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Zen and the Art of
Psychotherapy

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JOURNAL OF

Practical Psychiatry AND Behavioral Health

VOL. 1

NO. 4

NOVEMBER 1995



Williams & Wilkins
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Baltimore, MD

Zen and the Art of Psychotherapy

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With the provision of care today increasingly influenced by economic priorities, it is crucial to find ways to protect the quality and strength of the therapeutic relationship. For a long time Japanese psychiatrists have been dealing with the problem of having very limited time to spend with each patient. In this article, the authors present a solution. It is a remarkably creative and poetic blending of cognitive therapy techniques familiar to Western therapists with concepts derived from Zen Buddhism and the Japanese tea ceremony. This fascinating amalgamation of Western and Eastern thought can greatly enrich the viewpoint of Western therapists who increasingly must also deliver care under similar, very limited time constraints. This article reminds us that most often it is not the quantity, but the quality, of time spent that determines how much benefit our patients derive from therapy. (*J Pract Psychiatry Behav Health* 1995; 1:203-210)

KEY WORDS: cognitive therapy, brief psychotherapy, Japanese psychiatry, Zen Buddhism

The emphasis on economic pressures introduced by managed care has caused therapists to cut the time spent with each patient. In the United States, an increased focus on medication management has resulted in many therapists spending no more than 15 minutes with each patient, with sessions often occurring once a month or even less frequently. This has led to concerns about the dwindling role of psychotherapy and perhaps even more importantly of the doctor-patient relationship as part of the clinical encounter.

This new system, which seems so unfamiliar to many private practitioners in the United States, is in fact the system that has long prevailed in Japan, where interview time has been restricted due to the public insurance system. Almost all medical fees in Japan are covered by the public health insurance system, with patients making a 10%-30% copayment. In this system, however, psychological approaches such as psychotherapy tend to be neglected compared to more medically oriented procedures.

For example, the fee for psychotherapy by a psychiatrist is 2800 yen (\$33) at a hospital and 3300 yen (\$39) at a small outpatient clinic regardless of the length of the interview. This situation makes it necessary for Japanese psychiatrists to see as many patients as possible during their clinical hours.

In Japan this tendency is also related to the fact that 8000 psychiatrists serve 120 million people. According to the 1987 survey by Nishizono,¹ the average number of outpatients seen per day at 252 facilities was approximately 50, including 1.7 new visits. In most of these settings, patients are seen by only one psychiatrist, with an average interview time of less than 15 minutes. According to a study by Fujita et al.² in which psychiatrists were asked to review anxiety disorder vignettes, more than 90% of the respondents said they would spend less than 30 minutes with each patient.

Japanese psychiatrists have had to develop ways of making the most of the limited time available for patient contact. In this article, we present a model that combines Western principles of cognitive therapy with important aspects of Japanese Zen and the tea ceremony in a way that enables clinicians to provide their patients with valuable and meaningful treatment and to forge strong treatment alliances, even within the constraints of very brief therapy sessions.

A JAPANESE VIEW OF THE THERAPEUTIC RELATIONSHIP

Given the necessity to restrict the length of time patient and therapist are in contact, how can the clinician avoid trivializing the content of the session and instead make the most of the brief time allotted for treatment? Western clinicians are familiar with the important role of nonspecific factors in promoting positive psychotherapeutic outcomes. Three of the most important models have been 1) the use of the therapeutic relationship to create positive expectations and counteract demoralization,³ 2) the development of a holding environment,⁴ and 3) the conception of therapy as a corrective emotional experience.⁵ In the following section, we discuss how Western brief therapy techniques can be enriched by concepts from Zen and the Japanese tea ceremony.

Making the Most of the Moment

One of the most important internal attitudes of the therapist can be explained by the concept "Ichigoichie" from the Japanese tea ceremony. Ichigo means a "whole life" and Ichie means one meeting. Naosuke Ii (1815-1860), a fa-

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mous politician who tried to open Japan to the outside after 200 years of isolation, quoted the term "Ichigoichie" to describe the psychological attitude of the tea ceremony host.⁶ The host should think that this is possibly the only opportunity he will ever have to see the guest. With this in mind, the host is able to treat the guest with feeling in order to promote a meaningful psychological interaction. The guest, in turn, also feels the thoughtfulness of the host and is able to leave the room with satisfaction. This kind of experience makes it possible to internalize a good object image, so that both host and guest are able to "see" each other internally at any time in the future.

