Annales Academiae Paedagogicae Cracoviensis

Folia 55 Studia Psychologica III (2008)

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The applications of psychotherapy by Shomo Morita

Psychotherapy methods developed by Shomo Morita in Japan, in the nineteen-twenties, were designed for patients showing the symptoms known as *shinkeishitsu*. The problems suffered by this group of patients were related mainly to neurotic disorders embedded in fear. The psychological characteristics of this syndrome included excessive sensitivity, perfectionism, dogmatism, excessive self-concentration, circumstantiality and mood-influenced style of life. Morita's orthodox therapy was used in hospital conditions. Its objective consisted in the externalization of patients' interests and mobilization of their constructive abilities. Morita's essential psychotherapeutic guidelines relied on the acceptance of the fear of death, interrelations with the reality in its current condition, restructuring the focus field of attention, selecting activity rather than inactivity, and formulating the objectives.

Scientific community's interest in Morita's psychotherapy re-emerged in the nineteen-sixties and was related to the extension of psychotherapeutic procedures to outpatient consulting therapy. In the seventies, various increasingly theoretical and procedural interpretations were formulated. Typical and non-typical cases of *shinkeishitsu* patients were identified (Ishiyama 1990a). More recently, the group of disorders in which Morita's psychotherapy can be applied has been significantly broadened. Psychosomatic disorders, cancer cases and terminal conditions have been included. Experiments have also been made in combining Morita's methods with the psychotherapeutics assisting in individual personality formation and self-development. Alongside the growing popularity of Morita's approach, a number of problems have appeared concerning its clinical usefulness in the therapy of various individuals (in contexts differing significantly from Morita's classical model). Questions have appeared concerning the possibility of eclectic application of selected techniques. Ethical and professional dilemmas were encountered by practicing therapists, implementing modified versions of Morita's guidelines in Western countries.

The present article outlines Morita's psychotherapeutic principles, while indicating the philosophical sources of his concept. Conclusions are drawn which have considerable significance for patients. The application of Morita's therapeutic values is shown also in relation to the psychosomatic approach offered by Jnro Itami, and the full-life therapy. In particular, I emphasize the importance of inter-relation between fear of death and desire for life. The discussed elements of Morita's psychotherapeutic system are those which may be treated as useful tools by European psychotherapists, as well as those which may prove harder to adopt because of cultural barriers. The cultural background creates the context in which the didactic approach based on directives, or even authoritarianism, in management of Morita's classic procedure is compatible with the cultural conditions of interpersonal relations in Japan, and activates specific mechanisms of patient's response, different from those observed in the case of therapy relying on empathy (Ishiyama 1990b).

Philosophic and cultural principles of S. Morita's psychotherapy

The principles of Morita's psychotherapeutic procedure are strongly related to the values present in Shinto religion and Zen Buddhism. Traditional Japanese Shinto is based on monism and naturalism. Full adherence to the principles of naturalism would lead to the assumption that human being belongs to Nature, and appropriate therapeutic conclusions must be drawn from this fact. The truth, spontaneity and overall life vigor are the essential features of Nature. These very rules should be applied to the patient's mode of existence. In consequence, contact with nature (natural surroundings) is important in therapy, as well as physical work and accepting attitude to existing reality (Siwiak 1972). Morita underlined the natural regulation of human mind's activity. According to Kitanishi (1992), naturalistic values directed Morita to monistic comprehension of the body-mind-nature structure. Morita believed that '...the activity of our body and mind is a natural phenomenon. We cannot manipulate it artificially' (Morita 1974, quoted in Kitanishi 1992: 3). It was Morita's conviction that every individual is endowed with vital force, revealed in the need to live, develop and work. In his opinion, everyday experience provides the foundation for development of this force, and must be used actively in treatment. Arriving at the truth is possible mainly through experience, and facing concrete events. This point of view is characteristic of Zen Buddhism, which emphasizes that intellectual analysis is not the source of truth. Many authors have found obvious Buddhist influence upon Morita's concept, in spite of his frequent protests against such interpretation (Kitanishi 1992). The similarities between Morita's approach and Zen Buddhism can be seen in the following aspects:

- affirmation and acceptance of life passions, desires and conflicts,
- emphasizing the everyday life practice (Zen practices, the importance of physical work in Morita's therapeutic procedure),

- focusing on the method of practice: "through organization of external outlook or behavior, the individual's internal qualities or mind are maturing in natural way" (Morita 1974, quoted in Kitanishi 1992: 3),
- stressing personal experience resulting from undertaken concrete behavior, rather than abstract, conceptual structuring of reality,
- the similarities of *satori* and *arugamama* (Kitanishi 1992).

The notion of *arugamama* concerns the generalized approach adopted by individuals in relation both to external reality and themselves. Such attitude can be understood as acceptance of reality in all its features. The patient accepts life in all aspects and in result sees all the symptoms of disorders as a natural condition. Morita's followers describe this set of mind as 'creative passive acceptance', providing the source of strength which allows to overcome difficulties (Siwiak 1973). Arriving at this state of mind is an essential precondition for initiating the process of recovery. In the case of *satori,* the enlightenment (notwithstanding its origin) becomes the starting point of a new phase of life resulting from the transformed perspective of experience and understanding reality.

The structure of Morita's psychotherapy

S. Morita's psychotherapeutic concept arose largely in opposition to the inhuman methods of treating patients in psychiatric hospitals, prevailing in Japan and elsewhere at the time (Le Vine 1993). Morita's psychotherapy is focused not only on facilitation of behavioral and cognitive changes. In its classic version, therapy is conducted in conditions of hospitalization, restfulness and detachment from the pathogenic everyday existence of the patient, and is based on occupational therapy. Through such activities, Morita helped the patients to discover their own true self, relying on their creative instincts, resistance, and the need to assist (serve) others. In his opinion, these methods were superior to slow and painstaking elimination of symptoms. The introduction of therapy in isolation from other patients (in the first phase of procedure), restfulness and comprehensive medical care, created a paradoxical psychotherapeutic context. The patient could not escape his internal sufferings, being under constant care of the doctor who eliminated the possible somatic causes of current emotional condition and mood. This situation induced the patient to change his/her attitude to suffering.

Morita's psychotherapy was designed for patients showing symptoms of *shinkeishitsu,* close to the classic concept of fear neurosis. Therapeutic procedures were applied mainly to patients who were concentrated on subjective experience of fear and apprehension, unable to undertake activity and maintain closer contacts with their selves, with other persons and external environment. In Morita's interpretation, the patient was constructing a subjective reality, in which the symptom is perceived as

serious and threatening. In this situation, the patient's sense of life disappears from the field of perception and experience, in effect of strong focusing on symptoms and avoiding the struggle. Consequently, the individual's mind restricts spontaneous consciousness. Morita describes it as the case of denying the reality, which the individual cannot face.

Classic Morita's psychotherapeutic procedure is applied in four stages:

1. Rest in reclining position, in premises separated from other persons. Patients are not allowed to engage in any activity. They are recommended to experience emotion and to accept the free flow of thoughts. This procedure results in intensification of symptoms, and when the attempts to cope with experienced problems fail, the patient is given the possibility, or indeed has no other choice but to face his/her suffering and to accept it in the condition in which it comes (duration time: one week).

2. Light and tedious work, contact with nature. The relation between therapist and the patient is the central therapeutic element. Relying on the therapist's support, the patient gradually enters the group and starts to work. The patients are advised to write a journal, focusing on the registration of everyday activities, with no analysis of the emotions. Entries in the journal should be made in the mornings and evenings. The therapist inspects the journal every day and comments on it, in the patient's presence. In the course of the week, the therapist conducts an interview with the patient (duration time: one week).

3. Moderately intensive work with elements of artistic activity. In this phase, relations occurring between patients are the key element of therapy. Through social relations and work, patients can experience acceptance and the behavior of others. They can also present publicly their own behaviors. Continuation of journal writing is recommended (duration time: 2–3 months).

