A Bending Willow Tree: A Japanese (Morita Therapy) Model of Human Nature and Client Change

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ABSTRACT

Japanese Morita therapy is discussed to highlight its culturally and theoretically unique perspectives on human nature and client change. Key features of this theory are: (a) theory of the *shinkeishitsu* (nervous) trait, (b) multiple-dimensional model of causes and treatment of *shinkeishitsu* neurosis, (c) theory of mental attachment, (d) reframing anxiety into constructive desires, (e) emphasis on action taking and experiencing, (f) restoration of balance in mental activities and attentional focus, (g) four-stage residential Morita therapy, and (h) counsellor contribution to client suffering and symptom aggravation. Eight examples are given to illustrate Moritian intervention responses.

RÉSUMÉ

On traite de la thérapie japonaise de Morita en mettant l'accent sur ses perspectives culturelles et théoriques uniques sur la nature humaine et le processus du changement chez le client : (a) la théorie du caractère nerveux de *shinkeishitsu*, (b) un modèle multidimensionnel des causes et du traitement de la névrose de *shinkeishitsu*, (c) la théorie de l'attachement mental, (d) le recadrage de l'anxiété en vue de transformer celle-ci en désirs constructifs, (e) la mise en valeur de l'action concrète et de l'expérience vécue, (f) le rétablissement de l'équilibre concernant les activités mentales et la concentration de l'attention, (g) la thérapie de Morita résidentielle à quatre étapes et (h) le degré de responsabilité du conseiller dans l'aggravation de la souffrance ou des symptômes du client. L'auteur donne huit exemples afin d'illustrer des interventions propres à la thérapie de Morita.

Common psychological ingredients, such as trust, hope, use of labels, and shared worldviews have been identified as therapeutic factors across cultures (Frank, 1973; Torrey, 1986). However, the predominance of Eurocentric ideas and values is apparent in mainstream theories and practices of counselling and psychotherapy, and in professional training programs and textbooks.

Some theorists and researchers have pointed out the conceptual and paradigmatic narrowness and potentially iatrogenic effects of indiscriminately applying Eurocentric Western helping models in multicultural society (Marsella & Yamada, 1999; Sue, Ivey, & Pedersen, 1996; Sue & Sue, 1990). They have further stressed the positive value and cultural compatibility of indigenous therapies for working with the same culture members. It has recently been argued that, in order to be effective and ethical in practising in multicultural society, helping professionals need to: (a) have open attitudes toward different worldviews and value systems, (b) be willing to expand their knowledge base about cultural diversity, and (c) develop competencies in cross-cultural communication and culturally sensitive helping approaches (Sue, Carter, Casas, et al., 1998).

Morita therapy is a Japanese comprehensive psychotherapeutic system, developed by a psychiatrist named Shoma Morita (1874-1938) around 1920, as a therapy designed specifically for understanding and treating *shinkeishitsu* (nervous) type clients. It has been best known for its four-stage residential activity-based program for treating neurosis (Goto, 1988; Miura & Usa, 1970, Reynolds, 1976). Recent years have seen increased use of outpatient Morita therapy and its modified applications in Japan and abroad (Fujita, 1986; Ishiyama, 1988).

While Morita therapy has generally been regarded as a culturally embedded model of mental health, it has been argued that Morita and other indigenous therapies offer meaningful perspectives on, and alternative conceptualization of, mental health issues. Researchers have discussed its culturally unique perspectives on self, anxiety, client change process, therapist role, and therapeutic relationship (Ishiyama, 1986a, 1986b: Ives, 1992; Reynolds, 1976). Morita therapists in the West (Alden & Ishiyama, 1997; Ishiyama, 1990, LeVine, 1993; Ogawa, 1988; Reynolds, 1984) have uniformly argued that Morita therapy is not only a culturally fit approach for Japanese clients but also a viable and complementary helping model for other Asian and Western clients. They have indicated that Morita therapy is a meaningful alternative to Western talking therapies, many of which tend to focus on self-reflection and insight, control of symptoms, and enhancement of self-esteem. A Morita-based counselling model and intervention strategies have been suggested with technical modifications and cross-cultural considerations (Ishiyama, 1991, 1994).

