

Antioch University

## AURA - Antioch University Repository and Archive

---

Antioch University Full-Text Dissertations &  
Theses

Antioch University Dissertations and Theses

---

2011

### Integrating Morita Therapy and Art Therapy: An Analysis

Ayako Sato

*Antioch University Seattle*

Follow this and additional works at: <https://aura.antioch.edu/etds>



Part of the [Art Therapy Commons](#), [Psychiatric and Mental Health Commons](#), and the [Psychology Commons](#)

---

#### Recommended Citation

Sato, A. (2011). Integrating Morita Therapy and Art Therapy: An Analysis. <https://aura.antioch.edu/etds/782>

This Dissertation is brought to you for free and open access by the Antioch University Dissertations and Theses at AURA - Antioch University Repository and Archive. It has been accepted for inclusion in Antioch University Full-Text Dissertations & Theses by an authorized administrator of AURA - Antioch University Repository and Archive. For more information, please contact [hhale@antioch.edu](mailto:hhale@antioch.edu).

INTERGRATING MORITA THERAPY AND ART THERAPY: AN ANALYSIS

A Dissertation

Presented to the Faculty of Antioch University Seattle

Seattle, WA

In Partial Fulfillment of the Requirements of the Degree Doctoral of Psychology

By

Ayako Sato

January 2011

## COMBINING MORITA THERAPY AND ART THERAPY: AN ANALYSIS

This dissertation, by Ayako Sato, has been approved  
by the committee members signed below  
who recommend that it be accepted by the faculty of  
Antioch University Seattle in Seattle, WA  
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Dissertation Committee:

---

Liang Tien, Psy.D.  
Chairperson

---

Minoru Oishi, M.D.

---

Jane Harmon Jacobs, Ph.D.

---

Date

**© Copyright by Ayako Sato, 2011**

**All Rights Reserved**

## ABSTRACT

### INTEGRATING MORITA THERAPY AND ART THERAPY: An Analysis

Ayako Sato

Antioch University Seattle

Seattle, WA

This study presents therapeutic interventions combining Morita Therapy with art therapy techniques. The author presents literature reviews of art therapy as well as the original Morita Therapy formulated by Shoma Morita, M.D. A new art therapy technique based on the work of Kenji Kitanishi, M.D. (2008) for outpatient treatment is also presented. A case illustration of an eleven-year-old Vietnamese-American boy who presented with high anxiety and school refusal is used as an example of the effective integration of Morita Therapy with art therapy techniques formulated by the author. Even though the boy was not familiar with Morita Therapy principles, the creative process helped the client make therapeutic progress. The combined treatment of Morita Therapy principles and art therapy techniques resulted in an effective outcome for the client. As a central concept, Morita Therapy focuses on learning to accept one's emotions and the reality of one's life. This analysis concludes that art therapy techniques can be effectively integrated with Morita Therapy as a treatment method aimed at improvement in functioning. The number of clients that can potentially benefit from Morita Therapy increases with the use of art therapy.

Given that Morita Therapy is based on Buddhist philosophy, it may be particularly useful  
Buddhist based cultures.

## DEDICATION

I would like to dedicate this dissertation with my whole heart and love to my parents and my children. My mother instilled in me the importance of women pursuing higher education and independence, breaking with traditional Japanese culture. Through my father's compassion, perseverance and positive work ethics of never giving up, I learned to be diligent and affectionate. My children, Yuko and Yusuke, enriched my life by their willingness to follow me in living in the totally different culture of the United States for the eleven years of my professional journey. I will never forget to say thanks to Dr. Ikuo Takahashi for being my mentor and major support for my academic journey.

## ACKNOWLEDGEMENTS

I would like to express the deepest appreciation to my dissertation committee chair, Dr. Liang Tien, who had a strong passion and the skill to educate me as a psychologist through this dissertation process. As a respectful professor, personal mentor, and intelligent Asian- American woman, she provided a powerful role model. I would also like to thank my committee members, Minoru Oishi, MD. and Jane Harmon Jacobs, Ph.D. I appreciate Dr. Oishi's willingness to participate from Japan. As a medical doctor, his knowledge and clear opinions helped my thinking in this difficult project. Dr. Jacobs' continuing encouragement, professional perspective, and faith in my ability helped me persevere in this course of study.

In addition, I appreciate Mark Yamada, Ph.D., who is my clinical supervisor, and Andy Benjamin, Ph.D. I respect Dr. Yamada's wisdom, knowledge, and tenacious commitment to education and clinical support. I would have been unable to complete my studies without Dr. Benjamin. His wisdom and professional attitude gave me a model of how to live my professional life in the future.

I would also like to express my gratitude to Patricia Linn, Ph.D., Judith A. Rubin, Ph.D., and the faculty of Antioch University Seattle for their time, encouragement, and love.

Of course, many thanks to my strong supporters: Mr. Misao and Ms. Masako Yazaki, and to my many friends and professors in the U.S. and Japan. Especially, I appreciate Ms. Yuko, Mr. Hitoshi Chiba, Mr. Shoji Oshio, Ms. Ryoko Nabetani, and Ms. Chieko Kimura who have given me support to pursue my education.

I also thank my English tutor Mr. John Newman and editor Dr. Resa Raven, who never complained about my persistent questions.

Last but not least, I appreciate my ex-husband, Mr. Takahiro Akita. If I had not married him, I would not be where I am today. Thank you to all of my people. *Arigatou.*

## TABLE of CONTENTS

	Page
DEDICATION.....	iv
ACKNOWLEDGMENT.....	v
List of Tables .....	ix
List of Figures .....	x
I. WHAT IS ART THERAPY? .....	1
Definitions .....	2
What Is Art Therapy? .....	6
Usefulness of Art Therapy .....	12
The Place of Psychological Theory in Therapy .....	15
Art Therapy and Theory .....	16
Art Therapy as Assessment .....	17
Art and Culture .....	20
Zen Art Used in Healing .....	22
II. THEORETICAL HISTORY OF ART THERAPY.....	26
Art Therapy and Theories .....	26
Theoretical History of Art Therapy .....	26
Choice of Theory .....	30
Advantage of Integrating Art Therapy with Theory .....	31
Possible Integration of Morita Therapy and Art Therapy .....	31
III. MORITA THERAPY .....	33
Concept of Morita Therapy .....	33
History of Morita Therapy .....	35
Morita's Childhood Experiences .....	36
Birth of Morita Therapy .....	37
How Morita Therapy Views Pathology .....	39
The Core of Morita Therapy Pathology:	
Vicious Circle of Conflicting Thoughts.....	40
Anxiety and Desire .....	45
Nature Theory .....	46
Core Principles of Morita Therapy .....	47

Psychopathology .....	52
Morita Therapy and Buddhism.....	56
Morita Therapy and Western Psychology .....	57
Modalities .....	58
Treatments .....	59
Possibilities of Morita Therapy in Western Culture .....	64
Morita Therapy Past and Present .....	66
 IV. ANALYTICAL PERSPECTIVE OF MORITA THERAPY.....	 68
Background Considerations Regarding Morita Therapy .....	68
Morita Therapy and Medication .....	69
Analytical Issues of the Original Morita Therapy .....	69
Environment of Morita Therapy.....	69
Issues Regarding the Inpatient Unit at Morita’s Home .....	71
Relationship Between Clients and Clinicians .....	73
Difficulty Understanding Morita Therapy .....	76
After Morita .....	83
Morita Therapy Today .....	84
Conclusion .....	84
 V. THE INTEGRATION OF MORITA THERAPY WITH ART THERAPY.....	 87
Example of Art Therapy Intervention Technique .....	89
Case Summary .....	106
 VI. Conclusions .....	 109
 References.....	 112

## List of Tables

1. Context and History Morita Therapy.....	86
--	----

## List of Figures

	Page
Figure 1: Vicious Circle of Conflicting Thoughts.....	41
Figure 2: Discrepancy Between Imaginary and Real Self.....	43
Figure 3: Summary of the Vicious Circle of Conflicting Thoughts .....	45
Figure 4: The Connection Between Anxiety and Desire .....	46
Figure 5: Differences Between Buddhism and Western Philosophy .....	58
Figure 6: Changing Impact of External Evaluation.....	64
Figure 7: Distinguishing Between I Can Do It and I Can't Do It .....	89
Figure 8: Admitting Versus Fighting Emotions.....	90
Figure 9: Holding the Emotions.....	91
Figure 10: Holding the Emotions-2 .....	91
Figure 11: Observing Dynamic Emotions.....	92
Figure 12: Recognizing Dynamic Emotions.....	92
Figure 13: Observing the Behavior.....	93
Figure 14: Taking Action and Having Experiences .....	93
Figure 15: Making Decisions.....	94
Figure 16: Avoiding Perfectionism.....	95
Figure 17: Actions Change Emotions.....	95
Figure 18: Feeling Enough Energy to Live.....	96

Figure 19: Identifying External Judgments.....	96
Figure 20: Recognizing the Impact of External Judgments .....	97
Figure 21: Changing the Impact of External Judgments .....	98
Figure 22: Alex’s Family .....	101
Figure 23: Alex’s Picture of Self .....	102
Figure 24: Mother’s Picture of Self .....	102
Figure 25: Anxiety Temperature Indicators 1 .....	103
Figure 26: My Uncle .....	104
Figure 27: Alex’s Actions .....	105
Figure 28: Anxiety Temperature Indicators 2 .....	107

## **I. WHAT IS ART THERAPY?**

Shoma Morita who formulated Morita Therapy in 1917, focused on accepting life, resolving conflicting thoughts, and becoming free from obsession (France, Cadieax, & Allen, 1995). Morita believed that it is much easier for people to change their behavior/ action than to change their symptoms (Kitanishi, 2007). Morita Therapy stems from Zen Buddhism. Morita Therapy may be a good fit for many clients, particularly those from Buddhist-based cultures. With interest in Zen practice growing beyond Asia, Morita Therapy may also be helpful for individuals from Western cultures.

Art therapy in the United States has been influenced by an array of Western theories, but has not benefited from Buddhist-based cultural influences. Western influences have included Freudian psychology, the educational movement, and art education (Jung, 1994). An art therapy approach is frequently used to clarify and express an individual patient's emotions and to facilitate the finding of solutions to their problems (Rubin, 1998, 2001, 2005). Through the process of making art, a therapeutic dialogue between patient and art therapist is created. Art therapy then becomes a guide to lead a person to his or her goals.

As a discipline, art therapy does not have one compelling theory supporting its techniques. Rather, art therapy is one of the approaches that can be used to support treatment goals in a larger context. This requires the art therapist to integrate art therapy techniques with the theoretical orientation that guides the therapist's thinking. Integrating Morita Therapy and art therapy may be an effective therapeutic method to

help an individual patient understand their emotions and gain insight into their functioning. This paper explores the possible integration of art therapy with Morita Therapy.

There are no studies or discussions of integrating Morita Therapy and art therapy in Western psychological literature. The integration of Morita Therapy and art therapy by American art therapists has yet to be pursued. This doctoral paper will explore that possibility. In section one and two, I will review the current state of the literature regarding art therapy and theoretical history of art therapy in the United States. In section three, I will outline Morita Therapy as originally promulgated by Dr. Shoma Morita. In section four, I will discuss the analytical perspective of Morita Therapy. In section five, I will illustrate a method of integrating Morita Therapy for outpatient treatment which is based on Kitanishi's idea (2008) of art therapy. A case study example will be presented to demonstrate concretely how art therapy techniques can be integrated with Morita Therapy.

## Definitions

### Art

Many of us enjoy art by going to places where it is actively pursued, such as art museums, concert halls, and theaters. But art is a significant part of our everyday life. Art can be found in the foods that we select and present to the table, beautiful pictures we enjoy in the media, dishes and pottery we use in our homes, etc. Art takes many different forms that involve other senses in addition to sight and sound (Rubin, 2005).

Since ancient times, human beings have expressed themselves through art. Art is a powerful and effective means for the artist to express feelings. People have also used art to express ideas and to facilitate healing. Art education has assisted children in their development (Eckhoff, 2007). Education in the arts is considered by many to be a core curriculum. Viewing art and attending artistic performances are included in national educational standards and in curriculum requirements for children in the United States (Eckhoff, 2007).

### Psychotherapy

Psychotherapy is “the treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth” (American Heritage Dictionary of the English Language, 2009). Psychotherapy is a treatment approach that focuses on oral communication. The psychotherapist asks the patient to explore and recognize anxiety and conflicts (Thyme, Sundin, Stahlberg, Lindstrom, Eklof & Wiberg, 2007, p. 252). Thyme, et al. (2007) stated that research showed that any psychotherapy was more effective for psychiatric disorders than no treatment. Patients suffering from depression who received brief psychotherapy showed significant improvement when compared to patients without psychotherapy. Andersen (2005) argued that it was difficult to measure scientifically to what degree symptoms improved, because clients’ symptoms were different and the results might be

very subjective. Andersen concluded that successful psychotherapy often resulted in mindful awareness, a cognitive state central to Buddhist philosophy (2005).

Historically, psychotherapy emerged from the scientific observation of human behavior (Hayes, 2002). Carl Rogers (1957) stated that successful psychotherapy has three important elements: therapist empathy, unconditional positive regard, and congruence in relation to the client.

As part of their professional training, psychotherapists study a wide range of psychological topics such as developmental psychology, psychopathology, ethics, psychopharmacology, etc. In order to obtain professional competence, they must understand both the theories and techniques of psychotherapy. When art is used in a clinical setting, it is imperative to understand how to combine art techniques with psychotherapy. Psychotherapists who do this well, provide effective treatments for their clients. It is important for art therapists to be well versed in psychotherapy.

#### Art Therapy in the United States

According to Rubin (1998), art therapy is “art + therapy.” She contends that two kinds of theories about art therapy exist. The first theory is focused on the client engaging in the creative process of an art therapy session. This encourages the client to connect to the treatment process (Rubin, 1998). The second theoretical position considers that the artwork of clients illuminates their inner conflicts and unconscious processes. According to this theory, art is used in psychotherapy to assist in developing meaning through an analysis of the symbolism of the art. Rubin said that

there are different names for art therapy, including "expressive analysis," "clinical art therapy," "psychoaesthetics" and "expressive therapy" (Rubin, 1998, p. 61).

#### American Art Therapy Association's Definition of Art Therapy

The American Art Therapy Association defines art therapy as:

The therapeutic use of art making, within a professional relationship, by people who experience illness, trauma or challenges in living, and by people who seek personal development. Through creating art and reflecting on the art products and processes, people can increase awareness of self and others; cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and enjoy the life-affirming pleasures of making art (American Art Therapy Association, 2010).

The Association states that art therapy is a mental health profession. Also, the Association defines art therapists as:

...professionals trained in both art and therapy. They are knowledgeable about human development, psychological theories, clinical practice, spiritual, multicultural and artistic traditions, and the healing potential of art. They use art in treatment, assessment and research, and provide consultations to allied professionals (American Art Therapy Association, 2010).

In the United States, the American Art Therapy Association has supported the establishment of art therapy as a profession and the education of art therapists.

## What is Art Therapy?

“Art therapy’s roots extend as far back as prehistory when people drew images in caves in attempts to express and master their world ” (Jung, 1994, P. 1). Since ancient times, human beings have expressed themselves through art. Among other approaches, art is a tool to express feelings. People have also used art for healing and expression. Judith A. Rubin, a pioneer of art therapy, stated “Art is a natural way to communicate” (2005, p.21). Art therapy is a clinical way for people to express their inner thoughts. Art is a useful modality in which to express non-verbal thoughts and images. Malchiodi (1998) wrote that clients do not need to worry about their artistic abilities because all art generated in an art therapy session is automatically acceptable.

Art therapy techniques can be an effective tool for both assessment and treatment (Rubin, 1998, 2001). Art therapy developed as a way to treat patients. Because art therapy uses art to treat patients, mental health professionals who use art therapy techniques must be trained not just in the use of art, but also in the clinical use of art to treat different kinds of symptoms that afflict people (Rubin, 2005). Accurate diagnostic skills and effective intervention skills in clinical settings are also critical necessities (2005).

Art therapists focus on two aspects of functioning: psychological and physiological functioning. Psychological functions include mood, self-awareness, and self-esteem. Physiological functions include decrease in heart rate, blood pressure, and respiration rate (www.whole healthmd.com. June 4<sup>th</sup>, 2010). McMurray (2000)

described art therapy as being comprised of two main techniques: structural and the free creative approaches. The structural approach occurs when the art therapist gives concrete art directions and specific art materials to the client (McMurray, 2000). The free approach is when a client spontaneously creates images of his or her impulses and fantasies (McMurray, 2000). Through these art therapy experiences, clients are able to recognize and express impulses and fantasies that are not in their conscious awareness.

Art therapy is experiential therapy and as such, is different from other therapeutic approaches (Wadeson, 1995). Art therapists do not lead clients with language. Clients are able to discover their own strengths and reach their goals through their own experiences (Rubin, 2005). People process their own experiences viscerally in their bodies and minds (Rubin, 2005). For example, children typically demonstrate happiness when they build a model car for the first time. Frequently they will try to build a more difficult model the next time. They experience achievement and growth in confidence through these experiences. Clients also can self-discover and gain confidence through drawing pictures or creating objects. Art therapists support and encourage a client's internal processes, and facilitate the client reaching his or her own goals. Experiences during art therapy sessions can result in strong therapeutic movement for the client (Rubin, 2005).

During art therapy, challenges and solutions for problems are addressed in the process. At the same time, clients explore and express inner conflict and difficulties (Clements, 1996). Supporting clients in their process includes engaging in dialogue with

them, preparing tools that they can use to extend their reflections through art, and providing a safe environment for growth and learning.

Art therapy can give the client a positive experience of creativity as expressed through art. Creativity can lead to developing greater meaning in a person's life. People can free their minds by expressing themselves. Fun, creative experiences are important for human beings.

According to Rosen (2009) art therapy is similar to meditation or reflection. For example, people can obtain peace of mind in an art therapy session which is similar to the state of mind one experiences looking at a garden at a Zen temple, or engaging in any other meditation practice. A clinically-trained therapist can link relaxation with clinical treatment goals. Art therapy helps clients identify issues and consider ways to overcome difficulties. Such an approach can lead to effective strategies.

The role of the therapist is not just to treat clients kindly, but to design and implement treatment interventions so that the client's psychological symptoms are relieved (Rubin, 1998, 2005). Trained art therapists provide therapeutic interventions in a manner individually suited to each client (Rubin, 2005). For example, art therapy can teach clients about the impact of illegal drugs on the cerebral cortex, or the mechanisms of violence and anger and how to diffuse triggers leading to maladaptive affective states. Art therapists can be highly specialized in providing this type of psychoeducational training (Jung, 1994; Rubin, 2005).

Choosing art materials is a critical part of providing effective treatment (Rubin, 2001, 2005). It is a very important job to select art materials matched to an individual client's psychological state, developmental level, and physical condition. Art therapists provide many kinds of materials and methods to fit the client's need to develop insight and express feelings. It is necessary for art therapists to always consider whether the artistic medium is suitable or not, whether it really should be those particular materials. For example, a therapist might prepare clippings from magazines for making a collage for those who are not good at drawing. When choosing the materials for psychologically unstable clients, an art therapist needs to avoid materials that have sharp edges or can be used to inflict wounds and which can lead to self-destructive behavior or violence. The skilled art therapist considers those possibilities at all times. It is also important to organize materials. One needs to know which tools to prepare and how many of them, before the session commences. When working with clients in an inpatient setting, for example, it is important to confirm the number of pairs of scissors.

Art therapy methods permit assessment and treatment approaches to be identified. Art therapy can integrate knowledge about psychological developmental stages with knowledge obtained through assessment. An art therapist must be sensitive to the use of certain art therapy techniques. For example, some clients might be afraid of drawing pictures because sometime in their history, they have associated drawing with criticism. Art therapists should build trusting relationships with clients and show

them that the art therapy session is a safe environment, rather than a place of criticism and harsh judgment. Also, art therapy might not be useful for certain individuals who have physical disabilities or visual impairments. However, these individuals may be able to benefit from art therapy if art therapists are able to work with them individually and adapt art materials and directions to that which would permit expression.

Rubin (1998) distinguished between what art therapy is and what it is not. She said that if the art activity is for fun or recreation--even if it occurs in a psychiatric hospital--it is not art therapy. Art therapy is not activities for the sole purpose of engaging in fun. Further, she clarified that, "Even the most sensitive artist or art teacher is not a therapist," (Rubin, 1998, p. 63). Art educators may indeed engage in active influence of clients, but art therapists focus on the therapeutic process and provide quiet moments of self reflection and dialogue with their clients (Naumburg, 2001). Educational activities in art can promote social and emotional growth, but art therapy includes education to help clients express themselves (Rubin, 1998). For example, an art therapist may use art materials to help a client to express feelings, to encourage healthy sublimation, and to build a sense of self-esteem. Art therapists focus on how art processes and artistic materials can activate certain psychological processes. Teaching artistic technique is not the primary goal.

