The Concept of Self in Mindfulness-Based Cognitive Therapy and Morita Therapy

**The Similarities and Differences in the Therapeutic
Mechanisms, Philosophies, and Methods**

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in partial fulfillment of the
A.B. in Contemplative Psychology
Brown University
April 15, 2013

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Introduction

What is the Self?

Understanding the nature of the self has been one of the most prominent issues in psychology, philosophy, and many religions in the world. In this thesis, ‘the self’ can be thought as the reflective object of one’s own consciousness, or any thought processes and conceptualizations that involve the ‘I,’ ‘me,’ ‘mine,’ or ‘myself.’ Why study the self? There are a few possibilities that I can picture as to why people study the self. One reason may spring from the innate, human curiosity, from the existential to neurophysiological frames of reference – we want answers to why we are the way we are. Another may be for religious or spiritual reasons – to question the intrinsic nature of our existence and our relationship to divine forces. His Holiness the Dalai Lama, in his *The Universe in a Single Atom – The Convergence of Science and Spirituality*, explains that in the Pali canon of Buddhism, the question of the self occupies eight of the fourteen ‘unanswered questions’:

- Are the self and the universe eternal?
- Are the self and the universe transient?
- Are the self and the universe both eternal and transient?
- Are the self and the universe neither eternal nor transient?
- Do the self and the universe have a beginning?
- Do the self and the universe have no beginning?
- Do the self and the universe have both beginning and nor no beginning?¹

In the context of psychology, understanding the self leads to distinguishing what is normal and what is abnormal (i.e. pathological) in the subjective experience of the human mind. Such distinction (in the sense of two poles on a continuum, rather than a complete dichotomy) helps to develop methods of psychiatry and psychotherapy to treat those who are suffering in their subjective experience.

There are a multitude of paradigms of the self – of what it entails and how it’s constructed – across cultures, history, and intellectual disciplines. What the self means to a contemporary neuroscientist who studies the neural and biophysical mechanisms of self-awareness, may be quite different from how an 18th century philosopher would conceptualize it. However, regardless of the historical and cultural contexts, the various paradigms on the self can often be placed somewhere on a spectrum between the two poles of the ‘universalist’ view and the ‘social constructivist’ view.

The universalist view, in its most extreme case, would argue that the conception of self is constructed in a way that is common to the human species – to all people across cultures.² This view would be compatible with scientific naturalism, where human nature

¹ His Holiness the Dalai Lama, *The Universe in a Single Atom – The Convergence of Science and Spirituality* (New York: Three Rivers Press), 77-78.

² Donald Rothberg, “Contemporary Epistemology and the Study of Mysticism,” *The Problem of Pure Consciousness*, ed. Robert Forman (New York: Oxford University Press, Inc., 1990), 163-202.
(This ‘universalist’ view on the self is implicit in the ‘pure consciousness’ view of mystical experience.)

and experiences are reduced into physical, biochemical, and neurological substances and mechanisms, and do not take into account socio-cultural influences.

At the other end of the spectrum, in the social constructivist view, the self is constructed entirely in relation to socio-cultural contexts.³ An individual's race, gender, family, culture, education, socio-economical status, and age would be the contributing factors to shaping the self. In this view, the conception of self in an American teenage boy from New York would have little in common with that of an old Japanese female peasant from the Feudal period.

Through my research for this thesis, I have come to argue that the truth lies somewhere in the middle. There is a certain aspect of the self that is common to all human beings. The neurophysiological mechanism of self-awareness, cognitive processing of self-relevant information, and psychological construction of personal identity through linking past subjective experiences across time and pursuing future aspirations are all examples of what constitutes the inner layer of the self shared in human experience across cultures. There is also an outer layer that is subject to socio-cultural modulations. This layer of the self is constructed inter-relationally and socially, and may be closely related to what the social psychologists may call social identity – the sense of self that is developed over time as one participates in social life and identifies with others.⁴

One of the main objectives of this thesis is to consider these similarities and differences of the self across cultures by comparing two different therapeutic methods – both of which rely on the mindfulness practice as its primary therapeutic means. Comparing two cultural spinoffs of mindfulness-based psychotherapy, such as Mindfulness-based Cognitive Behavioral Therapy in the West and Morita Therapy in Japan helps to elucidate this point.

Morita Therapy is a form of mindfulness-based (although not explicitly labeled so) psychotherapy developed in the 1920's by a Japanese psychiatrist Shoma Morita. This form of psychotherapy was shaped by the principles of Zen Buddhism, and still holds a notable clinical reputation in Japan today, despite the trend in the importation of western psychiatric methods. In the West, a recent trend towards eastern philosophies, particularly towards the integration of Buddhism and empirically supported therapeutic approaches, has given rise to what has been referred to as the third wave in psychology: acceptance-based, or mindfulness-based behavioral approaches. Mindfulness-Based Cognitive Behavior (MBCT) is among one of these approaches, alongside Dialectic Behavioral Therapy (commonly used for borderline personality disorder), Acceptance and Commitment Therapy, and Mindfulness-Based Stress Reduction.⁵ Comparing Morita therapy and MBCT, we see striking similarities between the two psychotherapeutic approaches, despite the discrepancy in historical and cultural contexts of which they were developed. To my knowledge, there hasn't been explicit communication between the two; if you ask an MBCT therapist if he has heard of Morita therapy, there is a good

³ Steven Katz, "Language, Epistemology, and Mysticism," *Mysticism and Philosophical Analysis*, ed. Steven Katz (New York: Oxford University Press, Inc., 1978), 22-74.

(The social constructivist view of the self is implicit in the constructivist stance on mystical experience.)

⁴ John P. Hewitt, *Self and Society: A Symbolic Interactionist Social Psychology 7th edition* (Boston: Allyn & Bacon, Inc., 1997).

⁵ Morita Therapy, *The Morita School of Japanese Psychology*, <http://moritaschool.com/content/morita-therapy> (Apr. 13, 2013).

chance he will say no. The striking similarities in their philosophies and methods, however, may suggest that within the self there is an inner layer constructed similarly in people across cultures – the layer of which the mechanism of mindfulness operates at the neurological, psychological, and cognitive levels.

Mindfulness is an umbrella term used across various contexts such as theoretical construct, psychological process, and practice. However, I interpret from various resources that a basic definition of mindfulness would be “moment-to-moment awareness”.⁶ The various cultural and clinical interpretations of mindfulness will be further elaborated in Chapter One, where I also argue that mindfulness is an inherent capacity of the human mind regardless of one’s culture. Being mindful is to be aware of your mental and bodily experiences as they are occurring – the opposite of being ‘mindless’.⁷

Mindfulness and the Self

The relationship between one’s mindfulness and one’s self is bridged by one’s experiences; the conception of self is shaped through a unification of past experiences but mindfulness enables one to relate to each of those experiences in a unique way. Mark Epstein, a psychiatrist informed in both psychoanalysis and Buddhist psychology, contends that mindfulness is “a pivotal ingredient, the catalyst for a profound change in the way self is experienced”⁸...it is this practice that focuses attention on the self-concept and that teaches a different way for one to experience feelings.”⁹ He further explains,

With the mindfulness practices come a shift from a spatially based experience of self into a temporal one...mindfulness practices tend to reveal another dimension of the self-experience, one that has to do with how patterns come together in a temporary and ever-evolving organization.¹⁰

It is a common view in psychology that a sense of self arises out of the continuity in one’s experiences across time. John P. Hewitt, a social psychologist, states that the self is a biographical object in which “one becomes an object shaped by one’s experience as a whole.”¹¹ However, mindfulness practices allow us to reevaluate this view; the sense of self not only has a conceptual element of a ‘continuous narrative,’ but also carries a sense of ‘fluidity’ that arises out of each momentary experience. “The mindfulness practices cultivate the ability to surrender into the moment, and they elasticize the sense of self by emphasizing its inherent fluidity.”¹²

The Self as Experience and Narrative

William James was one of the earliest figures to emphasize the experience of continuity as an integral part of the self. He conceptualized the “self” as “a source of permanence beneath the constantly shifting set of experiences that constitute conscious life...often related to the construction of narratives that weave together the threads of

⁶ Jon Kabat-Zinn, *Full Catastrophe Living* (New York: Bantam Dell, 1990), 2.

⁷ Mark Epstein, *Thoughts Without a Thinker* (New York: Basic Books, 1995), 142.

⁸ Ibid.

⁹ Ibid., 96.

¹⁰ Ibid., 142.

¹¹ Hewitt, 86.

¹² Epstein, 154.

temporally disparate experiences into a cohesive fabric.”¹³ However, this definition calls for the question, is the sense of self solely made out of the narrative of past experiences, or does it also have to include the present experience? Philosophers such as Wittgenstein have distinguished between the subjective and objective forms of first-person in self-reference.¹⁴ Cognitive scientists, such as Shaun Gallagher, stress that the subjective first-person experience is an integral part of the conception of self.¹⁵ Without the subjective component of the self, there will be no objective form as it is the collection of the subjective immediate experiences that forms the objective ‘me.’

But can there be a subjective self-awareness without the conception of the self as an object? William James posited that self as ‘me’ exists as an explanatory agent to make sense of the self as ‘I’ acting in the present moment.¹⁶ He further deconstructed the self into three distinguishable modes of experience: physical self, mental self, and spiritual self.¹⁷ James’ conception integrates a variety of theories about the self which were articulated by earlier philosophers and psychologists; interestingly enough, recent findings in psychology, neuroscience, and cognitive science suggest the validity of James’ early theories about the construct of self. Gallagher distinguishes the ‘minimal self’ from the ‘narrative self’ as components of total self-awareness, which respectively resembles William James’ conception of the ‘mental self’ and to some degree the ‘spiritual self’.¹⁸ In Gallagher’s definition, the minimal self does not a self-perceptual or self-reflective act of consciousness.¹⁹ He explains that the minimal self is the phenomenological experience of immediate consciousness of oneself as an immediate or momentary subject of experience – it is the “pre-reflective point of origin for action, experience, and thought”.²⁰ He states: “The minimal self almost certainly depends on brain processes and an ecologically embedded body, but one does not have to know or be aware of this to have an experience that still counts as a self-experience.”²¹ He further posits that the minimal self does not necessarily need a first-person pronoun to mediate the experience. When one perceives objects or movement in the external environment, one gains pre-linguistic and non-conceptual information about himself. According to Gallagher, such non-conceptual, primitive, ecological self-awareness or self-consciousness exists in neonates and human infants.²² This suggests that subjective self-awareness, at some non-linguistic and primitive level, can occur without the reflective consciousness of the self as an object.

However, this does not mean that the self as an object is not important in mediating human experience. Gallagher posits that the other mode of self-awareness is

¹³ Norman A. S. Farb *et al.*, “Attending to the present: mindfulness meditation reveals distinct neural modes of self-reference,” *Social Cognitive Affective Neuroscience*, 2 (2007): 313-22.

(This quote is on page 313)

¹⁴ Shaun Gallagher, “Philosophical conceptions of the self: implications for cognitive science,” *Trends in Cognitive Sciences*, 4, no. 1 (2000): 14-21.

¹⁵ Gallagher, (2000).

¹⁶ Farb *et al.*, (2007).

¹⁷ Shihui Han and Georg Northoff, “Understanding the self: a cultural neuroscience approach,” *Progress in Brain Research*, 178 (2009): 203-12.

¹⁸ Han and Northoff, (2009).

¹⁹ Gallagher, (2000).

²⁰ *Ibid.*, 15.

²¹ *Ibid.*

²² *Ibid.*

the narrative self, defined as “[a] more or less coherent self (or self-image) that is constituted with a past and a future in the various stories that we and others tell about ourselves”,²³ whose neural substrates consist of the processing of episodic memory. The minimal biological self is merely a “principle of organization involving the distinction between self and non-self.”²⁴ Such principle is found throughout a number of living organisms, but what is necessary for the coherent continuity or identity over time characteristic to the human experience is linking those immediate experiences, through the use of human language. The use of language is able to coherently link our experiences over extended periods of time – it is what “extend[s] our biological boundaries to encompass a life of meaningful experience.”²⁵

A similar model to this distinction of the minimal self and the narrative self is also investigated by neuroscientists. Farb and colleagues²⁶ studied the neural mechanisms underlying the two different modes of self-referential processing – narrative and experiential – which show some correspondence to William James’ early conception of the ‘I’ and ‘me.’ They suggest that the narrative focus in self-referential processing is the neural characterization of the ‘me’: it supports self-awareness by linking subjective experiences across time. This type of self-referential processing involves the medial prefrontal cortices (mPFC) and calls for cognitive elaboration of mental events, thereby reducing immediate attention towards other temporally proximal sensory stimuli. Standing in contrast to the narrative self-referential processing is the experiential focus: the immediate, momentary experience of selfhood as the agent ‘I.’ Experiential self-processing calls for inhibition of cognitive elaboration on mental events, and instead favors broad and indiscriminate distribution of attention to the immediate sensory stimuli, thoughts, feelings, and physical sensations without focusing on a specific stimulus. Farb’s experimental results suggest that this experiential mode of self-referential processing (reminiscent of William James’ minimal self) is the underlying mechanism behind mindfulness meditation practices. As the participants underwent mindfulness-meditation practice, the brain network associated with this mode of self-referential processing became more salient under neuroimaging. This suggests that mindfulness-meditation practices help people attend to their immediate experiences, rather than being preoccupied thinking about the past or future (in the context of the self). Considering this suggested relationship between the experiential mode of self-reference and mindfulness practice, I contend that this experiential mode constitutes one layer of the sense of self, one that is shared by all humans.

The narrative self, however, is also important to an individual’s function. I contend that this layer of the self is also common to people across cultures. A sense of coherence and continuity through one’s past experiences is an integral part of one’s psychological health which is highlighted, for example, in the narrative approach to psychotherapy.²⁷ The narrative mode in self-processing not only involves the past, but also involves thoughts about the future. However, such a complex ability for humans to

²³ Ibid., 15.

²⁴ Ibid., 19.

²⁵ Ibid.

²⁶ Farb *et al.*, (2007). (All information in this paragraph drawn from this article.)

²⁷ Michael White and David Epston, *Narrative Means to Therapeutic Ends* (New York: W. W. Norton & Company, Inc., 1990).

think for the future (or the past) invites vulnerabilities to psychological distress. For example, in the Humanistic school of Psychology, Rogers characterized the difference between the ideal self (whom we aspire to be) and the real self (who we are in reality); he posited that symptoms of distress and mental illness arise when a potential route to personal growth is blocked, such as when someone lacks a coherent and unified sense of self or when there is a discrepancy between the ideal and the real self.²⁸ Based on my research in this thesis as well as on personal experiences of moving back and forth between Japan and the United States, I contend that this is quite true regardless of one's culture. We all develop a sense of self – a sense of 'me' – through narrating our lives, integrating our memories of past experiences, our present self-awareness, and some thoughts about our future – where we want to go, what we want to do with our lives, and who we want to become as individuals (although these thoughts may be neither realistic or reasonable).

However, we must also recognize that an individual does not exist without a society; they are two sides of the same coin. An individual is always an 'individual in society.' This idea is illustrated in a statement by G. H. Mead, one of the founders of social psychology, made on the formation of the self: "To be self-conscious is essentially to become an object to one's self in virtue of one's social relations to other individuals."²⁹ Although we may all dwell on past experiences or carry dreams and aspirations about our futures, this 'narrative' aspect of the self is partly shaped by societal influences. Hewitt states: "The self is a social object. It is tempting to think of the self simply as an object created in the mind of its possessor... One is an object of one's own acts, of course, but one is also an object in the eyes of the others with whom one interacts."³⁰ The inter- relationally and socially complex human society gives rise to parts of the self that are subject to socio-cultural variations, and I contend that this outer layer of the self is responsible for the differences between Morita Therapy and MBCT.

The Self as a Social Agent

Neural representation of self is not only biologically and psychologically significant but also ecologically important, as it determines the relationship between ourselves and others around us.³¹ Social cognitive scientists, Han and Northoff view that the sense of self develops in a specific sociocultural context – that the self may undergo modulations according to the surrounding social contexts and cultural values. In order to adjust for the most efficient interactions with others, the self formulates a particular style specific to that culture.³² The premise of social cognitive neuroscience is that within the brain there are dedicated systems that developed in order to process social stimuli, just as there are dedicated neurophysiological mechanisms underlying inherently social behaviors such as cooperating (of which behaviors are seen in non-human animals as well). Such processing is coined "social cognition," the cognitive and emotional processes involved in response to social stimuli. This includes knowledge about the self,

²⁸ Douglas P. Crowne, *Personality Theory* (Ontario, Canada: Oxford University Press, 2009), 365.

²⁹ George H. Mead, *Mind, Self, and Society* (Chicago: The University of Chicago Press, 1934), 172.

³⁰ Hewitt, 86.

³¹ Ying Zhu *et al.*, "Neural Basis of Cultural Influence of Self-representation," *Neuroimage*, 34, (2006): 1310-1316.

³² Han and Northoff, (2009).

perception of others, and interpersonal motivations. The processing of social stimuli involves mPFC, the anterior cingulate cortex (ACC), the temporo-parietal junction, the superior temporal sulcus, and the temporal poles. The involvement of mPFC in both social cognition and self-referential processing presents strong empirical evidence for the importance of self-referential processing to self-related processing.³³

Han and Northoff claim that their findings (which suggest a close relationship between self-‘referential’ processing and self-‘related’ processing at the level of neural mechanism) calls for the need to model the representation of ‘self’ and ‘other’ as a continuous spectrum. In other words, rather than dichotomizing the two, the brain possibly creates an internal ‘map’ of how related the ‘other’ is to ‘self’. ‘Self’ stands on the extreme end of self-relatedness spectrum, and ‘other’ is located on the same spectrum but not to the same degree. The distance of where a specific ‘other’ is located on the self-other spectrum is determined by the relatedness of this ‘other’ to ‘self’ – whether it is tagged as ‘like-self’ or ‘not-self’ by the same brain regions involved in self-referential processing. Han and Northoff also suggest that such ability to tag others on the relatedness scale “allows the organism to define relative relatedness of group members, predict behaviors, develop empathy, share resources, and navigate in complex social environments.”³⁴ Therefore, for species with complex social organizations like humans, this ability to internally construct a self-relatedness map most likely offered a selective advantage during evolution, and therefore became highly complex.³⁵ The complexity of our ability to evaluate ‘others’ on a relatedness-scale relative to our ‘self’ has in turn added another dimension to our conceptions of the self, which varies from culture to culture. I interpret this to involve the relationship between how ‘related’ the other is to self as a determinant of how much of the ‘private self’ is exposed to that other.

Some believe that although some aspects of the self may be universal, it is, in part, shaped through interaction with groups. For instance, Harry C. Triandis, a cultural psychologist, elaborates on the distinction between the private, public, and collective self as different aspects of the self.³⁶ The private self is “cognition that involve traits, states, or behaviors of the person”;³⁷ the public self is “cognitions concerning the generalized others’ view of the self”³⁸ (e.g. People think I am funny); and the collective self is “cognitions concerning a view of the self that is found in some collective (e.g. family, coworkers, tribe).”³⁹ He recognized that the self is an agent that engages in differential sampling (information that is self-relevant more frequently), processing (information that is self-relevant more quickly), and assessment of information (endorsing information that supports the current self-construction than those that rather challenge it). The differences in social behavior, thus, leads from the way people across different cultures expose the three different kinds of self with different probabilities.⁴⁰ The differences in the way

³³ Ibid.

³⁴ Ibid., 206.

³⁵ Ibid.

³⁶ Harry C. Triandis, “The Self and Social Behavior in Differing Cultural Contexts,” in *Pieces of the Personality Puzzle*, ed. David C. Funder and Daniel J. Ozer (New York: W. W. Norton & Company, 2010), 414-432.

³⁷ Ibid., 416.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Ibid.

Japanese and American people sample these distinct aspects of the self will be discussed in detail in Chapter Two, in which I elaborate on how part of the self is constructed differently in the two cultures – the differences in self-conceptions I contend to be partly responsible for the differences in Morita Therapy and MBCT.

Why compare Morita Therapy and MBCT?

There are several reasons to compare these two forms of psychotherapy. One prominent reason is the significance of mindfulness to human health and wellbeing. Mindfulness as a positive psychological asset has been a salient view since ancient Buddhism. Recently, this idea is beginning to spark the interest of various scientific investigators, who have successfully collected evidence-based therapeutic efficacy involving mindfulness practice (such as MBCT). Mindfulness has also been an implicit concept of the Zen Buddhist culture prominent in Japan, and in turn has shaped the philosophy of Morita psychotherapy. The ways in which MBCT and Morita Therapy explicitly or implicitly rely on the practice of mindfulness are elucidated in Chapter Three and Four, respectively, along with the methodological details of the therapies.

When I initially proposed this project, I was assuming to observe more differences than similarities as expected by the tremendous differences between the individualistic culture of the West and the collectivist culture of Japan. However, as I proceeded through this research, I came to realize that there are more commonalities between these two forms of mindfulness-based psychotherapy than differences (although the differences are nonetheless worthy of analysis). This finding amazed me, as I came to in turn realize that mindfulness is an innate capacity of the human mind—a point I elucidate in Chapter One. Given that the relationship between the self and mindfulness practice is implicit, seeing the similarities between Morita therapy and MBCT helps illustrate the aspects of the self common to human experience, regardless of the culture. The similarities between MBCT and Morita therapy are illustrated in detail in Chapter Five.

However, it is equally important to note and analyze the differences between the two therapies, which are elaborated in Chapter Six. I contend that cross-cultural analysis in psychology is of extremely important, especially in the globalized world today. People are often exposed to more than one culture in their lifetime, and their sense of self may in turn be uniquely shaped by their multi-cultural experience. As an international student from Japan studying in the U.S., I can say that this is true for myself as well. Cultural psychology springs from the premise that culture and mind are inseparable, and that psychological theories and/or methods grounded in one culture may not be completely applicable to another culture. Psychologists may say that, “The ultimate goal of cultural psychology is to reconcile cultural variety with common humanity.”⁴¹ My interest in this issue also roots from my personal experience of receiving psychotherapy in the U.S. as a Japanese student. Although psychotherapy helped me tremendously in a number of ways, there were nonetheless times that I felt that the theories on the human mind in Western psychology was inadequate in making sense out of my personal experiences.

Based on this research and personal experiences, I contend that there needs to be a paradigm that describes the human self that cuts cross-culturally, and at the same time

⁴¹ David C. Funder and Daniel J. Ozer (ed.), *Pieces of the Personality Puzzle* (New York: W. W. Norton & Company, 2010), 414.

recognizes the commonality for therapeutic mechanisms. Throughout this thesis (particularly in Chapter Five and Six), I call for a reassessment on the conception of self, especially around mindfulness-based psychotherapy. By the end of this thesis, I hope to accomplish two things. My first and primary objective is to illustrate that mindfulness-based psychotherapy across cultures share a common therapeutic mechanism involving the inner layer of the self. My second objective is to also show that the outer layer of the self produces cultural variations in the therapeutic philosophies and methods—particularly involving the differences between individualistic and collectivist values. My ultimate hope is that these two assessments, together, will spur research interests in cross-cultural analyses of mindfulness-based psychotherapies as well as the development of a mindfulness-based therapy for multi-cultural audience.

Chapter One: Mindfulness

In the Introduction, I have proposed that the construct of self has two layers: the outer layer which is constructed and modulated socially and culturally; and the inner layer which holds inherent commonality across cultures, which is also the layer on which mindfulness operates. In order to establish a framework in conveying that mindfulness operates on the inner layer of the self (which I later elucidate in Chapter Five through comparing the therapeutic mechanisms of MBCT and Morita Therapy), I will dedicate this chapter to introduce the idea that mindfulness is an inherent capacity of the human mind.

In doing so, I will present various cultural interpretations of what mindfulness means: the Theravada Buddhist context where mindfulness was initially conceptualized, the modern western psychological and medical context, and the Japanese Zen Buddhism context where there is no explicit labeling of ‘mindfulness.’ Presenting these various contexts of mindfulness across time and cultures should convey that: despite the slight variations in the interpretations of what ‘mindfulness’ means, mindfulness nonetheless operates on the self through a common mechanism in human experience.

Before presenting a detailed analysis of the various interpretations of mindfulness throughout this chapter, allow me to introduce a short preview of the evolution of mindfulness across history and cultures. Mindfulness was first given its name and emerged as a concept in the Theravadan Buddhist meditative traditions, as the word *sati* in Pali. This word, translated as ‘awareness,’ holds great importance in the path to enlightenment in the Buddhist tradition. “One of the distinguishing marks of the Buddha’s teachings was his repeated emphasis on the importance of mindfulness.”⁴² The concept of mindfulness as a catalyst to spiritual development was also imported to the Mahayana branch of Buddhism, which includes Japanese Zen Buddhism. Interestingly, in Zen Buddhism there is no explicit labeling or naming of ‘mindfulness.’ Nonetheless, mindfulness is implicit in their teachings and practices, which will be explained later in this chapter. In the 21st century today, mindfulness is not only used in spiritual practice, but is also applied to therapeutic approaches in clinical science. As Buddhism and meditation became popularized in the West, this term has come to take a new clinical meaning in western psychology and medicine—in “western mindfulness tradition.”

One of the most prominent movements towards a mindfulness-based therapeutic approach in the West is Jon Kabat-Zinn’s Mindfulness-based Stress Reduction (MBSR). Kabat-Zinn defines mindfulness as “moment-to-moment awareness”⁴³ or “paying attention in a particular way: on purpose, in the present moment, and nonjudgementally.”⁴⁴ He re-contextualized the concept of mindfulness from its spiritual context in Buddhism to extend its applicability and relevance to patients suffering from a

⁴² Epstein, 141.

⁴³ Kabat-Zinn, (1990), 2.

⁴⁴ Jon Kabat-Zinn, *Wherever you go, there you are: Mindfulness meditation in everyday life* (New York: Hyperion, 1994), 4.

variety of physical and psychological conditions, aiming to equip them with adaptive ways of responding to the stress of everyday lives.⁴⁵

In light of this emerging interest of mindfulness in modern medicine and psychological interventions, a number of attempts have been made to establish an operational working definition for mindfulness in order to standardize experimental research. In doing so, some scientists found that the original definition of mindfulness, founded in the pre-scientific spiritual and religious traditions, is not directly applicable or suitable for evidence-based scientific analysis. For this reason, a number of scientists have simplified its meaning so that it could be used as an independent variable in experimental research. Kabat-Zinn's definition was a start. Scott Bishop also defined mindfulness as a "state in which one is highly aware and focused on the reality of the present moment, accepting and acknowledging it, without getting caught up in thoughts that are about the situation or in emotional reactions to the situation."⁴⁶ Hayes and Shenk argued that even Bishop's definition has unnecessary philosophical and theoretical attachment, which may limit its applicability to basic science.⁴⁷ However, some scholars questioned whether mindfulness could be really understood separate from its cultural context; does the scientific simplification adequately address its true phenomenon? Bhikku Bodhi, for example, cautions against a reductionist understanding of mindfulness and argues that scientific researchers should respect the spiritual tradition in which it is rooted.⁴⁸ The contentious question then becomes: is it imperative to keep the integrity which the original meaning of mindfulness holds when incorporating it into clinical practice, or can we overlook such reformation as a byproduct of the emergence of 'western Buddhism'?⁴⁹

The truth of the matter is that linguistic, cultural, historical, and philosophical barriers in understanding mindfulness are present even among different branches of Buddhism—for instance, between Theravada and Mahayana branches. Therefore, contextual change is inevitable when importing mindfulness from Buddhism as a *religion* to modern therapeutic approaches as a *science*. With such barriers surrounding the issue of mindfulness, the assignment of a single definition—or even a construct—is difficult.

For example, the western clinical traditions (including MBCT) seem to emphasize mindfulness as present-centered, non-conceptual, and non-judgemental awareness, in an explicitly defined context. However, in the Japanese Zen Buddhism tradition (which significantly influenced the philosophies and methods of Morita therapy), there is no explicit labeling of the concept that directly translates to 'mindfulness' in English. This is peculiar, considering the fact that mindfulness is implicit in Zen Buddhist practices. The

⁴⁵ Zindel V. Segal, J. Mark G. Williams and John D. Teasdale, *Mindfulness-Based Cognitive Therapy for Depression 2nd edition* (New York: The Guilford Press, 2013), 39.

⁴⁶ Scott R. Bishop, "What Do We Really Know About Mindfulness-Based Stress Reduction," *Psychosomatic Medicine*, 64, (2002): 71-84. (quote from 71)

⁴⁷ Steven C. Hayes and Chad Shenk, "Operationalizing Mindfulness Without Unnecessary Attachments," *Clinical Psychology: Science and Practice*, 11, no. 3, (2004): 249-54. DOI:10.1093/clipsy/bph079

⁴⁸ Bikkhu Bodhi, "What does mindfulness really mean? A canonical perspective," *Contemporary Buddhism: An interdisciplinary Journal*, 12, no. 1, (2011): 19-39.
DOI: 10.1080/14639947.2011.564813

⁴⁹ John Dunne, "Toward an understanding of non-dual mindfulness," *Contemporary Buddhism: An Interdisciplinary Journal*, 12, no. 1, (2011): 71-88.

concept of mindfulness is also implicit in Morita therapy, which will be explained in later chapters.

How can we most easily explain what mindfulness really means? In order to understand the foundations of Morita Therapy and MBCT, it is imperative to study such cultural divergences in this concept, while at the same time developing a certain consensus of its common meaning and applicability to human health and wellbeing. By exploring the interpretations of mindfulness in the contexts of Theravada Buddhism (a tradition where the term mindfulness originates), Japanese Zen Buddhism (a tradition where mindfulness is not explicitly labeled but nonetheless implicit in the teachings and practices), and western clinical science (a tradition where establishing a scientifically compatible operational definition is imperative for research), I intend to convey two concepts throughout this chapter.

My first objective is to show that mindfulness can be best explained as a two-dimensional continuum, composed of non-dualistic and dualistic axes. What do I mean by ‘continuum’? The cultivation of mindfulness follows a gradual, continuous transition from one condition to a different condition. Mindfulness can begin as a set of meditative techniques, which gradually evolves into a psychological state, then to a psychological construct, and eventually to a permanent state of consciousness; there is no ‘end-point’ in the cultivation of mindfulness. In these ways, one’s commitment to cultivating mindfulness can span across one’s entire lifetime—as a continuum. What do I mean by ‘two-dimensional’? Just as a position in space cannot be described without defining its relative positions on the x- and y-axes, one’s journey of cultivating mindfulness involves two different modes of experience—the dualistic and non-dualistic. I depict these two modes of experience as the two axes that constitute the two-dimensional continuum of mindfulness, so that the concept can be imagined as something that resembles the familiar two-dimensional x-y plane from mathematics. I will propose this unique model to conceptualize mindfulness in order to facilitate a more complete understanding of what it means, and how it applies to the psychotherapeutic process. Later, in Chapter Five, I will show how the psychotherapeutic process of mindfulness-based therapy involves both non-dualistic and dualistic modes of mindfulness.

The second message conveyed throughout this chapter is that mindfulness is a phenomenon common to the human experience. By researching the various cultural interpretations of mindfulness, I have come to see mindfulness as an innate capability of the human mind, although some traditions may emphasize different aspects more than the other. Kabat-Zinn, too, shares this view: “mindfulness, it should also be noted, being about attention, is also of necessity universal. There is nothing particularly Buddhist about it. We are all mindful to one degree or another, moment by moment. It is an inherent human capacity.”⁵⁰

The two main messages—that mindfulness can be understood as a two-dimensional continuum and is a common phenomenon to human experience across cultures—are addressed throughout this chapter in the following order: first, I will begin by explaining in more detail what I mean by a ‘two-dimensional continuum,’ as well as presenting the historical origins of these two different aspects of mindfulness; second, I

⁵⁰ Jon Kabat-Zinn, “Mindfulness-Based Interventions in Context: Past, Present, and Future,” *Clinical Psychology: Science and Practice*, 10, no. 2, (2003): 144-157. DOI: 10.1093/clipsy/bpg016 (quote from 145-146)

will explain what the dualistic axis of mindfulness by presenting its roots in the Theravada Buddhist tradition; third, I will present the characteristic of the non-dualistic experience of mindfulness in the context of western clinical science, as well as Japanese Zen Buddhism; finally, I will show that one's path on the mindfulness continuum involves the interaction of the dualistic and non-dualistic modes of mindfulness, supported by the teachings in Zen.

Mindfulness as a Two-Dimensional Continuum

Culled from research in both science and humanities is my interpretation of mindfulness as a two-dimensional continuum—a continuous path that describes one's psychological and emotional development. The term mindfulness seems to be used in various contexts—as attention 'practice' or meditative 'technique';⁵¹ a 'state' of consciousness that varies *within* individual over time;⁵² or even a 'trait' that can vary *between* individuals as a result of differences in "inherent capability, discipline, or inclination".⁵³ I interpret that these various contexts of mindfulness suggest that the mindfulness continuum

can begin with learning a few meditative techniques; with disciplined and repeated practice, this state of awareness progresses to a psychological process that can be sustained for a longer duration of time. Eventually, it can lead to a more permanent state of consciousness of everyday living or a personal trait, having a limitless capacity of promoting wellbeing. As Kabat-Zinn says, "Mindfulness develops and deepens over time but invariably requires an ongoing commitment to its practice and cultivation in any and every moment."⁵⁴ An individual may be inherently inclined to have more mindfulness capacities compared to another, but with practice and commitment *anyone* can develop their mindfulness capacities further along the continuum.

Another key feature of this mindfulness continuum that I propose is that it consists of two different axes concerning the duality within phenomenological experiences. I call them 'axes' because each 'axis' represents the path of development—a type of quantitative progression, like in the x-y plane. You start from a smaller quantity or level of mindfulness, and with practice you gradually 'increase' in mindfulness. I contend that there are two axes, inspired by Jon Dunne's distinction of dualistic and non-dualistic types of mindfulness. In "Toward an Understanding of Non-dual Mindfulness," Dunne distinguishes and describes the dualistic and non-dualistic modes of mindfulness. Combining the interpretation of mindfulness as a continuum with this view that mindfulness consists of two different modes of experience, I came up with this modeling of mindfulness as a two-dimensional continuum; it consists of an axis of dual experiences

Figure 1.1: Mindfulness as a Two-Dimensional Continuum

⁵¹ Kabat-Zinn, (2009).

⁵² Kirk W. Brown and Richard M. Ryan, "The Benefits of Being Present: Mindfulness and Its Role in Psychological Well-being," *Journal of Personality and Social Psychology*, 84, no. 4, (2003): 822-848. DOI: 10.1037/0022-3514.84.4.822

⁵³ Ibid., 824.

⁵⁴ Kabat-Zinn, (2003), 148.

(the ordinary awareness structured by the clear distinction between subject and object); and another axis of non-dual experiences (awareness in which the subject-object distinction collapses). The meaning of the subject-object distinction and how it applies to mindfulness will be explained later in this chapter. But why and when was such diversion or distinction in the modes of experience in mindfulness made?

Dunne explains that the distinction between two modes of mindfulness could have emerged in the early stage in Buddhist history, as a result of the different arguments concerned with the progress in reaching Buddhahood—between what Dunne calls the “Innateists” and the “Constructivists”.⁵⁵ The Innateists argue that most of our ordinary structures of consciousness stand as the root of our suffering—including the usual perception of time, space, and identity—and eliminating such pre-conditioned structure of cognition through non-dual styles of practice leads to awakening.

The Constructivists, on the other hand, argue that these basic structures of cognition are not problematic in themselves. Rather, the Constructivists argue that the more specific content of ordinary consciousness (such as one’s fixed sense of selfhood) must be eliminated to end suffering. In addition, the Constructivists emphasize the benefits of not eliminating, but *cultivating* certain qualities, such as compassion and mindfulness. According to Dunne, Western Buddhism—particularly the healthcare communities—places a large emphasis on the Innateist, non-dual mindfulness styles of practice. This entails cultivating non-conceptual, non-judgmental states of awareness devoid of the subject-object duality. This mode stands distinct from the dualistic mode of mindfulness that was more strongly emphasized in the Theravada Buddhist tradition, which involves a type of ‘self-reflection’ or ‘self-monitoring’ abilities that rely on the subject-object duality—in which this case the self becomes the both the subject and object.