Two areas have received insufficient attention in the literature: (a) articulation of what are culturally and conceptually unique aspects of Morita therapy and how they challenge the mainstream counselling traditions and present a different paradigm, and (b) illustration of how the Moritian principles may be translated into concrete interventions and helping skills in the Western counselling context. Although not intended to be comprehensive, the present paper focusses on the following eight key features of Morita therapy: (a) theory of the *shinkeishitsu* (nervous) trait, (b) multiple-dimensional model of causes and treatment of *shinkeishitsu* neurosis, (c) theory of mental attachment, (d) reframing anxiety into constructive desires, (e) emphasis on action taking and experiencing, (f) restoration of balance in mental activities and attentional focus, (g) four-stage residential Morita therapy, and (h) a discussion on how counsellors contribute to client suffering and symptom aggravation. Concrete examples of Moritian intervention responses are offered at the end for the purpose of illustrating how Western counsellors might incorporate Moritian ideas into their practice.

UNIQUE ASPECTS OF MORITA THERAPY

Some people are prone to excessive introspection and affective ruminations. However, in Morita therapy, analyzing the past and identifying unconscious dynamics is considered to prolong self-focus and intensify subjective sufferings for certain types of clients (i.e., *shinkeishitsu*) who are predisposed to hypersensitivity

to subjective discomfort and perfectionistic self-expectations. Instead of reinforcing affective ruminations, clients are given alternative activity-focused instructions so as to direct their attention away from affective ruminations toward external events and necessary action in Morita therapy.

Shinkeishitsu Theory

Morita (1928/1974) developed a psychiatric classification system, and coined the term "*shinkeishitsu*" or "a nervous trait" to identify a group of related types of neurotic sufferings and symptoms mediated by certain common psychological and psychosomatic/somatopsychic processes. This class of neurosis has recently been called "Morita *shinkeishitsu*" among Japanese psychiatrists. It takes various forms, such as phobic obsessions, anxiety, avoidant behaviours, panic attacks, hypochondriasis, and related somatic problems (Goto, 1988; Miura & Usa, 1970). These roughly correspond to anxiety and panic disorders and somatoform disorders, based on the Diagnostic and Statistical Manual of Mental Disorder (DSM-III) (Mori & Kitanishi, 1984). Morita (1928/1974) indicated that his therapy was specifically designed for treating *shinkeishitsu* patients who fit such diagnostic criteria, and therefore, careful client selection was a prerequisite for successful and ethical practice.

Kora (1976) differentiated between *shinkeishitsu* as a trait and *shinkeishitsu-sho* (*shinkeishitsu* neurotic symptoms) to avoid confusion, and indicated that not all nervous individuals develop *shinkeishitsu* neurosis. *Shinkeishitsu* persons can overcome their neurotic sufferings, and live productively without changing their nervous dispositions. Following Kora's distinction, I shall use "*shinkeishitsu* neurosis" in this paper.

Multiple Causal Factors

Morita (1928/1974) considered that neurotic sufferings and anxiety disorders resulted from a combination of predispositional, cognitive, behavioural, and attitudinal factors. In essence, contributing factors to the formation of *shinkeishitsu* neurosis include: (a) nervous predispositions, such as affective hypersensitivity, anxiety-proneness, excessive introspectiveness, and a tenacious or obsessive trait; (b) perfectionistic, dogmatic, and idealistic cognitive tendencies (e.g., high standards for oneself and one's ability to self-control) which heighten one's proneness to inner conflicts and self-criticism; (c) introspective and self-monitoring focus of attention; (d) unproductive behavioural patterns and resulting lifestyles characterized by symptom-controlling attempts and anxiety-avoidance; and, (e) accidental or circumstantial factors and critical incidents (e.g., teasing and criticism by others, being put in the centre of public attention) that induced intense and painful awareness of certain aspects of self (e.g., blushing, body odour, facial features, bodily hair). Morita and recent researchers have argued from a developmental perspective that adolescence is a period of heightened self-awareness and marks a common onset of neurotic symptoms among those with a *shinkeishitsu* predisposition.

This is a multi-dimensional model of conceptualizing *shinkeishitsu* neurosis, and Morita therapy should not be classified simply as a Japanese version of cognitive therapy or as a trait factor model. Further, it should be noted that Morita therapy has a unique philosophy about human nature and personal growth with a strong Japanese and Buddhist cultural influence (Kondo, 1992; Suzuki & Suzuki, 1977). It is not a neutral and value-free system of psychotherapy.