Further differences exist between an art activity and an art therapy session. An art therapist is able to observe and assess the clients' psychological dynamics. Even though an art therapist and art teacher use the same materials, their methodology and

usage of those materials can vary greatly. An art therapist observes psychological dynamics throughout the therapy sessions (Rubin, 1998). One example of this is the use of projective drawing as a means of assessment. Projective drawing was originally developed as an assessment tool by clinical psychologists but has been widely used by art therapists as well. Social workers and psychotherapists, as well as psychologists, have found it useful to employ art in sessions because images can show the patient's unconscious (Rubin, 1998).

Art therapy involves not only expressing and enjoying oneself through art, but also engaging in therapy through the medium of art (Wadeson, 1987). Wadeson further clarified that, "Creativity is at the core of art therapy" (2000, p. xiii). Art therapy is useful for healing and can lead to catharsis, a releasing of emotions (Malchiodi, 1998). In addition, art therapists help clients to experience transformation and to find personal meaning and healing through art (Malchiodi, 1998).

Art therapy validates not only perspectives that are positive in nature, but also more negative perspectives that are sometimes hard for clients to accept, such as ugliness, strangeness, and so on. Art therapy can provide understanding, non-judgmental support, and a trusted relationship with another--the art therapist. Many clients have never been able to express themselves in this way before (Wadeson, 1987). Self-expression and exploration with an art therapist can support a client's positive personal development (Wadeson, 1987). Wadeson stated that art therapy can produce

a synergistic effect by using art and helping people discover and develop their inner selves which cannot be obtained in therapies that depend on verbal language alone.

### Usefulness of Art Therapy

Art is nonverbal language. Creativity and nonverbal imagery are useful with all kinds of people (Hoshino, 2003). Malchiodi (1998) wrote that visual art speaks in ways that words cannot. Gladding & Henderson (1998) stated that the creative arts are universal language (p. 187). People can transform their emotions into drawing and express affect and cognitions not easily put into language (Kearney & Hyle, 2004). Art can lead to disclosures that are harder to express through verbal language. Art provides visual data (McNiff, 2009). Because art therapy rises above cultural backgrounds, it is useful for clients and clinicians who are more verbally limited (McNiff, 2009). Art can serve as a communication tool that helps to mediate developmental and multicultural differences. If there is no common language between art therapist and client, a method of communicating with each other can occur through art. Malchiodi (1998) stated that expression in art does not depend on the rules of language, such as grammar and correct spelling. In addition, art therapy is useful for those who have little language ability, such as those who are impaired by emotional or cognitive disorders.

Art can naturally express sensations and emotions, unconscious thoughts, and underlying behavior (Kearney, & Hyle, 2004). For example, a client can freely express themselves without summarizing their thoughts or making an effort to be verbally understood by others. Through art, a client can express emotions, ideas, and

unconscious processes with fewer constraints and in a less threatening manner (Malchiodi, 1998). Art therapy treatment is useful for clients who have difficulty expressing their internal experiences as a result of inflexible defense mechanisms (McMurray, 2000).

Art therapy provides a safe environment for clients' inner feelings. Clients can describe themselves through art without any rejection or criticism (Naumberg, 2001). When people want to expose what is at the bottom of their hearts, it usually is only possible in front of those they trust. Art therapists build client trust, accept their clients, avoid judgment and assist clients in their psychological journey. Malchiodi (1998) stated that visual thinking helps to organize and describe our thoughts. Art therapy is nonverbal language and communication that displays values (Malchiodi, 1998). Art therapy is a first-hand experience (Malchiodi, 1998) that can lead to a richer understanding about the self.

The art therapy process of creative expression heals people (Gladding & Henderson, 1998). Art activities reduce stress (Malchiodi, 1997). Kramer (1972) opined that art therapy is useful for aggressive clients who require expression and energy reduction. Writing daily about distressful events helps people heal, in contrast to people that do not write (Gladding & Henderson, 1998). The experience of journal writing is similar to the art therapy process. Malchiodi (1998) stated that visual thinking helps people to organize and describe their thoughts.

Art therapy is especially useful for children. Engaging in art activities is beneficial

in that it improves children's self-esteem (Ozimo & Ozimo, 1989, cited in Gladding & Henderson, 1998). Art can be a less threatening way for children to address grief than to speak about it (Cumming and Visser, 2009). Other research has shown that through art activities, children discover new interests, ideas, abilities, and strengths (Appleton & Dykeman, 1996, cited in Gladding & Henderson, 1998). Art therapy can be useful for children in part because children do not have large vocabularies. Takahashi (1986) wrote that art allows us to explore both the unconscious and conscious realms, and access issues that can be difficult to describe verbally (p. 30).

Gussak (2009) showed that art therapy resulted in positive changes of mood and behavior in both male and female inmates. While his research findings indicated that art therapy was more effective for female inmates, there were clear findings that art therapy was effective for treating male inmates as well. Art therapy is more focused on inner experiences. During a session of art therapy, clients work on exploring their inner selves and/or conflicts. Paintings or objects created during such sessions are very personal. The process supports the client's behavior, motivation, and self-esteem through developing skills and sharing art with peers (Cumming, & Visser, 2009).

Because clients talk about very personal and private facts or feelings, it is necessary to keep confidentiality about the art work and conversations that take place during the sessions. Building a therapeutic alliance requires the therapist to validate the meaning for the client that emerges from art therapy, and keep secret that meaning from others outside of the session. Supporting clients also means building a sense of

personal safety with them. Without trust in the therapeutic relationship, clinicians are unable to provide effective treatments.

Art therapy can be effective for treating clients who have suffered severe trauma. Research shows traumatic experiences are encoded in the images formed in the mind (Malchiodi, 1998). It can be very difficult to remember or verbalize a traumatic experience. Art therapy can assist in integrating what is difficult to verbalize.

From a neuro-scientific perspective, art therapy provides distinct benefits. For example, using both hands during the creation of art engages both right and left brain (McMamee, 2005, p. 544-545). Also art therapy has been shown to be effective for cancer patients to decrease their depressive symptoms and increase their attentiveness (Thyme, Sundin, Stahlberg, Lindstrom, Eklof and Wiberg, 2007). It has been used in inpatient and outpatient settings; with severe mental illness; with those who suffer depression, anxiety disorder, and addictions; and with autistic children, prison inmates, and people who have problems with verbal expression (Rustin, 2008).

### The Place of Psychological Theory in Therapy

There are many kinds of theoretical orientations in psychology, such as psychodynamic, cognitive-behavioral, person-centered, object relations, existential, and family systems theory. Theories are important frameworks to help therapists understand their patients. They can indicate how to lead patients to reach their goals, step by step. It is important for art therapists to study and understand theories of human psychological functioning and psychopathology in order to effectively integrate

art therapy methods with the treatment orientation. As Rubin states, “I am quite convinced that only if the approach is comfortable for a therapist is it at all useful in his and her hands” (2001, p.3). Therapists need to find theories that they understand and with which they feel comfortable while working with patients. Rubin (2001) saw each theoretical orientation as providing “different sets of lenses, (which) illuminates slightly different aspects of human personality and growth” (p. 1). Each theory provides a different perspective to use in analyzing people. He further clarified that “ [I]f art therapists are to function as sophisticated members of a clinical, educational, medical, or social team, our comprehension of any theoretical stance needs to be as deep and clear as that of others” (Rubin, 2001, p.2).

Some theories may not fit for therapists from different cultural backgrounds and with differing cultural values. For example, for Asian therapists, it may be difficult to understand Western theories. Asian therapists may more easily understand an Eastern worldview or philosophy such as Buddhism. Religion is not psychotherapy, but therapists can integrate aspects of a religious belief system into psychotherapy, such as the practices of meditation and mindfulness. If therapists do not understand and consciously apply a structured theoretical orientation, they may be less effective in helping patients.

### Art therapy and Theory

Art therapy does not have one unifying theory upon which it is based. Because art therapy lacks a single foundational framework, art therapists are free to study many

theories during their training as clinicians (Rubin, 2001). Art therapists have to choose psychological theories which are comfortable for them to use with their clients and integrate these viewpoints with art therapy methodology.

All psychotherapists sometimes need to change the application of the technique to meet a client's individual needs. If on one day, a client needs education or behavior-changing skills, the art therapist might choose technique based on CBT- art therapy, which is a combination of cognitive behavior therapy and art. Another day, when a client struggles with her/his divorced parents, the art therapist can ask the client to draw a family tree/genogram. Through such an image, art therapists are able to observe the client's perspective of family history and cultural heritage. As a result of such portraiture, the art therapist might select family system technique as an appropriate invitation for treatment. On still another day, if the client has family problems, the art therapist might ask the client's family to be a part of a conjoint session and ask them to work together using an art therapy technique. Such sessions create an opportunity for the art therapist to assess family dynamics directly, leading to a more clear understanding of the client's therapeutic needs.

### Art Therapy as Assessment

Art is known to encapsulate human experiences, which is why art assessments have been described as "art based research" (Nissimov-Nahum, 2009). Drawings are used as a part of data collection because they show the client's thoughts, emotions, and

fantasies (Kearney & Hyle, 2004; Silver, 2009). Drawing can be a tool for unstructured interviews, as well as increasing the client's rate of response (Kearney & Hyle, 2004). However, art interviews must be carefully conducted in order to not invalidate the client (Naumverg, 2001). Clinicians need specific training on how to use art as assessment. When a clinician administers art as part of the assessment, it is important for them to be clear about what kinds of information can help to direct treatment.

Art therapy assessments are useful for family therapy. Art therapy can be used to assess family functioning and dynamics, including points of view of the various family members, relationships among family members, the family's communication mechanisms, family-held emotions, values, and beliefs, etc. It may be possible to determine who has the most power in a family when they work together on an art activity. For example, drawing the family dinner table may reveal family nutrition, daily life style, and communication style. Rubin (1984) stated that through family drawing, art therapists are able to observe family dynamics and interactions such as who sits next to whom and who interacts with whom (p. 138). Clinicians can ask about the family and relationships within it by using the family pictures. Drawing a picture of family also is useful to analyze family functioning (Rubin, 1984).

Clinicians must understand the meaning of symbols when art is used for assessment (McNiff, 2009). Symbols will be affected by the client's culture, religion, and philosophy towards art (McNiff, 2009). For instance, art can be used to learn more about the client's experience of death and grief, as well as how cognitive and developmental levels affect the process of dealing with death or grief (Nagy, 1948;

Singer, 1984, cited in Graham & Sontag, 2001). Sometimes it is difficult for clients to disclose and express their painful experiences of these events through language. Art can be a great way to feel safe enough to allow expression of these troubling affective states.

Clinicians can observe clients as their clients express feelings by using certain art materials. Some theories suggest that colors have certain meanings. However, it seems unlikely that a particular color has a particular meaning in all cases. For example, using a lot of black crayon does not necessarily mean that the client is depressed or that they are thinking about death. Cultural values affect the meaning of colors. Thus, it may be inaccurate to interpret clients' pictures without considering cultural context factors. When clients talk and describe their experiences, thoughts and feelings, diligent clinicians will also take note of such nonverbal expressions as tension in the face and body. Careful observation can lead to understanding when a client is self-regulating in an effective manner.

Most art therapists also recognize that a client's artwork may show aspects of the client's unconscious. Jung said that art has the power to work with the unconscious (Brooke, 2004). One approach to accessing the unconscious is to direct clients in the first session to scribble draw. Rubin (1984) suggested that by using this approach, art therapists are able to get a maximum amount of information with minimal stress. Such an approach can also serve as a powerful diagnostic tool (Rubin, 1984). Drawing can highlight the client's current level of functioning (Wadeson, 1980; Cohen, 1986; Gantt, 2001a and b, cited in Brooke, 2004).

Because drawing is easier than talking for children, especially younger children, drawing is useful to assess the course of their lives and process painful experiences (Graham & Sontag, 2001). Drawings are initial assessments in art therapy sessions (Brook, 2004). Art therapists are able to observe the client's motor skills, movement, personality, and cognitive skills. White, Wallace, and Huffman (2004) wrote about the benefits of art therapy assessment for children:

Art assessments offer (a) an uncensored view of a child's thoughts and feelings (Neale & Rosal, 1993), (b) a nonverbal method of assessment for children who are still developing language skills or who are unwilling to verbalize feelings emotions (Arrington, 2001), and (c) a nonintimidating means of assessment in which children are likely to participate (Peterson & Hardin, 1997). To be most useful, art assessments should be "non-threatening, easy to administer, nor too time-consuming to complete, and easy analyzed" (Anderson, 2001a, p.210).

### Art and Culture

Culture impacts people's functioning because of its strong traditions (Hoshino, 2003). It is important for clinicians to understand the cultural context of each client so that treatment does not invalidate aspects of their heritage. If clinicians do not understand the client's values, and where their thoughts come from, they cannot understand their clients' behaviors. Increasingly, clinicians are studying cross cultural psychotherapy practice (Tanaka-Matsumi, 1979). These days, when American psychologists diagnose their clients, the psychologist typically asks about the client's

religion, values, ethnicities, and family traditions, mental issues among family members, developmental history, socioeconomic status, and educational history. Sharing world views between clinicians and clients can be an effective intervention (Tanaka-Matsumi, 1979). Culture creates an important context which must be taken into consideration. For example, if parents sleep with their twelve-year-old child, through the American perspective, they might need to be reported as possible child abusers. However, if the family is comprised of refugees and has not slept separately during their long journey to the United States, their behavior may not be related to abuse.

In the same way, clinicians need to understand clients' cultures when art is used within sessions. For example, drawing a chimney might be normal for people in Western cultures. However, it might not be normal for people in Eastern cultures because they might not use chimneys. Art itself is a central aspect of culture that also plays an important part in psychological functioning. For instance, in Japan, each family owns a family crest. It is a concrete symbol of one's family and encapsulates the family history. Symbols in the work of clients often spontaneously emerge during art therapy sessions. The meanings of the symbols can lead to a deeper understanding about the client's issues.

Recently, cultural practices have begun to be more widely disseminated around the world. For instance, Japanese people are not the only individuals to sit and look at the Zen Japanese traditional garden, and reflect on their life. Many people in other parts of the world now enjoy this practice as well. These types of reflections help people realize new aspects about themselves. The efficacy of formal periods of

reflection may be one reason why many Americans are interested in learning about Zen and other Japanese cultural traditions.

Cultures are affected by environment, lifestyles, and values. For example, people who live in close relationships in a community are different from people who live in an individualistic society. The former group might believe that harmony is more important than the latter group, whereas the latter may value autonomy to a greater degree than the former. Culture is a very sensitive aspect of psychology that deeply influences one's worldview.

#### Zen Art Used in Healing

Today many people in the world are fascinated by Zen philosophy and Zen arts. It is clear that Japanese Zen culture can heal people psychologically. It is important for clinicians to know how Zen culture and Buddhist philosophy have influenced people's psychological well-being. Art has been used in the practice of Zen and can play an important part in healing (Yanagida, 1982). Zen and Buddhist culture have incorporated art as a healing tool. However, Buddhist and Zen art has not been used as a clinical tool in medicine or psychology because their religious origins have deterred scientific acceptance. The perspective of American art therapists about art therapy and what art therapy is can be incorporated in Morita assessment and treatment approaches. It is important for Japanese clinicians to know how Zen culture and Asian philosophy influence people's mental health. For instance, Zen promotes simple living, meditation, and the arts.

Japanese Zen has developed primarily since the thirteen century. It came from China (Yanagida, 1982). Buddhism was first established in India. However, each country has developed Buddhism in different ways and adjusted it to their cultures (Yoshida, 1985). Zen developed in many ways throughout Japanese culture. When Zen Buddhism and Japanese culture melded, Japanese climate shaped Japanese Buddhism, which is different from the strain of Buddhism that developed in other Asian continental countries (Yoshida, 1985). For instance, climate aspects such as high humidity, mountainous islands, many rivers, and the ever-present ocean have affected the philosophy of Japanese Zen (Yoshida, 1996). Zen says to look at truth, not at the outside surfaces. It values the inside, and does not value the outside (Yoshida, 1985). A major teaching of Zen philosophy is to live like a river. That means having no resistance and following your destiny. Another core principle is that all visible things are vain; all is vanity (Yoshida, 1985). Zen promotes meditation for mindfulness (Yoshida, 1985). On a practical level, the climate also influenced artistic techniques. High humidity influenced the use of simple colors for Zen art. Even though Japanese Buddhist sculptors decorated wood statues with many colors long ago, high humidity corroded the paint of these statues. That is why Japanese Buddhist sculptures are painted with resins from a lacquer tree and the colors are very simple.

Zen offers a philosophy for healing, and Zen art has been used for healing. Using black ink for Zen art means to be simple and avoid color, infinity and vanity (Yoshida, 1985). Zen art uses a minimum of lines and shapes (Suzuki, 1940). It does not

distinguish between beauty and ugliness (Yanagi, 1949, p. 95). Yanagi (1949) wrote that beauty and ugliness are opposites on the same line (p.90). Zen philosophy suggests making a circle of the line that is beauty and ugliness. According to Zen philosophy, the circle harmonizes or unites as one world (Yanagi, 1949, p. 90). There is a line which has opposite feelings (internal conflicts). Zen says that when you use the line and make a circle, the circle is your mind. Many Western art therapists use a circle picture for treatment. They ask their clients to draw inside of the circle, which is called a mandala. The theory is that creating a mandala is healing because the circle is able to contain and hold the client's feelings and thoughts (Rubin, 2001).

Also, Zen rock gardens have contributed many ways to heal people in the world. Rock gardens demonstrate Zen philosophy. The garden often does not use real water and trees; it uses only rocks to show nature (Yanagida, 1982). The rocks are symbols of death, and the garden is made to be imperfect. Zen art's goal is "before perfect" or "imperfection" (Yanagida, 1982, p. 19). The Japanese sense of beauty is obtained through imbalance and imperfection. For example, Japanese culture values odd numbers, not even numbers (Yanagida, 1982). Zen philosophy is contradictory to some Western values. For example, many Americans believe that having a lot of things is a source of happiness. By contrast, Zen philosophy says that materialistic desires and external beautiful objects do not make people happy. Zen emphasizes compassion toward people. Art has been used in the practice of Zen and can play an important part in healing.

Zen philosophy and healing methods have an important role to play in mental health. Asian culture, including Japanese Zen and Buddhist culture and philosophy, have much to teach us about healthy psychological functioning.

## II. THEORETICAL HISTORY OF ART THERAPY

### Art Therapy and Theories

In order to examine the integration of Morita therapy and art therapy, it is important to study the other kinds of theories upon which art therapists have drawn historically. Art therapists are drawn to psychological models to use with art therapy that are comfortable for them personally and that offer deeper understanding for them (Rubin, 2001). Theories are chosen as a framework for art therapy as a result of other reasons as well, reasons such as culture, psychological history, and social situations. Culture affects diagnoses and treatments. New theories have been developed throughout the history of the field of psychology, in response to changing times and historical events. Evolving social situations have resulted in new kinds of mental illness. In fact, mental illnesses and treatments do not exist without cultural influence (Frank & Frank, 1993). Mental illnesses occur in combination with one's physical and social relationship problems, profoundly affected by cultural norms in regards to communication styles, thoughts, behaviors, and feelings (Frank, & Frank, 1993). One example of the influence of culture on diagnosis is Shinkeisitsu-sho which was seen only in Japan, as classified by Morita. Another example of cultural influence is that during World War II, Russian soldiers were never diagnosed with psychoneuroses because the Russian Army did not recognize these as illnesses (Frank, & Frank, 1993).

### Theoretical History of Art Therapy

In the 1910s, Naumburg, who is called the mother of art therapy, chose Carl Jung's analytical psychology, which was closely aligned with psychoanalysis, as the

theoretical framework for her work in art therapy. At that time, Freud and Jung were very popular in the United States. After World War I, people in the United States were suffering a great deal of anxiety and struggling with poverty. Many victims of Nazi Germany had immigrated to the United States and were dealing with the traumatic aftermath of the war. Naumburg was an art teacher for children who suffered from mental illness. In working with them artistically, she found that their pictures were symbolic. She applied Jung's theory to analyze and understand her students. Naumburg believed that Jung's psychological model was useful for her students with its strong validation that art expresses the unconscious. Later, she became a psychologist and used the theory with art with her clients.

In short, there are many likely reasons why Naumburg chose Jung's theoretical model for her work. For one, psychoanalysis was a popular and major theoretical orientation in Western culture at that time in history. Psychology was a relatively new field and the numbers of available theories were limited. Additionally, Jung's analysis about images inspired her thinking and resonated with her work. She wanted to help and understand her students deeply. She became an ardent admirer of Jung. For the first time in American history, a psychological theory became the framework for the use of art in treatment.

During the same time period, art was used as a healing method in Zen culture. In the early 1920s in Japan, Morita studied Freud but believed that Freud's theoretical orientation was not useful because people did not need to get in touch with their unconscious in order to be helped. Instead, he formulated his own theoretical

orientation, which he called Morita Therapy and founded an inpatient unit using this approach.

