located in the liver, the main treatment would focus on removing this poison with a schizonepeta and forsythia decoction.[81]

The kampo revival in the 1930s was dependent upon results to survive; if doctors could not satisfactorily explain their process to their patients and then show them evidence of a successful treatment, their practices would cease to exist. Despite their attempts to rebrand their pathology through the use of biomedical terminology and equate their practices to the Western medicalized knowledge that was also developing at this time, kampo was still second place to the "modern" doctors whose knowledge of Western systems of mental healthcare were promoted by the government and industrial military complex.

## MORITA AND "NATIVE KNOWLEDGE"

Neither Morita's theories nor his therapy is completely incongruous with the knowledge about mental disorders that existed prior to the widespread acceptance of Western psychiatry. In comparison to ideas about spiritual possession and the role that ki played in the mental and physical health of individuals, Morita's ideas were more centrally located around Western medical terminology and concepts; yet his ideas about the relationship between mind and body bear a striking resemblance to ideas that had been circulating in Japan for centuries prior to his work.

All three mental healthcare systems—spirit possession, kampo, and Morita therapy—could be termed "culture-bound" systems. While spiritual possession and ki stagnation do exist in other cultures such as China, the particular processes and

[81] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," 72-73.

treatments have taken on a Japanese quality through their years of practice in Japan. For instance, in China, spirit possession is often treated through the intervention of an abbot in a trance-state, communicating through the spirits.[82] Specific names for Japanese healers (i.e. *itako*, *yuta*) and the particular methods of communication are unique to each healer, and the training that these healers receive is unique to the area of Japan that they come from. Ki stagnation theories—while based on Chinese medical science—used herbs and techniques specifically developed in Japan as a result of particular forms of ki imbalances.

In much the same way, Morita Therapy is often compared to meditation therapies and religions, specifically Zen Buddhism. Since the ultimate goal of Morita therapy is the self-actualization of the individual, which includes internal harmony with one's thoughts and feelings as well as external harmony in one's social relationships and with one's environment, many western psychologists have mistakenly classified Morita Therapy as being closely related to Zen Buddhism.[83] Morita himself acknowledged this similarity, citing the sermons of the Zen priest Hakuin (1686-1769) and the likeness between enlightenment and the state of inner tranquility achieved as a result of the rest-isolation stage of Morita Therapy. However, as Morita also states, "the psychological explanations for my method are not related to religion."[84] He founded his therapy based on his own observations on the nature of suffering and neurasthenia-related illnesses, which were based on the psychoanalytic theories devised by his early twentieth century

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[82] Tara L. AvRuskin, "Neurophysiology and the Curative Possession Trance: The Chinese Case," *Medical Anthropology Quaterly* 2, no. 3 (1988): 288.
[83] H.B. Gibson, "Morita Therapy and Behavior Therapy," *Behaviour Research and Therapy* 12 (1974): 353.
[84] Shōma Morita, *Morita Therapy and the Thre Nature of Anxiety-based Disorders (Shinkeishitsu)* (Albany: State University of New York Press, 1998), 36.

Western contemporaries.[85] The relationship between Morita Therapy and the Zen philosophies that it so closely mirrors, therefore, should be seen as confirmation that the goals of Buddhism were among those most closely related to the psychotherapeutic techniques being developed in Europe during this period. Both Zen and Western psychology during this period hoped to achieve the self-actualization of the individual and an internal balance between positive and negative forces.

In addition, since mental healthcare systems were by no means exclusive during the Meiji and Taisho periods, one individual who sought treatment from a shaman or mystic, a kampo doctor, and a psychiatrist could receive three different diagnoses for the same illness. Therefore it is not surprising that all three systems maintained a similar definition of what constituted a cure. A reoccurrence of symptoms was not necessarily a refutation of a particular diagnosis. In all cases, the management of symptoms so that they did not impede a functional lifestyle was the most important outcome of treatment. In spirit possession, one spirit might be considered expelled, but the host was a likely target for future possessions because they were known to be susceptible to a host spirit. Someone who suffered from ki stagnation or poison/toxins in a particular organ was advised to take care to seek additional medicines for future ailments. Patients who suffered from shinkeishitsu maintained contact with their Morita Therapy center for years after treatment, and in some cases, the full benefit of the therapy was believed to take up to two years before it could be felt by the patient.

Treatment of spirit possession or ki stagnation were necessary when there was an imbalance between the mind and body. When outside forces change the way that this connection functions, mental illness is experienced in the form of madness, hysteria,

[85] This relationship will be explored in the next chapter.

nervous disorders, and physical pain and discomfort. In the same way, Morita's theories about the connection between mind and body also rely on balance between opposing forces; in the cause of shinkeishitsu patients, this is a balance between the desire for sel-improvement and the fear of death. Those believed to be inhabited by animal or human spirits needed to force the spirit to leave the host, restoring normal relations between the mind and body. Those whose diagnosis was of a blocked ki channel or a stagnation of the ki inside the body, needed to correct the flow of ki to restore its movement in the body. Those who suffered from shinkeishitsu were forced to confront symptoms of suffering and the fear of death, allowing the desire for self-improvement to overcome fear. The concept of balance is equally important in all three epistemologies, and through this balance, mental illness could be properly alleviated.

Perhaps most interestingly, both Morita's therapies and his technique share many common traits with kampo revival doctors during the 1930s, perhaps even more so than with traditional medical doctors at the beginning of the Meiji period. Kampo was not just a method of treatment for mental illness; it was also a medical science used in the treatment of diseases and illnesses of the body. At the same time that mental healthcare was undergoing medicalization, there was a similar process occurring in healthcare overall. Beginning at the beginning of the nineteenth century as a result of the importation and translation of Dutch medical texts, medicinal knowledge of kampo practitioners was challenged by Western medical knowledge.[86] During the Meiji period, kampo was suppressed by the state as a "primitive" practice, and procedures such as acupuncture were not taught at medical schools. Kampo persisted through the practitioners who had learned the Chinese-style medical techniques, and the size and

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[86] Ann Bowman Jannetta, *The Vaccinators: Smallpox, Medical Knowledge, and the 'Opening' of Japan* (Stanford: Stanford University Press, 2007).

scope of the Japanese state's modernization efforts was not extensive enough to root them out completely.[87] Particularly in rural areas, kampo medicine was available when western-trained doctors were not, which resulted in a great deal of 'traditional' medical practices, mental healthcare among them.

The kampo revival movement in the 1930s represents an attempt on the part of some kampo doctors to not only "modernize" their specialty, but also to defend their practice from the encroachment of western medical norms on a widespread scale—the first such concerted effort to occur within the kampo movement after the Meiji Restoration.[88] Kampo doctors treated diseases and mental illnesses using traditional herbs and practices and giving them biomedical justifications for their effectiveness. In much the same way, the similarities between Morita Therapy and Zen Buddhism were specifically denied by Morita, despite the fact that they have been remarked upon by a variety of patients and experts in the psychiatric and Buddhist communities. Perhaps a reason for his refusal to attribute the influence of Zen on his technique can be found in the position of Buddhism during the early twentieth century in Japan. As a component of the nation-building practices of the Meiji Restoration, the state officially endorsed Shinto as the official religion of Japan. Shinto was utilized as an organizing mechanism for the hierarchy of the nation, from the Emperor down to the peasant population, and its position within the state became particularly important during the early twentieth century as Japan moved into imperialist acquisition of overseas territories in Korea and China.[89] Buddhism, which had been the official religion of the Tokugawa shogunate, was branded

[87] For example, see Keiko Daidoji, "Water Cures in Japan: The Case of a Health Manual in the Early Nineteenth Century," *Asian Medicine* 5 (2009): 80-107.
[88] Keiko Daidoji, "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors," *Culture, Medicine and Psychiatry* 37 (2013): 59-80.
[89] See Helen Hardacre, *Shinto and the State, 1868-1988* (Princeton: Princeton University Press, 1989).

by state propaganda as a primitive religion. More significantly, Buddhism was vilified for its wasteful practices; the same priests who had performed healing rituals for spirit possession were accused of graft and lechery. Buddhism survived in much the same way as kampo survived during this period—through the individual priests who persisted in practicing their religion, and through adapting Buddhist teachings to the terminology of the state-accepted nation-building rhetoric.[90]

Morita Therapy's relationship to Zen Buddhism must be considered in terms of the relationship between the two in the context of 1920s Japan, when Buddhism was still in many ways fighting for its position within the state. If Morita Shōma had chosen to openly admit to the influence that Zen thought had on the development of Morita Therapy, it would allow Morita Therapy to be branded with the same label of "backward" practice as the priests who practiced it, even though the state had by this time retrenched on its prosecution of Buddhist practices. Kampo doctors in the 1930 attempted to do the same by using terminology and explanations found in Western medical texts. Framing Morita therapy within the terminology of medicalized discourse from the West enabled Morita to not only brand his therapy as a form of treatment equal to Western psychotherapy, but also to avoid the possibility of being considered a primitive solution to the complex problem of mental healthcare.