The attitude of the host in the Japanese tea ceremony

Silence is felt to connect the patient and the therapist and, in Zen Buddhism, is considered to be the essence of human existence.

can also be applied to psychotherapy. The clinician should keep the Ichigoichie feeling in mind while conducting an interview—the clinician should try to help patients feel that they can get something important out of the session. For example, a meaningful experience for some patients could be just spending time with the clinician if they have not been able to associate with other people for a long time despite a desire to do so. Patients whose problems have developed secondary to cognitive distortions would also need to begin cognitive restructuring techniques.

By focusing on the patient's needs, the clinician enables the patient to leave the room with the satisfaction that a tea ceremony guest feels even if the length of the session is brief. This kind of experience helps patients to internalize the clinician's good object image as well as a good self-image with its accompanying warm affect; this modifies the "unlovable" schema. The patient can also internalize the strategies and attitudes the clinician has used in the treatment. These internalizations cultivate the patient's ability to cope with difficulties outside the sessions, which can then modify the "helpless" schema.

In order to strengthen these experiences, the "Zanshin" concept of the tea ceremony is also useful. ZAN means remain and SHIN means mind. Zanshin is the word used to express the psychological attitude at the time when a host sees a guest out. The host should not immediately start cleaning up after the meeting, but is expected to stay, qui-

etly reexperiencing the excitement of the meeting which still remains in the room. These psychological attitudes are also important for a clinician, who should spend at least a few moments of silent reflection on the meeting with a patient before beginning the next task. This attitude will be sensed by patients.

Making the Most of the Therapeutic Relationship

Western clinicians are familiar with the idea that, in order to treat a patient effectively in a brief session, nonspecific factors such as the atmosphere of the treatment setting play an important role.³ A clinician's empathic attitude and nonverbal communications are important in establishing the treatment atmosphere. They contribute to the development of a "holding environment,"⁴ which is thought to affect the outcome of psychotherapy.

Another especially important nonspecific factor in Japan that may be less familiar to Western therapists is the concept of silence, which is felt to connect the patient and the therapist and, in Zen Buddhism, is considered to be the essence of human existence. Silence in a Zen context is different from silence as it is ordinarily thought of in a Western sense. It does not mean nonspeaking or passivity; rather silence is considered the mother of speech. Silence continuously exists from the past through the future, and it creates the communication medium in which we exist. Silence contains a lot of nonverbal communication in addition to the lingering verbal communication from the prior exchange. Speech that arises from such rich silence usually has a great impact.⁶ Silence in the therapeutic relationship is colored by the clinician's internal and external attitudes and is not equivalent to unfriendliness. Internal attitudes consist of the clinician's way of thinking about the patient's psychological experiences. External attitudes consist of the clinician's facial expressions, postures, intonation of voice, timing of verbal and nonverbal expressions, and various other factors. These attitudes, as long as they foster the therapeutic alliance, contribute to an attunement of affect in the therapeutic dyad that is similar to the relationship between a mother and an infant as described by Stern.⁷ This therapeutic relationship helps to produce a corrective emotional experience,⁵ helps patients reconfirm their existence, and modifies both the "unlovable" and the "helpless" schema.

Respecting the Patient's Ability and Preventing Regression

The idea of helping oneself overcome helplessness through self-empowerment has a long history in Japan in Zen, in which one's potential strength lies only within oneself and only by one's own efforts can one increase it.⁸ As a fencer must learn to stand easily on a pillar, patients must learn to stand emotionally on their own. In Zen, one might asso-

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ciate oneself with a teacher, but the teacher cannot teach in the Occidental sense because only what is learned internally is of any importance.

Statements from the therapist might be akin to the Zen "Koan," or problems that have no rational solution (for example, "to conceive the clapping of one hand" or "to feel the yearning for one's mother before one's own conception"). The koans are felt to be bricks that help one knock on the door to enlightenment about human nature. For Japanese, this door is the door of *haji* (shame)—once you find a way out of shame, you are free to experience life without bonds. This can be seen as abandoning "on'e," the observing self, that for many Japanese patients keeps them bound in obsessions of duty, responsibility, and how they are perceived by others.