In the 1920s, behaviorism became a popular part of the world of psychology. In the United States, Edward Lee Thorndike (1874-1949) conducted a series of experiments with rats and puzzles. In Russia, Ivan Pavlov began his famous experiments with dogs, tones, and meat powder. Behaviorism studied human behavior through animal experiments. However, there is no record that psychologists, psychiatrists, or therapists used the theory behind behaviorism with art at that time. American art therapists did not appear to be familiar with behaviorism, but rather, were focused on psychoanalytic models. Interestingly, the theory behind Morita Therapy has some similarities with behaviorism because clients are taught how to think and behave.

In the United States, many hospitals were built following the end of World War I in order to address medical problems experienced by veterans. In the State of Kansas, the Menninger Clinic opened up with Jeanetta Lyle and Ruth Fasion Shaw providing treatment by using art with long-term in-patients who suffered from Post Traumatic Stress Syndrome (PTSD), especially children (Jung, 1994). Similar to what Naumburg was doing elsewhere, at the Menninger Clinic art was used in the treatment of children's mental illness under the rubric of psychoanalytical theory.

In the 1930s, Edith Kramer, who was an art teacher and fine artist, used art with children who had escaped from the Nazi concentration camps. The art allowed them to express anger with Hitler, fear, and unsolved conflict. She found that those children became more resilient through the art-making process and found hope for their future

lives (Kramer, 1972b). Like Naumburg, Kramer has used Jung's analytical psychology to interpret symbolic meaning and also used Freud's theory of the unconscious.

Essentially, Naumburg and Kramer chose an existing psychological theory upon which to base their clinical work. Morita did not find an available theory that was suitable for his work, and therefore, turned to creating a new one.

During the 1960s, with the influence of Freud and Jung having diminished somewhat, many art therapists integrated a variety of other psychological orientations with their clinical work. For example, Elkins and Stovall (2000) found that 28.2% of 1,846 members of the Art Therapy Association in 1998-1999 used more than one theory. 20.8% of the association members in the study declared themselves as eclectic, meaning they choose from a variety of theoretical orientations, depending on the case. 10.1% of them were psychodynamic practitioners, of which the Jungians were 5.4% and 4.6% employed object relations theory. Cognitive Behavioral Theory was used by 2.2% of the members. Between 1.0% and 1.9% of these art therapists ascribed to client centered theory, Cognitive, Gestalt, Developmental, Existential, or Family Systems theory. All other theoretical orientations were less than 1% of the responses (Elkins, & Stovall, 2000).

The above survey showed what kinds of theories art therapists chose. However, it did not show the reasons why they chose the theories. 80% of the membership chose a particular theory. Nonetheless, all theories do not fit with all kinds of mental illness. Certain theories are more helpful in explaining or treating certain illnesses. One model may not be effective for all kinds of psychiatric disorders. For example, it might be

better to use Cognitive Behavior Therapy or Existential Therapy for PTSD clients rather than psychoanalysis. The psychoanalytic method takes time and is costly. The client might need acute treatment or need to focus on the present and future rather than the past. For therapists who identified their theoretical orientation as Eclectic, there are reasons to choose particular theories for particular clients. It is not unreasonable to assume that a clinician would draw on different theories through the course of treatment. Using Western theory may not fit culturally for Asian clients whereas using Morita Therapy may be more appropriate for them. Future studies are warranted to study the reasons why art therapists chose particular psychological theories and how effective they are in using them.

#### Choice of Theory

There are two tendencies that influence how art therapists choose the theories under which they operate. First of all, many clinicians choose a theory to fit client conditions. Second of all, clinicians may choose a theory with which they personally are more comfortable, one that makes sense for them (Rubin, 2001). Art therapists who used Eclectic methods in the American Art Therapy Association survey subscribed to the first tendency. Those who used a particular theory subscribed to the second tendency.

For their part, clients often chose their therapist based on what they understand to be that person's theoretical orientation. However, they might not understand each theory very well. It is important for clinicians to be aware of the theory to which they subscribe, as well as the reasons for it.

### Advantage of Integrating Art Therapy with Theory

In the past, art therapy has been used with a variety of psychological theories. Using art is efficacious for many clinical treatment approaches. It can facilitate communication between the client and the outer world. An art therapist is able to be with the client's psychological process at its' most vulnerable. During the process of making art, clients are able to find their true self, and by making art, clients experience achievement. On the other hand, it is important to consider if there are psychological models which should not use art. Currently, there is no published information about this. However, in the future this issue needs to be examined because it is very important to find the most effective integration of theory with art.

### Possible Integration of Morita Therapy and Art Therapy

There are reasons art therapy may be able to be integrated with Morita Therapy. First, historically art therapy has been able to integrate with any theoretical orientation to treatment. So it should be possible to integrate Morita Therapy and art therapy. Typically, Morita Therapy has used art in its second stage, which is labeled Light Occupational Work, as well as in the third stage, Intensive Occupational Work. For example, the clinicians ask their clients to write daily journals and to make wood sculptures. Using art is a natural matter for Morita Therapy. Second, Morita Therapy might work well with some populations such as with Asian clients who are familiar with Buddhism. Asian clinicians and the people they treat typically are comfortable with the philosophy behind it. It may be easy for Asians to understand about Buddhist philosophy and healing methods. Other people, who are interested in Asian philosophy,

who are not inclined to explore their unconscious, who like to meditate, or who like to make a garden or sand tray may want to use Morita Therapy.

### III: MORITA THERAPY

#### Concept of Morita Therapy

In 1917, Shoma Morita, M.D. (1874-1937), who was a Japanese psychiatrist in Japan, formulated Morita Therapy. This therapy focused on accepting and holding all emotions, resolving conflicting thoughts, and becoming free from obsession (France, M., Cadieax, J. & Allen, E., 1995). Morita believed that mental illness occurred because of conflict between one's desire and one's attempt to control anxiety (Morita, 1929/ 1960/ 2004; and Nakamoto, 2009). Morita Therapy developed as a treatment for Shinkeishitsusho or Nervosity, which included problems with obsessive shyness, oversensitivity and feelings of inferiority (Ishiyama, 1986; Sansone, 2005). Morita (1929/1960) stated that clients with Shinkeishitsusho or Nervosity had long histories of inner conflicts and behavioral problems with social adjustment, anxiety and neuroses, including obsessive shyness, oversensitivity, and feelings of inferiority (Sansone, 2005). Clients with Shinkeishitsusho tend to persist in unrealistic, dogmatic thinking (Ishiyama, 1990). In particular, these Japanese neurotic clients tended to feel guilty because of laziness or self-centeredness and lack of socially responsible behaviors in the absence of physical sickness (Reynolds, 1969). Possibly because Morita strictly selected clients for his Morita Therapy treatment, his rates of successful treatment were high (Ishiyama, 1986). Currently Morita Therapy is also used for a variety of disorders such as depression, schizophrenia, borderline personality disorder, and alcohol dependence (Maeda & Nathen, 1999). However, Morita Therapy is not considered suitable for the

treatment of acute schizophrenia, borderline personality disorder, or aggressive behavior (Nakamura, 2008).

Morita Therapy is a holistic approach, which means that it is based on the premise that a person's mind, body, and environment are connected. It is called holistic human nature (Nakamoto, 2009). The holistic philosophy that nature and spirit cannot be separated, is a concept that is endorsed by both Taoism and Zen (Nakamoto, 2009). According to this belief system, because the mind and body are related, maintaining a healthy body leads to having a healthy mind (Morita, 1928/1998). Both psychological and physical well-being is maintained by balancing internal and external functioning (Morita, 2004). Morita stated that Morita Therapy is cognitive, transpersonal, and experiential psychotherapy (Morita, 1928/1998).

Morita Therapy is reality-based and focuses more on "the here and the now" of the client's everyday life. Less emphasis is given to past events, as the past cannot be changed (Sansone, 2005; Nakamoto, 2009). Ishiyama (1986, 1990) has argued that Morita Therapy is a Japanese version of Cognitive Behavior Therapy as practiced in Western countries. Both Morita Therapy and Behavior Therapy treatments showed improvement rates of 75% to 95% for individuals with obsessive-compulsive disorder with anxiety neuroses (Reynolds, 1969). Reynolds said that Acceptance and Commitment Therapy (ACT) in the West is similar to Morita Therapy because it encourages clients to focus on practicing mindfulness techniques, rather than changing their environment (Hofman, 2008). Japanese cognitive therapy is influenced by Buddhism and Eastern philosophy. Western therapies tend to focus on self-reflection,

insight, control of symptoms, and support of self-esteem (Ishiyama, 2003). However, the goal of Morita Therapy is to help clients change their mood-based and purpose-oriented lifestyles (Ishiyama, 1986). Morita Therapy is concerned with changing the client's dysfunctional cognitive and behavioral patterns and does not focus on reducing symptoms as the primary goal (Ishiyama, 1986). It is difficult for people to change their living situations and especially to change their family dynamics, even if those factors affect their psychological problems. In the case of abuse, the victims must be removed from their original family. In some situations, changing environments is the most reasonable action. However, in many situations, if the children live in dysfunctional family environments, even if they experience psychological distress, they cannot change their environments or caregivers. It might be difficult or impossible for them to move from the environment.

#### History of Morita Therapy

As a medical doctor, Morita's basic treatment beliefs were based on Zen Buddhism. He asked his patients to obey his direction (Fumo/不問), to become involved in inpatient treatment, and to learn from their experiences (Morita, 2004; Kitanishi, 2008). After a time, his initial inpatient program ran into difficulties and was changed into an outpatient program because of the financial problems associated with finding clinicians who were able to work twenty four hours a day, seven days a week. Today, outpatient treatment is the mainstay of Morita Therapy. In addition, in Japan there are now many kinds of support groups in the community such as "Seikatsu no hakken" and "Ikigai ryoho jissenkai" which carry out the goals of Morita Therapy. The group of

“Seikatsu no hakken” is a support group that counts more than 3,000 members among the Japanese. Each prefecture has its own group. Seikatsu means daily life. Hakken is discovery. The Hakken have meetings with trainers who are educated at the Morita Therapy Association and learn to support each other in regards to their mental health issues. The “Ikigai ryoho jissenkai” are support groups for cancer patients in Japan. “Ikigai” means that finding the reasons for our life. “Ryoho” means treatment. “Jissen” means practice. “Kai” means a group. These groups are dedicated to supporting cancer patients, and helping them learn how to live strong lives despite their illness. Morita Therapy’s theoretical framework is useful for them. Morita Therapy is about holding/accepting all emotions and living with them. By contrast, Western theories stress controlling/ suppressing emotion and finding it’s causes (Morita, 2004; Kitanishi, 2008; Nakamura, Iwaki & Kubota, 2007).

#### Morita’s Childhood Experiences

Morita’s childhood affected the development of Morita Therapy. He experienced fear of death during his childhood. Morita was exposed to a picture of hell at a Buddhist temple that he found disturbing. Following the exposure, he had repeated thoughts about death. The episode greatly affected the theory underlying Morita Therapy. “Fear of death” is one of the most important elements of Morita Therapy theory. Morita believed that because human beings have fear of death, they also have desire to live, as these tendencies are like two sides of one coin (Morita, 2004). Morita continued to have feelings of “fear of death” during his adolescence. He became anxious and continued to fear death. He agonized with his father about it. His chronic

anxiety meant that he needed an extra year before he was able to graduate from school. It also was a factor in his running away from his home. Later, Morita wrote that even while he experienced panic, he also felt a strong desire to live.

After Morita became a college student he found himself in conflict with his father. In response, he developed a “who-gives-a-damn” attitude. Though he had been treated for his anxiety by his doctor, he quit taking his medication and devoted himself to studying for his next examination at his college. The result of this defiance was surprising. He got good grades which he had never had before. Through these experiences, he developed another principle of Morita Therapy: if people want to remove anxiety and fear, they have to confront it. He stated that there is no way to resolve fear except to address it directly.

After he graduated from the university in 1903, Morita became a psychiatrist. He used hypnotism and medical treatments for his patients who had Shinkeishitsusho or nervousity problems. However, he concluded that the usefulness of hypnotism was temporary, making this form of treatment not essential (Morita, 2004). During this time period Morita studied Western and Eastern philosophies and psychology (Morita, 1928/1998). Morita studied Freud’s theories (Ishiyama, 1986), Montessori methods, abdominal breathing, Shinto rituals, and Zen meditation (Nakamoto, 2009).

#### Birth of Morita Therapy

Morita believed that all human beings have a fear of living, aging, getting sick, and death. These are basic tenets of Buddhism. He called this belief Seirobyoshi, 生老

病死. Sei,生, means live and life. Ro,老, means aging. Byo,病, means sickness. Shi,死, means death.

In 1915, before he started his inpatient treatment program, Morita had a significant experience in which he treated a patient who had panic disorder. Morita was able to help the individual in one session. This successful outcome led him to the develop an outpatient treatment program called Morita Therapy. In addition, Morita created the “vicious circle of conflicting thoughts,” a foundational concept in his new theory. In 1925, Morita proposed that emotions lead to cognitions and that those determine behavior (Morita, 1995). This is related to another basic Buddhist belief: that the body first experiences and then changes feelings, then changes thoughts, and next it changes consciousness, which eventually changes volition. He wrote that if the experiences of emotions were negative, then a bad circle of thinking was initiated and suffering grew, which meant that there were more chances that the person would become mentally ill. Before Cognitive Behavior Therapy was formulated, Morita had taught that emotion, cognition, and behavior relate powerfully to each other.

When Morita started inpatient treatment at his home in 1919, his basic approach was to provide treatment interventions with the expectation that they would not be questioned. Obeying Morita’s therapeutic direction (Fumo/不問) was consistent with the first step in Buddhist monk training. Patients were expected to write daily journals as a means to enhance their cognitions. In 1926, Morita Therapy evolved to a program that provided treatment through the mail for patients who were unable to stay in the

hospital for a long time and who lived far away. In 1929, Morita provided therapy in both in and outpatient settings.

During this period when Morita was developing Morita Therapy, he hospitalized patients in his home, turning it into a residential clinic. The original treatment of Morita Therapy was 40 days in the residential clinic of Morita's home (Maeda, & Nathan, 1999). Morita believed that in-patient treatment was inevitable, (Morita, 1928/1974). The duration of treatment could take up to several months. Morita observed his clients closely. During their first phase of treatment, he prevented them from doing anything, and then gradually allowed them to engage in activities only if they eagerly felt their own *Seino Yokubo* or "desire of life." *Seino Yokubo* is similar to Freud's "life principle" or Roger's state of "self-actualization" (Reynolds, 1969). In other words, Morita took total control of his clients in order to break down their habit of over-controlling themselves. Morita Therapy causes their self-defeating behavior and cycle of thoughts to change in a positive direction (Ishiyama, 1990). This treatment method is called "Re-educational Treatment" or the "Homelike Environment Treatment" (Nakamoto, 2009).

#### How Morita Therapy Views Pathology

A most important goal of Morita Therapy is the elimination of the "vicious circle of conflicting thoughts" (Morita, 1995, p. 112). Morita stated that suffering is not the natural result of mental illness. Rather, suffering occurred as a result of the "vicious circle of conflicting thoughts" (Morita, 1995). Moreover, he believed that most patients who had a mental illness were caught up in the vicious circle. The patients believed that they were powerless to overcome their illness, but that was incorrect. They just needed

to understand how the circle worked, and how to cut it out of their lives (Morita, 1995; Kitanishi, 2008; and Nakamura, Iwaki, & Kubota, 2007).

Both Cognitive Behavior Therapy and Morita Therapy believe that avoiding, controlling, suppressing, and endlessly searching for the cause of emotions creates a vicious cycle and a downward spiral (Nakamura, Iwaki, & Kubota, 2007). The difference between the two theoretical orientations has to do with how each understands the circle and what each proposes to do to address it. Morita Therapy theorizes that anxiety is the opposite of desire. It is important for a patient to accept and live with anxiety and fear because these affective states will not disappear. Cognitive Behavior Therapy (CBT) believes that if people change their thoughts, their behaviors will change. CBT teaches that anxiety and fear are learned reactions that come from wrong thoughts. The emphasis in CBT is on changing one's cognitions. By contrast, Morita Therapy focuses on action. This is consistent with the Buddhist belief that nothing is real except for actions.

#### The Core of Morita Therapy Pathology: Vicious Circle of Conflicting Thoughts

(Akujyunkan/悪環)

Pathology, according to Morita Therapy, comes from the “vicious circle of conflicting thoughts,” (Morita, 1995), Morita Therapy treatment strives to cut through the cycle and to focus on action (Morita, 2004; Nakamura, Iwaki, & Kubota, 2007; Kitanishi, 2008; and Nakamura, 2008). Morita therapists analyze where their patients are in the cycle of issues that stem from the “vicious circle of conflicting thoughts” (Kitanishi, 2008).

Kitanishi (2008) believed that the vicious circle of conflicting thoughts (Akujiyunka 悪循環) was affected by the relationships among emotion, cognition, and behavior. Nakamura said that the cycle happened as a result of the relationship among attention, clinging behavior, and narrow thinking. These two theorists used different words for explaining the vicious circle, but Morita used both sets of words.

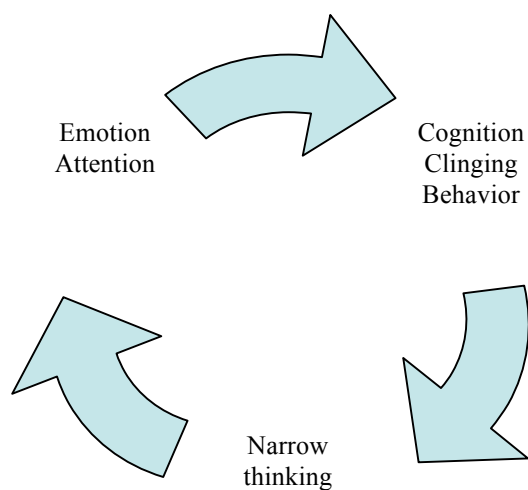


Figure 1. Vicious Circle of Conflicting Thoughts (Akujiyunka 悪循環)

A good example of the vicious circle of conflicting thoughts can be found in the experience of trauma victims. When clients remember, focus on, and attend to their traumatic memories, they suffer. Their emotions become heightened and they often experience acute anxiety. The more they remember, recall and think about those memories again and again, the more they experience suffering. The painful emotions increase in strength because the feelings become increasingly sensitive. Negative cognition and cling result. Eventually, clients become dysfunctional because those

experiences affect their behavior and narrow their cognitive focus increasingly towards the trauma. Finally, they become slaves to the vicious cycle and the cycle becomes a downward spiral. They cannot bear those painful experiences and become mentally ill.

### A Hypothetical Case of the Vicious Circle

#### The Traumatic Event

When Ms. A used a Metro bus to go to hospital for her appointment, she could not get off the right place. She missed the bus stop where she wanted to get off. She was upset and was late her appointment.

#### Attention to Negative Emotional Experiences

At the next appointment day, she remembered that she had gotten upset and missed her appointment. Those memories created in her the same feelings that she had undergone during the traumatic event. She was upset and felt bad again. She readily focused on having missed the bus stop and having been late to her appointment. She gave attention to these thoughts and emotions.

#### Negative Cognition and Cling to the Negative Emotions

Ms. A was afraid of taking a bus, but she did not have a car. She clung to the negative thoughts again and again. She imagined that if she took the bus, she would still not likely get there on time. She thought her doctor might be disgusted with her. Those negative thoughts and pains rolled over her like waves, attaching themselves to her. She suffered.

## Behavior and Narrow Thoughts

Ms. A. believed that she should be on time for the appointment in order to be a perfect and good patient for her doctor. She did not want to make mistakes. She believed if she could not make it, it was shameful. It meant that she could not do anything right.

## A Vicious Circle

Ms. A. remembered and recalled the first event, and then she thought that she had to be there on time. On the other hand, she was afraid of making the same mistake and arriving too late. She believed that she should not be that kind of person. She was afraid of taking a bus and going out.

The suffering came from the gap in the client's thoughts between her imagined or dream idea of self and her real self. She believed that she should be her imagined or dreamed perfect human beings. If the gap between ideal and real is very large, people become mentally ill.