## CONCLUSION

Though in the early twentieth century spirit possession ceased being utilized as an effective explanation for mental illness, ki stagnation was able to survive through Kampo

[90] Michael Mohr, "Japanese Zen Schools and the Transition to Meiji: A plurality of responses in the nineteenth century," *Japanese Journal of Religious Studies* 25, no. 1/2 (1998): 167-213.

doctors' willingness to engage with Western biomedical standards of health in order to continue practicing medicine.[91] This adaptability, particularly prevalent in the 1930s in Japan, occurred during the same decades in which Morita Therapy centers were attempting to expand their practices and gain international recognition for their theories about the nature of mental health. In order to understand the nature of the debate between existing forms of native knowledge on mental healthcare and the Western medicalized interpretations of mental healthcare, one must first turn to the expansion of the Japanese psychiatric healthcare system in the Meiji and Taisho periods.

[91] Spirit possession would eventually make a comeback as a form of popular fascination through such icons as Ehara Hiroyuki, the spirit counselor and psychic whose TV production is famous in Japan today.

# Chapter Three: Modernizing Japan, Medicalizing Psychiatric Knowledge

In his work studying beriberi disease in modernizing Japan, Alexander Bay has posited that in the past historians have paid too much attention on how states use health discourse as a control mechanism for citizens and colonial subjects. Rather than observing the process from the top-down, he argues, scholarship should also consider the "debates, divergences, and tensions over medical matters."[92] The beginnings of psychiatric medicine in Japan, which was influenced by many of the same factors as other forms of medical knowledge, is no exception. From the importation and adaptation of biomedical mental healthcare concepts from the United States and Europe to the early Showa period of psychiatrist research production, individuals influenced Japan's mental healthcare system as much as state policy.

Many scholars have written about the Meiji Restoration and its affect on the development of modern Japan. Industry expanded rapidly, resulting in greater production and new opportunities for consumption. The feudal class system was abolished and the state became directly involved in the creation of a national "Japanese" identity. The government itself was transformed as a result of conscious adaptation of Western norms of government, intended to convince the West to abolish unequal treaties. Every facet of daily life—ranging from food to popular culture to education—was affected in some way by this great transition. The rapid industrialization and growth that occurred in the post-Perry years resulted in Japan's growth as an international military power by the end of the period in 1912.

[92] Alexander R. Bay, *Beriberi in Modern Japan: The Making of Modern Disease* (Woodbridge: Boydell & Brewer, 2012): 5.

As part of its process of state building and industrialization, the Meiji government relied on the adoption of western concepts in order to bolster its position and authority as a modern nation. This included ideas related to the medicalization of psychiatric disorders, which had up until this time been dominated by primarily Chinese concepts of mental illness, as described in Chapter Two. The introduction of Western texts on psychiatry and the opportunity to send scholars and intellectuals to study and learn from experts in both the United States and Europe gave Western-style psychology its first footholds into the Japanese discourse on mental health. In addition, in 1873, the government formally outlawed many of the traditional methods of healing mental disorders, including shamanism.[93] This was the first of several attempts by the federal government to limit or ban folk traditions that threatened its image of a "modern nation." By limiting the alternative methods of assessment and treatment available to those with mental disorders and further discrediting Chinese medicine as a source of healing, Western psychiatric knowledge was given fertile ground in which to develop during the Meiji period and beyond.

With support from the government, scholars began traveling to Europe and the United States and learning the psychiatric methods that were brought back to Japan and then used to treat a wide range of mental disorders. Morita was one of many students who trained under this first generation of Japanese psychiatric specialists, and the knowledge that he and others created impacted both the definition of mental illness and the method and styles of treatment to the present day.

[93] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress* (Princeton: Princeton University Press, 2012): 41.

## INTRODUCING WESTERNMEDICINE: THE MEIJI PERIOD

Beginning in the late 1860s, Japanese scholars who were interested in Western concepts of physical and mental health began the process of translating a number of famous texts on the subject. Takasuna Miki, a Professor of Psychology at Tokyo International University who has written extensively on the development of psychology in Japan, has attributed many of these translations to Nishi Amane (1829-1897).[94] Nishi was a scholar and expert on philosophy, traveled to the Netherlands from 1862 to 1865 and brought back his studies of law, economics, and especially philosophy. Nishi is believed to have translated most of the first works to influence the development of psychology and psychiatric care in Japan, including Joseph Haven's *Mental Philosophy* (1869), Alexander Bain's *Mental and Moral Science* (1868) and *Mind and Body* (1871), and James Sully's *Outlines of Psychology* (1884) and *Teacher Handbook of Psychology* (1886).[95] These and other texts translated during this period represent scholarship from a variety of schools of thought on the subject of mental health and illness, and despite the contradictory nature of some of the evidence they present, these works were the basis for understanding modern medicalization of mental health practices. Takasuna also credits Nishi with coining the term *shinrigaku* (literally, "mental philosophy" 心理学) for what is now called psychology.[96]

In addition to the burgeoning field of psychiatric text translations, Japanese medical practitioners took advantage of state resources to travel abroad in order to learn from experts in both Europe and the United States. For instance, Motora Yūjirō (1858-

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94 Miki Takasuna, "Proliferation of Western Methodological Though in Psychology in Japan: Ways of Objectification," *Integrative Psychological & Behavioral Science* 41 (2007): 84.

95 Ayumu Arakawa, "Psychology of feelings and Emotions: its history in Japan," *Japanese Psychological Research* 47, no. 2 (2005): 107.

96 Miki Takasuna, "Proliferation of Western Methodological Though in Psychology in Japan: Ways of Objectification," 85.

1912), one of the first experimental psychiatrists in Japan, lived in the United States from 1885 to 1888 in order to study at Johns Hopkins University.[97] There he befriended G. Stanley Hall (1844-1924), a professor of psychology who was interested in evolutionary theory and childhood development. When Motora returned to Japan, he and Hall remained in contact until Motora's death. Hall's influence on Motora's work is believed to be extensive. Motora built the first clinical laboratory for conducting psychological and biomedical experiments in 1903, and it was through this setting that the first Western-style medical experiments were conducted in a non-Western country. His student Matsumoto Matataro completed the second laboratory at Kyoto University in 1907.[98]

German neuropsychiatry also came to have a strong influence on the development of Japanese psychiatric institutions as German doctors and Japanese doctors developed close relationships personally and professionally.[99] The effort to base the Japanese mental healthcare system on the German model seems to have begun in the 1870s, at almost the same time as the translation of many of Nishi's texts. The University of Tokyo was founded in 1877, and at the time almost all of the faculty in the School of Medicine (as in almost all departments of the University) were German. By the time it was renamed Tokyo Imperial University in 1886 this balance had shifted towards a faculty of mostly Japanese professors. By the beginning of the twentieth century, there were only two remaining German teachers—Internist Erwin von Baelz (1849-1913) and the surgeon Julius Karl Scriba (1848-1905). Baelz was particularly influential on the development of psychiatry during this time, as part of his teaching at the Tokyo Imperial

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[97] Ayumu Arakawa, "Psychology of Feelings and Emotions: its history in Japan," 107-108.

[98] Koji Sato and C.H. Graham, "Psychology in Japan," *Psychological Bulletin* 51, no. 5 (1954): 443.

[99] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress,* 21.

University included psychiatry. When the University formally opened a Department of Psychiatry in 1886, one of Baelz' students, Hajime Sakaki (1857-1897), was chosen to become the first Professor of Psychiatry.[100]

In addition to the formal educational relationship that passed psychiatric knowledge between German and Japanese experts, many Japanese psychiatrists studied in Germany during the early Meiji period and brought back knowledge about assessment and treatment that they learned abroad. One of the most notable of these was Kure Shūzō (1865-1932)—Morita's future mentor at the Tokyo Imperial University who was himself a student of Baelz. Kure was sent by the Japanese government to Germany to study neurology and psychiatry. While abroad, he studied at the laboratory of Heinrich Obersteiner (whose work centered on the importance of the central nervous system in mental health) and with Emil Kraepelin (1856-1926). His relationship with Kraepelin turned out to be particularly significant; Kure returned to Japan in 1901 and became a professor at Tokyo Imperial University, where he taught psychiatry based on Kraepelin's theories of diagnosis and treatment of the mentally ill.[101]

The Kraepelinian School differed from other psychiatric theories at the time because of its innovative approach to the definition and treatment of mental illness. This difference occurred in two major ways. First, Kraepelin believed that mental illnesses such as depression and neurasthenia should be classified and treated in the same way as any other disease like cholera or the measles. Rather than locating mental illness as a pathological defect, referring to it as an illness to be treated and cured made the condition less stigmatized and more scientific, rather than emotional. This included the

[100] Akira Hashimoto, "A 'German world' shared among doctors: a history of the relationship between Japanese and German pscyhiatry before World War II," *History of Psychiatry* 24 (2013): 181.
[101] Ibid., 189-190.

idea that mentally ill patients should be hospitalized rather than confined in asylums for their condition.[102] Second, Kraepelin's definition of mental illness was based on a scientific-objective analysis of the symptoms, one that was rooted in biological and genetic dysfunctions. Through careful observation of a patient's behaviors and (when possible) an understanding of the motivation behind certain thoughts and actions, Kraepelin believed that mental illness could be better treated as the course of mental illness progressed.[103] This view was contradictory to those such as Sigmund Freud, who emphasized the underlying psychological mechanism that caused mental illness.[104] Kure taught these principles as well as applied them in his own research later in the Taisho period. As a result, Kure's students went on to perpetuate these Kraepelinian philosophies within their own clinical practices and research.