4. Period of social integration. The patient reinforces and stabilizes new forms of behavior outside the isolated conditions of hospital room. At this phase of therapy, some patients work in their regular employment place, or attend school (duration time: one month) (Kitanishi 1992).

Each phase of the therapy is analyzed in detail, with precise definition of criteria allowing the patient to proceed to the next phase. In the phase of isolation, close clinical control of patient's behavior is required. Morita also indicates other categories of disorders, in the case of which the above procedure is not recommended. It is strongly discouraged in the case of suicidal thoughts, psychoses, profound depressions, extensive mental disabilities, pathological anti-social behavior. In the course of this phase, the patient intensively experiences the discomfort, in the very form in which it appears to him/her. There are no tasks or assignments to be fulfilled and no support is offered by the therapist through conversation, suggestion or intervention. In consequence of isolation, conditions are created in which the patient can:

- experience more easily the safe environment,
- reduce the urge to solve the existing problem, or to make life easier and less absorbing,
- increase the ability to tolerate contradictions,

- intensify the feeling of tedium and monotony related to suffering,
- stimulate observation efficiency of physical and social world,
- stimulate efficient observation of continuous changes which are characteristic for Nature.

Morita believed that the realization of the above objectives facilitated the recuperation of spontaneous mental activity, which was the essential precondition of proper therapy. Therapy is possible only at the point when the patient's attention allows him/her to receive stimuli from all possible sources and directions. In phase two and three, experience gained in the period of isolation is reinforced, helping the patient to get involved in forms of activity that are useful for external environment. Patients are motivated to approach objects as they are in themselves *(arugamama)* and to refrain from rejection of facts. They are encouraged to focus their attention on the current moment and the nearest tasks. Psychotherapy process aims at gaining health, consciousness and involvement. Health is preconditioned by "rhythmic interaction" between the body and mind, environment and the necessity of self-preservation and development in the face of fears and threats related to life and death (Fujita 1968, quoted in Ishiyama 1991).

Pathology mechanism of shinkeishitsu syndrome

Patients suffering from *shinkeishitsu* syndrome characteristically display strong desire for life. In consequence, they are oversensitive to all inconveniences and problems of their existence (Kora 1990). While trying to realize their ideal of full life, they consider the elimination of such inconveniences to be the crucial life objective. Usually, they underestimate the efforts which they have undertaken, and which need to be undertaken in order to make their activities more effective. In consequence of this negative perception of their activities and undertaken efforts, their attitude to life is pessimistic, and undermines effective adaptation to environment conditions. The classic neurotic vicious circle develops, preventing efficient and subjectively satisfying activity. The essential objective of psychotherapy consists in changing these negative attitudes through application of necessary and available psychological means. In his therapeutic work, Morita used the symptoms displayed by patients in order to teach them to understand the true nature of *shinkeishitsu* syndrome. As a rule, patients did not find it difficult, since Morita applied lucid conceptualization based on psychological facts that were easily understood by average individuals (Kora 1990). Morita devoted much attention to elucidation of symptoms which frequently allowed for understanding of their nature. Yet, it should be observed that understanding the nature of symptoms is not indispensable for an effective therapy. Even when the patient fails to understand their nature, the conditions of psychotherapy realization and therapist's instructions provide effective assistance. As mentioned before, the

perception of true nature of symptoms and living life as it is contribute to desirable psychic mood of patients suffering from *shinkeishitsu* syndrome. The development of such an attitude is close to the state of reality acceptance which is known as *arugamama* in Buddhism. Attaining such condition is usually considered to be the beginning of recuperation process. Yet, this condition is not treated in a fatalistic and passive way. An important directive consists in the acceptance of symptoms, and avoiding opposition and rebellion attitudes. The next step is related to constructive activities resulting from the desire for life, and allowing patients to learn to cope with natural fear in many stressful situations. It is recommended that patients should participate in all everyday activities, in spite of experiencing the symptoms. This procedure provides the experience of constructive activity, achieved in spite of symptoms. Thus, the symptoms' significance and negative impact upon patients' everyday functioning can be reduced and eliminated. In the situation of refraining from activity caused by the appearance of symptoms, patients remain under their demobilizing influence (Kora 1990). The described internal state of *arugamama* helps in discontinuation of the symptoms fixation mechanism. In Morita's opinion, active attitude towards symptoms and acceptance of pain experience is the shortest way to recovery (Kora 1990).