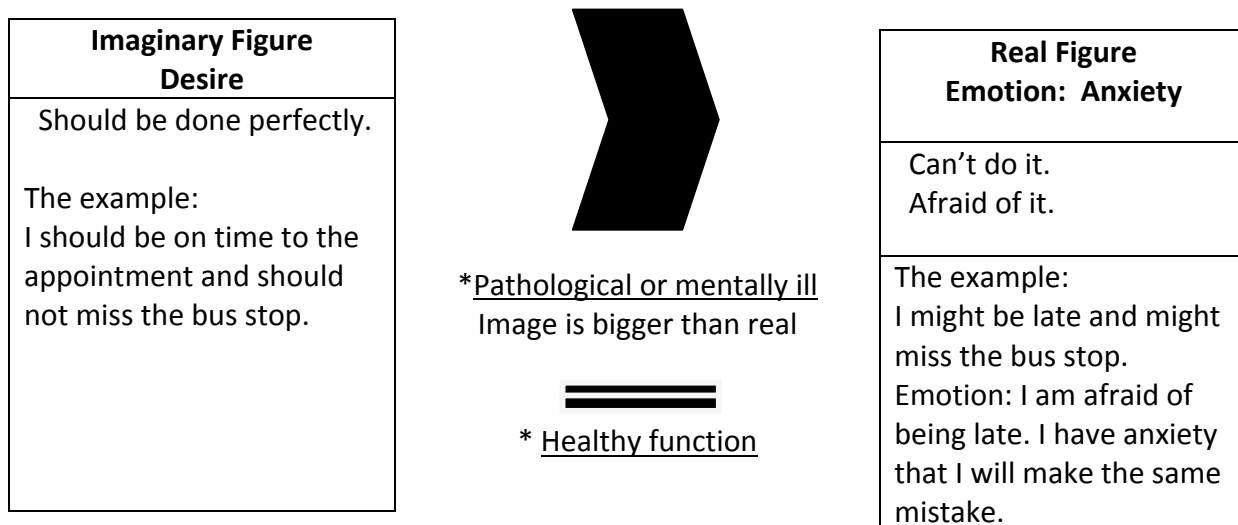


Figure 2. Discrepancy Between Imaginary and Real Self

Morita Therapy strives to cut through the vicious circle. The vicious circle happens when the imaginary self (desire) is bigger than real self (reality). Clients who have the tendency to believe that they have to be better than they really are, Morita named as “Shisou no Mujun / Incongruent ideas” (Morita, 2004). Incongruent ideas take place when people have conflicting ideas between desires and realities.

#### Human Relationships Within the Vicious Circle

The vicious circle and Shisou no Mujun / Incongruent ideas happen not only in regards to an individual’s psychological or physical state, but also within human relationships. An example of individual psychological and physical pain is as follows. If a person gets in a car accident, they feel pain because of the event. When they feel pain, they remember the accident. At the time they have memories of the accident, and they experience pain psychologically and physically. They believe that the accident is the cause for all their pain. When they see or think about a car, the vicious circle happens and they do not go outside.

An example of how the vicious circle operates within a relationship is as follows. If parents focus on their only child, their parenting style becomes overprotective. The child is unable to think and make decisions by herself. The child might find it difficult to communicate with friends at school. The more difficulty the child has at school, the more distress the parents experienced, leading them to protect their child to a greater extent. This example shows the vicious circle of relationships. Morita Therapy has a unique approach to solving these issues.

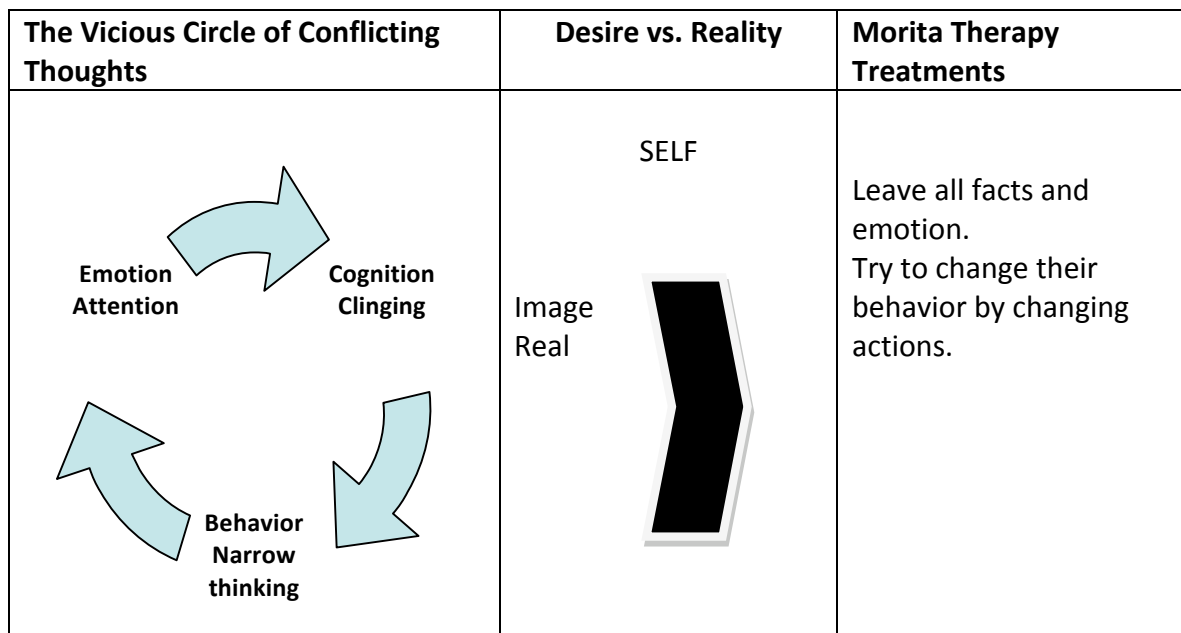


Figure 3. Summary of the Vicious Circle of Conflicting Thoughts

### Anxiety and Desire 恐怖と欲望

Morita (2004) believed that basic to all human beings are anxiety and desire .

All human beings have desire. Consequently, all human beings have anxiety. For example, a couple owns a house and they have to pay the mortgage. If they really want to get the house (desire), they have to have a job and work for the money to pay the mortgage. They worry about losing their job (anxiety). If they just cling to a thought of having the house but losing their job, they might panic because of the anxiety of losing the house. They worry and might become depressed and become unable to eat. Because they become physically ill, they cannot find a job. Morita said that anxiety and desire are two sides of one coin. It is impossible to take anxiety away. However, this also means that nobody can take desire away.

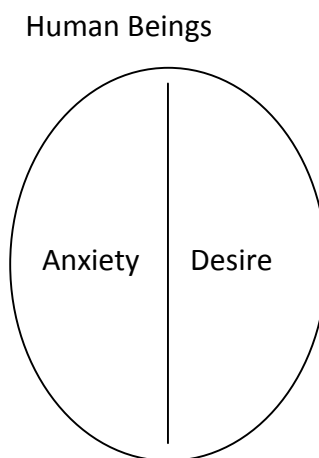


Figure 4. The Connection Between Anxiety and Desire

Morita (2004) stated that if human beings are unable to eliminate either anxiety or desire, they have to accept and hold these as natural phenomena. Additionally, he stated that human beings have to find something that we can do after accepting and holding anxiety and desire. Otherwise, humans engage in self-negation.

#### Nature Theory 自然論

Nature Theory is one way of understanding in Morita Therapy. Morita (2004) stated that it was natural for human beings to have a lot of kinds of emotions. He believed that anger, jealousy, and desire were normal human reactions. For him, these are not pathological reactions. Normal human reactions become mental illness only when the reactions are suppressed by our cognitions. If a natural phenomenon such as anger, jealousy, desire, and other emotion is accepted, it will reach its peak and eventually disappear, like a normal distribution function line. Even when the emotions

take time to peak, it is important to hold all of them until they disappear (Morita, 2004; Kitanishi, 2008).

### Core Principles of Morita Therapy

#### Shisou no Mujun / Incongruent Ideas

Incongruent ideas mean that people have conflicting ideas between their desires and reality. Often, reality does not allow a desire to be obtained. For example, if one thinks that it is necessary to go to the gym every day at 6 a.m. before work but cannot wake up and go at that time, one might feel a lot of stress. Thus, there are incongruent ideas between one's desire and reality. Morita said that if people are obsessive or attached to one idea, their thoughts will be limited. They will be unable to entertain other ideas. He said that clients do not need to think in terms of "should and shouldn't." Even if one cannot go to the gym at 6 a.m. before work, one will be fine and can change one's plans to fit with real life.

#### Syukan and Kyakkan / Subjective and Objective

Morita said that if the clients focus on their symptoms or feelings strongly, they will have difficulty thinking about other matters, such as their real life with its daily routines. They may persist in thinking about their symptoms and feelings subjectively. If a client feels that way, the clinician's objective advice will not work.

#### Kanjyo and Chishiki / Emotion and Knowledge

People have emotions, but they may try to control their emotions with their intellect. However, having and feeling emotions are natural for human beings. Morita

advocated that we try not to control our emotions. It is fine to feel emotions. If people try to control emotions, they will focus on them unconsciously. By contrast, if they leave emotions to run their natural course, and simply hold them, the emotions will calm down and disappear. Shinkeisitsusho clients try to control their emotions, which makes the emotions worse because of obsessing.

#### Taitoku and Rikai / Learning from Experiences and Deep Understanding

Taitoku means that people learn from their experiences. Rikai means that people understand wisdom through knowledge and imagination, and abstract ideas. Morita stated that deep understanding comes from learning experiences. Learning experiences strongly encourages the development of wisdom. That may be why Morita provided learning experiences to his clients in a residential treatment setting.

#### Shinnen and Handan / Belief and Decision

Behaviors come from Shinnen, beliefs which are subjective perspectives, emotions, and experiences. These same factors shape personality. On the other hand, knowledge and understanding affect behavior indirectly as elements of decision-making. That means that knowledge and understanding are just surface affectations. Clinicians need to know their client's personality. However, if people are motivated to obtain knowledge and wisdom and find these by themselves, those learning experiences strongly affect personality.

#### Ronri no Sakugo/ Logical Anachronism

It is very important for clinicians to understand the client's subjective and objective perspectives and the relationship between their emotion and their

intelligence. Understanding the client's basic emotional functioning is especially significant because those factors are very important elements for understanding the client's personality. If clinicians ignore their client's emotions or perspectives on their illness, and just give clinical advice or directions, treatment will not work. The client's perspectives and beliefs are their real world. Clinicians need to understand how these foundations are constructed.

#### Shizen and Jini, Mokuteki and Syudan / Nature and Artifice, Goal and Steps

Morita wrote that physical, mental, and psychological phenomena are natural matters. Nobody can change them. However, most people believe that they can. People should live in harmony with nature and be natural. If people lack motivation, they need to wait for their motivation to change. However, Morita Therapy and Buddhist philosophy believe that changing behavior/actions are a natural pathway to change.

#### Kannenn no Kyatukannteki Touei / Concept of Objective Projection

Acquiring self-confidence and courage are difficult. Similarly, it is difficult to leave or get rid of feelings of agony or anguish. Morita taught that there were two ways to leave and hold feelings of agony and anguish. One is to allow oneself to feel and be in those feelings (Arugamama / be in nature). Another way is to focus on and to observe and criticize one's feelings, observing the feelings objectively.

#### Shizenfukujyu / Obey the Laws of Nature

When people suffer, they feel pain and anxiety. Those are natural feelings. When it is winter, people feel cold. That is natural too. Shinkeisitsusho patients tend to think

that they should not think or feel that they are cold. If they think that they should change themselves, there will be conflict between their ideas and their realities.

#### Seishin no Kikkou Sayo / Psychological Conflicts

People have two actions that interact within their mind. When one feels anxiety (first action), one tries to get rid of the feeling or find a solution to reduce anxiety (second action). If the first feeling is strong, the second action also becomes strong. If the first stimulation is strong, the following second action tends to be strong. If the first reaction is not strong, one does not need to take strong action to reduce the reaction. These interplays are natural matters. Shinkeisitsusho patients often have strong reactions of which they strongly desire to rid themselves. When people have strong psychological conflicts, they have agony, and problems.

#### Kyogu no Sentaku / Choice of Situation

When people feel agony and anxiety, it is important for them to hold those feelings because the feelings are natural and real. One does not benefit from choosing a different situation in order to avoid feeling anxious. It is better for us to feel anxiety and be in reality.

#### Syukan Toiukotono Imi / Meaning of Subjectivity

When one drinks water naturally without any thoughts, that behavior is subjective. One does not experience feelings as a result of subjective behavior. The purely subjective is not a linguistic experience. When one uses language or thinks about behavior, it is objective. Objectivity includes other people's perspective and thoughts.

## Chui / Attention

People do not need to focus on a specific matter. We are able to live without focusing on or giving attention to our daily lives and bodily functions. Shinkeisitsusho clients focus on or give attention to specific matters.

## Chui to Ishiki no Kankei / Relationship between Attention and Consciousness

Morita allowed patients to fully focus on their agony instead of avoid thinking about it. Since it is already a natural situation for patients to think about their agony, it is better for them to feel enough pain until the pain lessens and goes away.

## Seishin no Chowa/ Balance of Minds

If people are hypersensitive to stimulation, they might be obsessive about or irritated by noise and other stimulation. They feel uneasy and try to dismiss the noise from their minds. On the other hand, if people are not aware of these noises, they are not uncomfortable with them at all. Morita believed that it is important for people to be able to find balance between their minds and outside stimulation. Shinkeishitsusho patients tend to be hypersensitive.

## Mushojuusin / Daily Functioning

It is important for healthy minds to be active, but it is not good for minds if they are focused on just one point. Because Shinkeisitsusho patients tend to focus on one area, their minds and resulting behaviors in their daily life are dysfunctional.

## Kannjyouno Housoku/ Rules About Emotions

Morita said that there are five rules about intense emotions.

1. Emotions will calm down and disappear like the curve of a mountain, i.e., intensify and then gradually decrease.
2. If the impulse satisfies, the feelings will disappear.
3. People will not feel strongly about their emotions if they do not stimulate them to an obsessive level or reject them altogether.
4. When emotions are stimulated constantly and focused on, they become stronger and stronger.
5. Emotions are derived from new experiences. Emotions are stimulated by repetition.

Morita's ideas were based on the concept of dependent origination in Buddhism, which is similar to Satipathana Sutra, the sutra for meditation on the body.

### Psychopathology

#### Characteristics of Patients who have the Vicious Cycle of Conflicting Thoughts

Typically, a person caught in this cycle tends to be introverted, perfectionist, self-centered, an alarmist, and easily worried. The gap between their ideal self and reality is large. The person's reality is not accepted by themselves. The person compares themselves to the ideal and looks for fault. The person tries to do the thing that cannot be done. The person is anxious and worries about other people's evaluation. The person is highly influenced by the judgment of others and changes their speech, behavior, and even their values to match the opinion of others. They have an obstinate and unyielding spirit.

#### Treatment Goals in Morita Therapy

Morita therapists encourage patients to look at and accept their real selves. Clients are taught that they are not perfect people. That means that they need to accept and hold their feelings and learn to live strong and well.

Clients need to change their emotionally-based thinking and learn to focus on action. For example, one client could not buy a shirt he needed due to severe anxiety about conversations that might take place with the people who worked at the store. In this case, Morita therapists helped the client focus on the specific goal of buying a shirt. When the client could go to a store to buy a shirt without the worry and anxiety stopping him, the person reached one of his goals. When clients have successful experiences like this, they are able to cut through the “vicious circle of conflicting thoughts.”

Another goal in Morita Therapy is to reach the state of *Arugamama*--acceptance of reality as it is (Hofman, p. 282, 2008). Ishiyama (1986) clarified that Morita Therapy encourages acceptance of a client’s tendency toward nervous sensitivity and anxiousness, but does not encourage focusing on personal weakness. Morita Therapy considers anxiety to be an acceptable emotion that one does not need to battle (Ishiyama, 1986). Obeying nature by accepting unwanted thoughts and feelings is better than trying to change an unchangeable situation (Hofman, 2008). Ultimately, acceptance includes accepting aging and death because these are natural (Kitanishi, 2007).

### Target Symptoms Addressed by Morita Therapy

Morita targeted Shinkeishitsusho or nervous problems because many of his patients had those symptoms. In addition, he had experienced similar symptoms in his own life. In his era, Japanese society faced strong social stressors as a result of World War I. After the war, the Japanese economy developed rapidly, and people had to work harder than before. Even though they worked hard, they did not achieve prosperity because of rampant inflation. Many people had anxiety about their situation. Morita had many patients who had Shinkeishitsusho or nervous problems which included no motivation to live. Ishiyama (1990) described the situation by noting that “the Morita therapist helps clients to focus on their neglected self-actualizing desires and ability to choose action and helps them to leave the escalated emotional symptom to a natural healing process” (p. 556).

Morita found that even Shinkeishitsusho clients had the desire to have good health, solid relationships with others, and meaningful life goals. Their problems were connected with trying to be more perfect than others (Morita, 1929/1960/ 2004). Morita Therapy interventions change the client’s lifestyle (Ishiyama, 1986).

One reason why Morita was interested in patients who had Shinkeishitsusho and nervousity problems was that he had faced similar symptoms in his life. He exhibited clinging behavior at some points in his life. He experienced debilitating fears of death and a high degree of anxiety (Morita, 2004). He wanted to be perfect. His anxiety primarily came from his relationship with his father. In his writing he acknowledged that conflict with his father affected his symptoms. For instance, when he was a student

at Tokyo National University Medical School, his father did not send money to him.

Morita was depressed and anxious and experienced panic attacks. He recovered by changing his lifestyle at that time. He learned firsthand that if people who have anxiety change their lifestyles, their symptoms can disappear.

Morita sought from his patients, their voluntary will to change (Gikei Medical School of Morita Therapy Center, 2007). Morita believed that if patients were not motivated regarding their treatment, they would not improve. Clinicians cannot force their clients to change their behavior because the clients sometimes resist (Ishiyama, 1990). It is important for both clients and clinicians to feel a natural and spontaneous motivation toward engaging in any activities (Morita, 2004). Morita stated that this idea was similar to Montessori teaching methods (Morita, 2004).

#### Target Goals of Morita Therapy Today

Nakamuta (2008) stated that these days, Morita therapists choose clients who possess good judgment because it is important for clients to understand about the basic theory of Morita Therapy. Clients need the ability to understand that they have responsibility for their problems and they need to have some ego strength. Clients must be able to realize that they suffer as a result of the discrepancy between their ideal and real selves. Morita Therapy is effective for cancer patients and most of the mentally ill with the exception of patients suffering from bipolar disorder or acute schizophrenia (Nakamuta, 2008).

### Morita Therapy and Buddhism

The philosophy of Morita Therapy is similar to Zen Buddhism, which was the religion practiced by Morita's family. Morita (1934) stated that after he formulated Morita Therapy, he found similarities between his new system of therapy and Zen Buddhism. Morita Therapy was influenced by Japanese and Eastern culture which are Buddhist (Suzuki, 1989). Zen, Morita Therapy and Japanese culture as a whole, all place importance on accepting one's phenomenological reality (Suzuki, 1989). This is reflected in Morita's primary principal, "Acceptance." When clients have a positive view of acceptance, they are able to benefit from practical activities (Ishiyama, 1986).

Morita did not form his therapy based entirely on Zen. However, he had a deep understanding of the basic philosophy of Zen (Suzuki, 1989) and used many Zen words and illustrations as examples to support his statements. The Japanese are almost entirely Buddhist. Zen has had an important place in Japanese society for some 2,000 years. Naturally, Japanese people have been heavily influenced by Buddhism, even Japanese people who are a part of a different religion. One example of the fundamental principles of Buddhism that have influenced Morita Therapy is the renouncement of all possessions and attachments to material things. In Morita Therapy, this principle has been extended to mean getting rid of mental obsessions as well as other adherences or attachments, even if they are generally regarded as virtues.

Another Buddhist principle that has had its effect on Morita Therapy is "do not think you have to do something, and if you think that you cannot do something, do not do it" (Kitanishi, 2007). The similar Morita Therapy principle is to not think about what

you have to do, but to accept your emotions and limitations. If an action is too hard to achieve, you do not have to force yourself to attempt it (Kitanishi, 2007). Nakamoto (2009) taught that mind and body should be balanced by nature. If people have emotional conflicts and disharmonies in their minds and lives, these problems will be solved naturally by time. Humans have strong survival abilities that are natural systems because we are part of nature (Nakamoto, 2009). Our minds and emotions always change because we are influenced by many people (Nakamoto, 2009). It is important in Morita Therapy for clients to accept themselves and to learn how to live with their emotions (Nakamoto, 2009).

#### Morita Therapy and Western Psychology

Morita Therapy and Buddhism both teach that the body generates feelings that lead to thoughts/ cognition, which leads to behavior. That is why Morita asked his clients to do some actions without any questions. Zen monks were often asked to do work without any conversations or questions of their teachers. However, most Western psychologies believe that cognition leads behavior. In addition, Western psychology looks for the causes of symptoms in light of the belief that our thoughts are able to control emotions and situations (Kitanishi, 2007). Eastern psychology does not focus on the cause of symptoms because it believes that people cannot and do not need to change their situation. Morita Therapy focuses upon accepting all kinds of emotions and environments. Morita Therapy is an experiential learning system, an approach that is different from Western therapy (Ishiyama, 1987). Morita Therapy holds that all psychological problems stem from anxiety (Kitanishi, 2007). According to Morita

Therapy, accepting aging, other life events and even death through the processing of emotions is our natural heritage. Morita Therapy helps restore a person's ability to engage in such healthy processes. If one tries to change those emotions and feelings through thought alone, those emotions and feelings may become stronger. Morita Therapy holds that it is difficult for us to decrease anxiety by using thoughts. Instead, Morita Therapy focuses on changes in behavior because anxiety decreases after changes in behavior (Kitanishi, 2007). Clients who have mental illness tend to be preoccupied with their symptoms and neglect their physical well-being (Nakamoto, 2009).