Between the psychiatric and psychological sides of this wide spectrum of intellectual diversity, there is some disagreement among contemporary scholars as to whether or not the development of psychiatry in Japan during this time was more influenced byschools in the United States or in Germany. According to Arakawa Ayumu (a researcher in the Department of Psychology at Doshisha University), G.S. Hall and the American system of mental healthcare had the most influence over the development of psychology in Japan because of the connection between Hall and Motora. Motora's influence over the design and development of psychological experiments during the Meiji period was essential to shaping the research conducted in the Meiji period.[105]

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[102] Akira Hashimoto, "A 'German world' shared among doctors: a history of the relationship between Japanese and German pscyhiatry before World War II," 182.
[103] Emil Kraepelin, *Clinical Psychiatry*, trans. A. Ross Diefendorf (New York: The Macmillan Company, 1907) 146.
[104] Akira Hashimoto, "A 'German world' shared among doctors: a history of the relationship between Japanese and German pscyhiatry before World War II," 182.
[105] Ayumu Arakawa, "Psychology of Feelings and Emotions: its history in Japan," 110.

Misumi and Peterson argue that the concepts that were employed in the Psychiatry Department at Tokyo Imperial University were based upon the importation of the Kraepelinian School and from Germany because of the emphasis on neuropsychology and the development of intelligence testing and techniques for psychoanalysis.[106] In the related field of medical science, the German model replaced the Dutch model of medicine that had been imported in the early nineteenth century when Western medical learning was brought to Tokyo Imperial University. While it seems clear that both Schools had some influence over the development of mental healthcare, the state's endorsement of German medical practices in relation to medical health certainly makes it more likely that the German model was also more significant in shaping mental healthcare during this period.[107]

When it comes to debating the influences that were greatest on Morita during this period, on the other hand, the matter is much more clear-cut. Morita—through both his connection to Tokyo Imperial University and to Kure Shūzō—was drawn almost entirely from the German mode of thought on mental illness and specifically the Kraepelinian method. Both Morita's belief in the value of hospitalization over incarceration for mentally ill patients and his emphasis on symptomatic interpretation as the path to proper diagnosis were taught as part of the Kraepelinian system of neuropsychiatry during Kure's tenure. Where Morita differed from both Kraepelin and Kure, however, was in his beliefs on the origin of mental illness. Kraepelin and Kure both believed in the somatic root of mental illness; all disorders were at their root physical problems. Psychosis, for instance, could be the result of the weakening of the nervous system and

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106 Jyuji and Peterson, Mark F Misumi, "Psychology in Japan," *Annual Review of Psychology* 41 (1990): 213-241.

107 Nancy Stalker, "Editorial: Consumerist and Transnational Perspectives on the History of Japanese Medicine," *Asian Medicine* 5 (2009): v.

degeneration of nerves over time.[108] Morita, on the other hand, believed instead in influence that personality and emotional constitution could have on the development of mental illness. He disavowed any direct link between hereditary traits and mental illness, insisting instead on the effects of one's environment over the genetic composition.[109] Nevertheless, Kraepelin's influence on Morita Therapy's methods of assessment of mental illness can still be seen in the practice of the therapy today.

## PSYCHIATRY, THE PEOPLE, AND THE STATE

Academic psychiatry was not the only arena in which the discourse on mental healthcare systems was being debated; it was also being debated in terms of practical usefulness to the general public. Spirit possession and ki stagnation had achieved great currency over the course of Japanese history for being useful categories to distinguish different kinds of mental illnesses. The Meiji government's attempts to modernize the country greatly contributed to the critique of these native concepts of mental illness through its systematic efforts to eradicate "primitive" or backwards practices. These included folk and native traditions, as well as Chinese health concepts, which were believed to be inferior to Western systems of understanding. At the same time that Kampo doctors were struggling to reinterpret ki stagnation under new biomedical terms, Western trained psychiatrists were also trying to market Western knowledge as a system of explanation that could be understood by those who were suffering from mental illness, as well as their families. With the help of scholars who had trained in this new medical knowledge, the state was then able to utilize medical discourse for the sake of nation

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[108] Emil Kraepelin, *Clinical Psychiatry*, trans. A. Ross Diefendorf (New York: The Macmillan Company, 1907), 145.

[109] Shōma Morita, *Shinkeishitsu no hontai to ryōhō (Nature and treatment of nervosity)*, in *Morita shōma zenshuū*, Vol. 2, ed. T. Kora, (Tokyo: Hakuyosha, 1974), 183.

building through the same rhetoric that equated individual bodies with the hierarchy of the state.

Mental healthcare was in many ways a process of social management rather than social control. While the state was attempting to eradicate practices like kampo medicine and spirit healing, Sheldon Garon has described the process of the Meiji period as one of social management rather than social control. Rather than viewing modernization during this period as an attempt to impose top-down control over every facet of everyday life, Garon argues that the term "management" should be used because "Japanese officials and groups within society frequently interacted in formulating and manipulating programs to manage society."[110] This is also the perspective that Susan Burns employs when examining the debate over Inari fox possession.[111] Psychiatrists and doctors engaged with government policies in order to co-opt the discourse on mental health in the early Meiji period, taking advantage of state policies that supported this goal. Through the translation of texts related to different fields of psychiatry, new specialties were brought to Japan that increased the available terms of assessment for mental disorders and diseases. For example, shinkeishitsu (or any anxiety-nervous disorder) might be called hysteria if one was talking to a Freudian psychologist.

State involvement in concepts of mental health was aided by increased control over individual bodies. Involvement in international disputes created the need for a modern army with healthy soldiers. Japan's engagement in several wars (the Sino-Japanese war in 1894, the Russo-Japanese war in 1904, and World War I in 1914) helped to promote the national hygiene movement, which equated public health with the health

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[110] Sheldon Garon, *Molding Japanese Minds: the state in everyday life* (Princeton: Princeton University Press, 1997), 6.

[111] Susan L. Burns, "Relocating Psychiatric Knowledge: Meiji Psychiatrists, Local Culture(s), and the Problem of Fox Possession," *Historia Scientiarum* 22, no. 2 (2012).

of the Japanese state.[112] This included mental illnesses, and as increased diagnoses were recognized for mental disorders, new legislation for caring for the mentally ill was introduced. Beginning in 1900 with the Law of Confinement and Protection of the Mentally Ill, the official government policy on mentally ill patients was to keep them locked up and physically restrained within homes. While prior to this, private hospitals as well as temples and shrines often took in mentally ill patients, hospitalization was not standard practice until well into the Taisho era.[113]

As the Meiji period came to a close, terms such as ki stagnation began to lose their theoretical underpinnings. Kitanaka Junko has attributed this to the fact that people began to use ki to simply refer to all feelings rather than just a select set of negative ones, which reduced its usefulness as a concept for understanding mental illness.[114] This process had begun before the end of the Tokugawa period, but this deterioration occurred only more quickly as international interaction led to an intellectual revival on the topic of mental health. At the same time that the term ki stagnation was disappearing from Japan, melancholia was receding from use in the West as well, so that the two phrases became extinct at around the same time.[115] In place of these terms, the idea of 'depression' was becoming more prevalent in Western literature, whereas in Japan, the common term became *shinkeisuijaku* (神経衰弱, literally, "nerve weakness").

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[112] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress*, 45.

[113] Haruo Kuwabara and Reiko H. True, "National Social Policy Toward the Mentally Ill in Japan and Its Consequences," *International Journal of Mental Health* 5, no. 3 (1976): 98. If treatment was unsuccessful, the mentally ill person was often confined for the duration of his or her life. Priva

[114] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress*, 31.

[115] Clark Lawlor, *From Melancholia to Prozac: A history of depression* (Oxford: Oxford University Press, 2012), 202.

