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# Editorial Note

The *Journal of Applied Ethics and Philosophy* is an interdisciplinary periodical covering diverse areas of applied ethics and philosophy broadly understood. It is the official journal of the Center for Applied Ethics and Philosophy (CAEP), Hokkaido University. The aim of the *Journal of Applied Ethics and Philosophy* is to contribute to a better understanding of ethical and philosophical issues by promoting research into various areas of applied ethics and philosophy, and by providing researchers, scholars and students with a forum for dialogue and discussion on ethical and philosophical issues raised in contemporary society. The journal welcomes original and unpublished regular academic papers as well as discussion papers on issues in applied ethics and philosophy broadly understood.

Tomoyuki Yamada
Editor-in-Chief

# Zen Buddhism, Japanese Therapies, and the Self

## Philosophical and Psychiatric Concepts of Madness and Mental Health in Modern Japan

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Abstract

In my paper, I propose to investigate the philosophical underpinnings of representative indigenous Japanese psychotherapeutic approaches, particularly that of Morita and Naikan therapies, that have, at their foundations, distinctly Buddhist psychological tenets, and that offer to deal with mental health issues in a manifestly different way compared with their western counterparts. I offer a comprehensive account of how the characterizations of madness and mental illness have been shifting over the last two hundred years in Japanese society and culture, and how this has affected mental health care in Japan. Finally, the ways in which modern day thinkers, such as Daisetz Teitaro Suzuki and Keiji Nishitani have been re-shaping the concepts of the self in Japanese religion and philosophy while, at the same time, taking care to remain faithful to the original East Asian sensibilities will also be expounded and connected to the themes of mental health and mental illness.

Keywords: Mental Health, Morita, Naikan, Psychotherapy, Self

### Introduction: Mental Health Problems in Modern-Day Japan

Extreme forms of social isolation (*hikikomori*), excessive fear of interpersonal relations (*taijin-kyō–fushō*), "overwork death" (*karōshi*), growing drug and alcohol addiction problems, severe maltreatment of schizophrenic patients both in home care and at psychiatric facilities, not to mention the scandalous governmental backed health care policies of forced sterilization of the mentally ill that lasted until recently, are but a few examples that periodically turn the public attention towards Japan's difficulties in dealing with contemporary mental health care issues (Nakamura 2013, 51-53; 57-60). This is of course not to suggest that Japan is alone in her plight of having to regulate and care for a population that seems to suffer from an ever increasing number of people living with diverse forms of mental illness: evidently, other countries have their fair share in this struggle as well. After all, as Karen Nakamura rightfully suggested, "Mental illness is a disease of modernity. (…) the regimentation of daily life and increased stressors of modernity have led to a rise in various types of mental illness, just as changing diet has led to an increase in diabetes." (Nakamura 2013, 35)

According to Yoshibumi Nakane, professor emeritus of neuropsychiatry at the University of Nagasaki, suicide and diverse forms of depression have gone rampant in contemporary Japan. Writing in 2010, he observed the following developments.

> Over the past decade, more than 30,000 completed suicides have been reported annually. The most frequent factor for suicide has been shown to be a high rate of health problems, more so than personal reasons and financial matters. Since many suicidal individuals were plagued with *depression* above all, treating depression has increasingly been attracting attention as the key to a strategy for suicide prevention. On the other hand, it is also said that depression has proliferated in the general public and is present in atypical forms. (Nakane 2012: 85)

Hommerich`s latest findings also support the argument according to which Japanese society is in a serious trouble on the mental health front, in this case, with regard to anxiety disorders. A prominent international study from 2013 indicated that compared "to their peers from the U.S., the U.K., Germany, France, Sweden, and Korea, young Japanese display low levels of self-esteem and strong anxieties with regard to finding employment, their current job, their financial situation and their future."[1] Although the increase of anxiety disorders can be observed in all age groups since the beginning of the 1990s, according to a 2014 government report young adults are more prone to suffer from higher stress levels than any other age group. "Asked whether they experienced uncertainty or distress, 79.4 percent of the 20- to 39-year-olds answered 'always' or 'sometimes'." (Hommerich 2017, 73)

Based on these and similar observations one could easily come to the conclusion that modern Japan doesn`t belong among those nations whose citizens could boast of high levels of mental well-being or a good general mental health. In fact, the opposite seems to be closer to the truth. Researchers at the Department of East Asian Studies at the University of Vienna have recently published a monograph on the state of affairs vis-à-vis happiness and the good life in Japan. The authors claim that the negative macro-level developments of the society of Japan of the early 21st century–"[t]he rapid aging of society, shrinking household incomes and savings, rural depopulation and economic decline in peripheral regions, the dismantling of the welfare state and the widening of the social gap"–make a powerful detrimental impact on the everyday lives of Japanese people. Owing to the off-putting filter of the media and the generally negative assessments of anthropological and sociological studies one is inclined to paint a pessimistic picture of "a society hampered by maladaptation at such a great scale that increasing proportions of its members, across all age groups, are threatened by dissatisfaction, deprivation, alienation, depression, fear, and hopelessness." (Manzenreiter & Holthus 2017, 1)

One salient example of extreme social isolation and maladaptation to society's demands is that of the *hikikomori*. Hikikomori is a phrase which was coined in the 1990s and refers typically to young people who have "withdrawn" from society, who choose to stay in their own self-issued home-confinement for years or even decades, without engaging in any regular social activity. They might have a virtual life, that is, they may carry out most of their daily business with other people online (including chatting, shopping, food delivery, and even working), but in terms of traditional "offline" human relationships, they are excessively cut off from society. Hikikomoris in effect lack normal human interaction with other people, and although this phenomenon is usually considered a social problem, rather than a mental disease, one could argue that the basis for this widening social problem lies in growing mental health issues on the individual level.