The Dualistic Mode of Mindfulness

Let me by explaining what the ‘dualistic’ mode entails and where it came from: in dualistic mindfulness—emphasized in the Theravada tradition—there is a clear subject-object distinction in the experience. Mindfulness in the context of the early Theravada Buddhist discourses and the *Abhidhamma* seems to rely on the structure of subject-object duality.⁵⁶ Dunne argues that the interpretation of mindfulness practice from the Theravada traditions seems to have emerged from a more Constructivist stance—that qualities such as mindfulness is something that can be cultivated.

The dualistic mode of mindfulness involves a connotation of ‘remembering’ and ‘monitoring.’ Mindfulness was first translated into English from the Pali word *sati*, which is a noun related to the verb *sarati*, which means ‘to remember’. The connotation of *sati* as ‘memory’ appears in the early Buddhist discourses as well as the definition of *sati* given in the *Abhidhamma*.⁵⁷ According to Bikkhu Analayo (a German Buddhist monk, scholar, and meditation teacher), in the context of *satipatthana* meditation (the authentic Theravada version of Insight meditation), *sati* enables one to remember what is otherwise easily forgotten—the present moment. Thus, the presence of mindfulness can be

⁵⁵ Dunne, (2011). (All information in this paragraph drawn from this article.)

⁵⁶ Dunne, (2011).

⁵⁷ Bikkhu Analayo, *Satipatthana: The Direct Path to Realization* (Trowbridge, England: Cromwell Press Ltd., 2003), 46.

understood to imply the strong presence of mind, allowing one to have lucid awareness with regard to the present moment—the exact opposite of being absent-minded or mindless.⁵⁸ *Sati*, therefore, occupies a central position among the faculties (*indriya*) and powers (*bala*), having “the function of balancing and monitoring the other faculties and powers, by becoming aware of excesses or deficiencies.”⁵⁹ In other words, *sati* stands as a mental quality that exerts a controlling influence on thoughts and intentions, preventing the mind from unwholesome thoughts and intentions that would otherwise distract one from the path.

The ‘monitoring’ and ‘remembering’ functions of the dualistic mode of mindfulness lay an invaluable attitudinal foundation for the non-dualistic practices. In addition to its role as one of the faculties and powers, *sati* also occupies a position in the noble eightfold path as right mindfulness, *sammāsati*—below right effort and above right concentration.⁶⁰ According to Analayo, in support of its neighbor ‘right effort,’ “*sati* performs a protective role by preventing the arising of unwholesome states of mind in the context of sense-restraint...in relation to right concentration, cultivated *sati* prepares an important foundation for the development of deeper levels of mental calm.”⁶¹ In other words, *sati* stands as a mental quality that exerts a controlling influence on thoughts and intentions, preventing the mind from unwholesome thoughts and intentions that would otherwise distract one from the path.

The dualistic aspect of mindfulness supports the progress of non-dualistic practice, but is characteristically distinct from the non-dual styles of practice for it requires some extent of conceptual and intellectual effort. Mindfulness, in the context of *sati*, can be understood as both a process of mental training, as well as a mental quality that develops as a result of such practice. In both cases, one must constantly reflect on his present state of mind with discriminating alertness and clear comprehension. Such monitoring function of *sati* cannot occur under non-conceptual, non-dualistic state of mind because it requires thought and effort.⁶² Whether as a faculty or one of the noble eightfold paths, mindfulness involves retention of information about the mind, prospection with regard to future spiritual goals, and recollection of instructions such as ‘Do not pursue the past. Do not usher in the future. Rest evenly within present awareness.’⁶³ Therefore, in order to remember these instructions and to implement them, one must step out of the ‘non- conceptual, non-judgmental awareness’ characteristic of the non-dual styles of practice, and to an extent, judge and evaluate one’s present state to confirm whether these objectives are being accomplished or not. In other words, the self—as a subject—reflects on the self—as an object—in a way that is inherently different from the non-dualistic type of mindfulness. In the non-dual type of mindfulness, experiences are being registered without the reflexive self-consciousness that perceives the self as an object that is the subject of experience. This will be explained more in the next section.

⁵⁸ Ibid.

⁵⁹ Ibid., 49-50.

⁶⁰ Ibid.

⁶¹ Ibid., 50.

⁶² Ibid.

⁶³ Dunne, (2011).

The dualistic axis of mindfulness is significant to one's ethical and effortful commitment to mindfulness, keeping oneself 'in check.' The dualistic mode of experience deserves its own axis on the mindfulness continuum, because one can progress in the path of cultivating this type of mindfulness alongside his development in the non-dualistic style of practice. For this monitoring function of the dualistic type of mindfulness, some have characterized it as "Effort Mindfulness" or "Spy-like Mindfulness".⁶⁴ These characterizations capture its effortful, monitoring, 're-mindful' function.

This type of mindfulness is an important contributor in one's psychological development as a whole. Even if one learns how to practice mindfulness in the non-dualistic practice (which are taught in clinical mindfulness-intervention programs), if he or she lacks this 'self-monitoring' capability of dualistic mindfulness he cannot advance forward in the mindfulness continuum. As Kabat-Zinn emphasizes, mindfulness requires an ongoing commitment and discipline, which requires a self-reflecting capacity that reminds one to practice diligently. Now that the dualistic mode of mindfulness has been explained, let us dive into the non-dualistic mode of mindfulness.

The Non-Dualistic Mode of Mindfulness

While the dualistic approach of mindfulness is essential to 'checking in' with one's progress, the non-dualistic approach is equally significant. Austin describes that "when *sati* is interpreted liberally, its breath and elasticity can (1) describe the ethical right mindfulness inherent throughout the noble eightfold path...and (2) accommodate a broad spectrum of overview capacities."⁶⁵ As mentioned before, the ethical framework of mindfulness is largely structured by subject-object duality. However, in achieving such state of "overview capacities" described by Austin, a bare, open, receptive, and non-prejudiced awareness becomes an important substrate in providing one "a clear picture of one's dependently arisen mental, emotional, and physical processes and states that are occurring in the present moment."⁶⁶ Such 'bare awareness' is founded on an "unattached perspective [which] enables its objective observer to remain impartially aware of events, beyond any immediate temptation of actively interfering with them."⁶⁷

By not "actively interfering" or personally engaging with one's mental events but at the same time being keenly aware of their impermanent presence, one experiences a rotation in consciousness in which what was previously 'subject' becomes 'object'. This is not to be confused with the subject-object duality explained previously, in which case the subject is the self that is reflecting on his own progress as an object. Here is a practical example that may illustrate this rotation in the consciousness: When we feel 'angry,' our usual interpretation of this internal event is 'I am angry' in which there is no objectification of the anger and the anger is 'attached' to the subject. With the rotation in consciousness, however, the 'anger' becomes an external object to the self as a subject; one may perceive, instead, 'here is anger arising.' As Sekida (a Zen Buddhism practitioner and author of *Zen Training – Methods and Philosophy*) quotes, "Subjectivity

⁶⁴ Ibid.

⁶⁵ James H. Austin, *Meditating Selflessly: Practical Neural Zen* (Cambridge, MA: The MIT Press, 2011), 97-8.

⁶⁶ Ibid., 98.

⁶⁷ Ibid, 96.

takes notice of other things but never of itself. Just as the eye cannot see itself, subjectivity cannot observe itself. When it is observed [upon meditative practice, for example], it is converted into an object.”⁶⁸ Modern developmental psychologists would call this shift in perspective of subject-object relation as “reperceiving,” which has been heralded as a “key to development and growth across the lifespan.”⁶⁹ The parallel between descriptions of mindfulness and the corresponding notion in western psychology suggests that mindfulness is a continuation and/or acceleration of the “naturally occurring developmental process whereby one gains an increasing capacity for objectivity about one’s own internal experience.”⁷⁰ The objectivity of self-observing or self-overviewing contributes to perceiving mental events ‘as they are,’ and to the eventual acknowledgement of the impermanence and passing of them.

In order to gain such—in a way, ‘depersonalized’—objectivity about one’s internal state of mind, one must first successfully release himself into a non-conceptual and objectless state of mind. This form of experience which is not structured by subject-object duality is the non-dualistic mode of mindfulness; it represents the mind’s true nature, free of the pre-conditioned habits of engaging in the subject-object duality.⁷¹ This non-conceptual, non-judgmental state of mind is accessed through meditative training. This can be described as deep concentration in which one loses the ordinary conception of time, space, and identity. Again, this non-dual style of practice most likely has emerged from the Innateist philosophy—one must step out of such ordinary way of conceiving reality in order to reach awakening.

This type of awareness, when practiced, leads to a continuous, uninterrupted awareness that is fully aware to the present moment without effort—without any adjustment. This type of mindfulness is sometimes called “Mindfulness of mere non-distraction”, whose title is congruent to the fact that one engaged in this type of mindfulness is not being distracted by the subjectivity of one’s thoughts and mental events.⁷² Others have characterized this idea as “Effortless Mindfulness”⁷³ which opposes the dualistic “Effortful Mindfulness” mentioned previously. This constitutes the non-dual axis of mindfulness.

Interaction of the Two Axes in the Mindfulness Continuum

Now that both modes of mindfulness have been articulated, I further propose that these two modes of mindfulness are dependent on each other. As explained above, the continuum of mindfulness consists of two different axes—the dualistic and the non-dualistic approaches; the “Effortful” and the “Effortless” Mindfulness; mindfulness of “Spy” and of “mere non-distraction”. I see that the two axes of mindfulness continuum are in constant interaction; this is particularly clear in the teachings of Zen Buddhism, as illustrated by Katsuki Sekida—a bilingual and respected teacher of Zen who practiced in Japan and later taught in Hawaii and London. The interdependence of these two axes is

⁶⁸ Katsuki Sekida, *Zen Training: Methods and Philosophy* (Boston, MA: Shambhala Publications, Inc, 1985), 114.

⁶⁹ Shauna L. Shapiro *et al.*, “Mechanism of Mindfulness,” *Journal of Clinical Psychology*, 62, no. 3, (2006): 373-86. DOI 10.1002/jclp (quote from 378)

⁷⁰ *Ibid.*

⁷¹ Dunne, (2011).

⁷² *Ibid.*

⁷³ *Ibid.*

not only implied in Theravada Buddhist teachings that explicitly explains it in the context of ‘mindfulness’, but is also implicit in the non-labeling traditions such as Zen Buddhism in Japan.

From my readings of Buddhist meditative practice, it seems that meditative practice usually falls into two types: concentrative meditation and insight (mindfulness) meditation. Modern neuro-scientific studies have identified the distinct brain states between these two types of meditation (such as in the studies done by Cahn and Polich as well as Dunn, Hartigan, and Mikulas).⁷⁴ In the Theravada context, the characteristic mental functioning of mindfulness (*sati*) and concentration (*samadhi*) are quite distinct. While *samadhi* “corresponds to an enhancement of the selective function of the mind, by way of restricting the breath of attention, *sati* on its own represents an enhancement of the recollective function, by way of expanding the breadth of attention.”⁷⁵ The objective of this thesis is to compare two forms of mindfulness-based psychotherapy: MBCT and Morita therapy. Therefore, further discussion on concentration meditation will be avoided in order to focus elaborating on mindfulness meditation.

This distinction between concentrative and mindful attentions, however, does not imply that the two are mutually exclusive or incompatible; in order to attain deep concentration, both *sati* and *samadhi* must be present. The continuous presence of well-established *sati* can be relevant for attaining, remaining in, and emerging from states of deep concentration.⁷⁶ For example, say that one is in the process of trying to attain *samadhi*, but his attention becomes distracted with other thoughts. Then, through *sati*, he can recollect this information and remind himself again of what his present objective is supposed to be—from narrowing his breath of attention to whatever the object he is concentrating on. Thus, the monitoring, recollective, and reminding functions of *sati* are also relevant for concentrative meditation, even though cultivating *sati* may not be the primary objective of this type of meditative training. In these ways, this example illustrates the interdependent relationship between *concentration* and *dualistic mindfulness*. However, how can we describe the co-dependence of *non-dualistic* and *dualistic* mindfulness practices? The answer is that deep concentration (which relies partly on dualistic mindfulness as described above) induces non-conceptual awareness – the non-dualistic type of mindfulness.

The relationship between deep concentration and this reflexive, non-conceptual, bare awareness has been identified by various contemplative traditions, regardless of the presence of the ‘mindfulness’ label. To name an example, Zen Buddhism is a tradition that does not explicitly utilize the term ‘mindfulness’ to explain its methods and philosophies. (This is most likely due to the Mahayana Buddhist concern—which is characteristically Innateist by nature—that human ‘language’ produces a misconception of the true nature of reality. Therefore, many of the Mahayana traditions, including Zen Buddhism, rejected some parts of the Pali canon⁷⁷ and developed a more experiential

⁷⁴ Rael B. Cahn and John Polich, “Meditation States and Traits: EEG, ERP, and Neuroimaging Studies,” *Psychological Bulletin*, 132, no. 2, (2006): 180-211.; Bruce R. Dunn, Judith A. Hartigan, and William L. Mikulas, “Concentration and Mindfulness Meditations: Unique Forms of Consciousness?” *Applied Psychophysiology and Biofeedback*, 24, no. 3, (1999): 147-165.

⁷⁵ Analayo. 63.

⁷⁶ Ibid., 61.

⁷⁷ Donald W. Mitchell, *Buddhism: Introducing the Buddhist Experience (Second Edition)* (New York: Oxford University Press, Inc., 2002), 103-21.

method of teaching, rather than promoting an intellectual, language-based understanding of mindfulness.)⁷⁸ Nevertheless, the essence of mindfulness—including the two axes and their relationship to concentration—is inarguably pronounced in the teachings of Zen Buddhism.

Sekida illustrates the relationship between concentration and non-dual awareness with the concept of “*nen*(念)” —translated as “thought impulse” in this context. I find this framework to be compelling and clearly depicting the nature of the process; therefore, I will continue to refer to this framework throughout the rest of this thesis. Sekida illustrates that our ordinary functioning of consciousness is structured by the succession of first, second, and third *nen*. The first *nen* is the awareness of the object being perceived, independent of one’s subjectivity; in other words, this may be identified as the unfiltered, ‘bare attention.’ The second *nen* is the reflecting action of consciousness that makes one aware of the observation. However, what makes the individual acknowledge himself of becoming aware of the observation is the third *nen*—a further step in self-consciousness. The third *nen* is what integrates the moment-to-moment impressions from the first and second *nen* into one stream of perception. However, before this perception is achieved, the third *nen* also reforms the perception based on previously stored conceptions or knowledge. In other words, the second and third *nen* prevent one from engaging in the moment-to-moment experience of the first *nen* by adding subjectivity and self-consciousness to the initial bare awareness of the object. The actions of the second and third are responsible for our ‘default’ mode of awareness,⁷⁹ which is what the Innatist saw as the source of our delusion and suffering.

The Zen practice of *zazen*, sitting meditation, encourages one to be absorbed in the first *nen* only. The steady succession of first *nen* actions develops into the condition of what Sekida calls ‘absolute samadhi,’ in which the mind is completely still, empty of thoughts and awareness of space, time and oneself,⁸⁰ “yet the mind is still very much active with whatever it is concentrating on.”⁸¹ The state of absolute samadhi, although consists of the Pali word of *samadhi* (meaning concentration), can be compared to the state of non-dual mindfulness as their underlying mechanisms of the consciousness are strikingly similar. Not surprisingly, “*nen*, 念” is also the Japanese and Chinese character for mindfulness, composed of two interactive figures: one meaning ‘now’ and the other meaning ‘mind’ or ‘heart’.⁸² Sekida further explains:

In absolute samadhi, [attained through the succession of first *nen*-actions,] there is no time. ‘No time’ means there is only the present time... This present time is interrupted if a reflecting action of consciousness occurs... You notice the order of events, recollect the past, conjecture about the future.⁸³

⁷⁸ Sekida, 70.

⁷⁹ Sekida, 108-13.

⁸⁰ Ibid, 120.

⁸¹ Ibid, 13.

⁸² Shapiro *et al.*, (2006).

⁸³ Sekida, 120.

Mindfulness, in the Zen context, thus implies the concentrated commitment of the mind or heart to the on-going present moment. In other words, absolute samadhi is simultaneously a state of deep concentration and a state of non-dual mindfulness—the mind is awake and present to the on-going moment yet devoid of ordinary intellectual operation.

In contrast to absolute samadhi, Sekida also defines another type of samadhi as ‘positive samadhi’—a state in which the faulty habits of consciousness is suspended, but at the same time one’s attention is directed outwardly to incoming stimuli, instead of being directed inwardly like in absolute samadhi. Sekida speculates that while absolute samadhi—the suspension of thinking—can be characterized by the appearance of theta frequencies under an electroencephalographic study, the state of positive samadhi may show an active cortical activity.⁸⁴ He further suggests that these two forms of samadhi can be attained by different styles of practicing the *Mu koan*⁸⁵ (the first *koan* assigned to a Zen student.)

[I]f you want to practice positive samadhi, you do indeed have to work on *Mu* using your head, and ask, “What is *Mu*?” But if you want to practice absolute samadhi you must watch—rather, become—the movements and contractions of the respiratory muscles.⁸⁶

This contrast in the presence or absence of intellectual functioning seems to suggest the possibility of comparing these two types of samadhi to non-dualistic and dualistic type of mindfulness practices. Practicing absolute samadhi through *Mu* is largely non-dualistic because the objectification of “*Mu*” is suspended; in other words, one *becomes Mu*. Practicing positive samadhi, on the other hand, still requires some extent of subject-object distinction between the practitioner and the *Mu koan*. Moreover, Sekida explains that through consciously repeating the *Mu koan*, “you will eventually find that the meaning [of *Mu*] was given long ago.”⁸⁷ This is reminiscent of one of the original Theravada interpretations of *sati*, ‘to remember’—the ability of calling to mind what has been done or said long ago.

Keeping the comparison of absolute and positive samadhi to non-dualistic and dualistic mindfulness in mind, the interrelated relationship between these two types of samadhi illustrated by Sekida further suggests the necessity of the interaction of the two axes of mindfulness.

We suggest that the right course is to develop positive and absolute samadhi equally. To enter the silence of absolute samadhi is to shake off what we call the habitual way of consciousness... Then, going out (or coming back) into the world of actual life and of the ordinary activity of consciousness, we enjoy positive samadhi and freedom of mind in the complicated situations of the world.⁸⁸

⁸⁴ Ibid., 63.

⁸⁵ Koan is a paradoxical anecdote or riddle used in Zen Buddhism to provoke enlightenment.

⁸⁶ Ibid, 81.

⁸⁷ Ibid, 80.

⁸⁸ Ibid, 62.

Although Sekida does not explicitly mention this, I speculate that the state of positive samadhi is experiencing the outer world through the first *nen*-actions, perceiving things ‘as they are at that moment,’ despite the presence of ordinary conscious activity. This theory can be applied to both ones outer world (i.e. observing a scene in nature) as well as ones inner world (i.e. being able to identify a emotional impulse right at its appearance).

The latter application can be especially useful in ones emotional development. Sekida explain: for example, if an unwholesome thought impulse such as greed, anger, or jealousy arises, one can honestly and objectively accept its emergence, recognize its true nature, and dismiss it as a mere mental event, rather than burying it in the abyss of subconsciousness which can later be harmful to the mind.⁸⁹ This is being mindful, even though it may not be explicitly labeled as ‘being mindful.’ As we see in Chapter Four on Morita Therapy, these implicit teachings on mindfulness in Zen become evident in its philosophies and methods.

Concluding Remarks

This chapter discussed the various cultural interpretations of mindfulness from the Theravadan, Zen Buddhist, and western psychological traditions. Despite the slight variations in the interpretations (regarding different emphases on dualistic and non-dualistic aspects), the construct of mindfulness seems to resonate in human experience across history and cultures. Mindfulness is indeed an inherent capacity of the human mind.

In this thesis that studies the mindfulness-based psychotherapeutic methods—where meditative practice and psychotherapy are integrated—it is helpful to maintain this framework of understanding: mindfulness is a continuum, composed of the two interactive axes representing the dualistic and non-dualistic modes of mindfulness. In the context of spiritual practice, while the non-dualistic aspect of mindfulness—such as the nonconceptual awareness—seems technically central to the meditative practices, the dualistic aspect of mindfulness—the conceptual, ‘monitoring’ capacity—is also imperative to one’s spiritual development.

The bimodal cultivation of dualistic and non-dualistic mindfulness is also inherently important to the process of psychotherapy. John Welwood, a clinical psychologist/psychotherapist and a meditation practitioner, writes:

Mindfulness practice provides a transitional step between reflect and nondual presence, incorporating elements of both. Directing mindful attention toward thinking allows us to notice a crucial difference—between thoughts and awareness, between the contents of consciousness, which are like clouds passing through the sky, and pure consciousness, which is like the wide open sky itself.⁹⁰

⁸⁹ Ibid, 109.

⁹⁰ John Welwood, *Toward a Psychology of Awakening: Buddhism, Psychotherapy, and the Path of Personal and Spiritual Transformation* (Boston: Shambhala, 2002), 110.

The use of both dualistic and non-dualistic mode of thinking in psychotherapy will be further elaborated in Chapter Five.

Chapter Two: Differences in the Self between Japan and the United States

The conception of the self arises partly from neurophysiological, cognitive, and psychological aspects and processes that are common to human experience; this point was articulated earlier in the Introduction. It is also my contention that such universal, inner layer of the self is where the mechanism of mindfulness operates. This was further supported by the arguments made in Chapter One – that mindfulness is an inherent capacity of the human mind. This Chapter, on the other hand, elaborates the outer layer of the self that is subject to socio-cultural modulations—on cognitive, affective, and behavioral levels. The contents in this chapter will help to understand where the differences in MBCT and Morita Therapy come from.

Independent and Interdependent Self-Construals

Cultural and social psychologists have consistently and successfully found different patterns of thinking and behavior in different societies. Most tends to compare East Asians and Westerners,⁹¹ with the individual's social orientation – the way they relate to self and others – as the independent variable.

Social psychologists such as Markus and Kitayama have noted major differences between Westerners and East Asians, and developed operational terms to describe the differences in self-conception. They noted that Westerners in general have 'independent self-construal,' in which they tend to view the self as an autonomous entity or an isolated unit separated from others and allowed to behave according to their own internal attributes and thoughts.⁹² In contrast, East Asians have 'interdependent self-construal,' in which the self is conceptualized in terms of its relationship to others. They emphasize the interconnectedness of individuals, as well as the contingencies between the individual's behavior and others' thoughts and actions in the relationship. The distinction between self and other is more blurred in this self-construal, which allows the self to be easily modulated by dynamic social contexts.⁹³

The characterization of these two types of self-construal and using self-construal as the independent variable allows researchers to empirically support their findings on the cognitive, affective, and behavioral differences between East Asians and Westerners. Many researchers, in these cross-cultural studies on achievement, cognition, control, and the self, have focused on differences between Japan and the United States, as these two cultures – despite economic and technological similarities – have profoundly different philosophies, politics, histories, demographics, and ideals and thereby embody notable

⁹¹ 'Westerners' in cultural psychological studies seem to imply the white Caucasian population in the U.S., Canada, Europe, and Australia.

⁹² Hazel Rose Markus and Shinobu Kitayama, "Culture and the self: Implications for cognition, emotion, and motivation," *Psychological Review* 98, (1991): 224–253.

⁹³ Ibid.

psychological and behavioral differences worthy of scrutiny. I suggest from both personal experiences and research that the independent self-construal is especially pronounced in the American culture; similarly, the interdependent self-construal is highly prominent in Japan.

In proving that the Japanese self is very distinct from the American self, I present a wealth of empirically based evidences that suggest the cognitive, affective, and behavioral differences among Japanese and Americans. Some of these studies directly focus on differences between Japanese and Americans. However, some use Chinese participants instead of Japanese, or British instead of Americans; some even have a more broad comparison between Asian Americans and European Americans. Regardless of the specificity of the research participants' exact nationalities, the independent variable in these studies remains as the individual's self-construal – whether they are independently or interdependently oriented in the social dynamics of their lives. This scale of measurement is the most important factor in comparison; therefore, for our purposes we may overlook the participant's exact nationality or ethnicity in some of these studies. If the independent variable remains as the individual's social orientation, the general differences between the East Asians and Westerners can most likely be applied to characterizing the differences between Japanese and Americans.

Cognitive and Affective Differences and Their Underlying Neural Mechanisms

It has been suggested that there exists cognitive differences between Westerners and East Asians. Specifically, that Westerners tend to be analytic and East Asians tend to be more holistic in thinking. For instance, in Varnum and colleague's publication "The Origin of Cultural Differences in Cognition: The Social Orientation Hypothesis," they contend that the differences in the cognitive patterns emerge from differences in social orientation (independent VS interdependent self-construal); hence, the title "The Social Orientation Hypothesis." Analytic cognition, arising from independent social orientation, is defined as: "taxonomic and rule-based categorization of objects, a narrow focus in visual attention, dispositional bias in casual attribution, and the use of formal logic in reasoning"⁹⁴ with a "tendency to focus on single dimension or aspect...and a tendency to disentangle phenomena from the contexts in which they are embedded."⁹⁵ In contrast, holistic cognition is characterized by "thematic and family-resemblance-based categorization of objects, a focus on contextual information and relationships in visual attention, an emphasis on situational causes in attribution, and dialecticism"⁹⁶ with an emphasis of "a broad attention to context and relationships in visual attention, categorizing objects, and explaining social behavior."⁹⁷

Some researchers speculate that other factors such as linguistic and genetic differences may account for these differences in cognition. However, Varnum *et al.* argues that these alternative explanations are contradicted by studies that compare social orientations within the same culture or racial group (hence eliminating such alternative

⁹⁴ Michael E. W. Varnum, Igor Grossman, Shinobu Kitayama, and Richard E. Nisbett, "The Origin of Cultural Differences in Cognition: The Social Orientation Hypothesis," *Current Directions in Psychological Science*, 19, no. 1, (2010): 9-13. DOI: 10.1177/0963721409359301 (quote from 9)

⁹⁵ Ibid, 9.

⁹⁶ Ibid.

⁹⁷ Ibid.

explanations), which in turn further supports this “Social Orientation Hypothesis.” They review that some researchers have shown that priming of social orientation (for example, circling of first-person-singular pronouns to prime independent social orientation or collective pronouns to prime interdependent orientation) produces corresponding shifts in cognition for both Westerners and East Asians.⁹⁸ They also summarize the results of other studies which reveal that these cognitive differences can be observed within the same ethnic groups when comparing residents between different geographic regions or different economic activities.⁹⁹ For example, one study found that residents in Hokkaido, an island in Japan where pioneers from the main islands settled, showed more independence than their counterparts from mainland Japan, and correspondingly showed more dispositional bias in attribution – a characteristic of analytic cognition.¹⁰⁰ Such evidence suggests that social orientation (independent versus interdependent conceptions of self) has a significant influence over one’s cognition, and that the difference is especially pronounced between East Asian and Western cultures due to the considerable discrepancy in their respective social orientation style.

Other researchers who studied social orientation differences also observed corresponding differences in affective regulation and social cognition. Singelis and Sharkey observed that when comparing Asian Americans and European Americans, the ease of embarrassment is positively correlated with interdependent self-construal, and negatively correlated with independent self-construal. In simplified words, Asian Americans were more easily embarrassed than European Americans.¹⁰¹ Brockner and Chen compared self-esteem and self-evaluation of American and Chinese participants. They showed that within the group of individuals with independent self-construal (which constituted most American participants and also a few Chinese with stronger independence), the higher their self-esteem, the more strongly the individual will demonstrate positive self-protective behaviors in response to negative feedback from others. The Chinese participants with interdependent self-construal, on the other hand, did not demonstrate such self-protective behaviors.¹⁰² Liew and colleagues also compared Chinese and American participants when studying “The Boss Effect.”¹⁰³ The premise of this study was that one’s self-construal affects how one interprets and reacts to social threats, such as the face of one’s supervisor. Previous studies demonstrated that American adults typically respond faster to their own face than to the faces of others. However, Liew *et al* showed that in Chinese participants, this self-face advantage is lost in the presence of one’s supervisor; they even respond faster to their superior’s face than to

⁹⁸ Ibid.

⁹⁹ Ibid. (Immigration to isolated geographic areas or different economic activities are assumed to promote different social orientations.)

¹⁰⁰ Shinobu Kitayama and Keiko Ishii *et al.*, “Voluntary Settlement and the Spirit of Independence: Evidence from Japan’s ‘Northern Frontier’,” *Journal of Personality and Social Psychology*, 91, no. 3, (2006): 369-384. DOI: 10.1037/0022-3514.91.3.369

¹⁰¹ Theodore M. Singelis and William F. Sharkey, “Culture, self-construal, and embarrassability,” *Journal of Cross-Cultural Psychology*, 26, no. 6, (1995): 622–644. DOI: 10.1177/002202219502600607

¹⁰² Joel Brockner and Ya-Ru Chen, “The moderating roles of self-esteem and self-construal in reaction to a threat to the self: Evidence from the People’s Republic of China and the United States,” *Journal of Personality Psychology*, 71, no. 3, (1996): 603–615.

¹⁰³ Sook-Lei Liew *et al.*, “Who’s Afraid of the Boss: Cultural Differences in Social Hierarchies Modulate Self-Face Recognition in Chinese and Americans,” *PloS One*, 6, no. 2, (2011): 1-8. DOI:10.1371/journal.pone.0016901

their own. This “Boss Effect” was not observed among the European American participants, who maintained faster reaction time to their own face in both low-threat and high-threat conditions. They concluded that self-processing in Americans is influenced more strongly by one’s social status than by one’s hierarchical position as a superior, and that ‘boss’ means general social dominance rather than a direct threat to the self in independent cultures. My understanding from reviewing these studies is that self-construal has a pronounced effect on self-processing in the affective and social domains.

The effect of social orientation and self-construal on one’s self-processing is further demonstrated by neuroscientific studies. Sui and colleagues¹⁰⁴ conducted an EEG study on self-processing in Chinese and British participants. When presented with one’s own face, compared to when familiar (e.g. the mother) faces are presented, British participants showed greater fronto-central activity – neural activity related to self-processing. In contrast, the image of one’s own face elicited less frontal-central activity in Chinese participants. Zhu and colleagues demonstrated through neuroimaging that Americans activate neural regions associated with self-processing (such as the mPFC) only when thinking about one self; however, Chinese participants activate the same regions when thinking about both oneself and one’s close family members – showing the blurring of distinction between self and related others.¹⁰⁵ Activation of the mPFC is also shown to be predictive of how independently or interdependently oriented the participants were.¹⁰⁶ From both behavioral and neuroscientific measurements, it appears that for individuals with independent self-construal the self and other (other being a familiar figure) are separated by a significant difference on their self-relatedness spectrum¹⁰⁷ for those with interdependent self-construal, the self and other distinction is more blurred and the two are much more proximal on the same spectrum. The interdependent ‘self’ seems to constitute not only itself but also related others, such as immediate family members.

Behavioral Differences – Control and Attachment

The previous examples showed cognitive and affective differences that arise from the differences in social orientation and self-construal, of which are especially pronounced when comparing East Asians to Westerners. In this section, I will focus on two aspects of behavior, control and attachment, directly between the American and Japanese populations. My contention is that such general differences in cognition and affective regulation between independent Westerners and interdependent East Asians precipitate significantly in these two aspects of behavior when comparing Americans to Japanese. These two aspects of behavior, control and attachment, seem to exhibit remarkable differences between these cultures.

Difference in Control:

¹⁰⁴ Jie Sui, Chang Hong Liu, and Shihui Han, “Cultural difference in neural mechanisms of self-recognition,” *Social Neuroscience*, 4, no. 5, (2009): 402–411. DOI: 10.1080/17470910802674825

¹⁰⁵ Zhu *et al.*, (2006).

¹⁰⁶ Joan Y. Chiao and Tokiko Harada *et al.*, “Neural basis of individualistic and collectivistic views of self,” *Human Brain Mapping*, 30, no. 9, (2009): 2813–2820.

¹⁰⁷ See Introduction p. 9

The feeling of control is a well-studied subject in psychology, and it is a popular contention that the feeling of being in control is one of the central ingredients to mental health.¹⁰⁸ However, Weisz, Rothbaum, & Blackburn noted that American psychologists have been defining control only in terms of their own cultural context, and that there are at least two general paths to feelings of control.¹⁰⁹ By observing that the Japanese values a different form of control than Americans do, they categorized the sense of control into its primary and secondary form. “In primary control, individuals enhance their rewards by influencing existing realities”¹¹⁰ such as other people, circumstances, symptoms, or behavior. On the other hand, “[i]n secondary control, individuals enhance their rewards by accommodating to existing realities and maximizing satisfaction or goodness of fit with things as they are.”¹¹¹ While the American culture emphasizes primary control, this form of control has been traditionally less valued and less observed in Japan. The Japanese culture rather emphasizes the use of secondary control in their everyday life.¹¹² This difference is even verified empirically by neuroimaging studies. Freeman and colleagues found that Americans show neural activity in the reward-related brain regions in response to signs of dominance, suggesting that they desire primary control. On the contrary, the Japanese participants showed neural activity in the same region in response to signals of subordination, suggesting that they desire secondary control rather than primary.¹¹³

Weisz, Rothbaum and Blackburn further identify four variations of secondary control in Japanese behavior, which would have typically been described as signs of relinquishing control by American psychologists.¹¹⁴ In the predictive form of secondary control, outcomes are attributed to low ability or status. With the combination of behaving in a passive and withdrawn manner, this form of control is an attempt to inhibit unfulfillable expectations and preparing oneself for future events. Vicarious secondary control is characterized by the attribution of outcomes to powerful others (e.g. supervisor in the workplace), showing submissive behavior, and abandons the pursuit of perceived control. The incentive behind this form of control seems to be the fostering of enhanced identification with the powerful others. Illusory secondary control is attributing outcomes to chance, luck, or fate combined with maintaining passivity in competitive circumstances. This form reflects an attempt to ally with forces of chance so as to feel a partnership with such forces, and comfortably accept one’s ‘bad lucks’ when things don’t go the way as desired. Finally, the interpretative form of secondary control requires gaining a sense of mastery over realities by altering their perspective on the realities so as to derive meaning from them and accept them as they are. These forms of secondary

¹⁰⁸ Daniel Goleman, “The Feeling of Control Viewed as Central in Mental Health,” *The New York Times*, written October 7, 1986, <http://www.nytimes.com/1986/10/07/science/feeling-of-control-viewed-as-central-in-mental-health.html>

¹⁰⁹ John R. Weisz, Fred M. Rothbaum, and Thomas C. Blackburn, “Standing Out and Standing In: The Psychology of Control in America and Japan,” *American Psychologist*, 39, no. 9, (1984): 955-969.

¹¹⁰ *Ibid.*, 955.

¹¹¹ *Ibid.*

¹¹² *Ibid.*

¹¹³ Jonathan B. Freeman *et al.*, “Culture shapes a mesolimbic response to signals of dominance and subordination that associates with behavior,” *Neuroimage*, 47, no. 1, (2009): 353-359.

¹¹⁴ Weisz, Rothbaum, and Blackburn, (1984). (All information in this paragraph from this source.)

control are central to many aspects in the Japanese culture, from socialization, religion and philosophy, work, child rearing, to psychotherapy.

Since one of the central purposes of this thesis is to compare methods of mindfulness-based psychotherapies between the Japanese and American contexts with different self-conceptions as the mediating factor, the comparison of the difference in psychotherapy that arise from different expectations of control will be elaborated in the final chapter. However, contrasting some of the other aspects such as religion, work, and child-rearing in the context of control will help to further elucidate the difference in self-conception between Japanese and Americans. The difference in control and their general characteristics are summarized in the table below.