Theory of Mental Attachment

Toraware. In Morita therapy, as in Zen Buddhism training, mental preoccupations and affective ruminations are regarded as obstacles to experiencing the here-and-now fully (Kondo, 1992). Morita's theory of mental attachment is one of the foundational premises of his *shinkeishitsu* treatment approach (Kora, 1976). Clients' sufferings, such as inner conflicts and escalated somatic reactions, are believed to result from the process of *toraware. Toraware* is a Japanese word for mental attachment or a blocked flow of attention and mental energy, due to cognitive rigidity and preoccupations with certain aspects of physical and mental experience (e.g., anxiety symptoms, obsessive or dogmatic ideations, imagined criticisms by others). Although humans are prone to mental attachments, prolonged and intensified *toraware* is viewed as pathogenic. Reducing *toraware*, therefore, is one of the critical turning points in clients' therapeutic progress in Morita therapy. Living without *toraware* means being free from preconceptions and narrow and rigid ways of experiencing self and the world. It means becoming open to new experiences in each moment, allowing a spontaneous flow of thoughts and feelings without dwelling on them, and living and experiencing self and the environment fully in here and now.

Arugamama. The opposite concept of *toraware* is *arugamama*, which may be described as "as-is experiencing and embracing reality." *Arugamama* is a person's lifestyle and attitude of embracing reality as it is without resistance or manipulation, accepting self as one experiences oneself, and living fully in here-and-now. It is a natural and unguarded stance or freely breathing relaxed style emphasized in many Japanese martial arts, compared to rigid, deliberate, and guarded stance. The former corresponds metaphorically to a willow tree bending and flowing with winds and still remaining alive and rooted in the ground. Achieving *arugamama* or an as-is stance of being fluid with vicissitudes of affective experiences and circumstantial challenges is considered the ultimate goal of Morita therapy (Kora, 1976; Morita, 1928/1974). A similar Japanese concept, *sunao* or "being uncomplicated" has also been used in the Morita literature to refer to an attitude of seeing things as they are and obeying the flow of human nature. Although both *arugamama* and *sunao,* casually used in people's daily conversations, are important clinical concepts in Morita therapy, therapists refrain from presenting such mental conditions to clients as goals to strive toward because of the danger of clients becoming preoccupied with such psychological states and losing sight of concrete tasks at hand.

Imposing dogmatism ("shoulds" and "shouldn'ts") and rejecting reality. Persistent fixation blocks an otherwise natural flow of our mental energy and activities. For

example, having a nervous personality or anxiety and other affective reactions is not a problem, but becoming preoccupied with such things is. Rejecting a gap between reality (e.g., how one experiences oneself) and ideality (e.g., how one thinks one should be or should feel) can form a cognitive platform for neurotic fixation and critical self-focus. The latter impedes a natural flow of energy and disturbs a fluid balance between introverted and extraverted attention in daily life.

Negotiating with the unnegotiable. Torawareoccurs at cognitive, affective, and behavioural levels, largely due to biased beliefs about anxiety and human nature and rejection of the negatively perceived personality traits and mental states. That is, clients misguide themselves to believe that certain psychological conditions and emotions (e.g., anxiety, fears, diffidence, indecision, inner conflicts, sexual and aggressive impulses and fantasies, dislikes and lack of gratitude toward certain individuals) are unacceptable or even abnormal, and that their inability to change such inner experiences and physiological symptoms is shameful and reflective of their character flaw. This sets off a self-defeating cycle.

For example, clients anticipate that the anxiety symptoms will get worse unless they control the symptoms now and willfully. Failure to do so escalates their anticipatory anxiety and they invest their energy further into a war with anxiety, as if anxiety control was a prerequisite for productive action and meaningful life. Through inaccurate social comparison, clients mistake others' lack of *overt* display of similar undesirable affective states as a proof that others do not *covertly* experience such thoughts and feelings. This false attribution renders themselves unusually and abnormally anxious or disturbed by inner conflicts, compared to other ordinary people.

Reframing Anxiety into Constructive Desires

In Morita therapy, the experience of anxiety is normalized and depathologized. Clients are helped to recognize the existential meaning of anxiety and its underlying self-actualizing desires.