In a fresh research on the hikikomori phenomenon Horiguchi aptly summarizes the basic factors that underlie the entire problem and also points towards possible solutions through which Japanese society typically attempts to handle the situation by reconnecting them with their peers and with society at large.

> *Hikikomori* in its physical dimension entails isolation from society in time and space, which often reflects and intensifies anxieties about the outside world. Retreat from interpersonal relations, often due to trauma induced by past failures to develop a "complete" friendship, characterizes *hikikomori*, and much of *hikikomori* support attempts to help withdrawn youth recover the joy of relating with others and larger society. (Horiguchi 2017, 68)

The research also draws attention to the noteworthy fact that albeit hikikomoris are indeed isolated and withdrawn to the extreme, one should not imagine them as being fatefully forlorn individuals who are eternally dissatisfied with life: there is happiness beyond despair. On another note, it is equally important to mention that although the phenomenon was first acknowledged and was given name in Japan, it is not a markedly Japanese phenomenon in any sense; besides, it doesn't adequately characterize the entirety of the Japanese youth population either.

## 1. Japanese Notions of Madness and Mental Illness

By turning our attention to the beginning of the modern era in Japan, we can observe telling similarities between the confusion surrounding the self and the perplexing and disquieting expansion of mental illnesses. In the politically unstable and axiologically turbulent times

1 "The share of young Japanese who stated that they felt sad, depressed, or unmotivated in the past week was larger than in the countries of comparison. 38.4 percent did not have hope for their future, by far the largest share of the countries compared (U.S. 8.9%, U.K. 10.2%, Germany 17.6%, France 16.7%, Sweden 9.2%, and Korea 13.6%). At the same time, the share who felt the future of their country was bright was the smallest of all countries (28.8%) in Japan, as opposed to U.S. (57%), U.K. (59.6%), Germany (66.3%), France (36.7%), Sweden (67.8%), and Korea (43.1%)". (Hommerich 2017, 73)

of the Meiji era not only did the self-identity of Japan and of the Japanese people become fundamentally questionable, so did the interpretation and understanding of madness. According to Professor Kazushige Shingu's assessment, the Meiji period's "intense and fast process of modernization (…) meant adhering to the rationality of western scientific, economic and political models. Mental illness as madness, insanity, irrationality was expelled, erased from the new modern State and confined into the *zashikirō*"–a closed space inside the family's house (Bucci et al. 2014, 110).

If we look back into the past, we can recognize that in earlier, less scientific times, madness in Japan was believed to be a result of spirit possession, whereby a spirit or a ghost with an evil intention would come to possess the body of a person. After having taken control of the body, the spirit would then make the hapless person become ill and suffer; in extreme cases, it would even go as far as to take the person's life. These wicked spirits were known as *mononoke*. Still other explanations in ancient and medieval Japan were also circulated explaining the etiology of madness; most notably, the one that tied madness to the deceitful activities of the supernatural and shape-shifting fox-spirits (*kitsune*) who would appear as beautiful women, and would prompt men to, literally "go crazy" over them. As medical knowledge was rather limited at the time, incantations by Buddhist monks of Chinese religious texts, or full-fledged exorcism were considered among the possibly most efficacious healing methods. "The best cures for possession were to physically drive the spirits out by hydrotherapy (sitting under a waterfall), by taking vile-tasting Chinese herbs, or by making the spirits so bored through quiet rest and meditation that they would leave for more exciting hosts." (Nakamura 2013, 38)

In the early modern period, that is, from the 1860s onwards, home confinement was the major strategy of dealing with mental illness. Families were made responsible for their "insane" relatives, and whoever was deemed to be mentally ill, could not realistically hope for any sort of improvement in his or her condition. This was largely due to the circumstance that the Japanese held a deep-seated view regarding the basic individual traits of a person`s character as being fixed. In effect, this meant that those with mental illness were viewed as stuck at a lower level of human existence which was thought to be a practically unchangeable status. Totsuka explains:

> Mental illness was regarded as genetic, incurable, impossible to understand and dangerous, namely one of the worst diseases. As a result, the mentally ill were thought to be a disgrace to the family. The Japanese did not want to talk about them, did not want to see them, to hear about them, to get married to them, and did not want to employ them. Japanese families hid these mentally ill relatives in a cell at home or in a mental hospital. Even conscientious doctors and families thought mental patients would be happier in remote asylums rather than in the community. (Totsuka 1990, 294)

In consequence, the first asylums were opened in 1875, following a regulation made by the Medical Affairs Bureau, which had published its directives in the previous year. Because there were not numerous options available yet for the medical personnel of the newly established mental health care facilities, most of the curative activities were limited to the continuous application of Chinese medicinal herbs and to the broadening usage of sedatives. Incidentally, most of the doctors obtained their medical knowledge in German universities and hospitals, for the Japanese government had decided to follow the German medical practice (Scull 2015, 201-202). As a result, in the field of psychiatry, the Kraepelinian tradition had become quite dominant at the time.

