

JAPANESE CONTRIBUTIONS TO PSYCHOANALYSIS

2004



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Cover illustration: Kiyoshi Yoshida (1876-1956), Mount Fuji Mirrored in a Lake, a gift to Sigmund Freud in 1932 from a Japanese pioneer psychoanalyst Heisaku Kosawa

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Preface

It gives me great pleasure to be able to publish this collection of English papers to commemorate the 50th anniversary of the founding of the Japan Psychoanalytic Society (JPS). This is the first time ever in the long, eventful history of Japanese psychoanalysis that a project of this nature has been realized. It no doubt shows how much and how far psychoanalysis has come in our country. The book covers most of the concepts, knowledge and wisdom originating in Japan—some of which have been discussed in international journals and recent congresses of the IPA, the International Psychoanalytical Association. Moreover, the book touches on the many issues and problems we face, and highlights the unique characteristics of our psychoanalytic practices. I am convinced that this book will play a highly significant role in Japan's continuing psychoanalytic contributions to the international community.

To describe this in more understandable terms, I believe that discussion of the frequency of sessions may be useful. The frequency of psychoanalytic sessions is often discussed at recent IPA meetings. Institutes in some countries are demanding that the frequency of psychoanalytical sessions, which are currently held at least four times a week, be cut to three.

Indeed, I have understood that psychoanalytic movements in many countries are being carried out with psychoanalysts split between groups whose members respect the minimum requirements for psychoanalysis that the IPA demands, and groups whose members practice psychoanalytic psychotherapy sessions from once to several times a week. Tensions, conflicts and splits are liable to occur between these groups. In Japan, however, the JPS has maintained a relatively peaceful

relationship with the Japanese Psychoanalytical Association (JPA), another Japanese group that imposes no special rules on session frequency which is usually once a week. The secret to this peaceful relationship lies in the fact that both groups are basically run by the same individuals and their close colleagues.

The authors of the papers featured in this book believe that training analysis should be held four or more times a week. This is because, if we understand how strong a personality's resistance can be, it is clear that training analysis requires deep experience over a long period of time. But most clinical cases quoted in the papers pertain to psychoanalytical psychotherapies which may be our own form of intensive practice, not psychoanalysis. I personally do not believe that this shows Japanese "double standards," or that they should be integrated at once.

The issue of frequency is an extremely symbolic matter that is over-determined; the current situation seen in Japan shows that two types—international-style psychoanalysis and Japanese-style analytic practice—can coexist. A growing number of young people and psychoanalytic practitioners are becoming involved in both. This, I am convinced, provides a model worth the immediate attention of the IPA, which is currently facing a serious crisis, with a sharp drop in the number of patients undergoing psychoanalysis and in the number of trainees and candidates hoping to take up psychoanalysis as a lifelong career. Analytic psychiatrists and psychotherapists in various Asian countries are increasingly regarding the practice of Japanese psychoanalysis as having the potential to become a model for their own practices.

Although we have psychologists among our Society's qualified members, all the contributors in this volume are psychiatrists or medical professionals in psychosomatic medicine whose analytic works are usually very clinical in nature. I strongly believe that a majority of Japan's psychoanalytic movements will continue to be propelled by analytic practitioners who have the flexibility to practice psychoanalysis in their uniquely Japanese ways, all the while contributing to international psychoanalysis. We should not confine ourselves to our own little world here in Japan, but must continue to expand and develop our

presence in the outside world. Japan's contributions in the form of these English-language reports will no doubt provide bright prospects for the future, as proof of our strong commitment to this principle.

Our form of psychoanalysis competes with Buddhism and Shintoism in the context of Japanese culture. Psychoanalysis, moreover, was imported from overseas, and as such, has been subject to cultural resistance. However, psychoanalysis has always been subject to resistance. The Japanese population is over 100 million people, and we are a minority group comprising only several tens of people. Still, we must not forget that thousands of colleagues and students have studied, and are studying, dynamic psychiatry and psychoanalytic psychotherapy with us. Resistance is thus being handled in a very gradual and non-confrontational manner.

Zen and a variety of musical instruments that were supposed to have been imported to Japan from other countries have been perfected after a history of about 1,000 years. On the other hand, some of these foreign imports have become extinct in their countries of origin. The 50-year history of our psychoanalysis is still very short if we considered the possibility of its future development in Japan. I predict that, for our psychoanalysis to become truly a Japanese original, it will require a long period of time—perhaps close to 1,000 years—for it to be ranked on a par with Buddhism. Our book is a first step toward this lofty goal. As Volume 1, it may be a bit belated; however, I am sure that it will not take another fifty years for Volume 2 to appear.

Although our numbers are small, our ambitions are high and will no doubt endure for many years to come.

Lastly, I would like to express my thanks to Dr. Kunihiro Matsuki for having agreed to serve as Assistant Chief Editor and his useful suggestions. My thanks also go to Ms. Toko Igarashi for her great help in translations and to Kyushu University Graduate School students for their valuable assistance in editing this book.

Osamu Kitayama, Chief Editor

A message to the world
from the Japan Psychoanalytic Society
that celebrates the 50th anniversary of its founding

Masahisa Nishizono
President, Japan Psychoanalytic Society

1. Celebrating the 50th anniversary of its founding

Our Japan Psychoanalytic Society (JPS) will celebrate the 50th anniversary of its founding in 2004. Of course, the history of the introduction of psychoanalysis into this country is older. At the beginning of the 1920s, theses and books of S. Freud were introduced and subsequently translated into Japanese. In the 1930s, there appeared those who visited Freud in Vienna or those who studied under Freud for psychoanalytic training, like Heisaku Kosawa. The behavioral pattern of those who are not satisfied with training only in Japan and want to accumulate training at major psychoanalytic institutes in various countries is a phenomenon seen even today among the young candidates. A branch of the International Psychoanalytical Association (IPA) was organized in Sendai and Tokyo, respectively, in the 1930s. It was a local or small circle led by a specific leader.

After World War II, interest in psychoanalysis increased throughout the country. Amid such a situation, Kosawa asked the IPA to dissolve old branches and start JPS as a nationally organized entity. It was in 1955 that the JPS was admitted to the IPA. A scientific body not based on the training criteria for psychoanalysts of the IPA was then started, apart from the JPS in order to spread and develop psychoanalysis and dynamic psychiatry in this country. The body is called the

Japan Psychoanalytical Association (JPA). The JPS and the JPA are two different bodies in terms of constitution. However, members of the JPS form the core of the leaders of the JPA. They hold yearly meetings or support scientific presentations through journals. So the two bodies are closely related to each other.

The JPS is following the training criteria of the IPA for psychoanalysts faithfully. In adopting the IPA 1991 regulation, however, separately setting up a system to make training analysis less strict was studied to develop psychoanalysis in this country. As a result, two tracks were made, namely, a psychoanalyst course based on the IPA criteria and a psychoanalytic psychotherapist course. This will be explained separately.

At present, the JPS consists of 22 members including one honorary member, 12 associate members, 21 candidates, 3 psychoanalytic psychotherapists and 10 trainees for that course.

Table 1 shows the executives including the president, secretary and treasurer in the past 50 years. Thanks to the devoted cooperation of the executive board members and the efforts of candidates and trainees in addition to innumerable advice and assistance from overseas and international exchanges, we were able to believe in the possibility of further development of psychoanalysis in Japan. While celebrating the 50th anniversary of the JPS, I wish to express my thanks to those concerned and would like to discuss some tasks.

Table 1 Presidents, Secretaries and Treasurers of the JPS, 1955–2004

		President	Secretary	Treasurer
1	1955~1968	Heisaku Kosawa	Michio Yamamura	Katumi Kaketa
2	1968~1985	Michio Yamamura	Keigo Okonogi	Tetsuya Iwasaki
3	1985~1992	Takeo Doi	Keigo Okonogi	Tetsuya Iwasaki
4	1992~1993	Masahisa Nishizono	Keigo Okonogi	Tetsuya Iwasaki
5	1993~2003	Masahisa Nishizono	Keigo Okonogi	Sadanobu Ushijima
6	2003~	Masahisa Nishizono	Osamu Kitayama	Sadanobu Ushijima

2. Introduction of psychoanalysis into Japan and characteristics of its development

I would like to discuss the introduction of psychoanalysis into Japan and characteristics of its development while avoiding duplication with "A History of Psychoanalysis in Japan" by Dr. Keigo Okonogi in the book.

I mentioned earlier about the introduction of Freud's books and contacts made between Freud and Japanese psychoanalysts who went to Europe in the 1920s. These phenomena seem to be closely related to the high intellectual curiosity of Japanese people and modernization of the then Japanese society. Speaking of intellectual curiosity, the "Collegio" founded by Catholic fathers of the Society of Jesus who came to Japan in the 16th century can be mentioned. It is said that selected local young people studied philosophy, theology, natural science, Latin, Japanese and Japanese literature and laws there. Textbooks and a printing machine to make them at in those days are displayed at a small museum in Amakusa (Kumamoto prefecture). The extensive interest and high quality of these textbooks are marvelous indeed. Uptake of Western medical science and breaking from Chinese medicine were exceptionally rapid in Japan compared with other East Asian countries. In this context, the increase of interest in psychoanalysis may be understood. For psychoanalysis to be used practically, however, changes in the social system including the medical service system and appropriate training of psychoanalysts are necessary. In Japan before World War II where the patriarchal system was prevailing despite the advance of modernization of society, psychotherapy including psychoanalysis failed to pay as a profession except in big cities like Tokyo. Training was not possible, either, except at some universities and circles.

With the advance of modernization and westernization of Japanese society after World War II, entailing changes in society and family, cases of neurosis increased and need for psychoanalysis or psychotherapy began to rise. The JPS and the JPA were established at such a time. Though not a characteristic seen only in

this country, cooperation and assistance of university academism had to be obtained for a certain study to develop at that time, particularly in this country. It sometimes meant a compromise from the standpoint of psychoanalysis. However, the place of working with university academism was limited to the JPA. So the JPS was able to carry out its activities while keeping the purity of psychoanalysis according to international standards.

In 1961, a national health insurance system (NHIS) was introduced into this country. Representatives of university academism who had the authority in managing the system succeeded in having psychoanalytic treatment introduced in the system. However, it was given once a week at very low fees. In short, it was impossible for a therapist to make a living with psychoanalytic treatment alone. Moreover, in this country after WWII, as was criticized as being "a Marxist nation among the free nations," it was considered ideal to create neither the rich nor the poor. It became a common practice for almost all the people to receive medical treatment under the NHIS. Moreover, receiving medical fees under a contract with patients in addition to the NHIS was prohibited by law. In this way, the frequency of psychoanalysis given was reduced from several times a week before the start of the NHIS to once a week, when viewed on a nationwide basis, after the start of the NHIS. This inevitably had an influence on the training of psychoanalysis. Recently, restriction on the frequency of psychoanalysts in the NHIS has been eased slightly, so reimbursement for up to six psychoanalytic treatments per month can be claimed, but the amount claimable still remains small. However, it is also a fact that many therapists are giving psychotherapeutic psychotherapy in such a situation and have produced satisfactory results in restoring patients' health.

Some 60 years after WWII, social changes in this country are remarkable. Individuals are now asked to form an "individualized self". And the conflict with the sense of value of the traditional family system is intensifying. Under such a psychic situation, various psychotherapies have increased, and the need for psychoanalysis has spread. There has arisen a diversification of value in which

one breaks away from the so-called "Marxist nation among free nations" after the war and seeks "what one wishes." A tendency for people to seek psychoanalytic therapy at their own expense is seen mainly in big cities. Interest in psychoanalysis is growing among young psychiatrists and clinical psychologists.

3. Changes and development of training

Kosawa was the only training analyst when the JPS was inaugurated. Today, 50 years later, the number of training analyst is fourteen. In designating a candidate as a training analyst, whether he meets the standard of the IPA and the possibility of his engaging in training are taken into consideration. Most of the persons trained in the days of Kosawa were enrolled at a university. With these persons as coordinators and with psychoanalysts from abroad as lecturers, many psychoanalytic seminars were held in some cities.

Dr. Roy Menninger of the Menninger Foundation came to Japan with his staff members including Dr. R. Ganzarain. Additionally, Dr. O. Kernberg, Dr. A. Cooper et al. of Cornell University also visited Japan several times. Dr. J. Padel was invited from Britain. They are only a fraction of the numerous international psychoanalysts who came to Japan. These seminars, though not a routine training of psychoanalysis, certainly gave a strong impetus to ambitious young people of this country.

Many contributors to the book published in commemoration of the 50th anniversary of the JPS are either those who received training at psychoanalytic institutes in various countries after having finished training at home, or those who continued training and completed it after having returned to Japan. Training analysts are coming out anew from among such persons.

A major crisis in the 50-years history of the JPS was the international criticism over the application of the 1991 regulation about the training at the IPA, which surfaced after the IPA Amsterdam Congress (1993). The training at the JPS

covered three fields, namely, training analysis, supervision and seminar, but it is not that the training was completely in conformity with the IPA 1991 regulation.

In particular, the course of training analysis offered 4 times a week was given only to a small number of candidates. This was due to the problem of the environment surrounding psychoanalysis as seen in the NHIS mentioned earlier and also to the dearth of training analysts who were actually available.

While obtaining the cooperation and advice of leaders of the IPA at that time, the JPS established a training and quality certification system in accordance with the IPA 1991 regulation. A psychoanalytic institute for training was set up in the JPS, and its branch was opened in Tokyo and Fukuoka. It is to be opened in other cities, for example, Osaka and Hiroshima, in the future.

This was made possible by those who had undergone training in various countries, engaged in psychoanalytic treatment in Japan to produce study results, and participated in the project of the JPS as training analysts. In this sense, we must thank the IPA as well as institutes and training analysts in various countries. As to the efforts of the JPS and the outcome of the reform, we would like to have the IPA executives evaluate them.

As mentioned earlier, the JPS started a psychoanalytic psychotherapist course on its own, irrespective of the IPA's quality certification for its members. The need for psychoanalytic therapy is increasing remarkably. However, it is practically impossible for a limited number of therapists to give treatment more than 4 times a week in response to such needs. Excellent results of learning do not become properties of the entire mankind until they are offered to those who need them by an appropriate method. Considering the need for psychoanalysis in this country, the JPS started a course anew where participants experience training analysis and treatment of patients for supervision, small as the number of times is, and seminars are given by the same criteria as for the psychoanalyst course. Moreover, the JPS placed these courses under the influence of the development of psychoanalysis by setting them up within the JPS.

Today, when the crisis of psychoanalysis is pointed out throughout the world, it

seems appropriate to have a different training course suited to the situation in each country in addition to the common psychoanalyst training course of the IPA. However, it is premised that such a training course is within the range of responsibility of the society in each country.

4. Conclusion

Conflicts over the "individualization of self" with the modernization of society in this country are one of the reasons for the rise in the need for psychoanalytic therapy in Japan, which was mentioned earlier. It implies an increase in the conflict between a new sense of value and a sense of value upheld by the old society.

The Ajase complex theory (Kosawa, Okonogi) and the Amae theory (T. Doi) were presumably obtained through a recognition of those conflicts in psychoanalytic treatment. The patients made the subject of study by the contributors to this book may also be those who suffer from such a conflict. These contributors are made up of those with different standpoints in psychoanalysis. That is because the academic background of leading psychoanalysts in the JPS is varied. In this respect, the JPS may differ from psychoanalytic societies in various countries. Under the current situation in which the crisis of psychoanalysis is pointed out, and when globalization is mounting its momentum and the development of psychoanalysis is rapid and diversified, sending the experiences and thoughts of psychoanalysts in Japan to psychoanalysts throughout the world as a message from Japan will be extremely significant. It will certainly go a long way toward deepening the understanding of the relation between the Oedipus complex and pre-Oedipal affairs, and further, of the current psychoanalysis. In the 50th anniversary of the founding of the JPS, the question of the JPS growing from a beneficiary to a giver or producer will be for the future to study. I hope that academic and friendly interchanges will develop further at the individual and

organizational levels with psychoanalysts all over the world.

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A History of Psychoanalysis in Japan

Keigo Okonogi

I. A Historical Overview

The history of psychoanalysis in Japan may be roughly divided into two periods: 1) the period before World War II; and 2) the period from the end of World War II to the present.

1. The period before World War II

(1) The introduction of Freud to Japan (the 1910s)

The first Japanese document on psychoanalysis, an article by Kaison Ohtsuki entitled "The Psychology of Forgetfulness," appeared in a journal of psychological research in 1912. The same year, Kyuichi Kimura published "How to Detect the Secrets of the Mind and to Discover Repression," which introduced psychoanalysis as a scientific method of exploring people's thoughts.

Psychologists and educators introduced Freudian psychoanalysis in a variety of forms over the next ten years. The most notable effort was *A Lecture on Psychology*, written in 1914 by psychologist Yoichi Ueno. While in the United States, Ueno had become acquainted with Freudian psychoanalysis through a lecture by Professor Stanley Hall of Clark University. On returning to Japan, he wrote *A Lecture on Psychology*, which included Japan's first systematic outline of psychoanalysis. It contained such chapters as: "The Origin of Psychoanalysis," "Psychoanalytic Therapy," "The Interpretation of Dreams,"

"Infantile Sexuality," "The Psychoanalysis of Mythology and Art," "Forgetfulness and Verbal Slips," "Wit," "Psychoanalysis and Education," etc.

(2) The publication of Freud's collected works in Japanese (1929 – 1933)

From 1929 to 1933, two collections of Freud's works appeared in Japanese translation. Both were the work of a group headed by literary figures Kenji Ohtsuki and Yaekichi Yabe.

On a visit to London in 1930, Yabe, a psychologist, met president of the IPA Ernest Jones. Yabe subsequently established the Tokyo branch of the IPA. Ohtsuki, a writer, later succeeded Yabe as president. The Association, however, promoted psychoanalytic theory to the general public only, as a system of thought, without inviting the participation of psychiatrists. It thus never developed as an association of clinical psychoanalytic psychotherapists, and was finally disbanded after the Second World War.

(3) Kiyoyasu Marui and Tohoku School (the 1920s to 1930s)

In the domain of Japanese psychiatry and medicine, Freudian psychoanalysis was originally dismissed as a misguided theory of pansexualism. Kiyoyasu Marui became the first Japanese psychiatrist to study psychoanalysis as a theoretical system of psychopathology.

Marui went to the United States in 1919 to study with Adolf Meyer at Johns Hopkins University. Witnessing the influence of psychoanalysis on American psychiatry, he hoped to introduce psychoanalysis to the Japanese psychiatric community. After returning to Japan, he began teaching at the University of Tohoku in Sendai (in northeastern Japan). Psychoanalysis became the focus of his medical school lectures on psychiatry. Beginning in 1925, he also taught psychoanalytic theory to practicing psychiatrists. Marui furthermore published psychiatric textbooks with a special emphasis on psychoanalysis. Psychiatrists who studied under Marui became Japan's first generation of

psychoanalytically-oriented psychiatrists, known collectively as the Tohoku School.

The Tohoku School flourished from the late 1920s to 1940. However, this school of psychiatrists led by Marui did not fully comprehend the techniques of psychoanalytic therapy. Rather, they understood psychoanalysis simply as a theory of psychopathology. On the basis of this understanding, members of the Tohoku School presented papers focusing on a psychoanalytical understanding of neurosis in Japan at meetings of the Japanese Association of Neurology and Psychiatry. They also published the *Journal of Psychoanalytic Psychopathology*. However, the mainstream psychiatric circle in Japan at the time was characterized by a German Kraepelinian trend. Marui's small isolated group was continuously subject to harsh criticism. In 1933, nonetheless, Marui visited Freud in Vienna and received approval for establishing a Sendai Branch of the IPA.

(4) Heisaku Kosawa, "the father of Japanese psychoanalysis" (the 1930s)

Heisaku Kosawa, a student of the Tohoku School, began to question Marui, who taught only theory without understanding Freudian psychoanalytic therapy (which Kosawa himself had been studying directly from the works of Freud). In order to learn psychoanalytic methods first hand, Kosawa left Japan to study at the Vienna Psychoanalytic Institute from 1932 to 1933.* He

* It was in the latter half of the 1980s that Dr. Arnold Cooper told me of Dr. Sterba. According to Dr. Cooper, Dr. Sterba fondly remembered the days when he had performed psychoanalysis on Kosawa in Vienna, and wished to relate this experience to psychoanalysts in Japan. Dr. Sterba was at that time living in Detroit, where he had moved from Vienna. I strongly wished to record an interview with Dr. Sterba, since I felt such a document would be invaluable to the history of psychoanalysis in Japan. I began to make arrangements for a meeting. However, to my great disappointment, Dr. Sterba passed away before our plan was realized.

received training analysis from Richard Sterba, and individual supervision on psychotherapy from Paul Federn.

While in Vienna, furthermore, Kosawa visited Freud at his home at Bergasse 19 and interviewed him directly. He presented Freud with a paper explaining his theory of the Ajase complex, which he contrasted with the Western oedipal complex. (Kosawa's theory will be discussed more thoroughly in Part II.) Unfortunately, however, Freud does not appear to have evinced great interest in Kosawa's thesis.

After returning to Japan in 1933, Heisaku Kosawa, now at odds with Kiyoyasu Marui, opened a private clinic in Tokyo. Here he began practicing psychoanalytic therapy as it was known in Europe and the United States.

With the outbreak of World War II in 1939, Japan became an ally of Nazi Germany—which regarded psychoanalysis as a dangerous, Jewish system of thought. Heisaku Kosawa came under constant surveillance from the special police. Nevertheless, he continued to conduct a private practice throughout the war.

2. The period after World War II

(1) The second-generation psychiatrists and the Kosawa School (the 1950s to 1960s)

The end of World War II brought an influx of learning and culture from the United States, which greatly influenced all aspects of Japanese society including the field of psychiatry. It created a generation of young psychiatrists who sought to study the model of American dynamic psychiatry. They chose to receive training analysis and individual supervision from Heisaku Kosawa.

This group of psychiatrists who studied under Heisaku Kosawa became the second generation of Japanese psychoanalysts, known as the Kosawa School. Some leading members included: Takeo Doi, from the University of Tokyo; Makoto Takeda and myself from Keio University; and Shigeharu Maeda and

Masahisa Nishizono, from Kyushu University. These young psychiatrists from the Kosawa School became members of the Japan Branch of the IPA.

After the death of Kiyoyasu Marui in 1953, Heisaku Kosawa had succeeded Marui as director of the IPA Sendai Branch. Through exchanges with Anna Freud and Heintz Hartmann, Kosawa later changed the name of the Sendai Branch to the Japan Branch. He then established its headquarters in Tokyo, a move approved by the IPA.

The Japan Branch of the IPA is known internationally as the Japan Psychoanalytic Society. Members of the Society have completed studies in training analysis based on rigorous international standards, as well as psychoanalysis through individual supervision. Psychiatrists who received training analysis from Heisaku Kosawa between 1950 and 1960 represent its core members.

At approximately the same time, from the end of the 1940s to the early 1950s, a study group for psychoanalysis was established by Heisaku Kosawa and professors of psychiatry from various universities. With this group as its center, the Japan Psychoanalytical Association was established in 1955.

As far as its focus is concerned, the Japan Psychoanalytical Association should more correctly be called the Association for Dynamic Psychiatry. It was established by psychiatrists and psychologists with a psychoanalytical orientation. Although it includes "psychoanalysis" in its name, the Association has no specific eligibility requirements or standards for membership.

Membership for the Japan Psychoanalytical Association has grown steadily over the years. It is currently a major scientific organization with 1,500 members, roughly 70 to 80 percent of whom are dynamic psychiatrists. A number of clinical psychologists also participate.

The founding members of the Japan Psychoanalytical Association, like those of the Japan Psychoanalytic Society, received psychoanalytic training from Heisaku Kosawa. Psychiatrists who have studied psychoanalytic psychotherapy and dynamic psychiatry in the United States and Europe have

also become members. The Association does not limit itself to any specific school of psychoanalysis; some members adhere to Freudian ego psychology; others advocate British object relations theory or the Kleinian school. In this sense, various schools cooperate to run the Association. Members who have joined after studying psychoanalytic psychotherapy abroad include: Akihisa Kondo, who worked with Karen Horney; Kenji Sakamoto, who studied under Clara Thompson; and Ikuo Miyoshi, who received training from Metard Boss of Switzerland.

(2) The third-generation psychiatrists (the 1960s to 1970s)

In 1969, following the death of Heisaku Kosawa, Michio Yamamura succeeded to the presidency of the Japan Psychoanalytic Society and the Japan Psychoanalytical Association. The period 1960–1970 also witnessed the return of several Japanese psychiatrists from clinical training abroad. Kiyoshi Ogura, for example, returned to Japan after undergoing complete clinical training at the Menninger Hospital. Third-generation psychiatrists, who had completed training with second-generation psychiatrists such as Nishizono and myself, returned from shorter sojourns in England and the United States. Among these returning third-generation psychiatrists was Tetsuya Iwasaki, who, after studying at the Menninger Psychiatric School, presented Otto Kernberg's theory on borderline personality organization and its treatment. He also translated the works of Hanna Segal, and introduced the Kleinian school of thought to Japan. During the same period, Joji Kandabashi, Sadanobu Ushijima and others received training from John Padel in London. They introduced the object relations theory of Winnicott to the Japanese clinical scene.

Boosted by the participation of these third-generation psychiatrists, psychoanalysis gradually gained importance in Japan, and became a major influence in the field of clinical psychiatry. However, as mentioned before, Japanese psychiatry has traditionally possessed a German—more specifically a

Kraepelinian and biological—orientation. This long-established tradition within Japanese psychiatry resulted in a variety of conflicts with emerging psychoanalytic dynamic psychiatry. It was under these circumstances that clinicians with a psychoanalytic orientation in psychiatry, clinical psychology, and psychosomatic medicine gradually began demonstrating their leadership through the vehicle of the Japan Psychoanalytical Association.

During the period 1960 to 1970, many important psychoanalytic works were translated into Japanese, in a movement towards internationalization organized by the Japan Psychoanalytic Society under the leadership of myself. The third Japanese translation of Freud's collected works appeared. In addition, most of the leading works on ego psychology by Wilhelm Reich, Heinz Hartmann, Ernst Kris, Anna Freud, and Erik Erikson were translated into Japanese.

The most original research in Japanese psychoanalysis at this time was that of Takeo Doi. As will be discussed later, his theory of *amae* eventually received recognition not only in Japan, but also in the international psychoanalytic community.

In terms of clinical practice, it was during the period 1960 to 1970 that the diagnosis and psychotherapy of borderline cases, as well as classic psychoanalytic therapy, began to attract keen attention. Reflecting contemporary trends in Europe and the United States, psychoanalytic psychotherapists in Japan began actively performing psychotherapy for schizophrenic patients. Soon, psychiatric family study, particularly that of the schizophrenic family, became a theme of major importance. From approximately 1970, however, Japanese psychiatry came under the influence of the worldwide anti-psychiatric movement; as a result, numerous disputes occurred among various psychiatric societies and universities.

(3) The fourth-generation psychiatrists, and increasing international exchange (the late 1970s to 1980s)

As disputes among universities and academic societies abated, a new wave of psychiatrists—who might be called the fourth generation—joined the established psychiatric community. This fourth generation, like the third, returned to Japan after studying psychoanalytic psychotherapy and dynamic psychiatry in Britain and the United States. Kuninao Minagawa, for example, received five years of training in psychotherapy at Michigan University from the Nagera group, focusing on the treatment of children and adolescents. Rikihachiro Kano returned to Japan after receiving training in psychoanalytic psychotherapy and dynamic psychiatry for three years at the Menninger Hospital in Topeka, Kansas. Osamu Kitayama received training in psychotherapy with a psychoanalytic orientation at the Department of Psychotherapy of London's Mousley Hospital.

During the 1980s, Japanese translations appeared for most of the essential works of object relations and Kleinian theorists: Melanie Klein, Michael Balint, Douglas Fairbairn, D.W. Winnicott, and Hanna Segal. The translation of Bion's work is still under way, although Leon Grinberg and Elizabeth Bianchedi's study, *"An Introduction to the Work of Bion,"* has appeared in Japanese.

From 1980 onwards, a growing number of psychoanalysts from overseas, particularly from the United States, began to visit Japan. Leading American psychoanalysts such as Cornell University's Otto Kernberg and Arnold Cooper conducted the first international seminar in Tokyo, on borderline cases and narcissism. Numerous psychoanalysts from other countries followed, resulting in a dramatic increase in the number of seminars and lectures held in Japan. Leading IPA analysts—including former IPA presidents Robert Wallerstein, Serge Lebovici, and Joseph Sandler, among others—came to Japan on various occasions to give lectures and organize seminars. Ramon Ganzarain visited Japan for the congress meeting of the International Association of Group

Psychotherapy, Serge Lebovici, Robert Emde and Joy Osofsky for the IACAPAP, and Efrain Bleiberg for the Menninger Workshop Tokyo.

Following the IPA Congress in Hamburg in 1983, the Japan Psychoanalytic Society has implemented English–Japanese simultaneous interpretation at subsequent IPA Congresses in Madrid (1985), Montreal (1987), etc. The number of Japanese members taking part in the IPA Congress increases each year, and full–scale international exchanges with the IPA have been organized.

During the late 1980s, I became interested in reviving Kosawa's theory of the Ajase complex, seeking to integrate it with my own clinical experience and subsequent psychoanalytic research. Presented at a variety of international conferences, this new interpretation of Kosawa's theory has received widespread attention. Doi's concept of *amae*, presented at the IPA Congress in Montreal as well as the Amsterdam Congress (1993), has also attracted attention for its universal applicability. Osamu Kitayama has made original presentations at several IPA congresses, including the Psychoanalytic Congress in Rome (1989), the IPA Congress in Buenos Aires (1991), and the Amsterdam Congress. His studies are beginning to draw worldwide interest as well.

II. Studies by Japanese Psychoanalysts

As studies by leading Japanese psychoanalysts frequently cited in overseas literature, I would like to introduce (1) Takeo Doi's theory of *amae*; (2) the Ajase complex theory, developed by Kosawa and later expanded by myself; and (3) Osamu Kitayama's "The Prohibition of 'Don't Look'" and "Studies on Mourning." In terms of chronology, I should rightly begin with Kosawa's Ajase complex. However, in order to include my own, subsequent research on the Ajase theory, I will follow the order in which the studies drew international notice, and begin by discussing Doi's concept of *amae*.

1. The theory of *amae*: Takeo Doi

The first paper by Doi introducing the concept of *amae* appeared in an American speech journal (the 1956 Spring issue of *Western Speech*), under the title, "Japanese Language as an Expression of Japanese Psychology." The relevant passage from this paper appears below.

"*Amaeru* [*amae* is its noun form] can be translated as 'to depend and presume upon another's love.' This word has the same root as *amai*, an adjective which corresponds to 'sweet.' Thus, *amaeru* has a distinct feeling of sweetness, and is generally used to express a child's attitude toward an adult, especially his parents. I can think of no English word equivalent to *amaeru* except for 'spoil,' which, however, is a transitive verb and definitely has a bad connotation; whereas the Japanese *amaeru* does not necessarily have a bad connotation, although we say we should not let a youngster *amaeru* too much. I think most Japanese adults have a dear memory of the taste of sweet dependency as a child and, consciously or unconsciously, carry a lifelong nostalgia for it (p. 92)."

Thus, although *amaeru* has its primary locus in childhood, it may also apply to an interpersonal relationship between adults, if that relationship contains the same desire for dependency and belonging experienced by a child. Doi argued that the visibility or conscious recognition of *amae* might itself be a distinguishing factor of Japanese culture.

Doi furthermore discovered that an unfulfilled desire for *amae* lies behind *toraware* (a state of obsession in which a patient adheres to one idea to the exclusion of all others), often seen among patients of Morita *shinkeishitsu* or "nervousness"—the type of neurosis most prevalent among the Japanese. Doi later concluded that the psychodynamics of *amae* plays a central role in a variety of other psychiatric disorders as well.

Eventually, Doi came to assert that *amae* was not a psychology unique to the Japanese, but rather a universal psychology, appearing in other cultures as well.

The psychology of keeping pets, for example, may be understood in terms of *amae*. Doi thus maintains that although the word *amae* originates in the Japanese language, the concept of *amae* possesses universal applicability and represents an important tool for psychoanalytic investigation.

In order to position his theory within the broader context of international psychoanalysis, Doi has compared *amae* with several existing psychoanalytic concepts. He writes:

"It has been my belief at the same time that this concept has a universal applicability inasmuch as the patient's transference can be interpreted in terms of *amae*. In other words, the concept of *amae* can lend itself to psychoanalytic formulation and may even complement the existing theories of psychoanalysts."

I would like to continue with another quotation from Doi:

"*Amae* agrees with object-relations theory and makes it more amenable to introspection precisely because *amae* and its vocabulary refer to inner experience. For instance, passive object love or primary love as defined by Michael Balint can be equated with *amae* in its pure form and as such, his concept becomes something quite tangible. In fact, Balint deplores the inadequacy of the word 'love' to catch its essence in nascency, and states as follows: 'All European languages are so poor that they cannot distinguish between the two kinds of object-love, active and passive.' (1965, p. 56) It is then remarkable that the Japanese language has this word *amae*, enabling the infantile origin of love to be accessible to consciousness. Incidentally, I began to correspond with Balint in 1962 and he confirmed that, after reading some of my papers, his ideas and mine were developing in the same direction. I also had the good fortune to discuss the matter with him personally when I went to London in 1964. I was furthermore delighted that he honored me later by citing my work in his last book, *The Basic Fault*.

In this connection, I would like to say a few words about the concept of attachment, which was introduced by John Bowlby into psychoanalysis from ethology, since it obviously covers the same area as *amae*. As is known, Bowlby sharply distinguishes attachment from dependence, saying that a child does not become attached to his mother because he has to depend on her. So he prefers attachment to dependence as a term, as the former can be more precise than the latter in describing behavior. He also mentions the negative value implications of the word dependence as another reason for avoiding it. Even so, it seems to me that he overlooks the fact that attachment involves a dependence of its own, as one necessarily becomes dependent on the object as far as one is attached to it. In this regard, *amae* definitely has an advantage over attachment precisely because it implies a psychological dependence in the sense mentioned above and unlike attachment refers to the feeling experienced rather than to behavior. All in all, one can say, paradoxical as it may sound, that the concept of *amae* makes it possible to discuss what is not verbalized in ordinary communication, hence is something that remains totally unnoticed if you are speaking European languages.

Next, I would like to explain how the concept of *amae* can be related to narcissism, identification and ambivalence. *Amae* is object-relational from the beginning, therefore it does not quite agree with the concept of primary narcissism. However, it fits in very well with secondary narcissism, in fact it is particularly well-suited to describe whatever state of mind may be called narcissistic. Namely, of the two kinds of *amae*, primitive and convoluted, that I mentioned before, the convoluted *amae*, which is childish, willful and demanding, is surely narcissistic. As a matter of fact, if you suspect someone of being narcissistic, you may be sure that this person has a problem with *amae*. In the same vein, a new concept of self object defined by Kohut as 'those archaic objects cathected with narcissistic libido' (1971, p. 3) will be much easier to comprehend in the light of *amae* psychology, since 'the narcissistic libido' is none other than convoluted *amae*. Also, Balint's observation that 'in the final phase of the

treatment, patients begin to give expression to long forgotten, infantile, instinctual wishes, and to demand their gratification from their environment' (1965, p. 181) makes perfect sense, because the primitive *amae* will manifest itself only after narcissistic defenses are worked through by analysis."

Doi's *amae* theory has prompted numerous debates and discussions. I myself, for instance, have discussed adult perceptions of *amae* behavior in children. The concept of *amae* as represented by Doi is an intrapsychic emotional state experienced by adults, and it is also a mode of interpersonal relationship. It should be noted firstly, however, that Japanese rarely use the word *amae* subjectively, for example, in the sense, "I want to *amaeru*." Rather, the word refers to someone else: "He or she is *amaeru*-ing," "is overly *amaeru*-ing," or "is resorting to *amae*." It is essentially a word used by an adult to refer to a child, or by an older or senior person to refer to a junior, describing the latter's emotions, or mode of interpersonal relationship.

Secondly, some adults experience negative feelings toward *amae*. They may want to prohibit or punish it in others, or they may feel ashamed and guilty of their own desire to *amaeru*. In certain cases, the mind may work to ignore or negate feelings of *amae*. In psychoanalytic terms, the conflict with the superego towards *amae*, or the defense of the ego against *amae*, generates a variety of emotions. Part or all of this mental process is then projected onto another person.

Finally, within the context of the parent-child relationship in Japan, the word *amae* frequently carries a sense of reproach: "Stop *amaeru*-ing," "See, you're *amaeru*-ing again," "I've had enough of your *amaeru*-ing," or "You're an *amaeru*-ing child."

2. The Ajase complex: Kosawa and Okonogi

(1) The story of Ajase and his mother: Heisaku Kosawa's version

The Ajase complex is an original theory developed by Heisaku Kosawa, and subsequently expanded by myself. Whereas Freud based his Oedipus complex

on a Greek tragedy, Kosawa developed his theory of the Ajase complex from stories found in Buddhist scripture. The story of Ajase centers on the Buddhist concept of reincarnation.

Well known to the Buddhist world, Ajase's story appears with many variations in the scriptures of ancient India. These scriptures entered Japan by way of China and Korea from approximately 700 to 1000 A.D. Kosawa modeled his theory on the version of Ajase's story appearing in the *Kanmuryojukyo*, a Buddhist scripture centering on the salvation of the mother. In this instance, the woman saved by the Buddha is Ajase's mother, Idaike.

Wife of King Binbashara, the ruler of an ancient Indian kingdom, Idaike feared that as her beauty faded she was losing her husband's love. She consulted a soothsayer, who told her a sage living in the forest would die in three years' time, to be reborn as her son. However, Idaike was too anxious to wait three years, and desperate to have a child, she killed the sage. As he was dying, the sage cursed Idaike, telling her that, reincarnated as her son, he would one day kill the King. Idaike became pregnant at this moment. The unborn Ajase had thus already been murdered by his mother's egotism. Moreover, fearing the wrath of the sage reincarnated in her womb, Idaike attempted to kill her son by giving birth to him from the summit of a high tower. Ajase survived; however, having broken his little finger as a result of his fall, he was nicknamed "the prince with the broken finger."

Ajase passed a happy childhood. However, on reaching adolescence, he learned from Daibadatta, the enemy of Buddha, that his mother had attempted to kill him by giving birth from the top of a high tower; he had only to look at his broken little finger for proof. The Sanskrit word *Ajatasatru* means both "broken finger" and "prenatal rancor" (a term to be discussed below). Disillusioned with the mother he had idealized, Ajase attempted to kill her. He was subsequently overcome by guilt, however, and developed a severe skin disease, characterized by festering sores so offensive in odor that no one dared approach him—except for his mother, Idaike. Despite his mother's devoted

care, Ajase did not readily recover; he even attempted several times to kill her. Seeking relief, Idaike went to the Buddha and told him of her sufferings. The Buddha's teachings healed her inner conflict, and she returned to continue to care for Ajase. Eventually, the Prince was cured to become a widely respected ruler. This is the version of the Ajase story Kosawa wrote in the 1950s, based on the *Kanmuryojukyo*.

(2) Themes of the Ajase complex

My own research has identified two fundamental aspects of the Ajase story as presented by Kosawa. I will also present, as a third point, Kosawa's own examination of guilt in the Ajase complex.

(a) The mother's conflict between the wish for a child and infanticidal wishes

Queen Idaike wished to have a child in order to protect her status as queen and maintain her husband's love—she took the extreme action of killing the sage to achieve her desires. However, believing that the birth of the reincarnated sage would bring disastrous results, Idaike began to fear the child in her womb. She then attempted to kill her child by giving birth to him from the top of a high tower.

The story of Ajase illustrates two conflicting emotions on the part of the mother. On the one hand, she wishes to have a child in order to protect herself, and to achieve her own desires. On the other hand, projecting persecutory imagery and hatred onto her baby, she becomes fearful of the child's birth and attempts to kill him.

According to Serge Lebovici, such conflict depicts the mother's ambivalence concerning her *bébé imaginaire*. The egocentric conflict of the mother—her wishes both to have a child and to eliminate her baby—arouses persecutory anxiety through projection onto the child she carries. This unconscious maternal conflict appears clearly in the Ajase story.

(b) The child's prenatal rancor and matricidal wishes

Ajase experienced rage towards his origins from the moment of conception. As a reincarnation of the murdered sage, that is, he desired to kill his mother even before his birth. In Buddhism, this anger experienced towards birth itself is termed *mishooon*, or prenatal rancor.

Kosawa compared the Oedipus complex and the Ajase complex as follows: "Freud's Oedipus complex originates in a conflict involving the libido, with the son's love for his mother and hatred for his father. The Ajase complex, on the other hand, concerns the more fundamental question of birth or origins." Kosawa further contended that whereas incestuous desire and patricide formed the core of the Oedipus complex, the Ajase complex centered on the themes of matricide and prenatal resentment.

(c) Two types of guilt, and the mother's forgiveness

The paper Kosawa originally submitted to Freud concerning the Ajase complex bore the title, "Two Types of Guilt." ("The Ajase Complex" was rather its subtitle.) In this paper, Kosawa asserted the following. When a child makes a mistake or does something wrong, he or she first experiences guilt as a fear of punishment. However, human beings have another sense of guilt, which is of a higher dimension than mere fear of punishment. This second type of guilt is experienced when the child who fears punishment is forgiven his or her wrongdoing.

In terms of the Buddhist legend, Ajase suffered feelings of guilt when confronted by a minister with his desire to kill his mother. Shocked at his own contemplated matricide, he began to shake, and became deathly ill. Idaike, however, forgave her son and nursed him devotedly. Under his mother's care, Ajase experienced a more profound sense of guilt, one of heartfelt remorse.

Kosawa termed this guilt resulting from forgiveness *zangeshin* or "repentance." He emphasized the need to differentiate between repentance

and the guilt related to punishment. This "repentance"—type guilt compares with Klein's depressive/reparative guilt. The Ajase story may thus be viewed as depicting the transition from a punitive to a reparative type of guilt. (Kosawa may in fact have read Klein's *The Psycho-Analysis of Children* before writing his thesis.)

Ramon Ganzarain, an American psychoanalyst who studied the Ajase complex, has delineated several defense mechanisms in its treatment of guilt: denial, confusion, etc.

(3) Subsequent discussions of the Ajase complex

The most important discussions will be introduced below.

(a) The mother's distress over losing paternal support

I once received the following remarks from Professor Theodore Lidz concerning the Ajase story. In his view, children should be raised by both parents; the conflict of the Ajase story originates in the father's declining an active role and leaving the child's fate in the hands of the mother. Ajase's difficulties, in other words, began with the mother's tragedy of losing her husband's—or, in a broader sense, a man's—support.

I believe this is a very important interpretation. One of the important themes of the Ajase complex is that, although children grow up in a triadic world of father, mother, and the child, a mother such as Idaike carries the burden of raising her child by herself. The world of the Ajase complex is therefore a dyadic world.

Lidz's interpretation is also relevant in light of the socio-historical background of the Ajase legend in Japan. Early Japanese Buddhism was highly influenced by Chinese philosophy. (As mentioned above, Buddhism arrived from India via China and Korea). An essentially Japanese, popular Buddhism began to develop during the Kamakura era (1183–1333)—through the efforts of such priests as Shinran and Nichiren. One of the issues in

popular Japanese Buddhism was the possibility of women's entry into the Buddhist paradise. Behind this issue lay the problem of guilt over infanticide, particularly abortion, since Japanese women have traditionally been assigned responsibility for disposing of unwanted children. The depiction of Idaike's salvation in the *Kanmuryojukyo* played an important role in assuaging mothers' guilt over infanticide.

(b) On the origins of the text of the Ajase complex

The Ajase story also appears in the *Nehangyo* quoted in the teachings of Shinran, the *Kyogyoshinsho*, with an emphasis on the father-son relationship and patricide as in the Oedipus complex. Kosawa, however, influenced by the *Kanmuryojukyo*, wrote his story as a uniquely mother-child story.

It is interesting to compare this textual history with recent Western studies of Freud's Oedipus complex. For example, attention has recently been focused on Freud's omission of certain aspects of the Oedipal story, particularly the conflict occurring between Laius and Jocasta before Oedipus' birth. Freud omitted this portion of the Oedipus myth and focused only on the conflict between the adolescent Oedipus and his parents, naming this the Oedipus complex. If Freud had included the incidents surrounding Oedipus' birth, his story might have possessed a greater thematic similarity with the Ajase complex. From a cross-cultural perspective, one might suggest that Freud was influenced by the Judeo-Christian tradition, whereas Kosawa was heavily influenced by the oft-cited "maternal" aspect of the Japanese culture.

(c) The Ajase complex of Sigmund Freud

Balmaly and Kruhl (1979) have proposed that one reason behind Freud's radical switch from the psychic trauma theory to the endogenic drive theory lay in defense mechanisms organized against the acknowledgement of his father's failures. They argue that, while married to his second wife, Rebecca,

Freud's father had a relationship with a 20-year-old woman who became pregnant. This child was Sigmund Freud. After Rebecca's flight and subsequent suicide, Jacob married Amalia, Freud's mother. If this hypothesis is correct, Freud would have experienced extreme conflict concerning his existence as his parents' "imaginary baby."

Does the avoidance of origins and of the "*bébé imaginaire*" in Freud's Oedipal story represent a repression of the Ajase complex? Joan Raphael-Leff, a psychoanalyst based in London, has compared Ajase's mother Idaike in the Ajase story with Oedipus' mother Jocasta in the Oedipus myth. In her paper, Raphael-Leff contends that, like Idaike, Jocasta, too, displays maternal ambivalence, expressing both the desire to have a child and infanticidal wishes. Further study of the Oedipus myth in light of the Ajase complex might prove to be highly significant.

In sum, the origins of both Oedipus and Freud, as well as Freud's Ajase complex, have recently become the subject of study in the West. The theory of the Ajase complex is thus not only applicable to Japanese mothers and children, it is a universal theme.

3. The study of *on*, the Japanese concept of debt or indebtedness, and of the "Don't look" prohibition: Osamu Kitayama *

As Osamu Kitayama states in "Metaphorization—making terms," the analyst's receptiveness to ambiguity is generally thought to be an essential part of his or her psychoanalytical practice. The interpretation of multiple meanings can effectively create a "bridging function" between personal metaphorical meaning and shared literal meaning. It appears that this ambiguous metaphor fails to function in the treatment of schizophrenics, who experience metaphor in literal terms. Some, however, can utilize metaphors, indicating positive signs (i.e., a non-psychotic part, an anal retentive tendency, creativity, ambiguity tolerance,

* The following summary of his work was contributed by Kitayama.

etc.)

Kitayama's paper concerns the transitional process from literal experience to metaphorical understanding in schizophrenic patients. In this process, the therapist's role of translating the patient's expressions, which are experienced literally, into metaphorical "here and now" events is essential. Among relevant technical issues, the appearance and usage of the "in-metaphor" and compound metaphor may play an important role in interweaving the words and meanings of the two persons in therapy.

Kitayama (1993) next analyzed several ambiguous metaphorical expressions in the Japanese language: for instance, the Japanese word "*on*," which expresses obligation, debt, guilt, and love or kindness. Whereas the English concept of guilt is associated with punishment, *on* implies repayment or "requital." It is interesting to note that concepts such as *oime*, *giri*, and *kari*, which also seem important to Japanese ways of thinking, share with *on* the core meaning of debt or indebtedness.

Intrigued by the importance of debt to Japanese motivational concepts, Kitayama (1985) investigated Japanese myths and folk tales, particularly tales of marriage between humans and non-humans, in order to relate them to his clinical experience. In one tale, the snake-wife, responding to the hero's demand, forfeits her milk-producing eyeballs. The most typical and popular legend is "A Crane's Repayment of Her Debt (*On*)."
Below is an outline of the tale.

- 1) The hero rescues an injured crane, which, in the guise of a beautiful woman, then visits his home and offers herself in marriage.
- 2) The young woman is a talented weaver as well as a devoted wife. However, she prohibits the hero from watching her at work, since, in her original form as a crane, she is weaving cloth from her own feathers.
- 3) Unable to resist temptation, the hero ignores the prohibition of "Don't look"—only to see the young woman in her animal form.

- 4) He becomes frightened; the crane-woman feels hurt and ashamed. The two separate in the end.

The prohibition of "Don't look" is a taboo which, in a two-body relationship, should be broken over time, in contrast to the oedipal incest taboo, the taboo to be kept. Kitayama concluded that the tragic development of the above tale shows a sudden transition, in Kleinian terms, from the paranoid-schizoid position to the depressive position.

Kitayama (1991) further argued that from the viewpoint of "environmental failure," "false charge" or "forced guilt" may occur when the infant is suddenly confronted with its causal relation to the fragile environment, and that maternal prohibition should be withdrawn gradually as the infant develops the capacity to tolerate causality. As an infant's feeling of indebtedness stems from the relative tension between his or her own destructiveness and the mother's survival, it is thus possible to speak of "forced" or "false guilt," generated in infants with masochistic caretakers.

Finally, Kitayama (1993) proposed the value of "indebtedness" as a psychological concept to bridge external charge and internal debt. When analyzing transference and repeated acting-out in the form of masochistic or suicidal behavior, we may discover a conscious or unconscious pathological accumulation of debt.

III. The Present State of the Japan Psychoanalytic Society

To restate briefly, on succeeding to the presidency of the IPA Sendai Branch in 1955, Kosawa changed its name to the IPA Japan Branch and relocated its headquarters to Tokyo. This IPA Japan Branch later came to be called the Japan Psychoanalytic Society. The Society is currently directed by psychiatrists who

received training analysis from Heisaku Kosawa, Japan's first generation of psychoanalysts.

Michio Yamamura succeeded Kosawa as president of the Society, to be followed by Takeo Doi, and current president Masahisa Nishizono. I myself have served as secretary for many years. Sadanobu Ushijima is the current treasurer, and Tetsuya Iwasaki the current chairman of the Education and Training Committee.

During the transition period between Kosawa's death and the start of training conducted by the first-generation psychoanalysts, training analysis was not actively performed in Japan. The present membership for the Japan Psychoanalytic Society therefore remains quite small, with 18 active members and 13 associate members.

Eighty percent of the Society members live in the Tokyo area, with the remaining 20 percent in distant Fukuoka (in southern Japan) and vicinity. Although the Japan Psychoanalytic Society has not yet established a psychoanalytic institute integrating these two areas, it hopes to do so by 1994. Members, however, have not yet agreed whether to establish one psychoanalytic institute covering all of Japan, or two psychoanalytic institutes—one in Tokyo and the other in Fukuoka.

The Society intends to establish, by 1994, new regulations in line with the education and training criteria set forth by the IPA. It also plans to increase the number of training analysts, and to implement training analyses in accordance with international standards.

IV. Conclusion

The psychoanalytic theory transmitted from the Vienna Psychoanalytic Institute via Kosawa forms the mainstream of psychoanalysis in Japan. From the 1950s to the 1970s, this dominant trend received its greatest influence from the dynamic psychiatry of the United States.

Presently, there is a mounting interest in Japan for Kohutian self psychology as well as object relations theory, particularly the work of Melanie Klein, D.W. Winnicott, and W. Bion. Establishing the clinical applications of these theories has become a major challenge for numerous Japanese clinicians. The application of psychoanalysis to the fields of adolescent and infant psychiatry is also a focus of interest, and has been the topic of international meetings conducted in Japan. There is finally a growing trend to conduct psychoanalysis independent of either dynamic psychiatry or psychoanalytic therapy.

The number of patients receiving psychoanalytic psychotherapy has increased dramatically in the Japanese cities of Tokyo, Osaka, Fukuoka, Kobe and Hiroshima. There has also been a sharp rise in the number of private psychotherapeutic clinics operating in Tokyo, including five or six psychoanalytic psychotherapy clinics. These trends indicate potential for the future growth of psychoanalysis and psychoanalytic psychotherapy in Japan.

Japanese psychiatrists' and psychologists' study of psychoanalytic thought generated an encounter between Western and Japanese culture. Indigenous Japanese patterns of thought merged with the imported theory of psychoanalysis, paving the way for such theories as those of *amae*, the Ajase complex and the "Don't look" prohibition. These theories aid in understanding the mentality not only of Japanese, but also of people from other cultures; they furthermore promise to contribute greatly to psychoanalytic understanding itself. I sincerely hope that Japanese psychoanalysis will continue to make significant theoretical contributions to the international community.

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Amae and the Western Concept of Love

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It is true that the reason for my initial interest in *amae* lay in the fact that its unique concept seems to indicate the characteristics of interpersonal relationships in Japan. But it has also been my belief from the beginning that the psychology of *amae* may claim universal interest nonetheless. That is why I presented my first English paper titled "Japanese Language as an Expression of Japanese Psychology," in which I explained the meaning of *amae*, among others, on the occasion of the First Western Divisional Meeting of the American Psychiatric Association in 1955. It was my good fortune indeed that Frieda Fromm-Reichmann was then in the audience. She expressed interest in what I had to say, inviting me later to give a talk on the same subject to a small group gathered at the Center for Advanced Studies in Behavioral Sciences in Palo Alto where she was in residence at that time. She was indeed the first non-Japanese psychiatrist who came to notice the significance of *amae*.

I think it is known to those who followed my work on *amae* in English that I subsequently related it to various psychoanalytic concepts in my writings, notably in that paper I presented at the 35th International Psychoanalytic Congress in Montreal, 1987, titled "The Concept of *Amae* and Its Psychoanalytic Implications." I shall not repeat here what I wrote there. I rather want to focus in this paper on the psychology of *amae* operating even where the concept of *amae* is not known. In other words, I want to show that *amae* may be detected in those cases where one would suppose the operation of love, but not of *amae*. This seems to be

contrary to what I did in the paper I mentioned above, because there I deliberately tried to bring out the distinctive features of *amae* against what is usually meant by love. In this paper, however, I shall instead call attention to the fact that love and *amae* may overlap more often than not.