The Morita therapist uses a non-judgmental stance toward human emotions. That is, there is no right or wrong emotion; emotion simply is. What is problematic is how emotion is handled. *Shinkeishitsu* clients judge certain affective reactions as undesirable or abnormal, and become critical and ashamed of themselves for having such emotional reactions. They escalate their initial anguish into an inner conflict and a psychological preoccupation by trying to control the undesirable affective reactions and then further criticizing themselves when they fail to do so. Morita (1928/1974) called it a process of "doubling and tripling the original suffering." In order to appease such a self-defeating process, the Morita therapist emphasizes that anxiety and other inconvenient feelings are normal and human beyond our preferences and judgments. Anxiety is presented not only as an inevitable companion of human existence but also as a reflection of clients' healthy and strong desires to live fully and in good health and to seek happiness, meaning, success, and accomplishments. Without such human desires, there is no anxiety. In addition, with our inability to control or predict future events, we

are always facing the unknown and may feel that the resulting fears and uncertainties are unconditionally acceptable. In fact, no further tampering or manipulation is needed, and these fears need to be simply accepted as they are. However, *toraware* or resistance to the spontaneous experience of anxiety becomes problematic, as discussed above.

The Moritian reframing method (i.e., "positive reinterpretation technique," Ishiyama, 1986b) offers clients an entirely new perspective and an opportunity to validate their healthy self. In this, anxiety and desire are presented to clients as two sides of the same coin. One does not exist without the other; behind every fear or anxiety, there is a desire. That is, behind the fear of death, we find our tenacious desire to live. Because we desire for social acceptance and success, we also experience fears of social rejection and failure. Denying anxiety means denying the corresponding desire. In Morita therapy, the notion of "desire for life" or *sei-no-yokubo* in Japanese (i.e., spontaneous interest in constructive activities and a wide range of health-related, interpersonal, career, educational, financial, and spiritual desires and wishes) plays a critical role in both theory and practice.

In Morita therapy, the desire side is brought to client attention, and concrete ways of actualizing such desires are explored. Instead of engaging clients in intellectual introspection and philosophical reflection, the therapist encourages them to recognize necessary daily chores and activities as well as short and long-term personal projects which contribute to the fulfillment of their desire for life. When clients recognize the evidence of strong and healthy desires and personal goals within themselves, their attention and energy begins to flow more into concrete and practical ways of actualizing personal goals. This process of engaging in purposeful activities gradually disengages clients from habituated self-preoccupations and avoidance of anxiety-provoking situations. Instead of reinforcing clients' self-pathologizing beliefs and misguided attempts to change their anxious nature and the symptoms of anxiety, the Morita therapist aims at bringing about and empowering the healthier side of clients' anxious nature.

One of Morita therapy goals is to help clients recognize their healthy desires to be active and productive in life. This goal is achieved by activating clients' ability and responsibility to choose action and engage in constructive activities in spite of anxiety and "other inconvenient feelings and life situations" (Ishiyama, 1990a).

Emphasis on Action Taking and Experiencing

Morita believed that dogmatic, perfectionistic, and self-abnormalizing thinking is at the base of *shinkeishitsu* clients' futile monitoring and tenacious attempts to re-shape their anxious self and remove the nervous symptoms at all cost (Fujita, 1986; Kora, 1976; Morita, 1928/1974). Although the theory of mental attachment has a strong cognitive component, excessive attention to the subjective process during therapy could further reinforce this type of self-preoccupation. In Morita therapy, freeing clients from the state of *toraware* becomes a critical point in therapeutic progress. Rational and persuasive interventions are regarded as counterproductive with clients who are deeply entrenched in their self-abnormalizing belief systems or those who display overly intellectualizing and

introspective tendencies. Instead, the Morita therapist offers a "doing therapy" mode rather than a talking mode.

The initial intervention goal is to reduce clients' heightened and selective self-focus and symptom ruminations. Their energy is redirected toward "what they can do and choose" and away from futile attempts at changing non-negotiable covert conditions and physiological reactions (e.g., anxiety, fears, obsessive ideations, and somatic symptoms). Further, heightening client awareness of and self-immersion in practical tasks is considered helpful to expand their behavioural repertoire and output in daily life. This in turn generates new experiential data that would challenge clients' dogmatic beliefs and assumptions. Moritian interventions are designed to mobilize clients' active and mindful choice of action for practical and constructive purposes.

Restoring Balance.

As in the traditional Chinese medicine that regards illness as a consequence of imbalance between the yin and yang energies, mental health in Morita therapy is conceptualized as a result of maintaining a fluid balance among thinking, feeling, and action, and between introverted and extraverted mental energies. Figure 1 summarizes the areas of balance restoration in Moritian interventions. *Shienkeishitsu* clients have overactive mental activities shown in the left column, and Morita interventions are designed to activate and reinforce those in the right.