The clinician should acknowledge that the patient has a leading part in the treatment and respect this position. This is a basic principle of cognitive therapy, in which patients need to use their own cognitive abilities to identify their distorted cognitions. In order to make the most of the patient's capability in treatment, a clinician can use Socratic questions. The clinician should avoid giving an interpretation of the patient's unconscious fantasies. Rather, when a patient complains of distress and psychological pain, it should be taken at face value.

Respecting the patient's decisions in a collaborative way may prevent further regression. When first seen, most patients are already regressed. If the patient is allowed to regress further, there is the danger of experiencing a "malignant" regression as described by Balint⁹ that can lead to various types of iatrogenic borderline-like behaviors. Preventing regression can improve both the "helpless" and the "unlovable" schema. Shortening session time can also help to prevent unnecessary regressions.

Patient-Therapist Match

In order to make the most of nonspecific factors, therapists and patients need to be congenial to each other. Okonogi¹⁰ suggested that the dropout rate in the psychotherapy of borderline patients is low when clinicians and patients are well matched and that it is important for referring psychiatrists to keep this in mind.

Because the medical fee is low in the Japanese system, patients can easily choose a clinician because they can decide after a few trial visits. The advantage of this is that patients can independently find a clinician with whom they match well. On the other hand, these patients might end up in a "revolving door" situation. In order to avoid this problem, during the initial session the clinician should ask about treatment history, especially about prior patient-therapist relationships. This information is important in predicting future therapeutic relationships. If necessary, the clinician should recommend that the patient go back to the former clinician.

The experience of behaving independently in therapy allows patients to practice coping strategies and problem solving by themselves. Patients also feel that they have achieved or acquired something in the session. This enhances their self-efficacy, strengthens their motivation for treatment, and finally modifies the "helpless" schema. Usually patients have been neglected by important others. The experience of having their thoughts and feelings respected induces a corrective emotional experience and modifies the "unlovable" schema.

COGNITIVE THERAPY THROUGH A JAPANESE LENS

The techniques described in this article are also based on Beck's cognitive theory¹¹ and dynamic psychotherapy. Beck (personal communication) stresses the importance of two "hard-core" schemata, as he calls them, in the pathology of personality disorder patients: "I am unlovable" and "I am helpless." The hard-core schemata can also be used to identify and modify distorted cognitions and heighten a sense of control and communication in treating other disorders. Recently, the experience gained from the treatment of personality disorder patients has led cognitive therapists to pay more and more attention to the underlying schemata.¹²

Beck's hard-core schemata concept overlaps considerably with the "triple C concept" (cognition/control/communication), which we have used in creating psychological change and in ameliorating symptoms. It is encouraging that the technique of focusing on the "triple C" developed in Japan can be integrated with Beck's concept. This sug-

Cognitive therapy is particularly well suited for use in the brief treatment setting.

gests that the hard-core schemata may be a universal theoretical framework. It is possible to shorten the therapy session by using this concept even with patients from different sociocultural backgrounds.

With the help of the clinician, patients try to change their distorted cognitions into more rational and adaptive ones, which helps them regain a sense of internal and external control. This change can improve their communication with their significant others, which then strengthens social supports. This kind of intervention may be similar to the focus put on roles seen in interpersonal psychotherapy.¹³ Regaining a sense of control leads to modification of the "helpless" schema. Improved communication leads to modification of the "unlovable" schema.

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As Beck¹¹ has pointed out, clinicians need to have their own basic blueprints for understanding and treating psychopathology. Individuals respond in different ways to internal and external stimuli, such as interpersonal conflicts, realistic burdens, physical conditions, and internal experiences such as fantasy and memory. These stimuli induce reactions in thought, mood, behavior, and body, which themselves can then become stimuli. These stimuli and reactions are mediated by cognitions that are determined by the underlying schema. The formation of the schema is influenced by both genetic and environmental factors.¹⁴

It is said that Japanese are emotionally less expressive, often use nonverbal communications, and tend to accept interdependency over individuation as described in the "Amae" concept by Doi.¹⁵ These factors color the way Japanese therapists approach psychotherapy with Japanese patients and are part of the reason why cognitive therapy may be more useful than expressive therapies in Japan. It is especially interesting that the ideas of the Zen priest Takuan and the concept of cognitive therapy share common viewpoints, which may be another reason why cognitive therapy is easily adaptable to Japanese patients. However, although these approaches have been developed on the basis of clinical experience in Japan, they could be modified for patients with different sociocultural backgrounds, as Freud¹⁶ recommended modifying therapeutic style to the individual personality of the patient.