One more caution. Since I am presenting this paper to the audience that does not have the concept of *amae* in their native languages, I naturally want to emphasize that the psychology of *amae* may exist even without being recognized as such. But in saying this I do not mean that in Japan where everybody is supposed to know what *amae* is, anybody can and does own up to one's *amae* when one is in such a state. That is not the case at all. Remember that *amae* by definition is something that takes place non-verbally. In fact, only the observer can call it as *amae*. This is most typically exemplified by a small child when it seeks its mother, but the same situation will prevail with adults when they take someone for granted or rely on someone's favor as warranted. They themselves seldom realize that they are engaging in *amae*. Hence it is only natural that *amae* is susceptible to repression or denial. Incidentally, that perhaps explains why many languages can get by without such an explicit vocabulary.

Let me first cite an example from the non-analytical literature to show that *amae* is indeed implied at times when you might think that you are talking about things related to love. The author I want to quote is C. S. Lewis who wrote *The Four Loves*, an excellent treatise on love. He begins the Introduction with a distinction between Gift-love and Need-love and states as follows:

First of all, we do violence to most languages, including our own if we do not call Need-love "love." Of course language is not an infallible guide, but it contains, with all its defects, a good deal of stored insight and experience..... Secondly, we must be cautious about calling Need-love "mere selfishness." Mere is always a dangerous word. No doubt Need-love, like all our impulses, can be selfishly indulged. A tyrannous and gluttonous demand for affection can be a horrible thing. But in ordinary life no one calls a child selfish because it turns for comfort to its

mother; nor an adult who turns to his fellow "for company." Those, whether children or adults, who do so least are not usually the most selfless. Where Need-love is felt there may be reasons for denying or totally mortifying it; but not to feel it is in general the mark of the cold egoist.

I think it must be clear from the above quotation that what C. S. Lewis calls need-love corresponds to *amae*. In this regard one may think of the usage of "lovable" as well. It certainly does not refer to the one who is able to love, rather to a person who is worthy of being loved, hence the one who is susceptible to *amae*. So if Lewis is right in calling our attention to the importance of need-love as a necessary ingredient in the concept of love, then we have to conclude that anyone who discusses love will also bring the question of need-love or *amae* into his discussion. This certainly seems to apply to the case of Freud.

Freud postulated, in his attempt to analyze forms of abnormal love, "two currents whose union is necessary to ensure a completely normal attitude in love." They are the affectionate and the sensual current and he stated about the former as follows:

It springs from the earliest years of childhood; it is formed on the basis of the interests of the self-preservative instinct and is directed to the members of the family and those who look after the child.

I think it is clear from his description that what Freud meant by the affectionate current corresponds to what Lewis called need-love, hence, *amae*. But Freud did not make much of this component of love in his later writings because he came to subsume it under the newly formulated concept of narcissism. So much so that it became customary among psychoanalysts to refer to the desire to be loved as narcissistic. Freud stated as follows:

The primary narcissism of children which we have assumed and which forms one of the postulates of our theories of the libido, is less easy to grasp by direct observation than to confirm by inference from elsewhere. If we look at the attitude of affectionate parents toward their children, we have to recognize that it is a revival and reproduction of their own narcissism, which

they have long since abandoned.

There is another statement of his to the same effect:

This situation is that of loving oneself, which we regard as the characteristic feature of narcissism. Then, according as the object or the subject is replaced by an extraneous one, what results is the active aim of loving or the passive one of being loved, the latter remaining near to narcissism.

This is not a place to review Freud's concept of narcissism. But it may be safe to say that it represented for him an ideal state which exists at the beginning of life and to which one aspires throughout one's life. Then both the attitude of affectionate parents toward their children and the need of children to be bestowed such affection would be only a function of original narcissism. No doubt Freud had reasons for reasoning in these terms. It seems to me, however, that this reduces an essentially interpersonal process to one person psychology. It would certainly diminish the importance of need-love, if not love itself. For practical purposes, one may also say, it has an advantage of mitigating the vulnerability in loving, since it implies that what is important is to love and not to be loved. Interestingly, this mind-set agrees with the modern trend of exalting liberty and independence by all means possible, the *Zeitgeist* that Freud surely shared.

In this connection I would like to quote here Erich Fromm's celebrated essay, "The Art of Loving." He states at the very beginning of the essay as follows:

Most people see the problem of love primarily as that of being loved, rather than that of loving, of one's capacity to love. Hence the problem to them is how to be loved, how to be lovable.

It is interesting to note that he rests his argument upon the same fact as C. S. Lewis did that people usually don't distinguish between gift-love and need-love. But he, unlike Lewis, treats it negatively. Thus he talks about the capacity to love, but not a capacity for being loved. In other words, his position exemplifies the modern trend of elevating gift-love while downgrading need-love. It must have been against such background that C. S. Lewis felt it necessary to clarify the importance of need-love. Furthermore, this way of downgrading need-love, in

my view, most likely goes far back in Western thought. For instance, one may identify its early sign even in Aristotle. One sentence in his *Nicomachean Ethics* reads as follows: "Most people seem, owing to ambition, to wish to be loved rather than to love, which is why most people love flattery." I contend, furthermore, that this tendency of downgrading need-love was reinforced, if anything, by the influence of Christianity in the Western culture.

It is perhaps no wonder under these circumstances that it was only Michael Balint among the early psychoanalysts who recognized need-love as an independent factor to be reckoned with in mental life. As a matter of fact, this became central to his thinking since he proposed that the primordial object-relation consists in needing to be loved, first and foremost. The Freudian concept of narcissism as an ideal prototype had to be discarded. It then became just a descriptive term denoting a secondary state. He first called need-love "passive object love" in accordance with Ferenczi. But later he preferred to call it "primary or primitive love," lest passive object love should imply pure passivity. Now this notion of his seems to me to be truly identical with the concept of *amae* as I indicated in my Montreal paper. His reasoning makes perfect sense as far as I am concerned. But I regret that it is not widely accepted among contemporary psychoanalysts. Is that because the legacy of Freudian concepts should not be easily abandoned? Or is it because Balint's emphasis on the need to be loved is too contrary to the prevailing ideology of the modern world that extols the virtue of gift-love at the expense of need-love?

I want to call your attention in this connection to one more curious fact. It concerns a close parallel between Heinz Kohut's self-psychology and the theory of Michael Balint. As I see it, what Kohut calls self-object needs should correspond to what Balint specified as "passive object love" or "primary love." But neither Kohut nor his followers seem to have noticed this correspondence. Of course this is understandable if Kohut developed his theory independently of Balint or even without ever reading him. I also do not want to deny that the emphasis on empathy as well as the terminology of idealization, mirroring and twinship which

Kohut articulated are useful conceptual inventions. I do deplore the fact, however, that none of these terms are related to the psychology of love. It is quite possible that one reason for his not linking his theory with the psychology of love comes from the use of the Freudian concept of narcissism as a motivating force. No doubt he was inspired in this by Freud's dictum that "the passive aim of being loved remaining near to narcissism." But I wonder if the term narcissism is justified to replace need-love. Need-love presupposes a significant other, since one desires to be loved by that other. But if one is only motivated by narcissism, wouldn't one love only to be loved or to be in love, no matter whom one may happen to associate with? Then it remains narcissistic forever, does it not?

I maintain that narcissism and need-love can and should be differentiated. In fact I maintain it is very important clinically to distinguish between the two. True, people often confuse the two in their mind. In this regard it should be interesting to note that the Japanese word *amae* may also apply to both cases in its everyday usage. That is why I pointed out in my Montreal paper that there are two kinds of *amae*, primitive restful *amae* and demanding narcissistic *amae*. It was regrettable indeed that Kohut could not come to the similar conclusion in differentiating genuine need-love from narcissism. But undoubtedly he could not have done so without criticizing first the solipsism that is inherent in the Freudian concept of narcissism.

At any rate, it is unfortunate to see that most psychoanalysts nowadays, whether Kohutian or not, would not and could not think of love when they observe the kind of phenomena which Kohut specifically described. What can we make of all this? Surely this is related to the modern trend of extolling gift-love at the expense of need-love. This trend incidentally may be more extreme among intellectuals, including psychoanalysts, since need-love is no longer recognized as belonging to the domain of love. Furthermore, it seems to me that nowadays love itself is being too idolized or romanticized, if not sexualized, thus losing its natural, robust flavor. In other words, it is safe to say that in loving, one loves love itself and not persons. This then is nothing but narcissism. It seems to me, therefore,

that all this proves that gift-love dissociated from need-love only leads to its impoverishment or eventual cancellation. So let me conclude this paper with a plea for the importance of need-love once again hoping that the mundane Japanese psychology of *amae* would help restore the precarious balance in which the too one-sided Western concept of love finds itself at the present time.

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Life phenomena and narrative: Psychoanalysis, psychotherapy and the systems theory

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1. Introduction

A therapist listens to what a patient says, as free as possible of prejudices, gains an understanding of the patient's pain and suffering in the context of the patient's life history, then conveys to the patient his or her version of the story as he or she understands it. The two continue their dialogue while studying the story together. Through continuous and empathetic interrelationships such as this, the patient acquires a new understanding of himself/herself. Continuing this process of dialogue is what psychoanalytically-oriented psychotherapy is all about. Until recently, this view was commonly held by most psychotherapists, regardless of school. However, the value of this "story," which until now was taken more or less for granted, is beginning to be newly understood. This trend is clearly attributable to the influence of narrative therapy and the social constructivism which is behind it. But is that all? In this paper, I would like to examine the practical challenges and tasks facing psychotherapy using "a narrative" and "a family story" as the keys, based on the systems theory.

2. Narrative therapy

First, I would like to study narrative therapy, which is shedding new light on “narrative” in the context of psychotherapy in general. I am not a narrative therapist in the strictest sense, so I have limitations in that I can understand only through things that are written. Still, I would like to use a series of books and publications in Japan which come from the field of family therapy^{6, 7, 10, 14, 15)}, as pointers to further my discussions.

As the subject of my study, I would like to focus my attention on the technique and attitudes which narrative therapy emphasizes. First is the intervention method called “externalization of problems.” Patients and their families have firmly acquired a negative perception, known as a “dominant story,” and look at the world through stories that they themselves have created. To change this perception, a therapist repeatedly asks skillful questions that enable the patients and their families to distance themselves from the problem, or, in other words, to allow them to externalize or objectify the problem and observe it from the outside. The premise here is that the dominant story differs from the patients themselves. As a result, patients and their families free themselves from the problem, regain confidence, and become able to create a new and more positive story, an “alternative story.” I would like to compare this technique with the technique used in psychoanalysis that makes ego-syntonic defense mechanisms and character traits more ego-dystonic. In character analyses, if a patient has an obsessive-compulsive character, for example, who “procrastinates and is indecisive,” a therapist never says that he or she “is a terribly indecisive person.” Instead, the character is understood and interpreted using words that match the context of “the relationship between a therapist and a patient in therapeutic situations.” In other words, a patient’s character is understood and interpreted using a story. Moreover, we therapists make interpretations after gaining a full understanding that those traits are being repeated in therapeutic situations or in interpersonal relationships outside the therapeutic setting. We also fully take

into account both the latent negative emotional reactions and the manifested ones that we believe are likely to occur when such interpretations are made. By going through a series of these procedures, patients become able to objectively view their pathological character traits after having voluntarily distanced themselves from them. Viewed in this manner, these two techniques appear to be extremely similar. What is similar, however, is their aim; the process by which the aim is attained is substantially different. The characteristic of the externalization technique is that an unambiguous or primary meaning is given to the dominant story itself, and that the therapist talks in depth about it with the patients and their family. What is more, the therapist appears to be initiating dialogues quite aggressively from the start; in this sense, this technique appears to be more manipulative than conventional psychoanalysis. On the other hand, the process used in psychoanalysis, of making pathological character traits more ego-dystonic, attempts to understand not only the character traits themselves but also the complex, unconscious psychodynamics in the background that creates such character traits. Therefore, a therapist listens attentively to what their patients say and takes on a relatively passive role.

What characterizes a therapist's stance in narrative therapy is the attitude of "not knowing" ^{10, 14)}. This is a clinical stance that best represents the clinical characteristics of narrative therapy that takes the standpoint of social constructivism. I will describe my understanding while quoting Kunitani ⁶⁾ as a reference. First, reality is constructed by an individual in a social context. It is organized by language and maintained in the form of a story. The individual believes that this story is reality. Therefore, a person's unique identity is fully respected. In other words, this is an attitude of trying to understand not the therapist's theoretical framework, but the story that a patient and his or her family have constructed. The patient's social and cultural environments, or a sense of discrimination deriving from ethnic or sexual differences, are considered extremely important elements. Second, since no truth exists that everyone can agree on, and since no single view of reality can be said to be the legitimate one, a

therapist is required to assume a specific sense of modesty. This means that patients and their families rewrite the stories themselves through mutual exchanges with the therapist, and acquire a sense of reality based on such story. This attitude of “not knowing” may be compared with the following attitudes of a therapist that are well-known in psychotherapy: Sigmund Freud’s “evenly suspended attention”; Wilfred Bion’s “no memory, no desire, no understanding”; Heinz Kohut’s “empathy”; and Robert Stolorow’s “sustained empathic inquire,” or Carl Rogers’ “congruence, unconditional positive regard, and empathetic understanding” seen in client-centered therapy. However, the attitude of “not knowing” stands out for its thorough respect for the patients’ and their families’ subjective views of reality. Moreover, this attitude regards the patients’ and families’ social-cultural and social-political processes (which have thus far not been sufficiently emphasized in psychotherapy) as integral elements to the actual stories. It includes the meaning of “considering, in a critical light, the influence which a therapist’s dominant culture has on the therapeutic system.” In those respects, the attitude of “not knowing” differs, quality-wise, from other attitudes.

If we study individual techniques and attitudes in this manner, we see that narrative therapy differs substantially from other psychotherapies. However, the long-term therapeutic process (whether it is a short-term psychotherapy or a long-term psychotherapy; and what sort of events occur in a continuous or discontinuous manner) and indications of patient cases (which patients and families may be indicated for this technique; for example, is it indicated in borderline patients?) still remain largely unknown.

Still, the psychotherapeutic principles of narrative therapies based on social constructivism have extremely contemporary significances. In other words, in psychotherapy, the central theme is how a story on a pathological level is broken down, and how an even higher-level story can be organized out of it. This has to do with explaining the mechanism of self-organization via psychotherapy. I will discuss this in the following section.

3. Psychotherapy and stories as life phenomena

Psychotherapy is a life phenomenon. Its target are not objects. In psychoanalysis, the targets are psychic and subjective realities, and in system family therapy, the target is a family system. In any event, these targets cannot be grasped directly by our sensory organs. We can neither see nor touch them. Therefore, it is correct to think that psychotherapy, as an organic body, entails a distinct mechanism that is different in nature from material substances. “Narrative” has come to the fore as one such mechanism. Although it may have been virtually unavoidable, this mechanism appears to have been forgotten in the rush towards the increasing medicalization of psychotherapy and the predominance of so-called evidence-based medicine, or EBM. Of course, we cannot deny the value of psychoanalysis having been positioned in medicine as either dynamic psychiatry or as psychosomatic medicine. It is true that epidemiological researches on psychotherapy have unveiled many things. I personally believe that, with psychoanalysis becoming overly “medical” in nature, it began declining, and, as a result, a momentum rose, mostly in the United States, to explore the basic principles of psychotherapy, including psychoanalysis. The central figures in this movement included Thomas Ogden, Robert Stolorow, Rachel Schafer, and Arnold Modell in psychoanalysis, and Michael White, David Epston, Harlene Anderson, Harold Goolishian, and Lynn Hoffman in family therapy.

What these clinicians proposed are based on careful observations and insights obtained in clinical practice. It is clear, however, that most of their theoretical organization is motivated by the development of recent systems theories. Thus, I wish to discuss, at the risk of making this section overly long, the relationship between systems theory and narrative while quoting Kawamoto’s massive work on systems theory ⁵⁾.

The common themes for these new trends are how an organism is built up from a stable organization to a new, higher-level organization; how it creates new mechanisms; and why it maintains the self while producing its component parts.

The view here is that the generating process that is being organized is itself an organization. In other words, this has to do with the issue of a second-generation system known as the “self-organizing system.” Incidentally, the theme of the first-generation system is a system of dynamic equilibrium that studies the mechanisms that continue to maintain the self while mutually interacting with the environment. Here, importance was given to an organization’s constancy, openness, homeostasis, boundary functions, and the inter-subsystems relations. That is to say, in the first-generation system, the “relation” that is the result of a dynamic equilibrium is the issue. In the second-generation system, however, a primary perspective is given to “generative” or creation (Kawamoto). Simply put, the process whereby a healthy organization is established out of a pathological organization becomes an important task. If seen clinically, the primary task is not focusing on a state of mental equilibrium resulting from making insights into something, for example, but elucidating the generative process through which a new mechanism of “making insight amid mutual exchanges” emerges. Kawamoto states that this is exactly where “narrative” is introduced. “If I were to describe the generative process, ...we must relate at least two junctures and discuss the generative stage at the other juncture... A generative process can be described only through the introduction of a narrative... A story is a hidden metaphor that organizes time; it is through narrative that one experiences the elapse of time as a single, integrated state of affairs.” (Kawamoto)

In other words, life is a “narrative,” and psychotherapy in its entirety can be explained by “narrative dialogue.” However, this mechanism alone is extremely relative in nature; no consistent self exists here. Modell ⁹⁾ criticized Shafer’s narrative psychotherapy by asserting that the uniformity of a psychoanalytic narrative ultimately derives from the physical self and affective memory, and that the only aspect in which the so-called narrative story is effective and helpful is that it speaks of the historical aspect of the self in the sense that the words used in the story organize the time experience. I will discuss Modell’s theory later. It is true, however, that, although a narrative is a mechanism by which an organization

is formed, they appear to have limitations in the sense that Modell had criticized.

Another important thing is that, in discussing the generative process as a narrative—in other words, in discussing self-organization—a narrative code from the observer is essential. In unveiling self-organization as a narrative, there is always an individual who observes the generative process from the outside. This in itself is desirable. However, if we were to deepen our study on self-organization whereby the self creates the self, we must inevitably think of a mechanism of a system that has no such observers.

This mechanism is called autopoiesis: a process whereby an organization produces itself. The intersubjective approach that Robert Stolorow advocates ¹²⁾ appears to explain this principle from the psychotherapeutic standpoint. He contends that there are two principles to this approach. The first principle is that the basic goal of psychoanalytic therapy is the unfolding, illumination, and transformation of a patient's subjective world; the second principle is that the process of transformation, initiated by analytic involvement as well as by the inevitable deviation of such involvement, always occurs within an intersubjective system. In other words, the reality that crystallizes within therapeutic exchanges is intersubjective reality, right to the very end. It is neither discovered, nor created, nor constructed; it is believed to be articulated through the process of empathy and resonance. It is said, moreover, that not only an analyst's emphatic attitude but also the intersubjective reality is formed by activities which the analyst organizes. Therefore, such reality is old in the sense that it had existed without being articulated. It is also new in the sense that, before entering an empathetic dialogue, it was not experienced in an articulated form within the context of an intersubjective system. In this approach, a therapeutic system is not observed from the outside; neither is the consistency of a story recognized only after it is recognized by the observer. It is a therapeutic system that creates an intersubjective reality by itself and maintains consistency while existing within a constantly interchanging therapeutic system. In this sense, it is an autopoietic system.

4. Approaches to narrative stories (1): Knowing a story and creating it

A narrative story often takes the form of a family story. Its clinical approach, however, can take on a variety of attitudes and techniques depending on the school of psychotherapy. There are also various types of family stories, from family romances that are created based on the Oedipal complex in psychoanalysis; as well as stories in family therapy such as family myths, family scripts, family legends, family secrets, family representations and family customs, and even family rules. Other perspectives may also be added, such as family stories that are transmitted intergenerationally, and family stories that are transmitted through multiple generations.

As can be seen, a variety of approaches exist. One of the most important tasks in psychotherapeutic approaches to narrative stories is addressing the pain involved with “knowing a narrative.” In psychoanalysis, in particular, emphasis is placed more on knowing a narrative than its content *per se*. Although the story of Oedipus has a wide variety of themes, the most important is the fear of “knowing.” Had Oedipus not known his own story, his tragedy may not have occurred. The story tells us, however, that even if there is pain associated with knowing, people cannot suppress their desire to know the truth of their own story, perhaps out of curiosity or a wish to seek and learn something.

It was Wilfred Bion ³⁾ who emphasized the meaning of “knowing” the most strongly. He perceived psychoanalysis as an intercourse of the two minds using a specific method to mutually listen and to talk. He emphasized that having one’s own mind or perspective through differentiating the self from the other was an important therapeutic turning point or tactic. Here, a dyadic relationship is believed to be a defensive by-product that occurs by refusing to “know.” It is a non-introspective dyadic relationship that may be summed up by the phrase, “I love you, and I love myself.” ¹¹⁾ (Thomas Ogden)

The so-called “as if” relationship, compliant relationship, and paralytic relationship (a relationship of presuming that two people think that they

understand each other) are characteristic phenomena that occur in dyadic relationships because of the denial to “know.” How, then, can we depart from such dyadic relationships? Freud’s famous words, “Wo Es war, soll Ich werden” may be translated as “Where it was, there I shall be.” According to Ogden’s interpretation, these words imply that “it,” or in other words, symptoms or pathological character traits, transform themselves into experiences that have the quality of “I-ness” and become “personal stories” ¹¹⁾. He states that through this process, one comes to understand why and how such a story had formed. That is to say, a story assumes a personal significance having both historical and special aspects. Ogden insists that the Oedipal experience that is established with the appearance of an “analytical third,” or the third in an analytic relationship is the exit through which to emerge out of a non-introspective dyadic relationship.

As seen, “knowing” things and having one’s own mind are based on an event whereby a “personal story” is organized during the course of forming a three-system relationship from a two-system relationship. In this sense, the experience of a triadic relationship is believed not to be pathological; rather, it is the therapeutic accomplishment of generating a meaning.

5. Approaches to narrative stories (2): Interpreting and prophesizing a narrative, and the futuristic orientation that a narrative has

A therapist’s attitude within a psychoanalytic relationship may be said to be a professional attitude backed up by specialized training. However, his or her identity is deeply involved with such attitudes. Incidentally, a therapist does not necessarily know everything about his or her patients’ past or present realities. It is more accurate to say that a therapist can never know the truth about his or her patients. Not being able to know his or her true self or the true others brings about tremendous pain to a therapist to the point of affecting his or her own identity. It is experienced as “object loss.” What is more, he or she experiences

this at every therapeutic session. To solve this pain of “not knowing,” he or she imagines things and uses stories such as representations, metaphors, and mythologies.

There are two aspects to the dynamics surrounding “not knowing” such as this. First is the generative aspect. Here, the mechanism mentioned above is at work. What led Freud to conceive the Oedipus complex was his experience of object loss. What inspired Heisaku Kosawa to write a modified version of the Ajase story was also his experience of “not knowing.” In other words, the creation of interpretations may be said to be motivated by “not knowing.” Another aspect of this is a defensive attitude against the pain and fear of “not knowing.” There are three typical attitudes to this. The first attitude is being obsessed with learning a patient’s past story. Also included in this category is an attitude of adhering to events that occurred, and understandings made, in past therapeutic sessions. The second attitude is adhering to, or relying on, analytical theories and principles. The third attitude is to use words to completely fill the void created out of “not knowing” or loss.

What I wish to stress here is that a therapist must assume an attitude of “no memory, no desire, no understanding” ³⁾ stated by Bion mentioned above, or an attitude which Donald Winnicott has described with the words “the capacity to be alone.” ¹⁶⁾

Next, I would like to examine the relationship between interpretation and prophesy. Here, I wish to use the story of Ajase as material. The reason is that the Ajase story contains meanings that offer interrelational interpretations much more so than Oedipus’ story. In the story, Queen Idaike, Ajase’s mother, believes a prophesy, made by a soothsayer, that a hermit living in the forest would die in three years’ time, and would be reincarnated in her womb. However, too anxious to wait three years to have a child, she kills the hermit. As he dies, he curses her, saying, “I will be reincarnated as the son of the king, but one day this son will kill him.” Idaike believes the prophesy and attempts to kill her son Ajase or labels him as being a *misshoon* (prenatal rancor or resentment for his origin).

By definition, prophesy and interpretation are two different things. I personally feel that interpretation includes some prophetic meanings. When a therapist creates an interpretation and presents it to the patients, it inevitably includes his or her wishes, expectations, or hopes that the patients will change in a particular way. In this sense, then, an interpretation always contains future-oriented meanings. Psychoanalysis traditionally placed importance on the work of recalling the past. Strictly speaking, however, this entails “imagining here and now what has occurred in the past,” meaning that it is not actually about pursuing past truths. A similar principle applies to the future. Understanding patients’ narratives is about patients and their therapists mutually imagining, sharing, and evaluating the representations of the patients’ future ⁴⁾. Steven Cooper makes a similar remark in his paper, “Interpretation and the psychic future.” ¹⁾ An element of prophesy that accompanies such interpretations, and interpretations that do not have an insight into the future, end up becoming more of an all-round or omnipotent interpretation; they carry the risk of repeating Queen Idaike’s tragedy.

What Daibadatta, the enemy of Buddha, had whispered into Ajase’s ear, revealing to him that his mother had attempted to kill him before birth, is also extremely interesting. In a sense, Daibadatta is making a legitimate developmental interpretation of the origin of prenatal rancor. However, it is accompanied by malicious intent. Ajase’s defense is undermined, his destructive impulse is stimulated, and he acts out the story. Even without any malicious intent, however, Daibadatta’s interpretation is a dangerous one. This is because he accentuates only the negative aspect of the story. Herbert Rosenfeld states that interpretations should be made only after a therapist understands the positive and negative aspects of a patient’s experience ¹²⁾. Interpretations that take up either one of these aspects have the danger of becoming an omnipotent interpretation. This carries the risk of the imagined story being transmitted to a patient as if it were the absolute truth. As mentioned previously, it is by no means a rare occurrence that therapists tend to rely on these omnipotent interpretations when

they can no longer bear the pain of “not knowing.”

6. Approaches to narrative (3):

Rewriting/updating a narrative (Nachträglichkeit), labeling, and de-constructing

Ajase was given the name *mishoon*, or prenatal rancor. In other words, he was labeled as such. His life-long theme was to think of a way to become independent of this prenatal rancor. There are many examples of labeling a person, such as “You are wild and rowdy,” or “You’re timid.” Family studies often show how members of a family put specific labels on each other and play out roles that match such labels. “Why do parents label their children and persist with those perceptions?” “Why do children accept those labels?” and “Why does removing those labels entail such tremendous pain and difficulties, as seen in the Ajase story?”—these are important themes and questions associated with “narrative.”

John Zinner and Edward Shapiro clarified that labeling is done via projective identification ¹⁷⁾. They stated that, if parents have not resolved their own conflicts surrounding the object loss they had experienced with the families they were born into, they project such unresolved conflict onto their children, and that the children accept and agree to such conflict because of attachment to their parents. In cases like these, parents tend to recognize, as absolute truth, the interpretations of their children which they themselves had once imagined. Children, on the other hand, identify themselves with the label, so removing it signifies the crisis of losing their identity.

A narrative story about oneself thus formed has consistency, and powerfully dominates one’s views on life and behaviors. Psychotherapy may be said to be the work of rewriting or updating the stories thus memorized (“Nachträglichkeit”). As stated previously, in the case of narrative therapy, this would be regarded as “de-construction” work. The idea of the former, or, in other words, Nachträglichkeit in memory, was conceived by Freud. However, he later

abandoned this view and came to believe in the theory of the trace of fixed memory. After Freud, it was Jacques Lacan and Arnold Modell ⁸⁾ who took note of this Nachträglichkeit. According to Modell, the essence of memory is process, and memory is constantly reorganized in a dynamic manner. In other words, memory is classified into different categories which are later constantly re-categorized. Therefore, memory stored in the brain is not accurate; it is very flexible and versatile. If one encounters a new experience based on such concept of Nachträglichkeit, a rewriting of memory is said to take place in a new context. Gerald Edelman ²⁾, a neurobiologist who advocates the theory of natural selection of the nerve network, evaluates Modell's view as a memory theory based on the nerve's natural selection concept, pointing out that this Nachträglichkeit is a special feature of the nervous system. Non-assimilated traumatic experiences are organized and categorized as long-term affective memory. Such memory is repeated in the present context in the hope of becoming re-categorized. This is what is known as transference. Transference can be rewritten through new experiences with a therapist. In other words, the Nachträglichkeit is believed to be the curing mechanism itself. In this manner, new meaning is given to a traumatic experience, the meaning of experience is expanded, and a mind having both coherence and consistency is thus created. Modell stated that the consistency of psychoanalytic narrative ultimately originates in affective memory and the physical self. Indeed, this is because a person's mind creates his or her history within himself/herself because of Nachträglichkeit of the nervous system that continues to work nonstop.

7. Conclusion

Psychotherapy is a life phenomenon. In writing this paper, therefore, I have focused on elucidating the mechanism specific to psychotherapy (which is a life phenomenon), and the involvement of a narrative in such mechanism. I have

used the systems theory to support my discussion on those themes. I also compared narrative therapy and psychoanalysis. Furthermore, as clinical tasks, I focused on narrative and discussed such topics as knowing, creating and interpreting such stories; the prophetic and futuristic nature of interpretations that accompany such narrative; family stories centering on labeling; and a narrative's rewriting function known as *Nachträglichkeit*.

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Guilt Which is not Conscious, and Afterwards

Kunihiro Matsuki

[Prologue]

This experience comes from my psychiatric practice. A man who became psychotic with persecutory delusion at old age was admitted the hospital where I work as a psychiatrist. Many doctors were refused by him and then at last I became his doctor. He insisted that he was not psychotic and firmly rejected anti-psychotic medication. He seemed to have become psychotic after retirement. Before his retirement, he had worked energetically at an administrative position in a company.

His complaints were as follows: The police watched him wherever he was, using wiretap, and tried to prove that he was a criminal. There were spies sent by the police in his ward and they pretended to be patients and ward staff, and told anyone that he had a criminal record, sprinkled toxic materials on him, and poured toxic smoke over him. In other words, he had a firm belief that the police made up the story and made him feel unfairly and unreasonably guilty. He was quite distressed that he was seen and treated as a criminal.

There was another characteristic in this old man's words and action. He was absorbed in establishing old people's homes especially dedicated to sexuality of the aged and charities for school-children. To my surprise, he put all his energy into calling and sending letters to newspaper publishing companies and broadcasting

stations from the ward. His behavior such as these seemed like a serious sort of reparations he could not stop from making.

Fortunately, I was given his trust and three years had passed since he has become my patient. One day at my interview, he was meek, quite different from his usual exalted attitude. "I have never told this story to anybody else before," he began, and talked about his wife who had died more than ten years ago.

His wife seemed to have had a strong sexual urge. She often used to seduce him to have intercourse. But he was deeply absorbed in his work and very busy in those days. And in that case, he suggested that they enjoy it after his retirement and rejected her. However his wife developed a cancer suddenly in her fifties, got weak and died soon thereafter. Even after her death, he kept working for his company with his whole heart until retiring in his middle sixties. "I was cruel to my wife." He told me quietly with a sad look he had never shown before.

He did not express his regret such as he was in the wrong, or he felt the blame. But through his facial expression, a feeling of guilt seemed to be swallowed just before it has almost been put into words. And this story was never to be told again.

This guilt feeling has not allowed to sojourn in his mind, but has kept persecuting him from the outside, threatening him as if declaring "It is sure that YOU had committed a crime. Take the punishment for your deed."

I . DISCREPANCY BETWEEN THE THEORY OF UNCONSCIOUS GUILT AND ITS CLINICAL ASPECTS

1 . Presentation of unconscious guilt by Freud, S.

Freud had the idea that there is unconscious guilt or guilt which one is not aware of. To begin with, this idea itself was primarily a clinical idea.

It was written in his paper "Obsessive Actions and Religious Practices" (Freud,

S. 1907:123). There he said, "We may say that the sufferer from compulsions and prohibitions behaves as if he were dominated by a sense of guilt, of which however, he knows nothing, so that we must call it an unconscious sense of guilt, in spite of the apparent contradiction in terms." He took up "unconscious guilt" from clinical facts. This development of finding out unconscious guilt can be seen as an inevitable conclusion in clinical psychoanalysis.

This is because Freud established the foundation of psychoanalysis by first finding out and investigating "unconscious" conflict, drive and anxiety in hysteria. The fact that, through deeper investigations, unconscious guilt was discovered can be considered the next step.

2. Polished

However, discussions about unconscious guilt were, in a sense, reserved until 1923, sixteen years later. At that point, Freud had introduced new concepts: the structure theory that presents the psychic structure model including superego, ego and id, and the death instinct (destructive drive) which serves destruction. And then, unconscious guilt was considered one of the important elements in the systematical dynamic theory.

In "The Ego and the Id" (1923), following "The Economic Problem of Masochism" (1924) and "Civilization and its Discontents" (1930), Freud explained that unconscious guilt is one of the important parts of anxiety that creates neurotic symptoms, and is the distress stirred by the strict and critical superego which is formed after experiencing Oedipal conflicts during infancy. And he thought that unconscious guilt is where the death instinct is expressed in a more direct way. It manifests itself as self-destructive activities, masochism, and negative therapeutic reactions in psycho-analytical work. This time, he explained the clinical fact from the viewpoint of unconscious guilt.

3. Discrepancy

Probably, in this way, the concept of unconscious guilt came to include the

following two directions itself: from clinical practice to the theory (the former: 1907) and the theory to clinical practice (the latter: 1923—). And because of these contrary directions, it cannot be denied that some discrepancy has arisen between the two directions. That is, the concept of unconscious guilt was first introduced and illustrated as one of the aspects of guilt, which is the anxious affect seen in the patients at our clinical work. Then next, there comes unconscious guilt put back to the clinical field, as representative feelings of the superego or the death instinct having already explained in Freud's new theory system, and what I want to mention is this discrepancy between them.

Indeed, the latter, or the theoretical aspect, is of course really important and significant, but today, some doubts about its constituents are being raised. For example, the death instinct had not been accepted as a theoretical element in ego psychology. Klein, M. was the one who positively accepted its significance.

It is well known that Klein defined the feeling of envy as the most pure expression of the death instinct. On the other hand, regarding the period of the formation of the superego and the Oedipus complex, Klein assumed the weaning period much earlier than that of Freud, and found the existence of the archaic superego before the Oedipus complex had been formed.

And there is much criticism of Freud's theory of masochism, especially about the theory of feminine masochism, that the theory is said to be merely a product of the culture in his time. The death instinct/masochism/Oedipus complex/superego/unconscious guilt: Freud's theoretical constellations themselves are swaying. Our careful consideration is absolutely necessary to return to the clinical practice from theoretical constellations.

Furthermore, the concept of unconscious guilt is a very psychoanalytical one, so it may easily tend to be complacent as a concept only for the sake of explanations, like some other poor analytical concepts, for example, narcissism and acting out. We can see why Freud intentionally connected unconscious guilt with a negative therapeutic reaction which is one of the clinical problems, because he, like myself, might have been worried about that kind of complacency.

In this paper, I shall put myself in a position to place unconscious guilt in the context of psychoanalytical practice. I also wish to try to connect unconscious guilt with contemporary notion of guilt.

II. A SENSE OF GUILT IN PSYCHOANALYTICAL PRACTICE

I shall examine how unconscious guilt arises in my daily clinical practice.

[Clinical Material 1] From analysis of a schizophrenic patient who seeks punishment

A middle-aged schizophrenic was in the hospital and I analyzed him four days a week. He was a big man and often became so excited and violent that he was recognized as a very coercive and brutal patient by the ward staff. But in his analysis with me, he began to show that he was being constantly tormented by the fear of literally losing himself.

The first time he experienced this unbearable psychotic anxiety as if he were about to be done something terrible and lose himself, was when he started working in a big city, just after having finished high school.

His distress was so terrible that he had struggled to deal with the anxiety hopelessly by himself. He told me as follows: He watched his mind while he suffered this terrible distress. Then suddenly he realized that this terrible anxiety might just be punishment for a crime he had committed, and that the crime must be the one he broke into a new house just before its completion and drew obscene scribbles on the wall.

He brooded over, wanted to apologize for his deed and then confessed to his friend what was on his mind. Although some years had already passed since then, he had his hair shaved and went to the house with the friend to apologize. He had expected that his guilty feeling would disappear and that his agony would

be eased by this repentant behavior. However, he found that the house had fallen into other people's hands and the then owner had gone somewhere. He lost the key to solve the problem and was at a loss. But he said he felt a little relieved after telling me about this.

After that, he began telling me what things were in his mind. One of them was that there was a concrete figure of the crucified Christ in his mind-chest. He also said because of this he became equivalent to God and acted like God to everyone in the ward. He felt a sense of superiority and omnipotence, but he was also very fearful.

Because he was very worried that he, like Christ, may also have a hard time any moment, just like Christ was criticized, captured and crucified by others.

He could not tell if he was being punished or persecuted for his crime, but he was in agony at any rate.

Afterwards, he claimed that many people and I blamed him for being a Buraku people (derogatory and discriminatory term in Japan) and told me, "You have recorded our conversation on tape and allowed everyone to hear it and to distress me" and so on. He unfolded the so-called delusional transference in his analysis with me, manifested his anxiety and even calmed it down after having the hardest struggle with me.

By the time four years had passed since I started his analysis, he hardly needed the psychiatric cell or anti-psychotic injections to quiet down. His image as a brutal patient he used to have had disappeared completely.

But he began to tell me in a session, "It seems to be my fault that other patients are injected by the staff in the nurse station...and with this, these people inflict the hardest distress on me." And from what he told me in the analysis, it became clear that the act of he himself being injected carried a meaning not only of easing his own psychic pain, but also of being punished by the staff in the ward.

For him, at first some intensely anxious feeling was experienced as he did not find what it was. Although the feeling was experienced by himself, it was

“nameless dread” for him which he could not conceptualize. Because of this, it could not be treated and could not be calmed down by him at all. In the struggle of managing to calm the fear down, he tried to identify it as “guilt.” And his effort seemed to succeed partly. It seemed to ease his anxiety a little bit.

But in fact, this anxiety was too strong to settle in the concept of guilt. He tried hard to look around the inside of his mind to find his own guilt or sin (karma; in Buddhism) which deserved the punishment he thought he had suffered at that time. But those past and present experiences he found did not truly make him experience the real feeling of guilt which his mind seemed to have craved for.

Gradually the substance of his unbearable fear came to be known. The fact was that it was a persecutory feeling and annihilation anxiety.

In this way, the feeling experienced by him was not the real feeling which he could become conscious of as guilt itself. The feeling of guilt which he became conscious of was, as it were, “a facade guilt.” This guilt was what Money–Kyle, R. called a misconception (1968), or premature guilt.

[Interlude]

From “Kokoro,” a novel written by Soseki Natsume (Kokoro means mind in Japanese.)

“From then on, a nameless fear would assail me from time to time. At first, it seemed to come over me without warning from the outside shadows around me, and I would gasp at its unexpectedness. Later, however, when the experience had become more familiar to me, my heart would readily respond to it. And in the end, even though it wouldn't come from the outside, I would begin to wonder if this fear had not always been in some hidden corner of my heart, ever since I was born. Every time I had such a feeling, I would then ask myself whether I had not lost my sanity. But I had no desire to go to a doctor, or anyone else, for advice.

I just felt very strongly the sinfulness of man. It was this feeling that sent me to K's grave every month, that made me take care of my mother-in-law in her illness."

[Clinical Material 2] From the analytic psychotherapy of a middle-aged woman who suffered from several physical symptoms

This patient had already undergone analytic psychotherapy for two years before we met. We had once-a-week therapy and finished treatment four years later.

At the beginning of treatment, there were many difficulties between us. She blamed me for not taking care of her at all, not understanding her, and not trying to understand her, and I was always being blamed bitterly. Although she herself worked very hard to support her family while she suffered tremendously from several physical symptoms, everyone, including me, her husband, her mother, the patients she got to know, and even her children, would not try to understand her great agony. They were enormously greedy for her care, and because of their needs, she could not help taking care of them. She always had an impelling thought that life was really unfair. No matter how hard I would tell her about my understanding about her anxiety or loneliness, it was always out of touch and would not touch her emotions, so it was totally useless. At least, she kept telling me so.

However, on the other hand, we reviewed back on her hard experiences from her infancy. She kept crying while she recalled them. Among the many episodes she told, two stood out as being impressive.

One event happened when she was still very small, maybe about two years old, when she lived near the sea. A man took her offshore far from the beach and let her enjoy herself, but suddenly he said to her, "I'll abandon you" although she did not understand the reason why. It was a horrible and un-understandable experience of an unfounded threat.

The other was her experience based on tubercular peritonitis she had suffered

for several years since infancy. At the beginning, although she suffered from strong fatigue and severe pain, the home doctor could not diagnose the illness. So her distress was seen to be only just her fret and her mother kept blaming her as “a troublesome child easy to fret without any reason.” Three or four years later, she was brought to a professional doctor because of swollen abdomen. There it turned out to be tubercular peritonitis and she was immediately admitted to the hospital to undergo intensive treatment.

Later she improved and returned home. But when she occasionally had a fever and was absent from school, her mother, who was working at that time, left her with an acquaintance. She felt all the more helpless and lonely with a family she did not know. But her mother would never realize how the child felt.

Meanwhile, I kept interpreting her helplessness and loneliness that lurked behind her apparently arrogant attitude or her behavior of looking after other people to the point of sacrificing herself. She gradually began recalling these hard experiences during childhood.

The first memory she could recollect about her guilt feeling was told in the form of self-reproach that she did not sufficiently take care of her poor father who was dying of cancer when she was eighteen. When she said “I should have taken care of him more tenderly,” she was crying out of distress.

However, the origin of her guilt feeling which finally became clear suggested that such guilt and depressive feeling of hers were of persecutory nature.

When the cause of her pain was not identified yet nevertheless she suffered from abdominal pain and strong fatigue, her mother persistently regarded her distress as “your karma (gō, in Japanese : this is originally a Buddhist word that means one’s past bad deed before birth as a determinant factor in one’s after-birth life).” And after the fact that she suffered from tubercular peritonitis became clear, it was still regarded as her “karma” as before.

In this way, she came to blame herself as a bad child because she had tormented her mother with her own karma. This guilt which was based on the phantasy of “my bad existence is tormenting the others” was in fact the guilt feeling having

been forced or implanted to feel by her mother. She had suffered from “persecutory guilt” induced by her internal mother object.

When our therapy had made substantial progress, she was able to think for the first time in her life that it was her mother herself who had suffered from pulmonary tuberculosis and that her tubercular peritonitis was not due to her karma but probably infection from her mother. This idea had been something unthinkable for her.

In this way, her guilt feeling, now being sufficiently aware of and ascertained as to its true cause, became different from the previous persecutory one that had overwhelmed her strictly in a persecutory manner and forced her repeatedly and obsessively to take care of people as atonement.

The episode concerning her feeling of guilt for her father’s death which was recalled again at this point of time is interesting. At that time, she was the only member of her family who made time to visit her dying father in the hospital and eagerly took care of him.

One day she was too busy to have time to eat, and visited him in the hospital without having a meal. Unable to contain her hunger, she ate some food that was laid at his bedside while he was sleeping. He awoke while she was eating and accused her, saying “You come and visit me because of these food, don’t you?” Although she got very angry that her father did not understand how busy she was, she suppressed her bitter feeling by blaming herself for eating.

The story was re-told by herself with a new understanding, which showed that her feeling of guilt for her father’s death was based on this very episode. After she recalled this episode, she felt she did not have to blame herself unduly any more.

Gradually she came to abandon her lifestyle of self-sacrifice that cornered herself and abused her body, and she began to bring her own personal pleasures into her life. She made up her mind to divorce her husband and carried it out. Her husband had depended upon her like a parasite, gone astray with stimulants, returned home only on a whim, left her to owe a lot of money and to look after

children, and lived as his fancy took him. He showed no reaction even to their divorce procedures.

Through experiencing this fact, she looked back on her 20-year marriage and grieved that their life had never born anything that led to hope or creation. She also blamed herself that she might have robbed him of his chance to remake his life. However, this feeling of grief or blame was something she was able to contain in her mind without doing immediate pseudo-reparative act.

She abandoned the interpersonal relationship of self-sacrifice and established a mutual dependant relationship with her children and obtained peace of mind with a will of wishing for her own enjoyment and hope in a natural way, and in due course we finished her therapy. Her superego object now was no longer persecutory and a guilt feeling had become her own feeling.

In this case, she made me feel that I was the person who should feel guilt through her strong anger against me for not providing understanding and care to her, and also through her excessive reparative behavior such as self-sacrificing devotion and care for others. In this manner, her guilt feeling was appeased and excreted through her actions and therefore remained unconscious.

She became aware of her guilt through experience in the transference. At first, it was verbalized through the episode about her father's death, and it sounded as if it was a reasonable and spontaneous feeling of self-reproach. However, it gradually became clear that it was "persecutory guilt" forced onto her by her mother.

By working through this conscious persecutory guilt, she was able to mature it into "depressive guilt" which is not a feeling that is forced or implanted by the objects, but is a feeling of self-reproach that is associated with reality testing in her mind. Further working through of this depressive guilt is something she is expected to accomplish by herself from now on.

Incidentally, of special note about this case was that she had never informed me of any improvements of her symptoms until mid-way through her therapy after

many sessions had been accumulated. The deeper our understanding about her psychic mechanisms and her guilt feeling became through my interpretations, the more she complained to me about her worsening physical conditions. And in fact, she stopped working for a while, and finally became utterly terrified that her condition would worsen as to be irreparable both mentally and physically. And because of those fears, she tried to break off her therapeutic relationship with me.

Indeed, because of her agony and repeated complaints, I, too, felt seriously deadlocked and feared that we cannot expect any progress in her therapy with the therapeutic setting I offered. In other words, although I had the sense that the working through of her internal conflict was in progress, I wondered that, unless I could provide a setting that could more sufficiently contain her, I may end up throwing her down and her condition and anxiety may become irreparable, as she had said.

Such a therapeutic situation, though the degree of it is not too extreme, may well be regarded as a negative therapeutic reaction. This situation can be understood as a catastrophic event — in the therapy as a transference as a result of her increasing dependence on me which heightened her fear of unreasonable punishment if she would be thrown out suddenly by me — like her experience at the sea when she was aged two.

At first, negative therapeutic reactions were understood as the effect of unconscious guilt. It was confirmed by Riviere, J. (1936) — though she turned her attention to object relation in the form of “fear of being persecuted” whereby one would be blamed for damaging good objects in an internal phantasy world. However, Klein, M. (1957) also explained that envy is one of the primary factors which bring about negative therapeutic reactions, and Rosenfeld, H. (1971, 1987) focused on pathological object-relationship, or the so-called narcissistic organization, which contains envy and guilt feeling, as the main cause of negative therapeutic reactions.

As Bion, W. (1970) and Joseph, B. (1988) pointed out, a drastic transformation of the internal world inevitably implies some catastrophic experience with a sense of

annihilation. Therefore, when internal transformation is truly progressing, it might be said that we cannot avoid facing what we call a negative therapeutic reaction. In a word, it may be said that the outcome of therapy depends on how the patient can tolerate it and how the therapist can recognize, deal with, and contain it.

Incidentally, I have taken up this clinical material because the details of the therapy which I have not described enough in this paper, including the understanding and the handling of transference, can be supplemented by my other papers (Matsuki, 1995, 1996).

III. FROM GUILT IN CLINICAL PRACTICE TO ITS THEORY : A CONTEMPORARY PERSPECTIVE OF GUILT

I think I was able to describe some accounts of guilt which is unconscious and its process to become conscious in clinical practice by presenting some of my clinical materials. Now, I would like to go back to the theory again and try to match clinical practice with the theory of guilt. Klein, M., Bion, W., and Grinberg, L. (1978, 1992) have made especially great contributions to the following theories of guilt.

1. Preliminary thoughts : Time for guilt to be born

Before showing my view on the development of guilt as an emotion, I would like to briefly note Klein and Grinberg's perspective of the time when guilt is born in one's life history.

It is well known that Klein first considered the emergence of guilt in parallel with the appearance of a whole object at the depressive position. The period during the first 4–6 months of birth corresponds to this.

However, later, she revised her idea and referred to 'early guilt' saying, "Guilt arises during the first few months of life" (1948: 38) and "Depressive anxiety and

guilt already occur in the paranoid–schizoid position” (1960: 265).

Klein’s early guilt corresponds to Grinberg’s ‘persecutory guilt.’ Incidentally, guilt in relationship with whole objects in the depressive position corresponds to his ‘depressive guilt.’

Klein also referred to early guilt with the expression of ‘premature guilt’ in her paper, “Envy and Gratitude” (Klein, 1957: 194), that is, “It appears that one of the consequences of excessive envy is an early onset of guilt.” However, in this paper, I distinguish ‘premature guilt’ from ‘early guilt’ or, in other words, ‘persecutory guilt.’

I present ‘premature guilt’ as a result of the self prematurely misconceptualizing a persecutory anxiety as guilt, since I apply Bion’s thinking that premature realization prevents conception from containing its true meaning to the word ‘premature.’

Meanwhile, Grinberg, although he generally followed Klein’s ideas on guilt, believed that early guilt was already in existence from one’s birth. He said, “The very act of birth produces guilt” (1992: 83). He also said, “Persecutory guilt co–exists with persecutory anxiety from the beginning of life” (1992: 72).

2. Guilt in emotional development: A feeling of guilt and the capacity to have guilt

It is said (for example, Winnicott, D.W. [1954] and Britton, R. [1985]) that guilt feeling is one of healthy emotions that is accomplished through normal emotional development (especially in the phase of the depressive position). I also support this view.

Guilt as healthy emotion comes to be realized and appreciated correctly by an emotion of guilt which matures enough to become the contained being contained by the self as a container which now has the capacity to have such guilt feeling. Winnicott, D.W. (1958) took note of this container function of the self and expressed it as ‘A capacity for sense of guilt.’ In this connection, Klein positioned the period of experiencing a guilt feeling adequately as the phase of depressive position. A feeling of guilt that becomes problematic in our clinical work is the

one that takes on a pathological nature to some extent by the failure of the mating of this contained/container.

Here, I would like to briefly mention the vicissitudes of anxiety which is mainly based on Klein and Bion. A newborn baby begins to experience some different natures of anxiety in one's growth process in the following order (Matsuki, 1996).

What a newborn baby first experiences is a sense of annihilation–disintegration itself (a feeling of annihilation–disintegration as alpha elements) that carries no meanings yet. It is a feeling as if the self is about to disappear and break down into pieces. Gradually, the experience is recognized by the self and experienced as an anxiety of annihilation–disintegration.

As a consequence, the destructive–aggressive drive which induced this disintegrated feeling in the self is projected onto the objects to protect the self from the annihilation–disintegration of the self, and therefore the fear of self–destruction changes into persecutory anxiety (paranoid anxiety) that constitutes fear that these (part) objects might attack the self.

Next, a maturing baby experiences depressive anxiety (a feeling of guilt and grief) based on the realization that one has directed not only love but also hatred, hostility and aggression to the whole object (the integrated mother having both good parts and bad parts) which is recognized under the development of various ego functions and trust in the good part of the self. A feeling of guilt, which is included in this depressive anxiety, becomes deeper at around 4 months after birth when persecutory anxiety which reaches its peak during first few months diminishes, and peaks from around 6 months to the weaning period.

3. Persecutory guilt and depressive guilt

Depressive anxiety is what we call 'psychic pain.' One of the core feelings of depressive anxiety is a feeling of guilt and remorse for having damaged or killed good objects. But the ensuing feelings of loneliness, sorrow, helplessness and pining for a lost good object are sometimes too strong to bear.

From the point of view of developmental history, this difficulty is likely to

happen when the self has not yet matured enough to function as a container to contain the feeling of guilt.

As the self is immature, a feeling of guilt is experienced by the self as something very punitive and destructive. Or for some reason, this guilt feeling as the contained may in fact be too violent. In that case, the self as the container cannot contain this guilt feeling even if it has already developed somewhat. (Here I refer to the period during which a guilt feeling arises, the intensity of guilt feeling, and the capacity of the self which responds to it as a container.)

In those cases, a feeling of guilt that is expelled from the mind becomes an unconscious feeling, then becomes persecutory guilt which is felt by the self as being put into, forced, or implanted to the self by the damaged object. The feeling of this persecutory guilt is therefore repetitive and compulsive. In other words, since this guilt feeling is in fact put into by the object (an even more cruel superego object) and placed in the self only as a foreign substance that had been forced into, it is not given any opportunities to work through for assimilation, and brings about a variety of pathologies, for example, pathological depressive feelings or obsessive behaviors.

On the other hand, a guilt feeling that had developed properly and was brought in spontaneously into the self which had matured enough to contain this guilt feeling, is appreciated as depressive guilt by the self. It is appreciated as a feeling of self-reproach that is accompanied by reality testing. This depressive guilt is a feeling that is not put into or forced, but is continuously experienced in the container/the self, as one's own feeling. It nurses a feeling of self-reproach to contain a psychic pain, remorse and grief. It is why Japan's first analyst Kosawa (1932) named it 'a remorseful mind (Zange-shin, in Japanese).'

Then, based on a healthy guilt feeling having been formed in this way, feelings such as reparation, restoration, and concern for the object develop. This is the point which Winnicott had emphasized. Of course, ordinarily, this maturity process of guilt is fluid and matures while repeating the ebb and flow.

Even depressive guilt that had developed quite healthily might be expelled out

of one's consciousness, or be experienced as persecutory as the one forced by the object, when it cannot be tolerated. I illustrated two kinds of guilt, namely, persecutory guilt and depressive guilt, in Clinical Material 2. And as you see the materials illustrated in [Prologue] and [Interlude] correspond to persecutory guilt.