## THE GROWTH OF JAPANESE PSYCHIATRY : THE EARLY SHOWA PERIOD

While the Meiji period was characterized by the launch and establishment of academic institutions related to mental healthcare, the Taisho and prewar periods were dedicated to the growth and specialization of the Japanese mental healthcare system. Despite the cooperation between the Japanese and the Germans initially during the late 1800s, by the turn of the century, the Japanese psychiatrists had begun to embark on their own clinical and theoretical investigations without direct supervision and input from Western experts on the topics. Tokyo Imperial University had emerged as one of the most prolific research institutions of the time, producing an abundance of clinical trials on the subject of abnormal psychology, developmental psychology, and the psychology of emotions.

Kure Shūzō, who had been one of the many Japanese scholars to travel abroad during the Meiji period, was considered by many to be the father of modern psychiatry in Japan because of his role in shaping psychiatry during the Taisho period. According to Kitanaka, Kure's role was one of "transinstitutionalization"—a process by which psychiatry was able to extend from academic circles into institutions in both the public and private sector, as well as across organizations and various actors in society.[116] In addition to taking on and personally training students such as Morita, Kure was responsible for the establishment of the Japanese Society of Neurology (renamed the Japanese Society of Psychiatry and Neurology in 1935). Through the Tokyo Imperial University, Kure and his students (Morita among them) conducted epidemiological surveys of mentally ill patients across Japan in both 1910 and 1916. These surveys helped produce some of the only data available on the mentally ill individuals faced in

[116] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress* (Princeton: Princeton University Press, 2012), 45.

home detention as a result of the 1900 law.[117] Kure's group was also key in lobbying for the Mental Hospital Law, which in 1919 established the state's responsibility for providing care to mentally ill patients and moved them from home detainment to hospitals.[118]

Just as Bay observed in his work on the medicalization of disease during the Meiji period, Tokyo Imperial University soon became the institution under which the majority of formal mental health research and treatment was conducted. The reputation of the University for producing important politicians and Nobel laureates is well documented, but less well documented is the influence that the University had over the medicalization process that took place during the Meiji Period. The students who studied under the Department of Psychiatry there were along the most notable names in modern Japanese psychiatry, including D.T. Suzuki (1870-1966), Oguma Toranosuke (1888-1978), and Morita, among others.[119] Tokyo Imperial University students during the Meiji period engaged with Western scholars and brought back modern knowledge in a wide variety of disciplines, and as they went on to begin programs in other parts of the country. In addition, the University was the center of scientific knowledge produced during the Meiji period as well as the official testing center used to verify results from nonaffiliated researchers.[120]

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117 Kure's data relieved that there were as many as 23,931mentally ill patients being treated at homes and temples in 1905, and by 1917 there were as many as 64,914. Eighty per cent of these were men.[117] At temples, the mentally ill were chained to pillars with only a few feet of chain to allow them to move between bathrooms and their beds.

118 Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress*, 44.

119 Akira Hashimoto, "A 'German world' shared among doctors: a history of the relationship between Japanese and German pscyhiatry before World War II," 183. Koji Sato and C.H. Graham, "Psychology in Japan," 444. Suzuki is famed for his depictions of Buddhist culture for Western audiences and his work as a philosopher. Oguma was one of the leading researchers on dream psychology and abnormal psychology during the Taisho and early Showa periods.

120 Alexander R. Bay, *Beriberi in Modern Japan: The Making of Modern Disease*, 6-7.

However, as Eleanor Westney has chronicled in the development of other modern Japanese institutions such as the police force and the postal system, adaptation and imitation of Western practices were not the sole processes of the Meiji period. Her research has shown the role that innovation played in the successful implementations of these "modern" systems. For instance, the construction of the Japanese national police force in the early Meiji period was modeled on the French police force, yet they employed organization mechanisms of the arm, including dispersion patterns and training procedures, which allowed them to be professionalized more quickly and efficiently than their French counterparts. In this case, the innovation was at the hands of Yamagata Aritomo, the architect behind the Japanese army, who built the police force in a manner similar to that employed by the armed forces. Rather than simply copying the example of the French, individuals like Yamagata improvised solutions to problems unique to Japanese modernization.[121]

In a similar fashion, the influence of the University over the process of medicalizing concepts such as the idea of a mental illness had to confront ideas that existing in the public consciousness—ideas such as spirit possession and ki stagnation that had existed for centuries previous. There was also a process of innovation on the part of individual psychiatrists in making the new biomedical concepts of mental illness available to the proverbial man-on-the-street. KureShūzō and other psychiatrists gave public lectures on the mentally ill; the popular journal *Shinrigakukenkyū* (*Psychological Studies)* carried stories of abnormalities and pathologies in every day life, as did *Hentaishinri* (*Abnormal Psychology*). Much like the tales of mysticism and monsters in

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[121] B.D. Eleanor Westney, *Imitation and Innovation: The Transfer of Western Organizational Pratterns to Meiji Japan* (Cambridge: Harvard University Press, 1987), 75.

the early Meiji period, these verbal depictions shocked audiences even as they educated them on various mental health conditions like schizophrenia.[122]

In order to appeal to a mass audience, psychiatrists such as Morita often based their practices on themes that were familiar to the general public. Morita's therapy, which began with a restive relaxation period before engaging in work-therapy, could be likened to the Buddhist technique of meditating to find enlightenment, before forcing the movement of ki in order to work through a blockage. In fact, the connection between Zen Buddhism and Morita therapy has often been remarked by both Japanese and Western scholars, despite the fact that Morita himself disavowed such a direct link between the two.[123] Morita was also openly critical of many other psychiatrists during the period for being too concerned with symptomatic alleviation rather than focusing on the underlying causes of mental illness.[124]

It was not enough for a therapy to conform to public conceptions of mental illness; it also had to be defensible in terms of the medical discourse on mental illness that existed in both Japanese academic fields and international psychiatric circles. Thus, just as Morita's treatment resonated with themes that were familiar to those living through the modernization era, his therapy also needed to be able to exist in the ever-expanding world of neuropsychiatry. Morita's acknowledgement that hospitalization rather than confinement was the best course of treatment for those suffering from mental illness was distinctly drawn from the Kraepelinian School, as was his characterization of mental illness as a disease rather than an internal defect. Furthermore, Morita's

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[122] Junko Kitanaka, "Jungians and the Rise of Psychotherapy in Japan: A Brief Historical Note," *Transcultural Psychiatry* 40 (2003): 241.
[123] See David K. Reynolds, *The Quiet Therapies: Japanese Pathways to Personal Growth* (Honolulu: The University Press of Hawaii, 1980).
[124] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, trans. Akihisa Kondo (Albany: State University of New York Press, 1998), xv.

explanations, assessment, and treatment were all couched in the modern, medical terminology of the West rather than relying on existing terminology such as ki stagnation and terms related to spirit possession.

Japanese psychiatrists during the Taisho and early Showa periods worked to contribute to the scholarship on mental illness and cognitive functions in as many fields as existed in the West. Foreign visitors to the Tokyo Imperial University's experimental laboratories during this time often wrote with surprise when describing the facilities. As the variety of Western medicalized psychiatric theories increased in Japan, there was related growth in the number of psychiatric associations dedicated to research and innovations in treatment of each specific field. Within a few years, Japanese academics had organized a number of associations specializing in a variety of fields, including clinical psychiatry, educational psychology, developmental psychology, and even social psychology. Communication between these groups was limited, despite overlap between their subject matter, and they remained fractionalized, much like the *iemoto* system that existed in kampo medical practice during the Edo period.

Under the Western conceptions of mental illness, as they were adapted by Japanese practitioners of psychology, the idea of mental illness was thereby detached from the social environment of the individual and relocated to an internal defect, a pathology akin to weakness that was present even through treatment and which could never be completely eradicated. The treatment of mental illness as a neurological defect created a medical condition that could be stigmatized. Furthermore, this pathology required the removal of the individual from his or her community in order to treat their ailments, and many people who suffered from depression or other mental illness found it difficult to reintegrate with their community upon release.

## MORITA, BEARD AND FREUD: ON NEURASTHENIA

Like many Japanese psychiatrists living in this era, Morita engaged directly with a number of western scholars in the debate over the nature of illness and the relationship between the mind and body. While Morita wrote on a wide variety of disorders and illnesses, perhaps his most prolific writing was on the topic of neurasthenia, or, as he preferred to call it, shinkeishitsu. His participation in the debate over the source and treatment of this disorder centered on the writings of two major Western figures: George Miller Beard and Sigmund Freud. George Miller Beard (1839-1883) was a U.S. neurologist whose work popularized the term neurasthenia in 1869, just before the translation of the first psychiatric texts into Japanese. He popularized the term because he believed that hysteria and hypochondria were too general to be useful categories of illness, and then spent the rest of his career arguing the somatic base of mental illnesses was not reason to treat them differently than one would treat any other disease.[125] Sigmund Freud (1856-1939) was the Austrian neurologist who was best known for being the father of psychoanalysis; however he also wrote on the subject of neurosis and its relationship to the unconscious. Each of these three men had a different conception of the assessment and treatment for neurasthenia that is believed to have influenced the development of Morita's theories.