Table 2.1: Summary of Primary versus Secondary Control¹¹⁵

Type of Control	General Strategy	Typical targets for causal influence	Overall intent
Primary	Influence existing realities	Other people, objects, environmental circumstances, status or standing relative to others, behavior	Enhance reward by influencing realities to fit the self
Secondary	Accommodate to existing realities	Self's expectations, wishes, goals, perceptions, attitudes, interpretations, attributions	Enhance reward by influencing psychological impact of realities on the self

Control in Religion:

Weisz, Rothbaum, and Blackburn compares the forms of control interpreted from the teachings of Christianity versus Zen Buddhism for the reason that Christianity figures prominently in the history, traditions, and culture of the United States as Zen Buddhism does Japan. They are under the assumption that even if an individual is not committed to a particular religion, the values and morals of the society that the individual belongs to most likely has been shaped by its most prominent religion(s), which will in turn affect that individual's social orientation and self-conception. They are careful to point out that generally, religions across sects and cultures distinctly emphasize secondary control by instructing followers to accommodate to higher powers, and be rewarded by allying with their power, wisdom, or virtue.

Weisz, Rothbaum, and Blackburn emphasize with precaution that Christianity does emphasize this type of secondary control in many ways; but they have also found certain aspects within the Christian teachings that show a considerable emphasis on primary control. They state that “the central objective of many Christian sects has been to alter the world to make it fit their own Christian percepts”,¹¹⁶ quoting a section from the Bible that describes God as having told Adam and Eve “Have many children, so that your descendants will live all over the earth and bring it under their control.”¹¹⁷ They also mention that although there are not many Christian contemplatives today, when they are

¹¹⁵ This table is a replication (with slight modification) from the one on page 956 from Weisz, Rothbaum, and Blackburn (1984)

¹¹⁶ Ibid., 961.

¹¹⁷ Ibid.

contemplative, “their meditation and prayer often aimed partly at becoming attuned to God and partly at convincing God to alter certain realities.”¹¹⁸ In these ways, they contend that there is a considerable amount of manifestations that seem to emphasize primary control in the Christian traditions. Similarly, when Pargament and colleagues¹¹⁹ observed people using Christian prayers in the hospital waiting room, they interpreted that certain prayers were approaches to achieving a sense of primary control (such as intercessory prayers, i.e. prayers for a divine intervention). While it is neither these researchers’ nor my contention that Christianity only reflects a means for pursuing primary control, I believe that pointing out a few examples like these can shed light on some historical roots of behavioral differences between the two cultures of the U.S. and Japan. The key point here is that while *some* forms of primary control is observed in Christianity along with forms of secondary control as well, Zen Buddhism in contrast seems to primarily emphasize secondary control.

Within this framework, Weisz, Rothbaum, and Blackburn further argue that Zen Buddhism places a significantly heavier emphasis on secondary control, when compared to Christianity. In Zen Buddhism, the main objective of religious practice is to abandon desires for realities that do not exist and to achieve a state of transcendental awareness or enlightenment, which catalyzes the changing of orientation toward realities. Attempts to alter existing realities are discouraged, even those that provoke suffering. *Arugamama* is one of the most symbolic sayings of Zen Buddhism, translated literally to “as they are” – to peacefully accept one’s outcomes, and is considered as “a sign of great maturity and wisdom” not only in Zen Buddhism but also in the Japanese culture as a whole.¹²⁰ The concept of *Arugamama* is also central to the philosophies of Morita Therapy, which we will see in Chapter Four.

Control in Work:

Weisz, Rothbaum, and Blackburn note that a significant difference in control is observed when comparing Americans and Japanese at work. Considering the highly industrialized status of modern society, work is an integral part of one’s life; One’s work environment and ethics is another aspect where the individual’s self-conception manifests. In general, work is a distinct precipitation of primary control; regardless of the culture, the reason most people work is to influence existing realities such as their income, social statuses, and living conditions.

However, Weisz, Rothbaum, and Blackburn observed that there is an especially strong emphasis of primary control in the United States with regard to work. Such emphasis is evidenced in the valuing of self-reliance, independence, and individual initiative, the higher rates in quitting jobs, and the more aggressive behavior of American workers in altering existing situations (e.g. through strike).¹²¹

They also observed that in contrast to workers in the U.S., workers in Japan practice the vicarious and predictive forms of secondary control.¹²² The predictive forms

¹¹⁸ Ibid.

¹¹⁹ Kenneth I. Pargament *et al.*, “The Vigil: Religion and the Search for Control in the Hospital Waiting Room,” *Journal of Health Psychology*, 4, no. 3, (1999): 327-341. DOI: 10.1177/135910539900400303

¹²⁰ Weisz, Rothbaum, and Blackburn, (1984).

¹²¹ Ibid.

¹²² Ibid. (All information from this paragraph drawn from this article.)

of secondary control are exemplified in the clear lines of status and hierarchy, as well as the related formalized rituals – for example bowing when greeting to a supervisor. The established hierarchies allow an individual to immediately identify superiors and inferiors, predict the nature of his interaction with them, and thereby minimize uncertainty, anxiety, and disappointment. A common example is the immediate exchange of business cards upon meeting. This serves as an instantaneous clarification of the “up and down vectors in their relationship”¹²³ and allows each individual to accordingly fix the language and behavior. Exemplifying the vicarious form is the common work ethic that a worker should dedicate self to the advancement of the group, which allows him to achieve a somewhat mystical union with his group. Weisz, Rothbaum, and Blackburn refer to a survey measured that 66% of Japanese workers rated their companies at least equal in importance to them as their personal lives. Americans, in contrast, only rated 24%.¹²⁴

The extremely high values placed on work by the Japanese has been historically pointed out by a number of anthropologists, including David K. Reynolds who studied Morita therapy in Japan.¹²⁵ Their extreme dedication to work is even exemplified, sadly, by the high prevalence of *karoshi*. *Karoshi* is a form of death caused by overworking, commonly involving heart or brain diseases; it is becoming increasingly common among Japanese salary men with long working hours.¹²⁶ Although Americans, too, ‘work hard’, we do not see this type of public health concern in the U.S. (at least not as nearly to the same degree as in Japan.) The extreme forms of dedication to work by the Japanese (which almost takes the form of ‘self-sacrifice’) further illustrate the interdependent nature of their self-construal; they not only work for themselves and their families, but they work because they feel a great degree of social responsibility within their company.

Differences in Attachment and Child Rearing:

Another aspect of behavior I will compare is attachment and child rearing – an aspect that reveals manifestations of not only difference in control but also difference in self-conceptions in the bigger picture. While the different perspectives in the feelings of control were addressed in the previous section, in this section I will explain how western attachment theory does not apply to the Japanese culture (based on Rothbaum *et al.*’s article “Attachment and Culture: Security in the United States and Japan”). Later in this section, I will also introduce Doi’s theory of *amae* articulated in his *The Anatomy of Dependence* (‘*Amae no Kozo*’ in Japanese). Doi’s theory of *amae* stands as the Japanese counterpart of the attachment theory in the West.

Attachment theory is western psychology’s most influential theory of relatedness; an individual’s attachment pattern largely dictates his/her experience of the self. It addresses the period of helplessness in each human infant, and the infant’s biologically programmed need to call for the mother’s protection and care.¹²⁷ Attachment theory also

¹²³ Ibid., 963.

¹²⁴ Ibid.

¹²⁵ David K. Reynolds. *Morita Psychotherapy* (London: University of California Press, 1976), 128.

¹²⁶ Kenji Iwasaki, Masaya Takahashi, and Akinori Nakata, “Health Problems due to Long Working Hours in Japan: Working Hours, Workers’ Compensation (Karoshi), and Preventive Measures,” *Industrial Health*, 44, (2006): 537-540.

¹²⁷ Fred M. Rothbaum *et al.*, “Attachment and Culture: Security in the United States and Japan,” *American Psychologist*, 53, no. 10, (2000): 1093-1104. DOI: 10.1037//0003-066X.55.10.1093

proposes that the behavior of attachment is rooted in evolution: increasing the mother-infant proximity provides survival advantage of the infant.¹²⁸

Rothbaum and colleagues summarize that there are three core hypotheses in the attachment theory, but they do not necessarily apply to other cultures. The three core hypotheses are: the Sensitivity Hypothesis, that caregiver sensitivity leads to secure attachment; the Competence Hypothesis, that secure attachment leads to social competence later in life; and finally the Secure Base Hypothesis, that children who are securely attached use the primary caregiver as a secure base for exploring the external world.¹²⁹ However, they further argue that these core tenets of attachment theory are “deeply rooted in mainstream Western thought”¹³⁰ –the culture of individualism—and that these hypotheses do not necessarily apply to other cultures or minority groups. Rothbaum and colleagues argue: “Western investigators [in attachment theory] have been blinded to alternative conceptions of relatedness.”¹³¹ To show the limited universality of western attachment theory, they use the Japanese parenting and attachment style as an example: the collectivist culture of Japan emphasizes different values than western parents do, and therefore the two cultures have completely different styles of parenting. A preview of these differences is summarized in the table below.

Table 2.2: Summary of Attachment Differences

Hypothesis in Attachment Theory	U.S.	Japan
Sensitivity	Being sensitive and respectful of the child’s own wishes, autonomy, and self-efficacy; communicational focus on information	Anticipatory sensitivity in helping the child regulate emotions; communicational focus on emotions and skin-to-skin contact
Competence	Social competence entails problem solving skills, higher self-esteem and ego resilience, and versatile interpersonal exploration; Standing ‘out’	Social competence entails extreme sensitivity to social cues, distinguishing of in- and out-groups, emotional restraint to out-groups, feeling oneness with in-groups; Standing ‘in’
Security	Attachment object acts as a secure basis for individuation and exploration of the external world, mastery of the environment	Attachment object acts as a secure basis for dependence (<i>amae</i>), accommodation to the environment

Difference in ‘Sensitivity’:

Let me begin by illustrating the differences in individualistic and communitarian values regarding the Sensitivity Hypothesis, as described by Rothbaum *et al.*¹³² This hypothesis is supported by Ainsworth’s early research, which revealed that primary caregivers’ sensitivity or responsiveness to their children is a major factor that determines

¹²⁸ John Bowlby, *Attachment and loss: Vol. 1. Attachment* (2nd ed.) (New York: Basic Books, 1982)

¹²⁹ Rothbaum *et al.*, (2000).

¹³⁰ *Ibid.*, 1094.

¹³¹ *Ibid.*, 1093.

¹³² *Ibid.*, 1096-1097. (All information in this paragraph drawn from these pages.)

the children's attachment security. However, the 'responsiveness' addressed in this hypothesis is defined in the context of children's autonomy as the main value. The various factors of 'responsiveness' include: *acceptance*, in which the mother values the child's own will even when it opposes hers and respects the child as a separate, autonomous person; *cooperation*, in which the mother avoids situations in which she may have to impose her own will on him and respects the validity of the child's own activities; and *sensitivity*, in which the mother gives the child whatever he indicates he wants so as to help the child gain a feeling of self efficacy.

However, Rothbaum *et al.* argue that 'responsiveness' to a Japanese parent means significantly different.¹³³ Instead of waiting for the child to communicate their needs like an American mother does, the Japanese mother would anticipate the child's needs by relying on situational cues. This includes taking anticipatory measures to minimize the child's stress, and is more related to emotional closeness as the mother's role is oriented towards helping the child regulate their emotional states. In communication, the Japanese parent's speech is more focused on emotions and prolonged skin-to-skin contact, where as Americans are focused more on information when communicating with the child. The Japanese parent also attempts to orient the child's attention towards social objects, particularly themselves; in contrast, American parents are observed to orient the child's attention to physical objects such as toys.

Difference in 'Social Competence':

Rothbaum and colleagues argue that The Competence Hypothesis is also rooted in the American ideals.¹³⁴ Specifically, it relies heavily on the American classification of 'social competence'. In the U.S. a securely attached child is predicted to be more autonomous, more likely to persist in problem-solving, has higher self-esteem and ego resilience, and engages in more versatile exploration including interpersonal ones – such as talking to unfamiliar adults. These classifications reflects on the Western focus on individuation, self-reliance, self-efficacy, and emotional openness.

However, contrary to the American value on individual autonomy, the path of depending on others is prescribed in Japanese parenting.¹³⁵ Dependence is perceived as a way of coordinating one's actions with needs of others – as a way to preserve the social harmony. Emotional restraint is valued for the same purpose, in which children are encouraged to keep hostile feelings to themselves, or to express them indirectly. Social maturity in Japan places a high value on one's capacity for *ittaikan*, a feeling of oneness with persons other than self. Other categories of mature sociability in Japan includes the child's ability to differentiate between appropriate behavior with in-group versus out-group members, to express empathy with others and compliance with others' wishes, and to be extremely responsive to social cues and norms. An assertive, autonomous person who engages in self-enhancement is considered immature and uncultivated. In America, making one's individuality salient or to 'stand out' is a valued group skill; in Japan, one must learn to 'stand in' – to become identified with the group that one's individuality remains unnoticed. These differences in socialization again illustrate the difference in the value of control as well as difference in their self-conceptions.

¹³³ Ibid.

¹³⁴ Ibid., 1097-1099. (All information in this paragraph drawn from these pages.)

¹³⁵ Ibid.

Difference in ‘Security’ – Individuation versus Dependence:

The last hypothesis in attachment theory is also incompatible to Japanese parenting values.¹³⁶ The Secure Base Hypothesis proposes that if the child is securely attached, he is able to engage in exploration of the external world, which leads to individuation. While *individuation* is highly valued in personal growth in the West, *dependence* stands as the Japanese counterpart of this value.

The capacity for adaptation is another skillset that supposedly emerges from a secure attachment; however, even the term ‘adaptation’ has a different connotation in Japan. In the U.S., adaptation has a major connection to exploration and primarily refers to individuation and autonomous mastery of the environment. In Japan, adaptation refers to accommodation, avoidance of loss, fitting in with others, and has a major correlation with dependence. Observation of both Japanese and American babies revealed that while American babies are more oriented towards the environment in circumstances involving both distress and positive emotions, Japanese babies were more oriented to their mothers in the same circumstances. The concept of dependence is not only highly valued in the Japanese culture but is also commonly studied by Japanese mental care professionals. Among them is Takeo Doi, who contended that the concept of *amae* is extremely influential in the Japanese psychology.

Dependence in Japan – the Notion of *Amae*:

Amae can be translated *roughly* to ‘dependence’ in English, and the notion of *amae* describes an attachment pattern unique to Japanese psychology. Rothbaum and colleagues noted that Doi’s theory of *amae* parallels exactly with the Western construct of attachment, and serves as an alternative theory of attachment in the context of Japanese culture. They highlight the parallels: *Amae* and attachment “both become fully developed around the end of the first year of life and take on different forms throughout the life span...both are fostered by caregiver responsiveness and empathy...both lead to emotional competence, including affect regulation”¹³⁷; in addition, both have identified the secure and insecure patterns.

Takeo Doi, a Japanese psychiatrist educated in psychoanalysis, was the first to introduce this notion of *amae* to western psychological audience. In his *The Anatomy of Dependence*,¹³⁸ he explains that the Japanese term of *amae* “represents an attempt to draw close to the other person...a craving of a new born child for close contact with it smother, and, in the broader sense, the desire to deny the fact of separation that is an inevitable part of human existence”.¹³⁹ The concept of *amae* does in fact share significant resemblance to the Western notion of attachment; however, it is not the same. There is a much stronger emphasis on dependence in *amae* – reflective of the collectivist value of the Japanese culture.

¹³⁶ Ibid., 1099-1100. (All information in this paragraph drawn from these pages.)

¹³⁷ Ibid., 1100.

¹³⁸ The original Japanese title for this book is *Amae-no-kozo* (甘えの構造), translated literally to the structure of *amae*. Since there is no exact translation for *amae* in English, the title was named *The Anatomy of Dependence*.

¹³⁹ Takeo Doi, *The Anatomy of Dependence* (Tokyo: Kodansha International, 1973), 167.

Doi points out that the concept of *amae* seems to be peculiar to the Japanese language, and that there was no appropriate translation in the languages of the West.¹⁴⁰ He emphasizes this point in an interesting anecdote:

An episode that brought home still more strongly to me the uniqueness of the word *amae* as an item of vocabulary in Japanese occurred when I was asked to undertake treatment of a woman of mixed parentage who was suffering from anxiety hysteria. One day I was questioning her mother concerning her upbringing the conversation turned to the patient's early childhood and the mother, an English lady born in Japan and fluent in Japanese, suddenly switched from English and said quite clearly in Japanese, *kono ko wa amari amaemasen deshita*—"She did not *amaeru*¹⁴¹ much" (in other words, she kept herself to herself...never behaved childishly in the confident assumption that her parents would indulge her)...I asked her why she had used Japanese for that single sentence. She thought a while, then said, "There's no way of expressing it in English."¹⁴²

I speculate that this translational gap surrounding the notion of *amae* may be explained in terms of the Lexical Hypothesis in personality psychology—that personality characteristics important to a culture eventually becomes a part of their language.¹⁴³

Although Doi contended that the concept of *amae* is unique to Japanese psychology for these linguistic reasons, he also speculated "the existence of the feeling of *amae* is possible for societies where there is no word to indicate it."¹⁴⁴ He interpreted the term "passive object love" in Michael Balint's *Primary Love and Psychoanalytic Technique* to be none other than *amae*.¹⁴⁵ Doi further explains,

[Balint's remark that] 'all the European languages fail to distinguish between active love and passive love' seemed to me to underline still more strongly my conviction that the existence of an everyday word for passive love—*amae*—was an indicator of the nature of Japanese society and culture.¹⁴⁶

His contention is that such peculiarity in the Japanese language – the mere existence of the word *amae* – has a close relationship with the unique aspects of Japanese psychology, in which that the feeling of *amae* is most pronounced in the Japanese society. "In a Japanese these feelings are somehow prolonged into and diffused throughout his adult life, so that they come to shape, to a far greater extent than adults in the West."¹⁴⁷

The value of dependence in the Japanese culture may spring from this unique *amae* psychology of the Japanese people. Doi posits that *amae* may ultimately be a

¹⁴⁰ Ibid., 14-15.

¹⁴¹ *Amaeru* is the verb form of *amae* – to show or exhibit *amae*.

¹⁴² Ibid., 18.

¹⁴³ Lewis R. Goldberg, "The structure of phenotypic personality traits," *American Psychologist*, 48, (1993): 26-34.

¹⁴⁴ Doi, (1973), 171.

¹⁴⁵ Ibid., 20.

¹⁴⁶ Ibid., 20-21.

¹⁴⁷ Ibid., 7.

psychological attempt for the infant to “deny the fact of separation from the mother.”¹⁴⁸ In contrast to the Western notion of attachment (where individuation and differentiation are considered products of ‘healthy attachment’), *amae* involves indifference or even a denial of the claims of the other person as a separate individual. In *amae*, there is a considerable blurring of the distinction between the subject (self) and object (mother). Sometimes the individual, enacting *amae*, may deliberately act in a childish manner as “a sign to the other that he/she wishes to be dependent and seeks the other’s ‘indulgence’.”¹⁴⁹ The act of *amae*, therefore, is not necessarily governed by moral or rational standards, and may often seem selfish from the eyes of the outsider. It is as if to obliterate the pain of separation from the mother as two separate human beings, which is nonetheless an inevitable process of human existence.

In both *The Anatomy of Dependence* and *The Anatomy of Self: The Individual Versus Society*, Doi posits that the strong emphasis on dependency in *amae* suggests that this feeling may be a mediator in establishing the ‘in’ and ‘out’ groups in the Japanese culture. Doi, in suggesting that *amae* permeates the larger Japanese societal structure, brings up the concepts of *tanin* (他人) and *enryo* (遠慮).¹⁵⁰ *Tanin* in the Japanese dictionary means “persons with no blood relationship” or “persons unconnected with oneself.”¹⁵¹ *Enryo* is another peculiar Japanese expression which may be translated approximately to “restraint” or “holding back [the wish to be dependent on that person].”¹⁵² I, myself, have had realizations that Americans do not have a concept of *enryo*. For example, if a stranger (*tanin*) offers me a seat on the train, I may politely decline his offer as a way to show my *enryo*. Parents and children cannot be *tanin*, since their bonds bound by ‘blood’ are considered unbreakable. There will be no *enryo* between a child and a parent; *enryo* decreases proportionately with intimacy and increases with distance. In another words, *enryo* can be thought of as the opposite of *amae*. A Japanese person might show *enryo* to most people, except their family members who will accept their *amae*.

Therefore, the family or the ‘in-group’ appears to be a safe haven where one is allowed to indulge in *amae*. *Amae* therefore establishes the distinction between ‘in’ and ‘out.’ Doi (1973) explains that this point is further emphasized in the Japanese interpretation of the word freedom, *jiyuu*. This word was traditionally used in the combination *jiyuu-kimama*, which basically means ‘fancy free’ – to behave as one pleases, without restraints. The word “[f]reedom in Japan, in other words, has traditionally meant the freedom to *amaeru*.”¹⁵³ In contrast to this, the idea of freedom in the West has become associated strongly with the rights and dignity of man, and serves as a basis for asserting the precedence of the individual over the group. In the West with its individualistic values, the type of emotional dependency that corresponds to *amae* has been looked down upon. In Doi’s words, “the Western concept of freedom depends on a rejection of *amae*.”¹⁵⁴ In the West, the existence of *amae* is faint, which may also be

¹⁴⁸ Ibid., 75.

¹⁴⁹ Ibid., 7.

¹⁵⁰ Ibid., 36.

¹⁵¹ Ibid.

¹⁵² Ibid., 38.

¹⁵³ Ibid., 84.

¹⁵⁴ Ibid., 86.

illustrated by the fact that there is no concept of *enryo* either, because without *amae* there exists no *enryo*. These two concepts are two sides of the same coin. These concepts may instead be characteristic to a society where interdependence is highly valued, such as Japan.

Doi, in his *The Anatomy of Self: The Individual Versus Society*, further deconstructs the ‘in versus out’ structure in the Japanese conception of self. The title of the original Japanese copy is translated literally to *Front and Back* (表と裏). To a Westerner who possesses no such clearly established dichotomy in his self-construct, this title may not ring a bell. However, the notion of ‘front and back’ is very descriptive of the Japanese experience of the self. Basically, the ‘front’ of a Japanese person is what is shown to the outside or ‘out-group’, and the ‘back’ is the aspect of his self that only his family or the ‘in-group’ sees. Such duality in the Japanese self-expression is emphasized by the dual existence of *enryo* and *amae* as illustrated previously.

Doi, in emphasizing this structure of the Japanese self, also introduces the concepts of *tatamae* and *honne*—a dichotomy of the Japanese public versus private self. If I am married to a man whose mother I dislike, I may have the *honne* (the private, inner, honest thought) of disliking her; but as an act of *tatamae* for the other family members—for the sake of maintaining the interpersonal harmony—I will not act on my *honne* so as to maintain my ‘front.’ In this way, *tatamae* refers to “convention created by people on the basis of consensus”¹⁵⁵ or a way of dealing with others by minimizing interpersonal frictions. Doi contends that the concept of *tatamae* may be the underlying factor behind Japanese people’s appreciation of “subtle consideration and delicate nuances in human relations”.¹⁵⁶ Although these types of interpersonal interactions may be present in other societies and that *tatamae* and *honne* can be translated into Western concepts, the fact that these words spring from everyday language show that the Japanese are keenly aware of the symbiotic relationship between them.¹⁵⁷ Without *tatamae* and *honne*, or *enryo* and *amae*, there will be no establishment of the distinction between in- and out-groups.

But why is the distinction of the in- and out-groups necessary for the Japanese self-conception? The answer is that by establishing the distinction, one can identify himself in relation to others who are emotionally or socially tied to him. According to Doi, the English word identity was first used in its psychological sense by Erik Erikson, and it refers to both continuity of the self and the self’s connection with others. The Japanese translation of “identity” is *doitsusei* and the term means to identify with someone or something. The awareness of the self for a Japanese person, therefore, is constituted on the basis of connection with others.¹⁵⁸ Only by establishing the ‘in’ and ‘out’ environments, one can permit himself to ‘*amaeru*’ within his in-group (e.g. family); through his feeling and behavior of *amae* towards his related others, he can identify himself with them in order to gain a more complete sense of self. In these ways, we see that the Japanese conception of self is constructed based on a different developmental path: in contrast to the western sense of self that develops through individuation,

¹⁵⁵ Takeo Doi, *The Anatomy of Self: The Individual Versus Society* (New York: Kodansha International, 1986), 36.

¹⁵⁶ Ibid., 43.

¹⁵⁷ Ibid., 47.

¹⁵⁸ Ibid., 80.

differentiation, and exploration of the external environment, the Japanese sense of self is constructed inter-relationally.

Concluding Remarks

This chapter explored the possible cognitive, affective, neural, and behavioral bases of the difference in the conception of self between Japan and the West (particularly the U.S.) These differences seem to arise from the difference in one's self-construal: independent versus interdependent. Americans (and in the more general sense, westerners) tend to have an independent self-construal, in which they view themselves as separated, autonomous individuals. In turn, they seem to exhibit analytical cognition, self-protective responses to social threats, pursuit for primary control, and attachment patterns based on self-efficacy, individuation, and exploration of the external world. On the other hand, Japanese people tend to have an interdependent self-construal, in which their sense of self is conceptualized in terms of their relationship to others. This type of self-construal tends to precipitate in holistic cognition, strong response to social threats, pursuit for secondary control, and attachment patterns based on emotional dependence. These examples all support my contention that within the self there is an outer layer subject to socio-cultural modulation, and will be helpful in understanding the differences between MBCT and Morita therapy in Chapter Six. To further set up the foundations for the comparison, the next two chapters will outline the philosophies and methods of MBCT (Chapter Three) and Morita Therapy (Chapter Four).

Chapter Three: Mindfulness-based Cognitive Therapy

This chapter is dedicated to describing the methods and theories of Mindfulness-based Cognitive Therapy (MBCT), a form of cognitive psychotherapy integrated with the contemplative practice of mindfulness. MBCT was founded by Zindel Siegel, Mark Williams, and John D. Teasdale, based on the theories from Mindfulness-based Stress Reduction (MBSR) which was pioneered by Jon Kabat-Zinn in the 1990's. MBCT can be thought of a cousin to MBSR, with elements of Cognitive Behavior Therapy (CBT) integrated into the program. While MBSR is used for patients with a range of physical and psychological conditions, MBCT was originally developed as a relapse-prevention program targeted to a group of depressive people in remission, where they can learn how to bring awareness to their thoughts, emotions, and body sensations and to respond adaptively to early signs of relapse.¹⁵⁹ However, the applicability of MBCT to a range of other conditions is being researched, such as chronic fatigue syndrome, oncology, treatment resistant depression, bipolar disorder, and residual depressive symptoms¹⁶⁰. Unlike other forms of conventional psychotherapy, MBCT, like MBSR, is an eight-week class format program that accommodates up to twelve participants¹⁶¹ who are treated more like *guests* than *patients* – with warm hospitality and respect.¹⁶²

We have touched on the various interpretations of the concept mindfulness across different historical and cultural contexts in Chapter One. Although mindfulness is a universally inherent capacity of the human mind, the concept holds a specific operational definition in western clinical science. This is particularly evident in the methods and theories of MBCT. I would like to begin this chapter by explaining the basic ways in which mindfulness is embedded in the MBCT program, followed by its roots in CBT, its basic theoretical framework, and detailed explanations of the cognitive and mindfulness-based exercises and practices of the program.

The 'Mindfulness' in MBCT

The ways in which elements of mindfulness are embedded in the MBCT program is based on the way mindfulness is taught in MBSR. In the development of MBSR, 'mindfulness' was recontextualized by Kabat-Zinn from its original Buddhist context to a context that is more directly applicable for clinical research and therapeutic purpose. The recontextualized concept of mindfulness was thus "taught in a group-based, secular, educational program and integrated with psychological understanding, models of stress from mind-body medicine, and explorations on working with challenges of modern living."¹⁶³ In MBCT, the sequencing of different mindfulness practice is similar to that in MBSR.¹⁶⁴

¹⁵⁹ Rebecca Crane, *The Distinctive Theoretical Features of MBCT* (New York: Routledge, 2009), 3.

¹⁶⁰ *Ibid.*, 76.

¹⁶¹ *Ibid.*, 3.

¹⁶² Siegel, Williams, and Teasdale, 137.

¹⁶³ Crane, 6-7.

¹⁶⁴ *Ibid.*, 7.

In MBCT, there are three broad elements of mindfulness embedded into the program.¹⁶⁵ First, it involves the development of awareness through a systematic methodology involving both ‘formal’ and ‘informal’ mindfulness practice. ‘Formal’ practice involves the exercises taught in the MBCT sessions, such as sitting meditation, body scan meditation, and mindful movement; ‘informal’ practice entails the cultivation of present-moment awareness in one’s daily life activities¹⁶⁶ (which are both to be explained in detail later in the chapter).

The second element of mindfulness is expressed through the attitudinal framework of kindness, curiosity, and non-striving; it involves the willingness to confront the unfolding of experience, pleasant or unpleasant. This attitudinal framework is both deliberately cultivated at first, and spontaneously emerges through the various practice of the program.¹⁶⁷ Self-compassion seems to be the implicit byproduct of this program¹⁶⁸, potentially emerging from this element of mindfulness. The last element is the embodied understanding of human vulnerability to suffering. This concept is developed through hearing teachings and exploring the validity of the theories through directly seeing our experience, and facilitated through dialogue, reflection, and group exercises as well.¹⁶⁹ These two elements together show that through MBCT, one develops a compassionate, non-judgmental understanding and acceptance towards his/her own suffering.

“At the heart of mindfulness practice is a paradox: it encourages full engagement with our lives while simultaneously stepping back and observing what is going on.”¹⁷⁰ Over all, there is a strong emphasis in MBCT on direct, embodied, experiential learning of the nature of one’s mind, which is central to the practice of mindfulness. However, the program also establishes an intellectual framework in understanding the nature of depression, which is derived from CBT.

Roots in Cognitive Behavioral Therapy

CBT:

Cognitive behavioral therapy was pioneered by Albert Ellis and Aaron Beck. This form of therapy focuses on the internal states and events in the mind – particularly how people perceive and interpret them. The premise of CBT is that psychological problems arise from maladaptive automatic thoughts, termed ‘cognitive distortions’. These cognitive distortions are categorized into five types: Dichotomous thinking (i.e. black and white thinking), which involves maintaining only extremes of ideas; Mental filtering, the directing of attention to negative qualities while overlooking the positives or alternatives; Mind reading, which is believing that you can read other people’s mind, particularly what they think of you; Catastrophic exaggeration, the anticipation of the worst possible outcomes and thinking that you won’t be able to handle them; and Control beliefs, believing that unless you keep things under ‘control, you will be helpless.¹⁷¹

¹⁶⁵ Ibid, 4.

¹⁶⁶ Kabat-Zinn, (1990), 57.

¹⁶⁷ Crane, 4.

¹⁶⁸ Segal, Williams, and Teasdale, 411.

¹⁶⁹ Crane, 4.

¹⁷⁰ Ibid., 61.

¹⁷¹ Robin S. Rosenberg and Stephen M. Kosslyn, *Abnormal Psychology* (New York: Worth Publishers, 2011), 122-132. (All information in this paragraph from this source.)

In light of these cognitive distortions that contribute to psychopathology, CBT promotes the process of cognitive restructuring – to help patients step out of these maladaptive cognitive habits. In promoting cognitive restructuring, the therapist helps the patient to consider the accuracy of their automatic thoughts and/or habitual ways of interpreting events. Through the reassessment of one's cognitive patterns, the developing of more realistic thoughts and/or interpretations occurs, and negative automatic thoughts are diminished. This process relies on the patient's written self-report of their identified dysfunctional thoughts each day; they are instructed to identify the context in which their automatic thoughts arise, and rate their emotional state in relation to those thoughts. They are also to record rational response to those automatic thoughts, and a new rating of their emotional state after the re-evaluation. In these ways, the patients are encouraged to see their negative thoughts and interpretations as 'testable hypotheses' that can be assessed through 'real life' experiments. The patients challenge the logic and truth of their automatic thought and develops a rational response. CBT may also employ psycho-education, which involves educating the patient with an intellectual framework about the nature of his disorder.¹⁷²

The CBT elements in MBCT:

In MBCT, the core theme is to prevent the establishment and consolidation of habitual patterns of negative thinking, with the aid of mindfulness.¹⁷³ Based on the evidence-based research on depression, the founders of MBCT, Segal, Williams, and Teasdale contended that such negative thinking habituation escalates negative mood states, eventually leading to depressive relapse. The aim of MBCT is not to "prevent negative thinking all together, but to rather prevent their establishment when they occur."¹⁷⁴ Negative mood states are inevitable to human experience; we all have our ups and downs. However, it becomes pathological when we cannot step out of them, or we cannot see that we are putting ourselves in a self-perpetuating downward spiral.

Segal, Williams, and Teasdale recognized that the habitual patterns of negative thinking are based on "old, well-practiced, automatic cognitive routines (often ruminative)."¹⁷⁵ Based on the theories from CBT, they further categorized the seven signs of such negative thinking habituation:

- 1) Living on 'automatic pilot' (rather than with awareness and conscious choice)
- 2) Relating to experience through thought (rather than directly sensing)
- 3) Dwelling on and in past and future (rather than being fully in the present moment)
- 4) Trying to avoid, escape, or get rid of unpleasant experience (rather than approach it with interest)
- 5) Needing things to be different from how they are (rather than allowing them to be or just as they already are)

¹⁷² Ibid. (All information in this paragraph from this source.)

¹⁷³ Segal, Williams, and Teasdale, 88.

¹⁷⁴ Ibid.

¹⁷⁵ Ibid., 89.

- 6) Seeing thoughts as true and real (rather than as mental events that may or may not correspond to reality)
- 7) Treating oneself harshly and unkindly (rather than taking care of oneself with kindness and compassion)¹⁷⁶

Through MBCT, the patient learns the core skills in stepping out of these self-perpetuating cognitive routines.

The bottom line is to be mindful (aware), let go. Letting go means relinquishing involvement in these routines, freeing oneself from the need for things to be different that drives the thinking patterns – it is the continued attempts to escape or avoid unhappiness that keep the negative cycles turning. The aim of this program is freedom, not happiness, relaxation, and so on, although these may well be welcome by-products.¹⁷⁷

The contribution from CBT in MBCT takes two forms.¹⁷⁸ First is the underpinning cognitive framework for understanding depression, as described above. There is a particular emphasis on rumination and experiential avoidance as the two major contributing factors to vulnerability to depression. Rumination is a “particular style of self-critical, self-focused, repetitive negative thinking,”¹⁷⁹ driven by the desire to solve emotional challenges.¹⁸⁰ Experiential avoidance is the “attempt to remain out of contact with the direct experience of challenging thoughts, emotions and body sensations.”¹⁸¹

Crane explains that: “The experience of depression comes as a constellation and interaction of lowered mood, ruminative thinking patterns, experiential avoidance and physical sensations of fatigue and heaviness.”¹⁸² When depressive episodes are repeated, the learnt associations between these cognitive, emotional, and physical components are strengthened, and reactivated at times of lower mood states.¹⁸³ In reducing the risk of relapse, the CBT elements of MBCT aims to create a gradual shift in the patient’s perspective – that emotions are passing events, do not represent reality, and are not central to the self. It aims to create a ‘de-centered relationship’ to their thoughts and emotions. Although the ‘de-centering’ is not a direct target of CBT, it is nonetheless implicit in the learning process. In MBCT, it is established explicitly as one of the objectives.¹⁸⁴

The second form of how CBT is incorporated in MBCT is the direct import of CBT curriculum elements. These CBT-drawn exercises are implemented in various places of the MBCT program.¹⁸⁵ In the thoughts and feelings “walking down the street” exercise in

¹⁷⁶ Segal, Williams, and Teasdale, 89.

¹⁷⁷ Ibid.

¹⁷⁸ Crane, 7.

¹⁷⁹ Ibid., 10.

¹⁸⁰ Ibid.

¹⁸¹ Ibid.

¹⁸² Crane, 11.

¹⁸³ Ibid., 11.

¹⁸⁴ Ibid., 12.