Patients with *shinkeishitsu* syndrome are usually inclined to perfectionism. They emphasize very much the tendency to reach their own ideal image, while relying on dogmatic convictions about what they should be like, or what particular objects ought to be like (Kora 1990). Obviously, such attitude leads to disillusionment resulting from the discrepancy between the reality and cherished expectations. The more the patient desires a given condition or property, the more he/she suffers because of the feeling of disappointment resulting from divergence between desires and reality. Thus, the essential objective pursued by the therapist consists in assisting patients in understanding facts related to the natural character of such divergences in human experience. In the result of therapy, it is easier for the patient to accept such conditions and avoid the idealist dogmatism based on wishful thinking. Morita believed that his therapy mobilized the natural psychological dimension of human functioning and directed the individual's mind towards external environment. It contributed also to the elimination of disorders in attention, resulting from the restricted field of interest (attention focusing area). Also, the therapy was building psychological conditions for relations occurring between the individual and environment as a whole (Morita 1990; Tro 1993).

Toraware psychopathology

The concept of *toraware* is interpreted in English as attachment. Yet, it seems that Morita's original understanding of this notion relied on the way of entering re-

lations with the surrounding world and with oneself. In Morita's opinion, *toraware* consisted of two elements:

- psychic interaction,
- contradictions in thinking.

While explaining the meaning of psychic interaction, Morita provided the example of a person focusing his/her attention on a certain object. In effect of attention concentration, intensiveness of the feeling evoked by this object grows. In turn, the intensified feeling attracts even more attention. The attention and feelings are closed in the trap of self-intensifying cycle (Morita 1974; Kitanishi 1992: 4). Morita claimed that contradictions in thinking develop on the basis of the individual's conviction about the impossibility to understand his/her own mind, and impossibility to control the mind in order to implement selected objectives (Morita 1974).

Thinking characterized by dominant contradictions is related to obsessive, rigid attitude influencing the other part of cognitive and emotional experience. Patients with *shinkeishitsu* syndrome are deeply convinced that everything should occur in a pre-defined way and cannot accept or accommodate their physical condition, emotions and reality. Constant changes occurring in the subject and reality make it even more difficult.

Psychotherapeutic principles

In Morita's psychotherapy, the role of acceptance model and behavioral model is emphasized. The principles represented by these models are in circular relation. Patients are encouraged to accept difficulties occurring in the surrounding world, as well as their fears and apprehensions. The purpose of acceptance is to obtain unconditional agreement to everything that is contained in the individual 'self'. The acceptance of fear, apprehension and suffering can be obtained only through behavioral experience (predomination of activity and practice over conceptual analysis of reality). The therapist helps to understand and experience the fact that it is possible to live with fear, and indeed it is more constructive than avoiding fear. Patients gradually start to perceive self-actualization needs which Morita calls **the desire for life** (Kitanishi 1992).

Morita used the name **therapy by experience** or **natural therapy** in relation to thus constructed psychotherapy. The following elements are characteristic of the psychotherapeutic process interpreted in this way:

- refraining from reaction to the patient's subjective complaints,
- leaving the symptoms without interpretation,
- **here and now** principle,
- no interpretation of therapist-patient relation,
- keeping appropriate distance in therapist-patient relation,

- immediate experience of the 'self', without trying to obtain idealized feelings and conditions,
- immersion in fear and apprehensions,
- emphasizing the choice of situations in which the patients cannot avoid fear and threat,
- providing experiences leading to acceptance of fear and threat (Kitanishi 1992).