In short, the Morita therapist recognizes, and tries to mobilize, clients' self-balancing and inner healing capacity and spontaneous interest in concrete and constructive activities. That is, when affective symptoms are left alone and not

FIGURE 1
Balance to be restored through a Morita intervention

self-focus	———	activity-focus
reflecting/analyzing	———	direct experiencing
focus on anxiety/fears	———	focus on constructive desires
resisting anxiety	———	surrendering to anxiety
idealism/dogmatism	———	realism/pragmatism
self-criticism	———	self-acceptance
affect monitoring	———	action monitoring
affective self-control	———	behavioural self-control
anticipation	———	spontaneity
avoidance/defense	———	immersion/risking
willful healing attempts	———	resorting to natural self-healing

tampered around with and when clients immerse in concrete and practical activities, their attention begins to flow spontaneously to external events. The previously self-defeating chain of affective, cognitive, and behavioural reactions begins to be replaced by a more productive one. Clients also begin to enjoy the simple pleasure of achieving chores and a positive sense of accomplishing practical goals. Through active choice of action, their resilience also increases in coping with imperfect and previously avoided psychological conditions and anxiety reactions.

Residential Morita Therapy

I consider that the structure and therapeutic principles of residential Morita therapy offer a culturally and theoretically unique perspective, and deserve further attention in this paper.

The residential mode of Morita therapy most clearly reflects the principles underlying Morita's residential and outpatient strategies. Morita's residential method departs from many Western therapies which tend to emphasize emoting, talking, analyzing, and symptom-controlling activities within therapy sessions curtailed for each individual client. The four-stage model reflects Morita's logical and strategic design for re-conditioning clients' self-focused attention and other mental activities and for dismantling a symptom-aggravating vicious cycle. Although ordinary counsellors may not deal with intensely phobic or obsessive clients or those who cannot conduct normal living tasks, understanding the residential treatment principles would be helpful in recognizing various ways of applying Morita therapy to outpatient and counselling contexts of helping.

Four stages of residential treatment. Inpatients move through four stages: (a) absolute bed rest (b) light work, (c) demanding work, and (d) social reintegration (Fujita, 1986; Goto, 1988; Kora, 1989). The internal and external directions of attention and awareness become more balanced as inpatients move through these stages. The experience of a week-long bed rest in the first stage is characterized by a relief from mental and physical stress in daily life, physiological rest, re-emergence of self-generated inner conflicts, and eventual boredom of being idle. The latter stimulates a new flow of attention and a spontaneous and heightened interest in getting out of the bed and engaging in even the simplest physical activities. A diary commentary technique is used to monitor clients' daily activities and their thought processes and to offer therapist feedback and Moritian guidance. It is used as a means of communication with the therapist, without relying on lengthy and individualized interviews.

When patients enter the second stage, they begin to engage gradually in uncomplicated tasks and activities, such as walking, touching the soil, observing natural phenomena in the garden, and watching other patients do chores around the hospital compound. The participatory nature and demand level of assigned tasks increase over time during the third and fourth stages. Their practical thinking and extraverted attention are increasingly required for performing more complicated tasks, such as: looking after plants and pets, cleaning, fixing broken

furniture, calligraphy work, cooking, grocery shopping for the hospital, and organizing residential entertainment and outing events, among other things. Commuting to school or work using public transportation, for example, are initially challenging to agoraphobic or social phobic patients and those with obsessive fears during the social reintegration stage.

While being action-focused and purpose-minded with such tasks, patients are instructed simply to persevere with the vicissitudes of emotional conditions and inner conflicts and leave the *shinkeishitsu* symptoms as they are without fighting. They are encouraged to evaluate themselves and assess their therapeutic progress not by the degree of symptom suppression but by their efforts to engage in practical tasks in spite of the symptoms.

Re-conditioning of fixed and self-focused attention. In the process of shifting from self-focus to activity-focus, *shinkeishitsu* patients' introverted attention and symptom-aggravating patterns gradually become more balanced with externalized and detailed attention to behavioural tasks, leading to complete immersion in a task at hand and forgetting the symptoms. While persevering with inner turmoil and anxiety symptoms, Morita patients engage in concrete and productive tasks as described above. As they achieve concrete tasks in spite of the symptoms, clients begin to experience rewarding feelings of joy and satisfaction and develop resilience and self-efficacy in their ability to carry out chosen tasks, without being controlled or victimized by the symptoms or moods.

