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A rapid shift from rural to urban life has meant growing mental health problems for the Japanese people.

FROM JAPAN

Oriental Psychiatry Veering West

While American techniques spread in Asia, Japan adds its own special blend of religion, philosophy and tradition.

Asian psychiatry, once dominated by Chinese herb medicine, has become strongly American-influenced, particularly in Japan. Differences between Asian and American techniques remain, but the original Chinese dominance has vanished and even Western European influence, important before World War II, is on the decline.

In the Orient, there were strong cultural barriers to acceptance of Western, especially Freudian techniques, and until the period after World War II, Freudian theories were not easily comprehended. They were considered uncongenial to the philosophy of most Asians, save perhaps for the few Westernized and Western-educated.

For the others, traditional therapy involved Taoist and Buddhist meditation, Zen mental exercises, specialized breathing, Yogi exercises, consultations within families or ostracism from families in extreme cases—plus the Chinese herbs.

Then came the massive postwar American presence.

Chinese, Korean and Japanese specialists were trained by Americans, first at U.S. hospitals in their homelands, and later in residence in various U.S. hospitals. Upon their return, they became active participants in psychiatric education, and pursued an increasingly dynamic psychoanalytic orientation. Some, however, still cling to an interest in European psychiatry and neuropathology.

Among Asian countries, Japan is the most advanced.

Her leading mental problems encompass the usual spectrum found in the West. Religion, here as elsewhere, is often used to conceal or rationalize neurotic feelings. Industrialization of a primarily rural agricultural people has produced, in new urban levels of living, growing problems of mental health.

Japan began with its own native psychotherapy, the so-called Morita therapy formulated before 1920 by Dr. Shoma Morita, then a professor of the Tokyo Jikeikai Medical College. Morita principle and practice blend modern Western and Japanese approaches.

Morita therapy, for instance, handles a Japanese neurosis, known locally as "shinkeishitsu" with both Western techniques and "Zen" meditative philosophy.

"Shinkeishitsu" resembles what the West calls nervous breakdown. It calls for three important therapeutic steps in Morita theory. First, the treatment must develop the patient's insight into his distressed personality. It must break up the vicious circle of "psychic interaction" and straighten out his contradictions in thinking.

Dr. Morita proposed that "toraware," the feeling of being trapped in a situation the patient feels powerless to resolve, is central to the ailment.

Therapy, thought Morita, must afford the patient fresh new insight into himself and strive to remove him from his depression-plagued introversion.

Present-day Japanese psychiatrists lean heavily still on the Morita theory and its therapeutic approach to mental illness.

Patients today are directed to four stages of treatment, each lasting a week or more: absolute bed rest, a light work period, a heavy work period and a period of out-patient social rehabilitation.

In Japan, the key focus of psychiatric theory and treatment in mental hospitals is organic in nature. There is relatively little interest in psychotherapy as a systematic procedure in its own right. Most Japanese psychiatrists and neurologists are young, and the great bulk of their hospitals are small in comparison with typically large psychiatric institutions in the U.S. Also, most of the hospitals are private, not public.

The attitude of most Japanese patients differs markedly from their counterparts in America. Traditionally docile, they accept doctors' authority unquestioningly. The old family doctor concept in America might offer a parallel, but only a rough one. This acceptance leads swiftly to an emotional, almost familial, warmth of attachment. Indeed, by American standards, the Japanese patient relies too much on the attending doctor. The psychiatrist, instead of remaining independent and aloof, becomes in turn too involved with his charge.

To the Japanese, however, this relationship is vital, endemic to his culture and way of life. Also different from U.S. hospital procedure is the reliance on what Japanese call "tsuki-soi." Patients are cared for, around-the-clock by sub-professional nurses, always women who are paid by the patient's family, and who live most of their lives within hospital confines, yet never really are a part of the hospital staff. With these women, who sleep in their rooms and cook and care for them, the patients form a quick closeness, akin to the familial warmth they soon feel for the attending psychiatrist.

The system is an integral part of Japanese culture, and relates to the Japanese feeling of "cosmic loneliness" without the constant closeness of other human beings.

Japanese psychiatry relies heavily, at first, on sedation, after which patients are encouraged, as soon as possible, to communicate with doctors. This is done daily, either informally in long meetings or indirectly through diaries.

Diaries have long played a part in Japanese life—in business and travel, in medicine, the arts, the sciences. Japanese appear devoted to keeping them, and lengthy writing in these diaries is considered by most Japanese doctors—and psychiatrists—very therapeutic.

The doctor's aim is to help his patients reach a plateau called "aru ga mama"—to take things as they are, i.e. to accept reality, and the world as it is. Once at that level of self composure, the next step, in Zen-like Buddhist precept, is a striving for "satori," —personal enlightenment, confident self-awareness and, thus self-reliance, self-possession, self-control.

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"Wagamama"—self-pity—plagues many women in all social strata.

Japanese doctors, by Western standards, are authoritarian, harsh, even caustic. They are so deliberately—in reflection of Morita concepts—even toward patients who complain of sleep disturbance, tension, anxiety, lack of self-confidence or general life interest, excessive blushing, sweating, fidgeting, stammering, inability to act or talk.

Most doctors, still following the Morita school, reject Freudian techniques of hypnosis and psychoanalysis and resort to psychosomatic medicine. They do not view the unconscious as a key factor in emotional problems. They do not recognize sexual drives as key factors. They do not talk of the "id," the "ego," the "super ego." They do not long linger on guilt and shame, especially when it is sexually based.

They tend to believe in an extension of the Morita therapy now called "supportive group environmental therapy," whereby the patient is surrounded as soon as possible, by people, activities, work and basic human situations.

Group action is, in fact, endemic to Japanese culture and way of life. Individuality is criticized and resented.

Japanese hold philosophically to the concept of "amaeru," which emphasizes the dependence of one person on all others, and on the community's benevolence.

Japanese women are often treated for "wagamama," meaning self-indulgence, self-pity, neglect of one's responsibilities and place within the community. It is a leading neurosis in Japanese eyes. Its symptoms, occurring mostly in women, are childishness, irrational behavior, hysterical crying, emotional outbursts, alternating with periods of gloomy withdrawal, listlessness and negativism.

Foreign psychiatrists practicing here agree that both "shinkeishitsu" and "wagamama" are, for the Japanese at least, specific mental diseases.

Both kinds of patients are prone, as Dr. Yoshiyuke Koga of the Jikei University School of Medicine points out, "to egocentricity, ultrasensitivity, and thus neurosis."

Freud and Freudian psychoanalysis are nevertheless gaining disciples. Freud's writings have long been available in Japan in two excellent translations. The postwar school of young U.S.-influenced U.S.-trained Japanese psychiatrists is turning increasingly to Freudian techniques, to hypnosis and to psychosomatic medicine.

Certainly interests in, and further refinement of organic therapies will continue. Similarly, the ideas of Dr. Morita, if not his specific treatment, will retain a meaningful place in Japanese psychiatric thought.

But, in the opinion of most foreign specialists, the future of Western dynamic psychotherapy is indeed bright and is growing brighter every year.

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