Non-classical applications of S. Morita's psychotherapy

Over half a century has elapsed since the publication of S. Morita's works. In this period profound changes have occurred within the social, cultural and medical aspects of explaining human functioning in Japan. These developments influenced the way of understanding psychotherapy, its implementation and expectations expressed by patients (Ishiyama 1993). Technical and procedural amendments have also been introduced to Morita's therapy. These changes were related to the development of dialogue between the therapist and patients, inclusion of playful activities to therapy program in hospitalization conditions, introduction of psycho-activating means, and application of longer hospitalization (two months and more). Recently, there have been cases of Morita's therapy application outside its traditional context (hospitalization, patients with the syndrome). Elements of this therapy have been applied in general psychiatric wards, self-assistance groups, in outpatient consulting and beyond the group of patients with *shinkeishitsu* syndrome (schizophrenia, depression, borderline cases, cancer cases) (Ishiyama 1993). The definition of Morita's therapy in its classic version emphasizes the treatment structure and applied procedures, and indicates the group of patients with *shinkeishitsu* syndrome as the principal object of therapeutic influence. Another method of defining this therapy refers to philosophical assumptions underlying Morita's system and considers *shinkeishitsu* syndrome with therapeutic procedures as generalized psychological principles (Ishiyama 1993). In the latter case, it is possible to use Morita's therapeutic guidelines in a broader and more flexible way. In consequence of application of such therapy by numerous therapists, Ohara suggests defining them as 'neo-Moritists'. Similarly, Ishiyama suggests the possibility of introducing the new concept: 'post-Morita' (Ishiyama 1993). Independently of these classification difficulties concerning the definition of Morita's followers and continuators, Ishiyama's statement is worth quoting: 'What Morita's psychotherapy can offer is too rich to be limited to only one type of clients and only one application method' (Ishiyama 1993: 3).

Aizawa introduced the differentiation between 'pure' and 'non-typical' *shinkeishitsu* syndrome, and suggested a modification of Morita's psychotherapy in relation to the latter group of patients (Ishiyama 1990a). Currently research is carried out in

the field of application of Morita's procedures to generally understood problems of assistance and self-development. Many authors writing about psychotherapy problems make it clear that the issue of selecting Morita's therapy does not need to be the choice between 'everything or nothing'. Individual elements of this therapy can be used in various forms of psychotherapy and in relation to various groups of clients (Ishiyama 1993). Western therapists have studied the clinical usefulness of Morita's therapy in work with various groups of clients. They have formulated the questions about amendments that need to be introduced for effective application of this therapy in the West. These authors have speculated whether it is possible to apply Morita's therapeutic guidelines when relying on different theoretical and psychotherapeutic position. What are the ethical and professional standards appropriate for Morita's therapy followers? In practical psychotherapeutic activity, it appears that Morita' therapy principles are useful also in relation to patients who do not meet the criteria of *shinkeishitsu* syndrome. Ishiyama (1990c) mentions the following cases: healthy clients with situational problems, borderline, depression, alcohol addicts, compulsive personality, persons experiencing difficulties in contacts with others, persons postponing or avoiding activity, terminal and incurable patients. Yet, the effective application of psychotherapy in various cases indicated by Ishiyama is possible when certain preconditions are met. These conditions are related mainly to interpersonal and intercultural sensitivity, in the case when culturally specific and homogenous dimension of Morita's psychotherapy is used in work with the non-Japanese client (Ishiyama 1991). It is crucial to emphasize the patient's cultural reference system, and his/her internal world of needs, emotions and meanings (Ishiyama 1991).