Limitations and challenges of outpatient and counselling applications. The outpatient mode of Morita therapy and its counselling applications obviously differ from residential Morita therapy. While the latter offers a well-structured milieu therapy, the former fundamentally lacks the temporal and spatial continuity in working with clients and monitoring their progress (Ishiyama, 1996). Nor does it have the same degrees of "treatment strength, integrity, and effectiveness" (Yeaton & Sechrest, 1981) or the positive modeling effects of other inpatients and the staff.

Some researchers have pointed out its culturally shaped social hierarchy and interaction modes among staff and inpatients and the formation of a teacher-student-like therapeutic relationship characterized by patients' unconditional respect for doctors as authority figures and their willingness to become learners of the therapist's life wisdom (Ives, 1992; Reynolds, 1976). Ishiyama (1991) has indicated potential problems with applying a directive outpatient method with Western clients and a younger generation of Japanese clients, and has proposed technical and conceptual modifications.

COUNSELLING IMPLICATIONS AND MORITIAN INTERVENTION RESPONSES

Counsellor Contribution to Client Suffering and Symptom Aggravation

Ishiyama (1990a) has pointed out how counsellors might contribute to clients' anxious self-preoccupations and persistent attempts at resisting the experience of anxiety by rejecting their anxiety-prone personality trait. He has sited

counsellors' four major counter-therapeutic attitudes that exacerbate clients' inner conflicts and self-rejection, as follows: (a) selective acceptance of emotion, (b) feeling-controlling approach, (c) not allowing feelings to change spontaneously, and (d) counsellor avoidance of confronting clients when clients are neglecting their choice of action and avoiding the responsibility for its consequences.

Counsellors generally try to help clients achieve certain positively regarded psychological conditions, such as being anxiety-free, relaxed, happy and content with self, self-motivated, energized, self-confident, and enjoying high self-esteem. These are often associated with positive indices of Western mental health. On the other hand, anxiety, tension, nervousness, inner conflicts, depression, self-doubt, diffidence, and low self-esteem are treated as undesirables in restoring mental health and achieving personal well-being and a productive lifestyle. Therefore, clients almost invariably ask for help to achieve these positive mental states and to eliminate the undesirables.

Symptom-aggravating Common Counsellor Responses

From a Moritian perspective, we need to re-consider how counsellors might inadvertently promote clients' self-focus and symptom aggravation during helping interviews. Certain counsellor responses have embedded messages to pathologize or criticize the presence of anxiety and related mental conditions. Such responses may also be reflective of counsellors' own attitudes and theoretical perspectives, or indicative of their professional and cultural encapsulation that promotes the rejection of anxiety and other inconvenient feelings and the promotion of control over the affective self. Resultantly, clients internalize such counsellor attitudes, and reinforce their own self-preoccupations and controlling attempts. Here are some examples of common counsellor responses:

Don't worry.
Cheer up.
Be strong, and don't get nervous.
Relax. Calm down. Take it easy.
Why are you so anxious? Where does your anxiety come from?
. . . (referring to action), *but* you did it so nervously.
Can you make yourself feel more at home?
Think positively. You'll feel more self-confident.
Next time, try not to feel so uptight.
Good! You didn't feel anxious this time.
Concentrate. Don't get distracted.
Persistent probing with "Now, how are you feeling? Do you still feel anxious?"

Examples of Brief Moritian Intervention Responses

Eight examples of Morita-based counsellor responses are offered below, for the purpose of illustrating how Moritian counsellors might respond to *shinkeishitsu*-type clients' hypothetical comments. These illustrations are presented to help

readers recognize a variety of verbal and instructional interventions, without giving specific descriptions of the helping context or client backgrounds. It may be assumed these intervention responses are made after sufficient empathic problem exploration and establishing good working alliance, as described in a Morita counselling model (Ishiyama, 1990b).

Embracing a nervous personality trait. Counsellors may introduce the notion of the *shinkeishitsu* trait as a predisposition, and encourage clients to surrender to this non-negotiable reality and look for creative ways of making use of it.

CT: I really resent my anxious personality. This has been a huge obstacle all my life. I wish I could be reborn as someone different.