¹⁸⁵ Ibid., 137-142.

week two, participants are invited to imagine themselves in the following scenario: “You are walking down a familiar street. On the other side of the street you see somebody you know. You smile and wave at them. The person just doesn’t seem to notice you and walks by.”¹⁸⁶ The participants discuss their interpretations and how they feel. The intention behind this exercise is to facilitate the understanding that emotions are shaped by a situation layered by an interpretation. They begin to see that their thoughts create a ‘filter’ or ‘lens’ through which they view the world. They also begin to notice that the lower their mood is at that time, the more negatively they will likely to interpret the situation.¹⁸⁷

In week four, patients learn about the ‘territory’ or clinical representation of depression, through using tools such as “Automatic Thoughts Questionnaire” and “Diagnostic Criteria for Major Depression Episodes”.¹⁸⁸ Through this educational process, participants are taught how to ‘identify’ characteristics of the condition, which paradoxically enables them to ‘dis-identify’ with depression by seeing it as a universal commonality rather than personal traits. For conditions other than depression, different educational material is used accordingly to psycho-educate the participants about their respective conditions.¹⁸⁹

In week six, patients engage in “mood and alternative viewpoints exercise”, in which they see that ‘thoughts are not facts’ (which is the theme of the week) – that “not only does what we think affect how we feel but that how we feel affects what we think.”¹⁹⁰ The participants are given a scenario that invites a range of different responses, which sheds light on the fact that our interpretations are shaped by several factors, including past experiences and current mood states.¹⁹¹

Week seven includes learning to see the connections between activity and mood through exploring what daily activities ‘nourishes’ and ‘depletes’ them.¹⁹² In light of the recognition (by cognitive therapists) that depression reverses the motivation processes, it is emphasized through this exercise that in depression, one must do something before wanting to do it.¹⁹³ The theme of this week is ‘How can I best take care of myself?’ Behind this theme is the premise that one should engage in activities that can lift the mood – activities that can give one a sense of pleasure, or a sense of mastery.¹⁹⁴

By combining what they learned throughout these exercises, the participant’s individual relapse-prevention action plan is developed through week six, seven, and eight¹⁹⁵: noticing what thought processes, or emotional and/or bodily sensations indicate a sign of upcoming relapse, and what actions can one take to prevent the onset of a spiral between negative thinking and negative mood states.

Theoretical Framework of MBCT

¹⁸⁶ Ibid., 137-138.

¹⁸⁷ All information in the previous sentences from Crane, 137-8.

¹⁸⁸ Ibid., 138

¹⁸⁹ Crane, 139. (All information in this paragraph.)

¹⁹⁰ Ibid., 139

¹⁹¹ Ibid.

¹⁹² Ibid., 141.

¹⁹³ Segal, Williams, and Teasdale, 342-3.

¹⁹⁴ Ibid., 349.

¹⁹⁵ Crane, 141-2.

In light of these contributions from theories in cognitive behavioral therapy and the teaching of mindfulness, MBCT has distinctive theoretical framework of which the practices and methodology are based upon. Much of its theories relate to the depressive relapse-inducing processes.

Automatic Pilot:

One salient feature of the depressive relapse-inducing processes is that the mind is constantly on ‘automatic pilot’. This is the state of mind “in which one acts without conscious intention or awareness of present-moment sensory perception.”¹⁹⁶ This feature of the mind is thought to be highly developed in humans, as it has provided us evolutionary advantage (we can carry out a range of complex task.) However, when this mode is applied to the way we process emotional experience, it creates vulnerability.¹⁹⁷ Specifically, it can potentially trigger a downward spiral between depressive symptoms and automatic pilot. The mind can influence on emotional experience without the individual being immediately aware of it. The individual only has a constricted awareness of present moment experience; therefore he or she cannot make conscious choices about how to respond to internal or external experiences, or cannot perceive the range of alternative choices responding to the emotional experience.¹⁹⁸ The individual is basically ‘out of touch’ with direct experience, and cannot process the emotional experience in an adaptive, healthy way.

‘Doing-mode’ of Mind:

Related to the automatic pilot is the ‘doing-mode’ of mind, which is where the ruminative state of mind comes from as a variant.¹⁹⁹ During this mode, the mind registers gaps between an idea of how things are in reality, and how we want them to be. We either try to reduce the gap (moving towards what we want) or keep the gap open (moving away from what we don’t want).²⁰⁰ The ‘doing-mode’ of mind is “primarily a conceptual, thought-based mode of processing experience: we are ‘thinking about’ rather than ‘being with’ our direct experience.”²⁰¹ This goal-oriented mode of mind is crucial to our survival and well-being; but like the automatic pilot, applying this mode of mind to the self can create emotional vulnerability.

There is nothing inherently wrong with this doing mode. In fact it is quite the reverse: This approach has worked brilliantly as a general strategy for solving problems and achieving goals in the *impersonal, external* world...It is natural, then, that we should turn to this same doing mode when things are not as we would like them to be in our *personal, internal* worlds—our feelings and thoughts, or the kind of person we see ourselves to be. And this is where things can go terribly wrong.²⁰²

¹⁹⁶ Ibid, 21

¹⁹⁷ Ibid, 22.

¹⁹⁸ Ibid., 23-4.

¹⁹⁹ Segal, Williams, and Teasdale, 68.

²⁰⁰ Crane, 27.

²⁰¹ Ibid., 28.

²⁰² Segal, Williams, and Teasdale, 68.

When we register the discrepancy between reality and ideality within the realm of some external problems, we either take action to reduce the discrepancy, or simply give up when we cannot find any effective actions at that moment. However, if the discrepancy involves the self, it is more difficult to simply let go of the goals and move on. For example, if a person is looking to move into a new apartment but there is simply nothing available on the market that is both affordable and preferable to her current place, she may just give up and maybe try looking again in a few months. However, if this person is rejected all of a sudden by her long-term, committed partner, it is more difficult to immediately see what the ‘most effective solution’ is to her emotional pain; she cannot just ‘let go’ of the problem the same way she gave up looking for a new apartment. She may continue to process emotional information in the doing mode, ruminating on the discrepancy between how things are (feeling alone and sad) and how she wanted things to be instead (getting married and having children, being ‘happy’). She may rationalize her feelings in the purpose of trying to reduce them. Segal, Williams and Teasdale characterized this mode of processing experience in the realm of internal and self-related goals, ‘driven-doing mode’, which more accurately describes the nature of the process distinct from the ‘doing-mode’.²⁰³ Breaking up with someone is probably an experience that we can all relate to; I am sure we all had some experience of being ‘self-driven’ in thinking about our ended relationship – particularly involving thoughts about the self such as ‘what did I do wrong’ or ‘what did he not like about me?’ Some of us can eventually get ourselves out of these thinking patterns, but some of us cannot.

‘Being-mode’ of Mind:

Contrast to this mode of mind is the ‘being-mode’. ‘Doing-mode’ and ‘being-mode’ are two different modes of processing experience. The key skill to be learned in MBCT is to ‘consciously’ disengage from one mode and entering another when it is necessary and adaptive to do so.²⁰⁴ In the ‘being-mode,’ attention is intentionally placed on the moment-by-moment experiences in the present; all experiences is perceived as events within the field of awareness, which can be accessed with greater continuity without being obscured by the analytical, judgmental, planning activities of our mind. In this mode of being, the person is in touch with reality directly through one’s sensory experiences, which is held within the attitudes of acceptance, kindness, curiosity, and non-striving.²⁰⁵ ‘Allowing’ and ‘accepting’ are the focuses of the ‘being-mode.’²⁰⁶ The woman who was rejected by her long-term partner, instead of being in the ‘driven-doing mode’ (ruminating on the discrepancy between self-related reality and ideality), may be better off to simply ‘accept’ how things are, ‘allowing’ herself to feel the emotional pain that anyone is subject to feeling after breaking up with someone.

Mind and Body:

One of the ways to bring back our ‘being-mode’ of experience is to be in touch with our direct experiences through our bodies. It is important to note that emotions are

²⁰³ Ibid., 74.

²⁰⁴ Crane, 27.

²⁰⁵ Ibid., 44.

²⁰⁶ Segal, Williams, and Teasdale, 72.

essentially a “constellation of fluxing sensations, thoughts and feelings in the body.”²⁰⁷ Segal, Williams, and Teasdale contends: “Habitually withdrawing attention from the body means that ‘processing’ emotional experiences remains uncompleted.”²⁰⁸ In both MBSR and MBCT, the body is seen as the “most accessible ground of our direct experience in the present moment”²⁰⁹ – a tool to more accurately and truthfully register our emotional experience. The metaphor that Crane uses to describe the body is “a window onto the mind.”²¹⁰ She further explains,

it is through the body that the healing process of completing the unfinished work of emotional processing can take place...Being present with experience in the body is very different from any attempt to ‘understand’ or ‘analyze’ emotions or their origins.²¹¹

The emphasis in re-establishing the mind-body connection distinguishes MBCT from any other forms of cognitive or behavior-based psychotherapeutic methods, particularly in contrast to psychoanalysis (where emotions and symptoms are analyzed in terms of their origins). Although MBCT is more cognitive-based (compared to MBSR), the value on the mind-body interconnection derives from MBSR with equal importance. Since adaptive emotional processing is one of the implicit goals of MBCT, attending to the body is invaluable; this is reflected on the various meditative practices within the MBCT curriculum (which is to be explained in the next section).

‘Formal’ Practices in MBCT

The various ‘formal’ practices are reflective of the distinctive theoretical features of MBCT. ‘Formal’ practices, once again, are the practices taught in session by the MBCT instructors. One of the theoretical emphases just mentioned was reestablishing our awareness to our bodily sensations. This objective is embedded in the various body-involving practices, such as body scan meditation, sitting meditation, mindful movement, and stretch and breath practice.

Body Scan Meditation:

The body scan meditation is one of the first practices held in the first week of session. This technique is explained as “one very powerful technique we use to reestablish contact with the body...an effective technique for developing both concentration and flexibility of attention simultaneously.”²¹² Body scan meditation is exactly what it sounds like – you lie down on your back, moving your awareness through the different regions of your body, like a ‘scanner’.

The idea in scanning your body is to actually *feel* each region you focus on and linger there with your mind right *on* it or *in* it. You breathe in *to* and out

²⁰⁷ Crane, 51.

²⁰⁸ Segal, Williams, and Teasdale, 158.

²⁰⁹ Crane, 49.

²¹⁰ Ibid., 51.

²¹¹ Ibid.

²¹² Kabat-Zinn, (1990), 76-7.

*from each region a few times and then let go of it in your mind's eye as your attention moves on to the next region. As you let go of the sensations you find in each region and of any of the thoughts and inner images you may have found associated with it, the muscles in that region literally let go too, lengthening and releasing much of the tension they have accumulated.*²¹³

There are two learning intentions in this practice. First is to “connect with direct experience of physical sensations and so access an immediate, intuitive way of knowing.”²¹⁴ Crane stresses that humans pay a price for being a ‘language-based species’: labeling our experience with language has offered us a way to objectify and separate from them, and therefore we tend to lose sight of this intuitive way of ‘knowing’ through our body.²¹⁵ Therefore, by ‘being with’ our body sensations rather than perceiving them from a distance, we are able to “reverse potential disconnection from bodily experience and supports us in ‘feeling at home’ in our bodies.”²¹⁶ This is beneficial in learning how to deal better with emotion.

Powerful feelings such as sadness or hopelessness can be expressed not only as thoughts or mental events but also as effects in the body. Stooped posture, heaviness in the chest, or tightness in the shoulders may at times signal the presence of strong feelings of which we are not fully aware.²¹⁷

Segal, Williams, and Teasdale noted that people who have a history of depression very often attempts to escape difficult emotions by thinking. By bringing awareness to the physical sensations indicative of the presence of strong emotions, the center of gravity of attention can be shifted away from thoughts in the head towards an awareness of the body.²¹⁸

The second learning objective of this practice is to learning to “be intentional about where and how the attention is placed”²¹⁹; the practice helps one learn how to aim and sustain attention in a target area, and to intentionally engage or disengage the attention as one moves his mind through the body. However, it is natural for one to start thinking about something else while trying to meditate, or recognizing an uncomfortable sensation in the body. The body scan meditation sets a foundation for other meditative practices by allowing one to learn that paying attention is a skill that can be developed through regular practice. Through this preliminary formal practice, one not only practices the cultivation of targeted and sustained attention, but also learns how to recognize his mind-wandering patterns.²²⁰ This simple acknowledgement can be helpful mindfulness practices and cognitive exercises later in the course. Kabat-Zinn’s comments:

²¹³ Ibid, 77.

²¹⁴ Crane, 106.

²¹⁵ Ibid., 49-50.

²¹⁶ Crane, 106.

²¹⁷ Segal, Williams, and Teasdale, 120.

²¹⁸ Ibid.

²¹⁹ Crane, 106.

²²⁰ Ibid.

Mindfulness does not involve pushing thoughts away or walling yourself off from them to quiet your mind. We are not trying to stop our thoughts as they cascade through the mind. We are simply making room for them, observing them as thoughts, and letting them be, using the breath as our anchor or “home base” for observing, for reminding us to stay focused and calm.²²¹

Mindful movement practice:

The next body-involving formal practice is the mindful movement practice, which is held in the third week of session. These practices are basically meditation involving body motion, drawn from hatha yoga postures.²²² This practice has similar learning intentions to the body scan meditation, such as ‘being with’ one’s body and bringing present awareness into bodily sensations. However, this practice also serves as the embodiment of life experiences and processes, taught through the various movements and postures. The balancing poses drawn from yoga are a metaphor for the process of creating balance in life; balancing is not achieved through just staying still, but through constantly recovering oneself through a process that has an end point of achievement.²²³ The transitions between postures offer the chance to practice being in the present with a future intention at the same time, emphasizing that in life we often lose sight of the present because we are preoccupied with where we are heading, rather than embracing the entire process.²²⁴ Kabat-Zinn contends that yoga is meditation, because “bringing mindfulness into any activity transforms it into a kind of meditation.”²²⁵ He further contends that mindful yoga not only has physical benefits, but also offers a new way for one to experience himself as a whole.²²⁶

Mindful Walking:

Mindful walking is exactly what it sounds like: we take a physical activity that we use everyday – walking – and perform it mindfully. This practice solves the issue of having to apply and generalize the greater meta-awareness of bodily sensations in the everyday life, and serves as a bridge between practice and daily life activities.²²⁷ During the practice of walking meditation, participants are encouraged “being with each step, walking for its own sake, without any destination...[and to] focus on maintain moment-to-moment awareness of the sensations accompanying our movements, letting go of any thoughts or feelings about the sensations themselves.”²²⁸ This practice emphasizes that along with the sensations of our breath, “our bodies are always available as an anchor to the here and now, at times when our minds ricochet between the past and the future.”²²⁹

Sitting Meditation:

²²¹ Kabat-Zinn, (1990), 69.

²²² Crane, 109.

²²³ Ibid., 111.

²²⁴ Ibid.

²²⁵ Kabat-Zinn, (1990), 94.

²²⁶ Ibid., 96.

²²⁷ Segal, Williams, and Teasdale, 240.

²²⁸ Ibid.

²²⁹ Segal, 241.

The practice of sitting meditation is formally taught from week four, although it is taught in a graduated way from week two.²³⁰ By adopting an erect and dignified posture with vertical alignment of the head, neck and back, the participant feels an “embodiment of the internal qualities that are being cultivated – an alert and relaxed awareness.”²³¹ This practice builds on the foundation built by the previous practices, such as the body scan and mindful movement,²³² which prepared the ground to transition into a form of meditation where attention is kept on a single focus.²³³ Participants are invited to sit on a meditation cushion or a chair, and the instructor offers clear guidance on which aspect to pay attention to.²³⁴ Sitting meditation is usually subject to more discomfort, compared to the previously mentioned formal mindfulness practices. Explicit invitation is given to “turn towards the experience of challenge or intensity as it is being felt in the moment”²³⁵, as well as to continue returning primary attention the breath while acknowledging the arising of thoughts and emotions.²³⁶ However, one is instructed to always come back to paying attention the breath even after recognizing these ‘obstacles’. If one recognizes physical discomfort or pain while sitting, one simply makes a mental label or note: “pain, pain, pain...” and return to focusing on his breath once again.

Segal, Williams and Teasdale explain how using the breath as a vehicle for meditation is relevant to people who have been depressed in the past. First, breathing always takes place in the present; there is no ‘breathing in the future’ or ‘breathing in the past’. People with ruminative tendencies tend to dwell on the past or future, so focusing attention on the breath helps to bring people back to the present.²³⁷ Second, breathing *always* takes place; therefore, it is always available as not only an anchor but also a “marker of one’s emotional state”.²³⁸ Third, bringing attention back to the breath can substitute for the ruminative thinking as it fills up the same channel of attention.²³⁹ Finally, the simple act of registering the mind-wandering and returning to the breath promotes the skills to decenter from negative thinking, and to switch mental gears from doing-mode in rumination to being-mode in direct experiencing.²⁴⁰ As a whole, sitting meditation offers participants a way to learn how to settle and calm the mind – an integral part of the therapy.

Three Minute Breathing Space (3MBS):

Along with the formal practice of sitting meditation, a more brief type of meditative practice is introduced from the first day of class. This “Three Minute Breathing Space (3MBS)” is intermittently distributed throughout the program. It is basically a “mini-meditation,” designed as a more practical and accessible way of

²³⁰ Crane, 115.

²³¹ Ibid.

²³² Ibid, 118.

²³³ Segal, Williams, and Teasdale, 166.

²³⁴ Ibid, 118.

²³⁵ Ibid.

²³⁶ Ibid.

²³⁷ Segal, Williams, and Teasdale, 183.

²³⁸ Ibid.

²³⁹ Ibid.

²⁴⁰ Ibid.

bringing the perspective of the longer formal sitting meditation into the various aspects of participants' everyday lives.²⁴¹ "It is to be used as the first step in dealing with difficult situations and feelings. In many ways, it forms the spine of MBCT because its varied use provides for participants a quick and effective way to switch into being mode when they most need to do so."²⁴² The way that 3MBS is used is refined across the eight weeks. The two main ways that it is used are: first, as regular practice of mindful breathing, and second, as a coping strategy during difficult times.²⁴³

During 3MBS (regular or coping), two types of attention are trained in a unique sequence. First step is an emphasis on general awareness, recognizing one's current experience. In the second step, attention is gathered in the sensation of breath – similar to the main objective of sitting meditation. In the third step, awareness is expanded into the body as a whole again, using the sensation of the breath as an anchor while maintaining a wide and open perspective to the range of experiences.²⁴⁴ Segal, Williams, and Teasdale uses the path of an hourglass as a useful teaching metaphor for this process: starting with a wide opening, moving through a narrow neck, and expanding again at a wide base.²⁴⁵

Various practice involving sensory experience:

Throughout the eight-week course of MBCT, there are several formal practices that involve sensory experience. For example, the very first practice in the MBCT course (done in week one) is 'The Raisin Exercise'²⁴⁶ – the first practical introduction to mindfulness practice in session.²⁴⁷ In this exercise, the participants are invited to eat a single raisin, but with awareness. "They are invited to let go of their knowing that this is a raisin and to see it 'fresh', much as a child first encounters experience."²⁴⁸ Following this exercise is the group dialogue, where the participants are invited to share each of their direct sensory experience that occurred during the raising eating exercise. The premise behind this exercise is that participants can achieve a direct sampling of a new way of relating to experience –through mindful awareness – in contrast to the usual automatic pilot mode.²⁴⁹ Participants tend to discover through this practice that intentionally bringing mindful awareness to an activity changes the nature of the experience.²⁵⁰ "I usually eat raisins by the handful, without particularly paying attention to them and I was shocked at how intense the taste of one raisin was. (Sue, MBCT course participant)."²⁵¹

Other than the raisin exercise that mostly involves the sense of tasting, there are other forms of sensory exercises, such as the 'seeing' (or 'hearing') practice introduced in week three. Segal, Williams and Teasdale explain that we often, upon 'seeing', naturally and automatically 'parse' the world – categorizing and analyzing each component. "One

²⁴¹ Ibid., 384.

²⁴² Ibid.

²⁴³ Crane.

²⁴⁴ Segal, Williams, Teasdale, 384-385.

²⁴⁵ Ibid, 384.

²⁴⁶ Ibid, 111.

²⁴⁷ Crane, 101.

²⁴⁸ Ibid.

²⁴⁹ Segal, Williams, Teasdale, 115.

²⁵⁰ Crane, 103.

²⁵¹ Ibid.

approach to offering a different way of being is therefore to take this most automatic of situations and renew our acquaintance with the sensations that make up the raw material of experience”²⁵², which is the premise of the ‘seeing’ (or ‘hearing’) exercise.

If there is a window in the room, we ask people to look outside, paying attention to the sights as they best can, letting of the categories they normally use to make sense of what they are looking at; rather than viewing elements of the scene as trees or cars, or whatever, we invite them to simply to see them as patterns of color, shapes, and movement. The instruction is that whatever they become aware that they have started to think *about* what is being seen, they gently bring the attention back to simply seeing. If a window is not available, then we substitute a “hearing” meditation, asking people to listen to sounds from inside the room and beyond.²⁵³

What is sought through this practice and the raisin exercise is the transition from the ‘doing-mode’ to the ‘being-mode’.²⁵⁴ The ‘doing-mode’ entails layering or filtering the experience with previous conceptual knowledge or categorization, where as ‘being-mode’ allows ‘un-filtering’. This process is reminiscent of the discussion of mindfulness in Chapter One – particularly in the context of Sekida’s notion of *nen*. We recall that Sekida explains (although not explicitly) the concept of mindfulness through *nen* – a thought impulse. When we perceive a sensory experience, it is often perceived through second or third *nen*, which is not the direct experience itself but the experience layered by the perceiver’s conceptual knowledge. With acute awareness, however, the perception of sensory experience can be experienced ‘fresh’ through the first *nen* – similar to the goals of these practices in MBCT involving sensory experience.

‘Informal’ Practices in MBCT

In MBCT, the ‘informal’ practices are equally important to the formal practices. The informal mindfulness practices are done at home, replicating what the participant learned in session through formal practices, such as sitting meditation, body scanning, mindful movement, and mindful walking meditation. This aspect of the therapy derives from MBSR, where participants were asked to practice mindfulness skills on a daily basis as part of their home practice. Kabat-Zinn notes:

The second way of practicing using the breath is to be mindful of it from time to time during the day, or even all day long, wherever you are and whatever you are doing... We call this ‘informal’ meditation practice. It is at least as valuable as the formal practice...[the two] complement and enrich one another.²⁵⁵

This is particularly relevant and useful to MBCT patients as well. Practicing mindfulness skills at home is a “valuable way to keep new learning active, so it is very relevant to

²⁵² Segal, Williams, Teasdale, 180.

²⁵³ Ibid., 181-182.

²⁵⁴ Ibid., 182.

²⁵⁵ Kabat-Zinn, (1990), 57.

depressed patients in recovery, whose task is to remain prepared for an event that might nor happen until months, or even years, later.”²⁵⁶ In the time of a difficult event in life, daily practice ensures that the mindfulness and cognitive skills could be recalled and implemented smoothly.

It seems that another purpose of daily informal practice is that through practicing the various mindfulness practice at home, participants can see for themselves what kind of practice suits them the best. Given the value of daily informal practice, it is imperative that participants can find a type of practice that they can stick to even after the MBCT course ends. For example, someone who works constantly throughout the day may not find the time for sitting meditation, but mindful walking may be suitable for him since he can practice it while walking to work. Another person may have chronically tense shoulders, in which she may benefit from daily mindful movement practice where she can stretch her body and cultivate mindfulness at the same time. ‘Customization’ of mindfulness practice seems to be one of the implicit goals of MBCT.

MBCT General Course Outline

In the entire MBCT program, these formal and informal practices are distributed in an effective order, centered around on four general learning intentions in relation to depressive relapse-inducing processes.²⁵⁷ The first intention is to learn how to step out of the self-perpetuating ruminative thinking patterns by deliberating focusing attention on the bodily sensations and breath. Second, participants are able to better recognize and be more aware of potential relapse-related mind-body processes. This is accomplished through directly experiencing to see the effects of their habitual ‘mindlessness’, including the tendency to automatic pilot and ruminate. Third, participants learn new and alternative ways to relate to their depression-related experiences, which involve acceptance, a mindful mode of being, and fostering of a de-centered and wider perspective that allows one to relate *to* rather than relate *from* experience. The negative thoughts and emotions are seen as *just* thoughts and emotions, instead of an integral component of the self. Finally, participants learn the ability to turn towards, befriend, and engage with all aspects of experience: pleasant, unpleasant, and neutral. This stance offers an alternative path to the experiential avoidance of difficult emotions, which is problematic.²⁵⁸

One of the features of MBCT is that it offers participants to simultaneously gain skills in managing their general and specific vulnerabilities. General vulnerabilities are traits shared by all humans, such as the tendency to separate ourselves from our experience with language, the ability to move thought process into the future and past (thus the tendency to experientially avoid the present,) and physiological responses to both external and internal threats.²⁵⁹ Specific vulnerabilities are those shared by people with heightened risk of depressive relapse, which may include “particular conditioning, life events, environmental influences, illnesses, or genetic makeup.”²⁶⁰ MBCT addresses both of these.

²⁵⁶ Segal, Williams, Teasdale, 47.

²⁵⁷ Crane, 16.

²⁵⁸ Ibid., 16 (all information in the paragraph)

²⁵⁹ Ibid., 70.

²⁶⁰ Ibid., 70-71.

In the first half of the entire program, participants learn to bring attention to internal experience. In the second half of the program, there is an emphasis on applying what they learned from mindfulness practices to their life challenges.²⁶¹ As a general emphasis, the MBCT teacher embodies the attitudinal qualities of mindfulness; therefore, the MBCT teacher's personal experiences in mindfulness practice is an absolutely integral part of the entire process. Throughout the program, "stories and poetry are read, which speak to the themes of the session and offer alternative doorways into new learning and perspectives."²⁶² The general course structure is outlined below, drawn from the sequences of practices outlined by Segal, Williams, and Teasdale, as well as Crane. Each week has its own theme, with respect to each aspect of the theoretical framework of MBCT. In light of the weekly themes, the practices in session, group exercises, and home practice are designed to work directly with each theme. Refer to the table below for a complete outline for the MBCT course content.

²⁶¹ Ibid., 81.

²⁶² Ibid., 82.

Table 3.1: the MBCT Course Outline

Week Number and its Theme	Practices in session	Exercises in session	Home Practice
1 – Awareness and Automatic Pilot	Eating a raisin with awareness; Body scan meditation	Self-introductions; setting up ethos of group course and group boundaries	45-minute body scan meditation; bringing attention to routine activity each day (e.g. showering); eating one meal mindfully
2 – Living in Our Heads	Body scan meditation; 10-minute mindfulness-breathing (introduction to Sitting Meditation)	Thoughts and feelings exercise (“walking down the street”)	45-minute body scan; 10-minute mindfulness breathing; bringing attention to a different routine activity from week 1; daily recording of pleasant experiences
3 – Gathering the Scattered Mind	5-minute seeing or hearing exercise; 30-minute sitting meditation; 3MBS; Mindful stretching and review	Exploration of pleasant experiences calendar	Stretch and Breath practice; Mindful movement practice; daily recording of unpleasant experiences; TMBS three times a day
4 – Recognizing Aversion	5-minute seeing or hearing exercise; sitting meditation (awareness of breath, body, sounds, thoughts); 3MBS introduced as a coping practice; Mindful Walking	Exploration of unpleasant experiences calendar; defining and exploring depression (or alternate focus, e.g. stress)	3MBS regular practice three times a day; 3MBS for coping whenever noticing unpleasant feelings
5 – Acceptance and allowing/letting be	Sitting meditation ; introducing a difficulty within the practice and exploring its effect on body and mind; 3MBS	Reading <i>The Guest House</i> poem by Rumi and explore themes with group; Exercise exploring habitual patterns of reaction and the potential use of mindfulness skills	Sitting meditation; 3MBS regular three times a day; 3MBS for coping; exploring the choice of opening ‘the body door’
6 – Thoughts are not facts	Same as Week 5	Moods, thoughts, and alternative view exercise; Start developing a personal relapse signature and action plan	Practicing for 40 minutes a day with different combinations of three core practices; exploring a range of short practices with and without using the CDs; regular 3MBS three times a day; 3MBS coping; further reflection on personal relapse prevention action plan
7 – How can I best take care of myself?	Sitting meditation; 3MBS and introducing difficulty and seeing the effects on body and mind	Explorations of the links between activity and mood; listing daily activities and label which ones feel ‘depleting’ or ‘nourishing’, and which give a sense of ‘mastery’; consider ways to increase the ‘nourishing’ activities; identifying relapse signatures	Select a practice pattern that one can continue after the program; regular and coping 3MBS; develop early warning system for detecting signs of relapse; develop action plan to be used when mood is low
8 – Maintaining and Extending New Learning	Body scan meditation; ending meditation	Review of early warning systems and prevention action plan for relapse; review the whole course; discuss how to maintain the momentum developed through the practices; questionnaire for personal reflection	Settle with a plan of home practice that is sustainable for the next month

Concluding Remarks

This chapter outlined the ways in which mindfulness is embedded into the theories and practices of MBCT, along with its roots from cognitive behavioral therapy. MBCT-unique concepts such as automatic pilot, doing-mode vs being-mode of the mind, and the mind-body interconnections are used to explain the depressive relapse-inducing processes, as well as integrated into the various mindfulness practices and cognitive exercises as a means of preventing a potential relapse in the future. Implicit in these theories and methods of MBCT is that the participant's perspective on the self is altered. This is further explained in terms of its comparison to Morita Therapy in Chapter Five, along with other loci of comparison and contrast, such as mind-body connection, empathy and self-empathy, patient-therapist relationship, and individualistic VS collectivist elements. The next chapter is dedicated to outlining the theories and methods of Morita therapy, to prepare for the comparison.

Chapter Four: Morita Therapy

Morita therapy was designed by Shoma Morita (1874-1938) – a Japanese psychiatrist who “believed that anxiety-based disorders share the same mind=body²⁶³ interactions.”²⁶⁴ Just as the development of MBCT was originally targeted for people who have a history of depression and are therefore susceptible to relapse, Morita designed his therapy for a specific type of anxiety disorder – termed *shinkeishitsu* (神経質)- type neurosis.²⁶⁵ The word *shinkeishitsu* in colloquial Japanese is often used to describe someone’s personality temperament (either as a noun or an adjective).

When the word *shinkeishitsu* is entered in a commonly used online translator such as Google Translation, it is directly translated as “nervousness”. Let’s say that a man, for example, is always anxious about being late to meetings. Despite the fact that he is actually always punctual, if he nonetheless worries about it constantly and his nervousness is reflected in his interactions with people, others may say “あの人神経質だね。 (That person is *shinkeishitsu*.)”

According to the continuity assumption²⁶⁶ in personality psychology, the difference between a normal and an abnormal (i.e. pathological) person is a difference in degree of personality traits. Morita identified the pathology characterized by the excessiveness of this *shinkeishitsu* personality temperament as a type of anxiety-based disorder, referring to this condition often as simply *shinkeishitsu*-type neurosis²⁶⁷. This type of neurosis is said to be “found commonly among the Japanese and characterized by interpersonally oriented symptoms such as obsessive shyness, oversensitivity, and feelings of inferiority.”²⁶⁸

I believe that such ‘interpersonally oriented’ aspect of this neurosis is intimately tied to the Japanese conception of self. David Reynolds, an anthropologist who has studied Morita therapy in Japan as both an outside observer and as a researcher/patient, also points out that the unique characteristic of the Japanese people – their extreme concerns over interpersonal interactions – invites equally unique forms of anxiety disorders.

Both in the cultural history and in the personal history of the Japanese people extreme sensitivity to interpersonal signals and cues has been strongly reinforced. In order to function smoothly in Japanese society today one must be careful to pick up small expressions of preferences and desires from significant others and to control the expressions of one's own

²⁶³ Throughout the translated work of *Morita Therapy and the True Nature of Anxiety-Based Disorders*, the notation ‘mind=body’ is used to symbolize the intimate interconnection between the mind and body, and to de-emphasize any presumption that they are two separate entities.

²⁶⁴ Shoma Morita, *Morita Therapy and the True Nature of Anxiety-Based Disorders (Shinkeishitsu)*, trans. Akihisa Kondo, ed. Peg Le Vine (Albany: New York Press, 1998), xviii.

²⁶⁵ Neurosis in this text seems to be referring to anxiety-related symptoms in a general context, rather than to ‘neurotic disorders’ as used strictly in the context of contemporary psychiatry.

²⁶⁶ Crowne, 21-2.

²⁶⁷ David K. Reynolds. *Morita Psychotherapy* (London: University of California Press, 1976), 4.

²⁶⁸ Ibid.

preferences and desires...The anthropophobic (*taijin-kyofusho*) Japanese neurotic patient clearly shows this national character trait to an extreme. He is so sensitive to detecting cues from others and processing and controlling his own emissions that he cannot function in society.²⁶⁹

I will further elaborate on this issue in the next chapter where I compare and contrast the different conceptions of self between Morita therapy and MBCT through its origins, philosophies, and methods. In order to establish a framework for such comparison, I will dedicate this chapter to describing the details of Morita therapy: its roots of origin, major principles and theories, and therapeutic methods.

Roots of Morita Therapy

Western influences:

Morita Therapy certainly was not created overnight. Stemming from his ambition to develop the most effective psychotherapeutic method for *shinkeishitsu* neurotic patients, Morita spent twenty years in making of this therapy. He reflected on and cited the works of a number of Western influences: Sigmund Freud, William James, Henri Bergson, Mario Montessori, and Jean Charcot, to name a few. He was interested in certain treatment methods proposed by these Western figures, such as rest therapy by Weir Mitchess, life normalization therapy by Otto Binswanger, persuasion therapy by Paul DuBois, Psychoanalysis by Freud²⁷⁰, and Hypnosis by Charcot²⁷¹. He imported many of these concepts and found out what works and what does not work on his patients, by the classic method of trial-and-error. The methods of Morita therapy are certainly reflective of its roots in rest therapy, work therapy, persuasion therapy, and life normalization therapy. However, Morita did not completely agree or comply with these therapeutic methods. For example, although he applied elements of life normalization therapy by Binswanger, Morita claimed that the original method was “too theoretical, relatively impractical, and ineffective...[and] deprived [his] clients of spontaneous activity.”²⁷² He developed his own method of treatment by simply extracting the elements that seemed effective, and discarded the methods that appeared ineffective²⁷³ or theories that seemed insufficient to explain the experiential nature of the human mind.

In particular, he especially challenged Freud’s theories. He did not agree with the view that the unconsciousness is a concrete structure, or that the consciousness is divided into concrete and separate entities (e.g. ego and superego) that reside in the mind. He contended that the attribution of neurosis to the unconscious influences on the mind is insufficient to explain how certain emotional experiences enter the unconscious, and that treatment of neurosis does not require the investment of time and energy to investigate the cause of symptoms. Instead, Morita interpreted that consciousness is something transitory and active; it is always changing and flowing in flux. Therefore, it is imperative to take into account such dynamics between external events and the self.²⁷⁴ Many of his

²⁶⁹ Ibid., 122.

²⁷⁰ Morita, editor’s introduction, xix (Le Vine).

²⁷¹ Kenshiro Ohara, *あるがままに生きる(How to live with things as they are)* (Tokyo: Seiwa-shoten, 2008), 274. (All citations from this work throughout this thesis have been translated by me.)

²⁷² Morita, 35.

²⁷³ Ohara, 21.

²⁷⁴ Morita, 9-12.

theories stem from his phenomenological appreciation and dynamic interpretation of the human mind. “In many ways, Morita was an early founder of cognitive, transpersonal, and experiential psychotherapies.”²⁷⁵ While the cognitive aspect probably derives mostly from the analytical influences of the Western psychiatric traditions, the transpersonal and experiential elements of Morita therapy spring from the Zen Buddhist influences. Moreover, identifying the Zen roots of Morita therapy further helps to recognize Morita therapy as a form of mindfulness-based therapy.