The turn of the century held a momentous event in the history of mental health care in Japan.

> In 1900, the Law for the Confinement and Protection of the Mentally Ill was passed by the Japanese national government. This was the first national law in Japan that explicitly dealt with people with mental illness. While the law used the modern term *mental illness* (*seishinbyō* ) rather than "lunacy and insanity," the law did not actually go into any detail as to what *mental illness* was in the actual text of the legislation . (Nakamura 2013, 43)

This event could be considered as the inauguration of the institutionalization of mental illness in Japan which period lasted until the end of the Second World War. The Law of 1900 was the first nationwide legislation about mental illness which, in turn, led to a standardization and rationalization in the handling of the mentally ill. All these rapid developments "fostered an objectivation-reification of mental illness that changed the social perception of the problem" (Bucci 2014, 86).

At the same time, during the 1910s and 1920s psychiatry as an independent medical discipline was also established in Japan, thanks largely to the efforts of Shūzō Kure, a psychiatrist at the University of Tokyo, who had been educated in Europe. The second national law concerning mental illness–known as the *Mental Hospital Act*–was ratified in 1919, stressing that mental illness was, in fact, an *illness*; in other words, it was to belong under the aegis of medical professionals. In addition, the Mental Hospital Act "empowered the central government to order the prefectures (local

administrative units) to build public hospitals, whose building and maintenance costs would have been partly covered by the State" (Bucci 2014, 87). During the next two decades a growing public demand made it possible that the custom of caring for the mentally ill in their homes by their families has been substituted by the professional care at medical institutions. Yet by the end of the Second World War the proportion of mentally ill patients who got hospitalized was rather small compared with western standards. However, compared to the previous trends the post-war period has propelled an enormous shift to come about.

In 1950 the *Mental Hygiene Law*, which was approved under the United States occupation of Japan, "forbade home custody and ordered the medical treatment of mental illness in the psychiatric hospital." (ibid) This 180 degree turn in policies eventuated the following development:

> From a very low rate of hospitalization in 1945, the population of Japanese mental hospitals grew dramatically over the next fifty years. Whereas the rate of hospitalized patients in 1945 was approximately 2 per 10,000 people, in 1995 it was more than ten times as high, and it decreased only very slightly over the next ten years, from 29 per 10,000 to 27 per 10,000. In 1989, patient stays in Japanese mental hospitals averaged 496 days, or more than forty times the average length of stay in the United States. (Scull 2015, 362)

This particular mental hygiene law was followed by numerous controversial cases of abuse and serious human rights issues that has not, in the end, evaded the criticism of the public, even though the public awareness about these notorious events came only a great deal later (Nakamura 2013, 47-60).[2] During the globally tumultuous and rebellious decade of the 1960s, heavy and sustained criticism fell upon the Japanese mental health care establishment both domestically and from abroad. The anti-psychiatric movement, which took off in earnest in the US and in Western Europe around the same period, has viewed with open disdain the paternalistic and oftentimes coercive and dangerous ways[3] in which psychiatric authorities "treated" their patents. The movement has not only spread to Japan in the 1960s, but it grew quickly strong, and before long it has established itself as a nationwide force. And while it undoubtedly and effectively "interrupted the longtime dominance of neuropsychiatry in Japanese psychiatric tradition, on the other hand, the break-up of the movement left a conceptual vacuum which was quickly filled by the DSM III." (Bucci 2014, 88).

Ever since then, in particular since the 1987 *New Mental Health Act*–which included, for the first time, measures to protect the human rights of the patients–the Japanese mental health care system has come under closer surveillance of international bodies. A significant development in this regard was that before the law the concept of "voluntary admission" didn't exist legally in Japan (Totsuka 1990). But after the law, the "acknowledgement of the possibility of a voluntary nature of the admission can be read as the sign of an increasing proximity between normality and pathology within the social representation of mental illness." (Bucci 2014, 88) In 1995 the *Mental Health and Welfare Law* has recognized mental illness as a disability, and along with other laws of similar nature, it endorses "the independence of people with mental disabilities and their participation in socio-economic activities. Within the scene of developing outpatient and community-based services, welfare homes and workshops as well as training and work services became active." (ibid.) Nonetheless Scull cautions that despite the apparent fact that the times have been changing for the better, and that there is clearly an increased pressure on Japanese mental health authorities by the international community, Japanese people will not likely to alter anytime soon the ways in which they tend to perceive mental illness as a whole.

> With mental illness still regarded as a great stigma, it seems many continue to prefer a policy of custodial care. Japanese culture privileges public order over individual rights, and families seek confinement to conceal someone whose madness is seen as threatening the marriage prospects of their relatives, and as the source of profound shame and embarrassment. The Japanese government, however, is fearful of the mounting costs of

2 Bucci explains that "the law established the principles of compulsory admission by administrative order in case of 'danger to self and others' and of involuntary admission by request of the family or a legally responsible person. Up to 1987 compulsory-involuntary admission has been pervading in Japan: according to some authors almost the 90% of admissions occurred under these principles. Such trend was strengthened by the fact that the expense for involuntary patients was subsidized by the government and hospitals tended to apply involuntary admission also to patients who were not an obvious threat to society." (Bucci 2014: 87).

