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CHAPTER THREE

Psychoanalysis in India and Japan

Identity and Psychoanalysis in India

The discipline of psychoanalysis—a Western import in India—frequently engenders identity conflicts in Indian mental health practitioners around questions of the fundamental nature of the Indian self and social change. By delving into these reactions to psychoanalysis, we can see more clearly contemporary Indian tendencies to assimilate or reject certain Westernizing/modernizing influences.

The Indian Psychoanalytic Society is one of the older members of the International Psychoanalytic Association; it was officially affiliated in 1922 (Nandi 1979; Ramana 1964). Its inception was entirely due to the pioneering work of its founder, Girindrasakhar Bose, a highly gifted Bengali physician who quite independently set himself on a course of clinical exploration similar to Freud's. In 1920, on something of a dare from some close friends, he formulated his own unique ideas on repression into a thesis, *Concept of Repression* (Bose 1966), for which he was awarded the coveted doctoral degree from the University of Calcutta and a lectureship in the Department of Psychology, University College of Science and Technology. Psychoanalysis thus became ensconced in Calcutta academia in the early 1920s, which was not to occur in many Western countries until decades later. Bose then began a lifelong correspondence with Freud in 1921, sending him his book and later papers on his elaborate theory of opposite wishes.

At the present time, the Indian Psychoanalytic Society is centered in

Calcutta, where there are some fifteen psychoanalysts as well as students and a sizable group of associates from other fields. At one time it included the noted social anthropologist the late Nirmal Kumar Bose. It also has its own mental hospital, Lumbini Park. There is now a dynamic branch of the society in Bombay, with a Psychoanalytic Therapy and Research Center and the Indian Council of Mental Health. The former is run by members and students of the Psychoanalytic Society, whereas the latter is a psychoanalytically oriented school and college counseling center organized by one of the psychoanalysts. There is also a very small handful of psychoanalysts, students, and psychoanalytically oriented theoreticians in New Delhi. In Ahmedabad, there has been an excellent, comprehensive, psychoanalytically oriented mental health center, the B. M. Institute of Mental Health, originally cofounded by Gardner and Lois Murphy, American psychologists, with the Sarabhai family in the early 1950s, and continued with intimate contacts with some members of the British Psychoanalytic Society, particularly Jock Sutherland.[1] There is an occasional psychoanalyst or analytically oriented therapist in other Indian cities, as well, where there are strong Westernizing influences. The National Institute of Mental Health and Neuro Sciences (N.I.M.H.A.N.S.) in Bangalore, for instance, the leading mental health center in south India, has a small group of psychodynamically oriented psychiatrists and psychologists on their staff who are involved in doing psychotherapy.

Of more central concern here is the theoretical stance of psychoanalysis in India. The overwhelming orientation of the Indian Psychoanalytic Society in Calcutta is what is commonly referred to as "classical Freudian," with emphases on the early topological and libido theories and the later structural theory, with relatively little mention of object-relations theory, ego psychological stages of development, or self psychology and identity theory. In Bombay, largely through the influence of one of two senior psychoanalysts, M. V. Amrith, now retired, the orientation is far more toward the work of Melanie Klein (Segal 1964) and object-relations theory, with considerable influence from Wilfred Bion (1977). In New Delhi, there is a strong Eriksonian cast to the writings of Sudhir Kakar (1978, 1979, 1982) and Ashis Nandy (1980a, 1980b, 1983), who have endeavored to integrate psychoanalysis with social science work

[1] Kamalini Sarabhai was trained at the British Psychoanalytic Society and had been director of the B. M. Institute since its inception. At the present time, with Kamalini Sarabhai's untimely death and the departure of the clinical director, B. K. Ramanujam, the psychoanalytic emphasis at the B. M. Institute has seriously declined.

on India.[2] This integration is missing from the work of the Indian psychoanalysts in Calcutta and Bombay (as well as from that of most Western analysts); the classical Freudian and Kleinian perspectives are based on the assumption of the primacy of intrapsychic reality, and tend to ignore complex cultural, social, and historical factors as they are internalized within the psyche. Drawing on broad Freudian theory as well as his extensive clinical experience at the B. M. Institute of Mental Health at Ahmedabad, B. K. Ramanujam (1979, 1980a, 1980b, 1981a, 1981b, 1986), the former clinical director, has made strides in formulating Indian psychological makeup and functioning within extended family relationships and Indian culture. His writings are based on extensive psychoanalytic work with individuals, families, and children afforded by the ample funding of the Sarabhai family and under the directorship of the psychoanalyst Kamalini Sarabhai.