Establishment of developmental differentiation between persecutory guilt and depressive guilt based on Klein's theory about guilt is Grinberg's achievement. (1978, 1992)

He explains that a characteristic of persecutory guilt is that it is also directed toward the part of the self which is projected outward (as it were, is sacrificed) with a death instinct. He also says that its main feeling is resentment and rancor. On the other hand, he states that the main feelings of depressive guilt include concern, sadness, nostalgia and responsibility.

Incidentally, the natures of these two guilt feelings are almost equivalent to Kosawa's differentiation between 'the guilt perspective (fear of being punished)' and 'the remorseful mind,' and in this recognition, his idea was 32 years ahead of that of Grinberg.

4. Premature guilt

It also appears that a feeling of guilt may not be acknowledged in the inner world at the earlier underdeveloped phase where persecutory anxiety is dominant (paranoid-schizoid world).

In this period, though the feeling of guilt as the contained has not matured enough to be contained, the concept of guilt tries to contain it prematurely, and as a result, premature guilt, which is the disguised one, emerges. Therefore, the true nature of this guilt is persecutory feeling, or annihilative feeling. In Clinical Material 1, I showed this difficulty of realization of premature guilt and how it unfolds.

5. The developmental model of guilt

In this way, if we were to place the feeling of guilt on the developmental process

of an infant's drive, emotion and object-relationship, we can see that when it is not conscious, that is, when it is unconscious guilt, some different natures of guilt can be found and each individual internal situation brings about them. Therefore, it is necessary for us to investigate the nature of unconscious guilt which we come across in our daily clinical work.

Finally, as conclusive remarks, let me show the developmental vicissitudes of guilt rather schematically here.

A development line unfolds like 'premature guilt' (or 'disguised guilt'), 'persecutory guilt' (or guilt that had been put into, implanted or forced) being placed over the paranoid-schizoid as well as the depressive positions, and 'depressive guilt' in the depressive position, and the feeling of 'concern/reparation and gratitude' to the object.

Needless to say, the feeling of guilt of these natures, in the internal situation when the self cannot tolerate or contain, is expelled out of the self into each individual's unconscious phantasy and becomes 'unconscious guilt.'

IV. CONCLUSION

In this short paper, I have investigated unconscious guilt and emphasized the need to investigate it in the context of our daily clinical psychoanalysis. Based on my clinical experiences, I have explained that there is an emotional maturational process of guilt, be it conscious or unconscious, in a rather too schematic form.

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Ajase Complex and Its Implication

Keigo Okonogi

[I] Introduction

It is well known by now by most clinicians and scholars around the world about the psychoanalytic concept of Oedipus complex that was proposed by Sigmund Freud in 1897 basing on Greek mythological story from the West. However, it is rather rare for the scholars to be aware of the Ajase complex which has been suggested by Japanese psychoanalyst Heisaku Kosawa in 1932 based on the Hindu mythological story of the prince of Ajase. These two complexes, one derived from the West and another from the East, both address the deep-seated emotional complex relating to parent-child relationship, but with greatly different focus for the nature of conflict and resolution. They provide concepts complementary to wholistic understanding of parent-child bond. Thus, it is pertinent to this chapter in this book to elaborate the story and the nature of complex for theoretical comprehension of human nature with more broad bases.

One of the pioneer Japanese psychoanalysts, Heisaku Kosawa, in 1932, left Japan to study at the Psychoanalytic Institute of Vienna. After an interview with Sigmund Freud, he underwent training analysis with Richard Sterba under the supervision of Paul Federn. Kosawa returned to Tokyo in 1933, and took his first step as a psychoanalytic therapist by opening a private practice, as was customary in the West. He pursued this work from the 1930s until his death in 1968. During this period, Kosawa continued to assimilate Western knowledge from

international psychoanalytic journals, and applied his learning to the treatment of Japanese patients and his clinical experience with them. Kosawa's work led him to develop his own method of psychoanalytic treatment and his own theories, of which the Ajase complex is a representative example (Kosawa, 1953).

Kosawa early on gave close attention to the mother-child bond of early childhood, and was extremely attracted to the ideas of Melanie Klein about infants' oral sadistic phantasy to their mothers (1932). He accorded particular importance to the hate and resentment experienced by the child towards the mother, as well as to the child's oral sadism. In addition, he was strongly influenced by the methods of his former supervisor Federn in the psychotherapeutic treatment of schizophrenia, and noted the maternal function of the therapist. Kosawa gradually found it necessary to treat not only classic neuroses, but also what are now termed borderline cases. Owing to the specific nature of his Japanese patients and the treatment of these borderline cases, the question of transference and counter-transference with regard to preoedipal object relations became an important theme in Kosawa's theory.

The text concerning the *Ajase* complex which Kosawa presented to Freud in 1932 derives from the story of the Indian prince *Ajatasatru* as related in the Nirvana Sutra (introduced to Japan between 700 and 1000 A.D.) and The Teaching, the Practice, the Confidence, and the Realization of Shinran, a celebrated Japanese priest of the Kamakura period (1185–1333) (Shinran, 1966). Nonetheless, during the twenty years of clinical practice which followed his return to Japan, Kosawa referred principally to the Buddhist classic entitled The Sutra of the Contemplation of Infinite Life to elaborate his own original version of the Ajase story (1954). It is this story which forms the basis of the Ajase complex.

The Sutra of the Contemplation of Infinite Life is rare among Buddhist texts in that its theme is the salvation of the mother. The central character saved by the Buddha is *Ajase's* mother *Idaike* (The names of characters, places, etc., in the legend will be referred to by their Japanese equivalents). The following constitutes the essentials of Kosawa's version of the *Ajase* story.

The Story of *Ajase*

Queen *Idaike* was the wife of the king of *Bimbashara*, ruler of *Oshajo*. Worried that the love of her husband was fading along with her beauty, she came to ardently desire the birth of a child. The soothsayer she consulted told her a hermit living in the forest would die in three years' time, to be reincarnated in her womb. *Idaike*, however, was too anxious to wait three years. Obsessed by her desire for a child, she killed the hermit—who cursed her as he died: “I will be reincarnated as the son of the king, but one day this son will kill him.” *Idaike* became pregnant at this moment with the future *Ajase*. The Prince had thus already been killed once, owing to his mother's egoism. After becoming pregnant, however, *Idaike* grew to fear the resentment of the child in her womb (the hermit's curse) and gave birth from the top of a high tower, so as to drop her baby to the ground below. The infant broke his little finger, but survived. Young *Ajase* was therefore nicknamed “the prince with the broken finger.”

Ajase subsequently passed a normal, happy childhood. However, on reaching adolescence, the enemy of the Buddha, *Daibadatta*, revealed that his mother had attempted to kill him by giving birth from a summit of a tower. He added that if the Prince had need of proof, he need only look at his broken finger. It was in this way that *Ajase* discovered the story surrounding his birth. Disillusioned with the mother he idealized, *Ajase* was overcome with rage, and attempted to kill *Idaike*. However, the Prince's subsequent feelings of guilt led him to develop a severe illness (*ruchu*), which covered his body with foul-smelling sores. When no one else dared approach, it was none other than Queen *Idaike* who devoted herself to his care. Finally realizing that these ministrations had no effect, however, and confronted with the unhappy fact that her beloved son had attempted to kill her, *Idaike* confided her problems to the Buddha and asked for his counsel. The instruction she received led *Idaike* to resolve her emotional conflicts, and to devote herself to the care of her son. *Ajase* recovered from his illness to become an enlightened sovereign.

[II] The Fundamental Themes of The Ajase Complex

The *Ajase* complex, as understood through Kosawa's reading of the Buddhist legend, involves three themes which can be identified as follows:

(A) The Mother's Desires Both to Have a Child and to Kill Her Child

Idaike wished for a child, to protect her status as queen and to retain the love of her husband. Her desire pushed her to the extreme act of killing the hermit. However, believing that the hermit would return to life and occasion unhappiness, *Idaike* came to fear her child and considered abortion—then finally attempted to kill *Ajase* by giving birth from the summit of a tower. This story depicts the psychological state of a mother who, on the one hand, wishes for a child to protect her position or to satisfy her own desires. On the other hand, however, she does not want to give birth, and projects feelings of persecution and hate onto her baby to the point that she fears delivery or even imagines ridding herself of her child.

Borrowing the concept of Serge Lebovici (1988), we could say that this story describes the conflicts of the mother in relation to her “imaginary baby.” The mother's self-centered conflict—between an egotistical desire to exercise the right of life and death over her child, and paranoid fears of the imaginary baby onto whom she has projected her own egoism—has always been part of maternal psychology. In contemporary society, however, as the myth of maternal love is disbanded, mothers' conflicts have come into the open. The author will later note his experience of these issues in the Japanese clinic.

(B) Prenatal Rancor and the Child's Desire to Kill the Mother

From the moment of *Ajase's* conception, he experienced a fundamental rancor towards his origins: the resentment of the hermit killed by *Idaike*. We could say, in other words, that he was animated by the desire to kill his mother from before birth. In the Buddhist language of the *sutra*, resentment directed at one's origin is termed *mishoon*, or “prenatal rancor.” Kosawa compared the Oedipus complex

and the *Ajase* complex as follows. “Freud’s Oedipus complex has its origins in the conflict surrounding erotic desire, where the son loves his mother and feels rivalry toward his father. By contrast, the *Ajase* complex involves the more fundamental issue of one’s birth, or of how one came into existence.” He believed that the originality of the *Ajase* complex lay in its themes of matricide and prenatal rancor, in contrast to the Oedipus complex, which emphasizes incestuous desire and patricide.

If Freud considered the Oedipus complex as a primal phantasy (*Urphantasie*), the author believes that the *Ajase* complex also possesses a universal character. It is a psychic state that focuses notably on questions linked to one’s origins: the identity of one’s parents and the circumstances surrounding one’s birth. At the same time, the author would note that there are also socio–historical factors peculiar to Japan which motivated Kosawa to present his thesis on the *Ajase* complex to Freud. Notably, there exists in Japan a contrast between the outward idealization of the mother, and a socio–historic reality in which the mother was often forced to kill or “thin out” her children. The Japanese term of *mabiki* refers to the thinning of a rice field, and indicates the killing of children as a community practice, particularly during famines, as was common until the Edo Period (1603–1868).

Later, the author will give clinical examples illustrating how children manifest prenatal rancor towards their parents, and resentment and murderous desire towards their mother. This theme, incidentally, appears most often in the case of adolescents.

(C) Two Types of Guilt

The text concerning the *Ajase* complex which Kosawa presented to Freud was entitled, “Two Types of Guilt.” A context for this theme can be found in Kleinian (1945, 1946) discussions of the comparison between paranoid and depressive guilt, or of the movement for a punitive type of guilt to a reparative type. These two

types of guilt, and the defense mechanisms employed against them, are important structural elements of the *Ajase* complex.

[III] The Ajase Complex Considered from a Clinical Viewpoint

In this article, the author would like to examine the two fundamental themes of the Ajase complex noted above—the conflicts of the mother surrounding maternity, and the “prenatal rancor” of the child—in light of clinical cases the author has treated as a psychotherapist. Concerning the former, I will present the case of a mother with symptoms of maternal rejection; and concerning the rancor of the child, two clinical cases of adolescents.

(A) The Conflicts of the Mother Surrounding Maternity

Based on clinical experience, the author has noticed that more and more mothers exhibiting symptoms of maternal rejection have begun to undergo psychotherapeutic treatment in Tokyo. One of the factors contributing to this phenomenon has been the disappearance of these mothers’ traditional support system. If previously a woman’s own mother, or her mother-in-law, aided her in pregnancy and with childcare, this structure of family support has been lost with the phenomenon of nuclearization. The growing number of women in the work force, furthermore, has meant an increase in their responsibilities. In this type of new family, no system dictates who should aid the mother with the difficulties of pregnancy, delivery, and childraising. Furthermore, in Japan, there is as yet no custom of men emotionally supporting their wives.

In these circumstances, mothers’ anxiety concerning pregnancy and delivery, and accompanying symptoms of maternal rejection, have come into evidence. Another factor underlying this phenomenon may be thought to be societal recognition of women’s self-assertion. Both society and the family environment

now permit mothers who have experienced hostility or rejection toward their children to express openly their feelings.

There have always existed mothers who experienced a rejection of maternity. In the past, however, this rejection could be rationalized as corporal punishment or discipline. Today, by contrast, respect for children's rights, and the general recognition that mothers may not feel affection for their children, have resulted in an increasing number of patients in Japan who complain of maternal rejection syndrome.

Case 1 — The Ajase complex as seen in Mitsuko and her mother, who both exhibit maternal rejection syndrome

Mitsuko is a thirty-one-year-old housewife, who has been married for five years. Since her son was one year old, and her daughter three, she began to complain of insomnia and migraines, and harbored thoughts of killing her daughter. One day, in front of her children, she cut up her daughter's favorite doll with a pair of scissors. Mitsuko agreed to see a doctor after this event, on the advice of her husband. In this way, her individual psychotherapy began. As Mitsuko's mother also expressed the wish for a consultation in view of the psychic changes that had occurred in her daughter, I became her therapist.

Gradually, during consultations with her therapist, Mitsuko realized that she was hypocritical with her daughter. She also felt that her daughter was coming more and more to resemble herself at the hated time of her own childhood. In fact, her daughter incarnated all the aspects of her own personality Mitsuko detested. On seeing her daughter, Mitsuko would be seized by the impulse to banish this other self. She would scream, "Get out!" or "Go over there and leave me alone!" and criticized every aspect of her daughter she disliked. As she showered her daughter with reproaches, however, Mitsuko would be haunted by the apprehension that she was coming to resemble her own mother, whose anxious nature she found extremely oppressive.

Until she began treatment, Mitsuko was largely unaware of the negative feelings she held towards her mother. Rather, Mitsuko considered her mother to be a fragile creature, in need of protection from a cruel father and grandmother. Mitsuko's mother had passed the thirty-five years of her marriage waiting on her husband and two mothers-in-law (her husband's biological mother, and the mother's sister, by whom Mitsuko's father had been adopted while in college). Mitsuko's father, furthermore, very attentive to both older women, would not partisan the wife subject to their control. He was an extremely self-centered man, and showed no interest in the management of the household or his children. On arriving home, he would take up a book; when on vacation, he would go off by himself to the mountains.

Mitsuko's first pregnancy ended in a miscarriage, for which her mother-in-law reproached her as though it stemmed from some physical deficiency on Mitsuko's part. After this event, Mitsuko began to see her own mother as having sacrificed her own life, in spite of fragile health, to serve her husband and two mothers-in-law—and began to be profoundly irritated by this masochistic attitude. Mitsuko directed all her conscious feelings of anger towards her grand-mothers and father; towards her mother, she felt sympathy, and advised her on numerous occasions to divorce.

Thus, Mitsuko began by feeling herself in sympathy with her mother. She could not escape the idea that her mother was in danger of dying from some illness or of committing suicide, and that in order to save her mother, she must bring about her divorce. However, as her therapy progressed, Mitsuko became aware that behind these worries and anxieties on behalf of her mother lay feelings of deep resentment and animosity.

Once, Mitsuko mentioned that her mother suffered from stomach problems, and had undergone medical examination. At the time of our therapy, it was determined that Mitsuko's mother was suffering from benign polyps, rather than an actual disease. Although her mother accepted this diagnosis, Mitsuko expressed to her analyst the conviction that her mother was suffering from a

serious illness, perhaps cancer, and became distraught at the idea of her mother dying. She gradually recognized that behind her anxiety lay a hidden desire for her mother's death. If only her mother died, her own psychic burden would be lightened, and she would experience relief.

On reflection, Mitsuko realized that she had always been treated with more coldness and severity than her younger brother. Although she had endured her mother's strict discipline—telling herself that, as the oldest daughter, she must be obedient—she lived with the fear that her mother would die or leave her family. Behind her fears of abandonment lay an idea that Mitsuko's mother had transmitted to her daughter in non-verbal form: "If only it weren't for you, I'd be living happily with my little boy."

The moment at which Mitsuko began to experience unpleasant feelings for her daughter, and to treat her cruelly, coincided with the birth of her son. Mitsuko herself had a younger brother. With the birth of this son, her mother's position in the family had stabilized, as a daughter-in-law who had given birth to a precious heir. Mitsuko was thus in certain aspects burdened with the uncertainty experienced by her mother at the beginning of her own marriage.

As Mitsuko realized this state of affairs, she began to verbalize a "prenatal rancor" of which she had not been conscious. "If my mother was happy, why did she force herself to have me? It would have been better for her if I'd never been born."

Mitsuko's mother had kept a secret concerning the birth of her daughter. According to what was recounted to me in therapy, she had married into a family of illustrious politicians. Her husband considered himself the center of the world, and accorded no importance to family life or his wife. As her father and mother-in-law were extremely severe as well, she soon bitterly regretted her marriage. At the time, however, incompatibility was not recognized as grounds for divorce.

One day, she learned by chance from a family employee that several members of her husband's family had suffered from mental illness, or committed suicide. One

of her husband's grandmothers, for instance, had been psychologically disturbed. On thus discovering that her husband's family had a history of mental illness, she fled back to her own parents. Mitsuko's mother subsequently decided to divorce at once, fearing that a child conceived with her husband would be at risk of psychological abnormality. However, she was at this time already pregnant with Mitsuko.

Mitsuko's mother was torn between returning to her husband's family, and bringing her pregnancy to term, or having an abortion, and proceeding with divorce. As she hesitated, she lost the opportunity and her child was born. Mitsuko's mother feared constantly that her daughter would show signs of abnormality. Each time she fought with her husband, or was bullied by her in-laws, she would feel resentment towards Mitsuko, thinking, "I wouldn't be in this house if it weren't for her."

Mitsuko became an anxious child, from her earliest years continuously anxious and lacking in self-confidence. However, with the birth of the second child, a son, this socially prominent family was delighted with the appearance of a male heir. The atmosphere of the family, and the manner in which they treated their daughter-in-law, suddenly improved—so much that she began to have the genuine impression that the child represented a blessing, and to rejoice in the enviable privilege of belonging to this celebrated family. The stronger this emotion became, the more Mitsuko appeared a nuisance, and she began unconsciously to discriminate between Mitsuko and her little brother.

Mitsuko was unaware that, after she was conceived, her mother had agonized over whether or not to give birth to her. However, on becoming a mother, Mitsuko reproduced unconsciously with her own child the conflict her mother had previously experienced in relation to herself.

Ajase's mother *Idaike*, like the mother of Mitsuko, had desired a child to preserve her social status. After becoming pregnant, however, she had thoughts of killing her child, frightened by the hermit's curse and fearing that a misfortune would occur if the baby were born. For Mitsuko's mother, also, a child was necessary for a

secure position in her husband's family; however, at the same time, she wondered if her baby would be affected by a mental illness. The conflict experienced by Mitsuko's mother toward her daughter reveals psychological characteristics in common with *Idaïke's* conflict regarding *Ajase*.

Ajase became conscious of prenatal resentment towards his mother, and experienced a desire to kill her, after learning as an adolescent of the events surrounding his conception and birth. Similarly, before beginning therapy with myself, Mitsuko's mother had spoken to no one of the conflict experienced while she was pregnant with Mitsuko, and had repressed her feelings up until the time she underwent therapy, considering it to be her secret alone. Over the course of her therapy, she gradually recalled, and became able to verbalize, the suffering she had experienced at the time, concerning her choice between pregnancy and divorce.

In this sense, one can say that her mother's conflicts concerning the issue of whether or not to give birth had been transmitted to Mitsuko in an unconscious, nonverbal form. Mitsuko unconsciously passed on the rejection she had experienced as a child to her own daughter.

In psychiatric terms, Mitsuko's mother had neurotic ideas of a hypochondriacal type. One of these manifested itself in the previously mentioned symptom, a feeling of permanent heaviness in the stomach. Mitsuko's mother confided to me that this sensation had persisted for thirty years. During the course of our therapy, she underwent her eleventh exam by gastrocamera. Finally, after her treating physician diagnosed a case of stomach polyps, she had them removed by endoscopy.

After having undergone this minor surgical procedure, Mitsuko's mother confided to me that, for thirty years, she had suffered from discomfort in her stomach, which had begun with the birth of Mitsuko. This discomfort having finally disappeared, she also felt released from an emotional sense of ill-being that had endured for thirty years. It gradually became clear that this sensation of discomfort signified for Mitsuko's mother, the daughter she had wanted to abort but could not.

From this moment, Mitsuko's mother rejuvenated in a surprising manner, displaying at times the expressions or attitudes of a young girl. It was just at this time that Mitsuko believed her mother to be suffering from cancer and was seized by temporary panic. This situation which appeared in the course of therapy reproduced what had taken place previously, when Mitsuko was still in her mother's womb and her mother wondered whether or not she should have an abortion. For Mitsuko, her mother's stomach cancer was the child (Mitsuko herself) in her mother's womb. In addition, this fetus had the power to kill her mother. It is here that the aspects of Mitsuko's case most clearly linked to "prenatal rancor" become evident.

In this way, the mother's conflicts as they appear in the Ajase complex were vividly reproduced during the treatment of Mitsuko and her mother.

(B) Changes in the State of Women in Japan and the Transmission of Conflicts from One Generation to Another

In a family with feudal values such as her husband's, Mitsuko's mother had no choice but to accept the traditional role of a daughter-in-law. Her principal role was therefore to serve her husband's adopted mother; however, she experienced deep frustration at being unable to experience love in the context of a happy marital relation with her husband.

Mitsuko, who did not want to become like her mother, chose to make a "modern" marriage of love. However, after marriage and the birth of their first child, her husband devoted himself to his company rather than his family, and no longer took notice of his wife. On the surface, there had been a transition from a feudal-type family to one of a democratic, nuclear type. However, in light of Mitsuko's failure to find happiness in a family life centered on the couple, her mother's frustration had only repeated itself in an identical form. Furthermore, Mitsuko projected her frustration onto her daughter and became psychologically aggressive towards her, exactly as her own mother had done with herself.

Although at first glance the mother and daughter existed in culturally different family environments, at a deeper, psychological level, the mother's conflicts had been passed on to her daughter unconsciously, through a process of intergenerational transmission. This unconscious repetition and transmission between generations, I would emphasize, occurs in the deepest strata of the mother-child bond, transcending historical change.

(C) The Child's Prenatal Rancor

The second aspect of the *Ajase* complex involves the experience of the child, and centers on the issue of prenatal rancor. Prenatal rancor is the resentment experienced by the child on learning of the mother's conflict concerning his or her birth.

In the story of *Ajase*, prenatal rancor is represented through the metaphor of reincarnation. As a reincarnation of the hermit murdered by *Idaike*, *Ajase* was born with the resentment of a child already killed by his mother. Psychoanalytically speaking, *Idaike's* conflict between the desire to have a child, and the desire to kill her child, was unconsciously transmitted to her son. On reaching adolescence, he attempted in turn to kill his mother.

In the logic of prenatal rancor, a child must recognize the sexual union between the parents that resulted in his or her own birth. Seen in the context of traditional psychoanalysis, which stresses the child's need to accept that the mother is a sexual object for the father, *mishoon* involves the question of the primal scene.

Prenatal rancor furthermore involves a questioning and an investigation of one's origins: "Who were my parents?" "How was I brought into the world?" To answer the question of identity, one must know the circumstances of one's birth. It was in adolescence, when curiosity as to his personal history led *Ajase* to discover *Idaike's* conflict concerning his birth, that the Prince was overcome with prenatal rancor.

Moreover, while children are conceived between a mother and father, the responsibilities of pregnancy, delivery, and child rearing (or alternately of abortion)

are often imposed on the mother alone. The story of *Ajase* also illustrates the mother's suffering when the father offers no support with the emotional burdens of giving birth to and raising a child. The child's empathy for the mother's suffering, and anger towards the father, are other elements involved in the theme of prenatal rancor.

In clinical practice, those who manifest most vividly the prenatal rancor aspect of the *Ajase* complex are adolescent boys and girls. *Ajase* himself attempted to kill his mother on reaching adolescence. In this connection, the author would like to present the concrete example of the second clinical case.

Case 2 — Akira, who exhibits violent behavior at home and refuses to attend school, asked question: "Why did you have me?"

Akira is a fourteen-year-old boy in the second year of middle school. His mother is what is known as a "kept woman" (a concubine). His father has visited Akira and his mother for nearly fifteen years. Akira came under treatment because of school refusal and violent behavior at home. From the onset of adolescence, he suffered from his legal status as an illegitimate child and turned his anger on his father. Akira blamed his father for not having recognized Akira and his mother, and accused him of irresponsibility.

At this point in time, Akira's mother complained vociferously to her son that his father was a "sneak" who had deceived her, and that he did not carry out his promises. They were in their current predicament for this reason. Spurred on in such a way, Akira began to create disturbances when his father arrived, lashing out at him and behaving violently.

During the course of events, however, Akira's anger gradually turned on his mother, as he asked himself why she had given birth to him under the circumstances. When his father was not present, he began to criticize his mother for having given birth to a child when she could not marry. Furthermore, though Akira's mother fiercely abused his father when he was absent, when his father

arrived to spend the night, the two seemed to be on very good terms. The sight of such intimacy between his parents was intolerable to Akira, and only increased his anger. He would fly into a particular rage on feeling that his mother and father were, as man and woman, engaged in what he called “flirting.” He would become violent towards his mother, screaming “Drop dead!” or “You’re always complaining, but when Dad comes, you turn into a doormat and wag your tail, you’re glued to him. You make me sick!” It reached the point where he threatened to strangle his mother.

As a result of these incidents, Akira stopped attending school, although he had previously been an excellent, dedicated student. He shut himself in his room, saying that he hated himself and wanted to die.

I thus began joint therapy with Akira, his mother, and his father. Our sessions began with Akira expressing all sorts of doubts and frustrations concerning his parents, and proceeded as, in my presence, Akira’s parents took turns responding to their son and recalling the past. Finally, Akira turned to the circumstances surrounding his birth, asking why his parents had had a child when they could not marry. Akira was haunted by the belief that his mother’s pregnancy had been motivated by a desire to create a bond with her lover, an idea he eventually came to express. This aspect of the case revealed a very close resemblance to the story of *Ajase*.

Akira’s mother admitted to her son that such had been the case. She had been in love with his father, though unable to marry him, and—wanting to affirm her love and strengthen the bond between them—had decided to bring her child to term rather than undergo an abortion. In response, Akira accused his mother of irresponsibility, and demanded why she had brought him into the world; however, his tone eventually changed. That his parents (although they had certainly considered it) were unable to carry out an abortion meant in effect that they had been unable to kill him. Akira gradually realized that behind his desire to know why he had been born lay a wish to discover why his parents had not aborted him.

It became clear to him that they had not wanted to do so, and for that reason he now existed.

Furthermore, Akira's father explained that he had not intended to deceive Akira's mother—it was with the intention of marrying that the two had agreed to keep their child. If he had been a “sneak,” he would surely have persuaded Akira's mother to accept the inevitability of an abortion. Sincerely believing at the time that he would be able to divorce and remarry, Akira's father had wanted to have the child as a pledge of their love. In present-day Japan, however, if a man falls in love with another woman, he cannot divorce without the permission of his legal wife. Akira's father is still thinking of divorce; however, according to him, his wife and children remain opposed. (He spends approximately half the week with Akira and his mother, in actuality, and the situation is to some degree acknowledged by his legal family.) As he listened to his mother and father, Akira began to realize that, in comparison to families united only by formal law, real love existed between his parents, and between his parents and himself.

Akira's violent behavior came to an end over the course of these experiences, and the family's home life returned to order. He furthermore returned to school, where, having been gifted at the outset, he was swiftly able to readjust. Two years later, he entered high school with no difficulty. Akira is pleasantly leading an emotionally healthy life.

Considered from the point of view of Akira's psychological process, on entering adolescence and beginning individuation, the identification with his mother began to dissolve. This experience of separation led him to search for his origins, and to question whether his mother had become pregnant in order to strengthen her ties with his father. Furthermore, when she was alone with her son, Akira's mother behaved as though she lived for him alone, and abused Akira's father as a villain. When her lover arrived, however, she would do an about face and show herself as a woman, attaching herself to his side and behaving seductively. This double aspect of his mother was extremely difficult for the adolescent Akira to tolerate.

Among the reasons for which Akira's anger took the conscious form of prenatal rancor were the difficulties he and his mother experienced living on their own, and his anguish as an adolescent on becoming conscious of social disapproval of his family situation. However, a short period of interventional therapy sufficed to restore the unity of the family, and Akira's good relations with his parents.

In adolescence, many children feel deep anxiety over the circumstances of their birth, and confront the problem of their origins by searching for their true parents. These issues involve prenatal rancor. In searching to discover how they were born, how they came into existence, these children exhibit a fundamental resentment towards the roots of their identity: "Why was I born this way?" "Why did I have to come into the world under these circumstances?" This prenatal rancor is one of the fundamental themes of the *Ajase* complex.

[IV] Problems Concerning the Feeling of Guilt in the *Ajase* Complex

In the context of Buddhism, *Ajase* is most often presented as a scoundrel who attempted to put an end to his mother. Nevertheless, he became an enlightened sovereign after being saved by the Buddha. A clear contrast can be seen with the treatment of crime and punishment in the story of Oedipus. Oedipus, feeling himself to be guilty, condemns himself to a life of blindness and exile. He lives, in other words, with the burden of his crime. By contrast, *Ajase* is eventually cared for and saved by the mother he attempted to kill. Through the character of the mother, the story seeks to put in evidence the vast compassion of the Buddha, a compassion which leads to the pardoning of *Ajase's* crime.

According to Kosawa, *Ajase's* feelings of guilt undergo a change over the course of the story. His guilt first appears as a fear of retaliation for wrongdoing. In the author's opinion, this resembles the "punitive" or "persecutory" guilt described by the school of Melanie Klein (1946). After attempting to kill his mother, however, *Ajase* is frightened at the possibility of punishment and falls gravely ill. His

mother, however, not only pardons her son, but also takes charge of nursing him. *Ajase* then experiences a second type of guilt: not fear of punishment, but rather remorse towards his mother. This second type of guilt is close to what Klein terms “reparative” guilt. It is no longer clear at this date to what extent Kosawa was influenced by Melanie Klein, but the author would like to note that Kosawa’s argument dates from 1932.

The theme of a sinner saved by the Buddha, as it appears in the *Ajase* legend, is very familiar to Japanese. This dynamism represents the other side of human relations described by Takeo Doi’s (1973) concept of *amae*, and is important for understanding personal relations in Japan. One party forgives, the other feels remorse, with a resulting experience of mutual pardon. This world of mutual pardon is clearly illustrated by the *Ajase* story. The centrality of sutras such as the Kan muryo ju kyo (The Sutra of the Contemplation of Infinite Life) to the popular tradition, moreover, lies in this point.

However, the psychoanalyst Ramon Ganzarain (1988) has noted several defense mechanisms as regards the treatment of guilt in the *Ajase* complex. The first defense mechanism he cites is the “sharing” of guilt—by sharing guilt with another, one is discharged of responsibility. For instance, when the Buddha saves *Ajase*, he does so through the argument that he himself, by making *Ajase*’s father king, initiated the string of unfortunate events that occurred between *Ajase* and his parents. The teaching that no one person bears guilt alone, as all people are sinners, offers a salvation that erases the problem of guilt. This process is evident in any religion. In Buddhism, however, it is specifically linked to the idea of self-renunciation, to the concept that the limiting of guilt or sin to an individual is illusion: people’s crimes arrive rather from various karmic relations.

The second mechanism of defense is denial by rationalization or reasoning. From the psychological point of view of *Ajase*, the Prince is told a number of secrets concerning his origins that justify his attempted murder of his mother: a pattern which also justifies his anger towards her. In terms of a psychoanalytic

interpretation, it is important to understand that *Ajase's* inherent desire to kill his mother was rationalized and acted out by his learning the secret of his birth.

The third mechanism is confusion. The Buddhist world of salvation in the *Ajase* story, from the point of view of a Westerner such as Ganzarain, represents a state that should rather be termed "confusion." In this situation, no one is really guilty, and no one knows who should be blamed; everyone is saved by mutual identification. Elements such as individuality, subjectivity, and the boundaries of self, are erased.

Ganzarain's identification of various psychic defense mechanisms against guilt brings into sharp focus the difference between the author's own Buddhist interpretation of the story, and that of a Christian such as Ganzarain. Clearly, as a Buddhist, the author has the tendency to affirm and idealize to some extent the idea of salvation as it appears in the story of *Ajase*, and to identify with it. Ganzarain's attitude, however, which considers this form of salvation to be itself a defense mechanism against guilt, is more truly psychoanalytic. Although the author agrees with him intellectually, the author cannot disengage himself as easily emotionally. The author received a type of culture shock from this confrontation, which led the author to make many new discoveries.

Mutual pardon itself can thus be seen as a defense mechanism against guilt, and the acting out of anger and resentment towards one's parents on learning of one's origins, a mechanism to justify inherent aggression against one's parents. This view is clearly important to the treatment of adolescents. In this light, it becomes necessary to pursue discussion of "two types of guilt" in the *Ajase* story from the point of view of defense mechanisms as well as that of socio-cultural context.

[V] The Difficulties of the Mother Who Has Lost Her Husband's Support

Kosawa's version of the *Ajase* story focused on the conflicts between mother and child, particularly the suffering of the mother connected with the issue of

infanticide. When the author spoke to the well-known American family psychiatrist Theodore Lidz (1989) about the *Ajase* story, he suggested the following interpretation.

The tragedy of the *Ajase* story arises from the fact that—although the parents have together created, and should together raise, a child—the father does not assume his role and leaves the child's fate in the hands of the mother alone. In other words, Lidz suggested that the point of departure for the *Ajase* complex was the tragedy of the mother, as a wife or a woman, having lost the support of her husband or male partner. The author believes this is a very important interpretation. Lately, the author has thought of Lidz's insight as one of the important themes of the *Ajase* complex. Despite the existence of an Oedipal, triangular world of mother, father, and child, the mother is haunted by the idea that she must take responsibility for the child in an exclusively dyadic relation. It is the conflict between mother and child in such a relationship—where a split appears between the idealized mother who wields all-powerful love and control and the frightening mother who wields the right of death—that the author believes Kosawa attempted to describe with the *Ajase* complex.

If one approaches the problem from a cultural angle, The Sutra of the Contemplation of Infinite Life became central to Japanese Buddhism approximately nine hundred years ago. To give a brief historical overview, Buddhism, which originated in India, came to Japan in the sixth century by way of China and Korea. It was not, however, until the Kamakura period (1185–1333) that there appeared a type of Buddhism that could properly be called Japanese. Its founders, who included Nichiren (1222–1282) and Shinran (1173–1262), sought to establish a popular Buddhism removed from the Chinese philosophy which had characterized it up to that time. A topic of great importance in this popularization was the enlightenment of women, in particular the salvation of mothers. Behind this topic lay the issue of infanticide, practiced in the form of “selection,” or of abortion. The Sutra of the Contemplation of Infinite Life played an important part in assuaging the guilt of mothers who had killed or aborted their infants.

During the Edo Period (1603–1868), the population of Japan remained stable at between 30 and 35 million. This era was punctuated with many periods of famine, during which children were often killed by abortion or “selection.” Furthermore, in Japan, there has been the historical tradition that this responsibility falls solely on the mother. For this reason, the salvation of mothers who had killed or aborted their children became a central topic for Japanese Buddhism.

There exist in Japanese shamanism certain rites by which the deceased takes possession of a medium (*miko*) and returns to meet with the living. Among these rites, one of the most important is a memorial service for “selected” or aborted children (called *mizuko* or “water children” in Japanese), in which the child meets and pardons the mother through the intercession of a medium.

The author has thus far spoken of the *Ajase* complex in the context of the “maternal” society of Japan, where the phrase “fatherless family” has become common, and where the father continues to work outside the home while the raising of children falls to the mother. However, it might also give insight into circumstances in the West, which has recently seen the progress of feminism, and a growing number of single mothers (particularly in the Scandinavian countries).

[VI] On the Sources of the *Ajase* Complex

Japanese Buddhist scholars have variously criticized Kosawa’s use of Buddhist legend in his theory of the *Ajase* complex. They argue that whereas the *Ajase* story as it appears in The Nirvana Sutra and Shinran’s text focuses (like the Oedipus complex) on father and son and the theme of patricide, Kosawa transformed the legend into a story of mother and child. While these criticisms are not entirely unjustified, it seems to the author that one could, like Kosawa, arrive at a different interpretation of the *Ajase* legend by emphasizing the mother–child story of The Sutra of the Contemplation of Infinite Life.

In terms of constructing a psychoanalytic argument, various factors lay behind Kosawa's decision to emphasize the dyadic world of mother and child. First, he wanted to define the boundary of his theme: prenatal rancor and the question of origins, as opposed to the themes of the Oedipus complex. Secondly, he wanted to emphasize the essential resentment towards (and particularly the desire to kill) the mother harbored by every human being. Thirdly, he wanted to highlight the anger and resentment of the child confronted with the fact that his or her mother was first of all a woman, and that his or her own origins lie in the sexual relation between the parents as man and woman. Finally, Kosawa wanted to underline the tragedy of mothers who had lost the support of their husbands. In other words, he wished to show the conflicts mothers experience in relation to their children when no help is available from their own mothers or family with pregnancy and childraising.

In addition, it is not unusual for psychoanalysts, when using a story from the classics as a metaphor for their own insights, to select and expand on those parts consistent with their own ideas, while ignoring or omitting others. In the case of the Oedipus complex, for instance, attention has recently been turned to the parts of the Oedipus legend which precede those selected by Freud, and which describe the events leading up to the birth of Oedipus to Laius and Jocasta.

As punishment for various instances of misconduct, a curse was placed on Laius: should he produce a son, the child would bring about misfortune. Laius thus determined never to have a child. However, he became drunk one evening and had sexual relations with his wife. The child born of this union was Oedipus. As an oracle had predicted that Oedipus would kill his father, he was thrown into the river directly after birth.

Freud omitted this initial half of the legend, and designated the "Oedipus complex" only those conflicts experienced by the son towards his parents. If Freud had taken up the story in its entirety, several themes in common with the story of Ajase would have become evident. In Otto Rank's The Myth of the Birth of the

Hero (1909), there appear many tales and legends resembling that of Oedipus; however, all recount the story of the parents as it relates to the hero's birth.

It is this aspect of the *Ajase* legend, linked to the circumstances preceding the Prince's birth, that Kosawa extracted from the Buddhist texts to make his principal subject. This transformation allowed him to express his own psychoanalytic insights in the form of a metaphor. Kosawa's version of the legend, which replaced a father-child story with one centering on mother and child, reflected his perception of Japanese family relations, whereas it is possible to discern in Freud's theory of the Oedipus complex the impact of a Judeo-Christian heritage.

[VII] Final Remarks

It is interesting to examine the opinions recently offered by Marie Balmory (1988) and Marianne Krull (1988) concerning how, as he was in the process of formulating his theory of the Oedipus complex, Freud moved from a theory of psychic trauma to one of interior drives. They argue that Freud's discovery of the errors of his father (with regard to Sigmund's own birth), and defenses against this knowledge, played a role in the above mentioned transition.

According to these two authors, Jacob Freud (Sigmund Freud's father) was already married to a woman named Rebecca before marrying Freud's mother Amarie. While living with Rebecca, he became intimate with Amarie, at the time a young woman of twenty, who subsequently became pregnant. If Rebecca disappeared, or committed suicide, as a result, we can easily imagine that Sigmund might have associated himself with somber images in his parents' psychic world as their "imaginary baby."

If Freud had retraced the events surrounding his birth in an attempt to find his own roots, he might have read the Oedipus story as that of someone searching for his identity. However, must not there have been some repression or split in

Freud's psyche as concerned this theme? A reexamination of the Oedipus complex from the point of view of the Ajase theory might prove extremely significant.

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An object no longer being just an object — the art of not knowing, being alive, and becoming open

Naoki Fujiyama

An “object” that exists in a theatrical space

Back in my twenties when I was working as the director of a small theater group, I was very much into props. To be more precise, I loved, more than anything else, the special moment that a prop created, when an ordinary vase, a pair of eyeglasses, a bandage, or a piece of watermelon suddenly took on an unexpected and entirely new meaning. As director, I always relished such moments.

For example, imagine a man biting into a slice of watermelon. His wife has just left him. The man leaves a half-finished piece of watermelon on the table. A slowly brightening spotlight falls on the watermelon from directly above. Melancholic music is heard. Surrounded by this music, the watermelon is illuminated, and in comparison, the man fades into a dimly lit shadow. The watermelon thus illuminated remains a watermelon, technically just an inanimate “object.” However, this very “object-ness” comes to represent and magnify the man’s feelings of loss and loneliness, and as a result, transmits his pain and pathos to the audience more vividly. The watermelon thus lit up speaks more eloquently than words. At this moment, the watermelon completely eclipses the actor and has become the leading character in the drama.

Then, something strange occurs. The audience notices some juice slowly flowing out from the half-eaten piece of watermelon. They begin to perceive this

juice as something else: blood, perspiration, or even milk. When this occurs, the watermelon, despite being nothing more than an ordinary watermelon, or precisely because it is nothing more than an ordinary watermelon, transcends its state of being just a watermelon.

The art of “not knowing”

In 1912 Sigmund Freud coined his now-famous phrase, “Turn his (the analyst’s) unconscious like a receptive organ towards the transmitting unconscious of the patient (Freud 1912).” He always held on to this idea. Even in 1923, when he was about to make a major epistemological shift, he still wrote as follows:

Experience soon showed that the attitude which the analytic physician could most advantageously adopt was to surrender himself to his own unconscious mental activity, in a state of *evenly suspended attention*, to avoid so far as possible reflection and the construction of conscious expectations, not to try to fix anything that he heard particularly in his memory, and by these means to catch the drift of the patient’s unconscious with his own unconscious. (Freud 1923, p. 239)

If the process of psychoanalysis were to be recognized in this manner, then it means that analyzing a patient would not depend on any rational inference or logical thought, but on intuitive and primary process-like activities. This recognition that getting to know a patient is done only by way of the unconscious, isolated from an analyst’s consciousness, seems to imply that an analyst can never truly understand a patient consciously. This can also be rephrased as follows: **Unless we can open ourselves to having a conscious experience of “not knowing” or “not understanding,” we cannot fully take part in psychoanalytical activities.**

A clinical material

This middle-aged woman had a variety of clinical symptoms. They included chronic depressive state, near-total frigidity, a feeling of barrenness and emptiness that pervaded every aspect of her daily life, and chronic suicidal feelings that had almost become a part of her personality. As a matter of fact, she had made several suicide attempts. She had a professional career and was divorced. After trying all sorts of treatments for over ten years, she finally came to me. Her father had died when she was still a small child. She was raised by one relative after another; then, at the age of 10, she began living with her mother and the man her mother had remarried. She began psychotherapy with me twice a week lying on a couch.

She said, "If someone eats something he or she likes the most, for example, he or she would feel happy, right? But not with me. I can understand very well that it's delicious, and people tell me that I have sophisticated judgment when it comes to food. But I never feel that it's good or feel happy eating it," telling me clearly how her life was stripped of *joie de vivre*. What she had wished to gain from my analytical treatment was to restore in herself this "feeling of being alive." Perhaps the term "restore" is not appropriate, since as long as she could remember, from her earliest recollection, she apparently had never experienced this solid feeling of being alive, or joy, or desire (these were her exact words. She spoke mostly in a "literary" style). Nevertheless, she had continued working for a long time, and has achieved a certain level of success in life. She had not withdrawn from private interpersonal relationships, either. In fact, after her divorce, she had sexual relationships with a number of boyfriends. But she explained that she formed such relationships because "she didn't want to say no and hurt the other person." But when her partner left her, she felt almost nothing. Despite this, she said that if any of her partners had asked her to die with them, she felt she would be ready to at any time.

These interpersonal characteristics were also evident in her relationship with

me. During our sessions, she talked coherently, at least on the surface, about her work, her affair with her boyfriend or something. There were very few moments of silence. In this sense, it appeared that she was participating in the analytical process. However, when I commented about something she had said, she would immediately begin giving me an orderly but lengthy explanation about it, or claim that she didn't know much about it. She would begin talking again as if nothing happened. During our sessions, she did not experience any doubt, curiosity, perplexity, hesitation, or discovery—or, in other words, “drift.” What was more important to her was whether what I had said was the correct answer or not; if so, why; and whether or not she could discover the correct answer herself. In other words, the therapy room was like a school. But I myself was not aware of this situation and did not name it as such. Even if I referred to this approach of hers, she would just keep on explaining endlessly about why she lacked curiosity, for example. She was not participating in the analytic process with me as a “living person.” At the same time, however, she had idealized my treatment as being different from any of the treatments she had received until that time, although she could not feel it for sure. She felt that, if anything were to change, this treatment would be the only way to do it. This sense of knowing that there is some connection, but that she can never experience it as an actual feeling, was exactly the same as the relationship she and her husband had had during their 15-year marriage which ended in divorce. I of course interpreted the situation that way. However, she never “felt” my interpretations; she only handled them as information, something she simply “knew about.”

At the start of the third year of therapy, her manic-depressive symptoms had improved dramatically, at least symptomatically. By then, she was able to go to work almost every day. Still, her awareness of a feeling of emptiness, barrenness, and the lack of an actual feeling of “being alive” tormented her even more strongly than before. Her treatment continued to be deadlocked. I myself regarded her therapeutic status in those days as her dead world, or her dead life itself, floating in a therapeutic space.

Then, at one session, something occurred that broke this deadlock. Let me describe it in detail.

That day, as the session began, she started talking about her work in the usual animated manner, at least on the surface. I knew consciously that this rather compulsive blabber was a desperate effort to bring some life to her dead world. I already knew that it was useless to tell her what I felt. I was also vaguely aware of the pattern that existed: I had realized that my feeling of powerlessness to make any headway, and the feeling that it was desperately difficult to involve myself in her case, were none other than her own feelings that were being communicated to me through projective identification. At the same time, I knew that her attitude of “knowing and understanding everything” was itself part of her way of knowing everything and yet not experiencing anything at all, or, in other words, it was part of her dead world. I felt that, even if I were to say anything at that point, it would be only half-hearted and superficial. So, as a result, I could not say anything to her. It was also true, however, that my listening silently to her empty talk was itself an indication of my being drawn into her dead world. I had no choice but to reluctantly listen. I was locked inside a closed room. Her stories were something I “already knew,” so I was not really listening to what she was saying.

With a certain sense of emptiness, I absent-mindedly stared at the desk about 2 meters from my chair. My eyes eventually stopped at a photo stand placed on the desk, showing my daughter’s photograph. When I was not conducting therapy, I usually used the desk for writing. During therapy with another patient earlier that day, I had noticed that the photo stand, which ordinarily is placed at a position not physically visible by either the client or me during therapy, was somehow placed in a position where it would be visible to the client if she turned her head. I remembered that I had tidied up the place during my previous lunch break, had seen the photo stand, and decided to return it to its original place during the next break. However, I had forgotten to.

When I refocused my attention on the photo stand during my session with her, I

became aware of a strange uneasy feeling that suddenly got into me. I felt compelled to keep a close watch on her, to see if she would turn her head. Clearly, I worried about her seeing the photo. And I was beginning to recognize this uneasiness as something a little strange. I didn't feel this way with the previous patient; why was I feeling so uneasy with her? Would she get upset if she saw my daughter's picture? No. She had never shown any interest in my personal presence. This strange lack of response was something she and I had already discussed. She would tell me, matter-of-factly, that I was a physician, so she held no personal interest in me. But that particular day, I knew for sure that I felt uneasy, although I did not know why.

Shortly thereafter, I once again turned my attention to her story. She finished talking about her work and was now describing some tiny details of her personal life. None of these details interested me. As always, her stories were endless but well set out; it appeared that she was trying to make her talk as clear and as easy to understand as possible. Her talk did not appear to be spontaneous and created on the spot; it was well prepared and worked out beforehand, even if she was relating them for the first time. Her talk reminded me of lectures I gave at college.

Then, she began reporting a certain dream she had recently, which was relatively unusual for her, and something she had not done for quite a long time:

I and a number of other children enter a room with a wooden floor. I am in the lower grade of elementary school. The place looks like a school classroom. We are all sitting down, waiting for something. I am feeling as if I have come to the wrong place. So I go to another room, but there again, everybody else is seated. I find myself feeling that something is not right, but I cannot move because everybody is well behaved and quiet. I feel that I have no choice but to stay put.

Hearing this, I suddenly remembered that her father was a schoolteacher. I

had known this since long ago. However, until that moment, it was merely one of the many facts I knew about her. When I thought about this, I began to feel that this interview room was a school, and that she had been giving classes to students or telling them the correct answers. These ideas suddenly took concrete form. Come to think of it, this interview room also had a wooden floor.

At that moment, my almost exaggeratedly anxious reaction concerning the photo stand emerged from another perspective. My overreaction showed that I was reacting to the fact that she was beginning to view me as her father. In other words, I was unconsciously imagining that she might become terribly jealous on seeing my daughter's picture. I was worried that her feelings of love toward me, or her love toward her father that had been transferred, would be injured because of this jealousy.

In looking back, I realized that until that time, she and I had never fully discussed her father, who had passed away when she was about 5. He was merely some distant, half-imagined character who had appeared and then disappeared along the timeline of her life history. Even within her story, she only referred briefly to her father, saying that she remembered nothing about his face or when he died. She said that even if other people told her about his death, it meant little to her. However, I felt that maybe she was ready to talk about this subject because it seemed to me that now her father appeared not as part of a story but in concrete form.

I said to her that I thought that in the dream she was looking for someone other than the person whom everybody else was waiting for in the classroom and that she had a hunch that this person was her father, so she lost the courage to continue looking for him. She remained silent for a while, then responded with "**I didn't know about that.**" I realized that she said this a little differently from her usual flat tone. I then said to her further, "You and I have been seeing each other in this room with a wooden floor for the past two years. This is something I've come to realize now, but our sessions were like classes inside a school. It was as if you were teaching me something like a teacher, or me, a teacher, telling you, a

little girl, the answers. I can now actually feel that your father had been a schoolteacher. Like in your dream, you may have been coming here to look for your father. And in your imagination, deep in your mind where you are unaware of it, your father was somebody who would keep his daughter close by him, watch her tenderly and love her. That's the sort of a father he is in your imagination, I think."

Again, she remained silent. This may have been the first long silence since I began my therapy with her. The noisy world of empty words—a dead world—had disappeared. After a while, she said, "**I did not know** that I was thinking about my father. But I **feel** that it may have been so. I believe that ever since my father died, I've been restless and moving from place to place." She remained silent for several more minutes until time was up. I, too, sat there without saying a word, feeling that, maybe for the first time in her life, she was able to mourn her father's death.

The art of not knowing, being alive, and becoming open

This session illustrates our progression from my and her world in which "we knew" to the world in which "we felt." Although it was just for an instant, she definitely experienced sway and drift, apparently having succeeded in "coming to life" within this analytical session. The talkative world of death transformed itself into silence characterized by relaxation and depth. One thing that should not be forgotten about this phase is that such progression or change was basically brought about after I could "no longer understand" something. When I saw the photo stand on my desk and felt perplexed and anxious, I could not at the time understand my perplexity. Of course, it was my own perplexity, not anyone else's. Still, I was not able to experience me who was the person feeling this perplexity. I could not understand where this perplexity had come from, or what had caused it. Because of this "failure to understand," I experienced sway and drift.

Until this phase had come about, the world of my experiences was dominated, through powerful projective identification, by her suffocating ways of experiencing things, or, in other words, “understanding and knowing” everything, but not living and experiencing anything, and hence not being able to feel anything. As far as such part inside me was concerned, everything about the world was a given; a known. Like tombstones in a cemetery, the world was filled with endless queues of all the things that were known. At the time, I must have been living in her world of experience that was completely confined within her world of internal objects. Inside such a world, there was not a single new thing.

But when I became concerned about the photo stand and experienced perplexity about its position, I saw not my daughter appear, but my patient who had already manifested herself as my daughter. And that moment, I was not only me but also her father. In other words, the photo stand contained a daughter’s picture, of course, but also a picture of the patient, as a daughter. As was evident from the fact that I was not perplexed during my previous session with another patient but felt uneasy only when this patient was close by, after this session began, the photo stand had changed to a new, different photo stand. At this point, a new world was being created that was essentially different in nature from the suffocating and completely foreknown world of before, where everything was *déjà vu* and dead. And it was none other than the patient and I who had created this new world. The changed photo stand was evidence that a new world had been created.

This may also be described as follows. While we were confined to a dead world where everything was known and nothing could be felt or experienced, we were unknowingly making preparations to allow her father to appear in our therapeutic space. Our dialogues up to that point were decidedly futile and unproductive. However, this futility was clearing a space for giving the dialogues a different, more personal meaning. That is to say, things like school, class, questions and answers emerged, with the patient’s father quietly sneaking into them. It was only after we had unconsciously set the scene that she was able to dream about searching for her father in a classroom. My behavior of moving the photo stand

from its usual place, making a mental note of it, then forgetting to put it back to its ordinary position, had probably emerged because of it. Her dream and my parapraxis both came about, and took form, in the context of our therapeutic interplay.

Ogden (1994) proposed that, in the practice of psychoanalysis, a third subject—an analytic third—is unconsciously co-created by the analyst and the analysand, and that the subject of analytical experience is neither the patient nor the therapist, but this new subject. This concept was inspired by Winnicott's view that there is no such thing as an infant but only a mother–infant pair (Winnicott 1960), and is based on the view that, in the practice of analysis, there is no such thing as an analyst or a patient. There is a third person. And this third subject, while conducting a dialogue with the patient's subjectivity and the analyst's subjectivity, and while maintaining a dialectic tension, continues to live in the analytic process, and, as the subject of analytical experience, continues to create analytical experiences.