When Beard began writing on neurasthenia in 1869, he believed that the disease was a culture-bound syndrome unique to middle-class Americans, a byproduct of modernity that resulted from "the fast pace of urban life."[126] The list of physical and emotional symptoms linked to neurasthenia included anxiety, despair, heart palpitations,

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[125] Charles E. Rosenburg, "The Place of George Miller Beard in Nineteenth Century Psychiatry," *Bulletin of the History of Medicine*, no. 36 (1962): 2

[126] Marijke Gijswijt-Hofstra, "Introduction: Cultures of Neurasthenia from Beard to the First World War," in *Cultures of Neurasthenia from Beard to the First World War*, ed. Marijke Gijswijt-Hofstra and Roy Porter (New York: Rodopi, 2001), 1.

insomnia, and dyspepsia (among dozens of others), and the severity of these symptoms varied from person to person.[127] The category neurasthenia enjoyed differing levels of popularity in different countries over the course of the nineteenth and early twentieth centuries before finally falling out of use in the United States and Europe in the 1930s. In Japan, however, the term remained in popular use until the postwar era.

Beard's definition of the term neurasthenia was exactly what the word meant: a weakness of the nervous system. Each person was born with a different amount of electrical energy inside his or her nervous system, and so what was weak for one person was different from what was weak in another. When there was not enough electrical impulses inside the nervous system, a person developed weakness around one of the central organs, which resulted in the wide variety of symptoms that Beard included in his definition of the disease.[128] This somatic view of the illness was common for psychiatrists in the mid-nineteenth century, and resulted from their attempts to include mental illness as a category of disease that should be treated in the same way that a physician treated diseases. In addition, Beard also believed that there could be a hereditary component to neurasthenia that made it prevalent in some families.[129] There were only two methods of developing this disease: one was either born with the inability to produce enough electricity to run the nervous system correctly, or one was struck with the inability

Both Morita and Freud, writing several decades after Beard, objected to the somatic nature of the term as well as the relative cause of the disorder, to say nothing of

[127] Tsung-Yi Lin, "Neurasthenia Revisited: Its place in modern psychiatry," *Culture, Medicine and Psychiatry* 13 (1989): 105.
[128] Charles E. Rosenburg, "The Place of George Miller Beard in Nineteenth Century Psychiatry," *Bulletin of the History of Medicine*, no. 36 (1962): 246.
[129] Ibid., 249.

the idea that the disease was a culture-bound syndrome.[130] Freud observed the same symptoms of neurasthenia in his practices in Austria and believed that the cause of 'true neurasthenia' was an underlying traumatic event or a psychosexual event, such as frequent masturbation that resulted in the same symptoms that Beard observed in his patients.[131] This was opposed to the category of 'anxiety-neurosis,' a category to which he believed most of Beard's cases of neurasthenia actually belonged. The symptoms of the anxiety-neurosis were chronic versus acute or intermittent, but they also manifested themselves in psychosexual trauma and the inability to reach orgasm during coitus.[132]

Morita, on the other hand, rejected the term 'neurasthenia' altogether as a category of illness; neurosis, he insisted, was caused by anxiety-based disorders that "emerge[d] from one's over sensitivity to felt sensations, or hypocondriasis."[133] Rather than resulting from trauma, as did Freud's definition, the symptoms of shinkeishitsu were manifestations of an underlying character or personality trait.[134] Both acute and chronic forms of shinkeishitsu had their base in this hypochondriasis, and the hypochondriasis developed in response to an event of psychic trauma. Rather than being the overall category of illness, neurasthenia was simply a state of chronic fatigue from which no mental illness or disorder could be assumed. To put it simply, Morita believed that "it is not prudent to differentiate this condition specifically as neurasthenia."[135]

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[130] In fact, in response to Beard's publications in the 1870s and 80s, psychiatrists in at least a dozen different European and colonized countries published on the existence and treatment of neurasthenia in their own modern civilizations. See Marijke Gijswijt-Hofstra, "Introduction: Cultures of Neurasthenia from Beard to the First World War."

[131] Eduard Hitschmann, *Freud's theories of the neuroses*, trans. Charles Rockwell Payne (New York: Moffat, Yard and company, 1917), 17.

[132] Ibid., 23.

[133] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, 106.

[134] Shōma Morita, "Shinkeishitsu no hontai to ryoho (Nature and treatment of shinkeishitsu) " in *Morita shōma zenshū*, Vol. 2, ed. T. Kora (Tokyo: Hakuyosha, 1974), 183.

[135] Shōma Morita, *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu)*, 125.

In addition, Morita did not subscribe to Beard's belief in the genetic component of neurasthenia. To Morita, more important than the presence of a hereditary trait was the underlying personality of the person in question. Certain personality types, such as those who were introverts versus extroverts, were more likely to develop some kind of shinkeishitsu in their lifetime, as were those who already experienced some level of emotional hypersensitivity. A constitutional predisposition did not always result in shinkeishitsu; many such introverted and anxious people were able to maintain internal balance necessary for a healthy life.[136]

Insofar as treatment for neurasthenia, Beard believed that the best cure for the modern disease of neurasthenia was an improved modern lifestyle. This included following a strict diet, massage to relieve perceived aches and pains, electrotherapy, hydrotherapy, increased eliminations to rid the body of toxins, and rest in a therapeutic environment. Psychotherapy and other forms of engagement were not recommended because the disease was located within the body rather than in the mind.[137] Freud, in response, believed that patients who suffered from either true neurasthenia or anxiety-neurosis needed to confront their initial trauma through the use of psychoanalytic techniques. A trained therapist would guide the patient through the traumatic event and restore the psychic condition through the management of symptoms.

Morita's treatment for neurasthenia—Morita Therapy—can be considered in some ways a combination of Beard and Freud's therapies. Many of the conditions of Beard's treatment plan were available to patients simply by virtue of the fact that Morita Therapy centers provided them. Food was provided by the therapy centers, and the

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[136] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis* (Tokyo: Igaku-Shoin, 1986), 16.

[137] Jacquelyn H Flaskerud, "Neurasthenia: here and there, now and then," *Issues in Mental Health Nursing* 28, no. 6 (2007): 657.

ability to control the location of the center meant that a restive atmosphere could be maintained. Additionally, Morita acknowledged the need for rest in order to recover from one's mental and physical fatigue; the rest period in the first stage of Morita Therapy was required in order to move on to the second stage of the therapy. Furthermore, Morita Therapy created conditions for communication with the therapist in the context of one's journal. This can be considered akin to the psychotherapy prescribed by Freud, who believed in the relationship between therapist and patient to be essential to healing. Unlike Freud, however, Morita envisioned a much less central role for the therapist in overcoming shinkeishitsu. The therapist assessed when the patient was ready to move on to the next stage of the therapy, but did not guide the patient's thoughts towards the source of their anxiety.

Morita's addition to these theories of treatment can be found in the second, third and fourth stages of his therapy. Occupation therapy was already accepted as a form of therapy by many psychiatrists during Morita's time. KureShūzō had written about the value of using work therapy in treatment of psychosis and had even successfully applied the practice to his treatment clinic in Sugamo.[138] Moreover, work therapy had resonance with the preexisting treatments for ki stagnation which made it familiar to people who were still transitioning to Morita's medicalized discourse.

Throughout his life, Morita exchanged correspondence with many western intellectuals and gave countless presentations on the benefits of Morita Therapy as a tool for assessment and treatment of neurosis. He attempted to introduce Morita Therapy to the German Psychiatrics Society before his death, but it was discarded as being too

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[138] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis* (Tokyo: Igaku-Shoin, 1986), 18.

difficult to understand. Despite his efforts, Morita Therapy remained a Japanese culture-bound therapy until well after his death.

## PROBLEMS OF THE PREWAR PERIOD

Despite the growing popularity of western psychology in academic and scientific circles in Japan, it remained largely confined to intellectual and academic circles for many years. After the Meiji period, the various associations of sub-specialties in psychology remained fragmented until 1927 with the establishment of the Japanese Psychological Association. The creation of this overarching organization did initially unite psychologists during this period and provided a common forum for the discussion of theories that spanned across several fields; however, after only a few years, new organizations directed at subspecialties began to reemerge thereby reinforcing the factional divisions amongst the fields. This proved to be particularly problematic for public reception of western psychology, as the subspecialties were often very similar in their purview for diagnosis. For instance, the systems of clinical psychology, psychiatry, and mental disability were unclear to most Japanese during this period.