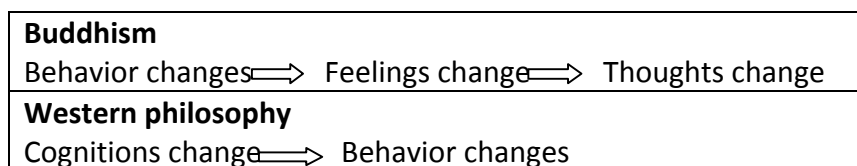


Figure 5. Differences Between Buddhism and Western Philosophy

#### Modalities

Morita Therapy has various modalities now available, including programs for residential patients, outpatients, groups, and other programs that combine several methods of treatment (Ishiyama, 1986). Morita Therapy is well-known in the Western world (Reynolds, 1969) and has been used there for many kinds of mental illness (Kitanishi, 2007). Morita Therapy does not focus on the unconscious using psychoanalysis (Reynolds, 1969). Western clinicians point out that Morita Therapy is a viable and useful therapy for not only Japanese, but also for other Asian and Western clients (Ishiyama, 2003). Some clinicians are concerned that Morita Therapy might be

difficult to accept for Western clients because of cultural differences (Ishiyama, 1987). However, these days many people are interested in Buddhism and have used practices such as Zen garden and meditation. If in the future, Morita Therapy garners scientific evidence as to its effectiveness, Morita Therapy will be used more prominently throughout the world. Morita Therapy has developed over time in Japan. The original Morita Therapy has not persevered in the exact same form. This proves that Morita Therapy can evolve to fit into different environments. Morita Therapy should be developed to meet the needs of different cultures in different countries.

### Treatments

#### Original Stages of Morita Therapy Treatment As Practiced by Morita and Possibilities for Greater Integration with Art Therapy

Morita emphasized that effort does not always lead to results. He stated that most treatments were not effective if clients were obsessive, in other words, attached to one thought. What is most important is for clients to leave treatment and first decrease their attachment before they can effectively reenter therapy. Morita stated that clinicians have to assess and diagnose patients. Without assessment and diagnosis, they cannot locate the core issues behind the symptoms and psychopathology. Morita likened the providing of treatment with the lack of proper assessment and diagnosis to committing a felony (Morita, 2004). When he formulated Morita Therapy, he utilized strict selection criteria and only worked with clients with *Shinkeishitsusho* who had hypochondriasis, anxiety neurosis, phobic-obsessive neurosis, or psychogenic physio-

motor malfunctions (Ishiyama, 1986). Once patients were identified, diagnosed and ready for treatment, they were taken through four stages of therapy, as follows.

#### The First Stage of Isolation and Rest

During this stage, clients are isolated from human contact and restricted from any activities with the exception of using the toilet, eating and bathing. The purpose of this stage is for clients to rest physically and mentally. Clients have to calm down and look at their inner thoughts and recoup their strength (Nakamoto, 2009) before they can engage in more active treatment. Because Western clients need more verbal communication for their therapy sessions, Western therapies encourage clients to talk and express their emotions, to analyze and control their symptoms (Ishiyama, 2003). However, Morita had his clients isolated from anybody, any activities, and any interaction. Morita believed that clients needed to reflect with themselves without interference. When clients are able to accept their emotions, they may experience inconvenient, painful or stressful feelings. However, through this process, clients can recover from their fatigue and begin to change behaviors (Ishiyama, 1990). Morita (1998) stated that the goal of this therapy is to fundamentally break loose the client's mental suffering and pain. It allows them to experience the mental state he referred to as immediate liberation through confrontation with one's suffering (Morita, 1998). During this stage art is not beneficial because the patients have to lie down and are not allowed to engage in activities.

### The Second Stage of Light Occupational Work

During this stage, clients are still prohibited from engaging in conversations, amusements, and active movements because those activities divert their concentration from reflection and developing insight. In this stage, therapists do not give tasks to clients. Therapists have to wait for the client's motivation to increase. It is important in this treatment that the client resumes feeling natural and spontaneous motivation toward engaging in activities. Small activities such as journal writing and art activities after dinner are allowed (Morita, 1998). The client's lifestyle was controlled by a structured schedule. This is consistent with the focus in Morita Therapy on lifestyles rather than symptoms.

During this stage, art therapy could be a part of the therapeutic process. Art therapists might be able to choose art materials for each client. For example, some clients might not like to write, but might like to draw or make a collage. Drawing and scribbling might be a good art direction for clients during this slow and quiet period.

### The Third Stage of Intensive Occupational Work

During this period, clients are encouraged to engage in any large motor skill activities such as sawing, chopping wood, and digging holes in the fields. Through intensive work, clients experience the reemergence of patience, cultivate self-confidence, accomplish small successes, and appreciate the value of labor. Such experiences help clients overcome their pain and difficulties (Morita, 1998). This stage focuses on supporting the natural interests of clients. Certainly there are many possibilities regarding the integration of art therapy with this stage of treatment. Some

clients do not want to make wood sculptures because wood is hard and using a knife to cut in can be difficult. Some clients might have a physical problem in making these types of sculptures, such as clients with arthritic hands. Because some clients may find intensive activities difficult to accomplish, art therapists might be able to provide many art activities, direction and materials that engage larger muscle groups in an outside context. Clients may prefer art work rather than menial labor.

#### The Fourth Stage of Preparation for Daily Living

This stage of treatment focuses on preparing the client to go back to their natural life. Clients slowly start to adjust to the world outside of therapy. They are allowed to read simple books and walk outside alone. During such moments, clients are encouraged to examine their feelings and thoughts about the future. Clients delineate what kinds of fears and obsessive thoughts they had before so that when such feelings or thoughts reemerge, the client can find the means to accept the feeling or thought. Art therapy may be useful for helping clients to find themselves because drawing and visualizing are often easier ways to find acceptance. There are many ways to use art to teach clients how to improve their daily living. For example, art pictures can be used to assist clients in practicing how to conduct basic social greetings.

#### Contemporary Outpatient Treatment Strategies

According to Kitanishi (2008), the following interventions: can be done with clients:

1. Experience how to accept and hold with emotions.
  - a. Distinguish between what you can do and what you cannot do.

- b. Try not to control or suppress the emotions.
  - c. Hold and accept your emotions.
  - d. Wait until high emotions become less intense.
  - e. Observe your emotions. Write daily.
  - f. Recognize the dynamic nature of emotions.
2. Review the principles of action.
- a. Realize the purpose of your action.
  - b. Take action.
  - c. Focus on the action and have a successful experience of it.
  - d. Do not allow yourself to need to be perfect.
  - e. Understand and find out about how your action changed your emotions.
  - f. Feel your desire for life.
3. Review the principles of relationships.
- a. Realize how you feel other people's evaluations, opinions, and judgments about you.
  - b. Consider your emotions and behavior and how the judgment of others affects you.
  - c. Find out how you try to fit them.
  - d. Find your behavior and emotion after you change to fit them.
- Have you eaten too much? Are you depressed? Have you drunk excessively?
- e. Try to focus on and realize your purpose of action.
  - f. Change your behavior as a result of someone's judgment as to your own purpose.

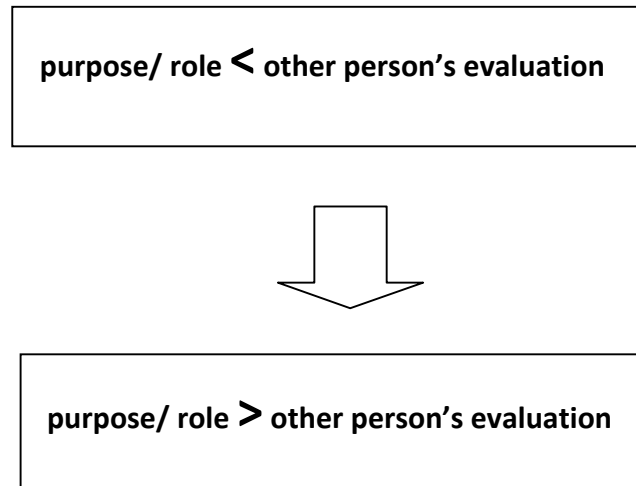


Figure 6. Changing the Impact of External Evaluations

#### Possibilities of Morita Therapy in Western Culture

Morita Therapy is based on Eastern philosophy and culture, and seems to be different from what is found in the West. However, these days, it may be easier for Western societies to accept Morita Therapy. First, Buddhism is more familiar in the West. For example, there is a long history of Zen in the United States. In the 1950s, Dr. Taisetsu Suzuki, a Japanese Zen monk, began teaching Zen in New York (Morgan, 2001). In the 1960s and 1970s, many Western psychologists and psychiatrists became interested in Eastern philosophy and practices such as meditation and yoga (Morgan, 2001). Acceptance and Commitment therapists believe that Buddhist philosophy relates well to Behavioral and Cognitive Therapy (Hays, 2002). Hays (2002) said that Buddhism teaches us to accept realities. Buddhism encourages us to not have a strong feeling of attachment. Also, Buddhism shows us how to create a good balance between the

insights of nature and mental functioning (Teneatto, 2002). The latter concept is relevant to Morita Therapy.

Western science has investigated the effectiveness of meditation. Meditation practice helps to promote calmness, awareness, open-mindedness, and being nonjudgmental (Anderson, 2005). It changes the brain. Meditation leads to the power of healing and to looking at the nature of the mind (Toneatto, 2002). Meditation has long been associated with Buddhism. The Buddhist principle of nonjudgmental awareness is consistent with the Morita Therapy concept of "Acceptance."

Buddhism is not science. However, some of its practices have a scientific basis. Combining Buddhist practices and psychotherapy may be valuable for many people, including non-Buddhists (Hays, 2002). Zen has become a bridge between Eastern and Western psychology (Kwee & Ellis, 1998). Morita Therapy could be an effective theoretical orientation for many populations.

It is important for therapists to be able to treat patients using a theoretical foundation. For Japanese therapists, it may be difficult to understand Western psychological theories because theories are influenced by the cultures, values, and philosophies of the places from which they originate (Kitanishi, 2007). Asian therapists may more easily understand Eastern philosophies such as Zen and Buddhism. The client's culture impacts their family functioning because each culture has its own strong heritage (Hoshino, 2003). People cannot ignore their own culture and heritage. Clear, logical, and systematic understanding of the theories that underlie the practices that are used with patients is a necessity. Understanding theories is important in knowing how

to apply interventions with patients in a step-by-step manner. In short, therapists should choose theories that they understand and can use successfully. If therapists use theories they do not understand, they cannot help patients.

Western theories make less sense to people who are raised in Buddhist cultures. However, Morita Therapy is based on Zen Buddhism. Asian therapists and clients might find it easier to understand its philosophy and principles. However, Morita Therapy may be useful not only for Asian clients, but also for some Western clients. For example, if a Western theory does not work well for a Western client, Morita Therapy might work well because new perspectives sometimes work well. Morita Therapy should be developed to apply to all kinds of populations. Clients do not need to understand the philosophical underpinnings of the therapy with which they are engaged, but clinicians have to understand it clearly.

#### Morita Therapy Past and Present

Morita (2004) wrote about psychopathology of Shinkeisitsusyo in his book, Shinkeishitsu no Hontai to Ryoho. This book was written to explain the causes of symptoms and how to treat clients who have Shinkeishitsusho. Even though Morita formulated it in 1919, those treatment principles are still used by today's Morita therapists for many kinds of mental disorders. Through Morita's books and articles, it is clear that Morita understood Buddhism well and was influenced by Buddhism. Buddhism teaches physical training. Morita Therapy taught physical training too. Monks never asked questions when their masters asked them to work during their

training. Morita did not allow his clients to ask questions or argue with Morita's treatment orders. Those methods still exist in today's Morita Therapy.

Even though Morita formulated Morita Therapy in 1917, over 100 years ago, his theory and philosophy are easy for Japanese people to understand because they are based on Buddhism. Morita Therapy can be a good fit for Japanese and Asian clients because they are influenced by Buddhism. These influences are strong and ever-present in their lives and their philosophy towards life. For example, in Japanese culture, it is very important to clean one's house and garden in the morning. Children have to clean their schools after school, including the restrooms. Sixth grade students clean the restrooms of the first grade students. This practice is from Buddhism which teaches that cleaning the environment means cleaning one's mind, thought, and life. Buddhism teaches that people find wisdom through service. That is why Morita Therapy asks clients to do work.

#### **IV: ANALYTICAL PERSPECTIVE OF MORITA THERAPY**

##### **Background Considerations Regarding Morita Therapy**

Today, many Japanese psychiatrists and psychologists have developed new applications of Morita Therapy. There are historical reasons why Morita Therapy changed and developed. The timeline below shows the development of Morita Therapy in the context of the history of Japan, the world, and medication. Understanding the historical context of development of Morita Therapy leads us to understand how it has evolved and why changes were needed. The history demonstrates that social situations such as cultural, economic, and philosophic variables affect medical technology and development. For example, after both World Wars, the economic and social situation affected people's nutrition and mental conditions. It is important to understand this historical background. Especially in regards to Morita Therapy, it is important to understand history and culture because both affected which clients were treated in what manner. Culture is a particularly important context here in that Morita Therapy was formulated by a Japanese psychiatrist in Japan and was influenced by Buddhism as well as Japanese culture. Indeed, Morita Therapy's concept of Shinkeisitsu-sho does not exist in DSM-IV and could be considered a culture-bound syndrome. Historically, it is also important to understand about the development of medication as well since medication has greatly affected clients' conditions.

## Morita Therapy and Medication

There is a big difference between the current and the past medical situation because of the modern development of psychiatric medication. Nakamura (2007) stated that in the last twenty to thirty years, medication for anxiety has become available. He said that in the past, when there were no medications for anxiety, psychotherapy was the only choice for treatment (2007). Today, medication has become a big part of the treatment regime. However, Nakamura (2007) pointed that even when medication is prescribed, it does not work for about 50% of clients. Therefore, therapy is still important. In the future, the theory and practice of Morita Therapy needs to take into account modern medications.

## Analytical Issues of the Original Morita Therapy

This chapter analyzes the original Morita Therapy. There are three issues to be considered: 1) the environment of Morita Therapy, 2) the relationship between clients and clinicians, and 3) the difficulty of understanding Morita Therapy. It is important to analyze these issues from a many dimensional perspective that includes the history of Morita Therapy and Japan, medications, and Japanese cultural perspectives in regards to the future development of Morita Therapy.

## Environment of Morita Therapy

In 1917 when Morita formulated Morita Therapy, it was just after World War I, the Russian Civil War, and Japan was preparing to enter World War II. Japan was in an economic depression. In that situation, Morita formulated Morita Therapy after his own experience of overcoming Shinkeishitsu-sho at his home (Kondo, 1966., Suzuki, 1967., &

Kitanish, 1989). Morita tried to provide the family atmosphere for his patients by using his home because he believed that environment was important for treatment.

At that time, the Japanese family style was the patriarchal system. The head of a family was a man--a father or grandfather--who had absolute power over family members. In this cultural situation, Morita Therapy was founded by Morita. He was a psychiatrist playing a father-like role at the inpatient unit established in his home. His wife became a very important treatment member, playing out for the clients the role of their mother. The mother role was important for Morita Therapy (Uchimura, 1970). Morita and his wife had a heavy work load. There were many responsibilities involved with providing treatment at their own house (Ohara, 1970). It was a hardship for them to use their own house for the patients. There was little or no private time. Morita sometimes worked 24 hour shifts, seven weeks at a time for several months. What was his motivation to work so hard? Perhaps he felt a great deal of responsibility to the new program of Morita Therapy. Perhaps his status as a psychiatrist led him to work hard and to make many personal sacrifices. It is possible that he recruited his wife to become a treatment provider because he needed the help with the extensive clinical and administrative work load. It would have been a natural matter for his wife to obey his request to follow him into treatment. The Japanese social norm was that he was in charge of his family as well as the patients. Having absolute power over family members was normal at that time in Japan. After Morita died, Aizawa and Maruyama inherited this style of providing inpatient treatment within a family atmosphere (Kitanishi, 1989). But in later years, Morita Therapy became simpler, including providing

inpatient and outpatient treatment in hospitals settings (Kitanishi, 1989). As noted by Kitanishi (1987), it is necessary for Morita therapists to have limits placed in regards to their workload and time.

#### Issues Regarding the Inpatient Unit at Morita's Home

Questions about placing the inpatient unit at Morita's home include ethical considerations, effectiveness of the treatment, and boundary between clients and clinicians.

#### Ethical Considerations

One of the stated reasons Morita opened an inpatient unit in his own home was that he believed that providing a family atmosphere was important for the treatment. Morita had his wife join the Morita Therapy program as treatment member even though she did not have any medical training. At a later time, Aizawa, a physician who was also a Morita therapist similarly would appoint a woman who did not have any medical training as manager of an inpatient unit practicing Morita Therapy at Jikei Hospital. Her position was as manager and her role was like a mother for the patients (Kitanishi, 1989).

Using contemporary standards of practice, we would consider these appointments unethical. Although Morita's wife and the unit manager did not have any medical training, they worked as treatment providers. Even if the clients had detailed schedules during the day, while Morita worked with outpatients in a hospital, his wife would have had many clinical responsibilities. Even if she had clinical supervision, she would have worked with clients all day and night in the absence of professional staff. It is not

ethical for people with no clinical training to provide treatment. His wife needed to be trained how to communicate with clients, for example, since communication with clients who have a mental illness is a delicate matter and a very important part of treatment. In Morita's books, there are no descriptions about training for his wife. We will never know how much her effort, behavior, and conversation affected the clients. It was Morita's responsibility to write about her training and educational background and impact on treatment. Did he think that his patients needed a mother figure? Did he supervise his wife? Did he give direction about diet or other matters to his wife?

#### Effectiveness of Treatment

Clinicians have a responsibility to take care of themselves physically and mentally as part of providing effective treatment to clients. Morita provided 24 hour and seven day a week treatment at his home. Such a workload calls the effectiveness of the treatment seriously into question because the clinicians did not have time to take care of themselves. In Japanese, this professional work style is called Shyuchiryō-sei (主治療制); a doctor takes care of all clients of the unit where he works. Morita took care of all his clients by himself. Such an excessive workload could easily lead to subjective and narrow treatment.

#### Boundary Between Clients and Clinicians

Clinicians must put boundaries between themselves and their clients. Using one's house as an inpatient hospital makes the relationship between client and clinician ambiguous at best. With no separation between the clinician's private and public life, there was bound to be confusion and ethically questionable decisions. Even if Morita

intentionally wanted the unit to recreate a family environment, it was still a hospital for clients. The place might feel like a safe treatment unit for clients because the atmosphere was like a home. However, the place might not be safe for clinicians. The staff there had no choice but to share their personal lives with the clients. Because the clinicians were available 24 hours a day and seven days a week, clients could easily develop psychological and physical dependencies toward the treatment staff. Was this useful for the clients' recovery? They had to be independent after they were discharged.

One argument is that it might have been effective for Morita Therapy to have a father figure to control the clients because the control made the clients worry less (Kondo, 1966; Ohara, 1970; Doi, 1963). For example, if people do not worry about money, their schedule, or obtaining food on a daily basis, people are relieved of important sources of anxiety. However, using Morita's own home might not have been the best way to provide a father figure. A surrogate father figure was often provided at out-patient units in local hospitals. Morita's followers, including medical doctors at the Jikei Medical School, have continued Morita Therapy with some changes.

Relationships between Clients and Clinicians: Fumon no Kankei (Do Not Question, Just Obey)

The relationship between clients and clinicians in Morita Therapy has had many issues that should be examined including power issues, ambiguity, and the unclear meaning of group treatment.

Power Issues

Morita Therapy has had a strict hierarchical order that is established between clients and clinicians. When Morita provided therapy, he wielded absolute power over his patients, like an old-style Japanese father. His patients did not have right to express their opinions or question his decisions. This is called Fumon (不問). Morita believed that such an environment decreased anxiety in his patients (Aizawa, 1967; Kondo, 1966; Ohara, 1970; Doi, 1963). “Just obey! Don’t ask anything” was an old-style Japanese family system philosophy. It was very male-centered. The father had all the family power. Morita Therapy strived to control the patients’ daily living. It was easier for clinicians to control the patients when the clinicians were with them 24 hours (Kitanishi, 1989). Morita Therapy taught that you do not look at the past or think about the unconscious causes of problems. You just accept your every emotion. However, Fumon (just obey and do not question) might not be an effective way to develop one’s cognitive and psychological growth. As Tatematsu (1986) stated, the client’s own issues were an important part of the process involved in growing psychologically and spiritually. Each developmental stage can produce psychological pain or even crisis at times. It is important for patients to learn to resolve these periodic problems. Those processes should be a part of treatment.