Cognitive therapy is particularly well suited for use in the brief treatment setting. Therapists who are trained in cognitive therapy techniques will be able to make the very most of the limited time they have available. The homework that is associated with this type of therapy also helps, because much of the work can go on outside the actual sessions.

The Four-Stage Process: KiShoTenKetsu

The usual treatment process consists of four stages that can be conceptualized based on the "KiShoTenKetsu" (introduction, development, turn, and conclusion) process. The concept of "KiShoTenKetsu" originated in the principles of classic Chinese writing style and is also used as a model for the Japanese writing style. Although the actual treatment process usually cannot be clearly divided into four stages, this conceptualization can help clinicians estimate where they are in the treatment.

In the first stage, the clinician and patient collaboratively and concretely assess the patient's realistic life difficulties and psychological problems. Based on the assessment, the clinician proposes psychological and biological treatment approaches, clarifying the similarities with, and differences from, the patient's expectations.

In the second stage, cognitive approaches are used to focus on and modify distortions of automatic thoughts and to

review the patient's daily schedule. In order to apply these cognitive approaches effectively in a brief session, the clinician focuses on the automatic thoughts derived from the "helplessness" and "unlovable" schemata.

In the third stage, the hard-core schemata themselves should be identified and modified based on the themes that repeatedly appear in the automatic thoughts.

Finally, in the fourth stage, the patient is prepared to separate from the clinician and to start moving into the real world independently.

Initial Interview

Although time per patient is limited, the clinician should try to spend between 30 and 60 minutes on the initial interview. In this session, the clinician and the patient collaboratively try to assess the problems based on the model described above. First, they assess the realistic problems and consider questions such as "Are there problems related to the family and/or work? How much support is available in these situations? What is the patient's financial condition? How much has the patient achieved in the tasks related to his or her developmental stage in life?" The clinician should also assess the patient's assets and strengths. Throughout the therapy, the clinician should continue to conduct this kind of assessment and identify which areas have improved and which have deteriorated. A screening physical examination and a mental status examination are also done as part of the initial evaluation.

During the initial assessment, the clinician tries to find the relationship between the problems the patient is manifesting and the underlying hard-core schemata. The patient and his or her significant others are encouraged to describe the characteristics of the patient's personality, using both dimensional and categorical descriptions. These descriptions are useful because they usually reflect the patient's self-image and interpersonal relationships and may help the clinician get to the underlying schemata. The discrepancies between the clinician's impressions and the patient's descriptions are important because they may reflect the patient's cognitive distortions. The results of the assessment are discussed with the patient, which promotes the patient's ability to conduct a similar assessment independently. The amount of information to be given to the patient is determined by the context of the treatment. This initial assessment enables the clinician and the patient to delineate the patient's concrete problems and establish their hierarchy, so that treatment can be focused on the more important and treatable issues and sessions can be shortened.

It is also important to discuss the long-term goals in the patient's life in the initial interview. If these can be clarified, it strengthens the patient's motivation. In this way, the clinician also conveys to the patient that the main pur-

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pose of treatment is to increase psychological well-being as well as to reduce symptoms. If the clinician and patient cannot clarify the patient's long-term goals, they should at least try to form an image of the patient's future that might then become clearer as both participants achieve the short-term goals they have set.

Some patients may feel frustrated early in the course of the treatment. If patients have strong expectations of being cured, they will soon realize that the clinician is not powerful enough and they can easily become disappointed. If this happens, the clinician can point out that the patient tends to have unrealistic expectations and that this tendency might have caused other interpersonal problems. However, because of cultural factors, Japanese patients rarely express such intense negative feelings outwardly and instead tend to keep them suppressed. It is therefore important for Japanese clinicians to look for discrepancies between what patients say and what their behavior, attitudes, and facial expressions reveal about hidden feelings. The more severe the personality disturbance (i.e., borderline structure), the more obvious these discrepancies will be.