3 Besides involuntary hospitalization and forced sterilization, another dangerous practice that was condemned internationally at the time was being applied rather frequently in Japan. This was the tarnished practice of *lobotomy*. In Pietikainen's words "In Japan, lobotomy became quite fashionable after World War II." (Pietikainen 2015, 262)

> institutionalization, particularly as unprecedented numbers of the elderly are being confined in mental hospitals. (Scull 2015, 363)

## 2. Japanese Notions of the Self

If mental illness is still regarded as a great stigma, what can be said about the modern notion of the self in Japan? There are of course anthropological, philosophical, religious, sociological, political and other angles and considerations that construct the matter as a considerably complex one. Nevertheless, there seems to be a widely accepted agreement in this regard. As Ozawa-de Silva remarks, "The existing scholarship on Japan tends to view selfhood in Japan as relational, harmonious, and so on, as opposed to the individualistic notion of selfhood found in the West." (Ozawa de Silva 2006, 110) However, she quickly adds that this view could be easily misleading: it carries the danger of inadvertently promoting a naive misinterpretation with regard to the distinctness of the Japanese self.

> Indeed, in certain extreme cases, one could almost get the impression from some accounts that the Japanese have no sense of individual selfhood at all, that is to say, that a Japanese person would not relate to himself or herself as an individual person, but merely as part of some larger organism. This kind of orientalism can lead to absurdity and make the Japanese appear as if they were some other type of creature altogether, rather than human beings like anyone else. Rather than accept such a dualism of self and society, it is perhaps more helpful to think of interdependence as that which transcends or moves beyond this dichotomy. (ibid.)

Interdependence certainly is a key aspect in how the Japanese understand their own selves, therefore it is worthwhile to further investigate this concept. The notion of interdependence (*engi*) has indeed a very long and respected pedigree that goes back to the Buddha's teachings (or even further). It has several dimensions interrelated to one another; however, in relation to the self, it basically means that no single self exists by and of itself, each self is intrinsically related to other selves. That is to say, each self depends on and relies on other selves not only for its identity but also for its very existence. For the Japanese, who, over many centuries have been influenced just as much by the various forms and interpretations of Buddhism, as by the Confucian, Daoist and Shintoist notions of the self, the generally accepted understanding of the self is not focused on having a singular, nuclear ego, but on possessing a self that encompasses various layers. Renowned anthropologist Takie Sugiyama Lebra for instance distinguished three essential layers within the Japanese self: social, inner, and cosmological.

> At the center of the inner self is the *kokoro* which stands for heart, sentiment, spirit, will, or mind. While the outer self is socially circumscribed, the *kokoro* can be free and spontaneous, and even asocial. Further, the *kokoro* claims moral superiority over the outer self in that it is a reservoir of truthfulness and purity, uncontaminated by circumspections and contrivances to which the outer self is subject. This association of the *kokoro* (or inner self) with truthfulness gives rise to the paradoxical notion that the "real" truth is inexpressible. Thus words and speech as means of expression are often regarded as potentially deceptive and false, and silence as indicative of the true *kokoro*. (Lebra 1992, 112)

What appears to be rather fascinating and possibly unique about the Japanese understanding of the inner self or *kokoro* is that not only is it differentiated from the social self–the latter being the one that is expressed in daily conversations and communication–, but that this inner self is virtually inaccessible even to the person to whom it belongs. Additionally, the inner self is understood to be inexpressible, and is, indeed, hoped be protected from both conceptualization and from forms of expression. The point being conveyed here is, I believe, remarkably different in comparison with western notions of the self: not merely in that in the name of achieving greater mental health western approaches routinely attempt to squeeze out as much as possible from the "true self", but also in that the goal to find a "real self" is understood to be essentially unattainable for the Japanese.

That reminds us of a famous essay written by one of the foremost minds of modern Japanese Buddhism, Daisetz Teitaro Suzuki: "Self the Unattainable". In this famous essay, Suzuki exhibits how the Zen understanding of the self is wholly harmonious with that of the more general Japanese understanding of the self. He writes:

> The essential discipline of Zen consists in emptying the self of all its psychological contents, in stripping the self of all those trappings, moral, philosophical, and spiritual, with which it has continued to adorn itself ever since the first awakening of consciousness. When the self thus stands in its native nakedness, it defies all description. (Suzuki 2004, 3)

It is important to keep in mind, Suzuki warns, that

the self that is emptied is not devoid of content. On the contrary: it is even richer than it was before, prior to the self-emptying process, because now it is connected to something greater than itself. "The emptied self is simply the psychological self cleansed of its egocentric imagination." Having got rid of its own egocentrism, the self realizes its true egoless nature, "which means that there is no psychological substratum corresponding to the word *self"*. No matter how deeply we dig inside ourselves, argues Suzuki, we can never find an ultimate point where we can stop and claim that we have finally arrived at the core of our being. Our term "the ego" is, in fact, "useful as it may be for our daily intercourse as social beings, is an empty phonetic symbol." (Suzuki 2004, 4)

Similar view can be found in the writings of Keiji Nishitani who was among the most distinguished members of the Kyoto School which was initiated by Kita*rō* Nishida, and which has been a major driving force in Japan's modern and contemporary intellectual life. Nishitani himself devoted most of his philosophical work to religious and existential concerns that were usually tied up with questions revolving around the self and nihilism. In his book titled *Religion and Nothingness*, he developed the concept of the "standpoint of emptiness (*sūnyatā*)" from which he believed one could overcome the perils of–moral and psychological–nihilism, and become one's authentic self. The true or "original" self in Nishitani's interpretation can be encountered through a kind of non-reflective knowledge; in other words, by emptying the ordinary self and hence endowing it with a non-conceptual, intuitive grasp of the real self (Nishitani 1982, 263).