Zen Influences:

Many aspects in the theories and methods of Morita therapy derive from Japanese Zen Buddhism. The isolation-rest stage (explained in the section on methods) is particularly reflective of the contemplative roots. In Zen Buddhism, the mainstream contemplative practice is *zazen* (‘sitting zen’); however, there is a more minor technique called ‘lying-down Zen’ which corresponds in some degree to this stage of the therapy.²⁷⁶ The isolation-rest therapy is where the patient initially develops his peripheral vision of *mushoju-shin* (無所住心, translated literally to ‘nowhere specific the mind resides’) begins.²⁷⁷ In Zen, it is said that *mushoju-shin* “occurs when one does not limit her or his attention to a single focus and uses the mind fully...[it] describes a state in which attention is not fixed on a particular point and the entire mind is alert and functioning; attention extends in all directions.”²⁷⁸ The term is used to describe this healthy form of attention; it is nothing other than the Western clinical interpretation of ‘mindfulness,’ as suggested by the striking resemblance in its definition. Through the cultivation of *mushoju-shin* (or the mindful attention field) in the isolation-rest therapy, the patient experiences “the ‘self’ simply drops into the larger ecological system in which the person thrives”;²⁷⁹ the patient is no longer ‘self’-focused and instead experiences the ‘self’ in ways that extend beyond the conventional conceptions of human experience. In other words in a more familiar context, the person undergoes a non-conceptual, non-self-referential experience, or experience that is not structured by the subject-object duality.

In addition to such phenomenological parallels, there are methodological parallels as well. In this stage of therapy, the doctor periodically checks up on the patient to see his progress, similar to how the master monk would make periodic appearances to see the monk’s progress of meditative practice. In both instances (isolation-rest and lying down Zen,) it is said that “one’s progress is reflected in one’s face and bearing so that a minimum of verbal communication (or none at all) is necessary.”²⁸⁰ The parallels also exist more on the general level, as noted by Dr. Suzuki, a Morita therapist in Tokyo that Reynolds interviewed.

Suzuki notes many parallels between the two systems. The patient and the new monk come seeking answers to life problems. Depending on his sect, a Zen monk may be given a *koan*, a kind of puzzle with no rational

²⁷⁵ Morita, editor’s introduction xix (Le Vine).

²⁷⁶ Reynolds, 48.

²⁷⁷ Morita, editor’s introduction, xxiii (Le Vine).

²⁷⁸ Morita, 30.

²⁷⁹ Morita, editor’s introduction, xxiii (Le Vine).

²⁸⁰ Reynolds, 48.

solution...He is placed under social psychological pressure to solve the problem, and yet he cannot do so intellectually. He is forced to deeper levels of mental functioning. Suzuki sees the patient's symptoms as a kind of *koan*. Their symptoms, too, are insoluble by rational understanding. The result is that the patient is forced to similar levels of functioning which ultimately frees him from his obsessions and delusions and lift him to an above-average plane of existence.²⁸¹

The level to which Zen concepts are explicitly explained in the therapy method varies between the different Morita therapists in Japan. However, even in the case when the therapist (such as Dr. Suzuki) makes explicit connections to the religion during therapy, there is never the intention to convert the patients into Zen followers. The purpose of making explicit connections is rather to provide an auxiliary support for the treatment.²⁸²

Principles and Theories of Morita Therapy

Etiology of Neurosis:

Through his personal experiences of neurotic symptoms and clinical observations, Morita developed his theories on the "etiology of neurosis"²⁸³ (in the Japanese cultural context, at the very least). In Morita's theory, neurosis arises out of natural instincts or tendencies that people indiscriminately possess,²⁸⁴ in some ways similar to Freud's psychoanalytic notion of eros. Morita conceptualized such instincts as *sei-no-yokubo* (性の欲望), translated by Reynolds as "self-actualizing tendencies"²⁸⁵ or "desire for life"²⁸⁶ by Kondo. *Sei-no-yokubo* has physical, psychological, and social components. The instincts impel our emotions and behaviors to avoid threats to our physical and psychological safety, to have interpersonal relationships with others, and to find and commit to worthwhile tasks. Kenshiro Ohara, a Japanese psychiatrist and a contemporary Morita psychotherapist, has categorized these instincts into five subtypes:

- 1) I don't want to be sick. I don't want to die. I want to live.
- 2) I want to live fully. I don't want to be scorned by others. I want to be accepted.
- 3) I want to know. I want to study.
- 4) I want to be successful. I want to be fortunate.
- 5) I want to develop and advance self.²⁸⁷

As illustrated, *sei-no-yokubo* includes many instinctual wishes and motives that we all have. Similar to what is said in the continuum assumption, Morita contended that these instincts or impulses are more pronounced in some individuals, resulting in the precipitation – triggered by other factors – of neurotic symptoms.

²⁸¹ Ibid., 47.

²⁸² Ibid., 48.

²⁸³ Ibid., 5.

²⁸⁴ Ibid.

²⁸⁵ Ibid., 5-6.

²⁸⁶ Morita, 21.

²⁸⁷ Ohara, 267.

For example, another feature behind neurotic symptoms is *Hipochondori sekicho*, or translated as Hypochondriacal temperament by Reynolds. This temperament describes the individual's concern with bodily state, or concern with him/her-self in general. Reynolds interpreted that those with this temperament seems to be described as 'introverted' in the Western context, characterized by being "introspective, perfectionist, self-conscious and shy...quite literally self-centered."²⁸⁸ This temperament, not surprisingly as suggested by its name, closely resembles the personality traits of those that develop the anxiety disorder Hypochondria (as termed by the DSM-IV). Together with *sei-no-yokubo*, the hypochondriacal temperament makes an individual vulnerable to neurosis. Having a strong desire to live fully, their drive for personal advancement is hindered by their oversensitivity to their personal limitations, such as blushing or shyness for example. *Chokusetsudoki* is the precipitating circumstance of neurotic symptoms, translated literally as 'direct motive.' They are unpleasant experiences or stimuli that trigger the neurotic symptoms.²⁸⁹ Examples may be an incidence of fainting that leads someone to be overly concerned that he may carry serious medical conditions, or someone being rejected which leads her to be overly concerned with her physical appearance. The precipitating experience induces one's attention in the immediate consciousness to be fixated on a particular object of concern (e.g. the bodily sensation of blushing), instead of being in the natural state of flowing between various objects. Morita termed this [pathological] interacting mechanism between the precipitating circumstance and neurosis *seishin kogo sayo* (精神交互作用), translated as attention and psychic interaction by Reynolds. Morita also posited that in this downward spiral between attention and sensitivity, attention is the more controllable one.²⁹⁰ This contention explains much of the motives behind the contemplative methods used in the isolation rest stage of Morita Therapy (explained later in this chapter).

When suffering, people have a tendency to try overcoming a difficulty by rationalization. Morita termed this neurotic tendency *shiso no mujun* (思想の矛盾), translated as "conflicts of thoughts"²⁹¹ by Reynolds or "the contradiction by ideas"²⁹² by Kondo. It describes one's "attempt to create, manipulate, or modify facts by means of ideas, without knowing the difference between ideas and reality".²⁹³ 'Ideas' are linguistic descriptions, explanation, or inferences of facts – mediators of rationalization in response to the recognition of irrational fears or concerns. If someone is afraid of speaking in public, he may try to rid his feelings rationally by convincing himself that there is no reason to feel that way. This tendency is reminiscent of 'intellectualization' – a type of defense mechanism noted in psychoanalysis. The 'contradiction' (in Kondo's translation) highlights the duality between reality and ideality that is important in understanding this tendency. There is always a contradiction inevitable between subjectivity and objectivity, emotion and knowledge, and intellectual and experiential understanding. However, "contradiction by ideas occurs when one fails to acknowledge such distinctions."²⁹⁴

²⁸⁸ Reynolds, 6.

²⁸⁹ Ibid., 7.

²⁹⁰ Ibid., 7-8.

²⁹¹ Ibid., 9.

²⁹² Morita, 3.

²⁹³ Ibid.

²⁹⁴ Ibid., 3-4.

This is somewhat similar to the notion proposed by Carl Rogers, a humanistic psychologist. He contended that symptoms of distress arise when personal growth is blocked by the incongruence between the ideal self and the real self.²⁹⁵ I should also introduce a preview into the next chapter by pointing out that this notion of ‘contradiction by ideas’ sound remarkably similar to the ‘doing-mode’ of mind as explained in MBCT. Recall that in the doing-mode of mind, one “registers discrepancies between an *idea* of how things are and an *idea* of how we want them to be or how we do not want them to be.”²⁹⁶ The difference is that Morita seems to be emphasizing the acknowledgement (or lack-there-of) of such incongruence as one of the causes of symptoms, rather than the incongruence itself. In the overall picture of Morita’s theory, neurotic symptoms seem to be attributed to “too much ‘self’” standing out in the “background on the perception of the external world.”²⁹⁷

Theory of Cure:

Morita’s theory of cure correspondingly addresses these major concepts in his theory of the etiology of neurosis. Morita contended that a proper diagnosis is particularly important to his therapy, as his therapy is “most effective for *shinkeishitsu* type of neurosis.”²⁹⁸ Diagnosis precedes treatment, but a more thorough and re-evaluated diagnosis may come after the initiation of treatment. Morita recognized that certain elements of his therapy may be harmful or incompatible for some diagnostic categories, such as depression with suicidal ideation and psychosis in general. Morita categorized neurosis into *shinkeishitsu* and hysteria types, based upon his observation that hysterics were just as emotionally sensitive as *shinkeishitsu* neurotics, but seem to be more extraverted.²⁹⁹ The diagnostic criteria for *shinkeishitsu* neurotics was further articulated by later Morita therapists, as having the following characteristics: a strong desire and will to recover; the ability to some extent achieve insight into his condition; hypochondriacal tendencies and asocial (but not antisocial) tendencies; perfectionism and a general pattern in symptom development as a result of precipitating experience and attention and psychic interaction. In general, a *shinkeishitsu* neurotic is preoccupied with one’s subjective experience.³⁰⁰ The Morita therapists often refer to this state of preoccupation as *toraware* (囚われ), literally translated as ‘obsessed’ or ‘preoccupied.’

There are two methods to escape from this state of ‘captivation’ by uncomfortable and unpleasant feelings; both of these approaches embody a state of mindfulness, as suggested by the externalization of thoughts in the first approach, and the cultivation of non-dualistic experience in the second.. One way is to “focus attention on the pain, and to observe, describe, and evaluate it, without attempting to eliminate the discomfort or to distract oneself” through which the pain and suffering eventually “become the objective entities projected onto the external world” instead of “the object of subjective attachment”³⁰¹. The procedure sounds remarkably similar to the cultivation of non-

²⁹⁵ Crowne, 365.

²⁹⁶ Crane, 27.

²⁹⁷ Reynolds, 9.

²⁹⁸ Ibid., 11.

²⁹⁹ Ibid.

³⁰⁰ Ibid., 12.

³⁰¹ Morita, 15.

judgmental, non-striving mindful attention cultivated in MBCT, and its result reminiscent of the “de-centered” relationship to symptoms.

The other approach is through ‘obedience to nature,’ in which the individual “become[s] the pain or suffering itself.”³⁰² When one is in a purely subjective state, one is entirely beyond evaluations due to dualistic or ‘subject versus object’ ways of thinking.³⁰² Such blurring of the subject-object duality identifies this method as the non-dualistic mindfulness as explained in Chapter One. The concept of ‘obedience to nature’ in Morita therapy gives birth to the central philosophy in Morita therapy: *Arugamama* (あ
るがまま) – acceptance of reality ‘as it is’. This concept was mentioned in Chapter Two in the discussion of secondary control in Japanese culture. This principle derives from Zen Buddhism; it stands as an underlining philosophical pillar of Morita therapy, and contributes to characterizing Morita therapy as a mindfulness-based therapy.

Principles of Emotions:

These approaches are closely tied with Morita’s theory on Principles of Emotions. Morita, in his therapy, focuses on the patient’s emotions rather than their system of logic.³⁰³ According to Morita, emotion (the things you ‘feel’) has a parabolic course when allowed to flow naturally. It initially increases until it reaches a climax, followed by the eventual dissipation. Emotion is intensified when the attention is focused on it; for example, more complaining will lead to more intensifying, as the emotion is expressed beyond its natural course. Emotion is dulled and becomes less worrisome when it is stimulated repeatedly by the same sensation, similar to how we become less sensitive to temperature as we get used to hot or cold temperatures. Finally, emotion is learned through new experiences and cultivated through repetition; this principle is particularly helpful when trying to foster positive and constructive ones, such as a sense of confidence.³⁰⁴

Most important to this theory is that these principles of emotions are learned through embodied experience, involving both the body and mind. The Japanese word for experiential understanding is *taitoku* (体得) – the knowledge and awareness obtained from direct practice and experience.³⁰⁵ The first *kanji* of this word is the character that symbolizes ‘body’. The same character is also used for the word *taiken* (体験) which is translated into ‘personal experience’ by no coincidence. The more general term for ‘experience’ is *keiken* (経験).

The fact that the word for the personal, ‘subjective’ aspect of experience involves the connotation of body seems to reflect the Zen influences on the Japanese culture as a whole. Morita contrasts the concept of experiential, embodied understanding to intellectual understanding (*rikai*, 理解). This is the more “abstract knowledge used to judge how things should or should not be and is based upon inference.”³⁰⁶ Morita also relates *taitoku* to the Zen concept of *satori* – the subjective experience of being one with the state of impermanence, and precedes the complete integration of experiential

³⁰² Ibid.

³⁰³ Ibid., 31.

³⁰⁴ Ibid., 31-3.

³⁰⁵ Ibid., 6.

³⁰⁶ Ibid.

understanding and intellectual understanding³⁰⁷. Morita says that the “deepest understanding, therefore, arises after a person’s concrete experiences bring realization in the body=mind.”³⁰⁸ Such is the opposite state from being mindless or trapped by contradiction by ideas, in which there is a significant gap between the two modes of understanding. The emphasis on ‘bodily experience’ is, again, indicative of mindfulness as this therapy’s primary therapeutic means. Recalling from Chapter Three, the intimate relationship between bodily sensations and emotional understanding/processing is also emphasized highly in MBCT with the explicit labeling of ‘mindfulness’.

Methods of Morita Therapy

Traditional Inpatient Treatment:

These Morita therapy methods are reflective of the above theories and principles articulated by Morita. Morita originally designed the therapy as a residential treatment, where the therapist (Morita) and the patients (alongside nurses and possibly some other therapists) lived under the same roof in a complex, composed of everyone’s own private rooms and communal living space, such as the kitchen, garden, bathroom, etc. Morita therapy, therefore, in its purest form, implies inpatient care. The traditional Morita therapy is divided into four stages: the isolation-rest therapy, light occupational therapy, heavy occupational therapy, and preparation for daily living.

The first stage, the isolation-rest therapy, requires the patient to rest in bed throughout the day, except bathing and using the restroom. The patient is prohibited from meeting or conversing with people, smoking, drinking, and reading. The only activity they are allowed to do is lie in the bed and sleep whenever one pleases to, and think about whatever one pleases to. This stage offers the clinician the chance to observe and further diagnose the patient, and offers the patient the opportunity to recover from physical and mental fatigue, as well as to come into full confrontation with their suffering which precedes liberation.³⁰⁹ This stage lasts four to seven days depending on the patient’s progress. The course of this stage varies from patient to patient, but there is a typical pattern. On the first day, most patients lie comfortably in a mentally and physical quiet state as they are removed from external stimuli. On the second day, clients begin to think more; they wander in their thoughts about their “personal affairs, discomforts, their pasts or future”³¹⁰ – frequently with pessimism and doubts, which turn these thoughts into painful and anxious experiences. Despite their suffering from unpleasant thoughts, they are told not to divert their mind or try to deliberately escape the pain. They are instructed to simply experience and endure the pain, “much like enduring a toothache or stomachache. In order to be relieved from suffering, it is better to endure discomfort rather than suppress it with the power of reason or thought”³¹¹, Morita said. This deliberate focusing of attention on and acceptance of pain and discomfort is indicative of mindfulness at work. On the third day, typically, the patient will experience their anxiety dissipating, even if he/she tries to experience it again. This in turn provides a feeling of invigoration and a sense of accomplishment, as patients recollect and reflect their

³⁰⁷ Ibid, 7.

³⁰⁸ Ibid, 6.

³⁰⁹ Ibid., 35-36.

³¹⁰ Ibid., 38.

³¹¹ Ibid.

experiences of overcoming the hardship of suffering, much like how people feel good after a rigorous exercise. The realization of their transience also induces the objectification of their symptoms – as something transient and external to the self. After their liberation from their passive pain, the patient enters a state of boredom by the fourth day. Patients in improvement typically do not like to tolerate boredom, and will show desires for mental and physical activity. To Morita, this is a sign of a healthy mind, and that they are ready for the next stage of therapy.³¹²

After the isolation-rest stage, the patient proceeds to the second stage – light occupational therapy stage. At the start of this stage, patients are also instructed to begin writing a diary entry everyday, discussing their physical and mental conditions, as well as what activities they did that day, etc. The diary-keeping is maintained throughout the rest of the course of therapy; each entry is read by the therapist who comments in red.³¹³ However, patients are discouraged to complain about their symptoms in excess, for Morita thought that complaints will induce too much attention-fixation on the symptoms, which may counterproductively worsen their conditions. The therapists and nurses generally ignore the patients' complaints of pain and discomfort, so as to de-emphasize a feeling-centered attitude and to instead foster a behavior-centered attitude in the patients.³¹⁴ The patients are also instructed to “read aloud beginnings of books such as the *Kojiki* (Records of Ancient Matters)”³¹⁵ before bedtime – books that are deliberately difficult to understand the meaning of. The reading aloud is not meant to have the patients analyze or understand the texts, but rather to simply resume mental activity and prevent rumination at night. The activity is much like reciting Buddhist scriptures.

Unlike in the first stage of therapy where patients were allowed to sleep whenever they wanted to, in this stage they are only allowed to sleep seven to eight hours a night, and encouraged to go outside during daytime (within the hospital) to perform their small tasks such as to tidy the yard, weed the garden, rake leaves, help cook, wash clothes etc. Although they are ‘encouraged’ to do these tasks, there is no explicit imposition of chores as the one of purposes of this therapy is to prompt spontaneous activity. The patients are still prohibited from having casual conversations, leaving the hospital, accepting visitors, using extensive muscle movement, and amusing themselves by taking a walk, exercising, singing, etc. These prohibitions are meant to induce some boredom, which stimulate the patients to engage in spontaneous activities in chores that may have seemed useless in the past.³¹⁶ During performing these light chores, patients are encouraged to ride their physical discomfort and obsessive ideas ‘as they are’, and “to try work they have never done or learned, regardless of their social status, gender, or lifestyle. When clients seek more difficult work, which is naturally driven by the impact of their improving health, treatment moves on to the third stage.”³¹⁷ The second stage lasts for about four to seven days as well, depending on the patients' progress.

The third stage is the heavy occupational therapy, where patients are assigned with more labor-intensive work, such as gardening, carpentry, cutting fuel, etc. This stage

³¹² Ibid., 38-39.

³¹³ Ibid., 42-44.

³¹⁴ Ibid., 46-47.

³¹⁵ Ibid., 44.

³¹⁶ Ibid., 44-46.

³¹⁷ Ibid., 47.

can last from one to two weeks. The patients are now allowed to casually interact with other patients, and cooperate together to work. The labor-intensive chores are aimed to have patients acquire patience and endurance; cultivate a more confident self and value subjective experiences through repeated experiences of success; and find ways to stimulate their mental functions and express their impulses through activities that do not involve over-thinking and rumination. The mental state of a patient engaged in a labor is described by Reynolds' personal observation of a patient in a Morita hospital:

He [the patient] does not notice the passing of time because he is fully occupied in his work. He has been a number of work groups of patients and has found it increasingly natural and pleasant to interact socially. He is working without pay, so he begins to realize the satisfaction and feelings of self-worth which spring naturally from contributing to social ends.³¹⁸

Patients also begin to attend the *Kowa* lectures (therapeutic lectures) in this stage, where a "therapist may read from a book, question patients about symptoms and progress, explain the meanings of various calligraphies hanging on the walls of the hospital, or he may simply talk from his experience in treating neurosis"³¹⁹. Patients are encouraged to foster their natural interests in the third stage, and in turn train their sense of endurance and confidence through the activities they chose.

In the fourth stage, on the contrary, they are trained to adjust to external circumstances instead of acting on the basis of their personal interests. The final stage, preparation for daily living, "aims to break all attachments, including fixation on one's own interests."³²⁰ The patients are now permitted and encouraged to go out of the hospital when one has a purpose, such as running errands, going to the grocery store, etc. "Sometimes this period is extended so that the patient can go to work or attend school outside the hospital while living within the security of the hospital milieu."³²¹ In this stage, the patients are encouraged to read books with simple, descriptive, factual, or scientific contents (such as astronomy, history, biography), but not books associated with ideological, fictional, or abstract matters, such as philosophy and literature. The reading trains patients to concentrate, without having anticipatory emotions that arise from their perfectionistic nature (which have prevented them from concentrating on reading in the past)³²². The emphasis of this stage is widening the range of attention-directed activities in order to smoothen the transition from the hospital to his everyday life. One may not be able to rid of anxiety and fears, but with a behavioral change he or she will be capable of living in spite of his still-existing symptoms. Reynolds observed that: "Morita therapists have consistently stressed that acts, not symptoms or feelings or moods, are most important for living fruitfully and therefore that changed behavior, not changed feelings, is the key criterion for discharge."³²³ This method of therapy was originally developed in

³¹⁸ Ibid., 30-31.

³¹⁹ Ibid., 37.

³²⁰ Morita, 51.

³²¹ Reynolds, 32.

³²² Morita, 51-52.

³²³ Reynolds, 36.

the early 1920's, and has been evolving in many ways so as to accommodate to the changing culture of Japan.

Modern 'Neo-Morita' Therapy:

Contemporary Morita therapists today still comply with much of Morita's original philosophies. However, with the changing culture in Japan, some of the aspects of these traditional methods have been modified to accommodate such changes. As Reynolds, the anthropologist who has studied the Japanese culture in depth, stated:

Japan is a changing culture. The economy, ideologies, values, leisure activities, the family structure, geographic mobility, population composition by age... The changes that are taking place in Morita therapy – a treatment form with a history of more than fifty years in Japan – have been influenced by other cultural changes.³²⁴

One of the major changes is the western influence of individualistic self-concept and emotional expressiveness.

In Japan of the 1920s a person found meaning in life by contributing to his family, his community, and his nation. His self-concept was tied strongly to the proper execution of his role. Recent alternatives such as individualism and expressivity challenge these traditional values; many patients feel the conflict though they may still learn toward the traditional values.³²⁵

This quote illuminates on two issues. First, the importation of individualism offers alternative ways of developing self-conception or self-construct for the Japanese people. Instead of having an entirely collectivist view on the self or an interdependent self construal,³²⁶ the modern Japanese may see himself as a more individualistic self, having an independent self-construal. Such change in the conception of self must be accompanied by corresponding changes to the methods of psychotherapy. Second, a person may experience internal conflict between choosing between traditional and new values. According to Jeffrey Arnett, in his publication "The Psychology of Globalization," the process of globalization and its consequential influence on non-Western cultures (including the challenged value on interdependence in Chinese and Japanese societies) can lead to psychological consequences, such as identity confusion.³²⁷ The first issue is directly addressed by modernization of Morita therapy. The second issue on identity confusion from cultural changes is not addressed in literature on Morita therapy, although I will elaborate on this myself in Chapter Five.

³²⁴ Ibid., 117.

³²⁵ Ibid., 125.

³²⁶ See Chapter Two p. 24

³²⁷ Jeffrey J. Arnett, "The Psychology of Globalization," *American Psychologist*, 57, no. 10, (2002): 774-783.

These cultural changes in turn influenced the therapy in a number of aspects. For one, patients became increasingly resistant to the authoritarian stance of the Morita therapist.

[T]he modern Japanese patient is dissatisfied (at least initially) with instructions to accept his symptoms. He desires to be rid of them. He sees them, as Westerners do, as attached to him rather than as part of himself...[he also] wants to understand intellectually why he must do what he is told to do. He is less willing than patients in earlier years simply to accept the therapist's instructions on the basis of his faith in the authority and experience of the *sensei*.³²⁸

This passage shows two changes in the Japanese culture due to Westernization. The first part, how the modern Japanese wishes to rid his symptoms, possibly shows the preference for primary control,³²⁹ imported from Western cultures. The second part, how the modern patient is less willing to be instructed by the therapist, shows the importation of individualism at work. The Japanese culture has been notably hierarchic; the Japanese themselves call their society *tate-shakai* (縦社会, translated literally as 'vertical society'). However, the value placed on each 'individual' challenges the hierarchic dynamics between the therapist and patient. It is not difficult to imagine that the modern Americans may also have similar problems complying with the instructions of Morita therapy – being told what to do or what not to do. The modern Morita therapist, therefore, must present himself as a softer, more reasonable figure rather than the traditional stern, authoritarian models in the past.

The Westernization of Japanese culture also likely induced (not an extreme, but a slight) change in people's work ethics. The modern Japanese work ethics are still considered very strong compared to other countries³³⁰, but as the competing values of leisure and personal expression became more prominent, they became evidently weaker in comparison. The interests in leisure became increasingly more popular. In order to accommodate this change, many Morita therapists have begun to incorporate recreational therapy into their program, although the therapist's perspective on the value of work versus play can vary. Some programs still emphasize heavily on work, while some also incorporate other forms of therapy, such as music therapy, art therapy, recreational therapy, and family therapy.^{331,332} One hospital incorporates what is called a 'nature therapy', in which patients sit quietly in nature, engages in gardening, go on nature walks, and observe wild life. Through these nature-related activities, patients learn to unite themselves in nature, which catalyzes the course of therapy. The purpose behind this method would not have been understood in Morita's times, when people's psychological connection to nature was simply a given.³³³

³²⁸ Reynolds, 126.

³²⁹ See Chapter Two p. 29

³³⁰ Ibid., 128.

³³¹ Ibid., 129-130.

³³² Ohara, 280.

³³³ Reynolds, 126.

However, some aspects of the traditional method are regarded as integral to the purpose of the therapy, and are therefore still used to this day in modern Morita inpatient programs. For example, “the principle of contemplative isolation is still maintained”³³⁴ in modern Morita therapy, with the same rules and expectations. The group lifestyle is also integral to inpatient programs; although the therapist may not necessarily live in the same building, he still spends a lot of time in the hospital interacting with the patients on a genuinely personal level – not based on a more clinically traditional therapist-patient hierarchy and distance.

The daily diary submission to the therapist is also considered absolutely integral even in the modern context, as diary writing has been a cultural tradition of Japan on its own³³⁵. Since the Japanese culture is characterized by a pronounced dichotomy between the private and public selves, diary writing provides a comfortable space for a Japanese to return to his private self, and confess and reflect on all of his *honne* – his private experiences and thoughts.³³⁶ Diary writing is especially helpful in Morita therapy, as it is a suitable way for shy patients (who are overly concerned with interpersonal signal management) to communicate with therapists. It gives them time and distance to organize their thoughts, the opportunity to channel control, and communicate with minimal discomfort. Patients are instructed to write one whole page of diary everyday, and are expected to spend at least 30 minutes on each entry. Modern patients are also encouraged not to ‘complain’ too much about symptoms, or write his anxiety as the major theme of each entry (similarly in traditional Morita therapy). However, in the beginning of diary therapy the patients are hardly imposed with explicit rules, and are encouraged to write freely to help maintain the habit. As the patients write about their symptoms or anxiety in the beginning, the therapist leave comments on the diary entry in red, pointing out the sign of patients’ *toraware* (obsession or preoccupation with regard to his symptoms). As he or she begins to improve, the therapist makes sure to emphatically endorse any signs of constructive behavior.³³⁷ Diary writing is an integral part of Morita therapy in general, and therefore is heavily utilized in outpatient programs as well.

It goes without saying that modernization of Japan, with the increasing demand for individual productivity and success, required the option of outpatient programs. Being able to maintain a job or attend school while being in treatment is a much more realistic choice for many people, rather than disappearing for a month to participate in an inpatient program. Through outpatient treatment, patients can also practice trying to live an active life despite his conditions, which may be a more constructive path for those with relatively less severe symptoms. In addition to the requiring the diary therapy, outpatient programs also offer private counseling sessions in which the therapist interviews the patient about his conditions and progress. Shigehisa Aoki, a Japanese psychiatrist and a Morita psychotherapist, highlights some of the key elements of private counseling. He stresses on using collective pronouns (such as ‘we’) when talking about the patients’ symptoms or concerns. This fosters the empathetic understanding of the universality of

³³⁴ Ibid., 131. (The isolation-rest stage, however, is also subject to a few changes. Some hospitals have more than one patients stay in the same room. Some allow more flexibility between therapist-patient contacts.)

³³⁵ Ibid., 37.

³³⁶ See Chapter Two p. 37

³³⁷ Shigehisa Aoki, 森田療法のいま、進化する森田療法の理論と臨床 (*Morita Therapy Today: the Evolving Theories and Clinical Practice of Morita Therapy*) (Tokyo, Hihyosha, 2011), 97-98.

human suffering. He often uses metaphors, similes, and proverbs to explain the nature of the human mind, which helps to deemphasize the necessity of intellectual understanding. For similar reasons, he also deemphasizes and discourages analyzing each symptom in terms of its cause, origin, and meaning.³³⁸ This point, in particular, stands in stark contrast to psychoanalysis. In the absence of direct counseling (e.g. patient lives too far from the hospital), there is an alternative of letter therapy, in which the counseling is conducted through the exchanging of letters between the therapist and the patient. Letter therapy offers the same advantages as diary therapy: “Convenience, control of the medium, permanent recording, and the Japanese tradition of freedom to express their inner conflicts and feelings through writing.”³³⁹

Most outpatient therapy programs have a significant group therapy component, so as to maintain the group-oriented dynamics integral to the traditional inpatient Morita therapy. Group therapy offers the opportunity to open oneself to the members of the group through mutual sharing of experiences, which helps to emphasize the universality of human suffering. There are two major forms of group therapy. One style is directed towards self-help outside the hospital. There is a ‘leader’ of the group, but the hierarchy between the group leader and the group members are much more flattened compared to a therapist-patient relationship. The organization that follows this style is called *Seikatsu no Hakken Kai* (The Discovery of Life Group), and was founded in 1957, and is still active today. Hakken Kai holds retreats twice a year, each for four to five days. The group holds these retreats in secluded places in nature (for example, in a mountain temple), where participants can cook, work, camp, and hike together, and at the same time learn about Morita therapy through lectures and discussions.³⁴⁰ Another group therapy format is called *shudankai* (集団会, ‘group discussion meeting’), which meets once a month in a public hall. The meetings are accompanied by one or more Morita therapy professional, and are relatively informal by Japanese standards. Each participant would introduce him/herself, including symptoms and treatment experiences, in front of the group and the therapists. The therapists are there to ask and answer questions, comment on each persons’ experience using Moritist explanations, and emphasize the similarity of a member’s conditions to those of other members and his past patients. “[The therapists, when commenting,] focus on work – what he [the patient] has accomplished, what he can do at the time, and what he wants to be able to do.”³⁴¹ This focus is reminiscent of the traditional Moritist value of emphasizing an act-centered attitude and de-emphasizing feeling-centered attitude. In these ways, the periodic group-therapy offers a more convenient alternative to inpatient programs for many modern Japanese people, all the while maintaining the integrity of the traditional Moritist values. The flexibility for change in Morita therapy has enabled this therapy to remain effective to the Japanese people despite major cultural changes.

Further Applications:

The Morita therapy does not only have room for modification, but also possesses philosophies and therapeutic methods applicable to the general nature of human

³³⁸ Aoki, 96.

³³⁹ Reynolds, 44.

³⁴⁰ Ibid, 42.

³⁴¹ Ibid, 43.

suffering. Both of these characteristics have enabled Morita therapy and Moritist philosophies to be applied to a variety of physical and mental conditions other than *shinkeishitsu* neurosis. Morita therapy is now used for an array of anxiety disorders classified by the DSM-IV, such as panic disorder, generalized anxiety disorder, various phobias, hypochondria, obsessive-compulsive disorders, and post-traumatic stress disorder; depression and other mood disorders; eating disorders; the mental healthcare of cancer patients; physiological conditions such as atopic dermatitis and Irritable Bowel Syndrome;³⁴² alcohol and substance dependence; borderline personality disorder; and schizophrenia.³⁴³ Some of these conditions, not surprisingly, require the integration of Morita therapy with pharmacotherapy for therapeutic efficacy.

Combining Pharmacotherapy:

Although Morita therapy was initially designed without the consideration of pharmacological intervention, the modern Morita therapist would not rule it out. Depending on the symptoms, it is usually the consensus to consider medication in conjunction as an effective therapy method, when the medication is rendered necessary or helpful. In one of his publications, “The method and techniques based on the guideline for outpatient Morita therapy”, Aoki states that when prescribing medication as part of Morita therapy, the therapist must emphasize to the patient that the prescription is simply an ‘aid’ to help him re-construct his lifestyle; the prognosis of his therapy depends rather on his own investment and interest.³⁴⁴ Aoki also sees that pharmacological intervention can be especially helpful when treating symptoms that arise partly from organic conditions, such as Major Depressive Disorders with recurring and/or prolonged episodes. He contends that Morita therapy, in his clinical experience, has served as a helpful alternative to patients who have been unresponsive to medication, despite being in pharmacological treatment for as long as four years.³⁴⁵ Ohara also shares this clinical experience of treating depressed patients by effectively combining pharmacotherapy and Morita therapy. He points out that a depressed patient may not respond well to the isolation-rest therapy during his episode; he either may not be able to sleep at all during the week, or may not show the sign of improvement at the end of the stage by showing his desire to get up and do something productive. Therefore, when applying Morita therapy for depressed patients, it is important to ‘fix’ his conditions with medication up to the level of just having *shinkeishitsu* type of neurotic symptoms; in other words, up to the level of remission but with the same maladaptive cognitive habits as before. Ohara further observed that depressive patients actually share many traits with *shinkeishitsu* neurosis patients: they are perfectionists, hard workers, earnest, and show desires to maintain good interpersonal relationships with others around them. Once they are not deeply depressed anymore, they are able to understand the philosophy of ‘arugamama’ and tend to show good prognosis.³⁴⁶ When combined with pharmacotherapy, 70% of depressed patients show signs of psychological improvement upon discharge³⁴⁷.

³⁴² Aoki, 85.

³⁴³ Ohara, 280

³⁴⁴ Aoki, 98.

³⁴⁵ Aoki, 43.

³⁴⁶ Ohara, 194-195.

³⁴⁷ Aoki, 44.

In these ways, Morita therapy offers room for modifications and synthesis with other forms of therapy for maximizing therapeutic effect; this therapy is able to evolve and adapt accordingly to the given societal and cultural conditions. Such flexibility stems from how the therapy was originally designed in the first place. Morita therapy is a constellation of various psychotherapeutic methods imported from the West, as well as some Zen Buddhist philosophies indigenous to the Japanese culture.

Concluding Remarks

In this chapter, the philosophies and theories, the methods –traditional and modern, and the Western and Zen Buddhist roots of Morita therapy were outlined in detail. The traditional method is divided into four stages: isolation-rest, light occupational, heavy occupation, and preparation for daily living. The modern Neo-Morita methods generally follow the same rule; however, modifications have been made to accommodate the changing culture of Japan. Many modern Morita therapists combine other forms of therapy to better suit the patient population, such as importing recreational therapy, creative (art and music) therapy, family therapy, nature therapy, and pharmacotherapy to name a few. Despite these changes, some aspects of the traditional method are seen as integral, such as diary-keeping, group dynamics, and the contemplative method of isolation-rest stage. Morita therapy stems from both influences of Western psychotherapeutic traditions as well as Zen Buddhist philosophies. The cognitive-behavioral aspect of the therapy seems to stem partly from the Western influences. But the experiential, contemplative aspect originates from the Zen influence, and characterizes Morita therapy to be a mindfulness-based therapy.