The questions we must ask ourselves are whether controlling the clients’ thoughts and behaviors is an effective treatment and whether it is ethical to provide treatment without the client’s participation in the treatment plan. There are already existing power issues between clients and clinicians. If a clinician used their own house as an

inpatient unit, their power is enhanced. It might be difficult for clients to say “No!” to a treatment provider who also owns and controls the very residence where they live.

Morita’s treatment could have possibly been more effective if he actively supported his wife in assuming a role as kind and warm mother. The wife’s role could soften the power dynamics between Morita and his patients. Morita played out a role as a very strict and strong leader and clinician. If his wife was allowed to be a kind and warm mother-like figure that encouraged the patients’ feelings, this might have added some needed balance. For example, when Morita was angry with his patient’s behavior, perhaps his wife gave encouragement and understanding that helped emotionally support the clients. Morita did not write about these issues so at this point we primarily have questions, not answers.

#### Unclear Role Relationships

Morita was a strict and strong leader who functioned like a father figure for the clients at the unit. Their relationship looked like father and a child or master and disciple (Ohara, 1970). Morita Therapy was considered the most effective if the relationship between clinician and client during inpatient treatment was like a master and a disciple (Uchimura, 1970, Niifuku, 1980, and Fujita, 1977). Morita Therapy is psycho-educational in nature. There are concrete steps for establishing the client’s daily life. It must have been difficult to keep the clinical relationship in the same condition. For example, one day clients are able to obey their clinician’s advice, but another day they might be unable to obey their clinician because of their psychological or physical conditions. The relationship between client and clinician was not stable. If the treatment depended on

the relationship, it's effectiveness also depended on the relationship. The relationship was not stable so its effectiveness for the clients was probably not consistent. In addition, if the client depended on the relationship too much, it might have been difficult for them to be independent when discharged.

A contemporary issue for Morita Therapy is this lack of clarity regarding the clinical relationship based on the old roles of father and child or master and disciple. A father role, mother role, family environment, or master and disciple are very different constructs in different cultures and countries. The implicit rules governing these roles change depending on the individual's history, and across time. Using those ambiguous words and culture-bound roles makes it difficult to understand Morita Therapy for not only Japanese people, but also people who want to study it around the world.

#### Unclear Meaning of Group Treatment

Morita provided Morita Therapy through an inpatient setting. The patients spent their day with other patients except when they were required to be alone. Essentially, they were involved with a kind of group therapy in the therapeutic milieu. Morita did not write about how to take care of the group dynamic or interaction among the patients. We know that this type of group therapy affected treatment positively (Kitanishi, 1987) but we know very little about it.

#### Difficulty Understanding Morita Therapy

It is important for clinicians who use Morita Therapy to be able to understand it clearly as a clinical treatment. If people are unable to understand it, it is difficult to use, evaluate, and develop. Morita therapists have a mission to provide effective treatment

as well as to support and to teach Morita Therapy to younger clinicians. Today, Morita Therapy is developing around the world, especially in China. It is important for Morita Therapy to demonstrate scientific evidence for its effectiveness. Some issues of importance for the use of Morita Therapy are its' scientific basis, dimensional clinical support, and clinical training needs.

### Scientific Basis

In 1938 the Japanese Society of Psychiatry and Neurology conducted research that statistically validated the effectiveness of Morita Therapy. The research project studied how effective Morita Therapy was for 541 nervousness clients from 1929 to 1937. The results showed that 58% of them experienced complete recovery and 36% of them experienced some recovery in a positive direction. In short, 94% of them showed improvements (Ichikawa, 2008). After that pivotal study, Kitanish and other Morita therapists have continued to research the effectiveness of this form of treatment (Kitanishi, 1989). Kitanish thinks that Morita Therapy is difficult to understand. Consequently, Kitanishi has tried to better describe Morita Therapy by developing and using new vocabulary.

Today, however, it is difficult to find many scholarly research papers about Morita Therapy in professional research data bases such as CINI (Cochran library), PsycINFO, and PubMed. Since there are few scholarly research papers devoted to Morita Therapy, it has been difficult to say whether or not Morita Therapy enjoys a scientific basis. If Morita Therapy is going to develop in the world, it will need to be more wide published and evidence effectiveness to scientists around the world.

Conducting research that is cross-culturally valid may pose some interesting challenges. For example, Morita stated that the treatment environment for Morita Therapy had to be like a family home (Hashimoto, 1985). However, this raises big question about what that means. People can have very different definitions of family. Family means something quite varied, depending on culture, individual history, and time period. Morita's words make it difficult for people in other parts of the world to understand Morita Therapy. This lack of understandable language has affected its development.

Hashimoto (1985) acknowledged that the atmosphere of an inpatient unit was an important factor for treatment. His opinion was based on his experience when he and his colleagues created an inpatient unit at the Jikei Medical School Hospital after Morita died. If the atmosphere affects treatment effectiveness so dramatically, it should be a research priority to determine what elements of atmosphere are needed for the effective use of Morita Therapy.

#### Dimensional Clinical Supports

Today, mental health professionals include many kinds of clinicians. Not only psychiatrists, but also psychologists, psychotherapists, social workers, occupational therapists, dieticians, nurses and the like are a part of treatment services to patients. They often provide treatment as a team for a client. Morita did not talk about medications and diet in his writings. These days, many mental health clients are prescribed medication but this probably was not the case in Morita's time. If clients

take medication, clinicians have to monitor the effectiveness of medications. There is no evidence whether or not Morita prescribed medication to his clients.

After World War II, psychiatric disorders were on the rise around in the world when the first psychotropic medications were developed (Kazamaturi, 1980). There were 520,000 patients in state public hospitals in 1955 in the United States of America. That number accounted for 50% of all inpatient admissions in the United States. In the same year in France, patients who needed psychiatric treatment at the public hospitals numbered about 100,000. That was 30% of inpatients admissions in that country. However, after chlorpromazine was discovered, the numbers of patients decreased significantly in countries that had the medication resources for patients. In the United States of America in 1975, inpatient admissions to psychiatric hospitals decreased to 200,000 people (30%). This dramatic change can be attributed not only to developing a national support system for psychiatric patients, but also importantly, access to new effective psychotropic medications (Kazamaturi, 1980).

Morita and his followers did not write about medication. Since the 1960s, well after Morita's death, Benzodiazepine compound medications have been available and been prescribed for anxiety in Japan (Ichikawa, 2008; Kazamatsuri, 1980). However, there has been little written about the use of these medications in conjunction with Morita Therapy. Ichikawa (2008) stated that Morita Therapy was not pharmacotherapy. If Morita Therapy remains primarily a psychological theoretical orientation, medication might take an ancillary role. This remains to be seen.

Today, nutritional education is an important part of Morita Therapy treatment. In Japanese culture, especially in Zen Buddhism, it is important to eat with good table manners. Morita and his wife might have emphasized good manners with their clients. Surely, Morita cared about manners since his basic philosophy was so intricately tied to Zen Buddhism where eating manners is one of the most important elements in good living.

Furthermore, Zen Buddhism values Samu (work). Working (Samu) is one part of treatments modalities in Morita Therapy. The treatment starts with light work and increases gradually to heavier work assignments. Heavy work was used to prepare the client for discharge. The work included the detailed and complex work of daily life. The work programs bore a close resemblance to the daily needs of the client (Hashimoto, 1985).

Morita wrote about some art activities such as making wood sculptures. Did the patients enjoy making sculptures? It is important that patients know how to have enjoyment in their daily life as well as having enjoyment in the treatment program. Morita did not write descriptions about art materials, the reasons for making art or the process of creating art. It is hard to know how Morita prepared and facilitated what clients expressed through their art.

What is clear is that Morita's followers placed a high value on knowing how to talk and interact with patients during the program. For example, Kitanishi (1987) stated that it is important for clinicians to have good communication with patients while being a part of the working program. He suggested that if clinicians give tasks that were too

easy to patients, clinicians would not have a chance to talk with and teach patients about the tasks. He pointed out that communication and interaction were important elements of effective treatment (Kitanishi, 1987). What did Morita think about communication with his patients? Kitanishi stated less communication was less effective suggesting that communication is important for Morita Therapy. Clinicians who want to use Morita Therapy should know how to communicate with patients and the reasons why communication is important. If clients cannot express their thoughts and a feeling verbally, does communication through art provide the needed expression? We have no information about how Morita might answer this question.

An additional gap of information is that we do not know how Morita took care of his patients' artwork. Taking care of client art is a very important part of treatment because the artwork itself is private and needs to be protected. Hashimoto (1985) stated that because Morita used his home as an inpatient unit, people did not have chance to know the details of Morita Therapy methods. It is very important for the future development of Morita Therapy that the scientific community have access to more information about key methodological issues. These issues include the role of the therapist, the importance of communication skills, and the role of expressive activities such as art. That information will help Morita Therapy to be more effective as a strong psychological treatment.

## Clinical Training

The competent Morita therapist does not need to be an ex-patient. Morita had suffered nervousness. After he overcame his illness, he created Morita Therapy, drawing upon his own experience. Indeed, there are advantages for treatment if a clinician has undergone the same kinds of experiences as the client. The clinician often understands the client's suffering well and can give realistic advice during the treatment (Ohara, Aizawa & Iwai, 1970). However, Kitanishi (1987) specifically stated that clinicians need not be ex-patients. That is a reasonable statement. Clinicians are expected to provide competent treatment even if they have not experienced the same things as the client. Moreover, clinicians need to have an objective perspective about the treatment and the clients. It might be fine for clinicians to have some subjective perspectives, but overall, they need to be able to detach from the core issues and maintain objectivity about them. If clinicians do not have an objective perspective, they are vulnerable to committing ethical transgressions and possibly even harming the clients.

Shuchiryō-sei, the closed treatment method of Morita Therapy, continued for quite a few generations. Mariyama ceased this practice by 1976 (Kitanishi, 1989). Morita had taught that it was important for patients' reintegration into society that one clinician had all responsibilities for the treatment (Kazamaturi, 1980). That was one reason that Morita opened his home as an inpatient unit.

### After Morita

In 1974, long after Morita's death, Jikei Medical School hospital in Tokyo, Japan where Morita had been a professor, built an inpatient unit for Morita Therapy (Kitanishi, 1984). At that time Aizawa, the director of the unit, hired two assistant doctors, a female manager as a manager who played the role of mother to the clients; and a female retired nurse as a general manager for the unit. In doing so, he changed Morita's original idea of only one doctor having all the responsibilities for the care of the patients. Aizawa recruited new treatment members as well. They still continued to provide treatment by a doctor, Shuchiryō-sei style. The manager, who took on the role of mother to the clients, had difficulties because she had heavy responsibilities but was not trained as a professional clinician. She later resigned. Aizawa himself experienced physical and psychological difficulties because he had insufficient time. He saw patients on an outpatient basis during the day in addition to treating patients all day in the hospital. However, he stayed on and lived in the hospital with the patients.

Maruyama took over the leadership of the Morita Therapy unit at Jikei Medical School in 1974. He continued the same style, Shuchiryō-sei. Moreover, Maruyama reduced the responsibilities of the assistant doctors and reintroduced the treatment style that had been used by Morita, even though the unit was in a medical school hospital (Kitanishi, 1984). Two years later, however, Maruyama reconsidered the treatment style. He changed it from Shuchiryō-sei style to Shyūjii-sei. Shyūjii-sei means that each doctor had responsibilities for the treatment of their own clients on the unit. It was no longer the case that only one doctor had the responsibility to care for all the

clients on the unit. Maruyama tried to reconstruct Morita Therapy as a simple system but using an updated working style. Clinicians did not live with the patients at the hospital and were not required to spend a lot of time, even their private time, with the patients. Maruyama found a woman to take on the mother role and live with the patients. In Japanese culture, women tend to take on a mother role in many situations. The clinicians who worked at the hospital began to have group supervision. This new style of Morita Therapy opened the door to allow more followers of Morita Therapy because it became more clear what the clinician was to do.

#### Morita Therapy Today

Today, the Morita Therapy unit at Jikei Medical Hospital in Japan provides treatment for individuals both through inpatient and outpatient programs. Some Morita therapists developed the outpatient program as a result of the fact that it is difficult for clients to commit to long-term hospitalization in modern times. Additionally, it is difficult for clinicians to commit to a heavy workload. Morita Therapy has been used for depression, Oppositional Defiant Disorder, anxiety, and panic disorders. The reason why Morita Therapy continues to develop is that many Morita therapists have reassessed the contents and methods of Morita Therapy and have addressed past problems.

#### Conclusion

Morita Therapy needs to be clear about its philosophy and be able to describe it clearly. Sometimes when Morita Therapy is described, its admirers use Zen words that are difficult and confusing to people who are not familiar with Japanese culture. This

may be preventing some from learning about Morita Therapy. Zen words and philosophy are not easy to understand. Even Zen monks need a long period of training before they can understand some Zen concepts. Additionally there are people who are not interested in Zen because they are committed to a different religion. They might feel resistance to learning about Morita Therapy if it is described entirely through Zen language. They might not want their clinician to use Morita Therapy for their treatment if it is associated in their mind with Buddhism.

Table 1: The Context and History of Morita Therapy

Year	World History	Medication History	Japanese History and Cultural Perspective	History of Morita Therapy	Target of Treatment
1914	WWI				
1919			-Fucho-sei: Strong paternal right -Big family system	Shoma Morita, M.D. formulated Morita Therapy. He opened his house as an inpatient hospital with his wife. (Syuchiryousya taisei)	Shinkeisitu-sho
1923	the Great Kanto Earthquake in Japan				
1926				Morita started providing treatment through correspondence.	
1929	Great Depression			Morita started to see outpatients.	
1938				Morita dies.	
1941-1945	WWII				
1950-1953	Korean War				
1960S		Benzodiazepine		New Morita Therapy Inpatient Hospital opened (Tokyo Jikei Medical School ):	
1972			Nuclear family system	Aizawa becomes the leader of Morita Therapy at Gikei Medical School in Tokyo. (Syuchiryousya- sei)	Shinkeisitu-sho
1974-1982				Mruyama becomes leader of Morita Therapy at Gekei Medical School in Tokyo.	Shinkeisitu-sho
1980S	DSM-III				

## **V: THE INTEGRATION OF MORITA THERAPY WITH ART THERAPY**

Although Art therapy techniques have been used in conjunction with many Western psychological theories, no scholarly articles or books have been written about using American art therapy techniques with Morita Therapy. However, Morita himself used art during the treatment he provided. He used art as an assessment tool and during treatment involving his light work stage. For example, he encouraged clients to write a letter or diary with their therapists to express their emotions and feelings (France, Cadieax & Allen, 1995) because through this process, clients could learn to understand and observe their own thoughts. Of course, the clinicians also benefited from the writing since it assisted them in understanding the client's thoughts, and becoming familiar with the client's cognitive style (Kubota, 2008). Morita also let his patients make wood sculptures during the light work phase of treatment (Morita, 2004).

Various historical documents have verified that that in Morita Therapy, art has been used as a treatment tool and as a method of assessment during the therapy process. However, there are no reports that Morita or his followers recognized that art and the processes involved in creating it affects clients in psychologically profound ways. Art therapy is a technique used in therapy that leads clients deeper into themselves and gives them the opportunity to understand and find out about themselves with the support of art therapists. For example, the art therapy process illuminates the inner dialogues resulting from the client's internal conflicts and affective states. That can be particularly useful for Morita Therapy clients because a focus of this treatment is on

developing an understanding of the differences between their image of themselves and their real selves. Working with the visual is an effective way to understand this conflict.

However, just engaging in art is not art therapy. Even though art is different from art therapy, both art and art therapy are similar in that both are a vehicle for human expression and both make healing possible through catharsis and in other ways. In addition, the creative process can support both psychological and physical development. That is why art has been used in rehabilitation as well as psychotherapy. However, those uses are also not art therapy. Art therapy is the clinical use of art.

According to the American Art Therapy Association, art therapy has to do with the use of art by an art therapist who has been trained clinically. Trained art therapists know about psychological disorders and are able to give diagnoses and treatment. Moreover, they know about which art materials are clinically useful for clients. Art therapists usually choose a psychological theory to help them frame their work with clients. Art therapists are able to use any theory with which they are comfortable. Morita Therapy can be used with art therapy.

Nakamuta (2008) stated that for effective Morita Therapy it is important to choose clients who are able to understand the concepts behind Morita Therapy. Chief among these is the belief that clients need to realize the difference between their idealized self and who they really are. In making this distinction, art therapy can be very useful. If art is used by clients to understand themselves, Morita Therapy's goal of increased acceptance of the real self can be realized.

In this section, we will examine Morita Therapy keeping in mind art therapy techniques from the perspective of Kitanishi's idea of good outpatient methodology (2008). A case study will be presented, one in which Morita Therapy and art therapy technique are used. A single case study does not constitute formal evidence for the efficacy of a treatment method. However, it will provide an example of how Morita Therapy might be enhanced through the use of art therapy technique.

#### Example of Art Therapy Intervention Techniques

The following exercises as based on Kitanishi's treatment methods for outpatients (2008). They are provided as a model for the possible uses of art therapy within the theory of Morita Therapy.

#### Experience How to Relate to Emotions

Directions from the art therapist: Can you confusing say in another way? You can draw a picture or make a collage.

I believe that I should be/have to do....	
Reality: I can do those... I want to do those...	Reality: I can't do those... I do not want to do those...

Figure 7. Distinguishing Between I Can Do It and I Can't Do It

#### Avoid Fighting with or Suppressing the Emotions

Directions from the art therapist: Can you describe how you are suffering now?

Honestly admitting my feelings	Fighting my feelings	If I don't fight with them, I might feel...

Figure 8. Admitting Versus Fighting Emotions

### Holding the Emotions

Direction from the art therapist: We have many different kinds of emotions. Those feelings are real. Can you write/draw all your feelings? After you finish expressing them on the paper, could you please hold the paper with your arms? You do not need to judge your feelings. I will not judge your feelings. You are able to hold all your emotions.



Figure 9. Holding the Emotions

### Taking Time to Let the Emotions Come Down

Direction from the art therapist: Emotions are not always the same level. They vary in intensity. When your emotions are very strong, you need to sit with them until your emotions lose some of their force. If you want to, you can do meditation or watch your breath while you give your emotions time to lessen. Look at the picture below. It is an example graph of the dynamic of a human emotion wave.

Where is your emotional level now? Use the graph and observe your emotion's dynamic. How long did your emotions run before they became calm? How did your body react? (breath, heart rate, and physical changes)

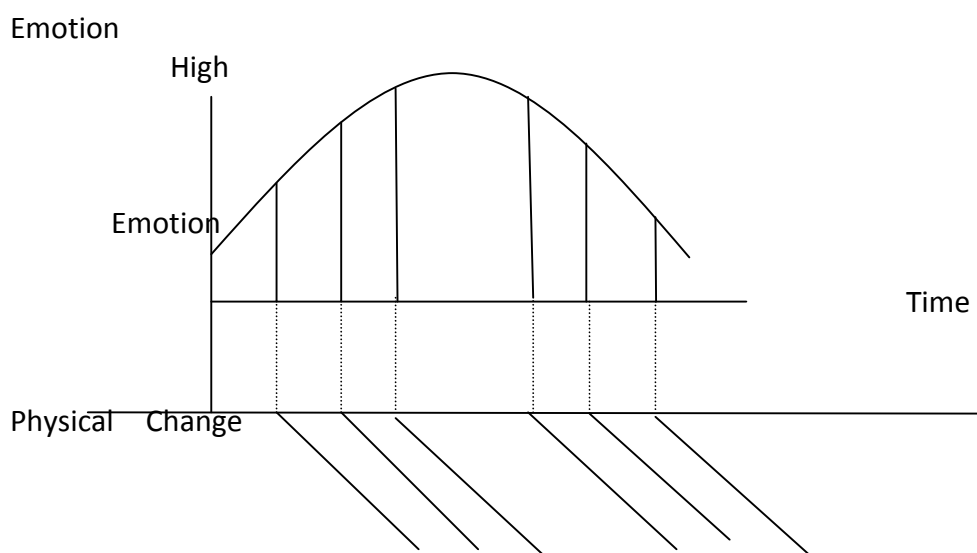


Figure 10. Holding the Emotions-2

Observing Dynamic Emotions

Original Morita Therapy suggested writing a diary. Here, clients can use art as well if they feel it would be easier to express your feelings without having to find words.

Direction from the art therapist: Can you use art to express your feelings with color?

You can add words as well.

Diary	
Date: _____	I feel and think today.
Picture	
Words	

Figure 11. Observing Dynamic Emotions

#### Recognizing Dynamic Emotions

Direction from the art therapist: Can you draw or express how your emotions have changed between the past and now?

Past Emotions	Current Emotions

Figure 12: Recognizing Dynamic Emotions

### Observing the Behavior

Direction from the art therapist: After you started treatment, have you felt some new feeling that you haven't felt before? In your mind, do you want to do something new? If so, what is that? You need to be honest in your mind. You can draw anything here. Could you draw or write what you want to do in this paper? Can you find that which you can do?