Furthermore, native conceptions of mental illness, while repressed during the Meiji period and into the later years of the twentieth century, still existed as an explanation for abnormal behavior and thoughts. While Susan Burns has documented the ways in which medical practitioners had critiqued spiritual possession long before the end of the Edo period, the resonance of these themes were still called upon by people who needed to explain the unexpected and unfortunate, such as the sudden suicide of an individual who had previously shown no symptom of disorder.[139] Even as the idea of

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[139] Susan L. Burns, "Relocating Psychiatric Knowledge: Meiji Psychiatrists, Local Culture(s), and the Problem of Fox Possession," *Historia Scientiarum* 22, no. 2 (2012): 88-109.

"melancholia" was replaced with "depression" and "neurasthenia" became "chronic fatigue," there were still many people who were willing to accept the intercession of spirits as an explanation for madness and were likely to seek out the services of a priest or monk in order to resolve such ailments. Particularly in small towns and rural areas located far away from urban centers, in many cases it was easier to locate a shaman or a priest than a psychiatrist for assessment and treatment. If the government tried to intervene or stop these practices, people would either hide or move to avoid detection.[140]

In general, most of the academic and clinical psychiatric work being conducted in Japan came to a halt in 1937 at the beginning of the second Sino-Japanese War. The funding for these programs was redirected into the offices of war and the military, and the research production itself was instead co-opted for the purpose of eugenics and the goal of creating a medical basis for racial superiority.[141] In addition to these general problems that persisted in the years leading up to the Second World War, Morita Therapy centers across Japan faced their own particular set of trials. After the death of Morita in 1938, there was no formal organizational structure left that held the various centers together. This allowed for different practices and techniques to be developed in different places in addition to the basic doctrine developed by Morita. In addition to his inability to persuade the rest of the world of the benefits of the Morita Therapy method, Morita's Japanese adherents remained relatively few in spite of his best efforts to advertise the therapy as a "Japanese" form of treatment. Regardless of the fact that therapy centers tended to have high satisfaction rates from clients and many successful treatments among those who were able to complete the therapy, Morita Centers continued to be outpaced by hospitals and other mental healthcare clinics.

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[140] Junko Kitanaka, *Depression in Japan: Psychiatric Cures for a Society in Distress*,

[141] Ibid., 47.

## CONCLUSION

The debate between native knowledge and Western biomedicine did not resolve themselves at any point during the prewar period. The effects of medicalization on mental healthcare concepts were not felt widely enough or articulated clearly enough to make them accessible for the common Japanese person, and due to the nature of Western psychiatric care as an individual practice removed from any kind of social context, many people found it difficult to embrace this radically different concept of treatment. Despite the fact that Morita and other psychiatrists worked to promote a modern version of mental healthcare that served the needs of the mentally ill, they were also attempting to cooperate in international dialogue about the assessment and treatment of mental illness. While some of these problems eventually resolved themselves in the postwar era, others continued to manifest, possibly as a result of the incongruous nature of these two conceptions of mental illness.

## Epilogue: Contemporary Morita, East and West

At the end of World War II, Japanese psychiatry was closely monitored and administered by the SCAP government along with many of the medical, educational, and governmental services that still existed after the destruction of the Pacific War. Morita Therapy Centers have continued to operate in the years since and have become an internationally recognized practice by therapists, psychologists, and psychiatrists around the world. In contemporary Western scholarship, Morita Therapy is commonly depicted as a type of East Asian psychotherapy (despite its lack of psychoanalytic techniques or theories) or as an East Asian Zen meditation therapy (despite Morita's assertion that his therapy was not Buddhist in nature). The position of Morita Therapy in Japan and around the world may offer some indications as to the unclear nature of its depiction in this scholarship.

### THE STATE OF MORITA THERAPY IN JAPAN

Morita Therapy Centers resumed practice along with the rest of the mental healthcare institutions in the postwar period, but these centers faced certain issues in the treatment of patients. The therapists who worked at Morita centers have traditionally carried a heavy part of the burden of patients. Kitanishi and Mori reported a movement towards outpatient Morita Therapy in the 1960s due to the amount of responsibility placed on therapists. After being so personally involved with the attitudes and emotions of the patients, many therapists found it difficult to separate their personal feelings with their obligations as psychiatrists.[142] However, this movement has been difficult to universalize, and due to the lack of connection between individual Morita Therapy

[142] Kenji and Atsuyoshi Mori Kitanishi, "Morita Therapy: 1919 to 1995," *Psychiatry and Clinical Neurosciences* 49 (1995): 247.

centers, Morita Therapy as an outpatient practice has not been well received. Further, only licensed Morita therapists were allowed to read patient journals and determine satisfactory patient progress. This reliance on individual therapists also made it difficult to universalize the system of Morita Therapy because individual therapists had to rely on their own judgment in determining appropriate courses of treatment for patients.

In addition, Morita Therapy has seen a change in the type of patients seeking treatment for nervous disorders. In surveying the reports from four different eras of Morita Therapy treatment between 1919 and 1986, Kitanishi and Mori found that there was a decrease in the diagnosis of ordinary shinkeishitsu (a hypochondriasis base that presented with fatigue, headaches, palpitations, nausea, insomnia, and other symptoms) and a corresponding increase in the diagnosis of shinkeishitsu with social phobia (*taijin kyōfushō*) and obsessive ideation (in which the patient obsesses about symptoms as evidence of a morbid condition).[143] This may be in part due to the decline of shinkeishitsu as a diagnostically relevant category of mental illness, or it may be because there has been an overall increase in the diagnosis of obsessive- and anthrophobia-related mental disorders in Japan in contemporary mental healthcare.

Despite the challenges facing Morita Therapy Centers and therapists, as well as the changing demographics of its patients, Morita Therapy continues to enjoy a high success rate in the treatment of nervous disorders. The Department of Psychiatry at Kyushu University claims a cure-rate of 76.2 percent and a favorable progress rate of 7.6 percent in the early postwar period.[144] Kora Takehisa, one of Morita's disciples and a major figure in the Morita Therapy community, has claimed a success rate above 60 per

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[143] Ibid., 246.
[144] Avrohm Jacobson and Albert N. Berenberg , "Japanese Psychiatry and Psychotherapy," *American Journal of Psychiatry* 109, no. 5 (1952): 321-329.

cent between 1925 and 1952. Between 25 and 30 percent saw an improvement in symptoms over the same period.[145] However, there is no indication as to the definition of what Kora considers to be an "improvement" in symptoms, nor whether this definition is universal across Morita Therapy Centers in Japan, so ascertaining the accuracy of these statistics is difficult.

In contemporary Japan, Morita Therapy's use has also been expanded to provide treatment for bulimia nervosa, chronic organ disease, and even menopause.[146]The Jikei University Hospital's Center for Morita Therapy is the largest facility practicing Morita Therapy in Japan today. According to the website, the Center logged data from 217 patients with various complaints ranging from the traditional shinkeishitsu to depression and obsessive compulsive disorder between May, 2007, and March, 2011.[147] Other major centers have reported similar statistics, with centers in Kyoto and Osaka reporting 34% and 44% female patients, respectively.[148]Despite the fact that there are only around ten major Morita Therapy Centers operating in Japan at present, therapists still manage to treat several hundred patients in a year.

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[145] Takehisa Kora, "Morita therapy," *International Japanese Psychiatry* 1 (1965): 611-640.
[146] See for example Peg LeVine, "Morita-Based Therapy and Its Use Across Cultures in the Treatment of Bulimia Nervosa," *Journal of Counseling & Development* 72, no. 1 (1993): 82-90.
[147] *Jikei University Hospital's Center for Morita Therapy*, http://www.jikei.ac.jp/hospital/daisan/morita/index.html (accessed 11 29, 2013). It should be noted, however, that the Morita Center at the Jikei University Hospital is unique among Morita therapy centers in that they often treat patients not traditionally accepted at Morita centers, such as those who suffer from schizophrenia and delusional patients. Therefore, their data is thought to represent a lower rate of success than generally attributed to the therapy.
[148] Kenji Kitanishi, "The Philosophical Background to Morita Therapy: Its Application to Theory," in *Asian Culture and Psychotherapy: Implications for East and West*, ed. Wen-shing Tseng, Suk Choo Chang, and Masahisa Nishizono (Honolulu: University of Hawai'i Press, 2005), 180.