CR: Can we look at it as something you were born with? Then, all you need is just accept it as it is. It's exhausting to keep fighting something that you can't change. How else could you use your energy in order to improve the quality of your life? . . . Can you see anything positive in this trait? If so, how would you use it for good purposes?

Normalizing anxiety and other inconvenient feelings. Neurotic self-preoccupations often begin with clients' regarding something normal as abnormal and unacceptable. Counsellors may help clients de-pathologize anxiety and other ego-threatening subjective experiences.

CT: It's so immature of me to get nervous about something so small like a parent-teacher meeting. I can't calm myself. I keep worrying about getting negative feedback on my child's school performance.

CO: You care a lot about your child. I would worry, too. There are many things in life that we cannot predict or easily control. Then we get anxious. We expect or hope for good things to happen to us; we also worry that things won't go that way. That's you and me. It seems as long we live, we are surrounded by anxieties. Maybe, anxiety is a good sign that we are alive and facing new situations daily.

Recognizing personal goals and re-ordering priorities. Clients place a higher priority on managing certain mental conditions as a prerequisite for moving to the next action stage. They do so at the expense of engaging in more constructive alternative activities. However, they are dissatisfied with their lack of productivity and maintain a strong desire for self-improvement. They also wish for achieving certain goals. They complain that a certain covert condition prevents them from engaging in a necessary activity. They request that it be put under control urgently as a pre-requisite. Counsellors may confront such clients as follows:

CT: I need to feel calm and clear-minded before I study for an exam. But I worry, and start thinking of other things. Why can't I make myself concentrate on studying right away?

CO: You want to study and prepare yourself for an exam. It's important that you do well at school. However, can you really afford to wait for the right mental condition to arrive? Another option would be, while feeling anxious and

distracted, you physically place yourself at a desk, open a text, and start reading it and taking notes. You just leave mental concentration and interest to a natural flow of ups and downs.

Reframing anxiety into constructive desires. In Morita therapy, clients are encouraged to accept anxiety and recognize its underlying constructive desires. Counsellors may bring anxiety-rejecting clients' attention to "the other side of the same coin" (Ishiyama, 1986b, 1990a) as follows:

CT: Every time I want to speak up in class, I get such a strong anxiety reaction! I worry about stuttering and looking nervous. Show me how to control it, so that one day I will feel more relaxed like other students.

CO: Such a strong energy in you! Social anxiety and social desire go hand in hand. It's important to express yourself and be appreciated by others. Instead of waiting for anxiety to go away, how about acting on your desire? Take anxiety as a cue for action.

Promoting choice over action, and not emotion. Perfectionistic clients with unrealistic self-expectations often trap themselves in unsuccessful attempts at controlling anxiety and other negatively judged mental conditions. Counsellors may help such clients recognize that they can choose action more readily and easily, and that they also need to take responsibility for the consequences of the choice of action or inaction.

CT: I was so nervous and scared that I couldn't knock on the professor's door to ask questions about the homework. Now, it's too late, and I don't even feel like studying.

CO: You needed to ask important questions about the assignment. When you felt scared, you chose not to knock on his door. Now, you don't feel like studying, but you want to do well in the course. What can you choose to do now, in spite of such a feeling? Or, would you rather choose not to do anything about it?

Allowing subjective states to flow. A static view on our affective experience is that it stays the same in intensity and content. Instead, we can take a fluid view that our emotions and psychological states go through numerous spontaneous changes throughout the day reflecting the situations and activities in which we are engaged. Clients' unrealistic demands of self-control are sometimes reflected in their use of adverbs and adverbial phrases coupled with verbs (action words), such as "perfectly," "willingly," "confidently," and "without hesitation." I call these "*killer adverbs*" because they defeat the value of action by setting an unrealistic performance goal. Counsellors may encourage clients to surrender to the fluidity and spontaneity of subjective experiences with simple acceptance, and instead redirect their judgment and choice over their own action.

CT: Why can't I stay calm and relaxed when I work with difficult and aggressive customers? I need to deal with my clients more comfortably and confidently. Until then, I always have to ask my colleague to take over in such situations.

CR: I wonder if you can face such customers *anxiously and nervously* and focus on doing your best in listening to their requests and offering your service. Would you not want to take a first step this way, rather than give it up entirely? Feelings come and go, and anxiety does not stay at its peak forever.