Psychoeducation

After the initial assessment, the clinician tries to share the information gained with the patient in an educational way. Patients are usually afraid of the idea that they are suffering from a psychiatric disorder or have psychological problems. Psychoeducation can reduce this kind of unnecessary fear and help patients face these problems. Booklets that describe disorders in lay terms are useful. One of us (Ono) recently wrote a book entitled *Utilizing the Depressive Experience: Cognitive Therapy for Depression*,¹⁷ which has been well received by Japanese patients and their relatives as well as by specialists. Some patients with severe depression, however, complain that it is difficult to read even an easy book. In response to this, Ono wrote a comic book¹⁸ that describes a middle-aged man who suffered and recovered from depression by restructuring his cognitions with the help of his family. Comic books are widely read in Japan and are a good way to provide educational information visually as well as verbally.

Pharmacotherapy

Psychoeducation is also necessary for pharmacotherapy. It is widely acknowledged that pharmacotherapy and psychotherapy are complementary rather than contradictory.^{19,20} Pharmacotherapy is expected to ameliorate the symptoms initially, which then makes it possible to focus on psychological or personality issues using psychotherapeutic approaches in shorter sessions.

We have found, however, that more than half of our patients in Japan have concerns about medication. They fear that medication will cause a disastrous change in their

bodies or that they might become dependent on the medicine. Some of them do not want to take medicine because they do not want to accept the idea that they have difficulties in their mind or they fear being controlled from outside. Because cognitive distortions can be identified in patients' reactions, it is useful to discuss their concerns related to medication. At the same time, the clinician should ask patients how much and in what way they want to take medication.

Four Stages in One Session

Sometimes the KiShoTenKetsu concept described above as a way of conceptualizing the treatment process as a whole can also be applied to the process of a single session. This is one way to make brief contact with the patient as valuable and productive as possible.

1. First stage: "Ki" (introduction).

In the first stage, "Ki," the patient reports what happened since the previous session. The patient also assesses both the positive and adverse effects of medication. The clinician helps the patient clarify his or her problems and gains and identifies one or two issues to focus on in this session. It is helpful for the clinician to use common sense. Although the clinician's common sense is not necessarily correct, the discrepancy between the patient's story and the clinician's common sense can shed light on the patient's underlying problems. When clinicians discuss a problem, they should avoid forcing patients to accept their viewpoint. The patient's own wording should be used as much as possible. Improvement in sleep and appetite are good indicators of change.

A person cannot see all the leaves if he stands in front of a big tree looking at only one leaf.

2. Second stage: "Sho" (development).

In the second stage, "Sho," clinician and patient collaboratively try to begin to solve problems from a cognitive point of view, especially the modification of "hard-core" related thoughts and images, which will be the main focus in the third stage.

Modifying cognitive distortions. In brief session therapy, thoughts are modified into more flexible and adaptive ones just as in standard cognitive therapy. For this purpose, Socratic questioning and guided discovery are used. Wider,

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flexible thinking has been considered important for psychological well-being for a long time in Japan. A Zen priest, Takuan (1573–1648),²¹ clearly pointed this out. His ideas, which had a great influence on the "Bushido" (the samurai spirit), share many similar points of view with cognitive theory. In his writing, he repeatedly underscored the importance of free movement of the mind. He said that a person cannot see all the leaves if he stands in front of a big tree looking at only one leaf. This is similar to the situation in which an individual becomes trapped in anguish when the mind loses flexibility and becomes unable to move freely. He writes, "It is best not to have your mind stop at one point based just on whatever you may see or hear."

It is not enough just to understand such ideas intellectually. You can only use them after acquiring practical techniques. Takuan underscored this by saying, "Even if you see reason, it is useless until you gain command of practical techniques . . . Technique and reason are closely connected to each other, like the wheels of a car." The importance of flexible thinking in Zen is related to the heavy burden the Japanese put on themselves through self-surveillance. Whereas Westerners identify their observer-selves with their sense of rationality and pride themselves on keeping their wits in time of crisis, the Japanese feel an incredible relief when they can release the restraints of self-watchfulness. Zen declares that there is a more efficient plane of human consciousness where this burden falls away.⁸

The techniques of cognitive therapy enable the clinician to identify and modify automatic thoughts and help patients adapt to reality. Focusing on automatic thoughts and images derived from both the "helpless" and "unlovable" hard-core schemata is important in order to help modify cognitions in a brief session. Patients will mention these thoughts and images as they discuss issues related to internal or external control or interpersonal relationships. These schemata are expressed as distorted views of self and others and of one's relationships to others.