## MORITA THERAPY OVERSEAS

Fujita Chihiro has divided the international appeal of Morita Therapy into three major periods—from Morita's death to 1945, from 1945 to around 1960, and from 1960 onward. In the seven years between 1938 and 1945, Morita Therapy experienced what Fujita calls "the barren years."[149] The practice of psychiatry in Japan had all but to come to a standstill in 1937 due to the redirection of state resources to the second Sino-Japanese War and then the Pacific War. Though Morita attempted to present his theories to the German Psychiatrics Society shortly before his death, he was rejected on the basis of his theories being too difficult to understand. Shortly after his death, the German Psychoneurology Society contacted the Jikei Hospital for information on Morita Therapy to publish in an article. However, this article did not attract much interest in Germany at the time of its publication in 1940.[150]

Between 1945 and 1960, Morita Therapy experienced what Fujita calls "the cradle age," in which international interest in Morita's ideas was slowly grown. During this period, renewed diplomatic relations between Japan and the West increased not only interaction between the countries but also brought international interest in Morita's theories. Karen Horney, a German psychoanalyst of the Neo-Freudian school who was living and practicing in the United States, visited Japan in 1952 and published her thoughts on Morita Therapy.[151] Horney was followed by Avrohm Jacobson and Albert Berenberg, who jointly published a psychoanalytic review of Morita Therapy in the same year. Both Horney and Jacobson and Berenberg concluded that the nature of the

[149] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis* (Tokyo: Igaku-Shoin, 1986), 328.
[150] Ibid., 139.
[151] Ibid., 138

therapy was akin to the psychoanalytic movement in the West.[152] Harold Kelman, a student of Horney, also visited Japan in the late 1950s, and in the article he published on the subject of Morita Therapy he concluded that Morita Therapy was unsuitable to use in the United States because of its inherently Buddhist nature.[153]

Morita had argued against the conception of his therapy as a Buddhist treatment during his life. He had admitted to the similarities between the two but was unwilling to base his treatment of mental illness on a Buddhist philosophy. Additionally, as Kora has pointed out, one of the major distinctions between psychoanalysis and Morita Therapy as practices is the relationship between the therapist and the patient. In psychoanalysis, the therapist must by direct in shaping the experiences of the patient to reflect liberation from inner psychic trauma. In Morita Therapy, on the other hand, the therapist is non-authoritative and relies on suggestion rather than direction to lead the patient towards whatever revelations feel most relevant to the patient.[154]

After 1960, Morita Therapy finally entered "the development age," in which misconceptions of Morita Therapy as a psychoanalytic practice and as a Zen Buddhist meditative therapy were rectified and Morita Therapy was finally beginning to be understood on its own terms. Behaviorists such as Gibson and Levy-Strauss took an interest in the therapy and defending it against the psychoanalytic comparison under which it had suffered in the 1950s. In addition to a number of new publications debating the nature of Morita Therapy, the practice itself finally moved beyond Japanese borders to North America. In the 1980s, Morita Therapy was brought as a practice to the United States by David K. Reynolds, the American anthropologist, and to Canada

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[152] Avrohm and Albert N. Berenberg Jacobson, "Japanese Psychiatry and Psychotherapy," *American Journal of Psychiatry* 109, no. 5 (1952): 321-329.
[153] Chihiro Fujita, *Morita Therapy: A Psychotheraputic System for Neurosis* 140.
[154] Takehisa Kora, "Morita therapy," *International Japanese Psychiatry* 1 (1965): 623-624.

by Ishiyama F. Ishu. Reynolds used Morita Therapy as a basis for what he calls "constructive living" therapy: a meditation therapy that enables patients to try both Morita Therapy and Naikan therapy. Ishiyama's Morita Therapy Center also runs an outpatient service for patients who cannot commit to the full course of Morita Therapy. Today there are several centers in the United States and Canada who practice "natural" alternatives to mental health—using Morita's mental healthcare theories in opposition to the prescription based alternatives found in Western biomedical psychiatry. There are also several Morita centers in Australia. Most, if not all of these Western centers feature Morita therapy as an outpatient practice, without the rest-isolation stage that Morita prescribed.

### FINAL THOUGHTS

It is somewhat ironic that Morita Therapy enjoys a greater international following today than Morita was ever able to achieve in his lifetime. Despite his attempts to interact with the larger international community on psychiatric issues, Morita's theories have been more successful as communicated by others in the postwar period. Perhaps Morita was simply writing at the wrong time for international reception, or perhaps his particular therapy is in some ways culture-bound by his conceptions of mental health and illness. As a theoretical perspective for understanding the nature of nervous disorders, shinkeishitsu can be understood as an anxiety-nervous disorder that is built on a base of hypochondria. As a personal guide for life, it can be understood as a need for balance between one's desire for self-improvement and a fear of suffering and death.

Morita Therapy—as both a theory and a practice—exemplifies the negotiation of assessment and treatment of mental illness that was taking place during the

modernization of Japan. Morita Shōma's attempts to redefine mental illness in a period of transition for Japan represent an important part of understanding how forces such as modernization versus medicalization affect the development of medical discourse. Additionally, Morita's attempts also showcase the ways in which multiple meanings of health and illness can coexist within a culture. Yet further trials for mental healthcare in Japan remain. The current state of psychiatry and its usefulness as a means to coping with Japan's current mental healthcare crises is still being tested. The fluid nature of Morita Therapy has ensured its survival thus far; it remains to be seen whether it can find a means to redefine itself in contemporary Japan.

# Appendix

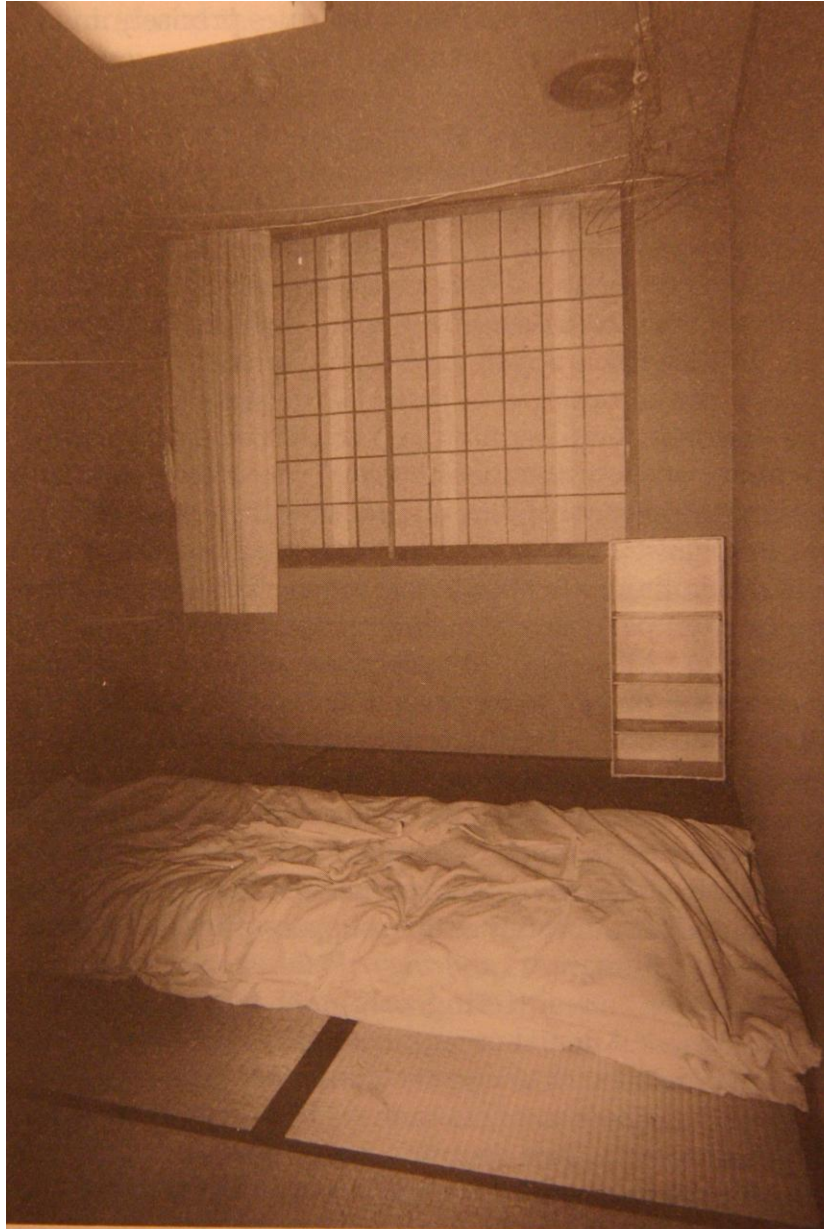

Figure 4: Stage One of Morita Therapy: an isolation-rest room at the Sansei Hospital, Kyoto, Japan.

Photo by John Maggoria, (Morita, Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu) 1998).

Figure 5: Stage Two of Morita Therapy: wood carving at Takehisa Kora’s private hospital, Tokyo, Japan.

Photo by John Maggiora(Morita, Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu) 1998).

Figure 6: Stage Three of Morita Therapy: chopping wood at Takehisa Kora's private hospital, Tokyo, Japan.

Photo by John Maggiora, (Morita, Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu) 1998).

# Bibliography


Allen, Matthew. "Therapies of Resistance? Yuta, Help-seeking, and Identity in Okinawa." *Critical Asian Studies* 32, no. 2 (2002): 221-242.

Arakawa, Ayumu. "Psychology of feelings and Emotions: its history in Japan." *Japanese Psychological Research* 47, no. 2 (2005): 106-114.