For example, my parapraxis about the photo stand, my ensuing experience of abnormally intense anxiety, and her dreaming experience, may be understood not as things I or she had simply created, but as an experience of the analytic third, a new subject. My parapraxis was not merely my parapraxis, and her dream was not merely a dream she dreamed. They were what this analytic third had done. When my subjectivity comes in contact with the experience of the analytic third, I feel that it is something foreign and therefore “unknown” to me. I become perplexed and anxious. And these fears, trepidation, and excitement are the very emotions that are behind the feeling of analytic discoveries. Seen from this perspective, the photo stand is something that was newly created as an analytic object by the third subject. The known fact that her father was a schoolteacher also made its appearance for the first time as an analytical fact.

I believe that what we analytical therapists should do is to give human form to the experience of this third subject. The premise for doing this, moreover, is to thoroughly accommodate, and savor, the interplay of our own subjective and

intersubjective experiences.

We receive intersubjective communication from a third person through reverie (Bion 1962, Ogden 1997). Reverie is not conscious reasoning or intentional recall; it is a spontaneous, temporary and vague thought process that is similar to daydreaming. It may sometimes take on an ordinary, everyday appearance that is simply meaningless, or it may appear as a notion lacking in context and beyond one's comprehension. More than anything else, we are not doing any active thinking during reverie. Instead, thoughts come floating into our minds in the form of ideas popping up, or inspirations, or passing fancies. We hardly ever think that we are the author of such thoughts. When an analytical therapist is lost in such reverie or contemplative thought, his subjectivity is being largely eroded. For example, as is clear from my reverie during the session concerning the photo stand, we have a sense of "thinking things by oneself," as well as a sense of passively being "merely a container for thought." What therapists should fundamentally do during psychoanalytic therapy is to open themselves to such erosion of subjectivity and to the experience of not knowing or understanding. Through this process, we give shape to the experiences of the analytic third via our human experiences. In other words, the experience of an analytic third can take on a "living voice" through our subjective experience of accepting such experience and giving human shape to it.

It appears that the concepts of "receiving the unconscious with the unconscious" and "evenly suspended attention" included in Freud's words quoted prior to this therapeutic material, touch on how the subjectivity of an analyst should be employed when talking with an intersubjective third person, with erosion of such subjectivity as the premise. Here, we experience this sense of "not knowing or understanding" what is happening, or what we are experiencing, or whose words we are saying. By not knowing or understanding things, we open ourselves to "drift." It is only by this drift and sway can a patient and a therapist "live" at that point.

In the context of our own reverie, we touch on the experience of the analytic

third and discuss it. As a basic rule, we analysts do not directly discuss our reveries. If we did, this would not only destroy the asymmetric elements that an analytic experience carries, or, in other words, destroy the basic premise that we deal mostly with the patients' inner world, but also jeopardize the indirectness of the analytic experience and turn the session into a mere forum for discussion or exchange of emotions. Analytic dialogue is by no means a play of catch between two human beings. With this particular material, I included, in my interpretation, my own reverie concerning the photo stand that contained my daughter's picture ("a father who enjoys seeing his daughter close by"). However, I did not mention it in my interpretation of the photo stand. An interpretation should be nothing more than the provision of views on a patient's world that is woven based on the imminent fear deriving from our experience of "not knowing or understanding why," or, in other words, from the swaying of recognition felt under analytical conditions. We should be extremely cautious about having things other than interpretations intervene in analytical treatments.

An object no longer being just an object

Let me return once again to the issue of "an object" in the context of such thought patterns. At the beginning of this paper, I described a moment when, because an object exists as an object inside a theatrical space, it suddenly transforms itself into something that is more alive than the characters in the play. The blood, perspiration, or milk which we, the audience, see in the juice of a watermelon, for example, is a product of our imagination based on our own unconscious fantasies. However, imagination such as this mutually interacts with the world of the drama that is performed. That is why, when we gaze at a watermelon while imagining such things, we simultaneously feel the state of mind of a man, no longer under the spotlight, being conveyed to us even more vividly than when he was at center stage.

The photo stand and the room with the wooden floor that appeared in this clinical material function in ways similar to the watermelon in this example. When we are living in an analytical space, our experience must be real. This reality coincides with what Freud (1916–1917) had referred to as “psychic reality.” The term psychic reality—reality that is not material reality—is at first glance somewhat self-contradictory. Things depicted in one’s mind, such as imagination, fantasies and thoughts, are essentially fabrications or pipedreams. For the proposition “This is reality” to be accepted with legitimacy, a substantial leap must be accepted. When the practice of psychoanalysis no longer becomes a fabrication, but takes on a certain reality or actuality, external objects and “things” become the source for providing that reality. By borrowing the externality of an “object,” we can, for the first time, come into contact with the reality that “being alive” entails, as well as the “unknowingness” that reality essentially carries.

For example, the anxiety and perplexity which I had felt vividly at the abovementioned session could not have been experienced if it were not for the photo stand, an external object, which contributed to opening a hole in the suffocating “known” world that was made up of her associations and my interpretations, creating a space for me to sway, drift, and immerse myself in reverie. These may be essentially related to Winnicott’s discussion on object destruction and use (Winnicott 1968).

We must not forget, however, that the reality that an “object” carries may destroy the therapeutic process if used in an erroneous manner. To return to my theatrical analogy, if our attention is drawn to the spotlight itself—an object—that sheds light on the watermelon at the key moment, we would be prevented from experiencing the emotional significance of that moment. An ordinary object presented as bare fact would dilute our theatrical experience, freeze it with chilling bluntness, and turn us off. It forecloses the object’s symbolic meanings from resonating each other. An object isolated from the intersubjective context of analytical experience is a foreign substance that obstructs the analytical experience. It may not open us to the analytic third that is the subject of the

analytical experience, and may even make our personal interests dominate the analytic space.

In practice, of course, we try to maintain physical stability in the therapeutic setting to prevent such foreign substances from appearing in therapeutic space. Just as a spotlight is painted black to make it less noticeable, we must design our consulting rooms in such a way to prevent objects from overly asserting themselves.

Things that may become analytic objects, or objects that are meaningful in analytic experiences, must provide sufficient “object-ness” within an intersubjective space. At the same time, they must emerge as a part of the experience of the analytic third, or, in other words, within the interplay of the patients’ and the therapists’ reverie.

This may be rephrased as follows:

In an analytic activity, a third person—a father in a sense—must appear within the context of the mother–infant (or therapist–patient) experience. At the same time, however, such a third person must take on an external aspect.

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Aggression: The Two Directions It Takes

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I. Introduction

The basic standpoint in dealing with aggression in psychoanalytic practice is the understanding that when aggression, which had been suppressed or split off, is consciously acknowledged as belonging to the self and duly integrated, it works as an important therapeutic mechanism. Aggression is evaded for various reasons. For instance, it is perceived as something extremely destructive, or feared as something dangerous that would lead to some fatal retaliation. But when it is gradually exposed and given ample opportunity to be contained in therapy, it becomes possible to consider it as a justifiable and acceptable mental element, and can be thus incorporated into the self as therapy progresses. However, in practice, we not infrequently encounter aggression that cannot be understood or dealt with from that basic standpoint. For instance, aggression may be persistently manifested in a definite, at times intense, way or may sometimes take an erotized form. Or, it could show itself every time signs of a good relationship with the therapist appear, as if in an attempt to crush them. They are quite often chilling and even rather perverted in nature, and not in keeping with the image of a justifiable mental element that can be considered a part of therapy. Such clinical cases seem to indicate the limits in our perception of aggression as a homogeneous phenomenon.

It is the intention of this paper to present the viewpoint of considering

aggression from two different aspects and to discuss it in a clinical context.

II. Self-Preservative Aggression: Aggression Directed at Persecutors

In many cases, aggression is directed at persecutors in the broad sense, who pose some kind of a threat to the self or to good objects. In the context of therapy, aggression is not only directed at actual outer threats such as inappropriate behavior or some failure on the part of the therapist, but it is also manifested when the patient experiences intrapsychic threats due to frustration and other causes. For instance, the therapist can be perceived as an irresponsible persecutor who abandons the patient and indulges in satisfying him or herself if he or she takes a holiday, even when it had been agreed upon beforehand. Such an attitude is illogical in terms of contract between the patient and therapist, but is quite comprehensible as the intrapsychic experience of the patient since it is directed at objects that are threatening.

Klein, through her abundant experiences in treating children, came to understand that aggression was an inherent element and had a different origin from libido, and that the human mind developed through the unceasing conflict between libido and aggression ⁸⁾. According to Klein, infants split off their annihilation anxiety derived from their death instinct, and project it onto outer objects in order to protect themselves. The object, in turn, becomes the persecutor and a threat, since it may actually work as the cause of frustration for the infant. The infant, pitting itself against the threat, manifests aggression by converting the death instinct remaining within itself. This is how aggression is considered to originate. It can be regarded as a healthy mental element that detects actual threats and takes measures to ensure protection for the self. In that sense, I would like to name it self-preservative aggression.

On the other hand, when, with the development of the ego function, infants are able to grasp the object as a whole, they realize that the aggression directed

towards their persecutors is also directed at objects which are the source of good experiences, and this induces serious anxiety. Klein clarified it by introducing the concept of depressive position ⁹⁾. I believe that this concept of depressive position is the most important in considering the clinical aspect of aggression. By working through this depressive anxiety, we therapists take on therapeutic assignments with the patients. In other words, the patient accepts the fact that he or she has aggression within, as well as the harsh reality that it can hurt their objects of love. They come to acknowledge that aggression is their own responsibility, that they must endure sorrow and their sense of guilt, and based on their suffering, be considerate of the objects and work to repair the damage, and thus nurture their ability to love; and as a result, they are able to control to a certain extent their aggressive impulse so that it is partly deflected to creative sublimation and symbol formation. In the process, we therapists act as the receptacle of projection for persecutory objects, and as a good object, are required to survive the aggressive attacks from our patients and offer ourselves for the patient's introjection.

III. Pathological Aggression: Aggression Directed at Good Objects/Relationships

In practice, we sometimes encounter situations where patients mercilessly direct their aggression at objects, or at relationships with such, that love them and provide them with good. It is fundamentally different from the abovementioned aggression directed at a persecutory object that results in involving a good object as well, since in that case the object is one and the same. With this kind of aggression, however, the object is attacked rather because it is the source of good experiences.

Freud was the first to take notice of these rather incomprehensible manifestations of aggression in therapy. There was a group of patients who expressed discontent when therapy provided them with satisfactory experiences,

which resulted in aggravation of their conditions. He named the phenomenon negative therapeutic reaction ³⁾ and believed it stemmed from unconscious guilt ⁴⁾, and further from the death instinct ⁵⁾.

Later, mainly Klein and psychoanalysts in her school studied this aggression directed at good relationships. Klein considered envy as the key to understanding the phenomenon. Envy is a destructive aggression that desires to spoil the good in the object or the good object itself. It stems from unendurable resentment against the object for possessing something good that they themselves want to possess as their life source. They cannot bear the fact that he or she has no choice but to depend on the object for the good ¹¹⁾. This aggression steeped in envy can also be directed full force on the self that perceives and deliberates the reality of the existence of such good objects, and seeks it. Bion refers to it as "attack on linking" ¹⁾.

Envy is closely related to the death instinct, and Klein defines it as the manifestation of the death instinct directed at the outside world ¹¹⁾. Segal, on the other hand, regards it as inevitably accompanied by ambivalent emotions, since it basically stems from admiration of the object's good qualities, and recognition and seeking of such as necessary to the self. She does not see it as something simply derived from the death instinct. She considers that the life and death instincts are fused together with the latter in an advantageous position, and describes it as one manifestation of the state ¹⁸⁾. Envy can certainly be said to be a composite emotional state, since, although it may be unconscious, one recognizes that the object has good qualities that one wants, while at the same time, one painfully realizes that one does not possess such qualities that one seeks and must depend on the object for them. In addition, it includes a defensive mechanism that schemes to destruct the good object and qualities, as well as the self that seeks them, in order to avoid the pain.

Envy is often accompanied by various forms of defensive mechanism, since acknowledging the existence of envy itself is painful and extremely unpleasant. However, Joseph points out that since envy and defense are intermingled and

appear in a variety of aspects, it is often difficult to discern where envy ends and defense begins ⁷⁾. She also mentions that when patients feel envy, they are usually not aware that the cause is the object's good qualities; instead, they often rationalize the attacks as legitimate criticism for the deficiencies of the object or some blunder it has made. She says that, in fact, the attacks seem appropriate since therapists are not perfect and every situation offers some grounds for criticism so that the fact that it is a manifestation of envy is quite frequently overlooked. The defensive mechanism for envy takes various shapes and often reinforces one another ^{7), 11), 16), 20)}. Envy is the core emotion in aggression directed at good objects and relationships.

Together with the study of envy, studies on intractable personality disorders and impasses in therapies have made a major contribution to understanding aggression directed at good objects and relationships. Rosenfeld and many other psychoanalysts have shown the existence of a defensive organization of the personality (pathological organization), which functions on aggression ^{2), 12), 13), 15), 17), 19), 21)}. The destructive aggression that oppresses the dependent self that seeks the object and tries to cut off any meaningful involvement with the object is a central theme common to these studies. Rosenfeld's study on destructive narcissism had an especially great influence in the field. It links the destructive element in aggression with the death instinct and discusses how it hinders personality growth and development, and obstructs therapeutic involvement. According to Rosenfeld, in cases of intractable personality disorders, the destructive and omnipotent part of the self becomes idealized, and the objects that are the source of good experience exposed to merciless attack, including devaluation, while the self that seeks the good object is considered weak, and either annihilated by narcissistic organization, which he calls a narcissistic gang, or taken in by the illusion of being omnipotently saved from pain, so that dynamic involvement with the object is severed.

Rosenfeld explains that an individual organizes this destructive personality structure in order to escape altogether the awareness of the separation between

the self and the object. It is because the awareness that they are separate immediately leads to the sense of dependency on the object, and the inevitable and accompanying frustration. It also violently stimulates envy. Steiner, who succeeded Rosenfeld and went on to develop his theory, called the psychological space protected by the pathological organization of personality, psychic retreat. He says that it is used to escape from the anxiety of the disorganization and persecution of the self in a paranoid-schizoid position, as well as from the guilt and anxiety over losing the object in the depressive position ²¹⁾.

When pathological organization is in control, libido does not help to counteract aggressive impulse as in a normal maturation process of the personality. Instead, as presented by Rosenfeld, it takes part in erotization, in pathological fusion with the aggressive impulse in domination, and becomes incorporated into the pathologically organized personality ¹⁵⁾. Therefore, the aggression manifested is extremely destructive, perverted, addictive, and pathological.

In view of the above discussions, I would like to name the aggression directed at good objects and/or relationships, pathological aggression. In self-preservative aggression, aggression is fully acknowledged by working through the depressive position and incorporating it into the self. However, in pathological aggression, it frequently hinders this normal development and maturation process, and therefore, can be regarded as pathological in this sense as well.

Now, in concept, it should be comparatively easy to separate pathological and self-preservative aggression. In actual clinical practice, however, they sometimes appear individually and at other times in an intermingled state. Pathological aggression derived from envy will also take on the aspect of self-preservative aggression towards persecutors so that it is not always easy to distinguish the two. The patients themselves are often in a confused state and cannot tell whether their aggression is directed at persecutors or at good objects. This, in turn, aggravates the excessive fear against the otherwise justified aggression and obstructs its manifestation, which then leads to failure of incorporation into the self. At times the attacks on good objects/relationships are

perceived as justified and persistently repeated so that the opportunity to incorporate them into the self and the resulting maturation of the self is lost, bringing about a futile situation. Clinically, it is, therefore, most important for the therapist to carefully distinguish the two types of aggression and share an understanding with the patient, and to work through the process of integrating it into the personality of the patient, while clarifying the defensive psycho-dynamics of the pathological aggression. During the process, the patient will need to have plenty of contact with self-preservative aggression and its actual consequences.

I would now like to further discuss the above viewpoint, using a certain aspect of one clinical case.

IV. Clinical Material

Mr. A was in his early thirties and came to me on recommendation. He had trouble controlling his impulse for violence and would be abusive to those close to himself. His use of violence on his mother and younger sister had continued since he was in junior high. He also had a ten-year history of being violent to Mr. B, his homosexual partner, with whom he was living. There were self-destructive behavior and withdrawal from society as well.

According to Mr. A, his father had extramarital affairs ever since he could remember, and by the time he was in junior high school, only returned home when the fancy took him. However, he continued to wield his power over the family, and used violence on his wife and Mr. A when he came home. His father was by nature rather tyrannical and violent, but when it was found soon after Mr. A entered grade school that he was nearly blind in one eye, his father became openly abusive towards the family. Up till then, he had had high expectations for his son's academic ability. But ever since, he began to beat Mr. A severely over trivial things, for instance, because he guffawed at a TV program or just

because he got engrossed in games and squealed. His mother did not come to his aid, and in fact, at times verbally and physically abused him in league with his father. With such parents, there seems to have been no other way but for his natural emotions to cower and freeze. At school he had to wear a patch over his good eye so as to train the weak-sighted one. He did not do well at studying and tended to lead a solitary existence even at school. In college, he at last found a comfortable niche in the realm of homosexuality. He described it as a world of fancy and told me that he found relief in fleeting involvements. After graduating, he took up several jobs, but could not put up with the inhuman nature of company structures and the unreasonable demands placed on him from his bosses, and ended up quitting, suffering from somatizations and persecutory phobias.

Unlike the horrific nature of what he related, Mr. A hardly showed any emotion and was deferential in demeanor and tone during the sessions. However, his destructive aggression exploded as early as in the middle of the diagnostic interviews. At the particular session, he began to relate how, since he thought of seeing a therapist, it had taken six months and four recommendations before he managed to work his way to me, and criticized and grumbled about, from his point of view, the unreasonable behavior of his former doctor in charge. As he proceeded with his story, I could see that he was trying very hard to repress his anger that was threatening to erupt. And that night, he smashed the furniture in his house, took an overdose, and was later rushed into hospital with burns. It seemed to me that he was unable to contain his anger once it welled up within him, and that he had to disperse the painful emotion in the form of violent excitement. He later described his feelings, saying, "The relief and joy at finally managing to work my way to you served to give vent to my anger." Every time he experienced vivid emotional contact with the object and felt there was empathy, his destructive impulse would well up, and Mr. A was to repeat this peculiar response all through the therapeutic process. Face-to-face interview sessions commenced at a pace of once a week, and was increased to twice a week about a year later.

At first, Mr. A was unable to engage in free association and had to come prepared on what he was going to talk about at the sessions. When he felt that he had exhausted his supply of subjects, he requested that I present him with hurdles for him to overcome, saying that a small one would suffice. He was afraid that he would not be able to maintain relationships unless he suppressed spontaneous emotion and confined it to a certain framework, i.e., unless, in his words, he made "robot-like" approaches. Also, he seemed to unconsciously associate me with his father, who beat him whenever he deviated in some small way from the father's intentions.

Although I repeatedly told him of my interpretations, we spent some six months in a rather awkward and stiff atmosphere. Then, at one session, he began talking about a tropical fish he had, with the introductory remark: "Do people talk about bizarre stuff? This really has nothing to do with anything." In free association, he told me how he had isolated the fish and was taking care of it, since it was growing weak. It was beginning to get stronger, which made him happy, yet at the same time he entertained something close to hatred for it, feeling that it would be better if it died since he did not want to see it in its weakened state, and he found this perplexing. My interpretation was that he felt he was gradually being healed through the therapeutic relation with me, yet probably found himself odious and weak because he was hoping for care from me and that a part of him wanted to obliterate himself. Through this exchange, Mr. A seemed to realize that there was a part of himself in his inner world that was difficult to manage by conscious control. He also seemed to experience a certain amount of relief and considerable surprise that I understood that inner world, and from then on did not come to the sessions prepared with what to talk about.

On the other hand, however, his sense of depression, anxiety accompanied by nightmares, and self destructive impulses became stronger. They became aggravated, including masochistic binge eating, excessive clipping of his hair, and leaping from high staircases, which sometimes resulted in minor injuries. They could indeed be labelled as negative therapeutic reactions. He also told me

about setting traps to lure people, and when they fell into it, how he jeered at them as fools. He called himself a schemer. I found it sad that it was the only way he could relate to others. My interpretation was that he had to warp his desire to involve himself with objects into sadistic and scheming attempts. Mr. A nodded in agreement and the atmosphere relaxed somewhat. But at the next session, he appeared with even closely cropped hair, telling me that he had felt better at the last session, but had been attacked by anxiety the moment he left my office and had gone straight to the barber's.

Now, how should the above be interpreted? My view is as follows. It seemed to me that Mr. A's self that was hurt and sought relationships, and which existed under his robot-like superficial stance of distancing himself from emotional involvement, did indeed come in contact with me at this moment, however brief it may have been. His expectations towards objects, which had long been exiled to a forgotten corner of his mind, must also have been faintly roused. At the same time, however, there existed a powerful part of himself that was wary of traps and threw cold water at attempts to link with objects. It could indeed be regarded as the comeback of pathological organization. As a result, the object-seeking part of the self had been projected as a fool into outside objects, including myself, and Mr. A had succeeded in placing himself as the sadistic victor who laid traps for such foolish objects. However, my interpretations had brought back the object-seeking part of the self into him so that he had attacked it in concrete form by clipping his hair. The series of aggression shown here is exactly what I mean by pathological aggression. In other words, whenever there are signs of trust and closeness with the object, anger and hatred will well up, so that destructive aggression is directed at the object and the object-seeking part of the self. Mr. A and myself gradually began to feel the presence of this unreasonable psycho-dynamics.

At this time, when about a year had passed since the therapies began, I proposed that we increase the sessions to twice a week. Mr. A, who had wanted to come twice or more a week from the beginning, welcomed my proposal, but it

took time to arrange our schedule and it was not until two months later that we were actually able to increase the weekly sessions. At one session, during the transitional interval, he began to relate, in free association, an incident at a dinner party held by the sports club he belonged to. He had had to tidy up the venue for the sports meet held prior to the party, and arriving late for dinner, he had, on request, agreed to give up his place for a man who had arrived earlier on. However, the table where he sat instead, obviously had only leftovers; moreover, he had had to listen to the man's sarcastic comment every time the man passed him his food from the new table. Mr. A found it difficult to suppress his fury at the unfairness. I sympathized with his actual indignation and situation, then gave him the interpretation that there was anger directed at myself, who in spite of proposing sessions twice a week, could only provide leftover time for him, which he could not eat (use), forcing him to be aware of his own hunger and desire. Mr. A denied this, saying that he was not conscious of such feelings, but then acknowledged that it may be because he was repressing something that his body felt flushed. His anger was the manifestation of self-preservative aggression directed at the therapist, who was the cause of his frustration and posed a strong threat, but he was unable to acknowledge it nor direct the anger at me.

There was a national holiday and we had to skip a session. Then Mr. A cancelled the next one, giving urgent business as the reason. Showing up after a three-week absence, he told me in free association that his hate and fury towards his lover had grown worse as if in inverse proportion to his increased trust and love for him, and that he had been frequently yelling at him. He also reported that he had removed the partition that had separated the weak fish and let the stronger ones devour it. At this, a feeling of utter disconsolation fell upon us. My interpretation was that the self that loved and depended on me and his lover, must have seemed to him to be miserable and despicable like the weakened fish, and that he must have thought it was the easier way out to get rid of it. Still looking gloomy, Mr. A told me he couldn't tell himself, then went on to say that he very much wanted to talk to me during the three-week break, at the same time

hating himself so that he had violently banged his head against the wall many times.

At the next session, he told me he was scared that his increasing aggression would be turned on his cohabitation partner, his lover, and his therapist (myself), and that he would end up injuring or killing them. Ever since the therapies had commenced, I had in fact continued the sessions feeling more than slightly apprehensive that he would attack me someday. He said that he couldn't fathom the feelings of the objects (his cohabitation partner, his lover, and myself) who would stay at his side in spite of being threatened with his destructive actions, and that he was infuriated by the fact that, while he found it impossible to maintain himself, other people accomplished it despite being plagued by emotions. He realized that he was now inflicting on the objects the pain he had suffered by the senseless violence of his parents.

The next session was just before the start of the New Year holidays, and in free association, Mr. A told me that his sister, in a fit of unbearable loneliness and insecurity, had called him many times. I pointed out that it was a projection of his own insecurity and loneliness with the holidays looming up. Then Mr. A, in an earnest manner quite new to him, wished that I would at least accept e-mail when he felt insecure, stating his demand and dissatisfaction.

V. Discussion

There existed within Mr. A deep wounds from the unreasonable violence inflicted on him by his father, and at times his mother. He had been overwhelmed with terror, and plunged deep into unhappiness where all urges for seeking were denied. He was alone in a dark place where he could not call for any help. His description, "There was nothing for me to do except to withdraw my hand that came back all bruised and with which I had reached out for my parents," symbolizes the reality of his inner situation. He had resorted to

defensive denial of his wounds, by a thorough annihilation of the object-seeking part of the self, and by the use of perverse methods, projecting it into objects and scheming to lure them into taking an interest in him and then jeering at them as being complete fools. His way of relating with people was frequently practiced on me. Even when he partially experienced the joy of his inner world being understood by me and felt that our relationship had deepened, he found it impossible to savor the situation. He aggravated the attacks on the object-seeking part of the self that sought me by actually inflicting bodily wounds on himself, or tried to experience the deepening of relationship with a good object as something of no value by regarding it in a warped way as a trap that the scheming Mr. A had set and into which I fell. Pathological aggression was at work here, persistently directed at relationships with good objects that should have been sought for as having value for the self.

On the other hand, he could not frankly express or experience as they came, the frustration and indignation he felt towards me when I took a holiday or failed to arrange therapy sessions that would be convenient for him. It seems that he could only resolve the self-preservative aggression he had for frustrations by mingling it into pathological aggression, for instance, by loosening the irrational hatred and fury he felt towards his lover for whom his trust and attachment had increased, or by intentionally letting the weakened fish, which needed protection, be killed. It was because, if he let himself fully acknowledge and feel his frustration, it would mean that he would have to face up to the reality of needing and depending on me, which would kindle his envy. Identifying himself with the inner father, who was tyrannical, destructive, and seemingly omnipotent, promised by far a speedier alleviation of pain for Mr. A.

It was important for me as the therapist to detect the pathological elements in the persistent attacks directed at others and himself and to delve into the psycho-dynamics behind them. It was equally important to distinguish and pick up the self-preservative aggression which was frequently intermingled in warped forms, so as to show that they were important psychological experiences that

could be understood.

Through therapeutic involvement, Mr. A began to accept the object-seeking part of the self, and by experiencing his attachment towards me and the frustration he felt when I failed to respond adequately to his wishes, he was gradually able to express his emotions. It was an interesting change that later on, as he became fully aware of how deeply he had been hurt by his parents' senseless abuse, and realized that he had been trying to revenge himself by identifying with the inner sadistic father and projecting the abused self into the objects, Mr. A was able to control his pent up emotion and not to manifest it in actual bodily abuse at the objects or the self.

VI. Conclusions

The integration of aggression into the self can be said to be the most important work—and one accompanied by the greatest pain—in the development process of an individual as well as in psychoanalytic therapy processes. In this paper, I have presented the view and discussed that it is clinically meaningful to consider aggression by distinguishing it into two types by the objects it is directed at, namely, self-preservative aggression directed at persecutors in the broad sense, and pathological aggression turned on the relationships with good objects. Using one clinical case, I have shown that it is the most important exercise in clinical psychotherapy to carefully distinguish the two types of aggression and to work through to incorporate the former into the personality, while delving into the defensive mechanism of the latter.

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Borderline Research in Britain and a Case Report

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BORDERLINE RESEARCH IN PSYCHOANALYSIS

Since most clinical research on the borderline concept in Britain has been done by psychoanalysts and very little indeed by psychiatrists⁵⁾, the author will focus on the work of British analysts, on the field of the borderline syndrome.

J. Rickmann⁹⁾, a psychoanalyst, is said to have been the first to turn his attention to latent psychosis in Britain (borderline or masked schizophrenia, 1928). Later, in 1959, W. Bion¹⁾ seemed to have borne this concept of latent schizophrenia in mind when he formulated his concept of Borderline Psychosis. Then in 1966, M. Little⁶⁾ discussed how to treat patients suffering from Borderline States and Borderline Psychosis. These concepts which include both neurotic and psychotic states, describe patients presenting with psychotic transference.

In the late 1960s Kernberg³⁾ et al. in the US proposed the concept of borderline as personality organization, yet it had at first very little impact in Britain. It is not until the late 1970s that therapists, mostly psychoanalysts, turned their attention to Kernberg's concept. Most prominent among them were H. Rosenfeld¹²⁾, H. Rey⁸⁾ and J. Steiner^{13), 15)}. Steiner, in particular, developed his own theory of borderline cases.

British psychoanalysts have been doing their own personality research since the 1940s. Although the concept of borderline is hardly used at all, patients similar to the American borderline cases have been studied according to different

diagnostic concepts. And it is well known that their research has influenced Kernberg's, Masterson and others' borderline personality researches.

Namely, D. Fairbairn's study of the Schizoid Personality²⁾, D. Winnicott's study of the False Self⁶⁾, M. Klein's study of the Depressive Position and the Paranoid-Schizoid Position⁴⁾ can be said to cover borderline cases in Britain. As their research is already well-known, I will limit myself here to introducing those British analysts who actually used the concept of Borderline in their clinical work and made the greatest contributions to recent studies on the subject.

H. Rosenfeld^{10),11),12)}

Together with Klein, Bion and Segal, he began psychoanalytic therapy of schizophrenics and severe neurotics in the 1950s. And in 1977, he discussed the problems involved in the treatment of "Borderline" cases.

Rosenfeld agreed with Kernberg's Borderline Personality Organization concept as well as with the idea described by Kernberg, that primitive object relations were activated. Rosenfeld particularly stressed the fact that to understand borderline patients who have fallen into psychotic transference, it is important to understand the persecutory role of the superego in their internal object relations.

Rosenfeld does not base his theory and understanding of such borderline cases on Klein's two-position theory only, but also largely on his own research into the narcissistic organization, i.e., the defensive organization which is encountered in severely neurotic as well as psychotic patients.

More specifically, Rosenfeld thought that in Destructive Narcissism, the self idealized the destructive part of itself as the "destructive self," and that part of the self would attack the other parts as if it were a violent gang. There, the individual completely destroys the self that seeks an object and yearns for dependency, refuses any help from that object which he devalues and thus cannot see the true value of. When in the course of the therapy, the treatment begins to go well, such patients often suddenly become self-destructive, turning to crime, attempting suicide, etc. Such patients obviously answer Kernberg's "Borderline"

concept.

J. Steiner 13), 14), 15)

In 1979, Steiner actively took up the question of borderline cases, discussing them from the standpoint of Kleinian theory. He hardly touches upon the issue of diagnosis and seems to accept Kernberg's borderline concept as is. He merely states that symptomatologically, borderline cases stand between psychosis and neurosis and does not go any further into the diagnostic debate.

He did stress that from a pathological standpoint, borderline cases stood halfway between Klein's "paranoid-schizoid" position and "depressive position," unable to progress to the "depressive position." Such people cannot bear the pain of losing the object or separating from it, and try to return to a state close to the "paranoid-schizoid position" whereby they can avoid the painful world of reality. Important here is the fact that Steiner stresses the existence of a third "borderline" position halfway between the two positions.

Steiner developed this idea further in a 1987 paper in which he introduces the concept of Pathological Organization. This concept integrates Rosenfeld's theory of Destructive Narcissistic Organization and Steiner's borderline theory in 1979. This Pathological Organization has two characteristics: first, the "bad" self part attacks the other parts of the self second, this organization centers on what should be called the Third Position existing halfway between the paranoid-schizoid position and the depressive position. This organization has partial object relations and defense mechanisms very similar to those of the paranoid-schizoid position (splitting, projective identification, denial, omnipotence, etc.), but although very much like the paranoid-schizoid position, it differs from it in that it is actually more defensive, resisting change and refusing healthy development.

Steiner sees this Pathological Organization in patients presenting with such personality disorders as drug addiction, homosexuality, etc., and in the inner world of Borderline patients.

As we have seen above, Steiner not only accepts the Borderline concept, but also develops his own theory within the Kleinian theoretical frame of reference. He also clarifies his theoretical standpoint within the Kleinian school regarding the defensive side of Borderline cases and its pathological structure. And the author, Kinugasa, bases his clinical practice on Steiner's theory and methodology.

Although Steiner is of the opinion that standard 4 or 5 times a week therapy should be applied, he also thinks that weekly therapies can be beneficial to many borderline patients.

METHODOLOGICAL ISSUES

The clinical work of Kleinian analysts consists in understanding the unconscious, inner meaning of the patient's gestures and verbal expressions, their acting out, etc., how they defend themselves against the "psychotic anxiety" and "depressive anxiety" of the two positions and how these are expressed. They also turn their attention to the defense mechanisms, etc., of the Pathological Organization proposed by Steiner which they actively interpret. Through appropriate verbal interpretations, the analyst will help the patient overcome the conflict of the depressive position and become integrated.

The same therapeutic course should be followed with borderline patients, the main objective being to make the patient aware of the anxiety of the paranoid-schizoid position and of the depressive position which the patient splits off, thanks to the destructive impulsive Pathological Organization characteristic of borderline patients.

The biggest problems with borderline patients are their extremely destructive acting out in and out of the consultation room, the problems created by the psychotic transference which may go so far that the therapeutic structure can no longer be maintained, and the possible occurrence of situations requiring hospitalization. Actually, the analyst often has to get help from psychiatric

hospitals or other psychiatrists. This raises the question of limit setting, of how to maintain the patient's therapeutic structure, and of how to make the patient talk of his self. These are the most typical and difficult problems involved in the treatment of borderline patients, problems which we find in all countries.

CASE

Let me now report on a clinical case based on Steiner's theory and methodology. The patient, a 26-year-old Japanese bachelor, has been suffering from "one's own gaze" phobia and depersonalization for 10 years. Treatment consisted of weekly, face-to-face therapy on an out-patient basis.

<History of present disorder> He began to feel that he had a fierce look when he entered high school which made other people shun him. Distressed, he would as much as possible avoid other people's company. But he somehow managed to get on with his studies and to enter university in spite of his symptoms of depersonalization. But his symptoms then worsened rather than got better and although he did his best to study, he ended up dropping out. He changed jobs a number of times, looking for one where he would not have to meet people. During that time, he tried a number of treatments such as hypnosis, autogenic training, etc., to no avail. Having recently read in the newspaper that psychoanalysis was effective, he himself asked for psychoanalytic therapy.

(1) Anxiety and Ambivalence during the Introductory Phase (First 3 Months)

At the beginning, the patient would relate extremely long dreams, and spend almost the whole sessions on those. As by relating those countless dreams, he might have been avoiding talking of his inner world and merely complying superficially with the treatment, so I asked the patient why he was telling me all those dreams. He replied that he was doing his best to relate his dreams because he thought that was the best way. He stopped concentrating on his dreams after

that.

The patient would say that only the principal could deal with a strike at his school, that there must be few real analysts, thus expressing how unreliable the therapist's ability and his ability to deal with the problem were. On the other hand, he began to feel that the therapist understood him and that only this treatment taught him who he was and started verbalizing these ambivalent feelings. Moreover, the patient remembered a scene where his father was crying, asking his mother for something, saying that he was probably asking her to have sex. He then recalled his father getting angry with him for watching. What he is saying there is that the therapist is also a despicable and unreliable creature provoking Oedipal envy, with therapy expressing his lack of confidence in, and doubt about, the therapist as an object of dependence.

In the next session, the patient told of how his parents were very strict about manners and how his mother fussed over him but actually had no real affection for him. He talked of how his sense of depersonalization became very strong when he was in junior high school, and could not believe he had had such feelings for his parents, after that he complained he could not remember anything, even things he had just done. The therapist interpreted that it was very difficult for the patient to realize that he felt such resentment and anger towards his parents and that these feelings had gotten all the stronger because, being in therapy, he had begun relating his inner world.

The patient who lived with his mother, felt terrible when he realized that the girl who he was in love with was the very image of his mother, and related a dream where he had sex with his mother, telling me of his fear that he could not deal with this sort of relationship. Confusing Oedipal sexual love and dependency, presenting strong feelings of depersonalization, etc., he clearly demonstrated a borderline personality organization.

In the following session, he said that weekly face-to-face sessions were not enough. He also told me of how he had stolen money from his mother when he was a child. He thought that he had started life on the wrong foot because nurses kept

telling him repeatedly that he was cute when he had been hospitalized for some reason or other, and that had made him far too conceited. He remembered how his mother was never nice to him unless she wanted something; how his father had scolded him very harshly when he had peed in the bath; and how his father soiled himself when he got drunk. These free associations expressed the expectations and fears he was beginning to have towards the therapist, his fear of being too conceited or of failing, his greed which made him want to steal what he desired, his fear of going too far and being punished by the therapist. Moreover, he came to accept a little his feelings of dependency towards the therapist when the latter took a holiday and he felt as if he was not being held together any more, as if a "hoop had come off." He then said that he wished he had been in analysis earlier and talked of his ambivalence towards the therapy, both trusting and distrusting it.

The following week, he related the following dream. "The Golden Pavilion had burnt down. Being the arsonist, he was arrested and put into a jail with tatami mats. In it was a leopard. A woman with two umbrellas gave him one and told him to kill the leopard. As he tried to kill it, it turned into a crow and then into a chicken. Although the tip of the woman's umbrella was pointed, his was not." His free associations showed that this dream expresses his guilt at, and wish for punishment for having destroyed something very precious to him (good object relations). Also, the woman who gave him the umbrella represents the therapist and the umbrella protects him. He feels that with what the therapist gave him, he cannot kill his destructive self (the leopard). Moreover, this changes from a crow into a chicken which is neither destructive nor sinister.

(2) Suicidal Attempt and Violence against his Family : Phase when his Destructive, "Pathological Organization" tried to destroy his wish for an object and his perception of reality (From the 4th to the 8th Months.)

It is about that time that the patient decided to start working. But as this reality neared, he got more and more anxious, saying that he was fine as he was

and did not want to change, complaining of a lack of confidence. He recalled a dream he had as a child; he asked his mother whether or not she was crying. There were two round rings and as one grew larger, the other got smaller and vice versa. He was terrified. This dream expresses his inability to separate from his mother, and in the patient's inner world, facing reality means separating from his mother.

He canceled the next session and went to see some old work friends. His friends had not changed at all and he felt that he had no real sense of having ever lived a real life like them. Working again would not give him a better sense of reality and he complained that his sense of reality had decreased since he had started analysis. The patient said he did not want to live with his parents who, he complained, were all over him; he also wanted to interrupt treatment for a month to concentrate on work. The therapist interpreted that the patient felt that he was getting too close to the therapist, too dependent on him and that instead of coming to clearly recognize these things by talking them over with the therapist, the patient denied them and escaped by interrupting treatment, suddenly starting work and trying to move into another world.

When the patient came a month later at the appointed session, he said that he had tried to commit suicide by taking a large quantity of pills, been taken to an emergency hospital where they had saved his life, and wanted the therapist to have him admitted into the psychiatric unit of an university hospital. The therapist recognized anew the patient's powerful destructive aggression against his ability to perceive his own reality as well as against his wish for an object (extreme defensive activity of his Pathological Organization), and thinking that in-hospital treatment was necessary, introduced the patient to a hospital where he worked. After seeing the hospital, the patient may have felt safer, thinking that with such a hospital backing him, the therapist would accept his anxiety and aggressivity, and expressed his wish to continue psychotherapy as before at the clinic. He then promised not to attempt suicide again.

After that, the patient started working again while continuing to come to

therapy. In the therapy, he was persecutory, saying that his colleagues had evil intentions towards him, that they made a fool out of him. He was no longer preoccupied with his gaze but worried about the whole relationships he had with others. The patient also began to criticize his father for being unfair with him and his mother for being self-centered and not understanding him. The patient then started drinking heavily, getting drunk as a skunk, complaining at his parents for what they had done to him. One day he exploded into rage and turned violent with his father whom he forced to apologize to him on his knees. The therapist told him that he should stop his violence and pointed out that the patient had had this terrible anger and despair inside of himself for a long time since infancy but was afraid that the patient's destructiveness would become active. He considered the need for admission into hospital but after that fit of violence with his father, the patient himself did his best to control his violence and admission was not necessary.

(3) Attempts at Independence and Conspicuousness of the Depressive Position (From the 9th Month until Termination on the 28th Month.)

The patient then rented an apartment near where his parents lived, trying to become independent from them. However, once he started living alone, the patient began to feel extremely lonely and would go to have dinner with his parents, which comforted him. He said that this was the first time he had had such feelings, and for the first time realized that he was dependent on his parents. As this was extremely painful for him, he finally asked the therapist whether he was not getting worse. Moreover, his feelings of loneliness would become exacerbated before the therapist took a holiday.

The therapist interpreted that these were brought about by the forthcoming separation and that they were similar to those he had experienced with his parents. The patient agreed, adding that he "did not know that [he] had such strong feelings" and asked the therapist if these were not "at the core of his illness." This meant that the patient had finally entered the phase when he could

deal with the problem associated with the depressive position.

However, in the next session, the patient showed the strength of his ambivalence and envy when he said that he was being hoodwinked and he was relying on pseudo-good parents, and denied he had said that his parents were actually good. The therapist interpreted that the patient wanted to deny that his parents had good sides, that he wanted and was dependent on them because he resented them for having repeatedly disappointed him and dashed his hopes.

However, the patient did not agree with the therapist's interpretation and emphasized how deceitful his mother was. Besides, he said that he did not understand the point of the therapy since he no longer had any symptoms (his symptoms had disappeared by then), that he felt comfortable with himself at the office and that he was working without any problem. He then denied his dependence on the therapist and part of him still seemed to distrust good objects. After that, he alternated between periods where his feelings of isolation and loneliness made him want his parents and the therapist, and with periods when, on the contrary, he denied this side of himself, felt depersonalized and distrustful of his parents and of the therapist, denied that he needed therapy, criticized the value of the treatment saying that he was not getting anything out of it. Thus he would look for an object or try to deny his lonely and isolated self. However, when the therapist's interpretations helped him work through these defenses, he again became depressive.

Moreover, as he became more dependent on the therapist, and when the latter took a holiday, he started to drink heavily again and was violent with his father, but this was dealt with as a problem of transference with the therapist. The patient moved like a pendulum between realizing the psychological origin of the Depressive Position and using his extremely destructive Pathological Organization to defend himself against it. Finally, his symptoms almost completely disappeared, as did his depression, and upon termination of the therapy, the patient became independent.

As described above, the therapist did his best to verbally clarify the internal

object relations and the unconscious motives present in the patient's free associations and in his acting out.

Most of the defenses that appeared in those were transferential elements of bad internal objects, linked to the question of his internal parental image.

When the patient began realizing that he needed an object, his Pathological Organization denied and rejected both that object and himself.

And when he was unable to control even stronger impulsive anger, he presented with typical borderline defensive behavior such as suicide attempt and violence against his family. Hospitalization became necessary at that time and at one time, there was a risk of the therapeutic structure being destroyed.

Fortunately, the patient came back to the out-patient therapeutic structure and, with the help of the therapist, resumed discovering himself through self-expression, could work through the the Depressive Position conflict and successfully terminated the therapy.

CONCLUSION

Borderline research in Britain has been going on since the 1940s under the diagnostic concept of personality disorders, namely, Fairbairn's Schizoid Personality Disorder, Winnicott's False Self, Klein's Severe Neurosis, etc.

Moreover, such authors as Little, Bion, Rey, Rosenfeld, Steiner, etc., actually used the concept of Borderline, particularly Steiner who clarified Borderline Pathological Theory with his concept of Pathological Organization.

The author reported on a borderline case whose chief complaint was "own gaze" phobia successfully treated on the basis of Steiner's Pathological Organization theory and Methodology.

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Weekly Session of Free Association Using a Couch; A Discussion on Frequency

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I. Introduction

It was only after Heisaku Kosawa's clinical practice that psychoanalysis was established as a therapy in our country. The details on how the present Japan Psychoanalytical Association was founded in October 1955, its movement onwards, and its having the "study group of psychoanalysis" as its parent organization, are described in Okonogi's papers. Concomitant with the development of the Japan Psychoanalytical Association, we acknowledge the growth of Japan Psychoanalytic Society as the Japanese branch of the International Psychoanalytical Association (IPA). Incidentally, psychoanalysis accounts for only a small fraction of our country's field of psychiatry. There is almost no opportunity to learn about psychoanalysis in psychiatric education in medical schools. As a matter of fact, I didn't have the chance to study psychoanalysis in my medical school curriculum. Instead, I was taught psychoanalysis through a psychoanalyst (Ikuo Miyoshi) who belonged by chance to the same department of psychiatry and under his influence, I attended the 14th annual meeting of Japan Psychoanalytical Association (1968).

II. The first question on psychoanalysis

Back in 1968, the basics in starting psychoanalysis such as therapeutic contract or the structure of psychotherapy were hardly regarded as important issues. It was not so much that they were so obvious that they didn't generate discussion, but that the therapeutic attitude from a contract perspective was not common in the field of psychiatry at the time in Japan.

One can deduce from Minagawa's words, "There is hardly any reference on therapeutic contract in the 1960's American psychotherapy textbooks" that the situation was a problem not only in Japan. The main topics discussed at the time were on problems of transference and counter-transference, problems of acting out, or on elaboration of psychopathology and character pathology.

Around this time, the following doubt came to my mind as I attended academic meetings for the first time. The description (including the frequency of treatment per week or the structure of psychotherapy) presented by persons debating on psychoanalytic psychotherapy and psychoanalysis had no significant difference (even though they were covering pathologies including transference and resistance), and the definition of each therapy was vague. But even now, there are no clear answers for this doubt.

Kosawa himself had experienced training analysis through everyday analysis in Vienna, and after he came back, he started to apply routinely psychoanalytic psychotherapy using mainly a weekly session of free association using a chair (not a couch), with the analyst behind the analysand. Later, Kosawa's weekly approach was deemed more suitable for the Japanese psychological climate and became common practice in Japan.

In Japan, "weekly therapy" used to mean "psychoanalysis," which is far less frequent than international standard psychoanalysis. Now in Japan, following international standards, everyday analysis will be defined as "psychoanalysis" and therapies conducted three times a week or less will be defined as "psychoanalytic psychotherapy." As a result, these two will be clearly

distinguished according to the frequency of the sessions conducted. This result to “distinguish in terms of frequency” was derived from Menninger’s research, also.

III. The significance of therapeutic contract in psychoanalysis; the Japanese situation in the late 60s to the early 70s

In the late 60s to the early 70s, Japan did not have a general tradition of valuing contracts, hence nobody ever gave thought to contracts when starting psychoanalysis. This became a blind spot, and as a result, therapeutic contracts were hardly discussed at the time.

Around the same time, campus disputes evolved into institutional disputes. There was a global anti-psychiatry strife, which spread to the Japanese psychiatry associations, also. The focal point of such institutional disputes was in the fact that many Japanese psychiatric patients at that time were in a medical environment in which their human rights were deprived. There were not a few psychiatric hospitals in medically underserved areas that could rather be called lawless areas. Psychiatric treatment was left to the discretion of psychiatrists, and for better or worse everything was experimental (of course this happened after consideration). The idea of having a therapeutic alliance or a therapeutic contract when conducting psychoanalysis or psychoanalytic psychotherapy was not obvious.

The fact that I myself have been part of this trend, in addition to many pitiful clinical experiences of the actual site of psychiatry, kept me questioning what psychiatry was. In the course of such experiences, I came to understand that “psychoanalysis is a therapy in which the patient and physician exchange a therapeutic contract to act on the patient’s ego.” I was extremely interested in the attitude of psychoanalysis, which was based on “therapeutic alliance” in which a patient and a physician aim to recover, by facing the pathology together

hand-in-hand. This respect of patients' human rights was the attitude that was lacking in the field of psychiatry at the time, and furthermore, this was a matter of overriding concern in human relationships.

IV. Frequency of the sessions in a Japanese situation

As previously noticed, psychoanalysis and psychoanalytic psychotherapy were never accurately differentiated because the "weekly session of free association using a chair (not a couch), with the analyst behind the analysand" established by Kosawa was widely practiced.

In the 19th (1973) annual meeting of Japan Psychoanalytical Association, the "therapeutic contract" was chosen as a section topic, and the issues surrounding contracts were discussed for the first time. This led to a feature entitled "Psychotherapy and Time-Structure: on Frequency and Time" in 1998, and the phrase "everyday analysis" was discussed in everyday practice. From that time, we entered into an era in which its significance was discussed.

I used to conduct a "weekly session of free association using a couch" as "psychoanalysis" knowing full well that by international standards, everyday analysis was required. I have followed Kosawa's prescription of a "weekly session," and many patient groups showed therapeutic effects. Here, I would like to continue discussion defining "weekly session of free association using a couch" as the "so-called Japanese method." This is called "psychoanalytic psychotherapy" under international standards.

The nature of "psychoanalytic psychotherapy" lies in the fact that the purpose and result of therapy is in the supportive dimension, and that the focus is solely on the improvement of symptoms, or on the resolution of current problems. However, I do not limit the therapeutic goal of the "so-called Japanese method" to be in the supportive dimension, which is the main subject of "psychoanalytic psychotherapy," nor do I focus only on the improvement of symptoms, or on the

resolution of current problems. This is because I have seen many cases in which by applying the “so-called Japanese method,” as a result of expressive and exploratory therapy, the character structure changed significantly, the patients were liberated from pathology, and the therapeutic effect could be seen from a psychoanalytical point of view.

After having many clinical experiences showing the significance and benefit of the “so-called Japanese method,” I would like to extract its useful dimensions. This is the main theme of this paper.

V. Clinical material

1) Ms. A was 25 years old when she first visited me, single, and diagnosed as Schizoaffective Disorder. She was 40 years old when she started a course of “weekly sessions of free association using a couch.”

2) At the beginning of her disorder, she came down with a Catatonic Type Disorder when she was close to getting married. She was found dancing in a city highway, far from her home. She was protected by the police and was hospitalized for the first time in a psychiatric hospital.

3) Her condition during her first visit was described as “moody, bad-tempered, with delusional behavior, and bizarre actions.” Forced hospitalization lasted for three months and after leaving the hospital, she was introduced to my clinic, as it was close to her home. She was hospitalized again for two months at the age of 30, and has maintained a therapeutic relationship with me for the past 16 years.

4) Familial background: There are six members in her family; her elder brother, her parents, and her father’s parents. She grew up in an extended family where both her sets of great grandparents lived together.

5) Description of Ms. A: She grew up as a very polite and obedient child and good looking and smart. After graduating from university, she was preparing for her wedding. Ms. A seemed to have an ideal existence that anyone would envy.

6) Clinical picture during therapy: During her stable periods, she worked as a part-time sales assistant, and in a friend's office, though employment never lasted more than a month. She also worked very shortly at tea ceremonies and flower arranging. She barely saw her university friends, and there was no regular contact. The only relationship they had was through letters that she wrote during her manic period. Only a few neighbors and relatives know about Ms. A's disorder, and most of her inter-personal relationships remain formal. Her inter-personal relationships are limited to the family, and her social activities are very limited.

7) Medication: The maximum dose given in a day in conversion to Haloperidol was approximately 9 mg, 1600 mg of Lithium.

8) Progress in face-to-face psychotherapy of 14 years and 3 months

① Phase 1: In principle, a completely supportive psychoanalytic psychotherapy was conducted. For the first four years, Ms. A had no insight into her disorder. She could not motivate herself to come to sessions, nor to take medication, and her parents had to persuade her to visit my clinic. She was almost mute, and I could not establish a rapport. Most of the time, her parents strongly wished to attend the session together with her. Ms. A left her parents to do the talking, and for a long time, there was close to no spontaneous speech. She hardly followed medication schedules and though she eventually started to take her medication, she used it irregularly. Some days she took the daily dose of her medication in one go, after breakfast or after dinner. It was very difficult even to control her medication.

- ② Phase 2: After three years she started to confirm her diagnostics, and began to have a feel of her disorder. For the following nine years, I suggested to her to visit the clinic regularly once a week, though the cycle of dysthymia became even more apparent. Thus, some months, she would visit only once a month, and other months she would visit almost every day. As a result, based on her and her parents' schedule and needs, the sessions became very irregular, and the structure of the psychotherapy could not be defined. The situation was as follows. During her depressive episode, she stayed all day in her room lethargically, and sessions discontinued for one to, at the most, five months. Later, during her manic episode, she frequently visited the clinic. Her clinical presentation varied considerably. One example is her attempt to commit suicide by diving into an old well, though luckily she survived due to the shallow water depth. In her manic episode, she repeatedly ran away from home, which often involved police intervention. During this episode, both her family and I were insulted through her vigorous actions. However she gradually started to put her aggressive emotion towards her parents into words when she came to sessions by herself. In the sessions she showed signs of separation-individuation, and her inner experience was verbalized into speeches such as "I want to end my life soon" and "I thought my existence had no meaning, but I feel life can be interesting" and she started to develop reality-testing abilities.
- ③ Phase 3: In her 12th year of therapy, her father who had strong control over his family committed suicide. As she entered her 13th year, speeches like "One can actually change" or "I sometimes feel sorry for myself" showed improvement in her introspection ability, and she confirmed her insight into the disorder. She reflected how she was always nervous and how her hands used to sweat. She also recalled how she suffered from erythrophobia and anthropophobia in her high school years, how she tended to be obsessive, and how she had ideas of reference, and she started to

confront her personality trends.

By this time, positive symptoms started to disappear, such as the almost complete disappearance of hallucinations, which led to her daily commitment to housekeeping, and a stabilized family relationship. Regarding her manic and depressive episode, she confirmed her insight into the disorder by recognizing early warning signs, and she became able to control the symptoms by medication and through changing her lifestyle. Although she repeated episodes of slight dysthymia, her superficial problems mostly disappeared. Ms. A was unsatisfied with the disappearance of symptoms, and started to look for a meaning in life. The sessions now evolved into a phase where Ms. A asked for guidance regarding fundamental and philosophical problems such as “what is life,” or “what is happiness.” This was a step forward from problems such as “how to adjust into daily or social life (problems in a supportive dimension).” Indeed, Ms. A would ask, “What does happiness mean to you?” The sessions were still irregular, but the period between meetings was never long.