Similarly to the unattainability of the self in Suzuki and in other generally accepted Japanese notions of the self, the self of pure subjectivity for Nishitani can only be grasped by actually not "grasping" it; at least not as a neatly delineated mental concept. As Carter puts it, "we know it is there, but we simply cannot capture it in ordinary consciousness whose only way of knowing is to objectify things with concepts. The self that we are searching for is not a self in the ordinary sense: it is a self that is not a self (…) The self is now free of self-centeredness" (Carter 2013, 119). The self that is not a self transforms the original self into an endless epistemological field upon which other entities can also appear, not as mere objects of a mind but as they truly are. By emptying itself, the self allows itself to become something other than itself: to become another person, a tree, a rock, an animal. This way the self can transcend the subject-object dichotomy, and according to Nishitani, by becoming empty, the original self is placed together with all the other beings in an originary nothingness that encompasses all beings.

> Such knowledge of things in themselves (the knowing of non-knowing) means precisely that in truly returning to our own home-ground, we return to the home-ground of things that become manifest in the world. This knowledge is a realization (apprehension) in the sense of a reentry to the home-ground where things are manifest in their suchness. (…) The field of s*ūnyatā* is a field whose center is everywhere. It is the field in which each and every thing–as an absolute center, possessed of an absolutely unique individuality–becomes manifest as it is in itself. (Nishitani 1982, 163-164)

Margaret Lock's pioneering ethnographic studies in medical anthropology also corroborate some of the previous claims vis-à-vis the Japanese sense of the inner self and its intrinsic incommunicability. During the course of one of her fieldworks in Japan, which was carried out in the 1970s and 80s concerning the topic of mental health and mental illness, she asked the participants, among whom were medical professionals, patients, and regular housewives as well, about the nature of the self. What she found was telling:

> It was agreed among the informants in this study that they have an awareness of their public presentation of self as being somewhat separate and different from their private, inner selves, and that this inner self *(jibun)* should not be exposed to others, including family members. It was also agreed that verbalization of ideas about one's inner self is an inadequate form of expression, because this concept is intimately associated with feeling states, rather than with cognitive awareness. (…) One's inner self is something which can and should be cultivated and developed throughout one's life and the fruits of such a cultivation are evident through one's bearing and ability to lead a balanced and hence, healthy life. (Lock 1982, 222-223)

The conviction that the silent nurturing of one's inner life and the cultivation of the uncommunicable self can lead to a healthier life was taken up by some of Japan's native psychotherapies as well. We will turn to them now.

## 3. Buddhism Enters Mental Health Care: Morita and Naikan Therapies

The Buddha was moved to begin his spiritual quest by the sight of suffering. He found the root of suffering to be within the mind. He prescribed a remedy whereby the common mentality may be transcended and suffering overcome. In consequence, he was called the great

physician and his teaching, the *Dharma*, the supreme medicine that relieves all mental pain. The notion of Buddha's teaching as a medicine for the universal human sickness is one of the commonest analogies used to describe the Dharma and it is certainly one which the Buddha himself encouraged as a useful aid to understanding his message. (Brazier 1996, 19)

According to Buddhist psychology, the ordinary mind of people is obscured and is basically ignorant of the true reality of the world. The ignorance causes suffering, and as long as one has not reached a state of enlightenment, one cannot be said to be completely healthy mentally. Accordingly, the Buddha states that "those beings are hard to find in the world who can admit freedom from mental disease even for one moment, save only those in whom the āsavas[4] are destroyed." (quoted by De Silva 2005, 123) Attachments to ideas, to worldly objects and desires are all negative factors that hinder one's process in comprehending true reality clearly. Those things that obscure the mind are called *kleshas*. "Kleshas are whatever seems to prevent us thinking clearly or acting sensibly. Collectively they constitute what Freud called the Id. In Buddhism, Freud's Id is represented by 'basic ignorance' (*avidya*)." (Brazier 1996, 87)

The goal of Buddhism is to assist people on various levels of ignorance in achieving an enlightened state of mind. With the help of the enlightened mind one is able to conceive the world without biases and without mental distortions, and see things as they actually are. Zen therapist Brazier notes that, quite understandably, some people would find an "essential difference" between Buddhism and psychotherapy, for the former seems to be concerned with the liberation of the mind, while the latter with psychological adjustment. (Brazier 1996, 30) However, Erich Fromm, eminent German-American psychotherapist and a pioneering figure in the Zen-psychoanalysis dialogue, would disagree. In his book, *Psychoanalysis and Zen Buddhism*, he argues that if the terminological differences are cleared up, it will become evident that the goal of psychotherapy and the goal of Zen are one and the same: liberating the self from its ignorance. (Fromm 2013, 58-59)

Fromm and an increasing number of professionals following him became seriously interested in the compatibility of Zen Buddhism and psychotherapy. Naturally, many people would identify Zen as being quintessentially Japanese; nevertheless Zen finds its origins in Chinese and Indian cultures. Still one could argue that Zen has been substantially transformed in Japan in order to be able to become what it is today. Even so, to complicate matters more, Zen approaches to psychotherapy are obviously not exclusively Japanese, since many of the present-day Zen therapists come from western countries, such as the United States, Great Britain or Italy. As Stuart Twemlow, renowned American psychiatrist makes it clear though, Zen poses an obvious challenge to western psychology and psychotherapy:

> Zen challenges an idea inherent in our current psychologies that attempts to feel secure and free from anxiety require the establishing of control and predictability over self and the environment. The search for security becomes a wild goose chase that is doomed to failure because the universe is *not* like that reality; security and changelessness are considered to be fabricated by the *control-oriented* mind and do not exist in nature. To accept insecurity is to commit oneself to the unknown, creating a "relaxing faith" in the universe. (Twemlow 2009, 189)

Brazier would likely to second Twemlow's conclusions. There appears to be a tendency in western therapies which forcibly attempts to tie the idea of attaining greater mental health with a heightened sense of individual autonomy and authenticity. But it is plausible to surmise that a fortified ego will easily become self-absorbed and overly narcissistic, and thus might develop various kinds of neuroses that are related to defending the precious kingdom of its inflated self. Seeking authenticity and self-actualization as ultimate goals in therapy might, in fact, fire back, and consequently carry a real danger. In Brazier's assessment, "If Buddha was right, then some Western therapies are misguided. They will not, for instance, achieve their aim if they seek to strengthen the individual's sense of entitlement and to reinforce the ego's anger against a world that doesn't provide instant gratification." (Brazier 1996, 31) Instead in Zen therapy the important thing to achieve would be to become independent, but not only of the others or of society as a whole, but of the self as well. A fully enlightened and mentally completely healthy person in Buddhism should be capable of being independent of his or her very own self, because enlightenment implies detachment from the illusion of the self and its deceptive demands. Therefore, Brazier argues that the "primary task of the therapist is to create space of a particular quality in order that the client be freed." (Brazier 1996, 27)

> In Buddhism, a particular form of 'being alone' is highly valued. This is the kind of aloneness in which one is not troubled by visitations from either seductive or troubling memories from the past, in which one is not hanging on to 'unfinished business', in which one is not living in hope or longing, nor waiting for real life to begin. This particular form of being alone involves letting go

4 The āsavas are mental defilements that cause ignorance and attachment to suffering.

> of 'internalized objects' and accepting life as it is, as it comes. (ibid.)

Creating a safe space in which the client can experience what it truly means to be alone is also crucial in Morita therapy, one of Japan's indigenous psychotherapeutic approaches. Morita therapy was established by Masatake Morita, a Japanese psychiatrist who treated patients suffering from anxiety-related disorders (*shinkeishitsu*) in Tokyo in the early 20th century. Morita worked out a therapeutic practice that would help cure patients by reengaging them with their community, the larger society and nature as well – with their own nature and also with the cosmic nature. His four stage method that begins with days of complete bed rest and quiet isolation is designed to progress toward an increased reintegration of the client into the society by means of the application of a progressively more active occupational therapy. Morita's underlying philosophy relies heavily on Zen Buddhist tenets, emphasizing the body-mind interconnectedness and the *arugamama* principle which compels the individual to accept reality *as it is*, thus assisting the self in its process of shedding its ego-centeredness.[5] (Morita 1998, 84-92) Chervenkova competently illustrates the ways in which Morita therapy differs from western therapeutic models. Western concepts of healing, as a rule, stress the "fight" against illness, whereas

> for Morita the cure is paradoxically hidden in the very opposite attitude, i.e., not in rebelling against symptoms or attempting to get around them by devising all sorts of intellectual tricks, but in accepting them directly as they are. Morita emphasized the idea of healing as reeducation: neurotic symptoms are self-made constructs that results from narrow, inflexible, and inappropriate attitudes toward reality, or from too much conceptualization of reality. These attitudes can be transformed through training or learning of more mindful ways of living, i.e., ways that respond to reality as it is. (Chervenkova 2017. 62)

Morita therapy has become increasingly acknowledged and adopted to various institutional settings in both Japan and abroad as well, including the US, Canada, Australia and Germany, etc. However, these developments took place chiefly from the 1960s and 70s. Before that, the Second World War and Japan's devastating defeat left many Japanese people in desperate need of mental health care. It is widely recognized that the lost war had left a deep psychological scar on the nation, and that masses of Japanese people experienced neurotic symptoms, loss of meaning in life, etc. This was the time, the immediate post-war period, when Ishin Yoshimoto entered the scene, and developed another prominent Buddhist-influenced Japanese psychotherapeutic approach: the Naikan method.

While neither Morita therapy, nor the Naikan method, in their current forms, could be properly claimed to be *religious* healing therapies per se, both of their founders were undoubtedly steeped in Japanese Buddhist religious thought. If it has been argued by several commentators that Zen Buddhism had left a decisive stamp on Morita's formulation of his therapy (Chervenkova 2017, 57-58), the case is even stronger with Naikan, for it directly derives from a Pure Land Buddhist practice called *mishirabe*. The founder of Naikan therapy, Yoshimoto came from a family who were followers of the *Jōdo Shinshū* sect of Pure Land Buddhism in Japan. As a young man he subjected himself to the radical ascetic practice of *mishirabe* or self-exploration in order to reach enlightenment (*satori*). Later on, realizing that the practice was clearly beneficial for people suffering from mental problems but it was excessively harsh and austere, he modified it, making it accessible for ordinary people too who lacked the religious fervor that Ishimoto himself possessed. Thus was born the Naikan method, a therapeutic technique which promoted thorough self-introspection and the reevaluation of the past, and facilitated a fundamental transformation concerning one's self image, along with the self's relation to others.