Using transference both inside and outside the treatment. Clinicians should pay attention to transference because it contains a lot of information related to cognitive distortions. The clinician should be problem-oriented as well as reality-oriented, with the main focus on here-and-now issues, in order to prevent regression. Even when the patient's past is discussed, it should be compared with the present.

In order to keep sessions short, the clinician must also deal with cognitive distortions that occur outside the session. Regressed patients easily transfer their maladaptive styles of relating to others to their outside lives, which can cause interpersonal problems and cognitive distortions. By discussing concrete examples of conflict in patients' outside relationships, it may be possible to briefly identify and

resolve the patient's maladaptive behaviors and thoughts by modifying cognitive distortions related to the hard-core schemata that occur both inside and outside the treatment.

Don't forget the positive side. The clinician should not overlook positive aspects of the patient's life and should support these in the treatment. Therapists are usually good at pinpointing patients' negative aspects and patients are also adept at reporting negative aspects in the most negative way possible. As a result, the clinician tends to conspire with the patient to find every fault, and this only strengthens the patient's negative cognitions. However, after listening for a while, the clinician should strengthen any ongoing cognitive restructuring and support those positive aspects of functioning that are already in place.

At the same time, clinicians should empathize with their patients' distress because, if the positive side is mentioned repeatedly, patients may become frustrated and think that the clinician does not appreciate their psychological pain. If the clinician says things like "You are always focusing on the negative side because you feel you are inadequate," the patient may feel criticized, and their "helpless" and "unlovable" schemata may be reinforced. If a patient says that he or she is not getting better, the clinician may say, "Although you say you are not getting better in a dramatic way, it is worth noticing the small steps that you are taking. Your voice became louder and you said you started walking faster." Additionally, clinicians can use questionnaires such as the Beck Depression or Anxiety Inventories to demonstrate objective improvement. The clinician can also use general information regarding symptomatology in order to avoid criticizing the patient. For example, the clinician could say, "Mood is generally thought to recover more slowly than other symptoms, so you may still be feeling distressed internally even if you look like you are getting better" or "Generally people tend to recall only the painful events and to focus on their distress. As you know, this is a cognitive distortion. Do you think this is happening to you?"

The clinician may clarify this by quoting some events that everyone can identify with: "You might not be able to see your own changes if you try to find them every day. This is the same experience parents have. They do not notice that their children are growing taller because they see them everyday. Grandparents who see their grandchildren once a year, however, easily notice the growth."

Sometimes it happens that nothing has changed during a certain period. In that case, therapists should not be in hurry or become despairing, but should evaluate themselves and identify any of their dysfunctional thoughts (e.g., "I am powerless," "The patient will be disappointed with me," "My colleagues will criticize my inadequacy"). It is also often necessary for patients to accept reality as it is and to acknowledge and psychologically integrate the fact

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that there are problems that cannot be easily resolved and that life can go on despite them.

Dysfunctional thought record. In order to properly assess both realistic and distorted thinking, it is useful to recommend that patients keep a dysfunctional thought record as described by Beck.²² The clinician should not force this on the patient, however, since patients often will not follow through with this (just as students don't always do their homework) and the therapeutic relationship can become strained. Patients should be allowed to record thoughts in their own way, since the purpose of the record is not only to modify dysfunctional thoughts but also to cultivate problem-solving ability. Having their own format and using it in their own way allows patients to feel that their individuality is being respected, which strengthens their motivation to participate in treatment and enhances their self-reliance.

Again, the clinician should not focus exclusively on negative aspects during this procedure. The way Morita-therapists handle a patient's diary is a good example.²³ In Morita therapy, patients are thought to be unable to escape their distress because they are obsessively fixated on their symptoms or daily problems. Because these symptoms and problems often cannot be easily ameliorated, patients are encouraged to accept the difficulties as they are and to do whatever they can, little by little. In order to foster this attitude, the clinician intentionally neglects patients' complaints and instead focuses on areas where they have dealt well with their difficulties. It is important for the clinician to determine what will be communicated to the patient because it is not therapeutically appropriate to convey everything. Patients may sense the therapist's benevolence by this and see that they are accepted and cared for even when it is not directly expressed verbally.