As previously mentioned, except in her manic episode, Ms. A could be described as a graceful model Japanese lady, and she strongly suffered from anthropophobia. Though our therapeutic relationship was nearly into its 15th year, Ms. A would still be overly nervous in front of me. Seeing her made me wonder about how to react to her questions, and I noticed how I myself was overly nervous. This was a projective identification.

- ④ Phase 4: After 14 years and 3 months, I gave thought to the process in which Sigmund Freud identified the method of free association. This was basically the attitude of a therapist to “carefully listen to the patients’ association out of the patients’ field of view.” I explained what “free association” was to Ms. A and asked for therapeutic alliance. Ms. A actively consented to conduct free association using a couch.

9) Therapeutic alliance between Ms. A

- ① Regular weekly visits to the clinic,

- ② Conducting free association using a couch,
- ③ Searching the cause of her disorder,
- ④ Acquiring psychological strength that can deal with various conflicts in life.

10) Progress in free association

① Characteristics

From the first free association session using a couch, there was a significant change. This was very important and meaningful, and showed much of the therapeutic effect. One of the notable changes was the fact that she never came late, skipped, or cancelled any of the 66 sessions we had over one year and four months. It was the first motivated attitude to this therapy that she showed in 16 years. She took medication as indicated, and even asked for information and advice on the medicine. Considering her past attitude, this change surpassed my expectation. For the past 14 years, she had mostly depended on my directions, but for the first time she started to show her ego autonomy. Moreover, we were able to reduce the medicine step by step.

② The first session

It started with her saying “Can it be something I imagined? It doesn’t have to be reality? I used to feel awkward to lie down in front of somebody, but now I am relaxed to lie down in front of you.” Even though Ms. A was proceeding with free association, she would immediately react in an extremely polite manner to even slight interventions I made. Therefore, I carefully listened to her without interfering.

In the third session, Ms. A quietly shed tears and said, “There are some moments these days when I feel I am all right as I am. I have tears in my eyes now, though I don’t know what the tears are for...”

Her only spontaneous speech in 14 years was on clarification or confirmation of words that I had said. After three and a half months of free association sessions, she asked questions on her own initiative for the first time in session No. 16, it

was about the medication. But anyway, she seemed very nervous, even after starting free association, especially at the beginning and the end of every session. Confrontation, while she had that attitude, could have made her even more nervous, so I never said anything about it, and just accepted it as her usual behavior. Let me describe what I mean by “nervous.” Ms. A always had a smile on her face, which expressed too much adaptation. Whenever she entered the room, she would bow and greet me in an extremely polite manner. After the session was over, she would keep on setting the couch and the pillow in order, again in an overly polite manner. Her attitude followed the traditional image of how an ideal Japanese lady should act. I would sometimes tell her to leave it as it was, though I would wait for the right time for confrontation. After seven months of free association, in session No. 30 she explained her personality as “I might say sorry even to a burglar.” I told her for the first time “It may be the same trend you show when you fix the couch or the pillow after sessions. You always care for others, though you don’t need to do so in this clinic” and made her confront with her nervous actions during therapy. Still, she remained nervous and continued to fix the couch. We discussed the issue over several sessions, and I gradually tried confrontation. By session No. 55 (after a year and a month of free association), this attitude started to disappear, and the smile on her face also started to change. Both Ms. A and I were less nervous during sessions. In session No. 60 (after one year and two months of free association) Ms. A herself mentioned, “I feel less pressure from others” and “I don’t worry too much over the past.” She could feel the anthropophobia disappear, and she said that, “All humans may be the same.” She also had insight into depersonalization and ideas of reference, and clearly, these were also disappearing.

③ Much change could be seen in her association

We proceeded with expressive and exploratory therapy, and much change could be seen in her association. Ms. A mentioned many times that “Clearly I am changing, and I clearly feel relieved.” Still, I believe that this was far from a perfect free association. This is because I concentrated

on not interrupting her during the association, and listened to her with complete acceptance and empathy. I carefully listened to her association, and allowed her to explore her internal world at her own pace. Ms. A was conducting free association under a relationship supported by what Winnicott D. W. mentioned as “holding,” so the transference here was limited to the oral phase of a dyad relation of mother and child. In that sense, I was “watching a very fragile bubble that could burst with the slightest touch,” and I constantly felt the tension during the therapy and I wasn’t relieved enough to react freely. I believe that much needs to be done before we can develop an Oedipal transference relationship.

VI. Discussion

1) “Free association using a couch” on the frequency of once a week

- ① The round trip to the clinic from Ms. A’s home takes over three hours. Although this is closer to her home than the first hospital she visited, this is still very far. During her first four years of visit supported by her parents, she had close to no insight into the disorder, but almost regularly attended the session once a week. After she entered phase 2, and until her 13th year of the therapy, regular attendance of sessions lasted no more than a year, even if the suggestion was once every other week. Therefore, I told her “Regular attendance is very important in starting this therapy (free association). Please decide after considering whether that is possible.” It would be too difficult a task to ask Ms. A to visit the clinic more than once a week, considering how she could not regularly attend sessions for 13 years, even once every two weeks, so that was never in my scope. The first reason was the realistic and feasible condition.
- ② The second reason was because I considered the dimension of the patient’s defense. In Ms. A’s case, rapid regression from free association could have

led to a psychotic experience. Therefore, I chose once a week in hope to avoid such risk. I aimed for gradual regression as a technique of psychoanalysis.

2) Gradual regression

Regarding this case, I learned a lot from the clinical experience I shared with the following patient.

Ms. B was 30 years old when she first visited the clinic, married, and was diagnosed as bipolar disorder. She had been hospitalized in her home country (the United States) in her early 20s. After her remittal, she stayed in Japan for a year, a country she had been interested in for some time. She revisited Japan in her late 20s, and married a Japanese man and had a child after two and a half years of marriage. Ms. B majored in areas of psychology, and graduated from University and she had experienced psychotherapy in her home country. Because of her background, her knowledge on psychoanalysis or psychotherapy was close to that of a professional. As I do with many patients, I conducted face-to-face psychoanalytic psychotherapy once a week, and finished after five years.

The point I want to make here is that Ms. B talked about the Japanese method of having a session once a week. “The Japanese way of having a session once a week has its merits. I had to think for myself until the next session, and I had to wait. The strength of ego developed during the above periods. On the other hand, when I could constantly meet my therapist in everyday analysis, I depended on my therapist to do the thinking for me.”

Ms. B had experienced everyday analysis, and also experienced the Japanese method. In the early days of the therapy, she called me almost every day and talked about her anxieties and asked for advice. As I do with other patients, my response on the phone had the purpose of making her concentrate the problems in her next session. Due to this, phone calls between each session decreased. This

may have led to her experience of “Japanese way of having a session once a week has its merits.”

This is to say that a frequent relationship with the therapist accelerates regression in the patient, and by reducing it, protected from regressing too rapidly. In Ms. A's case as a severe disorder, there was some risk that rapid regression may lead to a psychotic experience. Consequently, I aimed for a gradual regression (a speed acceptable for both the patient and therapist) and chose to have a session a week.

Ms. C underwent the following experience in her mid 30s, after two and a half years of training analysis using free association. In principle, her sessions were conducted twice a week, as this was considered the most realistic and feasible choice, since Ms. C also lived far from my practice. Once she skipped sessions for three weeks. Later she said “I was always unstable after sessions. There were various problems during the three weeks, but I was stable. I was again unstable after the last session after three weeks of absence. It must be tough to do this every day in everyday analysis.”

Her experience shows how psychological instability was caused due to analytical situations. At other times, she regained psychological stability, due to the defense mechanism to adjust into daily life. This is to say that the psychological regression necessary for analysis is related to the frequency of sessions. Kinugasa argues the significance of its effect by saying, “frequent sessions accelerate therapeutic regression, and hence associations become richer.” Though I agree that there is significance in such dimension, I would like to emphasize that there are cases in which the situation that “frequent sessions accelerate therapeutic regression, and hence associations become richer” may actually become a threat for the patient. In such cases, “association can be controlled without accelerating therapeutic regression” by less frequent sessions. This makes patients feel protected, and free association can be applied more effectively. I believe this is the significance of a “so-called Japanese method.”

Gill Merton M. also mentions “there are patients who get scared as the session becomes more frequent.” Suzuki’s comment that “by increasing the frequency of the sessions, there is a risk that the therapist may satisfy the patient’s infantile desires” also depicts the acceleration of regression. I believe he was also arguing this point when he went on to mention “the acceptable pace of therapy development.”

3) The problem of frequency in relation to pathology

- In case there is a risk of rapid regression or pathological regression (for patients with psychosis, where severe pathology can be a problem), frequency of sessions should be moderate and kept low, for example once a week, and the aim should be for an acceptable range of therapeutic regression both for the patient and the therapist.
- Routine defense is stable in the case of training analysis, so it is less likely for regression under analytic circumstances to occur. Therefore, the acceleration of regression needs to be considered, and frequent sessions (e.g. everyday) may be more effective.
- From the above two points, the following statement can be drawn. In cases where strong defense becomes a problem, defense analysis is needed. In such cases, frequency of the sessions has an influence on the effect of psychoanalysis.

4) Discussion from the defense point of view

Sigmund Freud developed psychoanalysis in hoping to “make patients aware of the unconsciously repressed conflicts.” Whenever the psychoanalysis has an effect, the therapist must work to change the pathological defense used by the patient into a healthy defense. I am interested in this change of defense mechanisms. In summary, for patients within the range of neurosis, repression centered pathological defense mechanism becomes a problem, and for this reason, psychoanalysis is valid for expressive psychotherapy.

From Melanie Klein's research onwards, by the clarification of primitive defense mechanisms, we can discuss pathological defense mechanisms to be treated in psychoanalysis from two classifications: neurotic defense mechanism and psychotic defense mechanism. Defense seen in severe pathologies such as schizophrenia, needs investigation from the dimension of primitive defense mechanism. Here, the function of a "so-called Japanese method" is significant.

The origin of primitive defense mechanism is pre-oedipal anxiety, including anxiety of existence, anxiety of extinction, and anxiety of persecution. Patients with these severe pathologies overreact to a therapist's words and behavior. Therefore, to treat this with therapeutic methods means that developing a gradual therapeutic relationship that does not evoke fear is necessary. The therapeutic significance is that therapists do not interfere and stay out of sight, but are present, and this act of carefully listening and devoting himself/herself to the patient with complete acceptance and empathy has an effect on the therapy. Supported by such therapeutic environment, the patients can develop their ego autonomy, and also improve their ability to face themselves, which is the ability to self-reflect, and to explore. The following case, Mr. D explains how difficult patients improved their ability to confront themselves.

Mr. D was in his mid 40s, married, and complained of an Obsessive-Compulsive Disorder with ideas of reference. His intellectual defense was so strong that after 2 years of therapy, we started to apply a "weekly session of free association using a couch." Symptoms disappeared after several years of sessions, but it took nearly 10 years to proceed into self-reflective and exploratory free association. Even then, one day during the session, when the FAX machine started accidentally working (usually it was not used), he reacted to the sound and sat up on the couch saying, "Can you do something about it? I can't concentrate on myself."

This showed how slight stimulus from the environment surrounding him could greatly interrupt his introspection and exploration.

5) Preparations needed to apply the “so-called Japanese method” to severe patients

I have been investigating the significance of “free association using a couch” to psychotic patients, under restricted frequency of sessions. To apply free association to severe patients, a solid therapeutic relationship, which follows the so-called basic trust, must exist between the patient and the therapist. Actually, it was after 573 sessions during 14 years that free association could be applied to Ms. A. When the therapist hides behind the couch in free association, the time should be after a solid therapeutic relationship is built up between a patient and the therapist, that the patient experiences the therapist as an object to completely accept and sympathize with him/her without posing any threat to the patient. This becomes the basis in developing introspection and exploration. I may be repeating myself, but the most important element is the attitude of the therapist not to interfere and to listen to the patient carefully. Note that clarification or confrontation is only possible after a considerable number of sessions. Kano mentions in his report “On Supportive Role of Therapist” that “the most important thing during therapy is how to establish a stable therapeutic environment, or structure of psychotherapy, and how to maintain it” and points out the supportive function of a therapist’s attitude. Wallerstein, Robert S. also mentioned the significance of “supportive elements as a basis of achieving various changes.” This is precisely what I mean by therapist’s attitude, not to interfere but to listen to the patient carefully, and how indispensable this is when applying free association using a couch to severe patients. Through this therapist’s attitude, the patients can develop their ability of introspection and exploration, then a change of their personality starts.

VII. Conclusion

I think that the reason why International Psychoanalytical Association defined

everyday analysis (propounded by Sigmund Freud) to be more than four sessions a week is because of the social trend to have two or three days off a week. Does this mean that if the social trend moves to be common having three days off a week, everyday analysis will become three sessions a week? In fact, in European countries, such as Germany and France, psychoanalysis is considered to comprise more than three sessions a week.

On the other hand, we are in need of theories and methods to expand the subject of therapies from neurotic patient groups in Freud's times. Based on Kosawa's practice of "Weekly session of free association using a chair (not a couch), with the analyst behind the analysand," I have tentatively defined "weekly session of free association using a couch" as the "so-called Japanese method," to investigate and report on the following two points, using some past example cases.

- 1) The significance of less frequent sessions in psychoanalysis
- 2) The significance of free association using a couch in cases with severe disorders

I conclude that "free association using a couch" has therapeutic effects from a psychoanalytical point of view, regardless of frequency, may it be more than four sessions a week. I hope this paper contributes to the future progress of psychoanalysis and the provision of therapy to severe patients.

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On the Use of a Metaphor to Establish Therapeutic Alliance with Borderline and Schizophrenic Adolescents

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The objective of this paper is to discuss some technical issues of interpretation that occur when treating adolescents with severe psychopathology including borderline personality disorders and those schizophrenic adolescents who may benefit from intensive psychotherapy. As Schmideberg (1986) wrote, borderline patients are "stably unstable," and it is always difficult for therapists to develop a stable therapeutic alliance with them. Treatment of these patients has been extensively described by Kernberg (1967, 1975, 1976, 1982), Mahler (1975), Masterson (1976, 1980, 1985a, 1985b), and Rinsley (1980, 1982). Therapeutic alliance, however, is the crucial factor which no analyst should neglect in any way in order for a therapist to facilitate the working through for the self- and object world of patients. The analyst can help a borderline and schizophrenic patient to recognize and grasp the healthy part of the ego (Fairbairn 1952; Greenson 1965) by interpreting the pathologic part, using a metaphor that symbolizes what the pathologic part of the ego is all about. If such an interpretation is accepted by the patient, the healthy part of the ego is able to relate to the therapist, although this relation will not be sustained long enough in transference (Kernberg 1976, 1982). I believe, however, that this will become the starting point for both therapist and patient to do the work of long-lasting intensive psychotherapy.

Initial Interpretation to Develop a Therapeutic Alliance with the Fragile Ego of Borderline and Schizophrenic Patients

Either therapists or borderline patients can usually come up with a metaphor that symbolizes what the patients are struggling to master in the beginning phase of psychotherapy. For example, a patient may say, "I don't want to be like a doll." Then the therapist can interpret to the patient, "It seems that you have been struggling with yourself not to be a doll, and I have the feeling this is why you come to me." "Doll" clearly conveys the nature of the struggle to the patient, who then immediately knows what difficulties she is going to work on in metaphorical terms in intensive psychotherapy. In other words, this kind of initial interpretation helps the patient recognize that she has not only a pathological part but also a healthy part of the ego. With such an initial interpretation, the therapist enables the borderline adolescents to look at the psychopathology, such as the fragile sense of identity (Kernberg, 1976) and manipulative nature of the object relations. An interpretation of this kind should not point out negative transference, but rather use a specific metaphor that describes clearly the burden that the patient has been trying to negate for a long time. The metaphor used in this process should be broad in meaning, but simple and clear as a word. This technique can be used for intensive psychotherapy with schizophrenic adolescents, although it may take months and even years until both therapist and patient find the metaphor.

Clinical Illustrations—Initial Interpretation and Therapeutic Alliance

The process leading a therapist or patient to find the metaphor is very spontaneous. Let me clarify this with a borderline and a schizophrenic patient I had treated.

A Borderline Adolescent

The patient is a seventeen-year-old, good-looking high school girl who was referred to psychiatric consultation because of depression and suicidal ideations following an abortion. The mother is a nurse who had divorced the father three years prior to the referral. The father named the child Yoshino, which means beautiful girl in English, a rather common name among girls of a certain character in Japan. Yoshino maintained her relationship with her father although her mother and brother had cut him off and never saw him after the divorce.

On entering high school, Yoshino decided not to see her father any longer because, as she said, "He expects me to behave as he wants and gets mad at me if I do things my way, so I quit seeing him." Her decision occurred shortly after her father remarried a young woman. It took several years to find out that the father had been married at least two other times. Yoshino ran away to a boyfriend. Her father forced her to break up with him. On the surface, she obeyed the father, but subsequently "fell in love" with one of her school teachers. Her relationship with him did not last long. She said, "He didn't care for me." She avoided talking about the issue further, and acted as if she were the victim. She went on to say that he was fired and she could not attend school. She went back to the boyfriend during that school year and became pregnant by him. She said, "When I told my mother about it, she cared for me for the first time in my life, but it was too late. She used to get mad at me, beat me, and throw me out." In the same affective context, three years later she recalled, "My mother punished me for no reason. Many were the times I was not allowed to have dinner when I was little. She threw me out of the house. I saw my mother and brother eat dinner together through the window from outside." The mother said that as a little girl Yoshino had reminded her of the husband, and that she abused Yoshino as a replacement object. The mother regretted having abused her child. She described her former husband as an alcoholic who had been overly jealous from the very beginning of their marital life. Because of his promiscuity and pathological jealousy and

because he beat her, she had thought of getting a divorce but had decided to wait until the children grew up; however, she was unable to wait, and she divorced the father when Yoshino was fourteen.

Throughout the first few weeks of diagnostic sessions, Yoshino seemed to behave according to the rules of the interview. Her compliant attitude as well as her perception of herself as a victim, not recognizing her provocativeness toward her mother, made me feel somewhat puzzled; her compliance did not fit with the historical picture of her delinquency and chaotic family relationships. Then I remembered that I had felt that she acted like “a doll” in the initial session to make me feel sorry for her. She did not tell me anything particular about her real fear and pain, which she did not want me to discuss. I realized that this was her defensive maneuver to avoid pain and to refuse to communicate her inner feelings to me. I then thought she might have wanted to stop being her father's doll or that she hated being her mother's abused doll. At the end of the diagnostic assessment, I thus interpreted to her that she did not seem to want to be a doll, emphasizing, “it seems that you don't want” in order to be in touch with the potentially healthy part of her ego. She agreed with me and decided to undertake psychoanalytic psychotherapy. The word “doll” was therefore a suitable metaphor symbolizing the pathologic part of Yoshino's ego. I believe that this process helped build the therapeutic alliance with the healthy part of her ego. It is this part of her ego that grasped her psychopathology of ambivalence that was uncontainable and that split off in her usual ego states.

A Schizophrenic Adolescent

The patient was a high school girl, sixteen years old, when she had an acute schizophrenic episode. She was hospitalized for three months and gradually recovered from the episode sufficiently to go back to regular school life. She had been placed on supportive measures including medication and supportive individual psychotherapy. At the end of the second year of the treatment, she

was isolated at home and in school, but she did very well academically. In individual sessions at the time, she blamed everybody but the “new mankind,” Nietzsche and Rimbaud, whom she admired. She read Nietzsche and Rimbaud almost every day and called them “new mankind”; she labeled everybody else “old mankind,” whom she devalued and ridiculed. The therapist took “mankind” as a metaphor and interpreted that she seemed to be afraid of the “old mankind” within herself and that she believed it was impossible for her to accept that there was “old mankind” in herself, which made her isolated from the therapist and peers. It became a turning point for her to talk about herself with the therapist. “Old” and “new mankind” were the keys to forming a therapeutic alliance with her fragile ego.

Therapeutic Alliance and Analysis of Transference and Resistance

It is always difficult to help adolescents with severe pathology handle stormy transferences of a primitive nature that are enacted during psychoanalytic psychotherapy. Borderline adolescents act out very easily in transference. The reenacted primitive object relations in transference sooner or later endanger the therapeutic alliance no matter what the analyst does to prevent it. The initial interpretation, however, serves as leverage to maintain the therapeutic alliance, as the analyst can point out, merely by repeating the initial interpretation, both all-good and all-bad object representations, that are being reenacted and threaten the therapeutic tie instantaneously. Analysts are, thus, able to deal with the patient's regressive moves. I will now illustrate this process with the same clinical material. Yoshino was threatened by a sense of separateness and loneliness as psychoanalytic psychotherapy began. In a few months Yoshino began to complain of the distance between the chairs in which the analyst and patient sat. And then she screamed at the analyst, “It isn't time for you to take a nap!” The analyst questioned her, “Well, I think you are trying to tell me you are

not a doll. But I am puzzled about why you are so threatened and so desperate; I wonder if you have some thoughts about it.” Before he paused, she moved her chair, sat down right in front of him, and said, “I can't stand your silence. The way we sit apart makes me feel left out. I can't take it.” The analyst interpreted that she seemed to feel he was not treating her as she was, but as if she were a doll. Subsequently, the transference paradigm appeared repeatedly, mostly through her acting out behavior. Characteristically, she stated, “You should have cared for me, but it's too late. It's your fault that I did such a bad thing.” It took a couple of years to get her acting out under control through here-and-now interpretations. I used the same doll metaphor, which was helpful for her to control her impulsive acting out. She said, “Don't tell me strange things that make me crazy; I cannot do things I used to do. Your words come up in my brain. I cannot get rid of them. I have to stop and think whether I am a doll or not.” Through her identification with the analyst, she diminished acting out and was able to look at her early childhood and her future.

Discussion

In light of the healthy part of the ego of borderline and schizophrenic patients, I think it is important for the analyst to specify the patient's self- and object representation by a metaphor like “doll,” which is acceptable to the patient. The part of a patient's ego that accepts the initial interpretation will ally with the therapist. In other words, it is one of the most important tasks for the therapist to sense the patient's developing healthy ego, which can tolerate the initial metaphorical interpretation. The therapist should have an empathic understanding of the patient based on his or her intuitive and trained perception of the patient's vacillating ego states, which consist of the healthy and pathological ego.

The metaphor I have described has many therapeutic functions in addition to

specifying and interpreting the psychopathology to the patient. Yoshino was able to grasp the affective context and meanings of “doll.” What is called a “doll” is pathologic (Fairbairn 1952), but the other part that recognizes it to be so is the healthy part of her ego. The former consists of part object images, and the latter is a growing part of her ego that is to develop and mature through intensive psychotherapy. The appropriate metaphor is very useful in interpreting the stormy transference because, as I have illustrated, it reflects both all-good and all-bad object images to the patient instantaneously and without increasing anxiety. My interpretation, “What you are saying is that you are not a doll,” is in response to her accusation of my taking a nap or “you seem to treat me as if I were a doll that you want to break up into little pieces.” Such interpretations point out her primitive defenses of splitting, denial, and projective identification as well as acting out. Here-and-now interpretation using the metaphor is effective because it touches on both the healthy and the pathologic parts of the patient's ego simultaneously. Her serious acting out behavior thus gradually diminished. The metaphor functions also act as leverage to change her ego syntonic behavior into ego alien behavior, which is evidenced by her saying, “Don't tell me strange things as if I were a doll. It comes up in my 'brain' and I can't get rid of it. It drives me crazy.” It also reflects the fragmented self- and object representations such as the abused and abandoned doll, the doll retaliating against her all-bad mother, the doll liked by her all-good father, the doll with all sorts of badness.

As she gained insight into these aspects of her fragmented self- and object representations (Greenson, 1965), Yoshino integrated more mature self- and object representations, so that she could develop intimate relationships with others and keep a job. The metaphor is useful in analyzing transference and resistance of a borderline patient, which helps him or her to integrate self- and object representations and establish the libidinal object constancy through growth of the healthy part of the ego.

We can expect the same functions of the metaphor for schizophrenic adolescents who are capable of maintaining secondary process thinking. This type of

communication, however, cannot be carried out whenever the patient's thought process is dominated by the pleasure principle.

Conclusion

In this paper I have emphasized the therapeutic use of a metaphor, which can be prescribed in the form of initial interpretation to borderline adolescents and sometimes to schizophrenic adolescents after acute episodes. The metaphor should be one that describes the pathologic part of the self of the patient.

It can be picked up by the analyst through countertransference in the initial stage of psychotherapy. As the analyst understands the pathologic part of the self of the patient that includes both all-good and all-bad representations and then translates it into a metaphor to be interpreted to the patient, the healthy part of ego is reinforced. Analysts are, thus, able to encourage adolescents to build therapeutic alliances.

The metaphor may be introjected and then projected. Once the introjective-projective mechanism of the patient is in operation within the psychotherapeutic relationship, it is possible for the patient to identify with the analyst's observing ego and to examine various identifications, thus helping the borderline adolescents consolidate their identities.

This interpretative technique can be applied to schizophrenic adolescents, but the analyst has to delay until the patient can sustain intensive psychotherapy with sufficient secondary process thinking to avoid ego fragmentation.

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A 7-year- and 2-month-old depressed boy who asked profound philosophical questions — A clinical vignette

Kiyoshi Ogura

Clinic Ogura

1. Presenting problems

Among many patient's complaints, compulsive hand washing, school refusal, depressed feeling, fatigue, poor appetite, and insomnia are notable.

2. Family and life history

The patient was born out of wedlock when both parents were 16-year-old high school students. The father's whereabouts are unknown up to the present. The mother, now 24 years old, was taken to a psychiatric hospital after delivering the baby, where she was hospitalized a few times till now. She is still under close psychiatric care with a rather high dosage of medication. The maternal grandmother, 52 years old, has also been under psychiatric care for many years. It is reported that she was physically abused and neglected by her own parents during childhood. The grandmother got married, only to be divorced soon afterward even before delivering her daughter, who was likewise abused and neglected by her mother. Following his birth, the patient was placed in the custody of the Welfare Dept., sent to a Child Guidance Center for physical checkup and evaluation, and eventually was sent to a Child Care Home. He stayed there

for 2 years and then to another Home for about 4 and a half years. As he approached school age, it was decided that the grandmother, mother, and the boy should live together. However, the grandmother became increasingly unstable, irritable, and aggressive, so the Welfare Dept. set up a plan for the grandmother to live alone separately in order to avoid possible abuses to the patient. The mother and the son have been living at a Mother-Child Home under the Welfare Care Program. Their medical, educational, and living costs are all furnished. This particular Home can accommodate up to 18 mother-child pairs. A security personnel is on guard to prevent fathers or men from entering the Home without permission. The mothers are permitted to do only part-time work. The children attend a nursery school attached to the Home or local public schools. The mothers can take occupational rehabilitation programs, additional schoolings, or vocational trainings.

3. Present illness

Soon after the patient moved to the Home with his mother, he began to complain of a series of symptoms, such as compulsive hand washing, acute anxiety episodes, insomnia, poor appetite, depressed feeling, and non-attendance to school. He was often heard to say that he was a bother to his mother, that he was sorry to cause her too much trouble. He often remarked that it would be better off if he were dead. He secluded himself in a room, stayed still, sighed often, and talked little. He lost 4 kg of body weight in 2 months. He never asked questions about his birth or his father, and seldom mentioned the two Homes he had stayed before he came to live with the mother.

He asks himself if he has stepped on his mother's foot and caused her pain. He asks the mother if she hears him clear enough when he speaks to her. He has to make sure ever so often if he has done things properly and not offended her.

4. The initial interview

He was referred to my clinic by the Welfare Dept. He was found to sit still on a chair with his eyes closed in the reception room. It was apparent that he was a depressed boy. He looked pale, skinny, and small for his age. The head appeared to be quite big in proportion to his body. As he was called upon, he walked very slowly and came into the interview room following the mother. He leaned over the mother's lap on a couch. He kept his eyes closed and sighed several times. He appeared not quite ready to speak up. But while the mother was talking about family history, his upbringing, and the present illness, he added a few words after her. For example: "Is that so?" "Really?" "I did not know that," "I really don't know," "That's strange," "Why was that?" "I don't understand that," and so on. Particularly he repeated "Perhaps," "May be so," "Are you sure?" "I doubt that," and "I want to know, but –."

These repeated remarks made me ask why he was so bothered, to which he replied, "I cannot be sure because there are no ways of proving things."

In response, I said to him, "You mean, you are not sure if you do exist, if you are really here or not, and you feel you cannot make sure of that to yourself?"

All of a sudden, he stood right up, his eyes kept wide open, and cried out loud, saying, "What do you mean here? Here means my hands? Is it my head? Is it my feet?" The glaring eyes were directed straight toward me. His voice was very sharp. Moments passed and I only could say, "Yes, your chest, your abdomen, and the rest of your body are all you. You are here. You do exist. You are surely alive."

He continued to say, "I want to know for sure if my mother did give me birth. I wonder if I can make sure by going to the hospital where I was said to have been born and ask someone there." To this I said, "Well, it is a matter of believing. You cannot make sure of it no matter what. You just have to believe that you are you and you are here now. Existing is believing and there is no other way."

Still unconvinced, he said, "Who does decide what we human being are? Why is

a tree a tree? Why is a mountain a mountain? Who in the world decides that? Why am I me?"

I said, "You mean, you want to know who has decided that you are born? You see, it is not that someone has decided it. You just have to believe it. You have to say you are here and you have to say you are you and nobody else. You say so in a loud voice!" "Do I say it in my mind?" he asked.

"That's right, in your mind. At bed time you may shout it in your mind. Try it," I said. "Why do people use words? Can we communicate without words?" he further asked.

"You ask why we use words. Well, it is probably because we trust each other. But even without words, we can communicate when we trust each other," I replied.

Squeezing his head with both of his hands, he sat in a crouch. "We probably talked too much on difficult problems today. You must be tired. Rest well," I said. The mother was speechless all through.

5. Session the day after

In the reception room, he was jumping on a chair while laughing, giggling, and talking to himself pretty much in a joyful mood. At school, a new class was set up only for him and the principal and other teachers would come to this one-student class whenever convenient. The setup delighted him immensely.

In the session, he said he was still worried about minor things, such as if it was OK to swallow nasal secretions down the throat, or if it was OK for him to speak loud in his room as neighbors might not like that, or what the consequences could be when he said yes to something and it might turn out otherwise, and so on. He said he was also worried about his poor memories, not remembering anything of the past, not even recent events. But all in all, things were settling down, he said.

The mother, very ill as she was, was trying very hard to tune in to her son's

emotional needs. She was trying to listen to him very patiently. She said she learned a lot from him everyday.

He leaned over to the mother as they spoke to each other, making jokes, or having some playful interactions. Good feelings were almost visually running between the two. The mother was used to taking quite a high dosage of major tranquilizers, but soon it was cut down considerably without any complications. The prescription for the patient was amitriptyline 10 mg at bed time.

6. Discussion

The early part of the patient's life history is unknown — how the pregnancy was dealt with and how his birth was received by the mother. None of the information was available during the period when he spent his early years at the two Homes. He has not asked anybody any questions about this period so far. Interestingly, he asked during the interview, why was a mountain a mountain, why was a tree a tree, and also who decided that was so. What he was asking for here is very clear. He was asking not only about his birth, or all the happenings that he had to endure in his early years, but also truly philosophical questions which were what the rationale of living, of human life, and of nature was. One might say he was asking the meaning of life, even the meaning of the very existence of the whole universe.

Now how in the world could one answer that kind of questions? But that is exactly because he lived in the kind of a world which necessitated such questions. I wonder what kind of an answer would have been appropriate to such questions. Let me repeat that he was dead serious and persistent. One could not answer those questions light-heartedly. Imagine that he was only 7 years and 2 months of age at that time. Mind you that he was not a talkative boy. In fact, he even questioned why people should use words. It was as if words did not mean much.

The core of these questions must have been planted at the very beginning of his

existence in this world. For him, memories or experiences per se were not so important. What mattered most was his being himself. The issue was the sense of being which was to be such that it should never fade away, but always here to stay.

During the sessions, probably for the first time in his life, he must have felt that his asking basic questions about the sense of his being was recognized, accepted, and respected by the interviewer. As a result he could allow himself to register his thoughts, feelings, understandings and also some interactive processes with the interviewer.

7. Summary

This short report deals with a young child who touched on very philosophical questions about life in a direct way during the initial interview. It was such a dramatic series of fundamental questions that the interviewer was almost exhausted in the interview.

As a consequence, however, only several sessions were sufficient to bring about a rather quick and bright transition in his life which had been full of severe traumatic experiences until then.

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Encounter and Prenatal Rancour

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Introduction

In a therapeutic relationship, one sometimes wonders what wheels of fate have worked to bring oneself into such a deep involvement with the patient. It is, then, not a very strange idea to think that the encounter of a patient with his or her therapist is governed by some outside factor unrelated to the intention of the parties concerned. From the olden days, we Japanese have referred to the element that works in bringing together people as "en." It seems impossible to eliminate completely the element of "en" in therapy, no matter how much importance is placed on reason and intellect during the sessions. However, only too often such aspects become submerged in the process as therapy progresses. The paper focuses on the subject of encounter in psychotherapy, taking up the concept of "en."

What is "en"?

Let me first clarify the meaning of the Japanese term, "en." The word, roughly, has the following definitions:

(a) An indirect condition that contributes to bringing about an outcome;

- (b) Relationships; and
- (c) Edge and/or brim.

The first (a) is derived from cause and effect (karma), the fundamental concept of Buddhism. In Buddhist thinking, nothing is isolated. No one thing occurs or happens of itself. "En" in this context can be considered as an abstract factor that is indirectly involved in some event and/or occurrence yet decisive to the outcome. In everyday terms, we place importance on encounters as the result of "en" that works to bring together strangers. In (b), relationships that cannot be easily severed, such as parent and child, siblings, and man and wife, are referred to as "en." The last (c) will be taken up in the discussions. Taking these into consideration, the paper will focus on "en," which is a familiar concept in Japan.

Encounters that occur in therapies can be said to be accidental, but they can also be regarded as a meeting brought about by "en." Here, I will discuss the encounter between patient and therapist as the workings of "en." The approach gives rise to discussions on how "en" affects the psychotherapeutic relationship, and how it intertwines with psychoanalytic thinking that places subjectivity in the self. I believe that it should be deliberated from both a cultural and clinical viewpoint; however, "en" is too large a theme to deal with in this paper, so I propose to take up prenatal rancour as one aspect of "en."

Prenatal rancour

The concept of prenatal rancour was first introduced in psychoanalysis, when it was taken up in the discussions of the Ajase complex. Okonogi has presented the following three aspects of the Ajase complex (Okonogi, 1988 a):

- (a) The conflicting desire of the mother to have a child and to kill it;
- (b) The prenatal rancour and the desire to kill the mother on the child's side; and

(c) Two kinds of guilt feelings.

Prenatal rancour is included in (b). In Buddhism, it means the resentment one harbors before one is born. According to the Nirvana Scripture, Ajase harbored ill will before he was born, and was called Ajatasatru (meaning both prenatal rancour and a broken finger in Sanskrit) since he was born with his finger broken as a result of some mishap during delivery. Based on the foregoing, Okonogi examined the significance of prenatal rancour, and interprets it as a resentment against the "en" that led to birth and which includes speculation over the origins of one's birth and inquiry into it (Okonogi, 1991). He goes on to discuss it in connection with a case of family therapy and another of an interview with the mother in treating adolescent patients.

Any therapeutic relationship, in fact, has something in common with the "en" of parent and child, since one becomes—in other words, one is born as—a patient by entering into such. Just as one may speculate the reason why one was born to one's particular parents, one may wonder why one has been placed in the position as the patient in therapy. Okonogi considers grudges and anxieties associated with the establishment of therapeutic relationships as the transference of prenatal rancour (Okonogi, 1988 b). However, there are no published studies on prenatal rancour in the context of transference in psychoanalytic psychotherapy, and this paper focuses on that point. Please note that, although prenatal rancour is a major element, the paper will not take up the entire Ajase complex.

Clinical material

Miss A, a woman in her 30s, attempted suicide and was brought into the emergency care unit of the hospital where I work. I provide psychosomatic and psychiatric consultations there, and subsequently took her on. Her life was

saved and she entered, so to speak, by the working of "en" into a therapeutic relationship.

Her family history and growth process, according to what she told me during the therapy sessions, are as follows:

Her brother, seven years her senior, was born with a handicap. It was when her mother's devoted efforts had finally borne fruit and he had just about managed to start walking, that Miss A was born. She was followed a year later by a sister. Miss A was bullied during grade school, but could never talk about her troubles to anyone, although she was reprimanded for not wanting to go to school. Anxiety continued and she could not feel relaxed in personal relations. She managed to finish high school, but stayed home and never went out, withdrawing from society. Miss A did not refer to the fact that her mother had not realized that she was being bullied; rather, she stressed the fact that her mother was the only person who understood and did not pressure her to go out into the world.

Her younger sister, on the other hand, succeeded in finding objects outside the home, and married. As for her father, Miss A referred to him only in passing. She merely mentioned that he was distant although he tried to love her in his own way, and almost immediately reverted to the subject of her loving mother. After her father's death from an illness, her mother, brother, and herself were left at home.

It seemed to Miss A that her mother had given up trying to discipline her brother, and in consequence, that he was increasingly getting out of hand. At a gathering of relatives, something happened to make Miss A lose face, while her brother became overbearing in manner. The incident rankled and eventually, his behavior began to infuriate Miss A. It seems that her resentment against her mother for not being her sole protector had been diverted to her brother. The mother was caught between the siblings and their quarrels began to tell on her, until at last, Miss A persuaded her to arrange for a separate residence for her brother. Her heart's desire was finally attained and she had her mother to

herself; however, the mother passed away from cerebral infarction only three months later. Miss A felt guilty, thinking that her quarrels with her brother had driven their mother to death. Despite these circumstances, Miss A repeatedly mentioned that "it was always just the two of us." I received the impression that the family's state of confusion had been aggravated by the death of the father.

Her first suicide attempt occurred just after her mother died. She had tried to kill herself in an attempt to follow her. She attempted suicide for the second time by taking an overdose and had been subsequently brought into the hospital where I work.

Psychoanalytic psychotherapy

(1) Beginning of therapy—start of a patient–therapist relation, "en"

In my consultations with attempted suicides, I have sometimes pictured the ambulance as a stork that drops the baby patient into my lap. Miss A turned out to be a very heavy baby indeed for my arms. I went to see Miss A according to the routine consulting system of the emergency care unit for attempted suicides, but she merely gave me wary glances from behind the bedclothes and was altogether unapproachable. On the second day, she thawed somewhat and talked about her suicide, which had been triggered by the death of her mother. She still wished to die and I suggested that she should go into a mental hospital; however, she refused and chose to visit me as an outpatient, a method which would not ensure her safety. She also checked on the time I would be able to allot to her, which was rather surprising. I felt that it expressed her strong object seeking even though she appeared to avoid personal relationships. However, she also seemed prone to persecutory anxiety. I could see that she would be a difficult case to treat as an outpatient, since she was now suffering from object loss on top of her personality problems and without any supportive environment. However, I felt I had no choice but to do what I could to prevent

her from taking her own life, and on that note, 45-minute therapies commenced at a pace of once a week. Incidentally, I assumed the double role of Miss A's psychotherapist and administrative doctor.

(2) Resentment against having been saved

Initially, Miss A was depressive and could not come up with any aim for the therapies, and told me that, for the time being, she wanted to talk about her feelings for her mother. She fondly described her as an idealized figure, saying that she was very kind-hearted and that she had loved Miss A the most. That was how I learned of the circumstances described above. Her feeling towards me, on the other hand, fluctuated between the desire to monopolize and the frustration of such. For instance, she would say that if you wanted to save a suicide, a doctor should be exclusively assigned to the patient on a round-the-clock basis. I was, of course, not her personal doctor, and the only time frame that could be exclusively allotted to her was the appointments she placed.

About a year passed without any notable progress, and Miss A, as was her wont, started reproaching me, saying that if the therapist was incapable of assuaging the pain of losing her mother, saving a suicide was plain torture. I was fed up with her attitude, but feeling that a similarity could be drawn between her life being saved and her being born into the world, said, "You ask me why I saved you, but haven't you been always asking yourself why you were born?" —at which Miss A dropped the offensive, and nodded in silent agreement.

During this time, however, Miss A gradually began to regress, staying in bed most of the time. She reiterated in a clinging manner that she wanted to die, and frequently rang me up. As her administrative doctor, I suggested having someone from the public health center visit her, but she turned down the idea. It was as if she were demanding that I take full responsibility for her, that I had the obligation to do so, having saved her life. She said that she needed me much more, that it was a natural enough claim from her viewpoint even if it sounded

unreasonable, and added that she deserved it, considering all that she had had endured. She wanted to have me exclusively to herself and I could see that she had all along been clinging to the fantasy that she could monopolize her mother as much as she liked if only she persevered. The fantasy had been threatened with disintegration when her mother died and she had tried to take her own life so that she would be united in death with her mother. Miss A's desire to have her mother to herself must have always been thwarted by the existence of her brother. As aforementioned, she had always pondered why she had been born and been saved, and I began to think that Miss A harbored prenatal rancour, that she could not be reconciled to the fact that she had been born into a situation that would never fulfill her needs. I suspected the splitting off of her prenatal rancour when she talked about her unity with her idealized and wounded mother. As for the therapy sessions, she resented having been saved against her will when they did not provide what she needed; in other words, it was manifested as transference of prenatal rancour. However, I did not directly communicate my understanding of the situation to Miss A.

(3) Relation ("en") cut off then formed again

At the time, I spent the days feeling that it would be difficult to go on supporting Miss A, and was rather overwhelmed with the premonition that it would be impossible to prevent another suicide attempt. I was like an agitated mother who felt she couldn't cope with the responsibility of caring for her baby. And finally, about a year and eight months into therapy, Miss A was rushed into hospital by taking an overdose in a third suicide attempt. This time, she unwillingly consented to temporarily going into a mental hospital. The primary objective of the step was to ensure her safety, but it was also because I felt the need to change the structure of psychotherapy, which hitherto had consisted of one therapist, namely myself. After various arrangements, Miss A was duly transferred to Hospital B near her sister's place, but she could not bear it and left only after three days. According to the report from Hospital B, she had

negotiated with her doctor, asking to be released on the condition that she would visit him for treatment from her sister's house. I was surprised with the rapid recovery of her ego function, but at the same time experienced a sense of futility, and expected Miss A to cut off the ties she had with me.

Three months later, however, Miss A appeared looking quite fresh and, equipped with a report from Hospital B, requested resuming therapy sessions with me, stating that she no longer wanted to die. I made it clear that she would have to face up to herself so that she could live a life on her own, and presented it as the objective of the therapy. I also gave as a condition of limit setting that she would have to consent to temporary hospitalization in a mental institution if she found it difficult to control her impulse to kill herself. Miss A consented to both, and I perceived, for the first time, her positive attitude to the therapies. Thus the 45-minute psychoanalytic psychotherapies were resumed at a pace of once a week.

(4) Resentment against having been abandoned

About three months into therapy, Miss A, seeming to make up her mind to tackle me, said that she had not even unwillingly consented to being sent to Hospital B and wanted to know my views on the matter. Afterwards, she became anxious that she had offended me, but rallied after a while. I interpreted her dreams and associations, and found that she had felt that she had been driven away to the mental hospital and resented me for the fact. I informed her of my interpretations.

In step with this, Miss A's idealization of her mother underwent a gradual change. She revealed she had conflicting emotions, saying that it felt as if she never had a life in her own right, since she was shackled to her brother as soon as she was born. She believed that parents whose first born is handicapped not only hope that the next one will be healthy, but expect the child to shoulder the responsibility of caring for the first. She had once told her mother that if she were her she would not have had any other children after the first handicapped

one, and regretted saying so. She also said that it made her feel bad to think that she reproached her dead mother, who had always looked over her in life. It seems that Miss A, in considering the origin of her birth, had long harbored prenatal rancour against the fact that she was assigned the role of guardian for her brother before she was even born and was not eagerly expected in her own right.

After a while, Miss A showed signs of separating herself from the lost object, saying that she felt a little strange that she could allow herself to think of matters other than her mother for the first time since her death. Yet at the same time she harped back on the subject of the mental hospital, repeatedly asking why I had sent her. I was exasperated with her persistence, but perceived a strong anxiety against being abandoned at the back of it. We had to skip one session due to my personal schedule, and at the next one, Miss A confessed for the first time after two years' elapse that she had felt abandoned when she was sent to the mental hospital. I told her that she must have been far too terrified to even mention the fact that she was afraid of being abandoned, and that while the skipped session aggravated her sense of being forsaken, she must keenly have felt the fact that she had no one to talk to. At this, she started to cry, saying that no one had ever been perceptive enough to tell her these things. I believe she recognized and appreciated the existence of a new object who was willing to face up to her anxieties, despite being still unable to give up pursuing the idealized object.

Gradually, Miss A began to intimate in a faltering manner her object seeking, while devaluating the therapy sessions, as can be inferred from her comments including, "I seem to be coming here in vain, but I do because I need the medications" and "I thought I would just mold away, not exchanging a word with anyone for so long." Even after sessions which she had particularly devaluated, she would mumble, "See you again," and slowly and wistfully leave the room. It was at such moments that I realized anew that an accidental encounter ("en") had become an indispensable relationship.

At one time Miss A brought a faded album containing pictures of her infancy, and talked about one of the photos taken with her mother. What struck me most was her father's eyes through the lens. I asked her about it, and she explained that her father had been into photography, and the album itself, with detailed descriptions concerning the photographing, had been compiled by her father. The radiantly carefree way they were smiling into the camera was ample evidence of the emotional exchange between them and the father. This was probably what she meant when she told me at the beginning that her father had loved her in his own way, and here, I felt, the family was presented as a whole with the father in existence. Soon after this, the New Year's holidays were upon us, and Miss A referred for the first time to my family, fantasizing that I would spend the holidays with them.

Discussions

1) Prenatal rancour as a key concept to understanding transference and countertransference

The transference in this therapy can, of course, be interpreted without using the concept of prenatal rancour. For instance, the usual interpretation would be that she had withdrawn into a narcissistic and omnipotent world and was experiencing rage at its collapse. However, unless we use the concept of prenatal rancour, it seems difficult to understand her manifested mix of dependency and aggression that includes the aspects of being born and/or reborn. Therefore, transference of prenatal rancour, rather than being considered a distinctive form of transference, should be seen to have the function of casting a vivid light on one aspect of the process of transference.

I would next like to take up the issue of countertransference, which had a serious effect on the treatment process. I myself as the therapist, had been destined by "en" to meet my child in the therapeutic relationship, whether I

wished it or not. I was, understandably, plagued with conflicting emotions. I wanted to "chuck" Miss A, yet knew I had to care for her. I rather ran to reaction formation and did not give close attention to my feelings of wanting to throw up Miss A. My stance can partly be attributed to my superego as a therapist, which dictated that it was out of the question, as the one responsible for the patient, to chuck her. However, I believe the guilt I felt for wanting to be rid of her played a large part. It drove me to make great efforts to take care of her. It was the concept of prenatal rancour that awakened me to the fact that I had been controlled by countertransference.

Clinically, it then seems that transference of prenatal rancour is not something to convey, as the therapist's interpretation, directly to the patient and work through with her or him. Rather, I believe that it is useful as a key concept for a more apposite understanding of transference and countertransference in the flow of emotions.

2) Does transference of prenatal rancour occur in all therapeutic relationships?

Kosawa described the concept of the Ajase complex and presented it as a universal psychological mechanism (Kosawa, 1954). Taking it up in a paper on the Ajase complex, Okonogi gave specific examples and described how prenatal rancour was actually experienced (Okonogi, 1988a). He points out that in the process of separation-individuation during adolescence, a child quite often encounters conflicts over prenatal rancour when he or she delves into the origin of birth, and awakens from the fantasy of unity with the mother and becomes aware of separation. He also gives several clinical examples of adolescent cases. Now then, can the transference of prenatal rancour be considered a general phenomenon that occurs in all therapeutic relationships?

In Miss A's case, although different from adolescent ones, there were many factors that made one consider prenatal rancour, such as her problems with the origin of birth and suicide attempts. Not all cases come with so many tangible elements, but latent thoughts and/or feelings about the "en" that brings people

into therapeutic relationships can be said to be inherent in all treatments. For instance, after some time into therapy, it is not uncommon for the patient to reflect on the beginning of therapies and talk about his or her encounter with the therapist. However, the manifestation of prenatal rancour seems to rest with the subjectivity of the patient.

Obviously, there is no question of subjectivity when we are born. That is an impossibility, since we ARE BORN. That is why we look into our origin of birth and reestablish it as our choice during adolescence, when we detach ourselves from the parents and become independent. In psychotherapy, on the other hand, the situation commences by contract, and at that point should be acknowledged as the result of the will of both the patient and the therapist. However, although the patient may recognize the fact intellectually, the therapies may not always be felt as a mutually subjective experience in his or her inner world. Some may actually perceive it as invasive or depriving. At the same time, it is not uncommon for patients to come to regard the therapy as valuable and become actively involved, even if they entered it on someone else's recommendation. However, when external factors are deeply involved and/or when there is excessive externalization or projection, the passive feeling that they had been dropped into the therapeutic relationship could persist. Consequently, the active part the patient played in making the choice to be treated tends to be obscured, and here lies the groundwork for prenatal rancour to manifest itself.

As mentioned in (1) of this section, prenatal rancour is a key concept, but it does not always appear in all therapeutic relationships, and I do not believe that it is necessary for, and must be taken up in, every therapy process.

3) Reestablishing relationship ("en") and three body relatedness

Although the therapeutic relationship with me began as Miss A's choice, it felt to her as if it had been thrust upon her and the "en" that brought it about was also perceived as having been forced on her. She resented yet clung to the relationship ("en"), and in fact, tried to draw it towards her. However, after I

had presented the structure of therapy, including sending her to the mental hospital as a consequence of her third suicide attempt, she became conscious of the fact that she herself wanted the therapy, which led to her request that the sessions be resumed. She now needed the therapist as an object in order to face the difficulties of living instead of dying. By entering into a renewed contract, the therapeutic relationship became her psychological support, since the "en" had been subjectively reestablished.

How did this process develop? Let us look at the change that had simultaneously occurred on the therapist's side. Before Miss A's third suicide attempt, I was, through the workings of "en," placed in a passive and impotent position thrust upon me; however, I then made positive efforts to reconstruct the structure of therapy as an active therapist. I believe that the aforementioned patient's change was in correlation with my move. We had been caught in a deadlock, but the idea of the structure of therapy, which had reality, gave us breathing space, and its introduction helped us review the object relation, making us conscious of our subjectivity in the matter.

However, for Miss A, the structure of therapy was not something that supported her active stance in the treatment; rather, it was perceived as an insurmountable barrier erected between us. In other words, in her eyes, I had become separate and was no longer an object within her grasp to which she could reach out. The presenting of the structure of therapy, so to speak, had been perceived as a paternal existence appearing beside the mother that broke into the symbiotic relation of the mother and child. The paternity here does not necessarily represent the Oedipal aspect that has a sexual relation with the mother, but is the superego that governs reason and order. With the manifestation of paternity in the therapeutic relationship as a significant turning point, the transference of prenatal rancour can be said to have started to undergo transformation, while three body relatedness also began to appear.

Afterwards, Miss A very gradually began the process of mourning work over her mother. It had been an off-limits realm while she had been caught in prenatal

rancour. She could previously think of nothing but the strong feeling of attachment to her idealized mother, but when she faced up to the destructive force of prenatal rancour, she began to speak of various other feelings she had had for her mother. The three body relatedness in the therapy can be said to have supported the progress of these changes.

The process in which the perceived "en" changes from a hated object to that of a mental stay can also be said to be a process in which a grudge turns into feelings of endearment. There is a complicated mixture as well of the process of mourning and the manifestation of three body relatedness, and much remains to be studied in depth.

4) The remaining definition of "en" and therapeutic relationship

Here I would like to take up the third definition of "en," edge and/or brim, which I briefly referred to at the beginning of the paper. An edge is a boundary of an area, and can be perceived as a separating line that one steps over. Obviously, a therapeutic relationship in psychotherapy belongs to an altogether different phase from everyday relationships. One must go across the edge and enter the realm. The entering into contract for therapies can be said to be a process of transit. Transference of prenatal rancour, consisting of speculations about why one had entered into the therapeutic relationship and whose subjectivity was decisive in the move, seems to be manifested owing to the realization that one is already over the edge and at the point of no return. In Miss A's case, she had been brought into the emergency care unit in a coma, and as part of the consultation routine, was passed on to the therapist, and subsequently entered psychotherapy. The situation must have worked to make her feel that she had not voluntarily crossed the edge, giving her the conviction that she had been born into the relationship. Once the edge is crossed and one is well into the treatment, one ceases to be conscious of the "en" that brought it about and therapy progresses.

5) Chance and "en" in psychoanalysis

Lastly, I would like to depart from prenatal rancour and consider Freud's view with the concept of "en." He states that everything to do with our life is chance (Freud, 1910). The words give a glimpse into his basic stance, since he tried to see everything from the standpoint of natural science, assuming that its law applied to human beings. On the other hand, there is a cause for everything in thoughts concerned with cause and effect (karma). It is interesting to compare "en" with chance, which Freud sees as the all-encompassing fundamental principle of life. I will refer to Tsuiki's categorization (Tsuiki, 1999) to clarify matters in order to consider chance in psychoanalysis. He classified chance into:

- (a) Something that appears to be an accident although determined by unconscious motivation;
- (b) Something that cannot or need not be taken up in psychoanalysis; and
- (c) Something that can be called chance but is incorporated into the unconscious and so processed that it ends up taking a part in creating the symptoms.

The basic work of psychoanalysis is to find out the chain of various events in the unconscious, as classified in (a) and (c), that seem like chance occurrences. And the connection is basically assumed to exist in an individual's inner world.