Meaningful Life Therapy

Meaningful Life Therapy is a new psychosomatic approach suggested by a Japanese psychiatrist, Jinro Itami, working with terminal patients. Itami's approach relies on the essential principles of Morita's therapy. The problem of death is emphasized in the context of its unavoidability. The fear of death is directly related to attachment to the world and one's own life. Therefore it is understandable that humans have created various methods to cope with the fear of death, both at the individual and cultural levels. Morita believed that the fear of death is a normal human reaction which does not need to be denied or eliminated. The acceptance of fear provides a far more constructive activity method (Ishiyama 1990d). Thus, it appears that two ways of coping with the fear of death exist:

- passive submission to the fear of death (with the consequences in the form of passivity and restricted individual activity),
- active experience of the course of life together with the natural fear of death (with the consequences in the form of recognizing death as natural and una-

voidable episode in our lives allowing for constructive activity in emotionally difficult situations).

The experience of pain, fear, frustration and hopelessness can make human life horrifying and radically unhappy. In such situations, the recommended experience of 'full life' may encounter obvious difficulties in realization (Ishiyama 1992). However, the fact should be observed that in the case of terminal patients the real threat to life may be a pacifying and calming experience for themselves and for persons close to them.

In the psychosomatic approach, the creation of practical tools is emphasized, allowing for psychophysical functioning and experiencing sense in the terminal period of life. The difference should be observed between the application of such method and inducing changes in religious convictions, introduction of stoic philosophy elements, application of positive thinking and education in the field of death problems.

Morita's psychotherapy and Meaningful Life Therapy

In Meaningful Life Therapy, techniques and guidelines are used relying on psychological principles of Morita's therapy. The following principles of this therapy are particularly significant:

- the recognition of interdependence between the **desire for life** and fear of death,
- helping the patient to recognize the fact that the fear of death is a normal human reaction and expresses the desire for life, which explains the fear,
- encouraging the patient to make the choices and control activities when facing spontaneous emotions,
- emphasizing the reality and activities resulting from it,
- accepting facts in their essence, independently of their possible negative character,
- cultivating positive emotions and the feeling of achievement resulting from patient's involvement in constructive activities.

The principal objective of Meaningful Life Therapy consists in encouraging patients to undertake constructive and meaningful activities as long as they live and desire life. It is worth quoting Itami, who advised the patients: '...you can be ill but never become an ill person' (Itami 1998, quoted in Ishiyama 1990:79).

Patients are encouraged to apply five basic rules of Meaningful Life Therapy, introducing order to their activities, in relation to illness and everyday life:

1. Active attitude in treatment; understanding illness and struggling with illness, as opposed to passive reliance on medical diagnosis and therapy;

2. Setting nearest life objectives, involvement in meaningful activities every day;

3. Activity for the sake of others and contribution to improving life quality of other persons,

4. Participation in consultancy sessions teaching to cope with the fear of death and in activities promoting the desire for life,

5. Recognizing death as a fact and part of the natural process of living and dying; preparation for one's own death in practical and constructive way (writing the will, arranging the unfinished problems, making preparations for funeral).

In Itami's psychosomatic approach, individual learning process is used in connection with medical consulting, group support and group learning sessions. Itami suggests to the patients two hours of session weekly, followed by more advanced courses held in three parts (referring to the above rules 1–3, 4–5, and 1–5) in connection with the patients' occupational roles and their relations with the environment.

In the course of therapy, patients undertake various forms of activity:

- involvement in activities providing the feeling of meaningfulness and achievement (hobby, creative work, social contacts),
- being useful for other persons,
- development of the sense of humor (humor understood as significant factor in building mechanisms of coping with problems,
- picture drawing therapy (ego transcending),
- visualization training (Simonton, Matthews-Simonton 1978),
- participation in the association devoted to practicing Meaningful Life Therapy.

In characteristics of Meaningful Life Therapy, it is emphasized that it is important for the patients to obtain the habits and techniques useful in longer and more meaningful life (e.g. biofeedback, visualization, undertaking activities). Patients are not encouraged to change or resign from their fear of death. They are encouraged to accept coexistence with this unwelcome feeling. No ideological intervention is used in order to alter the fear or ambivalent feelings towards death (Ishiyama 1992). In the therapeutic process, the set of psychosocial and behavioral habits is developed which are useful in leading meaningful life by the individual. The psychosomatic approach emphasizes the present time (in contrast to Kübler-Ross concept in which the significance of spiritual life after death is underlined). The contemplation of death and life after death and their religious interpretation is left to each patient and performed by him/her in the area of his/her philosophical and religious orientation.