By going through a strict self-reexamination for a whole week in isolation, whereby one is not allowed to talk to other people or communicate in any other way with the outside world, the client is faced with the grueling task of having to dig up memories from one's long forgotten past, and reflect upon them from a new perspective.[6] This technique, along with the three

5 „When clients are governed by symptoms, they confine and attach themselves to their ego. They are unable to view or understand things outside their attachment to ego-centered desires. This process is comparable to a person being unable to judge whether something is right or wrong while dreaming." (Morita 1998, 84-85). The aim of the therapy then is to wake the client up from this dream world, the ego-centered delusion.

6 „There are people who admit that they are afraid of realizing who they really are. (...) It is a horrible thing to recognize oneself, for sure. But it would be much worse to live without ever getting to know oneself. NAIKAN makes us recognize ourselves by looking at ourselves, not by someone else's telling us. Our image of ourselves is not destroyed by others but by the fact that a new image is being constructed. It can be compared to a caterpillar, breaking through the cocoon from the inside, instead of having someone else breaking it from the outside. If we claim that this is terrible, we will not turn into butterflies and fly into the amazing, wide sky in

fundamental questions[7] that are incessantly channeling the client's attention toward the right direction, is supposedly conducive to achieving a more balanced view of reality, devoid of self-deception and ego-centeredness. The method is designed to block the self's innate tendency to justify itself and retrospectively rationalize its own selfish actions, and also to draw awareness to the reality that one has been always generously assisted by many people along the way–a fact that is often overlooked or underestimated. Testimonies show that those who have completed Naikan therapy are frequently overcome with a feeling of immense gratitude and a sense of strong connectedness to other people and to the universe *in toto*. In the words of anthropologist Ozawa-de Silva:

> (…) most clients start Naikan with unquestioned confidence in the objectivity and factuality of their life stories. Gradually, however, clients start to see how their autobiographies are subjective and biased by their rigid perspectives on others, and they often start realizing that their autobiographical narratives are self-made constructs, subjective attempts to make sense of events and the actions of others. Through gradual and often painful stages, practitioners realize their utter dependence on other people, to the extent that their sense of being a self-made person collapses. Then, for the first time, the clients are able to see others, such as their mothers, as autonomous independent subjects, distinct from their previous expectations about how those people should be; and correspondingly, the clients begin to truly appreciate them (Ozawa-de Silva 2007, 430)

## Conclusion

Nishitani's earlier mentioned criterion that other beings and the self ought to become manifest in their "suchness" (*shinnyo*) is virtually the same criterion that the previously surveyed Japanese psychotherapies set as a goal: achieving an egoless tranquility from which one can see one's original connectedness to other beings. This *arugamama* principle, which has more to do with epistemological knowledge than with a medicalized concept of health, is believed to be the key to the individual's well-being, just as much as it is necessary for the "healthy" functioning of society as a whole. As Carter writes, in regard to Nishitani's 'ethics of emptiness' or 'selfless ethics': "the enlightened person acts compassionately by being a self that is not a self. Ethics of this kind arises when one's own home-ground is the home-ground of everything and everyone." (Carter 2013, 124) By "enlightened person" one doesn't inevitably mean a Buddhist saint who has achieved releasement from all worldly concerns. Far from it: the ideal of enlightened or selfless self from the Japanese perspective is a self which is infinitely more embedded in the world than was ever before its transformation. Whether this transformation is conceived as a spiritual or a religious one, or has more to do with a shift in one's values and view of life in general, is beside the point. As Naikan's and Morita's growing success in foreign or nonreligious contexts demonstrates, the basic structure and methodology of these therapies can be carried over with minimal modification from an originally Buddhist milieu to a Christian or even to a secular setting, still bringing about favorable and oftentimes dramatic changes in the clients' lives, particularly regarding one's mental health and overall well-being.[8]

As famed Jungian psychologist Kawai Hayao points out, this Japanese model of healing doesn't accept what the standard western medical models usually unquestionably presuppose, namely, that when sickness occurs, the doctor is there to "fix" or "cure" the patient.[9] As Chervenkova explains, "the Japanese psychotherapies seem not to fit this medical model; quite the contrary, they adopt what Kawai terms a natural therapeutic model, for which the proper verb should be "to get cured," "to recover" (Kawai 2009, quoted by Chervenkova 2017, 38). The doctor's or the therapist's task in this understanding is to arrange the best conditions under which the patient is allowed to get cured– not by the doctor or other medical professionals but by nature itself. In other words, the doctor is not the active agent in the cure; nature is. And in order to

our whole life. This is a fact, no matter whether we look at ourselves or not." (Ishii 2000, 181)

7 The three questions to reflect on are: 1. What have I received from X in my life? 2. What have I given to X? 3. What troubles and difficulties have I caused X? X can be one's mother, father, sibling, husband, wife, or any other significant person in one's life.

8 Both Naikan and Morita therapies have been demonstrably succesful in treating severe cases of depression, anxiety disorders, psychosomatic diseases, compulsive behaviour, and addiction.