Now, "en" is a different framework from psychoanalysis for understanding seemingly chance occurrences. Nothing stands of itself, everything is carried out by "en," and moreover, it does not exist in the inner world of an individual. If we go by that principle and blame everything on "en," one's self will never work as a decisive factor and responsibility is dispersed. If so, there is no common ground with psychoanalytic thinking. However, the term "en" has a deep significance embedded in Japanese everyday life, and is not to be used lightly. In fact, I may safely say that we are already deeply involved in something when we consider "en." It is something absolute beyond the reach of the individual, sometimes the object of rancour, and at other times the mechanism that enables us to accept

what cannot be helped. It is also the object of gratitude since it is perceived as something that directs good fortune. Another way of looking at it is as a buffer so that we are diverted from direct emotional involvement with the object in question.

I believe most of us go through everyday life accompanied by this idea of "en." Ganzarain pointed out the aspect of the Ajase complex that works as a defense system by dispersing the whereabouts of guilt (Ganzarain, 1988). Thinking about "en" means that one does not focus on the object one is thinking of, and in that sense, it can be said to work as a defense mechanism in terms of psychotherapy. However, when the situation becomes insupportable, people are forced to actively face up to the "en" in question. The arena for confrontation depends on the individual. A Buddhist may choose to go deeper into Buddhist thinking. Psychanalytic psychotherapy is another way, as has been shown in this paper. Just as in the approach to interpreting chance in psychoanalysis, I believe it is possible to make "en" a personal matter that concerns the self in terms of its positioning, even if "en" is something that is decided without any participation on the part of the self.

Conclusion

The encounter with an attempted suicide has led me to the discussion of "en" in a clinical case of psychoanalytic psychotherapy. In discussing the subject, the paper has focused on prenatal rancour, one of the major elements of the Ajase complex and which means resentment harbored against "en." We more or less live with ideas and concepts handed down to us and peculiar to the Japanese language and Eastern thinking. I hope to appreciate and deepen psychoanalytic thinking, conscious of my cultural heritage.

The paper's significance also lies in the fact that it has taken up prenatal rancour in the context of clinical psychoanalytic psychotherapy in studying the

Ajase complex. However, it discusses the subject by presenting a part of the case details and does not take up the entire process involved in the transference of prenatal rancour, and which therefore, will need to be discussed elsewhere.

Finally, I would like to thank Dr. Keigo Okonogi for his advice and Dr. Rikihachiro Kano for his comments, which proved very valuable.

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Current Status of Psychoanalytic Contributions to Japanese Psychiatry

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When discussing the contribution of psychoanalysis to Japanese psychiatry, one of the issues that is often raised is the difference in culture and the application of psychoanalysis. In other words, there is the question of whether psychoanalysis, which was developed in Western society where individual autonomy and independence are aimed for, can be useful in the same way in Japanese society where the “sense of the self” is more fused with the “sense of the other,” and where group belonging is valued and dependency is accepted. Sigmund Freud himself addressed this issue in 1919 when he stated, “I have been able to help people with whom I had nothing in common, neither nationality, education, social position nor outlook upon life in general.” In addition, Gertrude Ticho who stated in 1970 that, “given the usual criteria for analyzability, the difference in culture does not require a change in analytic technique” represents the position that psychoanalysis can transcend cultural boundaries. The author also believes that, although psychopathology is related to the culture to which the individual belongs, its essence transcends culture and corresponds to all human beings, and psychoanalysis as a treatment method is just as effective with Japanese patients.

On the other hand, the limited popularity of psychoanalytic practice in this country is accounted by Takeo Doi, in one part, to the particular aspect of Japanese culture, which is to encourage dependence and to restrain self-reliance;

he proposed that this sort of Japanese cultural mores handicapped analysts when working on patients' dependence. Keigo Okonogi emphasized the importance of probing more practical and realistic factors before discussing cultural differences, and maintained that we need to examine historical backgrounds conducive to devaluation of psychoanalysis in our reimbursement scheme of Japan's universal national health insurance system, the underdeveloped CME (Continuous Medical Education) infrastructure, and the prevailing academism.

However, rather than delving into the issue of the cultural and practical feasibility of applying standard psychoanalysis as a treatment method, the author intends to focus in this paper on how the theory and technique of psychoanalysis which have been developing for more than one hundred years in the West, has contributed to Japanese psychiatry and the relevance it may have in the future.

Since the Meiji Restoration in 1865, until the end of World War II, i.e., 1945, Japanese society was strongly influenced by Germany. The German influence pervaded throughout the political and legal systems, the art and other cultural fields and society as a whole. Medicine was not an exception and Germany was the main country for physicians to study abroad. Many of these physicians studied German medicine and upon returning to Japan, worked in university posts and had a big influence on Japanese medicine. As a result, modern psychiatry in Japan has its foundation in the tradition of descriptive psychiatry, beginning with Emil Kraepelin. Another influence of German medicine is the academism found in Japanese medical schools and the postgraduate education system which centers around universities. Under such circumstances, priority was placed on research. As a result, biological research centering around brain histopathology was actively pursued. This was further encouraged by the system of Doctor of Medical Science in which a doctorate degree in medical science is conferred upon those who have done postgraduate research. This degree is given more for research accomplishments rather than for clinical ability, but socially it

is regarded highly, and many physicians stay at the university to complete their doctorate before entering private practice.

Such biological orientation can be observed from the fact that psychiatric services in many universities are called the Department of Neuropsychiatry rather than Psychiatry. Thus the traditional foundation of Japanese psychiatry was built on biological psychiatry along with descriptive psychiatry.

Further impetus was afforded to reinforce this traditional inclination by the international acceptance of the operational diagnostic criteria, namely, the Diagnostic and Statistical Manual for Mental Disorders III and by the thriving dominance of biological psychiatry.

The oldest professional society of psychiatrists in Japan, the Japanese Society of Psychiatry and Neurology, was established in 1902, and the year 2002 was its centenary. This society is based on the idea of integrating psychiatry and neurology, and has played a pivotal role in shaping the modern history of psychiatric training and its practice in Japan. As of March 2003, the number of its members was 8,890.

At a total of 80 medical schools in Japan, there were only 3 psychoanalysts who ever held the office of chairman and professor of psychiatry. Most of the professors of psychiatry are biological psychiatrists or descriptive psychiatrists, such as psychophysiologists, psychopharmacologists, neurochemists, neuropathologists, and neuropsychologists.

In Japan, aside from the Japan Psychoanalytic Society marking its 50 years of establishment soon, there is another organization named the Japan Psychoanalytical Association, which embraces more broadly psychoanalytically – orientated psychiatry, psychosomatic medicine, as well as clinical psychology. 2,088 members are registered as of August 2002.

As stated above, although biological psychiatry and descriptive psychiatry have been in the mainstream of Japanese psychiatry, psychoanalytic theory and technique have, gradually and steadily, contributed to the development of dynamic

psychiatry in Japan.

Here, the author shall focus on how psychoanalytic education and training have influenced and contributed to Japanese psychiatry, content-wise.

First of all, the author wants to emphasize that the psychoanalytic view towards psychiatric illness influenced Japanese psychiatrists to go beyond the symptoms and nosological diagnosis of psychiatric disorders, and to pursue the understanding of psychodynamics and personality. Furthermore, such understanding has led to the notion that psychopathology cannot be polarized from healthy mental states or normal psychic function and the aspect of continuity, i.e., commonality rather than difference has become emphasized. This understanding has brought about a change towards the concept of psychiatric illness. There has been a change towards a holistic comprehension, a change from treating people as “objects” to treating them with human empathy.

Such psychodynamic understanding opened the path for a psychotherapeutic approach. It has also brought about a positive attitude in psychiatric treatment which transcends the model of diagnosis, classification and just prescribing of psychotropic medicine. In addition, it has made it possible to offer psychiatric help to those with characterological problems or interpersonal and adjustment problems. They used to be avoided as they were not considered targets of psychiatric treatment.

In terms of the treatment of neurosis, there has been a Japanese method of treatment known as the Morita therapy. Ever since the beginning, psychoanalysis has always been applied in the treatment of neurosis in the West and psychoanalytic psychotherapy has come to play an important role in the treatment of neurotic disorders in Japan as well.

Another factor which the author wants to point out is the psychoanalytic exploration of personality disorders. Personality disorders were previously viewed as an inborn degenerative illness and their treatment was considered

impossible. The only response was description and classification. The understanding and elaborations of treatment method which are based on psychoanalytic ego psychology and object relations theory have had a big influence in Japan.

Moreover, the understanding of how the response of the psychiatrists towards the psychiatric patient affects the treatment, has been brought forth by the psychoanalytic recognition of counter-transference.

Also, these trends have contributed to the development of psychosomatic medicine in Japan. The psychoanalytic explorations of psychosomatic disease have contributed to the development of psychosomatic medicine in Japan. Liaison Psychiatry which was developed in recent years, stems from the standpoint of being relation-centered rather than disease-centered. Since it focuses on the dynamics of therapeutic relationships, psychoanalytic understanding plays a central role.

In the West, dynamic psychopathology and its psychotherapeutic approaches towards psychotic states, such as schizophrenia, have developed over years of clinical experience. Most of these literatures have been introduced to Japan and have been followed up. Psychoanalytic understanding has played a large role in influencing psychiatrists to view psychosis not merely as biological phenomena and has encouraged them to converse with the patient as well.

The psychoanalytic approach in hospital psychiatry is well known in Japan, too. Concepts such as psychiatric hospital as a small society, issues of hierarchy and delegation of authority, team approach, group dynamics and system theory have become widely known in the diagnostic as well as therapeutic approaches in hospital settings. However, when viewing the overall situation of hospital psychiatric practice, it cannot be said that it is deeply ingrained in the system. On the other hand, one of the noticeable trends in psychiatric care in Japan is the emphasis on outpatient treatment.

An increase is expected in the number of psychotic patients, in addition to those

with neurosis, personality disorders and psychosomatic diseases, who will be receiving outpatient treatment. Under these circumstances, the role of psychotherapy shall increase along with that of pharmacology and there will be a significant role for psychoanalytic theory and technique to play at that time.

The psychoanalytic understanding of personality development in child and adolescent psychiatry is a necessity and its importance shall be increasingly recognized.

At the present time, within the Japanese Society of Psychiatry and Neurology, efforts have been made to improve the postgraduate education in general psychiatry. In the past, training tended to be similar to an apprenticeship system, but now the goal is to set up structured systematic training programs. The importance of the training system which was developed in the psychoanalytic field, in particular the supervision system, should be recognized within the entire field of psychiatric education and training.

In recent years, the significance of the role of psychotherapy in clinical practice of psychiatry has been more and more recognized, and there has been an increase in the number of psychiatrists who wish to study the theory and technique of psychoanalytic psychotherapy in a systematic way. However, as mentioned above, postgraduate psychiatric education takes place at universities and affiliated hospitals. As a result, even though there is motivation to study psychoanalytic and dynamic psychiatry, many belong to universities where educators in this field are not available.

Here, the significant role that the Psychoanalytic Seminars have played in meeting such needs will be pointed out. These seminars are run by extramural organization, and since its inaugural meeting in Tokyo in 1979, it has been held in many different venues throughout Japan. This type of education is thought to play a big role for the future of Japanese dynamic psychiatry.

Thus far, the author has talked about psychoanalytic contributions to Japanese psychiatry. As it has become clear in the discussion, the biggest psychoanalytic contribution to Japanese psychiatry is not the practice of psychoanalysis in a strict sense, but the fact that it has spread dynamic psychiatry, which is an application of psychoanalytic principles, throughout Japan. The significance of standard psychoanalysis is that it has an important role as the basic experiential foundation to learn psychoanalytic theory and technique which is necessary in learning dynamic psychiatry.

The lineage of academic development in this country so far described is evidenced in the outgrowth of the following organizations, the very fruits of the scientific leadership and dedicated administrative efforts of psychoanalysts of Japan Psychoanalytic Society: the Japanese Society for Adolescent Psychiatry, the Japanese Society of Psychosomatic Medicine, the Japan Association of Family Therapy, the Japan Association of Group Psychotherapy, the Association of Japanese Clinical Psychology, and the Academic Association of Psychoanalytical Psychiatry.

In closing, what the author wants to emphasize the most is the importance of psychoanalysis in the midst of biological and Neo-Kraepelinian psychiatry. There was a tradition of biological and descriptive orientation in Japanese psychiatry. This tradition was reinforced by U.S. psychiatry and other recent trends in the world. There is no question about the importance of biological factors and symptom and disease description and classification in psychiatry as a field of medicine. However, if the psychiatrist's interests are limited only to this field, then there is a danger that the meaning of the symptom is forgotten and one begins to view the disease and not the patient. Psychoanalysis tries to understand the human meaning behind the symptom and disease.

The author believes that the following historical fact needs to be recognized in the case of Japan. That is, in the case of the United States, biological psychiatry has emerged on the historical foundation of dynamic psychiatry. In contrast, in

Japan, the tradition of biological and descriptive psychiatry has always been strong and we had not had the historical process of dynamic approach spreading in Japanese psychiatry. Thus, in order to establish a comprehensive perspective in Japanese psychiatry, there is a need for dynamic understanding.

This is the greatest possible psychoanalytic contribution to Japanese psychiatry in the future, and at the same time, the possibility of psychoanalytic contribution to psychiatry which is so consumed by D.S.M.

Unless we are careful, we will be dominated by diagnosis for the sake of the computer so much so that we may develop a psychiatry which has forgotten individual development, personality and psychodynamics.

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Descending Love from “Great Mother”: Towards Henry Moore from Japan with a Clinical Insight

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1. THE METHODS OF UNCOVERING

When Freud (1905) compared his psychoanalytic therapy with suggestive psychotherapy, he quoted Leonardo da Vinci who had made a distinction between painting and sculpture in fine art. He concluded that the role of psychoanalysts was “to bring out something by taking away something,” in the same way as sculptors. This distinction, which is commonly seen in psychoanalytic textbooks, has led to the traditional antithesis between psychoanalysis as the “uncovering method,” and other methods, as the “covering method.” In this sense, psychoanalysts, as psychological sculptors, compete with real sculptors, since both take the same attitude towards human nature. In other words, being a sculptor and a psychoanalyst may be incompatible on some levels.

In fact, Henry Moore resisted analytic interpretations: “...but I stopped halfway through the first chapter, because I did not want to know about these things, whether they were true or not. I did not want such aspects of my work to become henceforth self-conscious. I feel they should remain subconscious and the work should remain intuitive.”

Here, we can see Moore’s nature to be independent and original, keeping a

distance not only from psychoanalysis but also from the other arts that were featured in the introductory books related to him.

Moore's originality and independence should be praised because of their value to art. The more original he is, the more interesting his works can be for us. Furthermore, his works are very silent, and resist our clever interpretations. In the case of sculptures, we usually start looking around the works to find the best place from which to get a good view of them, then meditate on or think about the non-verbal signifiers in an attempt to understand their endless meanings.

Among numerous works, it is probably easiest for us psychoanalysts to start our interpretative appreciation of Moore with his human figures, particularly his mother figures and mother-infant figures, two categories under which many of his works are grouped. In this context, we have Erich Neumann's study of the works centering on the Great Mother psychology (1959). This evoked Moore's famous resistance, which suggests that Neumann's interpretation may have been all too correct.

I am not a scholar of art and have not yet seen all of Moore's works, so I cannot prove the correctness of any interpretations through studies of his works or of his life, from the inside. But it is possible for me to try to approach the heart of his maternal art from the outside, through my own studies of maternal art in Japan. I encountered many of the works by Henry Moore towards the end of my journey of studying mother-infant figures in Western art.

It was ten years ago that I became interested in mother-infant figures in Japanese art, since they gave insight into Japanese characteristics of child-rearing and the Japanese psychological make-up. At first, I limited my study to artistic works produced about two hundred years ago before Japan opened up the country to the rest of the world. I found some interesting characteristics in Japanese mother-infant pictures. Then I compared them with maternal art in the West. However, until about one

hundred and fifty years ago, there were very few mother–infant pictures in Western high art, although many in religious art. As you all know, there are numerous works depicting Madonna and Child or the Holy Family. So I set out on a comparative study tour starting with the Italian Renaissance, and followed its development and evolution into modern art, including Henry Moore.

I would like to briefly introduce this comparative study in the first half of my presentation, and discuss my approach to Moore’s mother–infant art in the second half, making use of clinical insights.

2. MOTHER–INFANT FIGURES IN JAPAN

(1) Viewing Together

I have been studying Japanese mother–child figures, particularly in Ukiyoe pictures. There are numerous such pictures, so they provide a large sample for investigation. The word Ukiyoe means “picture of the floating world.” In my opinion, the floating world hovers between reality and fantasy, or between life and death. Most of these pictures—woodblock prints—were produced about two hundred years ago.

I have studied some twenty thousand Ukiyoe pictures, selecting out about four hundred that show mother–infant interactions. Then I found that, in approximately 30–40% of my samples, the mother and infant are pictured together sharing objects such as toys and fish. These pictures are interesting not only because they depict bridging objects between a mother and an infant, but also because they depict “joint attention” (Bruner, 1975). This repetitive pattern of “viewing together” (Kitayama, 1998, 2004) or “parallel looking” can be motivated by a strong urge to form emotional ties. At least in Japan, therefore, we can learn the importance of the psychology of mutual dependency through these painters’ invaluable sensitivities.



[Picture 1] "Catching Fireflies" by Choki

According to J. Bruner and some other researchers, joint attention is basically a form of language acquisition as well as inheritance of culture between a mother and her child, such as a mother and a child viewing an object, shoulder to shoulder. It has been pointed out that language acquisition or cultural inheritance is achieved not just by a mother and her child looking at the same object together, but also by doing the same thing or by becoming involved in the same thing.

This approach can be seen not only in mother–child figures but also in many other forms of Japanese art including Japanese movies that feature older couples, such as lovers and families. The main reason I have emphasized the importance of “viewing together,” especially for Japanese therapists, is that we have a variety of psychotherapies which feature repeated “viewing together” as their principles. Just like mothers and children in the pictures who share and involve themselves with the same object, therapists and patients share sand creations in sand play therapy and music in music therapy. In many forms of psychotherapy, therapists and patients share something and talk about it. This, of course, can happen in free association in psychoanalysis where the analyst listens to the patient. This is why I would like to emphasize the psychological importance of this “joint–attentive position.”

(2) Emotional Communication

When I ask Japanese people who appreciate Ukiyoe to describe the interchange between a mother and a child they see in the pictures, many of them see both verbal communication and nonverbal communication, citing rich emotional or physical messages, such as warmth, safety, trust, and dependence. In addition to sharing an object, conducting verbal interchanges, and intellectually contemplating about it, many mothers in the pictures are seen to be firmly in charge of the whole situation and hold their children securely.

Therefore, there exists a dual communication: an intra–dyadic communication and extra–dyadic communication in which two people’s attention rests on a third outside object. What we can learn from this kind of work of art is that the gist of psychotherapy is to simultaneously develop verbal or extra–dyadic communication, which is often verbally reported, and intra–dyadic communication between two people, shoulder to shoulder or side by side.

In one of Utamaro's pictures, a mother and a child are looking at a hole in an umbrella, with the painter drawing them from behind. We can clearly see that the mother is firmly holding the child in her arms. His way of describing an intra-dyadic communication is sensitive, something only a genius could do.

The fact that these two kinds of communication are salient in Japan supports the findings of a comparative research between Japan and the U.S. conducted by W. Caudill (1969) who investigated the attitudes of mothers toward their three- to four-month-old infants. One of the results of the research is that American mothers used various verbal approaches to infants, whereas Japanese mothers spoke less but stayed with their infants longer, touching and taking care of them.



[Picture 2] "Kindergarten" by Chikanobu

As Japanese researchers of joint attention may say, the two people described here are conscious of each other. The child knows that his mother is there and the mother knows how the child is doing. With the existence of "intra-dyadic communication," or a side-by-side relationship in which two people attend to an object, the dual interchange of words and emotions is formed. In many cases, the medium to be shared is mainly for verbal "extra-dyadic" communication, but what I think is important here is that this bridging medium paradoxically creates an opening towards the outside world between the two. Of course, from the standpoint of developmental psychology, the formation of emotional bonds and the holding environment in intra-dyadic communication comes first, followed by verbal exchange with an object in-between.

In one of the Ukiyoe pictures, an older child who is excited by the fireworks display, is held by a motherly figure on a boat. They are both supported by a boatman and they are all "held" by the quiet flow of the river. Without this concentric structure in which every character holds and surrounds one another, with a child as the center, this kind of festivity cannot be created. If a typhoon comes, then everything would be spoiled. In this multiple holding environment, the fireworks display connects everyone and opens all of them to the cultural world.

(3) International Comparison

It is almost impossible to find Western pictures comparable to Ukiyoe outside Japan. Furthermore, in mother-child figures in Western art before the 19th century, pictures which describe this kind of emotional "joint attention" are rarely found. Although there are exceptions like genre paintings in the Netherlands, Western "high" art seems to have avoided depicting deeply involved interchanges between ordinary mothers and infants. In Western art, furthermore, the number of ordinary mother-child figures as a motif was relatively small. So we have to use the Virgin and Child instead

for our cross-cultural comparisons.

As you can see, in most of the pictures of the Virgin and Child, and in religious iconography, too, which accounts for the majority of mother-child Western pictures, there seems to be a distance between the two, at least to the eyes of a Japanese observer. This distance, of course, may express individualism and the triangular situation involving a father in the West. That is, in many cases, even though the Child is thinking of Mary, she is thinking about the Father in heaven so that, in my view, the Child must say something to attract her attention, or to share “logos” to be in touch with each other.

Looking at the Virgin and Child, however, we may all wonder why the mother looks so distant. Does this accurately depict motherhood in the West? In different international comparative researches on child development, it has been pointed out that Japanese child-rearing puts more emphasis on directing the child's attention from outward to inward, whereas Western child-rearing directs the child's attention from inward to outward. It may be that Westerners, perhaps as hunting people, put value on independence, and Japanese people, perhaps as agricultural people, value interdependence. There may be similar differences not only in child-rearing, but also in general human relationships or even in the direction of psychotherapy or counseling psychology.

3. TOWARDS MOORE THROUGH EUROPE

(1) Mother Figures in Western Art

Before discussing the works of modern art by Henry Moore, particularly woman-figures or mother-child figures, I would like to touch upon the recent history of mother-figures in Western Art.

As we all know, the woman-figures in Western High Art took idealized or

purified forms until the 17th or 18th century when ordinary womanhood and motherhood started to be incorporated into the form and content of Modern Art. This revolutionary change is typically observed in the history of the Holy Mother in art. Mary, the Holy Mother, used to be depicted in paintings as a quiet and wise mother, mainly because of religious idealization and purification, if I may say so.

Michaelangelo's sculpture of the Pieta shows the whole picture. The young mother is carrying her dead child who looks older than her. Birth and death is a dichotomy she carries. However, artists, maybe reflecting the peoples' needs, went to extremes in their depiction of purity in contrast to the injury and death of Jesus.

The idea of the Immaculate Conception facilitated this purification process, typically shown by artists like Murillo. Mary in Murillo's paintings is always young and airy, looking up and ascending towards love coming down from above. This is an interesting contrast to Moore's heavy descending figures.

Let me look at some more examples among Renaissance paintings. Probably the most famous painter of Mary is Raphael of Italy. Mary in his paintings was depicted as a mature woman who was not only beautiful but also idealized as a religious figure with wisdom and insights. But we can have a real sense of her physical presence as well as her spiritual existence, which Mary figures of many other painters' works rarely show.

The Holy Mother figures in Renaissance Art do not show the happy concern which we usually expect from a mother to show for her baby, but you can find it in some works by great masters such as Raphael and Leonardo da Vinci. However, most Mary figures look distant and sad.

In my opinion, this impression is produced mainly by the mother's gaze, since she usually does not look at her baby, Jesus. For example, as you can see in the works by Botticelli, Mary does not look at her baby but at some distant spot, although the baby looks at her just like an ordinary baby. This distant gaze of Mary is frequently observed in paintings in churches and art

museums throughout the world.

Maybe we can trace back this gaze to the iconography of Byzantine. Again, Mary looks away from the baby, showing the same distant gaze. So we cannot help asking why she does not look at the baby Jesus. If we identify ourselves with the baby, we would wonder about her distant gaze. When I looked at those Western pictures as a child, I used to ask myself why she looked like this, particularly so sad and distant. I thought there must be a clear reason for the Holy Mother's distant gaze.

(2) Mary's Distant Gaze

In fact, I made a two-month trip to Europe in 2002 to find answers to this question, and discovered quite a few possible reasons with help from my colleagues in Italy. I would like to share some of these answers with you. I went to England at the end of the whole trip and saw a great number of mother-infant works by Henry Moore; and this encounter with Moore finally gave me one of the answers I wanted, which I will tell you towards the conclusion.

Of course she looks distant because she is the Holy Mother who should be naturally distant from us. But there are more formal reasons why she looks away from her child. Firstly, the persons depicted in the paintings are sometimes meditating or conducting a sacred conversation (*sacre convessessione*) which was a popular art style for religious couples in Florence, apparently inviting us to join their holy and meditative conversations. They are not looking at either us or each other, but are looking at something else: heaven, or inside.

There is one more reason why the mother appears sad and looks away from her baby. This is a psychological reason. In fact, she really is sad and full of sorrow, even in despair, with the newborn baby in her arms. She knew the future of Jesus who was going to sacrifice himself for the people, so she was not very happy about the child's birth and his growing up. Sometimes Jesus

tries to reach for a flower, a carnation representing his reincarnation, or a small bird with a red spot which symbolizes the blood of Jesus. Naturally, the mother cannot share the objects he is trying to reach for. She has to look up desperately and, in the end, ascends physically to heaven. Her child is not an ordinary child, but in a way, the mother holds very human emotions toward him.

Lastly, there is a practical reason why the Holy Mother and the baby in the religious pictures cannot look at each other. They are not a closed mother–infant dyad but were psychologically created by people for people such that the dyad should be open towards us. In other words, they must look at us instead of each other, since the Holy Mother is the mother to the world.

(3) Two Versions for Commission

This reason for their opened relationship is very understandable if you think about what happened to Henry Moore who had to make two works of the Madonna and Child on commission for St. Matthew's Church in Northampton, England. He originally made an ordinary mother–child model in his style, with the two figures apparently looking at each other. However, this version seems to have been dropped, maybe due to their closed relationship: Mary and Jesus were not looking at the worshippers.

So he made a second piece which was open to the people. As usual, Mary and Jesus do not at look each other or look in the same direction. Now we understand that Henry Moore's mother–infant works in his style were really trying to bring back many characteristics of motherhood which had been excluded in church art.

The illusion of immaculate purity or noble distance in the Holy Mother went through a process of disillusion in the end of Christian art. As a result, in Modern Art, we now have many religious statues looking more like an ordinary mother–infant couple. But generally speaking, the mother still

looks sad, gazing into the distance, thinking of the child's self-sacrifice in the future, or of her relationship with her child being broken apart.

But at the same time, you now have pictures of an ordinary mother and child. It is only natural that good works on the theme of maternity should have been created by many female artists, like Berthe Morisot and Mary Cassatt, who used to be rejected by Western art circles.

4. GETTING CLOSER TO MOORE

(1) Big and Small Mothers

Now, when I imagine Henry Moore's work again, I usually visualize one of his sculptures in a park or on a hill. I see it in the distance at first, then as I walk slowly towards, what was a small sculpture becomes bigger and bigger. This visual growth of the sculpture in size is really lots of fun. I feel grateful to the master for his preference for putting his works in the open air because I very much enjoy the transition from small to big in size, and also from big to small again.

It had been my impression that many of his works are really big, since I saw most of them outdoors in front of a railway station or art museums. I do not remember ever having seen any of his works inside buildings in Japan. But a few years ago when I visited a special exhibition of Henry Moore in Japan, I became interested in his small works placed inside showcases. I felt much closer to these works and experienced some surprise, too. These small sculptures are usually maquettes, some of which are artistically finished. He made many maquettes to play with his original ideas and to settle his plan. I hear that he often made working models after maquettes, and finally bigger ones, with the help of his assistants.

Many people who are not familiar with the modern sculpturing process may think that Moore worked directly with big materials from the beginning. I

personally had imagined that he himself struggled with huge stones from the start to create his masterpieces. So I was disappointed to see, for the first time, in films or on television, Moore working with small models to bring his ideas into shape. They appeared too small in contrast to the final outcome.

But now, having seen so many of Moore's maquettes, and having understood the existence of a transitional process between small maquettes and the big works, I am able to link the big images with the small ones, feeling that a big sculpture can be small and that a small work can be very big, to experience the inner image superimposed on the outer figure. I think these double experiences with small works as well as big ones are essential to understanding Moore's own experiences in his creation. He used his small works to play with his ideas. In my opinion, this experience of free transition and smooth movement in size is one of the joys associated with Moore's works.

(2) A Case: Fear of Looking at a Poor Mother

Here, let me quote one clinical case of psychotherapy with a Japanese woman to show the value of this transition in size particularly with a mother figure.

The patient, Yoko, was a 25-year-old female scholar who was born into a family of farmers in a Japanese village. She was the youngest of three children, with two elder brothers. She graduated from the graduate school of a famous university in a big city and got a job as a scientist at a national institute. One year later, she suffered pneumonia and became depressed while undergoing treatment at a hospital. She was referred to me since she was still depressed and anxious even after regaining her physical health.

Yoko seemed to have many things to talk about and looked happy to see me, a psychotherapist: a sharp contrast from her depressed and agitated mood she had felt in the morning. A psychiatrist prescribed some antidepressants which apparently did not work. She wanted to resume work at her institute as soon as possible but could not.

In the first phase of her psychotherapeutic sessions with me, she recalled how lonely she felt in a big family in spite of being surrounded by many people almost all the time, including her parents, brothers and grandmother. This crowded family were physically close to her but psychologically distant. She used to play with her big brothers but hated being with boys because she felt she was not welcome in boys' play although she knew they were good-natured.

She also recalled that, during puberty, she felt isolated and tried to be independent. However, her family treated her as a little child, something which still happens even now. They often tell her that she had been very dependent on them, saying "You are an Amaenbou (meaning a 'child of Amae')." Amae in Japanese means a sweet taste or a need for dependency. But she does not feel she was given anything delicious that she as a child wanted from her mother. She had always felt, since her childhood, that her mother was a bad cook. She remembers she got disgusted whenever her mother wiped her dirty face with a handkerchief moistened with the mother's saliva.

She did not like being treated as a small child but she was, in fact, physically small. Gradually, a sense of isolation in the middle of a crowd became one of her depressive complaints. I thought that her tendency toward self-isolation repeated itself even in her adult life. She likes to travel alone although she complains of her inability to socialize with other people. Often during our psychotherapy sessions, her voice became so faint that I could not hear her completely and had to ask her to repeat what she had just said. In other words, she isolated herself from me, too.

She secretly believed that she was misunderstood by her "big" mother and brothers, saying "I'm not an Amaenbou." The small Yoko even had a "big" ambition to become a "big" girl who could do anything on her own, to prove that she was not an Amaenbou. She hated her mother telling her, "You cannot go on like this. You will fail because you are so dependent." Yoko knows that her mother is afraid of Yoko abandoning her someday.

We gradually understood that Yoko wanted her “big” mother to come down to her and to adapt herself (the mother) to the small Yoko. But she at the same time was frightened to see the small aspects of those “big” people. In fact, her mother is more than 70 years old now, and recently started looking like a really old woman with a bent back, so Yoko’s mother is becoming small and losing power. Yoko feels guilty for her poor mother becoming small and for herself becoming independent. The “big” mother wanted Yoko to be smaller while Yoko did not want see her mother’s smallness since it was distressful and painful to her. So this image of a small mother was denied by both the mother and the child. While weeping in the session, Yoko said, “My mother is Itoshii (meaning painful as well as dear or beloved in Japanese, like the English word “tender” which can mean fragility).”

(3) The Hierarchy of Love

Although the patient felt burdened by the Japanese concept of Amai, it is generally viewed positively in Japan. The print by Utamaro [Picture 3] is a picture which D. Freeman (1995) selected from a variety of Ukiyo-e works as the one showing a child’s Amai, being also a variety of joint-attentive position. It is clear to Japanese observers that the painter is illustrating an intimate relationship in which a small child is passively asking his “big” mother to come down to pick him up, rather than him actively trying to reach to her.

T. Doi (1973), a Japanese analyst who pioneered researches on Amai, was interested in the overlapping meaning of sweetness and dependency that the word carries. He associated the pronunciation of the word “Amai” with the Japanese baby language “Uma-uma,” which usually means “eating.” I think language is a medium which can easily imply some oral meanings because language is a product of the mouth. Particularly the sound “ma” in Amai makes us associate its meaning with the oral experiences of infants. I can give you some other examples of words that contain “ma” in their sounds. Those are “mother,” “mouth,” “munch” in English, “mamma” (breast) in Latin,



[Picture 3] “Yamanba and Kintaro — Chestnut” by Utamaro

and the name of the Japanese Goddess "Amaterasu." We can say that the sound of "ma" embodies the memory of gratifying oral experiences, like “ma” of Mary, our heroine for today.

This "ma" sound is usually pronounced with the face held somewhat upwards and the mouth open. I suppose that this shape and position of the mouth express the desire of a person who is asking for something important to be given something from somewhere higher up, to his or her open mouth. I know from experience that a person showing "Amae" or dependency is looking up from a lower level, and the person being asked for love occupies a higher or more important level just as the Japanese Goddess Amaterasu, which literally

means "shining in heaven," shines on us from heaven.

As the patient complained, this linguistic hierarchy is so structured that we are linguistically expected to feel that love comes from above. Now, let me discuss some Christian iconography to help you to understand the hierarchy of love. In these pictures, I see the tiny Christ showing Amae to big mother Mary and asking to be loved by her. This impression is produced because of the vertical, overwhelming hierarchy between the too great and generous Mary and the too tiny Christ, and I may interpret that Christ as a child is showing Amae to his mother Mary. But Mary is too absorbed in heaven above to respond to his Amae.



[Picture 4]

However, Western psychoanalysis shows an interest in the possibility that the child can love his/her mother and wish to become big like an adult. Psychoanalysis studies mainly unrealistic or subjective fantasies, or this possibility of the small becoming big enough to love the big. Surely the small can love the big.

(4) Inter-Subjective Love Experience

Just for fun, let us pronounce "Ma" slowly or "Moore" aloud, and then return here to the Mother and Child by Moore. The sound experience of "M—a" indicates the need for the mother to come down, so I believe the reclining mother figure with the baby in her arm is really responding to our Amai, showing the movement from the higher to the lower, from the big to the small. Moore's descending and reclining figure, in contrast to the standing and ascending figures in Christianity, looks like an Asian statue of reclining or sleeping Buddha and is unique in the context of Western art history.

If you look at the reclining big mother holding the small baby by Moore, you may feel an impulse to leap up to the mother figure from below. But if you understand that she is coming down for you, you would like to wait to be picked up by her. Furthermore, if you recall that the mother figure is also a small maquette with a length of 21.6 cm under your shoulder, you may feel that she needs your caring and love.

The working model for "Draped Reclining Mother and Baby" is 78.5 cm but the finalized work of "Draped Reclining Mother and Baby" in front of the Hakata Station has a length of 265.5 cm. Looking at the small child in her big arms, we now understand it is too realistic and objective to cling to the interpretation that the child is asking for love from the mother and to be held because the child may also be caring for the mother. Although I admit that the concept of love coming from above as something valuable that may lead to useful and insightful knowledge, the idea that a small person is small sometimes destroys the big heart of the small person.

Let me pose some questions here while looking at Moore's works from above for the small model and from below with the big statue just like how Moore did in his creative process, I would imagine. Where does love, which is generated between the parent and the child, come from? Does it come from the child? From the mother? Or, from the father outside, Moore the creator or the Creator? There is no "single and final" answer to these questions. Rather, through this questioning process with his works, we can gain a variety of viewpoints and perspectives concerning love between a parent and his or her child, and we can exchange these viewpoints. And this exchange is full of joy and deep insights.

5. ONE MORE SPOT TO SEE

A sudden confrontation with two incompatible aspects like small and big in a mother or motherhood can be conflicting or threatening because of our difficulty in integrating them.

Moore said, "this conflict between the excitement and the great impression I got from Mexican sculpture, and the love and sympathy I felt for Italian art, represents two opposing sides in me, the 'tough' and the 'tender'. Many other artists have had the same conflicting sides in their natures..."

In my view, Henry Moore, in creating sculptures of women, had struggled for the integration of the dichotomy between the two Mothers, the tough mother and the tender mother, or the great mother and the poor mother. As I wrote at the beginning, there is a Jungian study of our archetypal mother figures, called the "Great Mother." If you take a look at this book, you will be surprised to find no poor mother or injured mother, although he covers the terrible mother and the frightening mother as well as the bad mother by quoting legends, folklores and so on from many cultures. I think it is very difficult to accept the poor mother or fragile mother like the patient I had

quoted.

However, it is very important for us to deal with poor mothers in clinical practice. In general, it is easier to talk about bad mothers as well as good and/or rich mothers, but how about fragile mothers for whom we easily feel sorry? In Christianity, the injury tends to go to Jesus since he died for us. But mothers may tend to die for their children more easily, and so many mothers died for their children at the time of delivery, as shown in the Japanese legends and mythology (Kitayama, 1985,1991).

Birth trauma is a term coined by Otto Rank to represent the primary trauma we experience when we are born. However, this could also involve the mother's delivery trauma which we cause when we are born. She is so fragile that we may cause her to die at our birth. This was very true a long time ago due to poor hygiene. So a woman's genital organs and her bleeding can be easily associated with the injury we caused.

On the other hand, there is a very common association with the womb in the mother as a home for us to go back to. Since Freud, it has been pointed out that the experience in the mothers' womb is peaceful like floating on a calm ocean. But Freud described children's curiosity about the inside of the mother's body. "This longing often turns into its opposite and gives place to disgust which in the years of puberty can become the cause of psychical impotence, misogyny and permanent homosexuality." (SE11, p. 96)

Moore is very famous for the holes and inner spaces in his sculptures. They are very new in the history of Marian art, marking the turning point of disillusionment from the idealized image of Mary.

I think that our interest in holes or what is inside the female body is universal, and the space inside is associated with a woman's sexuality. Freudian psychoanalysts may also interpret a hole to be our home where we used to be held safe inside. So the hole in Moore's sculpture is consciously or unconsciously associated with the mother's hole in the body into which we look and get.

It is human nature to peer into a hole for whatever reason. The secretive nature of holes or insides is very attractive to us. Being invited to look into secrets inside may lead us to the tragic revelation of something terrible, since it breaks the prohibition against looking. I have studied this Japanese taboo which may be a universal one against the secrets of a woman's body.

I like the smooth surface of holes in the sculpture by Moore since they are not guilt-producing, and the holes in his works look safe enough.

6. RETURNING TO JAPAN

I think I should stop here because my trip stopped there. As usual, it is difficult to be certain when trying to understand the thinking of another person. It is very true in the case of a sculptor who thinks that intellectual interpretation might destroy his creativity. So, here in the end, I would like to quote what Freud (1914) had to say in the end of the paper on the Moses of Michelangelo: "And finally we may be allowed to point out, in all modesty, that the artist is no less responsible than his interpreters for the obscurity which surrounds his work."

When I, on my way home, think of a sculpture by Henry Moore in a garden, one of my associations is a Japanese rock garden in Kyoto, featuring harsh rocks covered by green moss in white sand. I sit by the garden meditating. It is said that the rock garden usually represents the world or the four seasons. The garden with rocks with harsh surfaces here looks very paternal. My endless meditation starts here again.



[Picture 5] A Mother–Infant Sculpture in front of the Hakata Station

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Child-rearing in Japan in Transition

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1. Introduction

Dr. Daniel M. F. Freeman (1998), the organizer and chairman of this conference, sent me his paper entitled "Emotional refueling in development, mythology and cosmology; the Japanese separation-individuation experience" so that I can use it as a guide in preparing this paper. Incorporated in his paper is the rich harvest of the Interdisciplinary Conference on "Amae Reconsidered" held in San Diego, 1997. He describes in detail what direction the process of the development of children takes in Japan and the role of "Amae" in that process. His argument is based on the work of many Japanese psychiatrists and American anthropologists, mythology and old stories. His paper nevertheless contained many new lessons even to me despite the fact that I participated in last year's conference as a discussant.

In presenting my paper entitled "Child-rearing in Japan in transition" this time, I would like to discuss not only the mother-child inter-relation while attaching importance to Mahler's concept of the process of separation individuation, but also the father-child relation which hitherto has not been discussed, and how the role of fathers has an indirect influence on the mother-child relation. And I would like to touch on the sociocultural conditions which have allowed these relationships. The role of fathers may be called psychological and psychosocial or psychocultural, as opposed to the mother-child relation which is more

psychological. I would also like to discuss how child rearing and children's figuring things out themselves have changed in Japan amid Americanization called globalization today.

2. Development of children—Position of children in the home and in society



Fig. 1 “Mother and Child”

Pablo Picasso: 2004— Succession Pablo Picasso— SPDA(JAPAN)

Fig. 1. This is a mother–child picture drawn by Picasso. Subjectively, we feel oneness transcending a distinction of which person is holding the other, mother or child. They touch each other through a close contact of the skin.

We can see such kind of mother–child pictures drawn by many artists. In these pictures, too, the artist has drawn symbiosis between mother and child.

This may be the starting point of security and trust. These pictures represent what Mahler (1979) calls symbiosis. It is what caught the minds of artists throughout the world. The mother–child relation may be universal. Before long, children will come to enjoy peek–a–boo by using the muscles of their bodies, as

shown by the pictures in Fig. 2. In his paper, Freeman states that this peek-a-boo is succeeded by hide and seek, which children enjoy later when they ascertain the self by "disappearing and returning". I think it is meaningful for children to control the object through their own muscular activities. Children experience joy and courage in their minds. When children reach the toddler age, they gradually get beyond their mother's control because of their autonomous activities. Involvement by the father is required. According to recent studies in developmental psychology, fetuses can recognize their father's voice. So it would be wrong to belittle the father's influence early in life. Fig. 3 is a wooden doll of St. Anthony of Padua, a father who "loves children," which I bought at a souvenir shop behind St. Stephan Church in Vienna.



Fig. 2 "Bo-Peep"

Johnson, E.: Amon Carter Museum, Fort Worth, Texas (In) Langer, C. (ed); *Mother and Child in Art*. Crescent Books, New York, 1992



Fig. 3 "Father and Child"

A Wooden Doll of St. Anthony of Padua, a souvenir shop, St. Stephan, Vienna, Austria

A father is supporting a child's legs with his arms. The child is looking ahead with his spine straightened out. A father stimulates his child with his strength. Children learn joy and courage through muscular activities. In doing so they repeatedly try to have their father play with them and to control them. On their part, fathers may begin to have a fear of being challenged more than a feeling of joy. Prohibition begins there. In this way, castration anxiety--Oedipus complex may start budding in the minds of children. The same process of maturation--development of children occurs in Japan too. However, the position or the role of the mother in the family, relations between father and mother, their influence on children and the position of children in the family have cultural characteristics peculiar to Japan. Japan traditionally was primarily a rice-growing society. People rooted in a certain piece of land never moved from one generation to the next. The Japanese have a word "ie" meaning a house, but it represents neither a building nor a family of one particular period of time. It represents a family unit that has continued for many generations. The growing of rice is largely subject to natural environmental conditions. This has brought about many religions including Shintoism that originated in Shamanism in Japan.

Japan is a polytheistic society in which Buddhism, Taoism and Confucianism exist together with Shintoism. Before the war, these gods were worshipped in the morning and evening in almost all houses, and a festival at each shrine was observed at a certain fixed date. In short, the "ie" in Japan was very religious.

When young men and women got married, importance was attached to the succession in the "ie" of men rather than the happiness of the couple. So the "arranged marriage" was common, although it has all but disappeared today. And people went so far as to say that the husband-wife bond is determined in advance. It is against such a cultural background that the Japanese set great store in fate or relationship. It manifests itself as the phenomenon called "amae." The view that the other party is not an independent individual in the Western sense is also found in child rearing. A Japanese proverb says: "Children belong to God until they are seven years old." A child is taken as a gift from God to ensure

the succession of the “ie.” Accordingly, in the process of the growth of the child, a festival is observed to report the growth of a child to God in a Shinto shrine.

The baby and grandmother on the father's side are playing the leading role. Parents are relegated to the back seats in that place. Fig. 4 illustrates a hina-doll on March 3, the Girls' Day. This festival is traced back to the ancient event in which people wished a girl's health by letting a paper doll float down a river as a substitute for the child.

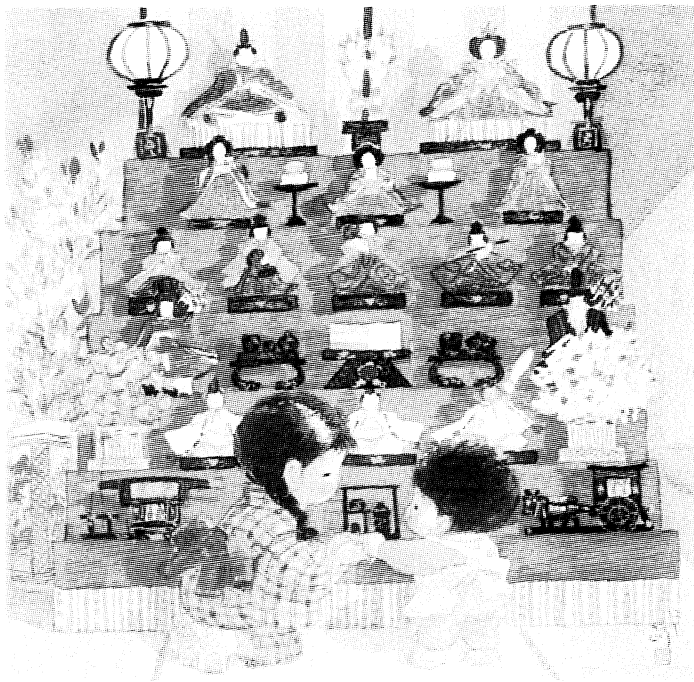


Fig. 4 “Hina-Doll Girls' Day”

Nishijima I.: Twelve months of Japan. Paintings on Children Book. Shukosha Publish Co., Fukuoka, 1973

Fig. 5 shows flying carps. It is a festival to purge poisonous air, in which people wished boys to grow well and strong — maybe this is a custom that was introduced from China, presumably originated in Taoism. In addition, there is an event in which children ages 7, 5, and 3 visit a shrine on a certain day in

November to pray to God for further growth. Indeed, there is no lack of events and customs which "regard children as belonging to God up to 7 years of age."



Fig. 5 "Flying Carp for Boy's Festival"

Nishijima, I.: Twelve months of Japan, Paintings on Children Book, Shunkosha Publish Co., Fukuoka, 1973

It was once proverbially said, "A wife with no child 3 years after marriage gets divorced." It is a dead proverb now, but it used to have a weighty meaning before the war.

For the succession of "ie," a wife or mother worked self-sacrificingly and made efforts to raise children so that the expectation of the house on children be realized. That is why children are called a "child treasure." This spawns a strong emotional bond between a mother and her child, particularly son. Doi connected the attitude of neurotic Japanese adolescent patients who do not realize that their dependent trend is abnormal with "amae" and stressed its pathology.

Showing a keen interest in Doi's amae theory, M. Balint (1959, 1968) stressed a common thread between Doi's amae theory (1973) and his primary love theory. I have participated in debates since Doi presented a paper on his amae theory for the first time in Japan, and I have taken up the double structure of amae for discussion. When a child directs his amae desire to his mother or father, they accept his request for amae or accept it partially while teasing him about amae, and they guide him toward the direction they desire. In short, the mother or parents try to strengthen family solidarity by being dependent on the child, and in this way the succession of culture of the "ie" is maintained. Many points concerning the concept of Amae are open to argument, such as the diversity of its meaning, its universality, gender differences and sensitivity to amae as pointed out by Dr. Freeman, but there is no denying that it is a key concept for understanding the importance that the Japanese attach to the relationships.

D. W. Winnicott (1965) has also stressed the importance of dependence in the process of maturation of children. According to his theory, the process of maturation involves stages of absolute dependence, relative dependence and towards independence. Winnicott explains that an ego-supported mother introjected by a self-supportive ego forms a capacity to be alone. In short, a mother as a holding environment is taken up by the personality core of a child, which enables her to be isolated from those around her. In the case of the Japanese, emphasis is placed on the succession of the mother-child relation or parent-child relation. This naturally determines the relationship of parents.

To Europeans and Americans, assertion of the individual, personality of nomadism, severance between individuals, contracts aiming at resolving it as an actual problem and love transcending it as a problem of humanity, appear to be essential qualities. To the Japanese up until the present, experiencing such love is said to have been difficult. The Japanese are said to have given first priority to "wa," sum or harmony or linkage in existing as a family community or family group. To that end, they adopt an attitude of restraining themselves and following others, while reading the expression and attitude of the other party. This

is probably the reason that the stranger anxiety 8 months after birth is carried over thereafter for a long time and that shame is particularly stressed among the Japanese. The phrases parents often use in restricting children's behavior are "You are the child we picked up from a river" and "A kidnapper is coming." The former suggests to the child that he is a temporary resident from another world, and the latter is a warning to the child against destroying his relations with others.

There are enumerated words representing Japanese culture such as Amai (dependence), On (debt of gratitude), Giri (duty), Iki (dapper), Bokashi (shading), Chijimi (shrink), Haragei (psychological act) and Tatemaie to Honne (principle and real intention). Many of these show the importance the Japanese attach to relations with others. H. Nakamura (1948) said, "In Japan, when asked 'Don't you go?', they answer, 'Yes, I don't.' In the West, it's the other way around. In the West, they answer negatively or affirmatively to the objective things contained as material in the interrogative sentence. But in Japan, they answer negatively or affirmatively to the idea or intention of the other party, that is, the standard focuses not on the things but on the other party. This also indicates the importance they attach to interpersonal relations."

Children acquire this way of thinking or conversation style in the process of learning words. Separation-individuation in Japanese children is very different from that in European and American children. The conversation style of the Japanese, as pointed out by Nakamura, can be noticed instantly when the Japanese are learning English conversation. Today the Japanese adopt the Western style when conversing with Europeans and Americans. The Japanese are liable to feel "ON," a debt of gratitude rather than gratitude to the other party, because they find it difficult to have a free and equal relation with the other party. Y. Soeda (1993) has maintained that there are 4 kinds of "ON," namely, (1) to parents, (2) to the public, (3) to the king and (4) to three treasures (Buddha, Law, the Priest) and that children experience ON to parents first in the course of maturation. H. Kosawa (1954) and K. Okonogi (1979) have pointed out that the

Japanese have a guilty feeling concerning their mother's care, as well as a guilty feeling based on the Oedipus complex. He named this the "Ajase complex" referring to a story about patricide in Buddhism.

During the war, many Japanese young men, as a member of the Kamikaze special attack unit, were forced to make suicide attacks against American armed forces. In carrying out the suicide attack, these young men rationalized it by defining their act as returning "ON." This attitude of identifying themselves with a group through self-sacrifice should be called Japanese masochism.

Fig. 6 depicts a scene of what could be called a holy family in old Japan. At a leisurely time after dinner, a father is seen joining children's conversation while a mother stops needlework, listening to their talk. With such a spatial structure and "sitting life" on the tatami mat, there are fewer moves and actions, and time



Fig. 6 "A holy family in old Japan"

Nishijima, I.: Twelve months of Japan. Paintings on Children Book. Shunkosha, Publish Co., Fukuoka, 1973

flows quietly compared with the "standing life" using a chair. No doubt, such a traditional Japanese home must have nurtured a peculiar sense in children. Also it is a stage suitable for parents to teach children self-regulation of "being docile" and etiquette in childhood regardless of sex.

Two spatial relations may be thought of as determinants of Japanese behavior. Each of these makes it difficult for the Japanese to express themselves as individuals. First, there is a vertical relation, which originated in the family relations that children experienced. Since the family is built on a proposition called the succession of "ie" as I have mentioned, children are controlled by the large family system and/or patriarchal culture. Children appear to be pampered as a child treasure, but actually they are controlled. However, there is a contradiction in that the head of family or father, while being a protector of the "ie" system, is protected or controlled by that system. In that regard, the father plays a "false self" role as a father. In other words, a father has two sides: strength and fragility. The second factor is a horizontal relation, outside and inside of the "ie."

I touched on the topic of shame earlier. The Japanese are sensitive to the assessment by "seken" or the world. They have been taught to give thought to relations with "seken" and assessment by "seken" from childhood. The Japanese tend to be particular about the distinction between uchi (inner) and soto (outer) and between omote (surface) and ura (back).

Fig. 7 is a diagram to illustrate that relationship. Uchi (inner) has diverse meanings, such as my side, my house, my husband or wife and myself. All the more because of that, the meaning is differentiated and is specific to the particular person concerned. In contrast, soto (outer) means other place, town, village and foreign land. The relationship between ura (back) and omote (surface) primarily means a spatial place in the house with the former referring to an inconspicuous place and the latter to a conspicuous place. Dr. Freeman in his paper touches on the statement of Doi concerning a "dual" or "two-fold" structure of consciousness. It is not that ura-back side refers to only the private consciousness. It is a place that is to be shared by those of the uchi side.