Focusing on tasks and activities. Shinkeishitsu clients often exercise finely tuned sensitivity to their subjective states and symptomatic reactions, but their attention to the outside (e.g., behavioural tasks, needs of the situation, and feelings of others) is narrowed and limited. Counsellors may help such clients increase their focus on activities and objective situations and decrease self-focus and anxiety-controlling behaviours, by asking re-focusing and externalizing questions.

CT: I couldn't make myself feel excited and enthusiastic like other participants of the meeting today. I felt tired, bored, uninvolved, etc. I often feel like an outsider looking in during those meetings. I dread going to another one tomorrow.

CO: Do you remember who was at the meeting, how they were dressed, and what they were saying? Was there any agenda item that was related to your role at work? . . . When you started feeling bored and uninvolved, where was the discussion going? Who was saying what? If you had stated an opinion then, what would it have been? Could pay attention to these things tonight? I'll ask you the same questions in our next session.

Validating personal resilience and commitment to constructive action. The use of "*killer adverbs*" as discussed above minimizes clients' sustained effort to persevere through difficult moments and engage in desirable action for a constructive purpose. Instead of focusing on affective imperfections and reinforce client perfectionism, counsellors may amplify clients' commitment to taking constructive action and perseverance, as follows:

CT: It took all of my courage, and I spoke up finally in class. But I was still nervous and it didn't come easily. How come I can't speak up freely and comfortably?

CO: You felt nervous and uncomfortable, *but* you spoke up. This is what counts. Anxiety did not stop you from doing what you wanted to do. It was tough, but you stayed on task and did not lose sight of it.

LIMITATIONS AND CHALLENGES OF COUNSELLING APPLICATIONS

Outpatient applications have technical limitations and depart from the original method, as widely acknowledged among Morita therapists in Japan (Ohara, 1977). Interview-based outpatient models, including a counselling model (Ishiyama, 1990b), cannot replicate the more powerful and comprehensive residential Morita therapy. Instead, outpatient Morita interventions need to rely heavily on: (a) a therapeutic dialogue (i.e., talking therapy), (b) client observation mostly during interview sessions, (c) monitoring client progress based on self-reports, (d) behavioural instructions for out-of-session activities, and (e) formation of relationship-based therapeutic alliance. However, the use of outpatient

Morita therapy has increased over the years due to the reasons of financial stress, time commitment, health care policies, client preference, and availability of residential Morita treatment facilities, among other factors (Ishiyama, 1988).

On the other hand, such limitations also serve as invitations to innovations and conceptual re-formulation in practicing Morita therapy in a multicultural social context. Alfonso (2002) has indicated the value of Morita-based psychoeducational interventions. She concludes, "Morita therapy can be used as a brief psychotherapy intervention model for facilitating clients' journey through life with anxiety. The reframing of anxiety and the notion of responsibility for action taking can allow patients to move beyond their habitual patterns and to make constructive changes that may generalize to other areas of their lives" (p. 4).

CONCLUSION

I have explored selected features of Morita therapy to discuss its culturally and theoretically unique perspective on helping *shinkeishitsu*-type clients, and given illustrative Moritian intervention responses. I believe that multicultural helping professionals can expand and enrich their understanding of cultural diversity in terms of its philosophical outlook on human nature, conceptualization of mental health and personal well-being, and change process. Further, the Moritian perspective can help practitioners re-examine their own clinical practices and intervention strategies as well as their personal attitudes toward anxiety and control issues.

For example, Westwood (2002) observed that Morita therapists "have the clients move into action or to a 'doing' phase rather than sensing or reflection" (p.2). A First Nations counsellor educator (McCormick, 2002) has recognized the following three key features of Morita therapy that would be useful for Native and Western counsellors: (a) positive reframing of anxiety, (b) experiential nature of Morita therapy to mobilize clients from a thinking mode to an experiencing mode, and (c) therapeutic goal of restoration of balance in living.

It is my hope that readers will recognize the conceptual and technical uniqueness of Morita therapy, not merely from a cross-cultural perspective but from a personal and professional viewpoint to reflect on their treatment of anxiety and other "inconvenient feelings." It is hoped that readers find the above illustrations of Moritian responses helpful in incorporating Morita therapy approach into their own clinical practice. It has been my experience that many Asian clients readily appreciate many of its concepts and underlying philosophy on human nature. With some creativity in presenting Morita concepts and suitable technical modifications to clients (see Ishiyama, 1990b, 1991), I have found Western mainstream clients also receptive to Moritian ideas and interventions.

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