AvRuskin, Tara L. "Neurophysiology and the Curative Possession Trance: The Chinese Case." *Medical Anthropology Quaterly* 2, no. 3 (1988): 286-302.

Bay, Alexander R. *Beriberi in Modern Japan: The Making of Modern Disease.* Woodbridge: Boydell & Brewer, 2012.

Benedict, Ruth. *The Chrysanthemum and the Sword.* 2nd Edition. Cleveland: Meridian Books, 1967.

Burns, Susan L. "Relocating Psychiatric Knowledge: Meiji Psychiatrists, Local Culture(s), and the Problem of Fox Possession." *Historia Scientiarum* 22, no. 2 (2012): 88-109.

Daidoji, Keiko. "Treating Emotion-Related Disorders in Japanese Traditional Medicine: Language, Patients, and Doctors." *Culture, Medicine and Psychiatry* 37 (2013): 59-80.

Daidoji, Keiko. "Water Cures in Japan: The Case of a Health Manual in the Early Nineteenth Century." *Asian Medicine* 5 (2009): 80-107.

Figal, Gerald. *Civilization and Monsters: Spirits of Modernity in Meiji Japan.* Durham, NC: Duke University Press, 1999.

Flaskerud, Jacquelyn H. "Neurasthenia: here and there, now and then." *Issues in Mental Health Nursing* 28, no. 6 (2007): 657-659.

Fujita, Chihiro. *Morita Therapy: A Psychotheraputic System for Neurosis.* Tokyo: Igaku-Shoin, 1986.

Garon, Sheldon. *Molding Japanese minds: the state in everyday life* . Princeton: Princeton University Press, 1997.

Gibson, H.B. "Morita Therapy and Behavior Therapy." *Behaviour Research and Therapy* 12 (1974): 347-353.

Gijswijt-Hofstra, Marijke. "Introduction: Cultures of Neurasthenia from Beard to the First World War." In *Cultures of Neurasthenia from Beard to the First World War*, edited by Marijke and Roy Porter Gijswijt-Hofstra. New York: Rodopi, 2001.

Hardacre, Helen. *Shinto and the State, 1868-1988.* Princeton: Princeton University Press, 1989.

Hashimoto, Akira. “A 'German world' shared among doctors: a history of the relationship between Japanese and German pscyhiatry before World War II.” *History of Psychiatry* 24 (2013): 180-195.

Hiruta, Genshirō. “Edo jidai ni okeru seishin igaku byōin ron.” *Seishin igakushi kenkyū* 3 (2003): 27-39.

Hitschmann, Eduard. *Freud's theories of the neuroses.* Translated by Charles Rockwell Payne. New York: Moffat, Yard and company, 1917.

Irokawa, Daikichi. *The Culture of the Meiji Period.* Translated by Marius B. Jenson. Princeton: Princeton University Press, 1985.

Iwakabe, Shigeru. “Psychotherapy Integration in Japan.” *Journal of Psychotherapy Integration* 18, no. 1 (2008): 103-125.

Jacobson, Avrohm and Albert N. Berenberg. “Japanese Psychiatry and Psychotherapy.” *American Journal of Psychiatry* 109, no. 5 (1952): 321-329.

Jannetta, Ann Bowman. *Epidemics in Mortality in Early Modern Japan.* Princeton: Princeton University Press, 1987.

—. *The Vaccinators: Smallpox, Medical Knowledge, and the 'Opening' of Japan.* Stanford: Stanford University Press, 2007.

*Jikei University Hospital's Center for Morita Therapy.* http://www.jikei.ac.jp/hospital/daisan/morita/index.html (accessed 2013 йил 29-11).

Kawamura, Kunimitsu. “A Female Shaman's Mind and Body, and Possession.” *Asian Folklore Studies* 62, no. 2 (2003): 257-289.

Kitanaka, Junko. *Depression in Japan: Psychiatric Cures for a Society in Distress.* Princeton: Princeton University Press, 2012.

Kitanaka, Junko. “Jungians and the Rise of Psychotherapy in Japan: A Brief Historical Note.” *Transcultural Psychiatry* 40 (2003): 239-247.

Kitanishi, Kenji and Atsuyoshi Mori. “Morita Therapy: 1919 to 1995.” *Psychiatry and Clinical Neurosciences* 49 (1995): 245-254.

Kitanishi, Kenji. “The Philosophical Background to Morita Therapy: Its Application to Theory.” In *Asian Culture and Psychotherapy: Implications for East and West*, edited by Suk Choo Chang, and Masahisa Nishizono Wen-shing Tseng, 169-184. Honolulu: University of Hawai'i Press, 2005.

Kora, Takehisa. “Morita therapy.” *International Japanese Psychiatry* 1 (1965): 611-640.

Kraepelin, Emil. *Clinical Psychiatry.* Translated by A. Ross Diefendorf. New York: The Macmillan Company, 1907.

Kuwabara, Haruo and True, Reiko H. "National Social Policy Toward the Mentally Ill in Japan and Its Consequences." *International Journal of Mental Health* 5, no. 3 (1976): 95-108.

Latour, Bruno. *The Pasteurization of France.* Translated by Alan Sheridan and John Law. Cambridge: Harvard University Press, 1988.

Lawlor, Clark. *From Melancholia to Prozac: A history of depression* . Oxford: Oxford University Press, 2012.

LeVine, Peg. "Morita-Based Therapy and Its Use Across Cultures in the Treatment of Bulimia Nervosa." *Journal of Counseling & Development* 72, no. 1 (1993): 82-90.

Lin, Tsung-Yi. "Neurasthenia Revisited: Its place in modern psychiatry." *Culture, Medicine and Psychiatry* 13 (1989): 105-129.

Maeda, Fumiko and Jeffery H. Nathan. "Understanding Taijin Kyōfushō Through Its Treatment, Morita Therapy." *Journal of Psychosomatic Research* 46, no. 6 (1999): 525-530.

Miller, Alan L. "Myth and Gender in Japanese Shamanism: the 'itako' of Tōhoku." *History of Religions* 32, no. 4 (1993): 343-367.

Misumi, Jyuji and Peterson, Mark F. "Psychology in Japan." *Annual Review of Psychology* 41 (1990): 213-241.

Mohr, Michael. "Japanese Zen Schools and the Transition to Meiji: A plurality of responses in the nineteenth century." *Japanese Journal of Religious Studies* 25, no. 1/2 (1998): 167-213.

Morita, Shōma. *Morita Therapy and the The Nature of Anxiety-based Disorders (Shinkeishitsu).* Translated by Akihisa Kondo. Albany: State University of New York Press, 1998.

Morita, Shōma. *Shinkeishitsu no hontai to ryōhō (Nature and treatment of nervosity).* Vol. 2, in *Morita shōma zenshū* , by Shōma Morita, edited by T. Kora, 183. Tokyo: Hakuyosha, 1974.

Morita, Shōma. *Shinkeishitsu no ryōhō.* Vol. 1, in *Morita shōma zenshū* , by Shōma Morita, edited by T. Kora, 96-108. Tokyo: Hakuyosha, 1974.

Reynolds, David K. *The Quiet Therapies: Japanese Pathways to Personal Growth.* Honolulu: The University Press of Hawaii, 1980.

Rosenburg, Charles E. "The Place of George Miller Beard in Nineteenth Century Psychiatry." *Bulletin of the History of Medicine*, no. 36 (1962): 245-259.

Sato, Koji and C.H. Graham. “Psychology in Japan.” *Psychological Bulletin* 51, no. 5 (1954): 443-464.

Sivin, Nathan. “Science and Medicine in Imperial China--the state of the field.” *The Journal of Asian Studies* 47, no. 1 (1988): 41-90.

Smyers, Karen A. “My own inari: Personalization of the Diety in Inari Worship.” *Japanese Journal of Religious Studies* 96 (1996): 85-116.

Stalker, Nancy K. “Editorial: Consumerist and Transnational Perspectives on the History of Japanese Medicine.” *Asian Medicine* 5 (2009): iv=xiii.

Stalker, Nancy K. *Prophet Motive: Deguchi Onisaburō, Oomoto, and the Rise of New Religions in Imperial Japan.* Honolulu: University of Hawaii Press, 2008.

Takasuna, Miki. “Proliferation of Western Methodological Though in Psychology in Japan: Ways of Objectification.” *Integrative Psychological & Behavioral Science* 41 (2007): 83-92.

Westney, B.D. Eleanor. *Imitation and Innovation: The Transfer of Western Organizational Pratterns to Meiji Japan.* Cambridge: Harvard University Press, 1987.

Williams, Duncan Ryūken. *The Other Side of Zen: A Social History of Sōtō Zen Buddhism in Tokugawa Japan.* Princeton: Princeton University Press, 2005.

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This thesis was typed by the author.