Uchi (Inner), Soto (Outer) — Omote (Front side), Ura (Back side)

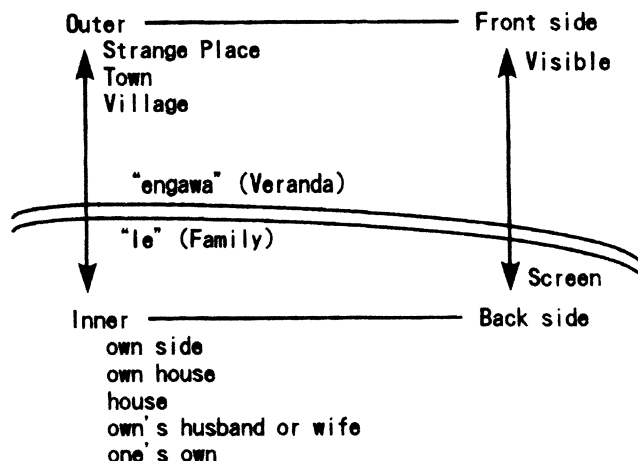


Fig. 7

3. Gender-related Differences in Personality Development in Japan

Touching on the gender-related differences in the maturation and growth of children from the viewpoint of separation-individuation process, Dr. Freeman has mentioned the characteristics of this process in the case of Japan. When a child reaches the rapprochement subphase or toddler age, the attitude of the mother and family begins to be different toward a boy and a girl. I showed you photos of Girl's Day and Boy's Day earlier. A girl is expected to grow to be beautiful like a peach blossom and to be an organizer of a happy family as symbolized by the hina doll. A boy is expected to grow to be active like a carp streamer swimming actively in the fresh air of May, and to be a strong and brave man as symbolized by the doll warrior.

Incidentally, the carp is believed to climb waterfalls. Parents expect a boy to overcome difficulties and to attain a goal like the carp. The attitude of a mother

toward her children differed according to the gender of children. To a boy, she would say, "You are a man, aren't you?" This was a phrase used daily. It means that a boy must endure hardships and follow through until he achieves success. To a girl, she always taught her to "behave as a girl should be." In other words, a girl should be docile, moderate, quiet in movement and has good manners and self-control. When giving food to children, it was more common for the mother to treat the eldest son more favorably. Such an act of the mother does not sit well with the eldest son himself and is objectionable to other children. When repeated and practiced daily, however, it becomes customary. It may have had the effect of making the eldest son become aware of the responsibility as the future head of the house and the effect of implanting in the other children the attitude of expecting protection by the eldest son.

Japanese children had to figure out how to adapt and how to grow up amid the logic and culture of "ie." This is different from realization of the modernized self in the Western sense. A. Roland (1988) named the self of Japan and India a "familial self," in distinction from the "individualized self" of Europe and America.

As I will mention later, M. Nishizono (1996) thinks the familial self has weakened so much as to be replaced by a "circle-based self" today. In traditional Japan, a father played a dual role: as an individual and as the head of "ie." The role of a father as the head of the "ie" was made possible by the support of a mother and other members of the extended family.

The process of a boy forming his self is a gradual process of solving the problem of integrating this duality. This gives rise to a strong tie between a boy and a mother who protects the "ie." Fig. 8 illustrates a boy being doted by women of the "ie" including a mother.

Fig. 9 is a mother-child picture entitled "Mountain Nurse and Golden Boy." Utamaro, the painter, is said to have drawn a mountain nurse in place of a mother in stressing the erotized love between a mother and son. Mountain nurse is an unmarried woman. She is said to show that women deep in their minds have a desire to seek love with their sons.



Fig. 8 "Celebrating Boy's Day, 1780"

by K. Shunsho Museum of Art, Carnegie Institute Pittsburg, U.S.A (In) Langer, C.(ed): *Mother and Child in Art*, Crescent Books, New York, 1992.

In the past, Japanese women were asked to "bear" and "bring up" their child, but their enjoying sex with husbands is said to have been disregarded. Self-control and self-regulation were always pushed on to girls. At the same time, empathy and alliance were likely to be formed between mother and daughter, who were on the same position. Girls too are shouldered with a dual problem, that is, suppression of sex and the self, and acquiring a traditional role ego in the process of their being brought up.

The Kaguyahime story depicts this psychological state of girls well. A pretty princess named Kaguyahime wooed by many young princes had a good time every day. But she never gave herself to young men. One evening a beautiful horse-drawn carriage came to fetch her. And she returned to the world of the

moon, leaving surprised people behind. The world she enjoyed with young princes was only a temporary one. This Kaguyahime story teaches that a girl must not give herself up to a boy until a pre-arranged marriage is materialized. This is also referred to as the Kaguyahime complex.

W. R. Bion (1975) has pointed to the importance of a caesura in the development of personality. To Japanese girls, adolescence is the caesura.



Fig. 9 “Mountain Nurse and Golden Boy”
painted by Utamaro

4. Child developmental issues in Japan in transition

Under the influence of globalization, or Americanization to be more exact, the Japanese society is changing rapidly. The Meiji Restoration in 1868 was the first phase of Westernization, but it concerned Westernization only of systems, such as

the administration, military and politics. In short, it was Westernization of the social form "outside the ie," and it was so-to-speak modernization for men. Traditional culture was rather strengthened "inside the ie." In other words, women, wives and mothers were forced to be a tool to protect the "ie." With Japan's defeat in World War II, however, the situation changed completely.

The revision of the constitution and civil law under occupation by the American Armed Forces negated many things in traditional Japanese society. Additionally, economic growth began in the 1960s. Modernization by women and for women was made possible. Urbanization and a shift to a nuclear family structure started and spread far and wide. Women freed from the pressure of traditional authority refused to personally learn and follow the experience of the old people. Instead, they used information obtained via mass media as the basis upon which to act. The mass media without exception considered the opinions of scholars who had just returned from foreign countries to be valuable. The industrial structure of Japan underwent a change from a rice-growing society to an industrial society and a post-industrial society. Higher education was realized. It became common for women to graduate from a university and advance into society. In short, a cultural revolution in a sense took place.

The separation of a place to live and a place to work has become common. A city as a place to live is over-populated and space for children to play freely has gone. Forming a local community is difficult since the population is constantly fluctuating. In the home the opinion of wives is strongly reflected, and an affectionate atmosphere full of gentleness rather than rigorous training characteristically prevails, unlike the old days when the place to work and place to live were the same.

Regrettably, husbands contrary to wives' expectation have come to remain silent in the home. Husbands and wives have become poor listeners and a communication gap between husbands and wives is no longer uncommon. This rupture between husbands and wives has a hidden possibility of establishing a form of love different from "wa" as a way to overcome the rupture, but so far no

sign of success is seen. Husbands press the responsibility of child rearing on to their wives. They are stuck to the traditional idea that women should always be around their children and take care of them. Many wives also think that this duty is realized only when their children have won success. Such an attitude of wives is still rooted deeply even at present when the tradition of ensuring the succession of the "ie" has faded. For example, a proverb says: "The parents' expectation grows as a baby stands and walks."

Granted that it is natural to place expectations on one's children, today parental expectations have become overheated by the belief that higher education is indispensable for children to succeed in industrial society and post-industrial society. Partly as a result of mothers advancing into society, it has become common for children to be put into the care of day nurseries, starting from the rapprochement subphase, and to be trained under a certain fixed program.

Dr. Freeman touches on the study W. Caudill, an American anthropologist, carried out in Japan in the latter half of the 1960s. He said that Japanese mothers compared to their American counterparts have more direct physical contact with their babies and are good at perceiving what their infants want by their expression and manner rather than through words. Moreover, he pointed out that when a boy cries, Japanese mothers tend to take it as anger and try to soothe it by holding behaviors, although the crying may be manifestation of a need or distress. Even today when there is less time for mother-child contacts, the characteristics of mothers' performance may remain relatively unchanged, since their intimacy will be increased when they are together. In Japan today, peer harassment and school refusal among pre-early adolescent boys and girls have become a social problem. These pathologies in the second individuation stage, as P. Blos (1979) calls it, can be said to be originated in the first separation individuation stage. Formerly, self-regulation was made possible in interrelation with the subject. Today, even the ego that creates such an interrelation is easily impaired.

Lastly, the author will show you pictures depicting children's play in traditional

Japanese society.

Changes in Japanese children's play as they grow older are (1) playing with a toy with parents, and (2) playing house—keeping under the eaves, on the veranda or in the garden as illustrated in Fig. 10—this was often seen among girls, and scenes depicted in Fig. 11 when they grew older. Children's spontaneity, joy and self-regulation through group mutuality, in-group rules and equality can be seen there. A child too much glued to the mother is isolated from peers, sticks to his mother and is looked down by peers. This is what M. Balint (1959) calls "Occnophilia." Today the place for children to play and the time to play have gone because of changes in the quality of the local community and attendance at juku (extra schools) after returning from regular schools.



Fig. 10 "Playing Ladies"

Chihiro Iwasaki: Chihiro Art Museum



Fig. 11 "A Sword Battle Playing of Boys"

Nishijima, I. : A Painting Book on Nostalgic Memories, Shukosha Publish Co., Fukuoka, 1979



Fig. 12 "Father and Child" in a new style

Chihiro Iwasaki: Chihiro Art Museum

With the spread of the 5-day-workweek system and with the budding of awareness about child rearing, fathers have come home as shown in Fig. 12. This may be taken as a hope for resolving such a desolate situation.

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The Narcissism and Death of Yukio Mishima

— From the Object Relational Point of View —

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INTRODUCTION

There has been no Japanese novelist who has attracted as much worldwide attention as Yukio Mishima. Though 17 years have passed since his death, European and American psychiatrists, who are interested in his unique talent and eccentric behaviors, often want us Japanese psychiatrists to discuss him and his works. In 1985, when the subject ¹⁾ about Mishima was announced at the 34th International Psycho-Analytical Congress, I, as a moderator, was surprised at the great number of those participants who filled the hall. At that time I felt sorry, however, that Mishima and his behaviors were not always understood adequately. For instance, there were not a few opinions that his “hara-kiri” or “seppuku” (an old Japanese ritual of suicide) surely reflects the modern Japanese mind. The reason for this seems to me that there are no English papers on the pathography of Mishima written by Japanese psychiatrists, although many insightful Japanese papers have appeared in Japanese Journals. ⁴⁾⁵⁾⁸⁾ One of my purposes here is to fill this void by presenting in English a paper on Mishima.

However, the more important purpose is that a study of his life would make a great contribution toward understanding the severe or primitive personality disorders ⁹⁾ which are currently one of the biggest interests in the psychiatric field. Although various kinds of clinical diagnoses like schizophrenia and others

have been made from the psychiatric point of view, this case seems to be difficult to explain merely by the phenomenological description. Fukushima, A. pointed out 10 years ago that in order to make a correct diagnosis of Mishima, we should wait for the development of a new way of psychodynamic understanding. Now we have the object relations theory ¹⁰⁾²⁰⁾ which could be useful in understanding the subjective inner world of a human being. It is certain that one of the decisive points for understanding Mishima is to deal with his massive fantasies which have a very intimate relationship with the inner world.

A BRIEF HISTORY OF HIS LIFE

Kimitake Hiraoka (Yukio Mishima's real name) was born on January 14, 1925, at the Tokyo home of his grandparents, Jotaro and Natsuko Hiraoka, with whom his parents lived. The Hiraokas were an upper-middle-class family: Jotaro had been a senior civil servant, and his only child, Azusa, Kimitake's father, was also a government official.

What attracts a psychiatrist's attention first concerning his infancy and childhood is the fact that Natsuko snatched Kimitake away from his mother's arms on the 49th day of his life. His bed was placed in her sick-room, perpetually closed and stifling with odors of sickness and old age. There he was held prisoner until 12. Natsuko was the strongest personality in the Hiraoka family, and demanded and received what amounted to total control of her grandson's life. For example, here is his mother Shizue's memories after Mishima's death: "We [parents] lived upstairs, while Mother [Natsuko] kept Kimitake with her all the time, ringing an alarm every four hours ... Kimitake's feeding times had to be precisely every four hours." She continues: "Even when Kimitake got to be three, permission for him to be taken out into the air was granted only when the weather was fine." And "Mother thought that boys were dangerous playmates so the only friends she permitted Kimitake were three older

girls she carefully selected from among his cousins. And it had to be even quieter than what girl's play normally is, because Mother's sciatica made her sensitive to noise and she insisted the children play in the room." No wonder the boy took refuge in his fairy tales and preferred to be by himself reading a book or playing with dolls, blocks and so on or "indulging in my willful fancies or drawing pictures." 7)

In April 1939, Kimitake entered Gakushuin, the Peer's School, to which the children of the class of the Hiraoka's would not usually go. Shizue says that he was always bullied by his classmates in those days.

In these circumstances, Kimitake developed a characteristic personality. He was a quiet, obedient, sensitive, precociously intellectual child who had never expressed his feelings. They were concealed as if behind a Noh mask. From this, he got the idea of leading the life of a "mask." In "Confessions of a Mask," 12) he wrote that by the end of childhood he was already firmly convinced that "life was a stage and that he was to play his part on the stage without once ever revealing his true self." This tendency is substantiated by the Rorschach Test which he undertook at 36. At the same time, he developed massive fantasies as a defense against his underlying anxieties. "The things that were happening before my eyes —my grandmother's spells or the petty family quarrels— and the fanciful events of the fairytale world in which I had just become immersed seemed to me to be of equal value and like kind. I could not believe that the world was any more complicated than a structure of building blocks, nor that the so-called 'social community,' which I must presently enter, could be more dazzling than the world of fairytales." 12)

What must not be forgotten in this line of thinking is that he had suffered from "autointoxication," a kind of psychosomatic disease during childhood, which is thought to be a reflection of his internal unbalance. This illness is said to be usually found in children who are sensitive, intelligent and overprotected, who have been trained by their mothers to be "good" boys or girls. His peculiar attacks of abdominal pain in his adult life seems to have something to do with this

childhood illness.

In March 1937, when he was 12 years old, Natsuko suddenly announced it was time for him to rejoin his parents. She was 62 and very ill. What should be kept in mind at this stage is the establishment of an intimate relationship between Kimitake and his mother after he moved back into her house. She protected him from his father's unrelenting attack on his preference for reading and writing in his room, and encouraged him to write poems and novels by reading them and by introducing him to Ryuko Kawaji, a well-known poet. Thus, his literary activities became intensified with the help of his intellectual precocity. Shortly after entering middle school, he came to the attention of members of the literary club and became a regular contributor to the school magazine. He published his first long work, "The Forest in Full Bloom" at the age of 16 under the pen name Yukio Mishima. And from 1942 until he graduated from the Peer's School at the end of 1944, he managed to produce eight novels, three long essays on classical literature and a slim volume of new poetry. All this work had been done with the support of his mother, Shizue. It is even more interesting that even after he became a successful writer he had to have her read all his writings before their publication.

In any event, along with his vigorous literary activities, his career at school was brilliant. He graduated from senior school at the top of his class and received an award, a silver watch, from the Emperor in March 1944. In May he passed an army physical, but he was not drafted and started his studies at the Tokyo Imperial University in October. When his draft call came in February 1945, he took leave of his parents in Tokyo, who shared the belief that he would not come back again alive. Fortunately, however, a false diagnosis of incipient tuberculosis made by an unexperienced army doctor exempted him from military service. Thus the war ended in August of the same year. After the war he continued to study law at Tokyo University and obtained a position at the Ministry of Finance in a competitive public examination at the end of 1947. Even after entering the ministry, his double life, working during the day and writing at night, continued

until September 1948 when he resigned from the ministry in order to commit himself totally to literary work.

What I would like to stress here is the fact that it may look like he walked on a royal road to a literary career, but this was not true. He himself had been struggling with conquering “the inner monster.” Mishima wrote in “My Age of Travels” (1963), ¹⁴ “It was a rare time when my personal nihilism and the nihilism of the age and of society at large perfectly corresponded,” so that “I had been made to feel a genius, the representative spirit of my age.” After the war, “the boy who had carried on like a genius within a small group during the war was now a helpless student taken seriously by no one.” When the pressure of war was eliminated, he lost his balance. Mishima then continues, “When I left the ministry, I had been feeling of weakening of my own body and mind, along with a feeling being strained by having become a professional writer. Severe helplessness had occupied my mind completely. A deep depression and a cheerful elatedness alternated unstably; I became the happiest and the unhappiest person in the world in a day....I was in a place closest to death.”

Here he had to complete two works in order to overcome this identity crisis. One was to write “Confessions of a Mask” in order to get a definition of himself (as sexual perversion). In his Note to this book he wrote, “This is a last testament I want to leave behind in the domain of death, where I have resided until now.” Though it was a success artistically and he could have an inclination to intellectual, bright classics through this, this was not by itself sufficient as a remedy. He needed another work. This work was to leave Japan at all costs, that is, to go on his first world trip, especially to Greece, the land of his dreams. Just before leaving Japan, he wrote, “Until now my work has been too highly sensitive. Perhaps I should say I have indulged my sensitivity too extravagantly until now. On this foreign trip I shall take only a little money with me, but hope largely to expend this sensitivity of mine before I return.”

Shortly after his return from foreign countries in 1952, he started many kinds of hard physical exercises, swimming, boxing, weightlifting and so on. “A

reconciliatory handshake with the sun on the deck of the ship on which he made his first trip abroad” and an encounter with a balance between intelligence and the body uncomplicated by the spirit in Greece had been a decisive turning point to this course. Through these exercises, Mishima with a thin and weak body had changed into a man of sturdy build and could acquire “the language of the flesh.” In “Sun and Steel” ¹⁶⁾ he wrote, “When I examine closely my early childhood, I realize that my memory of words reaches back far further than my memory of the flesh. In the average person, I imagine, the body precedes language. In my case, words came first of all ; then came the flesh. It was already, as goes without saying, sadly wasted by words. Thus reality and the body became synonymous for me. ...I was quite obviously identifying myself with words and setting reality, the flesh and action on the other side.” However, “Then sun was enticing, almost dragging, my thoughts away from their night of visceral sensations, away to the swelling of muscles encased in sunlit skin. And it was commanding me to construct a new and sturdy dwelling in my mind, as it rose little by little to the surface, could live in security.” For that purpose, “training of the body must take precedence over training of thought if it is to create and supervise its own ideas.” Nathan, J. ¹⁸⁾ wrote that his labor to transfigure himself had been in fact a quest for the ultimate verification of existence.

These changes brought him a fairly stable and prolific life. In “My Age of Travels,” ¹⁴⁾ he wrote, “Though I have had abundant unforgettable unevenness in the 10 years from 17 to 26 years of age, there are no ups and downs of which I want to make special mention in the 10 years from 27 to 37.”

His next crisis started around the age of 40. Mishima’s father pointed out that the political events (the Ampo demonstrations) of 1960 played a part in turning Mishima’s mind toward romantic imperialism. Shortly after these events, he started to write the three stories about the Ni Ni Roku Incident in 1939, “Patriotism” (1961), ¹³⁾ “Toka no Kiku” (1961), and “The Voices of the Heroic Dead” (1966). These were put together in one volume which he called his Ni Ni Roku trilogy in 1966. What attracted my attention in this line are the film version of

“Patriotism” in 1965 and “The Voices of the Heroic Dead.”

The film version with himself not only as the director but also as the leading actor seems to me to indicate that he had stepped beyond the realm of a writer and this could be a rehearsal of his last action in 1970. And “The Voices of the Heroic Dead,” ¹⁵⁾ in which the spirits of the young officers of the Ni Ni Roku Incident and the Kamikaze pilots of World War II bitterly reproach the Emperor for having betrayed them by declining to be a god, was the decisive turning point to his ultranationalism whereby his life had begun to have a strong political coloration. Training at the base of the Self-Defense Forces in 1967 and the foundation of The Shield Society (his private army) in 1968 had followed these. In this way he hurried to the last scene at the Ichigaya base of the Self-Defense Forces on November 25, 1970.

Fukushima, A. and Kajitani, T. pointed out that Mishima had had a depressive episode with suicidal preoccupations in those days which was generated by a decay of his body along with his aging. His above-mentioned behaviors can be thought to be his fierce struggle against this depression. In the postscript to this trilogy, he wrote as follows: “The melancholy within me became enlarged....How can I explain my mental condition? Am I rotten or in a state of exaltation? Slowly, a purposeless sorrow and anger pile up within me; sooner or later these had to combine with the intense cry of the young officers of the Ni Ni Roku Incident.”

It is interesting here that in this situation he wrote “Sun and Steel” ¹⁶⁾ which is a sort of his internal history that follows “Confessions of a Mask” written in the crisis of his 20s. In this he wrote, “At the moment when I first realized that the use of strength and the ensuing fatigue, the sweat and the blood, could reveal to my eyes that sacred, ever-swaying blue sky that the shrine bearers gazed on together, and could confer the glorious sense of being the same as others. I already had a foresight, perhaps, of that as yet a distant day when I should step beyond the realm of individuality into which I had been driven by words and awaken to the meaning of the group.” In this way, “The group for me had come to represent a bridge, a bridge that, once crossed, left no means of return.”

Along with this work he came to have the new idea of “reincarnation” which is well known in his last writing, “The Sea of Futility.”¹⁷⁾ It is certain that this idea has intimate bearings with his above-mentioned struggling behaviors against the depression with the severe suicidal wishes.

DISCUSSION

1. The Development of Object Relationship in Infancy

Yukio Mishima had recurrent episodes of depression with severe suicidal preoccupation in his life. In fact, his life was a history of struggles against the suicidal wishes which were likely to enlarge on occasions within himself. This suggests that not only his sexual identity but also the very core of his identity had been severely disturbed^{1), 23)} even though he had never been under any psychiatric treatment. So it will be important here to investigate into its origin in infancy.

What attracts my attention most in this regard is the fact that the family circumstances described in “Confessions of a Mask”¹²⁾ coincide fairly well with the facts which his parents spoke after Mishima’s death in “My Son Yukio Mishima.”⁷⁾ This shows that Mishima had been frequently talked to about his own infancy, probably by his parents. In this process they must have laid all the blame on his grandmother, consciously or unconsciously, consequently representing her as a bad object. On the other hand, the badness of parents in the sense that they could not have protected their son from the invasion of his grandmother was diminished by their becoming a victim together with their son. This situation will make it difficult for a child to develop the whole object relationship with the mother. This means that Mishima had been in the state of part object relationship¹⁰⁾ throughout his life, splitting into the bad relationship with his grandmother and the good relationship with his mother, in which he cannot bear rage or hatred toward his mother. Still more followed the changing processes of the bad into the good image of his grandmother by writing the stories anew, saying, for example,

that she was also a person to be pitied as a victim of her husband's misconduct (her husband was a good person, but he was a womanizer and was irresponsible with the family's money), or that she contributed much to her grandson's good manners. Thus there was no bad person in this family.

Consequently, Mishima could not find any channel for his aggressive discharge, except toward the objects in his fantasized world or himself (provoking suicidal wishes). This is the very reason, I think, why Mishima's aggressive and destructive behaviors had been extremely rare in his everyday life.

In addition, it would also be necessary to examine the personality of his grandmother who is thought to have been the key person in his early development. Many authors described that Mishima had been brought up as a girl. But I do not agree with this opinion. Mishima's grandmother, Natsuko, had never wanted him to be a girl, and had never tried to treat him as a girl, for example, putting girl's clothing on him or fixing his hair in a girl's style. Although she hated the naughtiness which ordinary boys usually have, she needed the first grandson as an heir under her control probably in order to instill in him the samurai spirit of her ancestors. The fact that Natsuko took no interest not only in his sister Mitsuko, but also in his brother Chiyuki, gives proof of this. When we reconsider Natsuko's attitudes toward the heirs in this family, her husband Jotaro and her only son Azusa, a characteristic figure comes out. Jotaro was hated and scorned by her for his misconduct, and Azusa was also dominated completely. In this sense, it could be said that Natsuko had been a kind of woman with a phallus. Therefore, Mishima had been forbidden to be naughty with his own feeling and submitted to be her penis. This relationship with his grandmother seems to me to be very close to the concept of impingements and reactions to them in forming the false personality, of which Winnicott, D.W. ²¹⁾ has spoken. Here could also be a wish to identify with his grandfather and father, that is, a wish that he wanted to become like his grandfather and father who might have been loved by his grandmother. This could be one of the elements of his homosexuality.

In this way he had developed "the type of a boy who leaned at the window,

forever watching out for unexpected events to come crowding in toward him.”

2. Peculiarity of His Instinctual Development

It seems to me that he had a kind of crisis when he was liberated from Natsuko's restraint in his 12th year. What was his psychological state like? He was an honor student at school and a good child in the family, but the state of affairs in his inner life was stormy. Sexual arousal had caused this unbalance. A boy of 12 who was provided with a curious toy (the penis), but had no idea of how to use it, was bewildered very much. But the encounter with a reproduction of Guino Reni's "St. Sebastian" enabled him to have his first ejaculation. Since then he indulged himself in this "bad habit." Here we must not forget that excessive masturbation has an important defensive function against the anxiety with sadistic and self-destructive tendencies.³⁾²⁰⁾ In any event, it was in this situation that he had begun active literary activities with the support of his mother.

This bad habit had brought about his peculiar fantastic world which Arlow, J.²⁾ has discussed thoroughly from the point of view of the primal scene. Mishima wrote as follows: ¹²⁾ "My inherent deficiency of blood had first implanted in me the impulse to dream of bloodshed. And in its turn, that impulse had caused me to lose more and more of the stuff of blood from my body, thereby further increasing my lust for blood. This enfeebling life of dreaming sharpened and exercised my imagination.... I had dreamed up the idea of a murder theater...all the deaths that took place there not only had to overflow with blood but also had to be performed with all due ceremony. I delighted in all forms of capital punishment and all implements of execution ... So far as possible, I chose primitive and savage weapons—arrows, daggers, spears. And in order to prolong the agony, it was the belly that must be aimed at. The sacrificial victim must send up long—drawn—out, mournful, pathetic cries, making the hearer feel the unutterable loneliness of existence. Thereupon my joy of life, blazing up from some secret place deep within me, would finally give its own shout of exultation, answering the victim cry for cry."

Here is a beautiful connection of the sex, blood and death with the following paragraphs which shows that this has paved the way to his homosexual world. However, what we should keep in mind is that the objects which appear on the stage in these worlds have a close relationship with the objects in the fantasies of his infancy and his behavior patterns in his later years.

He was excited at the sight of a young night soil man putting on close-fitting jeans which plainly outlined the lower half of his body and loved the picture of Joan of Arc taken for a knight who mounted on a white horse in his fifth year. And a reproduction of St. Sebastian determined the form of his sexual life not only in his early adolescence but also in his later years. It is also well known that in "Confessions of a Mask" he fell in love with his senior and junior boy friend in his middle adolescence, and in his late adolescence was beset by a sexual desire at the sight of the savage, but the incomparably beautiful body of a youth in his 20s while on a date with his girlfriend Sonoko. ¹²⁾¹⁸⁾

Shortly after returning from his first overseas tour, he started hard physical exercises with the help of "Sun and Steel" and transformed the thin and weak body of his past into a sturdy and muscular body in the following several years. Only by letting himself be an object of sexual desire, he was able to obtain a psychic balance. This balance is said to have been lost around his 40th year by his worrying over the decay of his body along with his aging. He began to tell often about a glorious death and his eccentric social behaviors as an ultranationalist came to draw public attention.

It should also not be forgotten along with these that there were groups of men who had excited him in the same way from infancy. As a child, he was "driven onward, awakened his longings and powered by the odors of sweat of soldiers passing his gate as they returned from drill and was fascinated and terrified by the spectacle of the mikoshi (the group of men shouldering the portable shrine). And he joined the mikoshi of the Jiyugaoka merchants' association in 1956. In addition, contact with the right, training in the Self-Defense Forces, and lastly, creation of the Shield Society followed these experiences. ¹²⁾¹⁷⁾¹⁸⁾

Viewed in this way, the body played an important role in his fantasies since infancy. This suggests that his instinctive life had had a strong autoerotic coloration. What interests us more than that here is that he had always prepared for the scene for him to take two parts, the self who is excited (as a penis like the body of a man or men) and the self who is excited by watching the excited body (the observing self). In addition, it deserves to be mentioned that the switching of activity and passivity or subject and object has occurred in the course of time. A boy who was waiting for unexpected events leaning at the window in his childhood and an adolescent in war time became a stout man who tried to evoke the public response (excitement) in peace after the war. It is certain that at the main defense mechanism in these processes might be projective identification, but the most important thing in this context is that he could feel alive only when he felt excited by watching his exciting partner or surroundings. It is the problem not simply of his libidinal life, but also of his existence itself. It was likely to form a vicious cycle which would continue forever. This is the reason why he escalated the narcissistic behaviors with a tremendously exhibitionistic and attention-seeking tendency, to the point where he had to choose the last act. He wrote in "Sun and Steel" like this: "Though I might be unable to change the world myself, I could not but hope that the world would change of its own accord....The transformation of the world was an urgent necessity for me; it nourished me from day to day; it was something without which I could not have been alive. The idea of changing the world was as much a necessity as sleep and three meals." Needless to say, it is certain that the origin of this behavior pattern was in his infancy in which he had been forbidden to play any games leading to his own excitation and must have to lead a symbiotic life with his grandmother's insanely hysterical fits.¹⁶⁾

3. The Intermediate Area as a Bridge between his Inner and Outer World

Following Mishima's life, it is not difficult for us to find out that he had led a kind of incompatible double life which I think deserves special attention. There

was a life under grandmother's control and one with the breast of his mother in infancy. After liberation from the grandmother, he had led an active life as a writer under the protection of his mother, but he had also been an honored student and officer in accordance with his father's wish. In addition, there had been his own internal fantastic world behind these lives. So to speak, the life with his mother had formed the intermediate area of experience ²²⁾ which functioned as a bridge between the inner and the outer worlds. What is characteristic in Mishima's case is that this intermediate area is wide and deep, but very fragile and intolerable to the invasion from the inner and the outer worlds. This brought the tragedy of his genius. At any rate, this form of life had continued until his resignation from the Ministry of Finance.

However, his literary success brought about severe identity crisis, because the literary activity with his mother functioning as an intermediate area (the place of sublimation ⁶⁾) directly exposed the external reality and it could no longer play the original role, that is, the intermediate area was invaded by the outer reality. The confusion of identity was its result. Therefore, efforts to make a new intermediate area, instead of the literary activity which now belonged to the external reality, were necessary, so that he would be able to live with himself. To write "Confessions of a Mask" and to do hard physical exercises for the language of flesh were the results of the effort to form a new intermediate area. It was after his completion of transfiguration that he could recover his psychic equilibrium. Now a muscular movement with no purposes ¹⁶⁾ appeared on the stage as a new intermediate area.

When he began to feel a decay of his body along with his aging, however, the action of his body came to have a tinge of bizarre socialness. They were the ultra-nationalistic behaviors and remarks, the approach to the Self-Defense Forces and the creation of the Shield Society which could never be accepted by the public. Here we see the emptiness of his intermediate area again which had caused his depression and suicidal preoccupation.

Looking back at his life in this way, Mishima was inevitably preoccupied with

suicidal wishes when the intermediate area was empty. As I have mentioned above, his life was a desperate struggle against the emptiness intimately connected with suicidal wishes. And when he socialized the body as his last fort, what was left for it would be only the idea of reincarnation, the paradox in which he could live forever by death of the flesh. It is well known that the thought of reincarnation had been realized in his last novel, "The Sea of Futility."¹⁷⁾ Though McPherson, E.D.¹¹⁾ pointed out its significance in Mishima's seppuku, the reincarnation had been a traditional thought to conquer the fear of death, on the basis of which the samurai liked to choose a heroic and glorious death through the fierce battle or the seppuku. There they could control life and death under their will. A miserable suicide or passive death could not be acceptable to Mishima who had been battling against suicidal wishes for a long time.

SUMMARY

No one can deny that Yukio Mishima had been a true literary genius. It is, however, certain that his disposition and unhappy nurturing environment had opened the door to, and his fierce and ceaseless struggles against disturbances as a result of his unhappy infancy, had paved the way to, his unique literary world. The examination of his life would teach us much on the profundity of human existence.

I think he should not be diagnosed as a schizophrenic. The examination of his life from the object relational point of view inclines me to think of him as suffering a severe personality disorder.⁹⁾ Although his instinctual life had an autoerotic coloration, this would be a manifestation of the disturbance around the core of identity. To feel alive, he needed the excitement of the surroundings around him, the excitement of his own penis, of the youth's body, and of the public. So he had to continue to evoke the surrounding responses in peace after the war. This explains the reason why he had shown so tremendously narcissistic behaviors

with attention-seeking, exhibitionistic and provocative tendencies.

Finally, his seppuku was thought to be his last defensive effort for the paradox based on reincarnation in which he killed himself to live forever.

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Leadership in Community Meetings: Toward a Therapeutic Community Approach

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Introduction

In this paper, I will discuss leadership at community meetings and a therapeutic community approach taken at a psychiatric hospital in Japan where I serve as the director. As psychoanalyst, conducting group psychotherapy in the form of community meetings at a hospital is an important component of my psychoanalytic practice. Therefore, I will contribute this paper to the publication of the Japanese Contribution to Psychoanalytic Practice for the 50th anniversary of the Japan Psychoanalytic Society.

I have given depth to my understanding and clinical application of psychoanalytic concepts, such as defense mechanism, transference, and therapeutic alliance, since I started psychoanalytic training and practice. On the other hand, I started group psychotherapy practice years after my individual psychoanalytic practice although I only had a limited understanding of a therapist's role as the leader and co-leader in groups.

When I entered medicine in the early 1970s, the world of psychiatry in Japan was going through great turmoil. In those years, the writings by R.D. Laing (1960) and David Cooper (1967), the film version of "One Flew over the Cuckoo's Nest" (1962), and M. Jones' "Beyond the Therapeutic Community" (1967) were introduced to Japan. As a result, I formed preconceptions about group

psychotherapy as well as therapeutic community.

Beginning of a Leader

When I participated in the group therapy workshop at the first Pacific Rim Regional Congress of the International Association of Group Psychotherapy (IAGP) in 1987, a group therapist was referred to as the leader. That was my first hands-on experience in training groups. Group therapists were also referred to as the leaders at the Japanese Association of Group Psychotherapy (JAGP)'s first training meeting in 1988, and training groups in the following years. Then, I started running community meetings at one of the inpatient psychiatric units of my hospital and naturally assumed that I was to become the leader in those meetings. My understanding of the leader in therapy groups at that time was based on my personal experiences. I also misunderstood that a group co-leader was a subordinate leader.

Additionally, I was determined to have a tight grip on my groups since I participated in the workshop of the IAGP. The workshop group completely lacked effective leadership and encouraged some group members' chaotic acting out on primitive dependency needs and fantasies. I desperately struggled to take control of the group process in my community meetings as the leader although I did not want to be too restraining as a therapist.

Incidentally, shortly after I lost my father, the co-leader of my community meetings also lost his father. Subsequently, we briefed our personal tragedies to patients at a community meeting. It was unprecedented that the clinicians shared their personal matters with the patients in the hospital. This group experience helped the co-leader and myself appear egalitarian to the patients (Suzuki, H. & Aida, 1996, March).

A Conductor's Functions

A conductor is a term introduced by S.H. Fouleks to refer to a group therapist. Later, I started calling myself a conductor in my community meetings. In the meantime, many members of the JAGP started referring to a group therapist as the conductor. Fouleks (1948) argues:

In a group composed of patients and meeting for the purpose of treatment, however, the Therapist is normally in the position of its leader. The term "Leader" has, however, become overloaded with meaning and particularly with fascist connotation. I will, for our purposes, therefore replace it by the less pretentious term of Conductor. (pp.134)

As Fouleks points out, I realize retrospectively that I called myself the leader because I was driven, largely unconsciously, to lead patients.

Moreover, I learned from my supervisor that the word, conduct, also means "to be able to transmit or carry; convey [iron conducts electricity]" (Webster's New World Dictionary, 1988). This has inspired me to reframe the conductor's functions in a group as conveying, or connecting, or bridging group process. In fact, I have found many things to convey, or connect, in my groups: group members' interaction, what they voiced and affective states behind their words; group affairs and their circumstances; and the worlds inside and outside the groups. Within this framework, I understand that "one can see how the person both speaks for his own issues, and also speaks for the group" (Agazarian & Peters, 1995, pp. 91). I have become more aware that the conductor also depends on group members (Aida, 1997). After I redefined my leadership roles, I have been able to self-monitor the "here and now" functioning and serve at my community meetings more effectively.

I conduct weekly community meetings at the long-term inpatient unit, which works with mostly chronic schizophrenics. All patients and unit staff members

are expected to participate in a community meeting in a day room on the unit at a scheduled day and time and discuss open topics. The meeting starts with my announcement, "It's time for a community meeting!" Discharges or transfers are announced, and new patients or visitors are requested to introduce themselves if there are any. At the end of the meeting, the nursing staff makes a brief announcement, which can be raised as a topic for discussion if it is a unit issue. The meeting ends with my announcement, "The meeting is adjourned."

The structure of the meeting is protected and consistent in time and space. This allows the participants to engage in group work on a regular basis. I assume leadership as the conductor by not only setting clear boundaries of time and space, but also by bridging those boundaries, so as to maintain a non-judgmental attitude to gather information about the group by utilizing the five senses (sometimes, a sixth sense) and intervene to facilitate the therapeutic process. In truth, the other clinical staff members at the hospital are also expected to perform and improve these skills.

Clinical Material: A session of one day

(1) Everything starts as usual, on the usual day and at the usual time. The conductor says, "It's time to start. Anyone who would like to, please go ahead." Patient N raises his hand and, without having received permission to speak, says with a bit of a laugh, "I want my life in the hospital to be pleasant and fun." The conductor asks, "Did anything happen that was unpleasant?" At this, a few patients laugh. N answers, "No. I think it would be better if it were more pleasant and fun." A few patients laugh, and O's voice is particularly noticeable. He might have just been in another one of his hypomanic states. A few others start talking among themselves, and there seems to be some restlessness. Becoming aware of the fact that this reaction might be a reflection of the group's psychotic reaction, the conductor continues with the following:

(2) “As I believe you already know, Mr. P has moved here from another hospital ward. Let’s have him give the usual self-introduction,” says the conductor as he invites P to come forward. He is not able to speak fluently, and he makes mistakes with things like the name of the ward he was in up until yesterday. Some patients seem to laugh disparagingly at P, and P seems to be getting somewhat upset with himself, so the conductor turns to P and shows his appreciation by saying, “Thank you.” The group suddenly becomes quiet. The patients take notice of how the conductor treated P, who is mentally retarded, and based on past experience, the conductor believes that there is a possibility in this ward for P to change so that he is treated more politely as a fellow member of the group.

(3) Q speaks out, saying, “I have a favor to ask.” He continues, politely requesting, “I’m happy to have the head nurse write different things for us on the notice board, but her writing is so good that sometimes I can’t read it. Please change your way of writing.” His conductor replies, “Are you not of the opinion that nice writing is a good thing?” “Her writing is too good,” replies Q. Similar comments follow, but the head nurse is relaxed (so it appears) and replies, “It won’t do if you can’t read what I’ve gone out of my way to write for you. I’ll be careful from now on.” Q says, “Thank you.” After some further discussion, the conductor asks, “We’ve been trying to make information as available as possible in this ward. As part of our attempt to do this, do you know why we’ve been posting different things on the notice board?” There is a lot of positive feedback about how things are done, but R comments (in stark contrast to the positive opinions) that there had been a change in the date that had been announced for the changing of the bed sheets.

(4)–a. After a somewhat long silence, O says, “It’s helpful that the head nurse notices small details. She fixed a tear in my work coat just the other day.” S adds to this, “The head nurse can be very nice. She ironed something for me. She’s very kind. That’s right.” He continues in this vein, but the conductor notices that the strong way in which S is expressing himself seems to be in

contrast with the content of what he's saying. The conductor asks, "What's wrong, everyone? Did something happen?" The patients seem to understand that in the conductor's remark, he is wondering why they are offering insincere compliments to the head nurse. A few of them laugh but soon become silent. The conductor continues, "Didn't you all say that, in the beginning (just after the ward staff had been changed last spring), you didn't like the fact that Y (the head nurse) was always nagging you?" With even more patients laughing this time, O says, "I got used to it. I came to understand her feelings."

(4)-b. The conductor begins to speak, "This is the men's ward. You and I are all males. As a man, don't you find women to be nags?" Without hesitation, O says, "Y doesn't nag. Not much." "The one who was here before, head nurse M (a woman who retired), she nagged us." "M. I was a bit of a nag myself, though." At this, many of the patients continue to laugh, and the discussion goes on. The conductor says, "Isn't it true that what men don't like is the fact that women are always telling you to be careful about this and that? Rather than offering the kind of thanks that O and S were just expressing, you end up feeling that women are nags. Would you say that's right?" S says, "You know, head nurse Y really is kind. She can be somewhat particular about things, but she really is kind." O and S then begin to speak at the same time. S is first, saying, "Conductor, you know, when women have children, it's really true that they just start to nag." There is no longer any discrepancy between what he is saying and how he is saying it, as there was just a moment ago, and he sounds even to be confiding something. And though it is almost drowned out by the voices of all the others, the conductor hears him say, "My mother was that way."

The conductor says, "I wonder if our mothers were all like that?" There's an upsurge that indicates agreement. "Your mothers probably nagged you more than M (the previous head nurse) did." The whole group quiets down. Continuing, the conductor says, "I have the feeling that because our mothers nagged so much, we immediately feel like we are being nagged when we are told things by women, even now that we are adults." He pauses, then says, "I wonder

if that's just me." Someone says, "It's the same for me, too." The entire group becomes silent for a very brief moment. Then N says, "But you know, those nagging mothers are right." The conductor responds immediately with, "Unfortunately." A few people laugh, and then people start speaking with their neighbors. The PSW says, "N, you know what you're talking about." The whole group become silent. Then N responds somewhat confidently, "But I don't really like it, because I'm a man." "Yeah, it's not such a great feeling," says the conductor.

(5) S says his room is cold. There's a proposal that the patients change rooms every few months just like the ward staff is regularly changed.

(6) Suddenly, V, who had hidden himself in a corner of the hallway, raises his hand and says to the conductor, "I'm going to the dentist's tomorrow, my older sister is coming to visit in a few days, and since I'm going to the dentist's tomorrow (he wants H to go with him), I was wondering if you would write a letter of introduction for me, my sister is coming every ten or more days. I don't have any money (while he's waiting for his sister), but write a letter of introduction for me." He lacked coherency, so the conductor was asking him to clarify what he meant. Q then attempted to explain for him. Then S impatiently turned to the conductor and added, "His (V's) teeth hurt!" N then says, as though relaying a message, "He says he'll be getting some money." Finally, everyone advises V to consult with the nursing staff in charge whenever he has a problem.

(7)–a. Fifteen minutes have passed since they began. T slowly declares, "There are some people who do not clean in the morning." His point is clear, and he says, "It has been agreed that community areas, such as the corridors and the day hall, will be cleaned on weekends by people who work outside the facility, and in the morning on the other days by everyone who works inside the facility. But there are certain people who don't clean. Some people get out of it because they claim they don't feel well, but then they go out to do things they enjoy, like making ceramics. In other words, saying they don't feel well is just an excuse. They should clean as it has been agreed. Otherwise, a system should be developed

whereby small groups take turns cleaning in order to make it fair.” The conductor checks T’s emotional state by asking, “T, are you angry?” T confirms that he is. The conductor then asks, “T was speaking out of extreme anger. What do the rest of you think?”

(7)–b. After this (while moving on to [8]), the patients continue speaking on the topic of “morning cleaning” for approximately 30 minutes. The conductor often interjects, and sometimes so does PSW, but this is only with the purpose of enlivening the conversation and not with the intention of leading it in any particular direction. The patients talked about various things. For example, W explained why he wasn’t able to participate in the cleaning at that time of day, but he was relieved when he saw that everyone understood his situation and that he wasn’t being criticized. X, on the other hand, also tried to defend himself in a similar way but was unable to do so very successfully because it was he who was being alluded to in the first place. The conductor felt moved to prevent any scapegoating directed toward X, so he interjected, “Didn’t you say that people with a reason didn’t have to participate? Isn’t it reason enough to not like cleaning?” But T responded in a scolding manner, “That’s not an acceptable reason.” S and some others laugh excitedly.

(8) V repeats what he was just saying about going to the dentist’s office. The conductor determines that V is getting bogged down in stereotypical comments and that it reflects his psychotic state, so he says, “Shall we talk about it later?” To this, S, T, Q and some others calm V by telling him, “He says he’ll talk with you about it later.”

(9)–a. T returns to the previous topic, exclaiming, “It’s strange that there are guys who don’t do the daily cleaning yet nobody gets angry. So let’s put it to a vote right here.” But nobody agrees on the vote. The overall excitement abates, and there is now an atmosphere in which everyone can talk calmly. There are, however, occasional outbursts such as, “You’re just trying to live your whole life in comfort, aren’t you?” And, “People who don’t clean are a disgrace to humanity.”

(9)–b. It seemed to the conductor that this was just like waves flowing up to

shore and then out again. Criticisms are hurled at people who don't clean; there is absolute agreement; those who clean ask those who don't to join them; and they don't join them so someone suggests they take it to a vote, but nobody agrees on taking a vote and the conversation continues in the same way without any clear progress being made. At length, people exclaim things such as, when a patient moves here from another ward, the nursing staff base their patient evaluations on whether or not a person cleans; it becomes impossible to distinguish if what the patients are saying is fact or fancy.

The conductor then leads the conversation in order to draw counterarguments such as, "This conversation divides us into two sides—those who generally clean, and those who think they don't," and, "It hurts not being able to come up with a good response when people tell you that you don't clean even though it had been decided that everyone would," "And on top of it all, they tell you that you're not willing to participate," and, "I was told that I'm not even human. It's enough to make you want to go hide away." In this way, the conductor attempted to focus on the dynamics of the group, but time passed without there being any obvious effect.

(9)–c. Q says, "We've been talking for 25 minutes with no progress. Please let there be some progress." Soon after that, S stands and continues, "Everyone, what do you say? If all sixty of us cleaned, there would be no problem." There's a moment of silence. He says, with what sounds like a cry of grief, "Everyone, please respond." A few people begin to say, "We could do it quickly if we all worked together," when suddenly, J appears from down the corridor and says, "Today, umm, T gave an opinion. And I think it's good because T had an opinion. T said he would do it." J often speaks but has a tendency to lack clarity, and those present appear a bit fed up. The conductor tries to clarify things. J says, "That's right. And because T voiced an opinion, some people may do it tomorrow. I myself am a bit lazy, but I think I'll do it from tomorrow." R says, "Let's have the room leaders tell everyone in the same rooms." T says, "That would be best." The conductor says, "Finding a solution certainly required a lot of perseverance.

It's a good thing we didn't take a vote right away." Some people laugh. It was probably an expression of agreement. O says, "But those who don't feel physically up to it should say so." "This is a hospital, so those who don't feel well should say so. They can participate when they feel better. And it would be nice if they got better quickly." Some people show their agreement.

(10)–a. Up to then, H had been silent, but he suddenly says, "I want to use the skipping rope." As though making a declaration, S says, "I put it away because we don't want anyone hanging themselves." Quite a few people laugh in a queer way. R says, "Apparently, he gathered them all up and burned them." S continues, "We don't want anyone hanging himself...isn't that right, Mr. H! So—and–so cut up a cloth, and the older brother died. The younger brother was barely saved. He hitched it to the crosspiece where there was no glass in that place on the way to the dining room and died." After a bit, the conductor interjects, "Just as a few people have mentioned, hospitals don't like to have ropes and the like around, so there's a problem with how to manage them. But just as we discussed karaoke(–set) and came up with a solution, I would say it's all right to ask about the management of the skipping rope." Some people laugh a little.

(10)–b. After a very brief silence, the conductor continues, "But it hurts when I think of people who have been driven to hang themselves." There is a silence that seems to suggest agreement. S says, "It hurts." U says, "It certainly does." A few people give a brief chuckle. The conductor says, "They must have been extremely lonely." Brief silence. S says, "Something caused it. Don't you think they must have felt bitter about something?" The conductor says, "Probably. It hurts to think of what that feeling must be like." Again, a brief silence. H says, "Conductor, light ones are no good (for rope–skipping). The rope must be heavy." The conductor says, "You're right. I thought so too. Thanks."

(11) The time to finish is approaching. As though taking the place of the conductor (as he always does), S adds, "What do you think, head nurse Y? Time's about up." V repeats, "Write a letter of introduction to the dentist's for me." Q calms him again, saying, "V. Doctor's going to write one for you later." The

conductor announces that, "Next week, a PSW trainee is coming to this group." A few people ask for details. Then Z says, "A trainee named B came yesterday." The conductor confirms this, saying, "That was a psychology student (and he explains further that there were a lot of people, so they divided up into the different wards)." U says, "She was cute." The conductor says, "She was cute, wasn't she? Just between you and I, of the seven people who came, that one was the cutest." Many of them laugh. Some had almost coquettish voices, and O says, "Conductor, you devil." The conductor says, "You'd all gotten together and were talking, weren't we?" More people laugh. Just as always, the conductor asks, "Y, is there anything to report today?" Y answers, "Not today," and the conductor says, "Then let's finish."

(12) After the large group has finished, the staff alone conducts a review for thirty minutes. At this time as well, the conductor asks for anyone to go ahead and start a review meeting, and staff members are given freedom to say whatever they feel with no prescribed format for the discussion.

Therapist's Leadership and Responsibilities in Group

I have discussed the conductor's functions as my focus of group psychotherapy techniques. The conductor's roles of connecting the group process also help clarify my responsibilities as therapist. For me, leadership is not leading patients or taking responsibilities for it (in the worst case, by resigning the position), but working with them by conducting. The therapist is responsible for understanding group functions, process, and dynamics, trusting them, expecting their effects, and working on the group to maximize these effects for therapeutic purposes.

In dealing with demanding group members, Watanabe (2002) addresses a therapist's dilemma over "crying for the moon (feeling obliged to meet their demands)" and resultant "isolation" from the group. The therapist might

disregard the underlying psychological issues of these members, or split treatment by blaming others (in most cases, the hospital, or nursing managers as the container). In this case, the therapist abandons his or her leadership roles. Therefore, the conductor's functions are a prerequisite to understand that everything is connected in the group, place him/herself in the web of these connections, and avoid splits in treatment. It is my view that conducting is indispensable for the therapist to fulfill his/her leadership roles and responsibilities in the group. In fact, the conductor's tasks described here are the essentials for psychoanalysts.

Toward a Therapeutic Community Approach

According to Clark (1996), the term "therapeutic community" was first used by T. Main and elaborated with meanings by M. Jones. Clark (1996) explicates the main characteristics of a therapeutic community:

For those of us who went through changing a traditional ward to a therapeutic community, it was one of the most liberating and exciting experiences of our whole professional lives. Although each ward worked out the therapeutic community model differently, all these units had some things in common. Most important was the egalitarian atmosphere. All in the ward were addressed by first names—from regressed patients to Consultants. The uniforms and trapping of rank were discarded... The ward meetings—usually daily—were unlike anything seen before in Fulbourn. Patients and staff sat round discussing the happenings and affairs of the ward as equals. Matters previously held secret or discussed only in selected groups were openly considered—why a certain patient was to be detained, or another discharged; why a nurse was leading the ward; which doctor would be

coming next: the hostility of 'Establishment' to the experiment and the possibility of the ward being closed down. Open criticism of a person's actions, and exposure of its unconscious roots was encouraged—by both patients and staff. I heard more truths about my failings in those meetings than I had many years (pp. 204–205).

Furthermore, Clark (1996) proposes a “therapeutic community approach” and “therapeutic community proper” to clarify the conceptual difference of a therapeutic community from milieu therapy and apply the principles of the therapeutic community to a variety of clinical settings.

Suzuki, J. (1975) explains that a therapeutic community approach aims at allowing all patients to have more freedom, activities, and responsibilities in hospital treatment. On the therapeutic community proper model, therapy is based on analyzing egalitarian relationships of patients and professionals in a small group (Suzuki, J., 1975). Suzuki, J. (1992) proposes the “therapeutic community as a container” model, which provides group process to work out various therapeutic modalities in a hospital. Horikawa (2000, March) and Renri (2001) propose the dynamically oriented treatment as a therapeutic community which encompasses inpatient and community based psychiatric services.

I did not start community meetings at my hospital to aim for a therapeutic community. However, community meetings and accompanying small group activities on the unit have helped increase the flow of communication among the staff and patients and allowed the patients to become more actively involved in the decision making of daily matters and issues on the unit. Then, the other units have followed this lead and held community meetings. In this way, the hospital works out, and probably progresses, toward the therapeutic community approach.

Conclusion

My preconceptions about a therapeutic community might be explained as a part of the “myth” surrounding therapeutic community from those decades to the present (Suzuki, J. 1986). However, as I have worked on my group leadership roles and inner obstacles to them, my community meetings have played a role of evolving the therapeutic approach at the hospital. The unfortunate fact that many psychiatric hospitals meet difficulties embodying the therapeutic community approach these days seems to be related to clinicians’ resistance to dealing with their inner obstacles. It seems to me that the conductor’s functions and inner work are of the greatest significance for group psychotherapy practice.

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Boundary as a Guiding Principle in Comprehensive Group Treatment — interface between intrapsychic, interpersonal, and system issues —

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I . INTRODUCTION

Treatment and psychotherapy through comprehensive inpatient group approaches (see Appendix) involve such complex group dynamics that those involved would get lost without a consistent guiding principle. Since we modified our practice in a long-term psychiatric unit five years ago, we have used the concept of boundary to guide us both theoretically and clinically in our inpatient group treatment. Our long-term psychiatric unit has 24 patients, 12 assigned to each of two teams, bringing the number of each team, including staff, to approximately 20. Before the modification, these 20 people had patient-staff team meetings three times a week. Although most participants found these meetings useful in generating a sense of belonging and in monitoring treatment (Horwitz, 1975), these meetings were too varied to define the specific goals of the group and the tasks of patients, to assess the effectiveness of the techniques used, and to improve the staff group skills consistently. We decided that we needed to make some changes to maximize the effectiveness of treatment and the opportunity to use “the interpersonal field of inpatient milieu as an object of investigation (Kibel, 1987, p. 101).”

Changes had to be made in team meetings. In order to meet the therapeutic

need of having both the team meetings and the group psychotherapy meetings that Yalom suggests (1983), we decided to preserve one team meeting a week, and to create within the team two separate small groups, the Gold Group, with patients who have relatively more severe ego weakness, and the Purple Group, with those who have relatively less severe ego weakness. Two therapists, at least one of them from the same team as the patients, were assigned to each group, and received supervision from the group–study group as well as from the section chief.