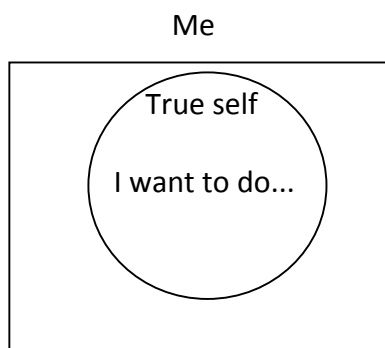


Figure 13. Observing the Behavior

### Taking Action and Having Experiences

Direction from the art therapist: Could you fill out this paper? You will find out how you feel after you take action.

Some actions that I want to take	Something I could do	Now I feel...

Figure 14. Taking Action and Having Experiences

### Having Experience Making Decisions

Clients often have difficulty making decisions because of anxiety. They need to practice making decisions and taking action.

Direction from the art therapist: Has it been difficult to make decisions? After you did so, how did you behave? What did you do? How did you think to make the decision?

I wanted to do...	But I was at loss to do...	Finally, I could do....	After I made decision and took action, I felt...

Figure 15. Making Decisions

### Avoid Perfectionism

Many clients try to be perfect. They need to forgive themselves and to realize their true abilities.

Direction from the art therapist: Nobody can be perfect. You have to not try to be perfect. What have you been able to do during this last week?

I believed that I had to do these things perfectly...	These actions I could do by myself for real.	This was something good I found in myself though I am not perfect.

Figure 16. Avoiding Perfectionism

### Having Experiences in Which Actions Change Emotions

Direction from the art therapist: You might worry about your action before you take action. Find action which you can do. Draw a picture your feelings before and after the action.

Before I took action...	After I took action, I felt...

Figure 17. Actions Change Emotions

### Feeling Enough Energy to Live

Direction from the art therapist: After you took action, how do you feel? Draw and write what you made and how do you feel. Give positive comments to yourself.

Action	I found out this new thing about myself	Some positive comments about myself

Figure 18. Feeling Enough Energy to Live

### Decreasing Sensitivity to Other People's Opinions

Clients tend to be very sensitive about other people's opinions and judgments. They often change their behaviors, thoughts, and goals as a result of these opinions and judgments. Clients often need to learn that it is not necessary to change their goals because of other people's opinions.

Direction from the art therapist: Let's think about how you see other people's opinions toward you.

Other people's judgments toward me

Figure 19. Identifying External Judgments

Direction from the art therapist: through this figure, you are able to recognize how you changed your behavior and reached at your goal. Reflect your thoughts and action with this figure.

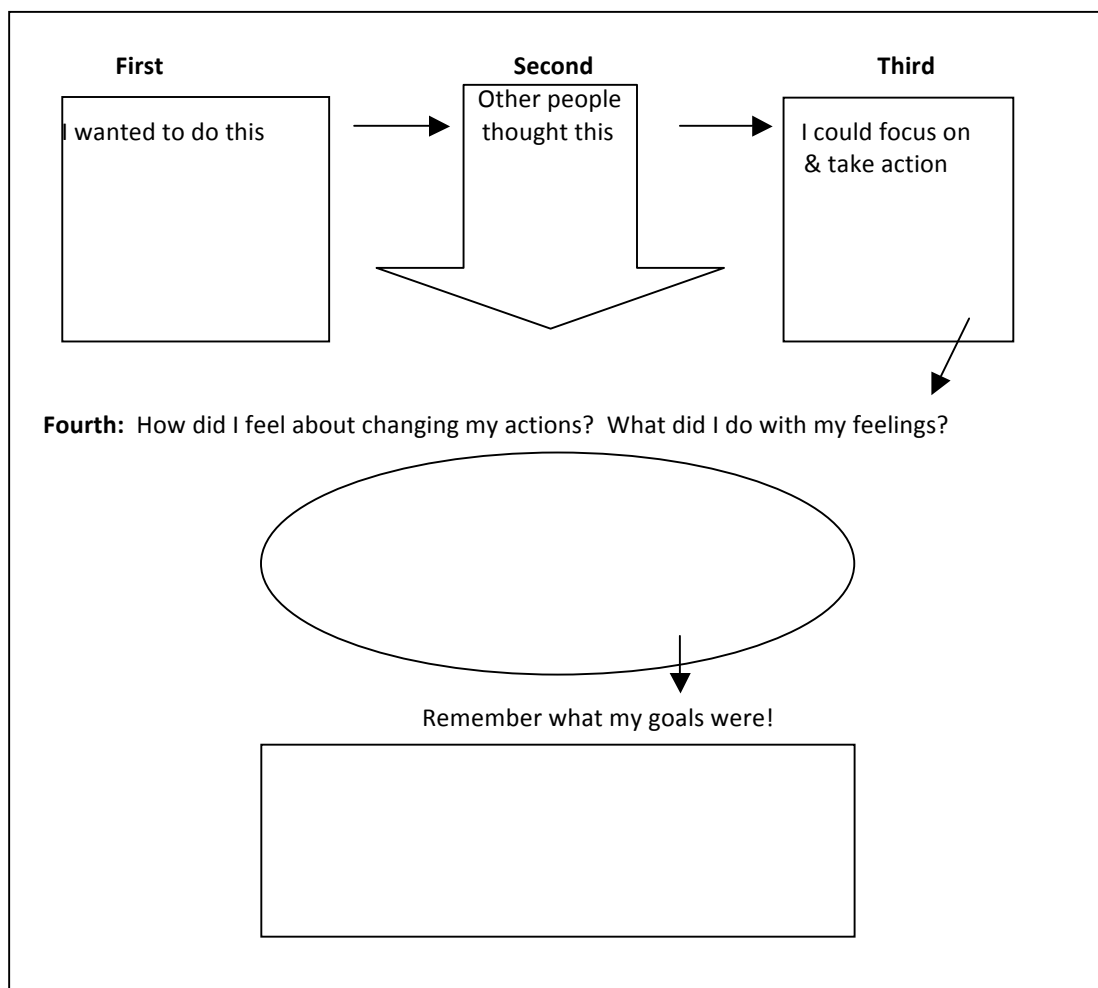


Figure 20. Recognizing the Impact of External Judgments

Change the dynamic between goals and others' opinions

Directions from the art therapist: Let's conclude your therapy sessions. Use the figures to find your changes. In the past, your thoughts, feelings, and behavior affected other's

opinions. However, today, through therapy sessions, you were able to take action to reach at your goal without other's opinions.

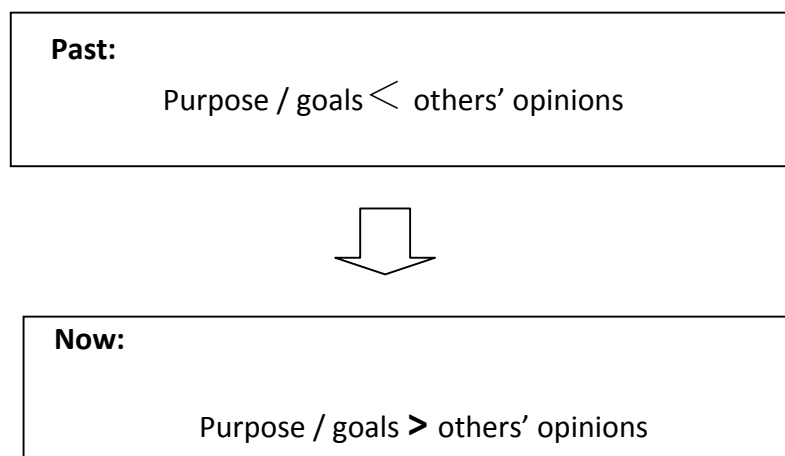


Figure 21. Changing the Impact of External Judgments

### Art Therapy Techniques with Morita Therapy

The original residential Morita Therapy procedure by Morita had four stages: Isolation and Rest, Light Occupational Work, Intensive Occupational Work, and Preparation for Daily Living (Morita, 1998). In Morita's procedure, art therapy does not apply during the first stage, "Isolation and Rest," because during this stage, clients are to rest and any activity is prohibited. During the second stage, "Light Occupational Work," clients are allowed limited activities such as writing in a journal and drawing after dinner. Even though therapists do not give any tasks to the clients, they can help in other ways, such as choosing the client's art materials. Another example would be that they could give directions on how to scribble or doodle which might be useful for some

clients during this slow, quiet period. Also, some clients might not like writing a journal, but might like to draw.

During the third stage, “Intensive Occupational Work,” some clients may find intensive activities difficult to accomplish. Art therapists may be able to provide art activities, direction and materials that engage larger muscle groups in an outside context. Clients may prefer art work to physical labor.

In the last stage, “Preparation for Daily Living,” clients are encouraged to examine their feelings and thoughts about the future. Clients can find meaning by accepting their feelings or thoughts. Art therapy may be useful for clients in finding themselves because drawing and visualizing are often helpful ways to find acceptance.

#### Case Illustration of Art Therapy Technique Integrated with Morita Therapy

The following case study is based on a sample of the author’s clinical work with a patient using art therapy techniques within the theoretical orientation of Morita Therapy. Names and details have been changed to protect client confidentiality. This case is presented as a means to describe in concrete terms, an attempt to integrate Morita Therapy and art therapy.

Alex was an 11-year-old Vietnamese-American boy. He was born in the United States and lived with his mother and sister in a single parent home. His maternal grandmother and 17-year-old maternal uncle also lived in the home. His parents divorced when he was seven years old. Alex’s father provided no support and maintained no contact with the family.

When he was in the sixth grade, Alex was referred for counseling for refusing to go to school. He typically missed school four days a week. He complained of difficulty

concentrating and expressed high levels of anxiety. His family was Buddhist. He was a picky eater and did not eat well. He often complained about somatic symptoms such as rapid heartbeat, shortness of breath, stomachaches, and headaches, and used them as a way to avoid going to school. Alex was always worried about being sick and most of the time, wanted to stay home to rest.

Alex was bilingual but preferred to speak English. His family identified with their Vietnamese heritage. His culture and heritage were very important to Alex and his family. Alex was depressed and experienced a lot of anxiety and stress about dealing with his uncle. This uncle was 17 and had significant mental problems.

The goal of treatment was to increase Alex's school attendance by management of his emotional stress and increasing his support. Morita Therapy provided the conceptual framework for treatment and focused on increasing acceptance--not resistance--of his life and all his emotions. This shifted the focus from symptoms to life style.

#### Expressing His Emotions

The primary clinical purpose of the initial sessions with the client was to make it possible for him to express, recognize, and reflect on his emotions. Art therapy gave Alex a safe way to both identify and express his emotions, which were often complicated and difficult to express verbally.

Alex drew pictures of environments that gave him significant distress. The picture below clarified right away that Alex was experiencing significant distress at home. The picture graphically demonstrated his feelings about family members.

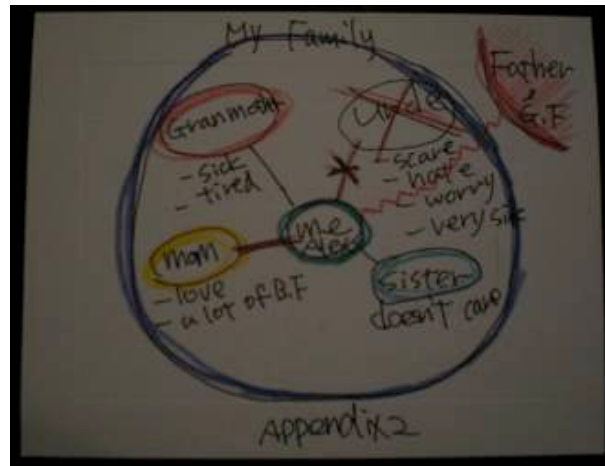


Figure 22. Alex's Family

Rapport was quickly established with client and therapist through the joint project of making art. Alex was able to discuss with this art therapist, the various emotions he was feeling. This greater level of disclosure helped Alex to increase his understanding of the nature of his emotional difficulties and problems within his family. Visualizing gave Alex greater clarity of thoughts as well.

Alex's mother participated in the second session. Alex and his mother drew pictures of their emotions reflected in the human figure. Alex and his mother discussed their feelings with each other and the therapist by sharing their pictures. Alex clearly felt safe enough to disclose that he was struggling with anger and sadness.



Figure 23. Alex's Picture of Self

His mother was also able to share her emotional struggles through her self portrait.



Figure 24: Mother's Picture of Self

The primary clinical purpose for this session was to teach Alex that all people have anxiety. By viewing the two pictures and being a part of the dialogue about the art, Alex came to realize that his mother also felt anxiety and stress. He was then able

to begin to understand that many people accept and hold anxiety in daily life situations. Even though his mother had anxiety and worries, she woke up in the morning, cooked and worked because she loved him and the family. At this session, Alex began to change his focus from his emotional symptoms to his behavior.

In the next sessions, Alex further expressed, recognized, and reflected on his emotions through the art work. He discussed how angry and sad he was. Through these sessions, Alex learned to not be afraid of expressing his emotions, but at the same time, to recognize and prepare to accept his emotions. He drew temperature indicators/bar charts portraying how much anxiety he felt.

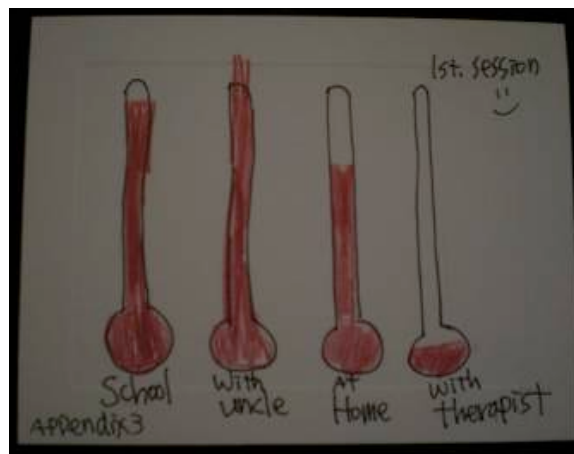


Figure 25. Anxiety Temperature Indicators 1

His pictures showed how much anxiety he felt in different social environments. When Alex did not want to go to school, the temperature gauge showed a high level. The highest temperature in his picture was reserved for when he was with his uncle. At that time, he pictured his anxiety as flowing so strongly that it went “through the roof”

of the thermostat. Alex shared his feelings both through his pictures, and increasingly with his words as he talked with the therapist.

#### Acceptance of his Emotions and Life

As treatment progressed, Alex was increasingly able to accept his emotions and real life. He appeared to feel safe with this therapist and seemed to be relaxing at times. In one session, Alex discussed that he could not remove family members from his life. He drew a picture of his uncle as a scary man with barred teeth.

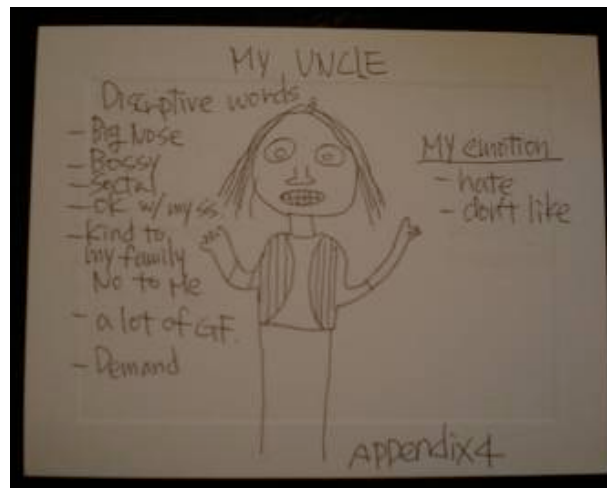


Figure 26. My Uncle

At the same time, he acknowledged that even though he did not like his uncle, his uncle was also a family member. Alex was able to accept his life circumstances rather than resist them. He was becoming more aware of the reality of his life situation.

#### Focus on Lifestyle Rather than Symptoms

In this latter stage of treatment, Alex was able to put more focus on behavior

and action, instead of focusing on his emotions. Alex drew a picture of what he could do to change his daily life, even though he still felt anxiety and emotional stress.

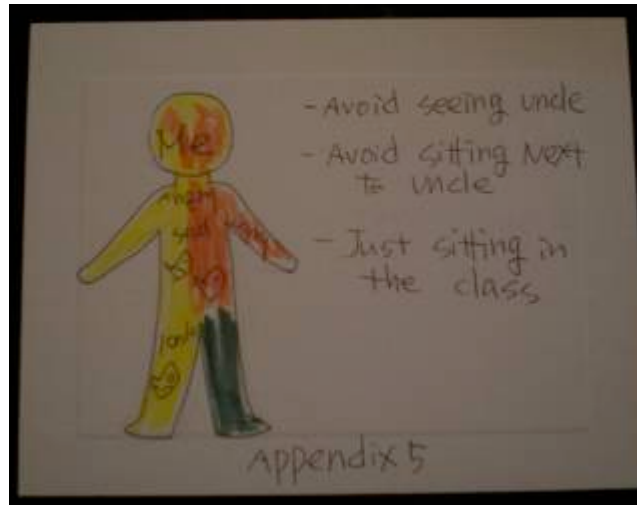


Figure 27. Alex's Actions

While Alex discussed his picture with this art therapist, he found a solution to reduce his emotions toward his uncle. He stated that "I am able to avoid being physically close to my uncle. When my uncle comes close to me, I can move and keep distance from him." Moreover, he realized that if he focused on his behavior, he could reduce his distress which was one of the causes of his depression. He found that changing his behavior was easier than changing or resisting emotions.

### Case Summary

At the beginning of therapy, Alex complained about his uncle, his teacher, and his life. He was very angry and disappointed about his life. He was absent from school at least three to four times a week. After therapy sessions, for the next two months, his attendance at school increased to three times a week. He said, "I can go to school more than before." He stated that he avoided physically making contact with his uncle when his uncle was in a bad mood instead of trying to eliminate his uncle from his life. He felt more energy than before his therapy. Alex said "Now I just can go (to school) and listen!"

Alex learned how to cope with his life circumstances. Morita Therapy was effective for him. Art therapy supported the expression of his feelings. It was an effective way for him to express his emotions. Dialogue with this therapist using his pictures helped him to clarify his difficulties, emotions, and issues. One big change took place when Alex found that all people experience anxiety, stress, and sadness, even his mother. He was very surprised. He also did not know that everyone had days when we did not want to go to work, but we had to go for our families. After that session, Alex started to go to school more consistently. He seemed to understand that all people have anxiety, but they work in their lives.

In his final session, Alex drew the following temperature indicators/ bar charts.

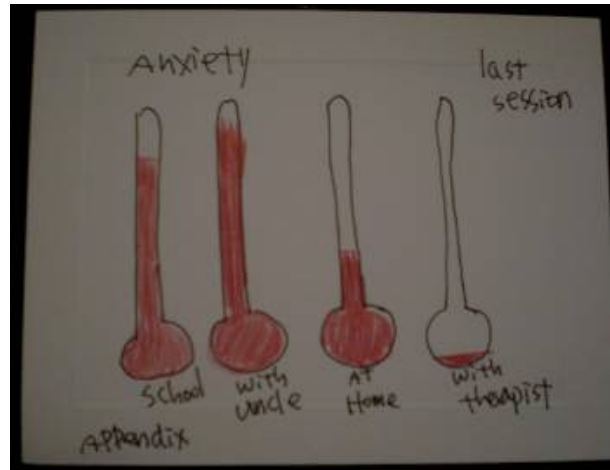


Figure 28. Anxiety Temperature Indicators 2

The picture shows Alex still feels anxiety, but at a lower level than before treatment. Even though he still felt anxious, he was able to go to school and set an appropriate boundary with his uncle.

Art therapy techniques are an effective tool with Morita Therapy. It is easy for clients to understand about Morita Therapy concepts, as well as about themselves through the visual medium of art. Morita Therapy promotes the expression of one's emotions, acceptance of them, and focusing on changes in behavior instead of symptoms. When art techniques are used, it helps clients to understand things with greater clarity and can be easier for them than through verbal dialogue. Morita Therapy is unique because historically it has made use of art. In Japanese and Zen culture, using art in many ways has been an accepted matter.

At this point, there are obstacles to be overcome in regards to the use of Morita Therapy in Western societies. Morita Therapy is not an evidence-based treatment modality, if for no other reason than no scientific research has been done on

it in recent times. But the question becomes, who needs to get scientific evidence that Morita Therapy is effective for clients? To this point, Japan has accepted Morita Therapy as effective and part of its cultural heritage without the scientific validation. Perhaps as psychology becomes a worldwide affair, Morita Therapy will attract the attention of Western researchers. If it is found to be a useful form of mental health treatment, we can only hope that art therapy will be incorporated into this innovative professional approach to human suffering.

## VI: CONCLUSIONS

This study explored an integration of Morita Therapy with art therapy technique. Techniques were presented based on Kitanishi's work with outpatient programs (2008) allowing for the integration of Morita Therapy and art therapy. Kitanishi gave directions that were easily understood. The study also presented a case example, of the integration of Morita Therapy with art therapy techniques. In the case, the client learned how to express his emotions and anxiety using art therapy techniques. His anxiety level did not go away, as evidenced by his final "thermostat" picture. However, the client showed improvement in his functioning in important life domains. This indicates that he was able to learn to focus on his behaviors, instead of on his emotions. Focusing on behavior and not symptoms is a primary Morita Therapy goal. Even though the client still felt his anxiety, he was able to handle his daily life better than previously.