Chapter Five: Similarities

In Chapter One, I argued that mindfulness is an inherent capacity of the human mind, irrespective of cultural context. Chapters Three and Four, respectively, outlined the theories and methods of MBCT and Morita therapy. You may have already found some similarities on your own from reading those chapters; in this chapter, the similarities will be explicitly outlined and elucidated. The similarities between the two forms of therapy are astonishing, and they generally spring from the fact that both MBCT and Morita therapy are mindfulness-based therapies. I have argued throughout my thesis that humans share a certain inner layer of the self that operates similarly irrespective of cultural differences; this layer is also where mindfulness operates. For these reasons, the therapeutic mechanisms of MBCT and Morita that revolve around mindfulness share a striking resemblance, despite the vast difference in historical and cultural contexts. This central similarity, that involves mindfulness and the self, is elaborated in the first section of the chapter. The second section of the chapter is dedicated to identifying and elucidating other similarities, such as diary-writing, emphasis on acting-centered attitude over feeling or thinking-centered, group-format, and patient-therapist relationship.

CENTRAL SIMILARITY: **THERAPEUTIC MECHANISM INVOLVING MINDFULNESS AND THE SELF**

Layers of the Mind and Mindfulness

I propose throughout this thesis that there are two distinct layers of the self – an inner layer that operates similarly across cultures, and an outer layer that is conditioned socially and culturally. Understanding these layers of the self helps to understand the therapeutic mechanism of mindfulness-based psychotherapy, through a cross-cultural perspective.

A psychotherapist and a meditation practitioner, John Welwood proposes an interesting construct of the mind that in some ways resonates with my model of the self. His model of the mind also helps to deconstruct the therapeutic mechanism of both MBCT and Morita therapy. He explains that there are three layers of the mind that are always active throughout our ongoing experience.³⁴⁸ The top layer is the ‘surface conceptual mind’ as he calls, which operates through a linear and focal attention (attention fixated on a particularly object, instead of a more diffuse and wide kind of awareness characteristic to mindfulness) and concepts (generated by language). This surface layer of the mind “perceives solid forms, thinks definite thoughts, and registers familiar emotions. This is the level of mind where ego operates – through forming self-concepts, setting up a basic division between self and other, pursuing control and mastery in worldly functioning.”³⁴⁹

Underneath the surface conceptual layer of the mind is the subtle operation of a body-mind sensing/knowing, which stands as a background and can be recognized through “a diffuse type of attention that can tune into subtle feeling and intuition, energy

³⁴⁸ Welwood, 7.

³⁴⁹ Ibid., 6.

flow, and a sense of interrelatedness.”³⁵⁰ Beneath this middle layer resides the deepest, **non-conceptual awareness** – the ultimate source of all our experience. Welwood contends that this layer of the mind is accessible through meditative practice.³⁵¹ He further provides a metaphor that compares his construct of the layered structure of the mind to the ocean:

If surface mind is like whitecaps and body-mind is like waves, then the deeper, unconditioned essence of mind is like the ocean itself, which makes possible and infuses all the activity happening on its surface. The waves and whitecaps represent becoming—our changing, evolving nature—while the ocean itself is Being, our changeless nature.³⁵²

I find this metaphor to be extremely clever and insightful. The white caps and waves are in constant flux: the patterns of the surface of the ocean changes every moment, either from its own natural course of wave propagation, or due to external forces like the wind, current, weather, and season. The surface of the ocean also looks different from one geographic area to another, in terms of the reflection of light, the color, and how the waves interact with the land. In similar ways, our surface layer of the mind is composed of changing emotions, moods, and thoughts, which are in turn to be influenced by not only its intrinsic fluctuation pattern but also by external factors such as the daily events and cultural molding. But the ocean at a deeper level is still, dim and void everywhere.

Although Welwood uses the layered structure to explain the construct of the mind, I believe his idea is also implicit for the construct of the self that I propose. From the way that the surface layer of the mind is described here, this layer seems to consist of elements subject to cultural and social variation: cognition, pursuit for control, registering emotions, and forming self-concept through distinguishing between self and non-self. All of these elements should sound familiar, as they were discussed in Chapter Two as factors underlying cultural variations in the construct of self.

The deepest layer—the non-conceptual awareness—is reminiscent of Gallagher’s minimal self as described in the Introduction: a type of non-conceptual, pre-linguistic, and somewhat primitive type of self-awareness. The middle layer (where body-mind sensing/knowing operates) and this deepest layer, together, perhaps correspond to the inner layer of the self that I contend to be the operating locus of mindfulness. Through mindfulness practice, we gradually gain the ability to depart from the surface conceptual layer of the mind; we then enter the middle layer to reconnect with the waves and currents of our bodily sensations. When we tune into this middle layer through the re-establishment of mind-body interconnection, we come one step closer to experiencing the stillness and depth of our non-conceptual awareness. Using this framework of the layered structure of the mind, let us analyze the therapeutic mechanism of MBCT and Morita therapy, which should illuminate the remarkable similarities between the two.

Both MBCT and Morita therapy seem to implicitly involve a change in the conception of the self in relation to the mental events. In both cases, it is perhaps the act of ‘tapping into’ the inner layers of the mind—the body/mind knowing and the non-

³⁵⁰ Ibid.

³⁵¹ Ibid., 7.

³⁵² Ibid.

conceptual awareness—through mindfulness that induces this change. Let’s compare how ‘the self’ plays an important role in the theories and methods of MBCT and Morita therapy.

Surface Layer: ‘Self-Centeredness’ as the Problem

Both MBCT and Morita seem to address ‘self-centeredness’ as one of the major causes to the patient’s psychological distress. Being ‘self-centered’ in this sense does not mean you are being ‘selfish’ (lacking consideration for others); it simply means that you are always thinking about yourself, processing information in a ‘self-referential’ way. The information can be either from an external event (let’s say that your friend seems to be in an incredibly bad mood, and you interpret that it has something to do with you) or an internal event (you feel anxious one day and think to yourself, “why am I feeling this way? It’s not like me. What is wrong with me? This is not who I am! I am usually a very calm person and I shouldn’t be feeling anxious at all.”). These concerns with the self initiate a cascade of self-referential, ruminative thinking, which in turn leads to psychological distress. This process should sound familiar in the context of both therapies.

‘Self-centeredness’ in MBCT:

The theories of MBCT implicitly address the problem of being ‘self-centered.’ Recall from Chapter Three that the founders of MBCT have articulated that the core theme of MBCT is to prevent the establishment and consolidation of habitual, ruminative patterns of negative thinking with the aid of mindfulness. In the seven signs of habitual negative thinking, three of them seem to be underlined to some extent or another by this narrative self-referential processing.

- 2) Relating to experience through thought (rather than directly sensing)
- 3) Dwelling on and in past and future (rather than being fully in the present moment)
- 5) Needing things to be different from how they are (rather than allowing them to be or just as they already are)³⁵³

To remind ourselves: in the narrative style of self-referential processing, one connects experiences of the self (me, my, and mine) across time (past and future) and situation.³⁵⁴

Let’s bring back the familiar hypothetical situation that I used in Chapter Three to elucidate the connections between these negative thinking patterns and narrative self-referential processing. Say Sarah was in a committed relationship, but her boyfriend dumps her. Then, she may relate to her painful experience through thoughts (2), such as “Is there something so unlikable about me? What did I do wrong? Are my physical and intellectual assets not good enough?” rather than directly sensing her experience, “Wow, this hurts a lot and I feel very sad.” She then may dwell on her past and future (3) in not necessarily an accurate or logical manner, “How come I always have relationship problems? I feel like boys have never appreciated me. Am I going to be like this for the rest of my life?” She may also think about the situations that she would rather have (5), “I

³⁵³ Segal, Williams, and Teasdale, 89.

³⁵⁴ Farb et al., (2007). (Also see Introduction)

wish we were still together. I want to get married and have children by the time I am thirty years old, and I am nowhere close to this right now.” In these ways, narrative self-referential processing is often implicit in the habitual ruminative thought patterns.

An important mechanism underlying ruminative thinking is the ‘doing-mode’ of mind, mentioned in Chapter Three. The function of this mode of mind is to ‘get things done’ – to achieve specific goals that have been set: “These goals could relate to the external world—to make a meal...or to the internal world of self—to feel happy, not make mistakes, never be depressed again, or be a good person.”³⁵⁵ The goals are achieved by registering the discrepancy between our ideals and reality. Although this mode of mind is crucial to our survival, it can become problematic when the self becomes involved. When the doing mode of mind registers that we are in an emotional state that we don’t wish to be, even if there are no immediate actions that can be taken to reduce the discrepancy, the mind can only continue to process ideas about how things are and how they should be in the hope of finding a solution.³⁵⁶ The repetition can continue, even without the individual being aware of it (i.e. on automatic pilot).

Within this repetitive process of the doing-mode of mind, the thoughts and concepts produced can be “experienced mentally as ‘real’ rather than simply as events in the mind.”³⁵⁷ That creates another vulnerability in it of itself, because the individual may begin to identify himself with these negative thoughts or concepts, rather than acknowledging that they are merely transient events of his mind, which may or may not be accurate in real life. This can also be applied to the hypothetical situation given above: the woman’s ruminative thoughts such as “I am unattractive” or “I am unwanted by men” due to her break-up becomes progressively pronounced in her consciousness as she continues to ruminate on automatic pilot. Eventually, she may become convinced that she actually is unattractive and unwanted—not because of actual confirmation from the external world, but because of her prevailing internal thoughts. This issue is particularly addressed in week six of MBCT, in which the theme of the session is ‘thoughts are not facts.’ In these ways, MBCT addresses the troubles of thinking self-referentially.

‘Self-centeredness’ in Morita therapy:

In a very similar way, Morita also argued that ‘self-centeredness’ plays a significant role in the etiology of neurotic symptoms. For one thing, it constricts the field of our attention. Reynolds, the anthropologist who studied Morita therapy in Japan, summarizes:

[F]rom Morita’s perspective, the problem of neurosis is that too much “self” stands out as figure against the background of the perception of the external world. When self-consciousness fills our attention we cannot attend to the other aspects of our world which require our interest and attention.³⁵⁸

³⁵⁵ Segal, Williams and Teasdale, 68.

³⁵⁶ Ibid., 71.

³⁵⁷ Ibid.

³⁵⁸ Reynolds, 4.

The constriction of one's attention as a consequence of being too self-referential is addressed in a remarkably similar way in MBCT, when discussing the effects of self-referential doing-mode of mind:

[The] mind will not be fully tuned in to the full actuality of present experience. It will be so preoccupied with analyzing the past or anticipating the future that the present is given a low priority. In this case, we are aware of the present only in a very narrow sense... The broader sense of the present, in what might be called its "full multidimensional splendor," is missed.³⁵⁹

When our field of attention is narrowed due to self-centeredness, we cannot grasp the essence of reality with rationality and accuracy. Morita also carefully addresses this issue:

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.³⁶⁰

Just as we perceive our dreams as reality while dreaming, our fixation of attention onto a self-related issue not only limits our freedom to attend to our surroundings and maintain active attention, but also causes us to interpret our ideas as real.³⁶¹ This notion, that the obsession or attachment to our ego-centered ideas leads us to believe that they are reality, seems indistinguishable from what was said in the context of MBCT in the previous paragraph.

The 'Egoic Self' in Buddhism:

In both theories of MBCT and Morita therapy, self-centeredness seems to be the emphasis in the etiology of symptoms. This view parallels the original Buddhist notion that holding onto our sense of 'I' as a something permanent, solid, or substantial brings unhealthy attachment and ultimately suffering: "the belief in a permanent substantial self is not only false, but also leads to selfishness and egoism, which, in turn, make the world so dissatisfactory for everyone."³⁶² This parallel is not surprising, as these two forms of psychotherapy ultimately share their roots in Buddhism. Where do our tendencies to withhold our sense of self as something permanent, solid, and substantial spring from?

Buddhist psychology views our 'egoic self' as recreating and reinforcing our concept of self over and over again at every moment. Welwood summarizes that these tendencies to secure our sense of self can be categorized into a five-layered structure, known as the "*skandhas* operating within and shaping our experience of reality."³⁶³ The

³⁵⁹ Segal, Williams and Teasdale, 71.

³⁶⁰ Morita, 84-5.

³⁶¹ Morita, 122.

³⁶² Mitchell, 37.

³⁶³ Welwood, 42.

first *skandha* sets up a division between self and not-self, known as the “birth of ignorance.” In western developmental psychology, this stage corresponds to the stage where the child’s consciousness identifies itself with the body, giving him a sense of boundedness in the body and separation from the rest of the physical world. The second layer is the *skandha* of feeling, in which our relation to reality becomes shaped by the dichotomous categories, such as pleasure and pain, like and dislike, etc. “The split between self and not-self that emerges in the first *skandha* now also takes place *within* the self. We like the good (adequate...competent) self we hope we are, and we dislike the bad (inadequate...unworthy) self we fear that we may be.”³⁶⁴ The third *skandha* is termed *perception* or *impulse*, and involves adopting a stance towards situation based on how we perceive them. The stances could be passion (grasping, possessing, or clinging to situations that confirm our identity), aggression (attacking or rejecting situations that threatens our identity), or ignorance (apathy or indifference towards situations that are not relevant to our identity). The fourth *skandha* is *conceptualization*, where we further solidify our identity but generate elaborate beliefs about reality—about self and world—which consequently “keep us imprisoned and isolated in a narrow, self-perpetuating conceptual world.”³⁶⁵ The fifth *skandha* springs from all four previous *skandhas*, as the ongoing *stream of consciousness* that maintains our mental activity in an attempt to prove that we exist. “Ego maintains itself through the endless self-talk of the busy mind, which covers up any gaps or open spaces in the mindstream.”³⁶⁶ In these ways, the egoic self has an intricate layered structure on its own. But this egoic self only operates at the surface, conceptual layer of the mind.

When someone is ‘self-centered’ in the problematic way addressed by MBCT and Morita therapy, it is perhaps that he or she is ‘stuck’ within these conceptual layers of the egoic self, unable to see the layers beneath. Welwood further argues that ego and ‘egolessness’ are inseparable in existence, although we may not be keenly aware of the egolessness of our mind:

If ego is awareness in a contracted state and egolessness is awareness in a relaxed state, it is clear that ego cannot exist without egolessness, which is the ground...Everyone has little glimpses of egolessness in the gaps and spaces between thoughts, which usually go unnoticed. Ego is dying and being reborn at every moment.³⁶⁷

Just as waves and whitecaps of the ocean surface cannot exist without the ocean itself, our egoic self (our sense of self created by conceptualization) is grounded in the existence of egolessness—the non-conceptual awareness that resides quietly and discretely beneath. However, clinging onto the conceptual layer of our egoic self holds us back from finding the egolessness—the unconditional openness to experience.

³⁶⁴ Ibid., 43.

³⁶⁵ Ibid., 44.

³⁶⁶ Ibid.

³⁶⁷ Ibid., 45.

Identifying a self-concept is an attempt to give ourselves some shape, some hold on things, some security. Experience may change, but at least, we hope, the experiencer endures. But in fending off its continual impending dissolution into openness, the experiencer gets in the way of its own experience, becoming an obscuration that prevents direct contact with our true nature, with others, and with larger sweep of life.³⁶⁸

To put this in the context of the ocean metaphor: Rough waves are inevitable; we all have our times of difficult emotions—our storms of life. But holding onto a pillar, trying to stay on the surface while waiting for the storm to die and the waves to calm, would only cause more pain and consume more energy as you are being smacked by the waves while you try to hold your face above the surface. It is perhaps easier and wiser to just ‘let go’ and dissolve into the natural motion of the waves—let the ocean itself take you where you are supposed to be. This metaphoric ‘letting go’ is an important therapeutic procedure in both MBCT and Morita therapy—to let go of our conceptual knowledge of ourselves, and open ourselves to the dimensions of experience that we have hitherto avoided. In both forms of therapy, the problematic ‘self-centeredness’ is the locus of treatment.

Middle Layer: Body-Mind Experiential Understanding

When we ‘let go’ of the pillar that we were trying so hard to hold onto, we must first learn how to ride the waves of the ocean in order not to drown. As mentioned previously in the metaphor of the layered structure of the mind, the middle layer—like the ocean waves—is our body-mind sensing/knowing. In both MBCT and Morita therapy, the procedure of re-establishing the mind-body interconnectedness is an integral part of the therapy for two reasons: it allows us to step out from our old habitual pattern of experiential avoidance through thinking (such as rumination and rationalization), and remind us with our intuitive ability to be in touch with our direct experience through our bodies.

In both theories of MBCT and Morita therapy, experiential avoidance is also addressed as a key factor in symptoms. In MBCT, the relationship or interaction between experiential avoidance and rumination is explained:

Rumination is intricately entwined with experiential avoidance—they are both strategies that are motivated by the attempt to get away from difficult emotional experience...It can become habitual to deal with emotions by switching into a conceptual brooding problem-solving mode (rumination). In doing this we are erecting a “smokescreen” through which we suppress or disconnect from difficult emotions (experiential avoidance).³⁶⁹

This problematic tendency for the mind to avoid ‘feeling bad’ about the discrepancy between ideality and reality by means of conceptual ‘problem-solving,’ is addressed in Morita therapy in a similar way—as *shiso no mujun* (思想の矛盾) or “the contradiction

³⁶⁸ Ibid., 46.

³⁶⁹ Crane, 36.

by ideas”. Recall from Chapter Four that this is the tendency to overcome a difficulty by rationalization, or “attempting to create, manipulate, or modify facts by means of ideas [linguistic descriptions, explanation, or inference of facts] without knowing the difference between ideas and reality.”³⁷⁰ Both therapies seem to address this problem of ‘being stuck in the head’ during difficult emotions and experiences as a means of avoiding them. By using variations of mindfulness-based contemplative practice, the two therapies assign experiential confrontation as both an antigen and vaccination against experiential avoidance.

Body-Mind in MBCT:

MBCT makes explicit instructions for re-connecting with our bodies to be in better touch with our direct experience. Recall that in MBCT, the body is seen as the “most accessible ground for our direct experience in the present moment”³⁷¹ – an indispensable tool for adaptive emotional registration and processing. This is the underlying premise of various mindfulness-based formal practices taught in the course, particularly for body scan meditation taught on the first day of class.³⁷² By deliberately placing attention to various parts of their body, MBCT participants may “discover what discomfort or boredom feels like in the body, what sensation accompanies each emotion, and their reactions to each emotion.”³⁷³ Body scan meditation is also the first opportunity in which participants discover their mind-wandering patterns, as they may also “become aware of negative, judgmental thoughts or difficult emotions.”³⁷⁴ In these ways, through the body scan meditation the MBCT participants begin to slowly open the door to their “immediate, intuitive way of knowing”³⁷⁵ when experiencing difficult emotions; this is the door that has been once closed by their habitual cognitive routines. Throughout the course the door gradually opens wider and wider as the participants engage in various mindfulness practices that involve the body-mind. In these ways, the participants progressively gain the ability to better ‘confront’ or directly experience their difficult emotions using their bodies as an anchor; at the same time they learn that these difficult emotions are only transient states in the mind, as they also observe them come and go.

Body-Mind in Morita therapy:

In Morita therapy, experiential confrontation through body-mind learning is rather implicit, but is nonetheless a fundamental aspect of the therapy and shares many similarities with the theories from MBCT. Morita wrote: “The essential characteristics from my therapy are the natural treatment of the mind=body, and the experiential methods.”³⁷⁶ Recall that Morita highly emphasized the importance of *taitoku* (体得) – experiential understanding through the body – in uncovering the nature of emotions.³⁷⁷ This is Morita’s central premise behind the isolation rest stage.

³⁷⁰ Morita, 3.

³⁷¹ Crane, 49.

³⁷² See Chapter Three pp. 46-47.

³⁷³ Segal, Williams, and Teasdale, 124.

³⁷⁴ Ibid., 125.

³⁷⁵ Crane, 106

³⁷⁶ Morita, 36.

³⁷⁷ See Chapter 4 p. 62

The main purpose of this [stage of] therapy is to radically dismantle the client's mental suffering and pain, and to let her or him experience the mental state that I call "immediate liberation through confrontation with one's suffering."...I have observed how pain and anxiety disappear through the natural course taken by an emotion when the client is left alone in a tranquil condition, without complicated external stimuli.³⁷⁸

Although Morita does not make explicit reference about experiential confrontation through the body, I interpret the body as nonetheless involved during this stage of the therapy. The client lies in bed quietly without any external stimuli (similarly to how participants lie on their backs without any distraction during the body scan in MBCT) experiencing the painful emotions and thoughts as they come and go. As the client is not physically moving, he is bound to notice the physical sensations of his difficult experiences that are moving in and out of his body.

The body-mind experiential learning is not only implicit in the contemplative aspect of the first stage, but also implicit throughout the rest of the course of Morita therapy. During the therapy, clients are discouraged from complaining about their symptoms because Morita contended that bringing conceptual attention to their thoughts, emotions, and ideal would exacerbate the condition. Instead, clients were instructed to engage in physical activities or chores—to foster spontaneous activities involving the body. This is particularly evident in the second stage of the therapy (light-occupational work): "The purpose of this activity stage is to let the clients calmly endure her or his distressful symptoms and to stimulate spontaneous activities and desires for action by driving the client to experience mental and *physical* boredom."³⁷⁹ The fostering of these "spontaneous activities of mind=body" allow clients to experience 'reality' instead of being caught up in their ideality.³⁸⁰ In these ways, in Morita therapy the body is the locus of therapeutic process as much as the mind is, similar to MBCT.

Bottom Layer: the Dissolution of the Conceptual Self

In both therapies, engaging in this middle layer of the mind—the body-mind knowing/sensing—through (explicit or implicit) mindfulness methods, eventually leads to accessing the bottom layer: the egoless/selfless, relaxed, and non-conceptual state of awareness. In this state of mind, one's attention is not constricted by or fixated on his attachment to his self-concept; instead, his attention is relaxed, evenly distributed, and unfiltered by conceptual knowledge. This type of attention may correspond to the non-dualistic mindfulness explained in Chapter One, or *musho-jushin* (無所住心)³⁸¹ in the context of Zen Buddhism/Morita therapy.³⁸² This type of attention—that is not limited by previous knowledge or conceptualization and is unconditionally open and curious for experience—enables a state of mind characterized as the *Beginner's Mind* in MBSR (thus implicit in MBCT) or the *Pure Mind* in Morita therapy. I believe that these two concepts, explained in slightly different ways, ultimately suggest the same phenomenon involved in

³⁷⁸ Ibid.

³⁷⁹ Ibid., 44. (Italics added by me)

³⁸⁰ Ibid., 95

³⁸¹ The characters for this term directly translates to 'nowhere specific the mind resides'

³⁸² Morita, 30.

the therapeutic mechanism of mindfulness-based psychotherapy: the dissolution of the conceptual self-representation.

Beginner's Mind:

The notion of “beginner’s mind” is not explicitly given in the theories and methods of MBCT, but nonetheless implicit. As mentioned in Chapter Three, much of the mindfulness-based aspects of MBCT derive directly from MBSR. Jon Kabat-Zinn, in *Full Catastrophe Living*, lists “beginner’s mind” as one of the integral attitudinal foundations of mindfulness. He explains:

The richness of present-moment experience is the richness of life itself. Too often we let our thinking and our beliefs about what we “know” prevent us from seeing things as they really are...To see the richness of the present-moment, we need to cultivate what has been called “beginner’s mind,” a mind that is willing to see everything as if for the first time.³⁸³

Kabat-Zinn further notes that this attitude is particularly important to cultivate when practicing formal meditation techniques as well as in daily life experiences.³⁸⁴ Although this notion of “beginner’s mind” does not appear explicitly in the literatures of MBCT, the concept is nonetheless implicit in the practices. The abandonment of previously gained conceptual knowledge and the fostering of this “beginner’s mind” is particularly evident in the various sensory experiences of MBCT, such as the raisin exercise of week one. The participants are invited to see, hear, and taste things without categorizing, analyzing, or judging each component—to experience them in a “fresh” way.³⁸⁵

In such unconditioned, unfiltered modes of experience, the previously conditioned sense of self dissolves into the background. As mentioned in Chapter Three, the premise of these exercises to promote the transition from the ‘doing-mode’ of mind to the ‘being-mode.’ The experience is therefore delivered through a non-dualistic type of mindfulness, in which the attention is brought to the present experience without the establishment of subject-object duality. In other words, when someone is truly ‘being with’ the experience, his self-awareness does not involve a reflective act of registering the ‘subject’ (the self) who is experiencing the ‘object.’ In Sekida’s notion of *nen*,³⁸⁶ the oncoming experience enters the mind as the first *nen*, rather as the self-reflected second *nen* or the conceptualized or categorized third *nen*. Being able to explain this phenomenon in terms of Zen Buddhist concepts helps to elucidate the parallel between this “beginner’s mind” and the “pure mind” in Morita’s terms.

Pure Mind:

Morita therapy, like Zen Buddhism, does not use an explicit labeling of ‘mindfulness;’ however, this type of non-dualistic, non-conceptual mindfulness discussed above is nonetheless recognized as imperative to the therapeutic process. Morita uses the Zen term of *musho-jushin* (‘mind that reside in no place’) to describe the type of attention

³⁸³ Kabat-Zinn, (1990), 35.

³⁸⁴ Ibid.

³⁸⁵ See Chapter Three pp. 50-51

³⁸⁶ See Chapter One p. 21

that is not fixed on any particular object but extends in all directions.³⁸⁷ According to Morita, this condition of *musho-jushin* can be achieved with a *sutemi* ('self-less') attitude, "leaving ourselves open to anything."³⁸⁸ His therapy aims to foster this state of mind in clients, as well as their own experiential understanding of the "pure mind."³⁸⁹

Pure mind is their [the clients'] original and natural intrinsic disposition; it requires a mental attitude that does not deceive the self. Pure mind refers to "natural emotion" and an attitude that does not deny or cover up the reality of emotions. As one acts on the basis of this reality one can develop her or his real self.³⁹⁰

In Morita's words, the pure mind is able to perceive and experience emotions *as they are*, without any cognitive filtering or distortions. Morita further explains that like *musho-jushin*, the state of pure mind is often experienced in the isolation rest stage of treatment, and further developed in a graduated way throughout the rest of the therapy.³⁹¹ In these ways, pure mind is integral to the therapeutic process, as both a catalyst and an end result. This point is still emphasized in contemporary Morita therapy today: Mari Iwata, a Japanese clinical psychologist and the author of *The Recitation of Morita Therapy in His Own Words—To Live with Pure Mind—*, claims that "the experiential understanding of the pure mind is the goal of Morita therapy, as well as its core... Without the experiential understanding of the pure mind, one cannot say that he understood Morita therapy."³⁹²

However, it is important to note that in the context of Morita therapy, the pure mind also entails a selfless, obedient, and compliant stance; the client's therapeutic progress is highly dependent on how well the client is able to abandon his egotistic or prideful self-assertion, and follow the instructions given by the therapist. Ohara, a Japanese psychiatrist and a contemporary Morita psychotherapist, mentions that the modern Japanese youth today is too egotistic, self-assertive, and far from obedient; they not only lack the state of pure mind (純な心, *jun-na-kokoro*) but also lack a sense of submissiveness (素直さ, *sunao-sa*). This prevents them from listening to the instruction given during the therapy, and therefore does not respond to the treatment as well as they should.³⁹³

Although this may appear as a more striking issue in Morita therapy in which the Japanese traditional values on obedience and submission are being challenged by the western alternatives of individualism and independent autonomy, I believe it can also be problematic for MBCT. Although MBCT highly values maintaining a flattened hierarchy between the MBCT instructor and participants (unlike the somewhat comparatively authoritarian style of Morita therapy,) the participant's incomppliance due to some egotistical defensiveness will block the progress. In both styles of therapy, one learns

³⁸⁷ Morita, 30.

³⁸⁸ Ibid., 31.

³⁸⁹ Ibid., 52.

³⁹⁰ Ibid., 52-3.

³⁹¹ Ibid., 54.

³⁹² Mari Iwata, 森田正馬が語る森田療法～純な心で生きる～(*The Recitation of Morita Therapy in His Own Words—To Live with Pure Mind—*), (Tokyo, Hakuyo-sha, 2010), 167-8. (translated by me)

³⁹³ Ohara, 101.

how to be ‘selfless’ both interpersonally (such as in the therapist-patient relationship) and experientially. I will discuss the ‘interpersonal selflessness’ shortly; for now, let’s focus on the ‘experiential selflessness.’

Self-less Experience:

To be ‘selfless’ experientially means to be in these states of mind (beginner’s mind or pure mind)—to attend to the present-moment experience without the lens of conceptual, self-referential thinking. “Selflessness does not require people to annihilate their emotions, only to learn to experience them in a new way.”³⁹⁴ To experientially understand the concept of “beginner’s mind” or “pure mind” is to see that nowhere can a solid, substantial, and permanent self can be found in one’s experience—that “self-representation is revealed as lacking concrete existence.”³⁹⁵

In Buddhism, this realization of “no self” is highly valued to the path of enlightenment. The Buddhist notion of “no self” does not discount coherent and integrative psychological operation; it does not mean that you suddenly lose a sense of identity or agency.³⁹⁶ Instead, it signifies that one lets go of the sense of “I am,” “to give up the automatic, reactive, inflexible identification with and attachment to self-representations,”³⁹⁷ which otherwise “prevent us from having direct, unmediated contact with reality.”³⁹⁸ This helps one to realize that “mental activity can be accounted for without a self.”³⁹⁹ Harvey Aronson, a Buddhist meditation teacher and a psychotherapist, further elaborates on this point:

If we are mindful and begin to look at the various functions operative in our mental states...we begin to observe that these are impermanent, arising and ceasing, and there is no permanent self to be found in any of them. The ontological self we presume ourselves to have is understood as a fiction. This is not ontological loss; it is seeing through a misconception.⁴⁰⁰

Through careful investigation of the mind through mindfulness, we begin to see that our mental activities are not central components of the self. “We have all become experts at being ourselves, and in so doing we have lost our ability to be present with our experience in a fresh, open-minded way.”⁴⁰¹

In mindfulness-based therapy such as MBCT and Morita therapy, this realization is more implicit but nonetheless an integral part of the therapeutic progress. Recall from Chapter Three that one of the explicit therapeutic objectives of MBCT is the fostering of a ‘de-centered’ relationship to thoughts. By holding mental events in awareness through mindfulness, participants learn that their thoughts and emotions are passing events—they do not necessarily reflect reality, and they are not central components of the self.⁴⁰²

³⁹⁴ Epstein, 96.

³⁹⁵ Ibid., 98.

³⁹⁶ Harvey Aronson. *Buddhist Practice on Western Ground* (Boston: Shambhala, 2004), 68.

³⁹⁷ Ibid., 83

³⁹⁸ Ibid., 82.

³⁹⁹ Ibid., 69.

⁴⁰⁰ Ibid.

⁴⁰¹ Welwood, 141.

⁴⁰² Crane, 12.

Instead of objectifying the self in relation to the mental events (“here is *me* feeling sad again” or “*I* am angry at this person,”) the subject-object duality between the self and mental events is gradually diminished during the therapeutic progress of “de-selfing”. A common instruction given during mindfulness practice is to label thoughts and feelings without the subject of I or me; for example “itch, itch, itch... (and return to breath) or “sadness, sadness, sadness... (and return to breath).”⁴⁰³ Therefore, the passing mental events are seen as objects *external to the self*, rather than as something *attached to your objectified self* who in turn stands as the subject of those mental events.

Morita similarly addressed that the projection of the self as an object for observation is problematic: “By contriving or endeavoring, one attempts to treat oneself objectively as a third person and subsequently ignores her or his real self.”⁴⁰⁴ The notion of “real self” that Morita uses here can be misleading, but in this context I interpret it as signifying one’s purely subjective experience or the natural states of emotions, unfiltered by self-referential processing. “When one is in a purely subjective state, one is entirely beyond evaluations due to dualistic or ‘subject versus object’ ways of thinking.”⁴⁰⁵ In this way, the conception of “self as an object” dissolves. Through careful and mindful observation in this purely subjective state, the pain and suffering eventually “become the objective entities projected onto the external world” instead of “the object of subjective attachment.”⁴⁰⁶

I will refer back to Sekida’s notion of *nen* in order to further elucidate the nature of this process:⁴⁰⁷ the ‘purely subjective state’ noted by Morita would correspond to being immersed only in the first *nen*, without the self-reflective act of the second *nen*, the contextualizing act of the third *nen*, or any other additional layering. In the section on the sensory exercises of MBCT, I applied Sekida’s framework to show that those exercises were a means to practice experiencing *external* sensory inputs in a selfless way; the therapeutic processes of both MBCT and Morita therapy regarding emotional processing, then, relies on applying the same principle to the direct experiencing of *internal* stimuli such as thoughts, feelings, and sensations. In these ways, MBCT and Morita therapy both aim to decouple the “the self as an object” from the various mental events. This process of ‘de-selfing’ is tapping into the deepest layer of the mind—the non-conceptual, non-dualistic awareness—while experiencing emotions, uncovering its nature as energetic phenomenon. “Uncovering the raw energy of emotions is like moving into the depths of the ocean, underneath the whitecaps of emotional frenzy and the broader swells of feeling, where all remains calm, where our personal struggles empty into the larger currents of life.”⁴⁰⁸

A neural mechanism of this ‘de-selfing’ process has been suggested by the studies of Farb and colleagues (2007). In the Introduction, I explained that Farb and colleagues characterized the two distinct neural mechanisms of self-referential processing—narrative and experiential. Earlier in this chapter, I also explained that the narrative type of self-referential processing is implicit in the maladaptive cognitive patterns of rumination.

⁴⁰³ Hiroaki Kumano. *ACT from Mindfulness – Self-discovering Project in the 21st Century* (Tokyo: Seiwa Shoten Publishers, 2011), 75-6.

⁴⁰⁴ Morita, 23.

⁴⁰⁵ Ibid., 15.

⁴⁰⁶ Ibid..

⁴⁰⁷ See Chapter One p. 21

⁴⁰⁸ Welwood, 187.

What I did not mention then is that narrative self-referential processing has a locus of operation in the brain: the “Default Mode Network (DMN)” – a network in the brain that is now understood to underlie certain aspects of our sense of self,⁴⁰⁹ and involves the medial prefrontal cortex (a region in the brain often associated with thinking about the self).⁴¹⁰ On the other hand, the experiential mode of self-referential processing is thought to operate from a network in the brain comprising the lateral prefrontal cortex and viscerosomatic areas—areas in the brain linked to direct, present-moment sensory experience (e.g. the insula). The result of their research was that for participants who had undergone mindfulness training, there were marked reductions in the medial prefrontal cortex (linked to narrative mode of self-referential processing) and increased activation in the brain regions associated with the experiential mode. Segal, Williams, and Teasdale recognized that these results elucidate the therapeutic mechanism of MBCT (or any other mindfulness-based therapy in this matter):

These data are hugely important. They are the first to support the notion of a fundamental neural dissociation between two distinct forms of self-awareness—narrative and experiential modes—that are habitually integrated but can be uncoupled through mindfulness training.⁴¹¹

The ‘uncoupling’ suggest that the individual is now able to attend to moment-by-moment embodied experience, without automatically engaging in ‘stories’ about the self. In other words, the conception (or mis-conception) of the self dissolves into the background of immediate experiences. This is perhaps the neural mechanism underlying the ‘de-selfing’ process in MBCT and Morita therapy.

The relationship between this ‘de-selfing’ process and psychological wellbeing is supported through various evidence-based studies, as well as noted by some of the most acclaimed authors on the subject of meditation and therapy. A number of studies document the correlation between this narrative type of self-referential processing (using the DMN activity as an experimental variable) and psychological distress and psychopathology such as anxiety and depression.⁴¹² In addition, other studies show that decreases of self-referential processing via the DMN are associated with improvement in symptoms of depression and anxiety as well as general increases in wellbeing.⁴¹³ Aronson also explains on the account of his personal experience as a psychotherapist and a meditation teacher: “Understanding that our sense of “I” is not as solid, permanent, or substantial as we habitually hold it to be ultimately uproots clinging, attachment, and

⁴⁰⁹ Pengmin Qin and Georg Northoff. “How is our self related to midline regions and the default-mode network?” *Neuroimaging*, 57, no. 3, (2011): 1221-33. DOI: 10.1016/j.neuroimage.2011.05.028

⁴¹⁰ Farb *et al.*, (2007).