Reorganizing daily activities. The life of psychiatric patients is usually disturbed. A large number of patients report that they are withdrawn from social activities, a tendency that is usually more prominent in patients with chronic illness. This withdrawal and isolation can maintain or worsen symptoms and lead to a vicious cycle. In order to interrupt this cycle and reorganize daily activities, the patient is advised to plan a daily schedule. As part of the cognitive therapy, it is also important to assess the patient's degree of pleasure and life satisfaction. The clinician should help patients develop a sense of fulfillment in their activities (job, housework, study, etc.)

3. Third stage: "Ten" (turn).

In the third stage, "Ten," the hard-core schemata are the main focus. Although it is difficult to clearly divide the second and third stages, they can usually be differentiated based on the main focus (automatic thoughts in the second stage and the schemata in the third). The task here is to modify the hard-core schemata based on an understanding of the repeating themes in the automatic thoughts. In ear-

lier sessions, the second stage is longer; in later sessions, the third stage becomes longer.

Clinical interventions are more acceptable to patients if the clinician uses the patients' own descriptions of their personalities in assessing the hard-core schemata. In the "Ten" stage, patients are helped to realize that it is unrealistic to think that they should be able to do everything or, conversely, that they cannot do anything. Patients need to acknowledge that it is natural for them to be cared for by someone but that they cannot get this from everyone. During this process, it is useful to keep the long-term goals in mind.

4. Fourth stage: "Ketsu" (termination).

In the final phase of the session, "Ketsu," the clinician asks for feedback from the patient, assigns homework, and prescribes medication if needed. The homework assignment is important in order to allow for shorter sessions, to modify cognitive distortions through actual practice, and to understand transferences in daily life.

The homework assignment is important in order to allow for shorter sessions, to modify cognitive distortions through actual practice, and to understand transferences in daily life.

TERMINATION OF TREATMENT

Once the hard-core schemata have been modified and patients become more confident, they should be able to have more meaningful interactions with others. At this point the patient is ready to separate from the clinician without much difficulty. At termination, patients are told that they can come back whenever necessary. In Japan, where a strict appointment system has not been established, the patient can easily return to the therapist at any time. This situation fosters the feeling in the patient's mind that they are supported. It is interesting that oriental culture has symbolized human interdependency in the Chinese character "人" (human being), in which two lines can be seen supporting each other.

Some patients may become overdependent due to this system. Overdependency can be avoided by respecting the patient's individuality and making the decision to terminate together with the patient, based on improvement in the patient's daily activities.

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CONCLUSION

Although recent findings suggest that pharmacotherapy can ameliorate not only symptoms but also problematic behavior, we believe that it is usually difficult to modify underlying schemata by medication alone. In order to modify these schemata to an extent to prevent relapse, psychotherapeutic approaches are often required.

It is becoming more and more difficult to be able to spend 45 or 50 minutes per session in some settings, and furthermore, full-time sessions may not be necessary for all patients. Frances et al.²⁴ pointed out that the theory and research supporting the 50-minute session are not very convincing. There are, of course, patients who do require longer-session psychotherapy such as psychoanalytic psychotherapy, cognitive therapy, or interpersonal psychotherapy. Full-session psychotherapy also plays an important role in training clinicians to understand psychodynamic and therapeutic processes.

In Japan, many patients seem to benefit from a brief session cognitive approach of approximately 15 minutes per session. Shortening the treatment session not only improves the cost performance but also prevents malignant regression by limiting the intensity of the relationship with the therapist. This is true even for those patients who develop a network of multiple specialists and relatives to provide support.

Although it is certainly difficult to deal with the entirety of a patient's psychological problems in a brief session, this approach can help patients change by providing them with a sense of fulfillment because they have identified and resolved their problems by themselves and have grown through the experience of sharing communication with another person. These experiences strengthen their sense of control and cultivate self-confidence, which can then modify the hard-core schemata. While this brief session cognitive approach seems promising for certain patients, these clinical impressions remain to be systematically studied.

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