9 One might not be far from the truth by suspecting that the standard western medical model is, by and large, identical with the standard Japanese medical reality of the western-style biomedical clinical practice. Although there are certainly differences in both the perception of certain illnesses and in the different modes as to how a Japanese medical doctor might approach an ailment, the fact remains that the biomedical model strives to direclty intervene into manifest problems, and it focuses eminently on the symptoms and on their intrusive and forceful elimination. Morita and Naikan therapies have a fundamentally different way of relating to health, sickness, and healing.

allow nature to perform the act of healing, one thing is indispensable for the Japanese: *silence*.

> (…) silence, after all, "sharpens" our senses and enhances our mindfulness, we realize that silence could not lead to sterility, but to a deep insight about our common human condition. This, we suggest, is the cornerstone of the Japanese psychotherapies, which are worth due attention as the quiet, yet eloquent counterparts of the Western approaches (Chervenkova 2017, 40)

## References


Bucci, F. (2014), 'Cultural representations of mental illness in contemporary Japan, *Rivista di Psicologia Clinica*, *1*: 82-108.

Bucci, F.; Campagnola, F.; Taguchi K. (2014), 'The Shifting Place of Madness in Modernizing Japan : Interview with Kazushige Shingu', *Rivista Di Psicologia Clinica,*1: 109–139.

Brazier, D. (1996), *Zen Therapy: Transcending the Sorrows of the Human Mind.* New York: Wiley.

Carter, R. E. (2013), *The Kyoto School: An Introduction*, Albany: SUNY Press.

Chervenkova, V. (2017), *Japanese Psychotherapies: Silence and Body-Mind Interconnectedness in Morita, Naikan and Dohsa-hou,* Singapore: Springer.

De Silva, P. (2005), *An Introduction to Buddhist Psychology*. Palgrave Macmillan.

Fromm, E (2013), *Psychoanalysis and Zen Buddhism*, New York: Open Road Integrated Media.

Holthus, B.; Manzenreiter, W. (eds.) (2017), *Life-course, Happiness, and Well-being in Japan,* London and New York: Routledge.

Hommerich, C. (2017), 'Anxious, stressed, and yet satisfied? The puzzle of subjective well-being among young adults in Japan', in B. Holthus and W. Manzenreiter (eds.), *Life-course, Happiness, and Well-being in Japan,* London and New York: Routledge, 72-93.

Horiguchi, S. (2017), '"Unhappy" and isolated youth in the midst of social change. Representations and subjective experiences of *hikikomori* in contemporary Japan', in B. Holthus and W. Manzenreiter (eds.), *Life-course, Happiness, and Well-being in Japan,* London and New York: Routledge, 57-71.

Ishii, A. (2000), 'Recommendations for NAIKAN', in A. Ishii and J. Hartl (eds.), *Das Wesen von NAIKAN. The essence of NAIKAN,* Wien: Naikido Zentrum, 169-185.

Kawai, H. (2009), *Introduction to Psychotherapy: Psychotherapeutic Approaches–Collection IV.* Iwanami Shoten (in Japanese).

Lebra, T. S. (1992), 'Self in Japanese Culture', in N.R. Rosenberger (ed.), *Japanese Sense of Self,* Cambridge University Press, 105-120.

Lock, M. (1982), 'Popular Conceptions of Mental Health in Japan', in A. J. Marsella and J. M. White (eds.), *Cultural Conceptions of Mental Health and Therapy*, Dordrecht, Boston, London: D. Reidel Publishing Company, 215-234.

Manzenreiter, W. and Holthus, B. (eds.) (2017), *Happiness and the Good Life in Japan*, London and New York: Routledge.

Morita, S. (1998) *Morita Therapy and the True Nature of Anxiety-based Disorders (*Shinkeishitsu*),* Albany: State University of New York Press.

Nakamura, K. (2013), *A Disability of the Soul. An Ethnography of Schizophrenia and Mental Illness in Contemporary Japan,* Ithaca and London: Cornell University Press.

Nakane, Y. (2012), *Progress in Social Psychiatry in Japan. An Approach to Psychiatric Epidemiology,* Tokyo: Springer Japan.

Nishitani, K. (1982), *Religion and Nothingness,* Berkeley, Los Angeles, London: University of California Press.

Ozawa-de Silva, Ch. (2006), *Psychotherapy and Religion in Japan: The Japanese introspection practice of Naikan,* London and New York: Routledge.

Ozawa-de Silva, Ch. (2007), 'Demystifying Japanese Therapy: An Analysis of Naikan and The Ajase Complex through Buddhist Thought', in *Ethos*, Vol. 35 (4). The Society for Psychological Anthropology, Wiley, 411-446.

Pietikainen, P. (2015), *Madness: A History,* London and New York: Routledge.

Scull, A. (2015), *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine,* Princeton and Oxford: Princeton University Press.

Suzuki, D. T. (2004), 'Self the Unattainable', in F. Franck (ed.), *The Buddha Eye: An Anthology of the Kyoto School and Its Contemporaries,* World Wisdom, 3-10.

Twemlow, S. (2009), 'Zen, Martial Arts, and Psychoanalysis in Training the Mind of the Psychotherapist', in S. Akhtar (ed.), *Freud and the Far East: Psychoanalytic Perspectives on the People and Culture of China, Japan, and Korea,* Lanham: Jason Aronson, 175-195.

Totsuka, E. (1990), 'The History of Japanese Psychiatry and the Rights of Mental Patients', *The Psychiatrist* 14: 193–200.

## Notes to Contributors

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2. Papers should not exceed 8,000 words including references.

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