⁴¹¹ Segal, Williams, and Teasdale, 417.

⁴¹² Farb *et al.*, (2007). ; J. Paul Hamilton, *et al.*, “Default-mode and task-positive network activity in Major Depressive Disorder: Implications for adaptive and maladaptive rumination,” *Biological Psychiatry*, 70, no. 4, (2011): 327-33. DOI: 10.1016/j.biopsych.2011.02.003; Zindel V. Segal. “Appraisal of the self-schema construct in cognitive models of depression,” *Psychological Bulletin*, 103, no. 2, (1998): 147-162.

⁴¹³ Pauline Delaveau, *et al.*, “Brain effects of antidepressants in major depression: A meta-analysis of emotional processing studies,” *Journal of Affective Disorders*, 130, no.1-2, (2011): 66-74. DOI: 10.1016/j.jad.2010.09.032; Norman A. Farb *et al.*, “Minding one’s emotions: Mindfulness training alters the neural expression of sadness,” *Emotion*, 10, no. 1, (2010): 25-33.

hostility... Those who have understood this report a sense of spacious lightness and freedom.”⁴¹⁴ Kabat-Zinn, similarly, mentions: “It is remarkable how liberating it feels to be able to see that your thoughts are just thoughts and that they are not “you” or “reality.”⁴¹⁵ This evidence in aggregate conveys that the process of ‘de-selfing’ from present-moment experience is responsible for the therapeutic mechanism of mindfulness-based practices.

To close this section, I once again return to the framework of the layered mind set by John Welwood, and the metaphor of our being as ocean. The therapeutic processes of both MBCT and Morita therapy involve a remarkably similar therapeutic mechanism: to notice and withdraw from our compulsion to staying on the surface, conceptual, dualistic level of the mind, to tune into our intuitive body-mind knowing/sensing, and to experience the non-conceptual level of awareness. You ‘let go’ of trying to stay on the surface of the water, learn to ride the natural waves of the ocean, and ultimately trust the ocean itself to take you along the larger sweep of your life. In a sense, it is the ‘descending’ or ‘diving into’ the depth of your mind that induces the therapeutic change in the conception of self.

Figure 5.1: Interpretive Image of the Layered Structure of the Mind and the Mechanism of Mindfulness

⁴¹⁴ Aronson, 64.

⁴¹⁵ Kabat-Zinn, (1990), 69.

OTHER SIMILARITIES BETWEEN MBCT AND MORITA THERAPY

The previous section elucidated the central similarity between MBCT and Morita therapy: both therapies rely on the mechanism of mindfulness, which operates to promote selfless experiences, which gradually culminate in a more fundamental shift in the conception of self. This fundamental shift in the conception of self springs from the original Buddhist notion of “no-self.” These similarities regarding the therapeutic mechanism of MBCT and Morita therapy, although remarkable considering the historical and contextual differences, are not entirely surprising because mindfulness is an inherent capacity of the human across time and culture. I will now dedicate this section to highlighting other noteworthy similarities, which also directly or indirectly relate to mindfulness.

Diary Writing – Monitoring with Dualistic Mindfulness

From reading Chapters Three and Four, you probably noticed that both therapies view the daily diary-writing regime as imperative to the therapeutic progress. In Morita therapy, diary writing is essential to both inpatient and outpatient programs. The therapist reviews each entry and comments in red, point out the signs of the client’s self-centered preoccupations or obsessions, specific concerns, or progress. In MBCT, the writing assignments are not diary writing *per se*, but the participant nonetheless keeps a written record of his therapeutic progress: a calendar of pleasant/unpleasant/neutral events (and his corresponding reactions,) a table of the various mindfulness practices he did at home and whether it suited him or not, and a list of daily activities that he finds as either depleting, nourishing, or gives a sense of mastery.

In both therapies, the purpose of keeping a written record is to better ‘monitor’ the patient’s internal world. This component of the therapy may partially derive from different reasons between MBCT and Morita therapy; for example, the founders of MBCT imported the aspect of scheduled daily homework from CBT,⁴¹⁶ and the diary writing in Morita therapy springs from the Japanese tradition of freedom to express inner thoughts through writing.⁴¹⁷ However, despite these differences in the origin, the diary writing aspect in both therapies shares the same purpose: to help the patient monitor his own progress. This is made explicit in MBCT: “In monitoring our actions, we become more aware of the pattern of our lives—what we are doing that maintains a mood state, what we are not doing that might allow things to improve.”⁴¹⁸

The elements of mindfulness are also embedded in this aspect of the therapy; this ‘monitoring awareness’ should remind you of the dualistic type of mindfulness explained in Chapter One,⁴¹⁹ where I also argue that one progresses on the path of the mindfulness continuum through practicing both dualistic and non-dualistic types of mindfulness. We foster the non-dualistic type of mindfulness through the ‘de-selfing’ process implicit in the methods of the therapies, while we keep our progress ‘in check’ with the dualistic type mindfulness. We call it dualistic because this type of self-reflecting awareness involves looking at the self as an object again, and evaluating our progress—but with

⁴¹⁶ Segal, Williams, and Teasdale, 339.

⁴¹⁷ Reynolds, 44.

⁴¹⁸ Segal, Williams, and Teasdale, 339.

⁴¹⁹ See Chapter One p. 18

kindness and compassion, and not with the harsh, self-critical standards that once troubled us.

Although the nature of the therapies calls for practicing awareness that is not shaped by subject-object duality (non-dualistic mindfulness), this does not mean that having a conceptual, dualistic reflection on yourself is bad all together, or that you should be in this state of awareness all the time. “The meditative approach to emotion... involves opening to feelings directly, without trying to discover their meaning. When surges of emotional turbulence arise, we practice keeping our seat and opening to their energy.”⁴²⁰ The non-dualistic mindfulness is a tool that is, ideally, available even when we are caught up in emotional reactions. Aronson explains that in the Buddhist context, the process of spiritual development involves three parts: “(1) disidentifying from unchanging, constricting self-images and thus (2) seeing things ever more clearly as they are, while (3) still being able to sustain, though not in a limiting way, a sense of psychological identity.”⁴²¹ I believe that these aspects also apply to the process of psychological development. As long as it is not limiting us from opening up to experience, our dualistic awareness keeps our psychological functioning integrated.

To psychological healing and development, both types of mindfulness—dualistic and nondualistic—are integral to the process; to balance the non-dualistic practice of meditation, the diary-writing part of the therapy promotes the practice of dualistic mindfulness. The balancing of the two is also implied in Welwood’s notion of “unfolding,” an essential process that sheds light on how change happens in psychotherapy.⁴²² He explains that the “unfolding that happens in psychological inquiry is a process of making implicit felt meaning [of psychological events] explicit...⁴²³[moving] back and forth between articulation and the nonarticulated”.⁴²⁴ The nonarticulated, implicit meaning is registered by the body-mind sensing, and the articulated, explicit meaning is registered by the surface mind. “This dynamic interaction between two ways of knowing induces the therapeutic unfolding, and moves through three main stages: “widening attention to feel out a global felt sense of a situation; inquiring directly into this felt sense; and, by successively articulating it from various angles”⁴²⁵. Where have we seen this wide-narrow-wide structure of a process? This process outstandingly resonates with the hour-glass metaphor of the Three Minute Breathing Space of MBCT.⁴²⁶ I speculate that the 3MBS practiced in MBCT was in part implemented to complement the book-keeping of experience by accelerating the process of articulating, monitoring, and reflecting.

Changing Through ‘Acting’ Rather than ‘Thinking’

Both MBCT and Morita therapy aim to help patients adapt their new skills into the aspects of their daily lives—outside the realm of the hospital or therapy sessions—based on the premise that psychological change is achieved through behavioral

⁴²⁰ Welwood, 187.

⁴²¹ Aronson, 82.

⁴²² Welwood, 87.

⁴²³ Ibid., 90.

⁴²⁴ Ibid., 93.

⁴²⁵ Ibid., 94.

⁴²⁶ See Chapter Three pp. 49-50

modification rather than manipulation by thinking. In doing so, both forms of therapy integrate ordinary activities of the daily life into curriculums of the therapy.

MBCT aims to foster mindfulness in the participants' daily lives in various ways. For example, in addition to practicing during session, the **Three Minute Breathing Space (3MBS)** is assigned weekly as home practice. The aim is to encourage participants to integrate the 3MBS into the various aspects of their daily activities. **"One idea is to anchor the practice to a specific activity in one's day (e.g., morning coffee, before or after meals, taking children to school, or sitting at the computer)."**⁴²⁷ Deliberately paying attention to ordinary activities during the day helps to identify which activities that lift their mood—activities that the participants can actively engage in when they sense signs of depressive relapse in the future. The importance of taking action when dealing with depression is highlighted in the literature of MBCT:

Normally, we can wait until we want to do something before we actually do it; in depression, we have to do something *before* we are able to want to do it...Part of "taking care" of yourself in those moments is to "stay in the game" or keep participating in activities, even if your mood and thoughts seem to say that there is no use.⁴²⁸

When the participant notices that his mood is sliding, he can participate in activities that either gives a sense of nourishment and pleasure, or a sense of mastery and control. The nourishing activities may be as simple as soaking in a bubble bath, going for a walk in the park, or eating your favorite meal. The activities that give a sense of mastery can also be simple accomplishments, such as cleaning the house, shopping for groceries, or planting flowers. One of the exercises in MBCT is to expand the list of these 'mood-lifter' activities, in preparing for potential relapse in the future—so that these actions can be engaged.

Although Morita therapy was not designed for preparing patients for future depressive relapse, it equally places importance on the power of action. "The attitude Moritists foster in their patients is less one of 'Do what you need to do' and more one of 'Do what is there to be done.'"⁴²⁹ This emphasis is particularly clear in the work therapy aspect of the program. During the light-occupational work therapy, although clients are prohibited from doing intense physical work, they are encouraged to find things that need to be done around the house (such as washing clothes, weeding the garden, or raking the leaves, etc.). The prohibition from casual conversations in this stage is meant to induce physical and mental boredom, which in turn spur clients to mindfully engage in spontaneous activities—in chores that may have seemed useless in the past. In the subsequent heavy-occupational therapy, clients engage in more physically intense chores that give them a sense of mastery, accomplishment, and self-confidence. The "do what needs to be done" philosophy is also maintained in contemporary Morita therapy. This is reflected in two of the six distinct characteristics of Morita therapy, summarized by Ohara:

⁴²⁷ Segal, Williams, and Teasdale, 385.

⁴²⁸ Ibid., 343.

⁴²⁹ Reynolds, 31.

- 3) “Do not try to manipulate the mind, and rather emphasize manipulating your behavior.” (One cannot willfully change the state of mind, such as the unpleasant emotions. The productive approach is to rather try forming healthy habits in daily behavior; then, the mind will catch up to become healthy as well.”
- 4) “Treat the symptoms within the realm and setting of daily living.” (There is no need for special equipment or a facility. Except for the isolation-rest period when the patient must be in absolute isolation in his or her room, the Morita in-patient hospital setting fosters a family-like environment. The patients can not only practice healthier habits within the setting of everyday living (through, for example, doing everyday chores) but can also grow as a social being.⁴³⁰

In these ways, both forms of therapy emphasize the importance of daily living as the locus of therapeutic change, via behavioral engagement.

Interpersonal Dynamics

Another striking similarity between MBCT and Morita therapy is the unique interpersonal dynamics of group learning. The reason for using the group format may differ slightly between the therapies. For example, in MBCT the group format is seen as cost-effective compared to the traditional one-to-one therapy for dealing with depression. For Morita therapy, the group format may spring from the collective, group-oriented nature of the Japanese society. However, both therapies commonly emphasize that the group-format can help convey the universality of human suffering. For example, Crane comments about the group-learning style of MBCT:

Through engaging with the details of personal experience we come to see universal patterns. These illuminate the general nature of the human mind. For example, when the teacher explores experience with a participant, it is a conversation with an individual within the context and implicit engagement of the group...Through witnessing each other's experience in these ways participants come to feel how normal it is to struggle in the ways that they have been experiencing. They come to sense how universal rather than personal it all is. This in itself is core to shifting participants' perspectives and stance in relation to their experience.⁴³¹

In these ways, one of the contributing factors to becoming less ‘self-centered’ is perhaps by seeing through group learning that your suffering is not special or personal. The group format used in Morita therapy also fosters this understanding. In these ways, the group format is essential to both therapies.

The relationship between the patient and the therapist in both MBCT and Morita therapy is in quite unconventional by the standard of traditional one-to-one psychotherapy. In many ways, the therapist becomes the patient's friend who mutually shares experience, as well as an embodied model for the qualities being fostered throughout the treatment.

⁴³⁰ Ohara, 277-279.

⁴³¹ Crane, 150.

The sharing of experience is not only important between the patients, but also essential in the patient-therapist relationship. For example, a literature on MBCT reads:

The processes of mind that are under investigation fall under a continuum of experience that *everyone* can relate to. There is therefore no way in which the teacher separates him- or herself from the process of investigation. In the spirit of adventure that is core to this learning style, the process of exploration within the sessions becomes a collaborative venture between all those engaged in it—there is a feeling of “co-journeying”.⁴³²

In these ways, there is always the assumption of ‘continuity between the experience of the teacher and those of the participants. Welwood is not an MBCT instructor, but as a psychotherapist and a meditation practitioner, he too recognizes the importance of harmonized experience between the therapist and the patient:

When two people meet and connect, they share the same presence of awareness, and there is no way to divide it neatly into “your awareness” and “my awareness.” I am not speaking here about losing my conventional boundaries or identifying with client’s problems, but rather about letting the other person’s experience resonate in and through me.⁴³³

In a similar manner, Morita therapists also value the sharing of experience with patients. This is remarkably evident in the original inpatient care, where the therapist lives with the patient under the same roof, sharing the experiences of daily life. Even in the realm of outpatient care of contemporary Morita therapy, the friendly, warm relationship between the therapist is rendered important. Aoki explains his interpretation of his role as a therapist: “I may be extreme, but rather than guiding the patients, I tell them that I am their friend walking on the same path.”⁴³⁴

In both therapies, it is also important that the therapist embodies the qualities that the patients are learning to gain. For example, both in MBSR and MBCT, the training requirements for instructors recommend prior contemplative practices. A similar point is emphasized in Morita therapy, elucidated by Ohara:

The therapist leads the way and behave as a model for the patients. It is often difficult to actually carry out the advices the psychotherapist, even if the patient understands it intellectually. In order to foster an embodied experiential type of learning, the therapist must lead the patients by embodying the lessons and teachings himself.⁴³⁵

In Morita therapy, contemplative practice by the therapist is not required like in MBCT. However, his own embodiment of the lessons and teachings is nonetheless imperative.

⁴³² Crane, 150-1.

⁴³³ Welwood, 171.

⁴³⁴ Aoki, 78.

⁴³⁵ Ohara, 279.

Concluding Remarks

This chapter discussed the ways in which MBCT and Morita therapy are similar. The most significant *and striking* similarity between these therapies is the therapeutic mechanism of ‘de-selfing’ (or changing one’s perspective on the conception of self) through mindfulness. Throughout this thesis, I have argued that the self consists of an outer layer that is subject to socio-cultural molding, and an inner layer that functions similarly irrespective of cultural and historical context. Highlighting the therapeutic mechanism of mindfulness and ‘de-selfing’ under Welwood’s framework of the ‘ocean metaphor of the layered structure of the human mind’ help to further support this model of the self. The therapeutic mechanism of ‘de-selfing’ through mindfulness involves a process of departing from the surface, conceptual, dualistic level of the mind, becoming attuned to the subtle mind/body interconnectedness, and eventually experiencing the non-conceptual, non-dualistic awareness. The practice of mindfulness seems to facilitate this process of ‘descending’ through the layers of the mind—eventually reaching to the bottom. Other than this remarkably similar therapeutic mechanism, there are other striking similarities as well. These include the method of diary-keeping (which elucidate that both dualistic and non-dualistic mindfulness are integral to the psychotherapeutic process), the emphasis on ‘acting’ over ‘thinking,’ and finally the unique interpersonal dynamics. In the next chapter, I will elaborate on the major differences between the two therapies, which likely arose due to the differences in the outer layer of the self.

Chapter Six: Differences

So far, I have discussed the theories and methods of MBCT and Morita therapy in chapters Three and Four. The previous chapter presented a detailed analysis of the commonality between MBCT and Morita therapy, in light of the discussions from the Introduction and Chapter One: mindfulness is an inherent capacity of the human mind, and operates on the inner layer of the self (which also shares commonality in human experience across time and cultures). The major therapeutic mechanism of both MBCT and Morita therapy involves a change in perspective of the self through mindfulness. This therapeutic mechanism is central to both therapies, despite the historical, geographical, and cultural gaps. However, this is not to say that these two forms of therapy are identical to each other. It is as important to highlight the differences between them as it is to observe their striking similarities. Therefore, this final chapter will discuss the major differences between MBCT and Morita therapy.

The analysis and discussion of the major differences will be drawn from the ideas and concepts outlined in Chapter Two –Differences in the Self between the United States and Japan. Let us remind ourselves with what is being said throughout this thesis: although the inner layer of the self functions similarly in people across cultures (elucidated by the therapeutic mechanism of mindfulness), there is nonetheless an outer layer of the self that is subject to cultural modulations. I contend that this outer layer of the self is responsible for the differences in the therapeutic approaches between MBCT and Morita therapy.

In the previous chapter, I imported a framework of the human mind proposed by John Welwood in his *Toward a Psychology of Awakening*.⁴³⁶ Welwood categorized the mind into three distinct layers of experience, and characterized the surface conceptual layer as a layer of the mind that “perceives solid forms, thinks definite thoughts, and registers familiar emotions. This is the level of mind where ego operates – through forming self-concepts, setting up a basic division between self and other, pursuing control and mastery in worldly functioning.”⁴³⁷ In these ways, implicit in his framework is that this layer of the surface conceptual mind (reminiscent of the outer layer of the self that I propose) is subject to cultural molding in terms of the following contexts: pursuit for control, registering emotions, and forming self-concept through distinguishing between self and non-self. These concepts were discussed in detail in Chapter Two. Therefore, I recommend skimming through Chapter Two once again before diving into this chapter.

In light of the themes discussed in Chapter Two, I contend that the major differences between MBCT and Morita therapy often arise from the difference between the individualistic, self-expressive culture of the west and the collectivist, conformist culture of Japan. This is not to say that MBCT is completely individualistic or that Morita therapy is completely collectivist in nature. Because for one thing, MBCT represents a dramatic change in direction in terms of the nature of therapy when compared to psychoanalysis, which in my opinion stands as a psychotherapeutic extreme of western ‘analytical thinking’ and individualistic values. We cannot call Morita therapy as

⁴³⁶ See Chapter Five

⁴³⁷ Welwood, 6.

completely collectivist either, because there are aspects of Morita therapy which seem to foster ‘self-confidence’ and ‘self-empowerment’ in the patients.⁴³⁸ Self-confidence and self-empowerment are not taught with priority in the Japanese culture. However, the variations between the two therapies emerging from this prominent cultural difference are notable.

Such cultural difference between individualism and collectivism are evident in two aspects of the therapy: hierarchy in the patient-therapist and patient-patient relationships, and the emphasis (or lack-there-of) on validating or expressing personal emotions. I would like to discuss the origins, nature, and the implication of these differences by dividing this chapter into three sections. In the first section, I will reiterate some of the major emphases made in Chapter Two—such as the difference in attachment and pursuit of control between the American and Japanese cultures. Then, I will explain how these elements in turn influenced the nature of Japanese and American psychotherapy *in general*. The first section will help to understand the roots of the differences between MBCT and Morita therapy, as discussed in the following sections. The second section will elucidate the individualistic elements of MBCT: how the western individualism plays a role in the flattened hierarchy in MBCT, the promotion of self-exploration, as well as the emphasis on ‘self-compassion.’ The third section will highlight the collectivist elements of Morita therapy: how collectivism plays a role in the vertical patient-therapist (or patient-*sensei*) hierarchy, as well as its emphasis on the suppression of emotional expressiveness and the promotion of maintenance of social harmony.

ATTACHMENT AND CONTROL—INFLUENCING THE NATURE OF PSYCHOTHERAPY

Attachment

As discussed in Chapter Two, the American and Japanese cultures seem to have different perspectives on what a ‘healthy attachment’ entails.⁴³⁹ While the attachment theorists in western psychology stress that individuation and exploration of the external world is important for child development, these are not emphasized in the child-rearing traditions of Japan. Instead, child rearing in Japan emphasizes emotional closeness and fosters the child’s ability to maintain social harmony with others. Emotional dependence does not hold a negative connotation like it does in the U.S.; this is signified in Doi’s conception of *amae*. An example that underlines this discrepancy is the different child punishment styles between the two countries. In the U.S., parents punish their children by ‘grounding’ them—to prohibit them from going outside to play. In Japan, parents punish their children by kicking them out of their house. How do these cultural differences regarding ‘attachment’ in turn influence psychotherapy in the two countries?

In their publication “Attachment and Culture,” Rothbaum and colleagues⁴⁴⁰ propose how different cultural perspectives on attachment have led to differences in the styles of interventions—including psychotherapy. They claim that in the United States, parental programs and therapeutic approaches are often based on the attachment theory. For example, for parental intervention programs, western attachment theorists would interpret the rebellious and disruptive behavior in children as signs for their “need for

⁴³⁸ See Chapter Four pp. 64-65 on the heavy-occupational therapy stage

⁴³⁹ See Chapter Two p. 31

⁴⁴⁰ Rothbaum *et al.*, 2000.

control and autonomy.” Therefore, they may advise that parents should deal with them by “praising children's success and otherwise enhancing their self-efficacy, helping children recognize and label their emotional states, and verbally communicating and negotiating with the child.”⁴⁴¹ However, this style of parenting is not valued or recommended in Japan. From my personal experience of being raised by a Japanese mother, I agree with Rothbaum on this point. In a similar way, “attachment-oriented American therapists aim to help their clients individuate.”⁴⁴² This includes helping patients become aware of their ambivalent emotions toward their parents, as well as their defense against such feelings of anger or sadness. In contrast, expressing negative feelings towards one’s parents is highly frowned upon in Japan. “Japanese therapists, by contrast, often encourage their clients to reflect on the kindnesses that others, particularly parents, have bestowed on them, and they stress client’s ingratitude and the virtues of giving care and devotion back to others.”⁴⁴³

Moreover, there is a noticeable difference in the way therapists deal with their clients’ dependency needs. In the U.S., clients’ dependency towards the therapist is viewed as rather unproductive to the psychotherapeutic progress. Rothbaum *et al.* explains: “attachment-oriented therapists in the United States are ambivalent about meeting their client’s dependency needs,”⁴⁴⁴ because they assume that psychological and psychiatric disorders are almost always associated with a lack of autonomy. Therefore, they believe that the best way to help them is to serve as “a secure base for their clients’ exploration and interpretation of internal states”.⁴⁴⁵ In contrast, the clients’ dependency is viewed as “positive movement toward healing”⁴⁴⁶ by Japanese therapists. In consequence, Japanese therapists are more likely to meet their clients’ dependency needs—to serve as “indulgent, benevolent, and nurturing caregivers.”⁴⁴⁷ I interpret that perhaps the Japanese therapists are responding to their clients’ *amae*. Doi also comments that American therapists are rather insensitive or blinded to their patients’ dependency needs: “American psychiatrists were extraordinarily insensitive to the feelings of helplessness of their patients. In other words, they were slow to detect the concealed *amae* of their patients.”⁴⁴⁸ The Japanese value on emotional dependence is even reflected in the patient-therapist relationship. This further illustrates the difference between therapists in Japan and the U.S. in terms of their views on attachment.

Control

Recall from Chapter Two that the Americans and Japanese radically differ in the ways of pursuing the feelings of control: primary control plays a central role in the U.S., while secondary control is more preferred by the Japanese.⁴⁴⁹ Such difference was thoroughly articulated in the publication “Standing Out and Standing In – The Psychology of Control in America” by Weisz, Rothbaum, and Blackburn. According to

⁴⁴¹ Ibid., 1101.

⁴⁴² Ibid.

⁴⁴³ Ibid.

⁴⁴⁴ Ibid.

⁴⁴⁵ Ibid.

⁴⁴⁶ Ibid.

⁴⁴⁷ Ibid.

⁴⁴⁸ Doi, (1973), 21-22.

⁴⁴⁹ See Chapter Two p. 29

them, in primary control, one feels reward by influencing existing realities. In secondary control, one feels reward by accommodating to existing realities.⁴⁵⁰ In Chapter Two, I outlined examples that illustrate these differences in control, in the realm of socialization pattern, child rearing, religions, and work ethics, but left the comparison of psychotherapy for this chapter.

Let's examine the differences in psychotherapy arising from the differences in the pursuit of control. Weisz, Rothbaum, and Blackburn (1984) argue that psychotherapies in the two cultures seem to have different emphases on primary and secondary control, focusing their comparison on the two most prominent therapeutic practices in both countries: the psychoanalytic and behavioral schools in the U.S., and the Morita and Naikan schools in Japan. For example, both the psychoanalytic and behavioral schools share the general objective of controlling symptoms or maladaptive behaviors. The way these two schools both support the client's efforts to modify existing symptoms or behaviors show that these therapies place a higher emphasis on primary control than their counterparts in Japan. In contrast, the primary objective of Morita therapy is to shift client's perspectives on their symptoms rather than to alter or diminish them. Weisz, Rothbaum, and Blackburn point out that the therapeutic philosophy and objectives of Morita therapy convey "the epitome of interpretive secondary control. Rather than attempt to alter existing realities, one alters one's perspective on those realities so as to find purpose or meaning in them and thus accept them as they are."⁴⁵¹ This is quite similar in Naikan therapy, although Naikan therapy is more interpersonally oriented in which that it helps to promote one's social-awareness.⁴⁵² Now that the general differences in psychotherapy between Japan and the United States have been elaborated, we shall move on to directly contrasting MBCT and Morita therapy.

INDIVIDUALISM IN MBCT

MBCT is not entirely individualistic. In the previous section, I illustrated how primary control is more prevalent in the psychotherapeutic traditions in the United States—namely in the psychoanalytic and behavioral schools. Comparing the therapeutic objectives of these schools to the objectives of MBCT, we see that MBCT takes a radically different approach from these traditional approaches in the west. MBCT, like Morita therapy, does not aim to eliminate symptoms; instead, the patients' relationship to their symptoms is altered (showing emphasis on secondary interpretative control, like Morita therapy). MBCT also departs from the conventional one-to-one therapy sessions used in the psychoanalytic and behavioral schools, and takes advantage of the group-format teaching style. In these ways, I perceive MBCT as having a fundamentally different approach from the conventional psychological interventions in the west, and leans more towards a collectivist teaching and therapeutic style. Therefore, I am not in any way labeling MBCT as 'individualistic.' However, *in comparison* to Morita therapy, there are nonetheless signs of individualism that we cannot ignore: its emphasis on self-

⁴⁵⁰ Weisz, Rothbaum, and Blackburn, (1984).

⁴⁵¹ Weisz, Rothbaum, and Blackburn, (1984), 964.

⁴⁵² Mark Unno. *Buddhism and Psychotherapy Across Cultures* (Somerville MA: Wisdom Publications, Inc., 2006), 162.

compassion, the promotion of self-exploration, and the flattening of patient-therapist hierarchy.

There are many positive aspects to the individualistic culture. On a personal account: as a female student from Japan studying at Brown University, I have come to appreciate the individualistic culture of America. I am able to express my opinions to others—even superiors—without being afraid or constrained by the hierarchy. I don't have to wear school uniforms or conform to the school regulations on hair color/length, piercings, or even makeup. Most importantly, being 'different' here is generally deemed as a positive quality, where as in Japan it often entails difficulties making friends or being accepted into a group. Welwood also notes the highlights of individualism in a more societal context:

The Western idea of the individual has also helped liberate the capacity to ask questions and freely investigate the nature of things without allegiance to rigid orthodoxies, giving rise to the scientific method. This in turn has led to the development of Western psychology.⁴⁵³

As much as I personally appreciate the individualistic culture, I have also come to realize that it can be problematic as well—especially in relation to our emotional lives. Epstein highlights this issue:

The emphasis on individuality and autonomy, the breakdown of the extended and even the nuclear family...and the relentless drive for achievement versus affection in our society leave a person all too often feeling cut off, isolated, alienated, empty, and longing for an intimacy that seems both out of reach and vaguely threatening.⁴⁵⁴

He concisely lists the emotional vulnerabilities that spring from individualistic ideals—the feelings of isolation and the lack of (and perhaps fear of) emotional intimacy. The focus on personal achievement and success of this culture also makes us vulnerable to low self-esteem. In my view, the number of 'spots' available for the so-called 'achievement' (such as admission to the top medical schools, the high-paying Wall Street careers, or celebrities such as artists and musicians) cannot in any way catch up to the *exponentially* higher number of people coveting these spots.

The focus on individual success creates not only our emotional vulnerabilities to isolation, but also to low self-esteem. Epstein mentions an anecdote from the first cross-cultural meetings of East-Asian meditation teachers and western therapists:⁴⁵⁵ when the Dalai Lama heard the concept of 'low self-esteem' for the first time, he found it incredibly difficult to understand the meaning. Apparently in Tibet, a positive sense of self is inculcated early and supported through the web of interdependent relationships of the family; therefore, a positive feeling about oneself is a given. The drive for and focus on personal achievement and success have made the Western mind increasingly vulnerable to feelings of alienation and unworthiness—feelings that are seemingly

⁴⁵³ Welwood, 4.

⁴⁵⁴ Epstein, 177.

⁴⁵⁵ Ibid.

unfamiliar in a traditionally collective society. This issue of low self-esteem implicitly underlies some of the emphases made in MBCT.

Self-compassion

One of the implicit ways in which MBCT can help with people's low self-esteem is by fostering the sense of compassion towards self—or 'self-compassion.' This concept is one of the concepts that are *not* explicitly addressed in Morita therapy, but is in MBCT: "one of the most important things people learn from an MBCT program is kindness and self-compassion. We regard this as fundamental. *Unless the class takes place within this atmosphere, the MBCT program loses one of its foundational features.*"⁴⁵⁶ While Morita therapy seems to put a stronger emphasis on being considerate for others or doing things for others (which will be elaborated in the next section), MBCT directs participants to be kind to themselves. This is most reflected in the theme of week seven, "How Can I Best Take Care of Myself?" However, how can self-compassion help people with their feelings of unworthiness and low self-esteem? What exactly is self-compassion?

Although self-esteem and self-compassion are both ways in which the 'self' relates to the 'self,' they are fundamentally different in nature. The leading investigator in self-compassion research, Kristin Neff, identifies self-compassion as being distinct from self-esteem; however, she and her colleague also found that self-compassion is highly correlated with self-esteem (people with high self-compassion tends to feel good about themselves).⁴⁵⁷ Based on ideas discussed in the Insight tradition of western Buddhism, Neff proposed the construct of self-compassion as a healthy and productive form of self-acceptance. She developed the Scale of Self-Compassion based on the three main components: self-kindness, common humanity, and mindfulness. Self-kindness entails holding kind understanding toward oneself in emotionally difficult situations or perceived inadequacy—the opposite of being harshly self-critical or self-deprecating. Common humanity entails accepting that life is not always easy, and perceiving one's own difficulties as part of the larger human experience which are generally no worse than other people's problems. Mindfulness—in the context of self-compassion—entails holding one's painful and unpleasant thoughts and feelings in balanced, clear awareness rather than over-identifying with them.⁴⁵⁸ Self-esteem is like a tree that grows, feeding on aspirations, hard work, and success. Self-compassion is the root that keeps our self-esteem grounded; it is what keeps the tree standing even when the storm of life brings turbulence and threat.

In mindfulness-based interventions, even though self-compassion is not declared as the primary goal, it is implicitly and explicitly interwoven into the meditation instructions. This is also true for MBCT. An example might be "let your attention focus on an object, and if your mind wanders off, please gently bring it back to the object with kindness and openness." A considerable body of literature shows that self-compassion improves with mindfulness meditation practice, and also partially mediates the

⁴⁵⁶ Segal, Williams, and Teasdale, 137.

⁴⁵⁷ Kristin D. Neff and Roos Vonk. "Self-Compassion Versus Global Self-Esteem: Two Different Ways of Relating to Oneself." *Journal of Personality*, 77, no. 1, (2009): 23-50. DOI: 10.1111/j.1467-6494.2008.00537.x

⁴⁵⁸ Kristin D. Neff. "Self-compassion: an alternative conceptualization of a healthy attitude toward oneself." *Self and Identity*, 2: 2003, 85-102.

improvement in well-being in mindfulness-based interventions.⁴⁵⁹ Self-compassion requires ‘being with’ your experience, even if it entails sadness or pain.

Compassion comes from the Latin roots *com* (with) and *pati* (suffer), or to “suffer with.” Being compassionate means that we recognize when someone is in pain, we abandon our fear or resistance to it...It’s full acceptance: of the person, of the pain, and of our own reactions to the pain.⁴⁶⁰

Self-compassion is simply an extension of the compassionate behavior to the self. Although self-compassion is associated with positive affect, it actually stems from the ability to hold difficult or negative emotions in non-judgmental and balanced awareness without denial or suppression—paying attention to momentary experiences through experiential self-referential processing that is neither pessimistic nor optimistic. Self-esteem, which is constructed narratively from positive aspects of oneself, does not allow room for the acknowledgement or acceptance of the individual’s shortcomings and weaknesses. Self-compassion requires accepting negative experiences and traits, without filtering them in the interest of maintaining a positive self-esteem.

In MBCT, the instructor is expected to embody this quality: “self-compassion in MBCT develops through pervasive, indirect, even implicit, instruction, then much of the responsibility for embodying this rests with the instructor.”⁴⁶¹ It is reported that many participants have described that “the self-compassion and sense of goodwill towards themselves developed during the program was kindled through the acceptant and kindly stance of the MBCT teacher.”⁴⁶² Given the relationship between mindfulness meditation and self-compassion, it is not surprising that the founders of MBCT emphasize the importance of this concept.

Self-compassion is recognized as both a byproduct of the program, as well as a catalyst for the participant’s personal growth. For example, the fostering of self-compassion is embedded in the exercises of week seven “How Can I Best Take Care of Myself?” As explained previously,⁴⁶³ the participants are asked to expand the list of the activities that give them a sense of nourishment or a sense of mastery—activities that are meant to be carried out when they register signs of potential relapse in the future. In the last few weeks of MBCT (including week seven), the participant develops his or her own relapse-prevention plan, which not only lists these elating activities but also the participant’s exploration of the ‘territory of depression.’ This includes the early warning signs of depression, which may vary from person to person.

The important thing is to let the past experience of relapse be the teacher. Some participants decide to write themselves a letter, including a list of actions to take, with an instruction to choose at least one, even if they expect

⁴⁵⁹ Britta K. Hoezel *et al.* “How Does Mindfulness Meditation Work? Proposing Mechanisms of Action From Neural Perspective.” *Perspectives of Psychological Science*, 6:2011, 537-559.

⁴⁶⁰ Christopher K. Germer. *The Mindful Path to Self-Compassion: Freeing Yourself from Destructive Thoughts and Emotions*, (New York: The Guilford Press, 2009), 33.

⁴⁶¹ Segal, Williams, and Teasdale, 140.

⁴⁶² Crane, 148.

⁴⁶³ See Chapter Three

not to feel like doing it at the time. Then, they seal the letter and open it only when they start to feel depressed.⁴⁶⁴

In these ways, in addition to the fostering of self-compassion, MBCT—compared to Morita therapy—seems to be embedded with a stronger element of self-exploration.