As small a change as this may seem, creating this kind of new boundary within the team provoked misconceptions which caused intense, deep, and extensive anxieties, among staff members first, then among patients. Those anxieties reflected various concerns: the section chief seemed to be imposing changes, leaving other people no choice but to accept them (feeling of helplessness); some changes seemed to serve the special interests of others (fear of exploitation); certain activities in which some members were involved were evidently going to be eliminated (fear of destruction), or at least implied criticism of the previous treatment (feeling of self criticism); the section chief seemed to be selecting his favorites for group therapists (feeling of competition); and, in any case, familiarity was exchanged for unfamiliarity (feeling of bewilderment and confusion).

All of these feelings were understandable, but their depth and extent suggested that they were reactivations of early developmental anxieties which could be defined as schizoid, paranoid, and depressive in Melanie Klein's terminology; narcissistic anxiety might be added.

In this reorganization of group treatment, only one new sub–boundary was created in the old team meeting, and yet its impact spread to the entire system of the section group treatment as well as affecting individual psychology. It seemed important for boundaries to be clarified structurally (based on time and space), or conceptually, or emotionally, because, as mentioned above, primitive anxieties seem to be caused by any change of boundary which confuses the until–then familiar selectivity of informational and emotional exchanges. Outgrowing these anxieties is directly related to the restoration of a mature sense of boundaries.

II. THEORETICAL CONSIDERATIONS OF BOUNDARY

A selective review of the literature on the concept of boundaries may help us to synthesize psychoanalytic, general systems, and cognitive points of views so we can better comprehend the comprehensive group treatment. The following brief review is presented in such a way that covers the current, established psychoanalytic psychologies, i.e., drive, ego, object relations and self (Pine, 1990) with a few representative authors from each school.

A. FEDERN'S SEMINAL PAPER written from drive-ego psychological point of view

Federn discussed the concepts of the ego and the ego boundary in a lecture given in Topeka (1949) and published (Federn, 1952). His formulations seem to pave the way for later discussion of the ego boundary (Landis, 1970) and related developments as applied to inpatient group treatment, encompassing defensive and developmental aspects of ego psychology, and interpersonal dimension, structural, and general system theory.

Federn states that "the ego" is not merely a concept: its existence is established through the familiar phenomenon of the ego feeling (page 212). "One recognizes the unique paradox which characterizes the ego; it is subject and object in one...the ego is the feeling of itself" (page 216). According to Federn, the ego is not formed by the crystallization of the ego "nuclei," but "is a united cathexis from the beginning, and for a long period the infant's ego unit, body as well as mind, still reacts as a whole...." "The ego does not develop through crystallization but through organization. This is achieved by acquisition of typical reaction patterns in habitual emotional attitudes, notwithstanding the succession of ego levels (pp. 217-218)." This notion is particularly valid in inpatient group psychotherapy where interaction and organization are a vital force

affecting the patients with different levels of the ego function. In discussing the ego boundary, Federn defines the nature of the ego as a changing union of components which are entering or leaving. "The use of the word boundary or periphery is necessary to express the fact that the ego is actually felt to extend as far as the feeling of the unity of the ego content reaches... Because the ego of a unit exists, there is also a boundary or a limit of the unit (p. 222)."

Federn adds that "maintenance of ego cathexis is necessary for all mental functioning, active or passive. Furthermore, the cathexis necessarily increases with each functional effort, with every claim from the outside world, and particularly with every task concerning adaptation and maturation. The ego cathexis, which is otherwise diffuse, is implemented by such demands, depending on what specific functions are needed to carry through a specific effort or to satisfy a specific claim on the ego (page 227)." This notion is particularly pertinent to how the ego cathexis is obtained when working in group treatment, where, as will be illustrated later, groups with different tasks and goals demand the ego to cathect specific functions of the ego boundary.

Rinsley refines the definition of ego boundary as a "vaguely perceived line of demarcation between what is, as it were, within the ego and what is outside it" (Rinsley, 1982, page 5–6). He also reminds us that Federn distinguishes two different kinds of ego boundary, an inner ego boundary (separating conscious from unconscious mental content), and an external (I will use "outer" instead of "external") ego boundary (separating intimate subjectivity from the outside) (Rinsley, 1982, page 6). According to Rinsley, Federn concludes that the ego boundary plays a critically important role in the maintenance of the sense of reality, and that the ego cathexis guarantees the integrity of the ego boundary both internal and external; hence one may speak of "the ego boundary cathexis" (Rinsley, 1982, page 6), which will be further explored later in

terms of familiarity. The ego boundary cathexis echoes Bion's concept of "contact barrier" vis-à-vis "beta-elements screen."

B. KERNBERG

More recently, Kernberg (1973) summarizes ego growth in psychoanalytic theory in terms of "structural intrapsychic change," which refers to changes in the relationship between the ego, the id, the superego, and external reality; in clinical terms, these changes manifest themselves in impulse–defense configurations, that is, modifications in the defensive structures which determine the boundaries between ego, superego, and id (page 363).

With these psychoanalytic developmental as well as system models and theories in mind, over time, in long-term inpatient treatment, the therapist can see various kinds and levels of shifts in, and developments of, boundary formation taking place within individuals, between individuals, between individuals and the group, and between different groups, as reflecting the individual patient's ego–growth.

C. MAHLER

Mahler observing infant's symbiosis, separation–individuation, describes a three–part development of the ego within the context of the mother–child relationship: first, an autistic shell, rigidly isolating the primary ego, then an orbit, isolating a symbiotic mother–child dual unity, and finally, a hatching of the baby, breaking the symbiotic eggshell, at which point (7 months) outwardly directed perceptual activity gradually replaces inwardly directed attention cathexis (Mahler, 1968, page 16). This hatching process reflects intrapsychic structural changes occurring in the self–object boundary.

D. KLEIN

Klein, from the earliest object relations' point of view, describes a shift from paranoid–schizoid position to depressive position as occurring at age five months when oral sadism begins. During paranoid–schizoid

position, “bad-parts” of the primitive ego are projected and, during depressive position, they are reintrojected, across the primitive ego boundary. The directions of the permeability across the boundary in these two positions are opposite. This shift is significant because with this shift the baby begins to develop a sense of responsibility, however primitive it may be, for whatever is affecting him (Klein, 1952).

E. BION'S NOTION OF THE CONTACT BARRIER written from the primitive object relations, perception and thoughts

The contact barrier is formed by the proliferation of alpha elements — thought material transformed from direct perception and emotion through repression and accumulation. The contact barrier coheres and demarcates contact with a selective passage of elements from one to the other. This contact barrier being in the constant process of formation performs the function of a semi-permeable membrane which separates mental phenomena into two groups, the conscious versus the unconscious, being awake versus being asleep, and the certainty of the past versus the uncertainty of the future (Bion, 1967, page 110–119). “The contact barrier is the basis for the normal relation to reality, and to the internal and external world.” (Grinberg et al., 1977, page 50) In psychotic state, the contact barrier falls apart and is replaced by the beta-elements screen, which is the conglomerate of beta-elements — raw perception and emotion — which creates bizarre objects by connecting with residues of ego and superego of psychotic patients, which is discharged through primitive projective identification. The patient feels his emotions getting lost in an infinite vacuum. “Words, images, and ideas of these patients are remnants, debris, or fragments floating in a space without limits.” (Grinberg et al., 1977, page 94–95) The concepts of alpha elements, the contact barrier, beta-elements, and the beta-elements screen were proposed by Bion as interpretive concepts and not as observable facts. When these concepts are applied to group situations,

however, each abstract concept has its observable counterpart: The alpha elements and the contact barrier are comparable to members predominantly using secondary process thinking and the group thinking formed by them, and beta-elements and the beta-elements screen to members predominantly using primary process thinking and the group phenomena developed by them. For example, the contact barrier is quite obvious in well-functioning patients-staff team meetings, and the beta-elements screen, in chaotic community situations that foster bizarre incidents of acting out.

F. FAMILIARITY VS UNFAMILIARITY IN RELATION TO EGO BOUNDARY CATHEXIS written from the epistemological self developmental point of view

That unfamiliarity is a crucial factor in inducing a psychotic state (Erikson, 1964, Doi, 1981) is totally in keeping with the theory that the ego boundary and ego cathesis play a major role in maintaining the cohesive sense of self. Interacting with people and environment that are well known cathects the ego boundary through recognition of the familiar, as I discussed elsewhere in terms of acute paranoid disorder, often seen among immigrants (Takahashi, 1983). Piaget observed that babies five to six weeks old recognize familiar faces and voices. The recognition occurs when they experience the linking of the image and the real perception of an object, and later can develop into a welcome impression of familiarity linked with satisfaction, when the object is consistently "good." Also, Kohut's concept of mirroring points to the crucial role that this early experience of recognition plays in fostering the cohesive sense of the self, that is, the secure sense of ego boundary.

In groups, especially when groups have different structures and goals, and when one "emigrates," as it were, from one group to another, the familiar to the unfamiliar, one is constantly confronted with one's own ego boundary with regard to the specific culture of the group. If the ego

boundary is mature, dynamic equilibrium of assimilation and accommodation (in Piaget's terminology) enables the ego to function adaptively. When the ego boundary is immature, one responds to these kinds of pressure by either refusing to join or fusing one's identity with the group, as will be illustrated later.

G. WINNICOTT, HOFFMAN, and BENJAMIN

Winnicott discovered the third potential area between subject and object, later ushering us to social constructivism (Hoffman, 1998) and inter-subjectivism (Benjamin, 1990), both of which can be thought of as dynamic conceptions of boundary. Winnicott points out that when discovering something to push — the boundary of the mother's uterus, — the baby discovers the world of "not-me" whose experience is fundamental for the development of reality testing (Winnicott, 1958). His concept of the world of not-me leads to the concept of transitional phenomena, and helps us to understand a definitive developmental phase in which a transitional object — an object both me and not me — plays a crucial role in the development of self and object differentiation, and their relations, while a third potential area (Winnicott, 1966) — a boundary area between the me and the not me remains — in which creativity, play, and art can develop. It is clear that the maintenance of mental health requires an adequate possession and use of the third potential area.

H. GENERAL SYSTEM VIEW

It has been established that when an individual becomes a member of a group, there is constant, reciprocal influence; hence there are three different but dynamically related systems: an individual, a group interacting with the individual, and the group as a whole. Moreover, this whole group is part of a larger system. This idea is particularly important when conceptualizing inpatient group treatment, because any therapeutic system, small group for example, interrelates with other systems, such as the individual in therapy, and is at the same time, a

dynamic part of a larger system, such as the team, the unit, and the hospital.

For the past 60 years, general system theory (Von Bertalanfy, 1968) has developed slowly but steadily, and now helps us to comprehend the living system as living, and not as a mechanical entity to be broken down into unconnected parts of non-living material. The living system is an open system, where constant autonomous exchange of energy and information, within and without itself, and self-regulation and self transformation occur, and not such a closed system as a machine, where such vital functions need to be generated and regulated from outside.

In an attempt to apply GST (General System Theory) to psychoanalytic clinical practices, H. Durkin proposes the principles of isomorphy and flux equilibrium in GST as most relevant to group psychotherapy. Isomorphy is the revolutionary discovery, achieved through the GST comparative study of systems, that certain basic structural features are shared across the board by living systems of all categories. "The therapist may view his group, its members, and their internal personality structures as three systems at different levels of complexity. Focusing on the system boundaries gives the therapist a single uniform approach to all levels (H. Durkin, 1981, page 11)." Flux equilibrium is the unique phenomenon of a "living" or "open" system. This phenomenon is accounted for by the structural features of permeable boundaries which the system is inherently capable of opening or closing to exchange energy and information with other systems and with the environment (Ibid. page 12). She proposes "boundarying" as the key to the therapeutic change of input processing and system restructuring, based on growth-promoting exchange of information and energy, and the realistic and flexible opening and closing of boundaries.

In the same vein, Ganzarain summarizes the functions of the boundaries subsystem as: 1) holding together the components; 2)

protecting them from the environment; and 3) controlling their own permeability through permitting the entry of, or excluding, information and matter–energy (Ganzarain, 1977).

GST also encompasses the epistemological theory of assimilation and accommodation in Piaget's terminology. As James Durkin proposes, shifts between these two modes of cognitive adaptation change boundary functions. "The assimilation process is a boundary closing process where external influences are altered to suit the internal structure of the individual. ...the accommodation process is a boundary opening process where the individual restructures itself to suit the environment's terms (Durkin, J.E., 1981, page 38–39)."

III. THE BOUNDARY CONCEPT AS APPLIED TO CLINICAL PRACTICES IN INPATIENT GROUP PSYCHOTHERAPY

In a clinical situation, experiences about boundaries occur rather in the context of pathology. In other words, the very existence of boundaries is experienced when they are dysfunctional. Any boundary can become dysfunctional as a result of either inside or outside forces, and the individuals experience dysfunction as violation of their boundaries.

In comprehensive group therapy in an inpatient setting, a violation may be experienced within an individual, or between individuals, or within a group, or between groups, or between the unit and the outside. This violation also causes primitive anxieties as previously mentioned, and interpretations of anxieties with attention to boundaries provide comprehensive views of all individual, interpersonal, and group–as–a–whole aspects, so the sense of security of the self in the system is restored.

Kernberg states that "the primary task of the individual is to negotiate with the environment so as to fulfill the need that stems from his own internal world; his

control function, including boundary control, is the ego (Kernberg, 1976).” It can be said that our comprehensive inpatient group treatment (Appendix) helps to modify and mature the patient’s ego boundary. This notion is supported by H. Durkin’s point that the goal of therapy, to help the group members restore or enhance their own autonomy, is concretized into the more practical goal of helping group members more effectively open and close their own boundaries (J. Durkin, 1981).

Our core treatment groups (Appendix) are designed to prompt changes in the patient by confronting him with various aspects of himself. To elaborate on Kibel’s argument that the small group represents a dynamic interface between the external and the internal world (Kiebel, 1986), I propose that our small group therapy, in which patients communicate, explore, and understand, provides the format best suited to confront the inner ego boundary, namely, separating the conscious from the unconscious; the patient–staff team meeting, in which patients report on their own progress, provides the format best suited to confront the outer ego boundary, namely, separating intimate subjectivity from the outside. In Kernberg’s terms (1973), a lower level of internalized object–relationships can be best activated in small groups, and a higher level of internalized object–relationships in team meetings. The community meeting, in which patients discuss milieu issues as they relate to treatment, provides the format best suited to confront the combination of the inner and the outer ego boundaries. This definition of the community meeting fits with the community meeting model proposed by Rice and Rutan as the combination of the family and the town meetings (Rice and Rutan, 1987). Participation in the patient government in conjunction with the section council is the format best suited to strengthen the outer ego boundary through the training of organizational and political adaptability to the administration, which aspect of a therapeutic community cannot be neglected if effective treatment is to result (Kernberg, 1981). Our supporting groups are designed to support the core groups to achieve their goals. The group study group (Appendix) serves as the staff to examine, sensitize, study,

and improve group treatment, as well as to train as group therapists. The morning report provides for morning greeting and general information sharing in the section. The evening “opportunity meeting” educates patients on health issues. Leisure time activities provide the group with fun. These group activities thus serve a supporting function for the core treatment groups.

IV. CLINICAL VIGNETTES AND DISCUSSION

In this section, I will first highlight three kinds of boundary formation problems that individual patients presented; second, describe boundary issues as dealt with in different kinds of groups; third, follow up on the vicissitude of the boundary functions of one patient during the course of her inpatient treatment.

A. INDIVIDUAL PATIENT

Case 1: This case illustrates outer as well as inner ego boundaries through which psychic reality and unconscious material constantly pass to objective reality and consciousness.

In a small group, Troy, a borderline patient, constantly attacked therapists and fellow patients in the group for their intimidation and their abuse of power to hurt, frustrate, and damage him. By this attack, he in turn hurt, frustrated, and damaged the group, pushing people away more and more, and becoming alienated. What was observed in the small group was also observed in any kind of relationship the patient became involved in, whether in individual relationships or interaction in small group, team, and community meetings.

It seems that the patient consciously holds on to his rigid outer ego boundary to deal with his interpersonal difficulties. His outer ego boundary is rigidly semipermeable; there is almost full passage of aggressively charged information from him to others, but little passage the other way. Moreover, his inner ego boundary is also rigidly semipermeable. His unconscious material constantly

passes outwardly through projection. He barely holds himself together by refusing to listen to all objective and potentially nurturing input, and projecting or acting out the internal bad; that is to say, he is in the schizoid–paranoid position.

Case 2: This case illustrates loose, fluid outer and inner ego–boundaries through which psychic reality and objective reality, and the conscious and the unconscious, are loosely differentiated, and actively intermingled.

In small group therapy, Mary was eager to reveal incidents involving her own sexual and aggressive acting out, such as bomb threat calls she had made at home. This information threatened the group, as her prank calls had threatened people on the outside. Without adequate knowledge of her background and adequate working alliance with her, the group was totally immobilized except for their ineffective attempts to emotionally isolate her. She was successful in acquiring a sense of control by exploiting the sadistic power of unifying all the group members around the fears she had provoked.

It appears that the patient's outer ego boundary was loose and fluid. In the meeting described above, she acted as if she made no distinction between herself and others, and “there and then” and “here and now.” Projective identification, and as a result, confusion and profound anxieties, developed in the group. Moreover, her inner ego boundary was also loose, and both projection and introjection were actively occurring.

Case 3: This case illustrates varied ego–boundary formation observed in a patient in different groups.

Luella, a case of borderline disorder with narcissistic features and minimal brain dysfunction, functioned best in settings where she had clearly defined tasks and authority, and where her authority did not get challenged, such as secretary or chairperson of the hospital patients' government. She did least well in her small group, where she was either silent, contemptuous, or emotionally overwhelmed. Lacking an ability to develop insight, it is not surprising to know that she had difficulty translating “there and then” to “here and now” and vice versa, and her moment–to–moment affective experience was very intense without integration of

her various experiences. She also disliked the community meeting where she felt that she had no recognized role to play. On the other hand, she felt more positive about the team meeting because of the structured procedure whereby everyone had his or her own time to share factual aspects of treatment.

It appears that the patient's outer as well as inner ego boundaries have a mixture of rigidity and looseness. She uses these boundary characteristic to defend herself consciously or unconsciously from revealing herself to a degree that would initiate change. It is as if the dysfunctional ego boundary is externalized in the way she deals with different kinds of groups.

We will return to this case later to describe how her ego boundary, dysfunctional as it originally was, matured over time.

B. BOUNDARY ISSUES AS DEALT WITH IN DIFFERENT KINDS OF GROUPS

1. Violation of Boundaries by Outside Forces

This clinical vignette illustrates that environmental influences sometimes make the outer as well as the inner ego-boundaries of patients and staff dysfunctional. This causes confusion and acting out in the whole unit.

a. Environmental Boundary Confusion

For the past few weeks, the whole hospital has been busy preparing for the JCAHO (Joint Commission of Accredited Hospital Organizations) survey, while four or five patients on the unit struggled with their insurance problems, which could lead to the premature termination of their treatment here. During the preceding week, a number of unusual things happened on the unit: for example, a patient wandered away from the unit day or night in spite of staff efforts to contain her; the clothes of four female patients were missing; painting men and repair men worked almost all day long, spreading a repellent odor and continually making squeaking noises; the medical record staff also came in and out, carrying bunches of record, consequently making a number of patients suspicious that they might be doing something bad against their confidential records; loud rock and roll

music tapes were almost constantly played in several of the patient's rooms, and the music was heard in every corner of the unit; and the staff was suspicious of secretive misuse of alcohol by patients on the unit. All in all, the members of the staff were quite preoccupied and uptight with the upcoming survey to be held soon, nervously checking on whether their documentation was complete. Confusion and violation of familiar boundaries of multiple kinds and levels were noticeable, whether intrapsychic, or interpersonal, or socially.

b. Regression to Primitive Object Relations and Feelings

On Wednesday, early in the morning, the section chief, a Japanese immigrant, had a dream in which he saw and heard his elderly mother sing an old Japanese folk song. He was moved and felt urged to return home in the dream. In the afternoon of the same day, there were small group meetings on the unit. In one of the Gold Groups, composed of 6 patients with severe ego weakness, several different rock and roll songs could be heard through the wall, and a patient began to hum one of the tunes. This behavior prompted the group to talk about their favorite songs, most of which were found to be despairing in nature. A few patients actually sang in the meeting. Significantly, they felt they were listened to by the group better than ever. They then agreed that they wanted to return home.

This vignette illustrates boundary confusion of medicine, economy, law, and regulation extensively and intensively experienced by patients during a particular week. Projective identification by patients and staff, reflecting uncanny desires to retreat into "the symbiotic orbit of the mother-child dual unity" (Mahler) seems to reflect a reduction of boundary cathexis, or, in other words, the loosening of the contact barrier and the emergence of the beta-elements screen in Bion's terminology.

2. Violation of Boundaries among People

This clinical vignette illustrates that boundary violation of different kinds is contagious in a unit, and concurrent with an increase of primitive anxieties.

a. Violation of Individual Boundaries

During the past month, when Beatrice began to work on her discharge plan, her old symptom of paranoid anxiety returned. She loudly and abusively accused a few fellow patients of conspiring against her, and even called the police to investigate one of them. The other patients, angry as they were, tried to keep distance from her, but this physical boundary-making was not as effective with her as they had hoped. They requested the section chief to call for an emergency special community meeting.

b. Attempts to Restore Boundaries

The section chief decided not to call an emergency meeting, but instead encouraged the patients to discuss the issue in the team meetings, the small group, the patient government group, and especially in the regular community meeting to be held soon.

c. Boundary Clash between Patients and Staff

In the next team meetings, for Team A and B the issue discussed was their fears of violence, unexpected, sudden, and incomprehensible violation by several severely disturbed patients, including Beatrice, of their own physical, as well as psychological, boundaries. The majority of patients accused the staff of not doing anything to protect them from these kinds of violations. The staff's reality-oriented feedback made the patients more angry. In one of the meetings, they yelled, "You don't live on the unit. You are not the community. We are the ones." The team leader explained the similarity between Beatrice's paranoid attack on others and other patients' attacks on the staff. The patient whom Beatrice reported to the police became furious, stood up, and shouted at him, threw a chair and a trash stand and left the group crying. She later told the staff that the issue was not really about "violent" patients, but about staff not caring how other patients felt.

After that particularly emotional meeting, the staff reflected that the process of patients' active projection, as an outlet for the aggressively perceived bad object, prevented patients from accommodating the staff's reality-oriented feedback, including refusal to call for an emergency meeting, and concrete and realistic

input, because, although intended to cathex the outer ego boundary of the patients, all this feedback was perceived, on the contrary, as counterattack on the outer ego boundary or abandonment of support for the ego of the patients. Empathic comments may have helped, since empathy can be said to cathex the ego boundaries from the inside.

d. Working-Through

In the community meeting during that week, the original topic was tension on the unit, and they talked about two patients who were either threatening violence or actually slapped across other patients' faces. Patients were also worried about people slamming the door, throwing magazines or coffee, kicking the door, and yelling and screaming, because those kinds of behavior were warnings for imminent violence. A patient stated that sudden or shocking information (such as her doctor's absence) had an impact like violence, shattering the coherent sense of herself. The impact of violent video shows was also discussed.

The discussion of violence continued in the next community meeting. Patients first talked about the vandalism that had recently been committed in the canteen. Although they were actively discussing and able to understand the connection between anger and acting out, the group continued to be tense, and soon became silent. When focus was redirected to the unit, patients brought up the issue of the staff eating food from the unit kitchen. Some patients felt the staff was stealing their food. After some clarification was attempted by the staff, some patients shifted to a criticism of staff unavailability. The section chief offered an interpretation to help the group comprehend and process what had been observed and experienced on the unit for the past month, that is to say, the violation of various boundaries perceived as violence, the paranoid anxiety violating the psychological safety boundary, physical violence literally violating the physical safety boundary, and the abrupt or excessive information violating the psychological capacity boundary, staff eating kitchen food violating the patient's right boundary, with intense anger being aroused as a consequence. The section chief concluded that too rigid a boundary keeps people from relating to each other,

while too loose a boundary creates conflicts with intense feelings; we need to be aware of boundaries, to respect them, and at the same time to try to be flexible in negotiating them with others.

A few days later, the staff agreed that the unit had become calmer and there was a sense of greater cooperation. Some sense of achievement was also felt by the patients and staff, because they had pursued the issue of violence systematically.

It appears that at the height of the boundary confusion pervading the unit, staff clarification of group boundaries helps to restore security within each group, as Rice and Rutan point out (1981), so that patients can restore interpersonal and intrapsychic boundaries. It can be said that the staff's clear feedback about boundaries cathects the patients' own sense of boundaries. Interpretation of "isomorphic" phenomena in different groups helps patients to develop insight into their underlying fear of boundary violation, and the primitive defense of identification with an aggressor.

Kernberg (1975) elaborates on the effective leader's boundary function in terms of 1) his task, 2) knowledge of subsystems impinging upon his observing ego, and 3) tolerance for uncertainty and contradiction (page 274). "The simple awareness of the need to define as many boundary functions as possible increases the scope of the observational field of the group leader" (Kernberg, 1975). While concurring with him on the importance of the therapist's boundary function, I would emphasize that the patient's struggle with boundary has therapeutic value, and that flexible and therapeutic assistance from various staff members, and not the leader alone, is an important component of inpatient treatment, and, in the same vein, so is the staff struggle. True, too much boundary confusion is negative in treatment, but some degrees of confusion are not only inevitable but also useful in helping to identify the source of the confusion, and to recognize its ramifications, to correct neurotic or defective ego functioning, and to develop adaptive ego functioning. By participating in the same confusion, the staff faces the same source of problems within themselves as patients, but more quickly and effectively overcome the confusion. Staff difficulties with boundary and related issues are

also worked through in staff meetings and more specifically in the group study group so that the staff can effectively help patients.

C. THE GROWTH OF BOUNDARY FORMATION AS OBSERVED IN A PATIENT DURING THE COURSE OF HER EXTENDED TREATMENT

This clinical vignette illustrates that the characteristics of boundary formation differ significantly from one patient to another and, with one patient, from one group to another, and from one phase of treatment to the next, and that, over time, it becomes more and more flexible and effective, concurrent with the growth of other ego functions of the patient.

The patient, Luella, described earlier, had a varied ego boundary against both incoming and outgoing information. Initially, she misused the boundaries of different groups just to avoid meaningful communication with other people. She would say, "I won't talk about it in the staff-patients team meeting, but I will do so in a small group," for example, when in fact she would not reveal any significant information about herself anywhere. On the other hand, she was quite alert to any reality boundary violation committed by the staff, and, when it happened, relentless criticism of the staff ensued. It was as if by so doing she needed to secure the sense of her ego boundary.

The patient's perception of the group treatment first began to improve during the team meeting. She felt the team meeting was the only meeting where something was accomplished. In those sessions, she was able to describe the state of her treatment clearly, but still left out such important issues as her eating disorder and family conflict. When those issues were brought up by the staff, she would become enraged, feeling her ego-boundary had been violated. For a while, she continued to despise the small group, feeling the meeting to be futile because the therapists' responses constantly betrayed her expectation of them. After consulting with her hospital psychiatrist, the patient decided to switch to the more structured (Gold) Group. Instead of continuing in the directly sharing her decision with the small group members, she found out for the first time that she

was valued by group mates. Her desperate attempt to be more open was met with unexpected, positive narcissistic rewards which were most needed by her. The patient began to change gradually, finding the small group to be increasingly useful, using the team meeting even more efficiently, while also being active in other groups. Her original sense of different boundaries was first supported, by the staff regardless of how rigid or distorted it seemed, and, later on, confronted so that it could be modified, tested, and adjusted to the therapeutic culture, maturing over time and acquiring more adaptive flexibility. In other words, she can now “play” with judgment as to when, where, for what, how, and how much to open or close her boundary. It can be said that she has developed between the ego and the external world the third potential area in Winnicott’s terminology where her creative capacity is exercised. These very processes reflect her ego’s growth.

V. CONCLUSION

Several years ago, we established separate small groups within the team, according to the patient’s need for more or less structured psychotherapy, namely, the Gold Groups and the Purple Group. This relatively small change, creating divisions within the team, caused intense, deep, and extensive anxieties among staff members and patients: feelings of helplessness, meaninglessness, self-criticism, competition, confusion, fear of exclusion, deprivation, exploitation, and destruction.

The depth and extent of these feelings suggested that those involved re-enacted early developmental stages of our emotional lives, and they could be defined as schizoid, paranoid, and depressive anxieties (using Melanie Klein’s terminology) and also as narcissistic anxiety.

Only one new sub-boundary was created in this reorganization, yet its impact not only affected individual patients’ and staff’s psychology, but also spread to the entire system of group treatment. It seemed that the new boundaries needed to

be clarified again, structurally, conceptually, or emotionally, because the primitive anxieties mentioned above seemed to be caused by boundary confusion regarding information and energy exchanges (in terms of general system theory). These anxieties were overcome when the effective dynamic boundaries were restored. Patients can then function more effectively to achieve their specific goals.

It can be said that our comprehensive inpatient group treatment helps to modify and mature the patient's different ego boundaries, i.e., the inner and outer ego boundaries. Among the core treatment groups, the small group therapy meetings provide the format best suited to confront the inner ego boundary, while the staff-patients team meetings are the format best suited to confront the outer ego boundary, and the community meetings are best to integrate both. Then the patient government meetings serve to train patients to adapt themselves to the organizational boundaries. Last, but not least, supporting groups (study groups, morning report, opportunity meeting, leisure time activity) perform supportive functions for the core treatment groups.

Clinical findings and theories adopted in this paper add a new comprehensive dimension to staff attention, understanding, and interpretive group techniques. Confusion of boundaries occurs constantly to a greater or lesser degree; attention to and understanding of the confusion help groups of patients and staff not to be overwhelmed by it, but rather to examine and learn from it, and to achieve ego growth with a more mature sense of boundary.

The theory and techniques evolved through our day-to-day clinical practice in a particular setting, and during a particular period of time. However, they can be applied, I believe, to any psychoanalytically informed comprehensive treatment setting at any time, including the inpatient, the outpatient, and the day care.

ABSTRACT

Boundary confusion (between groups, between the individual and the group,

between individuals, and within the individual) leads to regression or to psychotic-like experiences. Based on this innate linkage between the boundary and primitive experiences, systematic and dynamic use of various kinds of groups — small groups, team meetings, and community meetings, for example — , on an extended care unit can help patients to negotiate and mature their own inner and outer ego boundaries. In this paper, there is a selective review of boundary concepts in psychoanalytic as well as general systems literatures. Clinical vignettes follow to illustrate rigid, loose and mixed ego boundary confusion in the system that stirs up primitive anxieties and regression, which then stir up additional boundary confusion. Attention to, and understanding of, the confusion help groups of patients and staff not to be overwhelmed by it, but rather to examine and learn from it, and to achieve ego growth with a more mature sense of boundary.

Appendix

GOALS, TASKS AND TECHNIQUES OF TREATMENT GROUPS

CORE TREATMENT GROUPS

STAFF–PATIENT TEAM MEETING (once a week)

The goal is to develop reality testing or observing ego.

The task is to utilize structure of meeting, in which each patient talks about one's own progress, and other patients and staff give feedback.

The therapist's techniques include reality orientation.

SMALL GROUP MEETING (Gold) (twice a week)

The goal is to relate better.

The task is to communicate to one another.

The therapist's techniques include the use of nonverbal or verbal tools, and activities.

SMALL GROUP MEETINGS (Purple) (twice a week)

The goal is to understand oneself better in the context of groups.

The task is to explore one's mind and behavior.

The therapist's techniques include clarification, confrontation, and empathic interpretation of patients' behavior.

COMMUNITY MEETING (once a week)

The goal is to understand milieu issues as they relate to treatment.

The task is to share information regarding the environment and events of the unit and the individual, and to connect to the environment and the events.

The staff techniques include helping the group to focus on agenda.

PATIENT GOVERNMENT MEETING (once a week)

The goal is to assume responsibility for decision making for the patient's community.

The task is to organize.

The staff techniques include interested observation.

SUPPORTING GROUPS

STAFF TEAM MEETING (once a week)

For clinical administration, including diagnostic and treatment evaluation, as well as staff support.

GROUP STUDY MEETING (once a week)

For staff supervision, study, and synthesis.

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Adolescents with developmental psychopathology in adulthood

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INTRODUCTION

It has been said that the therapeutic understanding of a new condition that results from inner turmoil during adolescence and in which psychiatric disorders tracing back to infancy is interwoven, ought to be differentiated from the previous conditions. Therefore, the special psychiatric conditions peculiar to adolescence need to be addressed. Although some investigators disagree,¹ the majority of adolescent clinicians believe strongly that adolescent psychopathology is peculiar to adolescence.²⁻⁷ They would agree that without monitoring both the adolescent mentality as well as the changes within the parent-child relationship from early childhood, the adolescent's psychopathological status cannot be accurately ascertained. Rutter et al. considers the previous notion that 'adolescent turmoil is a fact, not a fiction, but its psychiatric importance has probably been overestimated in the past' to be inappropriate. Their contention is based on findings from a total population epidemiological study of Isle of Wight's 14- to 15-year-olds, so it may be considered limited to this age group.

In the present study I would, therefore, like to outline the problems in the lives of adolescents, and the problems related to the treatment and to the prognosis, on the basis of data obtained from 77 cases (age: 12-22). In addition, I will examine the adolescent psychiatric condition more closely.

SUBJECTS AND METHODS

The subjects were those who were regarded as having an identity crisis or identity disorder selected from a group exhibiting adolescent developmental psychopathology. Cases determined to have conclusive psychopathologies, such as schizophrenia and other distinctive psychoses, major affective disorders, obsessive-compulsive disorders, hysterical neurosis, hypochondriacal neuroses and depersonalization disorders, were excluded.

A 7-year follow-up study was previously undertaken on 142 cases of 12- to 22-year-old adolescents with adolescent developmental psychopathologies (previously identified as adolescent neurosis) in 1981.⁸ Of the 155 cases who underwent psychotherapy at Kyushu University Hospital and Fukuoka University Hospital for one year or more during the 13-year period (1968–1980), 142 cases with whom a follow-up interview was conducted were used as the subjects. In addition, a detailed study was also made of 84 cases who underwent psychotherapy 6 years prior to the study and with whom a follow-up survey was conducted. Treatment had already been terminated in 69 of the 84 (82.2%) cases.⁸

In order to clarify the criteria for adolescent developmental pathology, I defined six groups:

(i) those showing a depressive picture with an explicitly ambivalent attitude of dependence and defiance towards their loved ones;

(ii) those showing antisocial behaviors with an antagonistic attitude towards an authoritative figure with a disguised help-seeking attitude;

(iii) those showing a hypochondriacal picture with great hurt to one's pride and with feelings of ill health;

(iv) those with feelings of tension in the interpersonal relationship associated with hidden dependence;

(v) those demonstrating a borderline personality trait and lacking basic trust; and

(vi) those who demonstrate psychotic episodes yet generally have good emotional

contact with others.

In 1992, 11 years after the completion of the 7-year examination period, six cases who had received treatment for less than 1 year by the data collection year (1981) were added to the 7-year data pool.

The mean age of onset was 15 years and the mean age at the first medical examination was 16.7 years. The mean age at the 7-year follow-up study was 23.7 years and the mean age at the 17-year follow-up study was 33.4 years.

For the follow-up study, a questionnaire was sent to all the subjects and interviews were held with those who agreed to participate in the study. In case the subjects lived in remote areas or were hospitalized, information was obtained by telephone interview or from the therapists in charge. Data on the condition were obtained for 98 out of 148 (66.2%) cases.

In 90 cases, the interviews were undertaken by psychiatrists who were able to obtain sufficient clinical data and make a final diagnosis.

Psychiatric profiles were formed in 90 cases. Of the 90 cases in the 17-year follow-up study, 77 cases were part of the 84 in the 7-year follow-up study.

The subjects included 77 cases who had undergone more than 1 year of psychodynamically-oriented psychotherapy after first medical examination by the time of the 7-year follow-up study (published elsewhere⁸) and for which reliable information could also be obtained at the 17-year follow-up study.

The conflicts brought about by independence were resolved within 1 to 2 years of initial treatment. Prognosis is assumed to develop from the second to the third year of treatment. It is postulated that patients' end state is fixed in terms of psychiatric classification after 5 years.

Fifty-five per cent of the subjects were able to live ordinary lives, and 15% developed classical adulthood neuroses. Furthermore, several factors that had affected the outcomes were considered.

Differences between groups were tested using the X^2 test with Yates' correction or Fisher's exact test as appropriate according to the total number of subjects observed.

RESULTS

Comparison between the outcomes of both studies

There was an interval of about 11 years between the two follow-up studies. As shown in Table 1, a few changes in the outcome were seen between the 17-year and the 7-year follow-up studies. However, the development of mood disorders in four (7.7%) who seemed to be able to resolve identity conflicts and lead ordinary lives and who had developed adulthood neuroses at the time of the 7-year follow-up, and an aggravation to psychosis in two cases (18.2%) who developed personality disorders, were noted as outstanding deterioration during this 11-year period. These end stages were observed to show the more solid features a few years after the 7-year follow-up study (Table 1).

Social adaptation at the 17-year follow-up

When social adaptation was examined, 74% of the patients showed excellent or good social adaptation at the second follow-up (Table 2).

Relationship between the patients' stage of life and their parents' ability to discipline

The intrafamilial emotional interaction and the parents' ability to discipline were studied (Table 3). The data were obtained from reports by the adolescents and by their parents during therapeutic treatment. Observation of the adolescents' emotional attitudes towards their parents was made when they were young, during which the parents' attitudes on discipline were explored. When the reports of the adolescents and of the parents matched, these were considered to be reliable. As shown in Table 3, intrafamilial emotional factors were examined by development stage: infancy (0–6 years), early to mid-childhood (7–10 years), preadolescence to early adolescence (11–14 years), mid-adolescence (15–18 years), and adolescence (19–22 years).

Table 1. Relationships between the outcome at the 7-year follow-up and the outcome at the 17-year follow-up

Outcome at the 7-year follow-up (down) and at 17-year follow-up (across)	Completely normal condition	Fairly normal condition, with slight and non-clinical (neurotic) complaints	Anxiety somatization, obsessive-compulsive disorder, and hysterical neurosis	Personality disorder	Mood disorder	Psychotic disorder and schizophrenia	Total (%)
Those who seemed to be able to resolve identity conflicts and live ordinary lives	30 (85.7)	5 (62.5)	1 (10.0)	0	2 (40.0)	0	38
Those who developed adulthood neuroses	2 (5.7)	1 (12.5)	8** (80.0)	1 (10.0)	2 (40.0)	0	14
Those who developed personality disorders	0	1 (12.5)	1 (10.0)	7** (70.0)	0	2 (22.2)	11
Those who developed frank psychoses	0	0	0	1 (10.0)	0	5* (55.6)	6
Those who committed suicide	0	0	0	0	0	2 (22.2)	2
Fluctuating states of identity	3 (8.6)	1 (12.5)	0	1 (10.0)	1 (20.0)	0	6
Total (%)	35 (100)	8 (100)	10 (100)	10 (100)	5 (100)	9 (100)	77

*P<0.05 **P<0.025 (d.f. = 1).

Table 2. Social adaptation at the 17-year follow-up

Social adaptation	Excellent	Good	Poor	Bad	Committed suicide	Total
No. of cases(%)	45 (58.4)	12 (15.6)	9 (11.7)	8 (10.4)	3 (3.9)	77 (100.0)
						
	(74.0%)					

Excellent: getting a regular job, sociable lifestyle without any psychiatric support; good: getting a regular job, sociable lifestyle with only limited and sporadic psychiatric support; poor: working on a part-time basis, not so sociable lifestyle with slight to moderate psychiatric problems; bad: not working, unsociable lifestyle with severe psychiatric problem or hospitalization.

In infancy, those with a completely normal or a relatively normal condition were significantly easier to discipline compared with those who showed other outcomes ($P < 0.05$). Those who showed worsened outcomes often expressed tantrums, anxiety due to separation, withdrawal, night terror, habit disorders, vomiting and so on. In early to mid-childhood, inversely, those within normal conditions gradually became increasingly difficult to discipline, while those showing other outcomes were easier to discipline ($P < 0.005$).

In preadolescence to early adolescence, however, it was common to find unstable and emotionally strained relationships with parents (e. g., aloof, selfish, assertive and defiant attitudes and sometimes provocative attitudes), whatever the outcome. In mid-adolescence, instability of the parent-child relationship submerged gradually following the development of completely normal and fairly normal conditions of mental stability. In contrast with those with normal conditions, those

with other outcomes still remained conflictual and strained in their relationships, However, there were no significant differences between the two groups. In late adolescence, the degree of uneasiness for parents to treat children with a normal outcome was significantly less than that in those with other outcomes ($P<0.025$).

Relationship between the problems that required treatment and the outcome at a 17-year follow-up

With regard to the problems that led youngsters to receive psychiatric treatment, 57.1% of the subjects often had low self-esteem and an identity crisis, 59.7% experienced a lack of self-control, while 71.4% suffered from their parents' lack of ability to set limits, instill values and provide support. Those whose problems included low self-esteem and an identity crisis showed significantly better outcomes than those whose problems had been in the other five categories (Table 4). These findings suggest that during adolescence, youngsters become increasingly estranged from their parents and find it difficult to establish their self-esteem and an identity and yet need their parents to set limits, instill values and provide support.

Relationship between family intervention and the outcome/social adaptation

The group placed under the care of active and persistent family intervention in addition to individual psychotherapy showed success and good results regarding the outcome and significantly good results regarding social adaptation ($P<0.025$) after 17 years. This suggests that a direct therapeutic intervention in the parent-child tensions and conflicts which had occurred by adolescent turmoil appears vital (Tables 5, 6).

Table 3. Relationship between the patients' stage of life and their parents' ability to discipline effectively as grouped by the outcome

Stage of life	Completely normal condition (n=35)	Fairly normal condition, with slight and non-clinical (neurotic) complaint (n=8)	Anxiety, somatization, obsessive-compulsive disorder, and hysterical neurosis (n=10)	Personality disorder (n=10)	Mood disorder (n=5)	Psychotic disorder and schizophrenia (n=9)
Infancy	14	4	6	5	3	8
Early to mid-childhood	22	6	5	3	2	2
Preadolescence to early adolescence	32	7	7	8	4	6
Mid-adolescence	18	5	5	7	3	6
Late adolescence	10	4	4	8	2	7

*P<0.05; **P<0.025; ***P<0.01; ****P<0.005(d.f. =1).

Table 4. Relationships between the reason for treatment and the outcome with psychiatric evaluation 17 years after initial diagnosis

Reason for treatment	Completely normal condition	Fairly normal condition, with slight and non-clinical (neurotic) complaint	Anxiety somatization, obsessive-compulsive disorder, and hysterical neurosis	Personality disorder	Mood disorder	Psychotic disorder and schizophrenia	Total (%)
Conflicts concerning the patient's own self-esteem and identity	31	3	2	4	2	2	44(57.1)
Absence of an individual to set limits/establish values and provide support	21	5	10	9	3	7	55(71.4)
Confusion with uncontrollable inner drives	19	6	5	9	1	6	46(59.7)
Vagueness and / or lack of development of the generational boundary	4	2	3	5	2	9	25(32.5)
Chaotic and tense family situation	3	1	1	8	1	1	15(19.5)
Traumatic peer experience outside of family	7	1	2	6	0	3	19(24.7)

*P<0.005(d.f. =1).

Table 5. Relationships between family intervention and the outcome

Active and persistent family intervention	Completely normal condition (n=35)	Fairly normal condition, with slight and non-clinical (neurotic) complaint (n=8)	Anxiety, somatization, obsessive-compulsive disorder, and hysterical neurosis (n=10)	Personality disorder (n=10)	Mood disorder (n=5)	Psychotic disorder and schizophrenia (n=9)	Total (n=77)
With	22*	5	3	4	2	3	39
Without	13	3	7	6	3	6	38

* $P < 0.1$ (d.f. = 1).

Table 6. Relationships between family intervention and social adaptation

Active and persistent family intervention	Excellent (n=45)	Social adaptation				Total (n=77)
		Good (n=12)	Poor (n=9)	Bad (n=8)	Committed suicide (n=3)	
With	28*	5	3	2	1	39
Without	17	7	6	6	2	38

*P<0.025 (d.f. =1).

DISCUSSION

The number of years of follow-up and the outcome

Because there is a slight difference between the outcome of the 7-year follow-up study and that of the 17-year follow-up study, including some minor tendencies, the following may be said concerning the diagnosis, treatment and prognosis of adolescents with developmental psychopathology.

Some of those with a strong self-examination power and who were within the normal conditions of mental stability at the time of the 7-year follow-up study, generally responded successfully to the stresses of adulthood and tried to answer their own questions and, as a result, were prone to present only a few mood disorders. According to the follow-up study of childhood and adolescent depression conducted by Harrington et al.,⁹ they concluded that the depressive group was at an increased risk of affective disorders in adulthood. With regard to this study, the cases presenting mood disturbance were at a relatively high risk of affective disorder in adulthood. On the other hand, some patients who demonstrated personality disorders were prone to develop schizophrenia; however, the overall social adaptation was high (74.0%), even after the 11-year interval between the two follow-up studies.

The parents' inability to discipline and the nature of the parent-child relationship

On examination of the parents' feelings of uneasiness to discipline their children and the tense interaction between parents and children, the proportion of normal condition cases was significantly less than that of other groups in infancy ($P < 0.05$). However, the proportion of the normal condition cases become significantly higher than of other group in early to mid-childhood ($P < 0.005$). This paradoxical phenomenon was due to the different content of untreatable problems for parents: the content of untreatable problems of the normal condition cases often shift from tantrums, separation anxiety, withdrawal and night terror in infancy, to selfishness, fastidiousness and demand in early to mid-childhood. However, those

of other groups often shift from tantrums, separation anxiety, withdrawal, anaclitic depression and night terror in infancy to obedience to parents, a tendency to be undemanding, and a tendency to self-nurture and to play alone in early to mid-childhood. It has also been noted that earlier pathology becomes transformed into an alternate form in latency.^{10,11}

The former attitudes seem difficult for parents to effectively discipline, yet those attitudes provide the parents and children with the opportunity to emotionally interact. In contrast, the latter attitudes, associated with a fear of abandonment or strong separation anxiety, would appear to be easier for parents to discipline; however, these attitudes often deprive both parents and children of the opportunity to emotionally interact and also prevent the parents from empathizing with the children's deep-seated emotions. This phenomenon can be regarded as a pseudo-stability in which the emotional interchange between the two is tenuous.

These findings in infancy coincide well with those of Capes et al., who noted that the prognosis was better for those whose first five years of life were reasonably trouble-free.¹² Of those who showed both normal conditions and psychiatric disorders of some form after 17 years, it is noteworthy that the cases that demonstrated a basically normal condition had often experienced a significantly more complicated but emotional parent-child relationship in early to mid-childhood than the cases showing psychiatric disorders during early to mid-childhood. Thus it could be assumed that those who develop psychiatric disorders later in life had an emotionally smoother and more stable family upbringing in early to mid-childhood. However, I cannot accept such a conclusion per se, given that in this study the cases who showed psychiatric disorders after 17 years had been in a stable family environment in early to mid-childhood. As highlighted previously, children who showed rather severe emotional disturbances in adolescence often showed a higher rate of obedience, self-nurturing and undemanding attitudes during early to mid-childhood.¹¹ Therefore, initially it would appear that there exists a peaceful family life and a good child-parent

relationship during early to mid-childhood, but the child is compelled to fear separation and abandonment. Therefore, the manner in which the children experience pseudo-stable family atmospheres and emotionally pseudo-warm parent-child relationships in early to mid-childhood may be crucial to the severity of psychopathologies in the long-term prognosis. Of course, infancy is an important stage for personality development, but it is considered that the emotional interactions between parents and their children during early to mid-childhood is crucial as it fosters a base for a flexible and socially refined superego. This may be one factor that influences the prevention of severing psychopathologies in adolescence and the prognosis of adolescent developmental psychopathology.

Furthermore, an unstable family atmosphere in preadolescence to early adolescence may also risk developmental psychopathology. This is because the period during preadolescence to early adolescence is when a revision of the mode of pathology between parents and their children will occur. It is said that the instability during this period is due to the instability of the resurgence of infantile preoedipal drive. Therefore, the ability (or inability) of parents to empathize with their children's state of mind may sometimes eventuate and/or may even influence the onset of treatable or untreatable adolescent turmoil. The latter seems to be a crucial trigger of, or may directly cause, adolescent developmental psychopathology.

Relationship between problems that required treatment and the outcome

Of the problems which eventually led the adolescents to receive psychiatric treatment, the parents' inability to set limits, to instill values or to provide support,¹³ and confusion with uncontrollable inner drives, showed significantly high rates of 71.4 and 59.7%, respectively. These were followed by low self-esteem (57.1%). These problems are all said to be closely related to adolescent turmoil and are often combined with such risk factors as a lack of knowledge regarding the generational boundaries which exist from early childhood between the child and

parents. Also a factor is a traumatic peer experience from outside the family, as well as chaotic and tense family situation which lead to more severe adolescent psychopathologies and generally result in poor outcomes. However, in cases where the adolescent has recognized and worried about their failure at self-control or their conflicts with self-esteem, the outcome is often good.

Attention should thus be paid to how such inner turmoil is addressed when it occurs. Therefore, the way in which the inner conflict manifests itself is vital in the development of personality in youngsters.

Family intervention and the outcome and /or the resultant social adaptation

According to Rayner, youngsters, particularly those in mid-adolescence (15–18 years), certainly confront their own individuality and this presents itself in the form of confrontation with parents or oppositions to their parents' wishes, which thus becomes a nuclear task during adolescence.¹⁴ Thus, patients in an adolescent developmental psychopathology with signs of such are therefore likely to have stormy relationships with their parents. This psychopathology may be interpreted as indicating the necessity to therapeutically intervene in the parent-child neurotic bonding and tense interaction, while exaggerating the adolescent turmoil and to help them to reconstruct their inner structure in order to assist the child in developing his own personality. The findings in my follow-up studies proved that making active and persistent family interventions in the parent-child neurotic bonding and tense interaction while intervening therapeutically in the exaggerated adolescent turmoil often brought about good results regarding the long-term prognosis 17 years later.

Adolescent turmoil

When children enter preadolescence, they begin to see themselves as individuals, separate from their parents. In fear of losing the bond which they have with their parents, the children adopt infantile and provocative attitudes towards them in order to test the acceptance of the child's identity. Upon confirming the parents'

acceptance, the children discard the provocative attitudes and begin to adopt negotiating attitudes towards their parents and others. While they are treated as individuals throughout these stages, the children begin to question their independence. From this study, I am of the opinion that whether children remain in the infantile provocative state or proceed to the ambivalent and bargaining state depends not solely on the emotional interchanges between parents and children in infancy but also largely on the interchanges in early to middle childhood. I believe that this ambivalent and bargaining attitude must be what constructs the core of adolescent turmoil.

CONCLUSION

The subjects were those who were regarded as having an identity crisis or identity disorder, selected from a group exhibiting adolescent developmental psychopathology.

With regard to the 77 cases of adolescent developmental psychopathology, we conducted a comparative study of the outcomes seen between 7 years and 17 years after initial diagnosis. Few distinctive changes were found in the outcomes at 7 years and at 17 years, with the exception of a few cases.

The above results can be deemed to have demonstrated my hypothesis in the 7-year follow-up study that the prognosis of cases showing adolescent developmental psychopathology could be fixed at 5–6 years after commencement of medical treatment.

It was shown that the parent–child relationships from infancy to adolescence affected the long-term prognosis of adolescent developmental psychopathology.

In the results, the following influences were established:

(1) Forty (51.5%) of the 77 adolescent developmental psychopathology cases had troubled parent–child relationships during infancy and had poorer outcomes in the 17-year follow-up study than did the other cases. Conversely, significantly better

outcomes were presented by those cases that had some form of emotional interchanges in the early to mid-childhood period, even if these were emotional conflicts. However, many of those who had passed the period of early to mid-childhood without parent-child relationship problems also presented poor results in the 17-year follow-up study.

(2) Both good and bad outcome groups at the 17-year follow-up had commonly presented tense parent-child relationships during preadolescence to early adolescence. This was assumed to be due to a premonitory sign or a manifestation of adolescent turmoil. Transitions of these relationships were examined for both groups during mid-adolescence and late adolescence. Although the good outcome group gained stabilization through these stages, no stabilization could be observed with the poor outcome group. Presumably this result was greatly influenced by the lack of emotional interchanges of any form during early to mid-childhood between parents and children, prior to moving onto adolescent turmoil.

Therefore, in view of the onset of adolescent developmental psychopathology and its long-term prognosis, I believe that emotional interchanges between parents and children in early to mid-childhood are vital.

(3) Finally, the development of more nature and 'productive' adolescent turmoil as a means of establishing an identity is an essential and indispensable part of growing up, and must be considered in the treatment of adolescent developmental pathologies.

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Abstract

We conducted a comparative study for the outcomes at 7 years and at 17 years after initial diagnosis of 77 cases of adolescent developmental psychopathology. The results suggest that the prognosis of adolescent developmental

psychopathology could be derived at 5–6 years after commencement of medical treatment. The parent–child relationships during infancy to adolescence, considered to affect the long-term prognosis of adolescent developmental psychopathology, was studied. It is believed that the emotional bond between parents and children in early to middle childhood affects their relationships during pre-adolescence to early adolescence and are vital to the development of adolescent turmoil. It is important that the development of the infantile provocative state during preadolescence to early adolescence should progress to a more mature ability to negotiate and which forms the core of adolescent turmoil. The function of the latter will bring better results to adolescent developmental psychopathologies.

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