The overview of basic theoretical and methodological guidelines of Shomo Morita's psychotherapy leads to the finding that Morita's ideas can be successfully transferred and applied in contexts which diverge from the classical form of his psychotherapeutic concept. Numerous efforts have been undertaken, aiming at thorough interpretation and understanding of Morita's concepts. It seems that it would be useful to construct a theoretical and technical synthesis relying on the broad perspective of psychotherapeutic process interpretation. Such suggestions have been tentatively formulated by Ishiyama, who has actively promoted Shomo Morita's psychotherapy

outside Japan for many years. Doubts appear when we contemplate the philosophical sources of this concept. Many authors have identified elements of Zen philosophy and Buddhism, while Morita himself discouraged such interpretations, indicating the naturalistic sources of his theory. The latter similarities can be seen in: presentation of the nature of suffering and change, understanding the essence of self, the essence of needs, understanding of unnecessary suffering caused by ignorance, and understanding of experience as a set of interdependent phenomena (Matesz 1990). This problem requires detailed comparative analysis focusing on the assumptions of these concepts. It seems that Shomo Morita's concept was not designed to construct a certain life philosophy with the patient. On the other hand, it aimed at creation of the system of psychosocial and behavioral habits allowing to lead the life consistent with personal characteristics of the individual and creating optimum conditions for expressing individual possibilities.

It is meaningful that F. Ishu Ishiyama, professor of the University of British Columbia, started the publication of International Bulletin of Morita Therapy, in Vancouver, Canada, in 1990. This periodical is published twice yearly and presents problems of Morita's psychotherapy as well as related methods of approach to the issues of psychic health and personality development. The editor has treated this periodical as a forum of exchange of knowledge, views and practical professional applications of Morita's therapy and other psychotherapy forms of the East and West. The Bulletin is devoted to promotion, deeper understanding and critical assessment of Morita's psychotherapy and other forms of psychotherapy. Editorial activities have been focused on creative integration of Eastern and Western psychotherapeutic orientations, which are useful in clinical practice and individual personality development. Undertaking activities referring to two different psychotherapeutic orientations is necessarily linked to the problems of the cultural conditions of social activities performed by the individual. In the world of Western therapy, empathy is a crucial condition of comfort in therapeutic relation. In the situation of applying Morita's psychotherapy in Japan, its essential instrument relies on didactic and directive character (Ishiyama 1992). The cultural diversity of the East and West has induced Ishiyama to cooperation with authors representing both cultures. The consulting board of the Bulletin consists mainly of Canadian and American authors. However, an additional advisory team has also been formed, consisting exclusively of Japanese authors.

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Zastosowanie psychoterapii Shomo Mority

Streszczenie

Artykuł prezentuje psychoterapeutyczne podejście rozwijane przez Shomo Moritę w Japonii. Nawiązując do kulturowych doświadczeń Wschodu i Zachodu, autor analizuje specyficzne cechy metody przeznaczonej dla pacjentów reprezentujących objawy określane nazwą *shinkeishits.* Dominującym objawem tego zespołu jest lęk, oprócz którego występują: nadwrażliwość, perfekcjonizm, dogmatyzm, nadmierne skoncentrowanie na sobie, lepkość i uwarunkowany nastrojem styl życia.

Artykuł odwołując się do filozoficznych i kulturowych założeń leżących u podstaw omawianej formy psychoterapii oraz specyfiki patomechanizmu syndromu *shinkeishitsu* analizuje jej strukturę i psychoterapeutyczne zasady. Wskazuje także możliwości aplikacyjne dla wykorzystania psychoterapii S. Monity w zachodnim kręgu kulturowym.