Self-exploration

Many authors such as Welwood, Epstein, and Aronson discuss the difficulties that arise when adopting traditionally Buddhist values and methods to the modern American culture. All authors seem to pinpoint that the notion of ‘no-self’ central to Buddhism need to be re-contextualized for Americans, as having an individuated, differentiated, and autonomous ‘self’ is highly valued in the American culture today. Furthermore,

Many North American practitioners are embedded in their sense that it is good and right to realize and express individual selfhood. They often use Buddhism to pro-mote their *individual* health and welfare, to heighten awareness of their own feelings, and to allow for more successful individual engagement. When seen from the holistic worldview of the traditional Buddhism, such an approach ignores the tradition’s rich interpersonal vision of spirituality... We have taken a traditional Asian discipline that was oriented to spiritual liberation in the context of a community and used it to serve our quest for individuality.⁴⁶⁵

Aronson points out that the way North Americans use meditative practice for individual self-exploration ignores some of the traditionally Buddhist orientation towards spirituality. However, I believe this can be appropriate for the purpose of psychotherapy as, “Psychotherapy often involves the creation of a narrative to explain a person’s history, while meditation is a process of questioning the most basic metaphors that we use to understand ourselves.”⁴⁶⁶ Although the realization of ‘no-self’ in one’s experiences is central to the therapeutic mechanism of MBCT (as illustrated in the previous chapter), the exploration of one’s self narratively (reflecting on their past relapse experience and having an action plan for the future) also seems to be imperative to the process. However, in Morita therapy, the patient’s personal history or exploration of emotions and symptoms are not viewed as integral process to the therapy (explained later). Therefore, this element of self-exploration of MBCT may stand as a hallmark of western individualism.

Flattened Hierarchy

Another individualistic element that I find in MBCT is the complete flattening of hierarchy in the interpersonal dynamics—involving both patient-therapist and patient-patient relationship. This characteristically distinguishes MBCT from Morita therapy, where there is a more clearly established hierarchal relationship in the interpersonal

⁴⁶⁴ Segal, Williams, and Teasdale, 352.

⁴⁶⁵ Aronson, 29-30.

⁴⁶⁶ Epstein, 129.

dynamics. This feature of Morita therapy is not surprising, given the central role of interpersonal hierarchy in the Japanese society as whole.

Segal, Williams, and Teasdale emphasize the importance for MBCT teachers to guide the participants without taking the role as ‘an expert.’ They are quite careful with advising MBCT teachers to guide the program in this specific way. They explain: “it will be important to find ways to guide the practices without feeling as if ‘orders’ are being given.”⁴⁶⁷ In MBCT, the instructor’s role is to help the participants guide themselves through their journey; a great emphasis is placed on the participants’ self-empowerment:

The teacher has a strong degree of responsibility to create the particular conditions for this learning to take place but beyond this the person takes responsibility for their own learning process. The intention is to empower the participant to come to know that they are their own experts... This is conveyed in a range of ways including a strong invitation to take care of themselves within the learning process and to only follow the guidance and participate as much as feels appropriate and right to them.⁴⁶⁸

In other words, all the guidance given in MBCT is conveyed as an *invitation* to co-experience rather than *instructions*; no one is telling anyone what to do. “When guiding a practice, you are meditating out loud—not ‘telling people what to do.’ This means that you are guiding out of your own moment-to-moment experience during the guided meditations.”⁴⁶⁹ Implicit in this instructional framework is also the attitudinal foundation of ‘non-striving’: the MBCT instructors are advised to give encouragements by using phrases like ‘as best as you can’ rather than using the word ‘try’.⁴⁷⁰

The flattened hierarchy between the participant and instructor is also embedded in the empathetic approach of the instructor—the instructor is expected to emotionally and experientially relate to the participant. Segal, Williams, and Teasdale advise how to respond when a participant talks back, or refuses to follow the guidance. They suggest that the instructor, instead of taking it personally or asserting his authority, should think and remember about their own personal struggles in their past. In this way, the instructor can empathize by being “more likely to feel at one with a participant’s expression of frustration.”⁴⁷¹ Willoughby Britton, a clinical psychologist and research scientist at Brown as well as an MBCT/MBSR instructor, emphasizes the significance of a non-hierarchical, non-dependent relationship between the teacher and the participant to the learning environment of MBCT:

The ability of a provider to take the perspective of the patient reflects a shift in the clinician-patient relationship, one that flattens a sense of hierarchy. The patient is no longer below the doctor, reduced to a disease, dehumanized or dependent. In order to further break down notions of hierarchy that disempower the patient, the mindfulness instructor and

⁴⁶⁷ Segal, Williams, and Teasdale, 86.

⁴⁶⁸ Crane, 151.

⁴⁶⁹ Segal, Williams, and Teasdale, 87.

⁴⁷⁰ Ibid., 86.

⁴⁷¹ Ibid., 141.

students sit in a circle, and the instructor uses co-inquiry rather providing answers to questions.⁴⁷²

In these ways, although the instructors in MBCT are called ‘instructors’ or ‘teachers,’ they are perceived more as a co-participant in the program. Although American psychotherapists in general are not fans of nurturing the client’s dependency needs (as described in the previous section of this chapter), this type of *complete* flattening of the patient-therapist hierarchy is quite distinct.

Moreover, the disclosure of the MBCT instructor’s own suffering is viewed as an invaluable source of teaching. During my personal conversations with Britton, she used the term ‘a wounded healer’ to describe the role of the instructor in MBCT. She articulates in her writing that:

Mindfulness-Based Stress Reduction (MBSR), and by extension, most mindfulness instructor training models, rely heavily on first-person experience... In contrast to traditional models where the clinician's personal history of trauma or distress is disregarded, in this model, the instructor's own suffering, especially if prolonged, is viewed as a valuable source of expertise and as well as shared humanity.⁴⁷³

The disclosure of the instructor’s personal history or experience of suffering—and therefore some exposure of his or her emotions—further shortens the emotional and hierarchal relationship to the participants.

In these ways, the patient-therapist relationship in MBCT stands quite distinct from that in Morita therapy, despite the fact that they are both mindfulness-based. For example, in Morita therapy, one would not observe a therapist disclosing about his own personal history of suffering. He may use other means of conveying that suffering is universal to human experience, but this type of personal privacy disclosure or emotional expressiveness is rare in the Japanese society. While a vertical hierarchy is seen as a source of ‘disempowering’ the patients in MBCT, in Morita therapy the patients’ dependence or ‘looking up to’ the therapist seems to be seen as rather helpful to the therapeutic process. Let’s examine these differences further by looking at the way in which the collectivist culture is embedded in Morita therapy.

COLLECTIVISM IN MORITA THERAPY

In Chapter Two, the neural, affective, and cognitive factors underlying the collectivist culture in Japan were outlined, which in aggregate showed that the heart of collectivism is the interdependent self-construal. Moreover, given the rigid vertical and

⁴⁷² Britton, W.B. , Brown, A.C., Kaplan, C.T., Goldman, R.E., DeLuca, M., Rojiani, R., Reis, H., Xi, M., Chou, J.C., McKenna, F., Hitchcock, P., Rocha, T.A. Himmelfarb, J., Margolis, D.M. Niles, H.F., Eckert, A.M., Frank, A.(in press) *Contemplative Science: An Insider’s Prospectus*. In Marilla Svinicki (ed). *New Directions for Teaching and Learning: Contemplative Studies in Higher Education*. (San Francisco: Jossey-Bass), 14.

⁴⁷³ Ibid., 13.

hierarchical structure of society as well as Zen Buddhist influences, Japanese people seem to prefer the feeling of secondary control. In Japan, not everyone is 'equal' in the sense everyone is equal in the U.S. Even if one has his own opinions and emotions, the behavior of self-assertion and emotional expressiveness *outside the person's 'in-group'* is frowned upon.

The Japanese self has a strong dichotomy between the public and private self: the private self, or *honne*, is what you expose to your 'in-group' or people tagged as 'like-self' for example your immediate family members and close friends. To the public of other people tagged as 'not-self,' you will only show your *tatamae* – your public self. The private-public self dichotomy exists to maintain social harmony, as well as to promote the behavior of *amae* towards between 'in-group' members.⁴⁷⁴ Understanding the collectivist culture of Japan sheds light on many of the philosophies and methods of Morita therapy, given that the therapy was developed during the 1920's when the western, individualistic influence on Japan was still at its minimum.

However, in this collectivist culture where there is a lack of emphasis on the individual 'self,' how do people come to be 'self-centered'? Perhaps the context of which 'self-centeredness' arises in Japan is distinct from its counterpart in the more individualistic culture of the west. Reynolds was also curious about this seemingly paradoxical phenomenon, and speculates its cause:

Why should a culture that is as group-oriented as Japan is be so plagued by self-consciousness in its styles of neurosis? Why should Zen Buddhism, a form of religious training aimed at destruction of a strong 'self,' thrive in a culture noted for self-abnegation? How can Japanese be both humble and egotistical? These paradoxes melt like shaved ice in a Tokyo summer when the public-private dichotomy of self is taken into consideration.⁴⁷⁵

I too share Reynolds' speculation that the public-private dichotomy of self is a significant factor in causing the Japanese 'self-centered' neurotic symptoms. I recall from personal experience that the expectation to maintain the social harmony among others can sometimes be energy consuming. I can definitely relate to how this vertical structure of Japanese society causes self-consciousness to precipitate. To elucidate this point, I will reiterate the quote by Reynolds that I used in Chapter Four:

In order to function smoothly in Japanese society today one must be careful to pick up small expressions of preferences and desires from significant others and to control the expressions of one's own preferences and desires...The anthropophobic (*taijin-kyofusho*) Japanese neurotic patient clearly shows this national character trait to an extreme. He is so sensitive to detecting cues from others and processing and controlling his own emissions that he cannot function in society.⁴⁷⁶

Although Japan's increasing contact with the west has gradually introduced the individualistic values of autonomy, self-expressivity, and individual freedom (e.g.

⁴⁷⁴ See Chapter Two p. 37

⁴⁷⁵ Reynolds, 97.

⁴⁷⁶ Ibid., 122.

women in Japan today have more personal freedom when compared to women from Morita's generation), the Japanese self is still entangled to the mesh of hierarchy and social structure. The modern Japanese today is still expected to behave while respecting the societal hierarchy and maintaining social harmony; for example, one must use *keigo*, honorific speech, when speaking to elders, superiors, and even strangers. Aspects of Japan like these have not changed despite the increasing dose of westernization over the past few decades.

Client-Sensei Hierarchy

In the traditional Morita therapy, the patient-therapist hierarchy is more clearly established in comparison to MBCT. The clients in traditional Morita therapy are given many explicit instructions (e.g. to stay in bed during the isolation rest stage, or participate in a chore without conversing during the light-occupational stage, etc.). Although many contemporary Morita therapists still rely on much of the work therapy stage, they (such as Ohara and Aoki) have also realized that as the modern Japanese youth have become increasingly individualistic (self-assertive and expressive), it is more constructive to incorporate recreational or art therapy in replacement of work therapy. (The heart of these work, recreational, or art therapies is that the patients can 'lose themselves'—to be absorbed in an activity with 'pure mind').⁴⁷⁷ It is also important for contemporary Morita therapists to present himself as softer, more reasonable figure than the traditionally authoritarian style for similar reasons.⁴⁷⁸

However, the 'softening' of the authoritative stance of the therapist does not imply the complete diminishing of the hierarchy. In MBCT, the participants address the teachers by their first names. Given such emphasis on flattened hierarchy in MBCT, it is hard to imagine a MBCT asking the participants to address him or her with a title and last name. In contrast, I would be shocked to see a Japanese patient today addressing the therapist by his or her first name. In Ohara and Aoki's books on Morita therapy, both of which show transcriptions of the conversations or letters exchanged by the therapists (the authors themselves) and patients, I did not find any exception to the patient addressing the therapist as *sensei*. The characters of the word *sensei* literally translates to 'person born before another'; in general usage, the term means 'teacher' and is used as a title to address teachers, professors, and professionals such as lawyers, doctors, therapists, politicians, and other figures of authority. The use of this honorific title in the patient-therapist relationship alone indicates that in Morita therapy, there exists a hierarchy—at least more so than in MBCT.

In addition, the Morita therapists are not afraid to come off as 'experts,' unlike their counterparts in MBCT who refrain to consider themselves so. In MBCT, the room setting embodies this dynamic by having everyone sit in a circle to promote the atmosphere of 'group-investigation'; in contrast, the group meetings of Morita therapy follows a more conventional style of ask-the-therapist format. This is particularly illustrated in Reynolds' observation of Morita group therapy sessions:

They [the therapists] offer simple, clear advice for overcoming particular problems. They direct the discussion to clarification of the member's own

⁴⁷⁷ See Chapter Five pp. 81-83

⁴⁷⁸ See Chapter Four p. 67

errors and failures rather than to what happened to him, how others influenced him, or how the external environment affected him...I have heard some therapists at these meetings guarantee cure and even predict the course of improvement over time. They certainly speak with confidence and authority.⁴⁷⁹

In these ways, the patient-therapist relationship in Morita therapy is hierarchal.

However, in the previous chapter, I presented that in Morita therapy the therapist is also expected to present himself as a warm, empathic, family-like figure to the therapist. Aoki is a contemporary Morita therapist who especially stresses his patients to view him as their 'friend' rather than their '*sensei*.' He further explains to his patients that learning goes both ways—that he too can learn something from them as well.⁴⁸⁰ This may sound contradicting from what was said in the previous paragraphs: how can a relationship be hierarchal and friendly at the same time? The truth of the matter is, in Japan, even if there is a buffering of hierarchy, the hierarchal relationship will always exist to some extent. This is simply the nature of Japanese society. However, the hierarchy itself does not take away the 'friendship' in the relationship. I have personally experienced that it is still possible for people to form a solid friendship, despite the presence of hierarchy. An example in Japanese literature that illustrates a close friendship across hierarchy is *Kokoro* by Soseki Natsume. *Kokoro*, explores a friendship between a young man (the narrator, "I") and an older man, 'Sensei.'

In the last section, I mentioned how Japanese therapists are much more likely than their American counterparts to accept, nurture, and respond to the patient's dependency needs. Perhaps, a form of *amae* relationship is being fostered in this hierarchal but friendly relationship between the Morita therapist and the patient. Doi contended that a healthy attachment pattern in Japan implies that one is able to indulge in *amae* to the appropriate object of his *amae*;⁴⁸¹ a primary example of this 'object of *amae*' would be one's mother. The hierarchal relationship seems to allow the patient to in some ways *amaeru* (to exhibit *amae*) to the therapist. This does not imply that the therapist acts like the patient's mother, and the patient acts like a child. Although the primary reference for the feelings of *amae* is the mother-infant relationship, *amae* can exist in other types of relationship. Doi in his *Amae-no-kozo (The anatomy of dependence)* defines *amae* as "in the broader sense, the desire to deny the fact of separation that is an inevitable part of human existence"⁴⁸² or a feeling that "seeks to achieve identity with another."⁴⁸³ This notion can be tied to the 'friendship' that exists between the therapist and the patient, similarly to how an MBCT instructor is recommended to *share* experience in a way that his awareness cannot be *separated* from the participants' awareness.⁴⁸⁴ In these ways, although the patient-therapist relationship between MBCT and Morita therapy share much in common, there are also noticeable differences due to cultural gaps.

⁴⁷⁹ Reynolds, 43.

⁴⁸⁰ Aoki, 78, 130.

⁴⁸¹ Doi, (1973).

⁴⁸² Doi, (1973), 167.

⁴⁸³ Ibid., 79.

⁴⁸⁴ See Welwood's quote on Chapter Five p. 91

Another notable difference in the interpersonal dynamics between Morita therapy and MBCT is the hierarchy that sometimes exists within the patient group. This is not the case in MBCT, as *everyone* (including the teacher) in the group is seen as equals. For example, in a group therapy format called *shudankai*,⁴⁸⁵ there is usually one or more “lay leaders”⁴⁸⁶ in the group. These ‘group leaders’ are usually participants who have been in the program for the longest. In this way, the group therapy members of Morita therapy follow the traditionally Japanese *senpai*(先輩)-*kohai*(後輩) relationship.⁴⁸⁷ In these ways, hierarchy—the ‘role’-taking dynamics characteristic to the collectivist culture—permeates in Morita therapy.

De-emphasis on personal emotional-expressiveness and emphasis on the collective social harmony

Another aspect of Morita therapy that is characteristic of the Japanese collectivist culture is the de-emphasis on personal emotions and self-expressiveness, and instead, the emphasis on maintaining social harmony. Morita therapy, like MBCT, promotes self-acceptance embracing both the positive and negative qualities of person. However, the extent to which the person can show the ‘negative’ sides of his personality is rather limited in a sense. Ohara, who especially emphasizes the importance of social harmony, summarizes one of his therapeutic objectives as:

Take advantage of each individual’s character. We cannot change our characters and personalities overnight. However, every character has its strengths and weaknesses – they are just two sides of the same coin. We encourage patients to learn how to prevent revealing too much of the shortcomings of his character and at the same time foster his positive assets even more.⁴⁸⁸

Although one accepts his positive and negative qualities as they are, the patients should take advantage of their positive assets and not expose the negatives in front of others. Ohara further explains, that to embody the attitude of *arugamama* (to accept feelings as they are) does *not* mean to cry when you feel like crying or to laugh when you feel like laughing; *arugamama* means to accept your feelings *as they are*, but to do what needs to be done with a goal-oriented, behavior-centered, and socially considerate attitude.⁴⁸⁹ He clarifies what he means by this in the context of maintaining social harmony:

It is not productive or possible to manipulate the mind. However, it is possible to manipulate your behavior. Even if you’re feeling sad, you are able to smile in front of other people; even in the midst of feeling ecstatic about something, you are able to show grief if you are attending someone’s funeral. If you can’t do this, you are the equivalent of an

⁴⁸⁵ See Chapter 4 p. 69

⁴⁸⁶ Reynolds, 42.

⁴⁸⁷ *Senpai-kohai* relationship in Japan often takes the form of older-younger, more experienced-less experienced, or mentor-student relationships.

⁴⁸⁸ Ohara, 278.

⁴⁸⁹ *Ibid.*, 261.

infant... It is imperative to carry a specific attitude according to the situation. In doing so, your mind will naturally catch up to your behavior.⁴⁹⁰

This attitude is quite distinct of the Japanese culture, where ‘showing a good face’ or *tatamae* in public is considered a social norm.⁴⁹¹ One is to accept and experience his feelings (even grief, sadness, and anger) but to expose those negative affect in public is a taboo; you would be viewed as inconsiderate. He further mentions that Morita once used the metaphor of riding a bicycle to describe the process of life: to live is like riding a bicycle. You *must* pay attention to not only your own footsteps but also your surroundings—the landscape as well as the people around you. If you just stare at the ground and your own footsteps, you will fall.⁴⁹²

In addition to the emphasis on maintaining social harmony, Morita therapists usually advise the patients to not be caught up trying to express or thinking about their personal feelings; consideration towards others is an integral component of healing—more important than validating or expressing emotions. This consideration for others can take multiple forms. First, it can imply reconsidering the kindness that others have bestowed upon them—particularly their parents. This is characteristic of Japanese therapists in general, as discussed in the first section of this chapter. In a number of letter exchange with patients, Ohara advises the patients to reconsider the pain and anxiety that they have caused to their parents before they attend to their own. In one letter, he writes:

When you go home, make sure you thank your parents... You often cried a lot in the hospital out of loneliness, but you were crying for When you go home, make sure you thank your parents... You often cried a lot in the hospital out of loneliness, but you were crying for yourself—you never shed a tear thinking about your parents. Your mother must have been crying to, but she was crying for *you*... Your improvement is of course, important for your own sake too, but it is for your family’s sake as well.⁴⁹³

In these ways, the emphasis is on the patient’s interdependent nature on others, rather than his individual autonomy. Aoki, who seems to have a ‘softer’ stance than Ohara, uses a variation to this approach. He calls himself a ‘Green Morita therapist,’ in which he incorporates environmental issues to the therapeutic philosophy. When a patient is caught up thinking about her personal problems, he often compares her problem to the problems of humanity in general in relation to our environmental problems—to widen the patient’s perspective all the way to a global perspective. For example,

A depressed female patient confessed to me, “Doctor, even if I recover from depression right now, I have already lost my job. I am old, and I can’t find a husband at this point. What is the fate of a person like me?”
“Even if I recovery from Morita therapy, I don’t quite see the purpose at

⁴⁹⁰ Ibid., 132-133.

⁴⁹¹ See Chapter Two, p. 37

⁴⁹² Ibid., 188.

⁴⁹³ Ibid., 183.

this point in my life.” I answered, “We don’t know whether humanity will continue to live or die. You worry about your future a lot, but as humanity we don’t quite know what is our future either. We all continue to live with hope, but in all honesty, we don’t know what’s going to happen in the future either.” As I tell her this, as if she thought to herself “oh yeah, that’s true” and seemed to show less distress. In these ways, widening one’s perspective seem to alter the course of one’s perception of life.⁴⁹⁴

Aoki, in these ways, engrave the idea that literally *all* of humanity share the same anxiety and doubt about our future, but we continue to live fully anyways. These approaches in minimizing the patient’s personal problems or difficulties were used by Morita himself, and derived from Morita’s importation of the elements of Persuasion therapy. Morita explains:

Most clients with *shinkeishitsu* constantly complain, “I alone suffer while others are highly spirited and enjoy life.” We persuade them by asking, “By what kind of standard and observation do you compare yourself against others? How have you decided that you alone suffer, or feel cold or hot? Does this experience come from an indulgence in self?”...In short, these clients are self-serving. Their intention is to make their unfavorable circumstances known to others by confession or self-disclosure. They realize that when they confess a difficult, others act empathically toward them; and if they present only favorable events, they receive little attention or sympathy.⁴⁹⁵

Compared to the contemporary therapists, Morita may sound more didactic; although this approach may seem harsh to the western audience, it is important to consider that in Morita’s generation, self-serving behaviors were looked down upon while self-sacrifice was considered highly noble. (This is still true in modern Japan, to a lesser extent).

While in MBCT the group format and flattened hierarchy between patient and therapist are meant to promote sharing stories to validate each person’s experiences, in contemporary Morita therapy, therapists still highly discourage about thinking or talking about personal history or emotions. The group format is rather to promote being a ‘model’ to each other, and not to think or discuss personal history or experience:

I would like you to apply what you learn from observing the behavior of others [around the hospital] and how they come to heal. Within the hospital, I don’t recommend to talk about your symptoms with other people. There is not so much use in conversing with other about each other’s symptoms.⁴⁹⁶

⁴⁹⁴ Aoki, 69-70.

⁴⁹⁵ Morita, 86-7.

⁴⁹⁶ Ohara, 133.

Do not question the past. Unlike the psychoanalytic school, Morita Therapy does not attempt to find the cause of symptoms from childhood or past experiences. The focus of attention is on the ‘now.’⁴⁹⁷

These elements further illustrate the differences between MBCT and Morita therapy. Although MBCT also differs from psychoanalytic approaches or other forms of psychotherapy in which the focus is on the ‘now,’ there are still elements of recollecting the past experience—such as recalling the past relapse experiences, or disclosure of personal suffering between patient-patient or patient-therapist. These are absent in Morita therapy, along with the concepts of self-compassion and self-exploration. Rather than emphasizing to be ‘kind to oneself,’ Morita has always emphasized being ‘kind to others.’ A well-known phrase that Morita supposedly used frequently is “人のためにつくす”—to live for other people. Morita recognized the great healing power of this philosophy, and this notion is still used today particularly in the Morita intervention for terminal cancer patients.⁴⁹⁸

Concluding Remarks

“Psychotherapy in both Japan and the United States is aimed at helping people so as to better adapt to their world.”⁴⁹⁹ Although some aspects of human experience are common across cultures (the experience of the inner layer of the self), some aspects (outer layer of the self) can be different according to cultural context. Therefore, some aspects of psychotherapeutic method are expected to vary—such as the aspects discussed in this chapter: hierarchy, and the fostering of consideration and compassion towards oneself versus others. MBCT, born in an individualistic culture, emphasizes a flat hierarchy, promoting self-exploration, and the emphasis on self-compassion. Morita therapy, embedded with collectivist values, respects the role of hierarchy, and emphasizes the consideration and compassion towards others before oneself. However, as the process of globalization brings these two cultures together, could there be reconciliation or merging of the values between the two therapies? Can there be a mindfulness-based therapy for bi-cultural people, such as myself among many others in the world today? We will save the discussion that possibility for the conclusion.

⁴⁹⁷ Ibid., 277.

⁴⁹⁸ Aoki, 142.

⁴⁹⁹ Weisz, Rothbaum, and Blackburn, (1984).

Conclusion

Summary

MBCT, founded by Segal, Williams, and Teasdale, is a relatively new form of therapy that integrates the mindfulness-based practices and philosophies of MBSR and the cognitive theories and methods of CBT. It was originally developed to treat depressive relapse as an eight-week, group format program. The distinctive theoretical and practical features of MBCT were outlined in Chapter Three.

Morita therapy was founded during the 1920's by a Japanese psychiatrist, Shoma Morita. This therapy integrates Zen Buddhist philosophies and contemplative methods and some of the most prominent styles of western therapies during Morita's time (such as rest therapy by Weir Mitchell, life normalization therapy by Otto Binswanger, and persuasion therapy by Paul DuBois). It was originally developed to treat *shinkeishitsu* neurosis—a type of anxiety disorder characteristic to the Japanese population. The theories and methods of Morita therapy—both traditional and contemporary—were outlined in Chapter Four.

This thesis investigated the concept of self that is implicit in the philosophies and methods of both MBCT and Morita therapy. Despite the vast difference in historical and cultural context (Morita therapy was developed in Japan during the 1920's and MBCT was developed quite recently in the West), these two therapies have remarkably similar therapeutic styles. I contended that the striking similarities are due to the fact that there are certain aspects of the self that function similarly across cultures and time—that there is an inner layer within the construct of the self that is responsible for the commonalities in human experience.

Both therapies use mindfulness as their primary therapeutic means, as mindfulness operates on the inner layer of the self. The use of 'mindfulness' is explicitly labeled in MBCT, but not in Morita therapy. This is likely due to the fact that Zen Buddhism—which shaped Morita therapy—does not use the exact word 'mindfulness.' However, mindfulness is nonetheless implicit in the teachings and practices of both Zen Buddhism and Morita therapy. Whether it is labeled or unlabeled in a tradition, mindfulness works similarly across cultures and time, as it is an innate capability of the human mind.

Mindfulness can be understood as a two-dimensional continuum. It is a 'continuum' because one's cultivation of mindfulness follows a gradual, continuous progression; it can begin with learning a few meditative techniques but with repeated and disciplined practice, it can eventually advance to a more permanent state of psychological construct. In these ways, mindfulness has a limitless capacity of promoting wellbeing. It is 'two-dimensional' because there are two modes of mindfulness experience: the dualistic or conceptual mindfulness that is shaped by a clear subject-object distinction, and the non-dualistic or non-conceptual mindfulness in which the subject-object distinction diminishes. Both therapies take advantage of both modes of mindfulness, as both are imperative to one's psychological development. These characteristics of mindfulness were shown through Chapter One.

One of the most striking similarities between MBCT and Morita therapy is the therapeutic mechanism of 'de-selfing' through mindfulness. In both therapies, 'self-

centeredness' (excessive self-referential thinking) is thought to be the central cause of problems and distress. To help patients disengage in the problematic self-centered thinking, both therapies—through mindfulness—promote the experience of non-dualistic awareness. Through such experience, the therapies change the patients' perspective on their conception of self. The dualistic aspects of mindfulness are also used in both therapies. This is evident in other similarities between the therapies, such as the unique interpersonal dynamics, the method of diary writing, and the emphasis on changing through actions rather than thinking. These similarities are elaborated in Chapter Five.

However, the historical and cultural gaps between the two therapies are quite significant. MBCT was founded within the individualistic culture of the west, while Morita therapy is embedded with the collectivist values of Japan. Throughout this thesis, I also contended that there is an outer layer of the self that is subject to socio-cultural modulation. Although the two therapies share much in common (as there is an inner layer of the self that cuts cross-culturally), there is nonetheless an outer layer of the self that is shaped differently in the U.S. and Japan. Chapter Two explained that the difference between individualism and collectivism precipitate in the difference in one's self-construal or social orientation. The difference between independent (individualistic) and interdependent (collectivist) self-construals brings about cognitive, affective, neural, and behavioral variations, which in turn have shaped MBCT and Morita therapy differently in some respects.

The major differences between MBCT and Morita therapy and their cultural roots are elucidated in Chapter Six. MBCT seems to have some individualistic components, underlined in its emphasis on self-compassion, self-exploration, validation of emotional expressiveness, and flattened hierarchy between the patient and therapist. In contrast, Morita therapy in some ways still relies on an established hierarchy in the interpersonal dynamics, and emphasizes consideration for others, maintaining social harmony, and withdrawing from being overly expressive of one's personal emotions.

The Future of Mindfulness-based Psychotherapies—a Cross-Cultural Perspective

My hope is that these findings through the comparison of MBCT and Morita therapy can spur future research interests from both humanistic and empirical perspectives. In particular, I personally see the potential benefits of conducting cross-cultural studies on mindfulness-based therapies. Both MBCT and Morita therapy are now being used to treat a wide range of conditions other than their original target disorder. This implicitly shows that mindfulness is capable of delivering therapeutic efficacy and wellbeing, irrespective of personal, historical, or cultural context.

Culled from my personal experience of going back and forth between the U.S. and Japan and my personal interest in mindfulness-based psychotherapies is a hope that one day, there will be the development of a mindfulness-based therapy for bi-cultural people. With the increasingly prominent influence of globalization, I predict that the need for reconciling cultural differences (commonly between the individualist and collectivist values) will be more in demand. As I was originally born in Japan and was raised with Japanese values, I cannot speak from a truly American perspective—to predict what it is like, needing to adjust to collectivist values originally coming from an individualistic environment. However, I believe I have some perspectives on what it is like to be a 'westernized Japanese.' My Japanese mother raised me emphasizing the importance of

being respectful and considerate towards others—to be, in some ways, ‘selfless’ in the interest for others around me. On the other hand, as I became older, my Chinese American father taught me the importance of independence, self-efficacy, and self-motivating behaviors. It is perhaps for these values taught by my father that I am here at Brown today.

Although my personal bi-cultural background may be more extreme compared to most Japanese people, I believe that in today’s society many Japanese people are finding themselves trying to find a balance between the traditional collectivist values and the western individualistic alternatives. Some people may be well-adjusted, but other people may find it difficult—even to the point that the conflict between the values is causing them psychological distress. In his essay “The Borderline Between Buddhism and Psychotherapy,” Mark Unno (a bilingual Japanese American Buddhist scholar) explains the psychological consequence of westernization in Japan, as well as its implication for the future of integrating Buddhism and psychotherapy.

Within the confluence of these two fields [Buddhism and psychotherapy], Japan and the United States together are unique situated to further the discussion and interaction between them. They are the two largest psychotherapeutic cultures in the world, a fact that is both promising and troubling. It is promising because Japan and the United States provide some of the best psychotherapy in a world that is increasingly needs psychotherapy. It is troubling because the scale of psychotherapy reflects both the intensive and extensive nature of psychopathology in the two cultures. Twenty years ago it was said that new pathologies became widespread in the United States appeared in Japan ten years later. These included school absenteeism, borderline personality disorder, and eating disorders. More recently, such pathologies as dissociative identity disorder (formerly “multiple personality disorder”) have begun to appear just five years after they become prominent in the United States. While all of these disorders are found in other cultures, in particular in the so-called advanced industrial nations, most of them appear with greatest frequency in the United States and Japan.⁵⁰⁰

This phenomenon of psychopathology in the U.S. appearing in Japan a few years later its first appearance in the U.S., seem to reflect some of Arnett’s perspective—the author of “The Psychology of Globalization,” where he basically argues that a fracture in the culture causes a fracture in the psyche of the people.

Some people may interpret this phenomenon differently, but a common view on this issue among Japanese mental healthcare professionals seems to be: the individualistic values imported from the west have destroyed the traditional nuclear family structure in Japan, which used to serve as a buffer against psychopathology. For example, Doi attributes the appearance of a variety of neurotic symptoms to the social upheaval following the Meiji Restoration as well as World War II.⁵⁰¹ A clinical psychologist in

⁵⁰⁰ Mark Unno, “The Borderline Between Buddhism and Psychotherapy,” in *Buddhism and Psychotherapy Across Cultures*, ed. Mark Unno (Somerville, MA: Wisdom Publications, 2006), 153-154.

⁵⁰¹ Doi, (1973), 108-109.

Japan, Okada Yasunobu, also shares this view. Okada uses the method of Sand Play Therapy to treat his patients. Sand Play Therapy is based on the Buddhist symbolism of sand as maternal environment, and his essay is also compiled in Mark Unno's *Buddhism and Psychotherapy Across Cultures*.⁵⁰² When I interviewed Okada about Unno's remark about psychopathology in the U.S. appearing in Japan shortly after its first appearance in the states, he stated:

Such disorders began to manifest in Japan years after they appeared in U.S. and they are on the rise. Borderline personality disorder, dissociative identity disorder and eating disorder are in fact at their peak in Japan, perhaps as rampant as in US. I think these disorders are caused by parental relationship. Changes in familial system I think has caused problems. Large families and community solidarity assumed supportive function and prevented problems from happening in the past but they are quickly disappearing.⁵⁰³

During the interview, I had also asked Okada whether he thinks psychotherapeutic methods based on Buddhist philosophies and contemplative practices are appropriate for the westernized Japanese. He stated:

If a patient is suffering from maladaptation caused by mental conflict between Western values and idiosyncratic and traditional Japanese ways of things, then, the therapy is directed toward how to find a good balance between the two sets of values, in other words, how to be a Westernized Japanese. Morita and Sand Play therapies are both needed even more because of Japan's westernization.⁵⁰⁴

It seems to me that the modern Japanese people would benefit tremendously by either the more traditional mindfulness-based psychotherapy such as Morita therapy, or the more modern ones such as MBCT, MBSR, or ACT (Acceptance-Commitment Therapy).

It seems that the idea of mindfulness, in the context of western mindfulness tradition, is catching on in Japanese society. In fact, when I visited the bookstore to find books on Morita therapy, I found a considerable number of books on mindfulness-based therapies (MBCT, MBSR, and ACT) that are either translated by the original western authors (such as Kabat-Zinn) or written by Japanese authors. Although mindfulness is not labeled explicitly as a term in Zen Buddhism or Morita therapy, it seems that the concept—in the western clinical context—is slowly being imported to Japan, labeled as mindfulness (マインドフルネス, written in *katakana* to denote that it is an imported word.) Some authors such as Hiroki Kumano, points out that the concept of 'mindfulness' is nothing more than the Japanese colloquial word of 気づき (*kizuki*, 'to notice'). Iwata also uses this word, *kizuki*, to explain the theories and methods of Morita therapy to the modern audience.

⁵⁰² Yasunobu Okada, "Psychotherapy and Buddhism: Attending to Sand," in *Buddhism and Psychotherapy*, ed. Mark Unno (Somerville, MA: Wisdom Publications, 2006), 121-138.

⁵⁰³ Okada Yasunobu, personal communications, January 22, 2012.

⁵⁰⁴ Ibid.

If certain psychopathologies in Japan are directly caused by the conflict between western individualistic and the traditional collectivist values, perhaps the Japanese people can benefit from a form of mindfulness-based therapy that respects both values. I personally speculate that the integration of the two—a therapy that respects both the collectivist, socially considerate values of Morita therapy and the individualistic values of MBCT (among others) that promote self-compassion and self-exploration—will be extremely promising. As evidence-based mindfulness research continues to expand today along with the increasing process of globalization, I propose that in both Japan and the west, there should be more communications between the Morita school and western clinical mindfulness practices. In such cases, there needs to be a reassessment of the construct of the self from a cross-cultural perspective; I hope that this thesis have eased the bridge between them by showing that within the self there is a common inner layer—the operating locus of mindfulness—and a varying outer layer that is shaped by values specific to one's culture.

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