A significant therapeutic moment was when the client entered into a dialogue with the therapist, using his art in which he was able to clarify his reality and gain insight into his issues. Art therapy techniques supported the client in understanding key Morita Therapy concepts. Having experiences is a powerful learning method for clients. It is important for clients to have their own experiences to understand their issues and find solutions. Art therapy techniques provided experiential learning, using a step-by-step process. Going through the process with art therapists is very important for clients engaged in Morita Therapy.

A result of one case study cannot be generalized. However, it was clear that art therapy technique with Morita Therapy was useful for this particular client. The

treatment was effective. Art therapy can be used to help clients understand the underlying principles of Morita Therapy. Additional studies could present more case studies and show more results. It is hoped that Morita Therapy will become an effective way to treat clients of Asian heritage. It is also hoped that this will be helpful for some clients from Western cultures.

For the future, Morita Therapy needs to have more scholarly papers published in English for clinicians around the world. Morita Therapy will be useful for Asian clients and clients who come from a Buddhist heritage. These days, scientists have demonstrated the effectiveness of meditation. Studies on Morita Therapy would make a fine addition to the professional literature on Asian therapeutic methodologies. It is important for Morita Therapy to demonstrate its' methods and explain its' unique view of pathology to the world.

In particular, studies on Morita Therapy should be published more in English-speaking journals. There are many articles about Morita Therapy in the libraries of Japan. However, most of them were written only in Japanese. It is difficult to find many scholarly articles in English and in scholarly research databases. I strongly believe that Morita wanted to help people with his skills as a clinician. That is the reason why he created Morita Therapy. His research is fascinating because the breadth and depth of his knowledge of mental illness, human phenomenon, and Eastern and Western psychology was profound. Even though he is no longer alive, his philosophy is still living and attracts many people. Morita Therapy is useful and should be used in the world to help people.

Although it has been said that understanding Morita Therapy's theoretical constructs is difficult, art therapy is able to help the client understand and benefit from the process. For Asians, there is cultural significance to this methodology. Zen Buddhism has used art and creative process for believers to understand its principles for centuries. However, it has used art as a healing method only within the bounds of its religious role in society. The combination of art therapy and Morita Therapy examined in this paper makes possible the use of Zen teachings for medical purposes. This possibility brings with it a great deal of hope. People who were raised in Buddhist cultures may enter therapy more readily if Morita Therapy becomes better known, because Morita Therapy concepts and processes are more familiar to them than Western-based therapies. Therapists should not push clients to use art. However, for those clients who are comfortable with art therapy techniques, integrating Morita Therapy and the process of creating art can be a powerful and effective form of treatment. A balanced combination of art therapy's amazing ability to be a catalyst for human growth, coupled with the evolving structure of Morita Therapy's culturally-congruent methodology may offer healing to a broader range of the world's peoples.

## REFERENCES

- Aizawa, S., Ohara, K., Masuno, H., Kojima, Y. & Iwai, K. (1967). *Morita ryouhou niokeru bashoteki jyoken nitsuite* [Regarding the environmental condition that is required for Morita Therapy]. Tokyo, Japan: Nomura Kyoju Syuunin 10 syunen kinen ronbunsyu.
- Andersen, D.T. (2005). Empathy, psychotherapy integration, & meditation: a Buddhist contribution to the common factors movement. *Journal of Humanistic Psychology*, 45, 483-502.
- Brook, S. (2004). *Tools of the trade: a therapist's guide to art therapy assessments*. Illinois: Charles C Thomas Publisher, LTD.
- Clements, K. (1996). The use of art therapy with abused children. *Clinical Child Psychology & Psychiatry*, 1, 181-198.
- Cumming, S. & Visser, J. (2009). Using art with vulnerable children. *Support for learning*. 24, 4, 151-158.
- Doi, T. (1963). *Sieshin ryouhou to seishin bunseki*[Psychotherapy and psychonalysis]. Tokyo, Japan: Kaneko shobo.
- Dunn-Snow, P. & Joy-Smellie, S. (2000). Teaching art therapy techniques: Mask-making, a case in point. *Journal of American Art Therapy Association*, 17, 2, 125-131.
- Eckhoff, A. (2007). The importance of art viewing experiences in early childhood visual arts: the Exploration of a master art teacher's strategies for meaningful early arts experiences. *Early Childhood Education Journal*, 35, 463-472.
- Elkins, D.E. & Stovall, K. (2000). American Art Therapy Association, Inc.; 1998-1999 membership survey report. *Journal of American Art Therapy Association*, 17, (1) 41-46.
- Fenton, J. (2000). Unresolved issues of motherhood for elderly women with serious mental illness. *Journal of American Art Therapy Association*, 17, 24-30.
- Frank, D.J. & Frank, J. B. (1993). *Persuasion & healing: A comparative study of psychotherapy*. MD: The Johns Hopkins Ltd.
- France, M., Cadieax, J. & Allen, E. (1995). Letter therapy: A model for enhancing counseling intervention. *Journal of counseling and development*, 73, 317-381.

- Fujita, C. (1977). *Morita ryouhou ni okeru chiryou wo meguru shomondai* [Issues regarding Morita Therapy treatments]. In Takara, T. & Ohara, T. (Eds.), *Gendai no Morita ryouhou*. Tokyo, Japan: Hakuyousha.
- Furuta, S. (1982). *Nihon no Zen: Nihonjin no bi-ishiki* [Japanese Zen: Japanese concept of beauty]. Yoshida (Ed.) *Zen & arts* 1 (13). Tokyo, Japan: Perikan Co.
- Gladding, S. & Henderson, D. (1998). The Creative art in counseling: A multicultural perspective. *Arts in Psychotherapy*, 25, 183-187.
- Graham, M. & Sontag, M. (2001). Art as an evaluative tool: A pilot study. *Journal of the American Art Therapy Association*, 18, 37- 43.
- Gussak, D. (2009). Comparing the effectiveness of art therapy on depression and locus of control of male and female inmates. *The Art in Psychotherapy*, 36, 202-207.
- Hashimoto, K. (1985). Shinmoritaryouhoutou niokeru chiryoujyou no syomonndai: chiryoukannkyouno setteino hennka to sonoeikyounikannsuru kousatsu [Issues of new Morita therapy method]. *Morita ryouhou situkiyou*, 7, 33-39.
- Heyes, S.C. (2002). Buddhism & acceptance & commitment therapy. *Cognitive and Behavioral Practice*, 9, 58-66.
- Hayes, P. (2001). *Addressing cultural complexities in practice*. Washington, D.C.: American Psychological Association Publications.
- Hofman, S. G. (2008). Acceptance and commitment therapy: New wave or Morita therapy? *Clinical Psychology: Science & Practice*, 15, 280-285.
- Hoshino, J. (2003). Multicultural Art Therapy with families. In Malchiodi (Eds.), *Handbook of art therapy* (pp.). CA, NY: Guilford Press.
- Houghton Mifflin Company (2009). *The American heritage dictionary of the English language*, (4<sup>th</sup> ed.,) IL: Houghton Mifflin Company.
- Ichikawa, M. (2008). *Gairai Morita ryohou: sinnkeisyouno tannki cyuchutiryouno* [ Morita Therapy for outpatient]. Tokyo, Japan: Hakuyousya.
- Inoue, R., Miwaki, Y., Seki, N. & Film Art Inc. (2008). *Art x therapy chouryu* [Art and therapy movement]. Tokyo, Japan: Film Art Inc.
- Ishiyama, F. I. (1990). A Japanese perspective on client inaction: Removing attitudinal blocks through Morita therapy. *Journal of Counseling and Department*, 68, 566-570.

- Ishiyama, F. I. (1986). Morita therapy: Its basic features and cognitive intervention for anxiety treatment. *Psychotherapy*, 23, 375-381.
- Ishiyama, F. I. (1986). Positive reinterpretation of death: a Japanese (Morita) psychotherapy approach to anxiety treatment. *Psychotherapy: Theory, Research, Practice, & Training*, 23, 556-562.
- Jordan, K. (2001). Family art therapy: The joint family holiday drawing. *Counseling and therapy for couples and families*, 9, 52-54.
- Jung, M. & Asawa, P.P. (1994). *A history of art therapy in the United States*. Alexandria, VA: American Art Therapy Association Inc.
- Kazamaturi, H. (1980). *Kokoro no yamainikiku kusuri: kousinnyakunyumon [Medication for mental illness]*. Tokyo:yuhikakusensho.
- Kalmanowitz,D. & Potash, J.S. (2010). Ethical considerations in the global teaching and promotion of art therapy to non-art therapists. *The Arts in Psychotherapy*, 37, 20-26.
- Kearney, K. S. & Hyle, A. E. (2004). Drawing out emotions: The use of participant-produced drawing in qualitative inquiry. *Qualitative Research*, 4, 361-382.
- Kitanishi, K. (2008). Moritaryoho towa: Kihonteki Na Kangaekata [Motion picture]. (Available from Mental Health Okamoto Memorial Foundation, 1-5-10 Sonezaki Kitaku Osaka 530-0057 Japan).
- Kitanishi, K. (1987). Morita ryouhou ni okeru chiryousha kanjya kankei [Relationships between clients and clinicians in Morita Therapy]. *Moritaryouhousitukiyo*, 9, 2-5.
- Kitanishi, K. (1990). Morita ryouhou no keisho to hatten: Jikeidai daisan byouin no kensyu ni kanrensite [Development of Morita Therapy at Jikei medical school]. *Moritaryouhou gattukai*, 1, 96-98.
- Kitanishi, K. (2007). *Morita ryouhou no subetega wakaru hon* [Everything about Morita Therapy]. Tokyo, Japan: Kodansha.
- Kitanishi, K. (1984). Morita ryohou jyuninen no chiryoutaiseino henni [Development of Morita Therapy treatments in twelve years]. *Moritaryouhousitsukiyou*, 6, 24-30.
- Kitanishi, K., Toyohara, T., Nagayama, K., Hashimoto, K., Minakawa, K. & Miyake, Y. (2007). *Morita ryouho to seishinbunsekitekiryoho [Morita Therapy and psychoanalysis]*. Tokyo, Japan: Seishin Shobou.

- Kitanish, K. & Mori, A. (1989). *Morita ryohou no kenkyu: aratana tennkai wo mezashite* [Study of Morita Therapy for new development]. Tokyo, Japan: Kongousyuppan.
- Komatsu, J., Kitanishi, K., Mori, A. & et.al. (1985). Statistical study on Morita Shinkeishitsu for twelve years. *Jikeidaishi*, 100, 293-307.
- Kondo, K. (1966). Tanki ryohou to Morita ryoho [Short term treatments and Morita Therapy]. *Shinkeisitsu*, 6, 47-61.
- Kwee, M., & Ellis, A. (1998). The Interface between rational emotive behavior therapy (REBT) and zen. *Journal of Rational-Emotive & Cognitive Behavior Therapy*, 16, 1, 5-43.
- Kramer, E. (1972). *Art as therapy with children*. NY: Schocken Books.
- Kramer, E. (1958). *Art therapy in a children's community*. NY: Charles C. Thomas.
- Kubota, M., (2008). Gairai Morita Ryoho no Susumekata1, [Motion picture]. (Available from Mental Health Okamoto Memorial Foundation, 1-5-10 Sonezaki Kitaku Osaka 530-0057 Japan).
- Lieberman, F. Zen Buddhism and its relationship to elements of eastern and Western arts. Retrieved October 21, 2009, from <http://artsites.ucsc.edu/faculty/lieberman/zen.html>.
- Malchiodi, A. C. (1997). *Breaking the silence: Art therapy with children from violent homes* (2<sup>nd</sup> Ed.). NY: Brunner/Mazel.
- Malchiodi, A. C. (1998). *The art therapy sourcebook*. LA: Lowell House.
- McMurray, M., Schwartz-Mirman, O. & Maizel, S. (2000). Art therapy: Indication for treatment of choice. *The Arts in Psychotherapy*, 27, 191-196.
- McNamee, C. (2005). Bilateral art: Integrating art therapy, family therapy, and neuroscience. *Contemporary Family Therapy*, 27, 545-557.
- Maeda, F. & Nathan, H. J. (1999). Understanding taijin kyofusho through its treatment, Morita therapy [Morita therapy treatments for taijin kyofusho]. *Journal of Psychosomatic Research*, 46, 525-530.

- Matsumi, T. J. (1979). Cultural factors and social influence techniques in naikan therapy: A Japanese self-observation method. *Psychotherapy: Theory Research & Practice*, 16, 385-390.
- Morgan, D. (2001). Assimilation from the east and the spectrum of consciousness. *Journal of Psychotherapy Integration*, 11, 87-104.
- Morita, S. (1998). [Morita therapy and the true nature of anxiety-based disorders \(shinkeishitsu\)](#). In Kondo, A. & LeVine, P. (Eds.) NY: State University of New York.
- Morita, S. (1929/1960/2004) *Shinkeishitsu-no hontai-to ryohou*. Tokyo, Japan: Hakuyousya.
- McNiff, S. (2009). Cross-cultural psychotherapy and art mental health: A report of the surgeon general. Retrieved February 8, 2010, from <http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec5.html>.
- Milne, L.C. & Greenway, P. (1999). Color in children's drawings: The influence of age and gender. *The Arts in Psychotherapy*, 1, 261-263.
- Nabors, L., Reynolds, M., & Quinlan, A. (2000). The Effectiveness of art therapy: Does it work? *Journal of American Art Therapy Association*, 17, 207-213.
- Naitou, A., Seki, N., & Yamashita, Y. (1995). Art therapy ni okeru sozai no imi [Meaning of art materials in art therapy]. *Rinsho Byouga Kennkyu*, 10, 140-150.
- Naumburg, M. (2001). Spontaneous art in education and psychotherapy. *American Journal of Art Therapy*, 40, 46-65.
- Nakamoto. (2009). Comparing and contracting Morita therapy with western therapies. ( Doctoral dissertation, San Diego, CA: Alliant International University San Diego).
- Nakamura, K. (2008). Morita Ryoho no Tekio to Chiryō Keitai, [Motion picture]. (Available from Mental Health Okamoto Memorial Foundation, 1-5-10 Sonezaki Kitaku Osaka 530-0057 Japan)
- Niifuku, N. (1980). Morita ryohou de okorigachina 'seishin ryohou teki fukusayou' [issues of Morita Therapy treatments: side effects of the treatments]. *Kikanseishin ryohou*, 6, 16-23.
- Nissimov-Nahum, E. (2009). Use of a drawing task to study art therapists' personal experiences in treating aggressive children. *The Art and Psychotherapy*, 36, 140-147.

- Ochanomizu Hospital Shinryo Naika. (2007). Tokyo, Japan: Mitsuhiro Ichikawa.  
Retrieved January 4, 2010, from <http://www.moritatherapy.com>.
- Ohara, K., Aizawa, S., & Iwai, K. (1970). *Morita ryohou [Morita Therapy]*. Tokyo, Japan : Bunkodo.
- O'Hare, D. & Cook, D. (1983). Children's sensitivity to different modes of color use in art. *British Journal of Educational Psychology*, 53, 267-277.
- Palmer, L., Farrar, A., Valle, M., Ghahary, N., Panella, M. & DeGraw, D. (2000). An investigation of the clinical use of the house-tree-person projective drawing in the psychological evaluation of child sexual abuse. *Child Maltreatment*, 5, 169-175.
- Pifalo, T. (2007). Jogging the cogs: Trauma focused art therapy and cognitive behavior therapy with sexually abused children. *Journal of the American Art Therapy Association*, 24, 170-175.
- Rosen, A. (2009). The Heart lift operation. *Journal of the American Art Therapy Association*, 26, 130-134.
- Rubin, J. A. (2001). *Approaches to art therapy theory & technique, second edition*. Edited by Rubin, J. A. NY: Brunner-Routledge.
- Rubin, J. A. (1998). *Art therapy: An introduction*. PA: Brunner/Mazel.
- Rubin, J. A. (2005). *Artful Therapy*. NJ: John Wiley & Sons, Inc.
- Rubin, J. A. (1984). *Child art therapy: Understanding and helping children grow through art* (2<sup>nd</sup> Ed.). NY: John Wiley & Sons, Inc.
- Rustin, T. A. (2008). Using artwork to understand the experience of mental illness: mainstream artists and outsider artists. Retrieved January 4, 2010, from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2736519/>.
- Reynolds, D. K. (1969). *Morita therapy and the behavior therapies*. Berkeley: University of California Press.
- Suzuki. C. (1967). Morita ryohou no gijyutsu to riron: tokuni ningenkankei to chiryouzou wo megutte [Morita Therapy' methods and technique: human relations]. *Seishinigaku*. 9, 471-479.

- Suzuki, T. (1989). Concept of neurasthenia and its treatment in Japan. *Cult Med Psychiatry* 13, 2, 187-202
- Sansone, D. (2005). Morita therapy and constructive living: Choice theory and reality therapy's eastern family. *International Journal of Reality Therapy*, 25, 26.
- Sorai, K. (2000). *Shinri tests* [Psychological tests]. In Y. Tokuda, K. Omori, M. Imori, H. Nakai, & Y. Yamanaka (Eds), *Geijyutu ryouho*: 1 (PP.162-172). Tokyo, Japan: wasaki Gakujiyutu shuppan Inc.
- Silver, R. (2009). Identifying children and adolescents with depression: Review of the stimulus drawing task and draw a story research. *Art Therapy: Journal of the American Art Therapy Association*, 26, 4, 174-180.
- Suwaki, H. (1985). Naikan and danshukai for the treatment of Japanese alcoholic patients. *British Journal of Addiction*, 74, 15-19.
- Suwaki, H. (1985). International review series alcohol and alcohol problems research. *Japan, British Journal of Addiction*, 80, 127-132.
- Suzuki, T. (1940). *Zen and arts*. In 1996, Yoshida, S. (Ed.). *Zen and arts*. Tokyo, Japan: Perikan Co.
- Suzuki, T. (2005). *Zen and Japanese culture*. Tokyo, Japan: Koudanshya International Inc.
- Tatematsu. I. (1986). Nyuin morita ryouhoucyu no chiryou chudan kiki to kokufuku [Issues of inpatient treatments in Morita Therapy]. *Morita Ryouhou Sitsu Kiyou*, 8, 22-32.
- Toneatto, T. (2002). A metacognitive therapy for anxiety disorders: Buddhist psychology applied. *Cognitive & Behavior Practice*, 9, 72-78.
- Tanaka-Matsumi, J. (1979). Cultural factors and social influence techniques in Naikan therapy: A Japanese self-observation method. *Psychotherapy: Theory Research & Practice*, 16. 385-390.
- Thyme, K.E., Sundin, E. C., Stahlberg, G., Lindstrom, B., Eklof, H. & Wiberg, B. (2007). The Outcome of short-term psychodynamic art therapy compared to short-term psychodynamic verbal therapy for depressive women. *Psychoanalytic Psychotherapy*, 21, 250-264.

- Uchimura, H. (1970). Morita ryouhou ni okeru “ toraware” to chiryou no “ba” nituite [Pathology of obsession and the treatment environment in Morita Therapy ]. *Seishinigaku*, 12, 741-784.
- Vick, M. R., (2003). *A brief history of art therapy*, Edi. Malchiodi, A. C. (2003). Handbook of art therapy, NY: Guilford Press.
- Wadeson, H. (2000). *Art therapy practice*. NY: John Wiley & Sons, Inc.
- Wadeson, H. (1987, 1995). *The Dynamics of art psychotherapy*. NY: John Wiley & Sons, Inc.
- Wallace, J., Yorgin, P.D., Carolan, R., Moore, H., Sanchez, J., Belson, A., et al. (2004). The use of art therapy to detect depression and post-traumatic stress disorder in pediatric and young adult renal transplant recipients. *Pediatric Transplantation*, 8, 52-59.
- Wegman, P. & Lusebrink, V. (2000). Kinetic Family Drawing scoring method for cross-cultural studies. *The Art in Psychology*, 27, 179-190.
- White, C., Wallace, J. & Huffman, L. (2004). Use of drawing to identify through impairment among students with emotional and behavioral disorders: An exploratory study. *Journal of the American Art Therapy Association*, 21, 210-218.
- Wicks-Nelson, R. & Israel, A.C. (2009). *Abnormal child and adolescent psychology*. NJ: Person Prentice Hall.
- Yanagida, S. (1982). *Nippon no zen, Nipponjin no biisiki [Japanese Zen and Japanese sense of beauty]*. In Yoshida (Ed.) Zen & arts I (13). Tokyo, Japan: Perikan Co.
- Yoshida, S. (1985). *Nippon Bunka to Zen [Japanese culture and Zen]*, In 1996, Yoshida (Ed.) Zen & arts I (13). Tokyo, Japan: Perikan Co.