Provocative questions may be asked here both as to why psychoanalysis developed so early in India, and why it has not grown there as it has, for instance, in America or even in France since the late 1960s. Although Hindu culture has never developed a theory of unconscious psychological processes, it has certainly stressed a variety of dimensions of psychological functioning. These range from the extraordinary interpersonal sensitivity needed for extended family and other group relationships to the culture's highly particularlistic emphasis on a person's development through the combination of their qualities (*gunas*), powers (*shakti*), effects of familial and individual actions (*karma*), and attachments (*samskaras*) carried over from past lives. A theory of unconscious motivation and structures could rather easily be integrated into a culture that in certain ways so stresses the psychological.

On the other hand, it is obvious that psychoanalysis has not taken off in India. There may be a number of factors involved in this, not the least being the absence of a sizable number of well-trained practicioners and the inhibiting factor of economics. In Ahmedabad, where the Sarabhai family fortune had enabled the B. M. Institute of Mental Health to offer low-cost psychoanalytically oriented treatment to anyone who came, and where high standards of treatment by an interdisciplinary team of workers was implemented, the community came in droves from all castes and classes, from the most traditional to the most Westernized.

Nevertheless, we are faced with the question of why the psychoanalytic movements of Calcutta and Bombay have not developed to any

[2] Ashis Nandy is a psychologist who is a psychoanalytic theoretician rather than a practicing psychoanalyst.

extent, though both are presently expanding, the latter in an apparently more dynamic way. One answer to this question may be derived from the work of Phillip Rieff (1968), and as applied to French society from Sherry Turkle (1978). Psychoanalysis has flourished in the United States over the past several decades, and in the late 1960s exploded in France after a period of being an alienated, miniscule movement; Rieff and Turkle relate this burgeoning to important sociocultural factors and changes in both societies. They particularly emphasize the "deconversion" from the belief systems and symbols of traditional "positive communities" to a less culturally and socially integrated society that shares only the symbols of science, where each individual must create his or her own personal world view of symbols and meaning. This, of course, has been the prevailing situation in the United States, where there has not been any integrated national culture and where a militant individualism has been combined with enormous social mobility oriented initially around the frontier and then around the acceptance of large waves of immigration. In France, a unique synthesis of state, society, and the individual has only recently crumbled, a deconversion that has thrown the person back upon himself, thus enabling a psychoanalytic orientation to become enormously influential.

In India, although there are indeed small highly Westernized elites in the major cities who tend to be alienated from Indian culture, and although Indian culture has been profoundly affected by the impact of Western culture, even in the urban areas there is a strong continuity of Hindu, Moslem, Christian, and Parsee cultural and social institutions. Indigenous mental health healers are still important in the society.[3] Deconversion of positive social and cultural communities has simply not occurred, even in Bombay, to nearly the extent it has in America and France. A psychoanalytic world view that guides the individual and family in a world of crumbling supports is not, therefore, at this point appropriate enough to the Indian scene for psychoanalysis to become a major factor in Indian culture. On the other hand, where greater individualization is slowly developing and being incorporated within the core Indian self in the urban areas, and where social relationships are often less traditional and ritually grounded, it can reasonably be expected that there will be a continued and sustained growth of some kind of psychoanalytic orientation and therapy.

[3] For information on north India, there is the work of Hoch (1977) and Kakar (1982). In south India, this tradition has been investigated by Dr. R. L. Kapur, formerly head of psychiatry, National Institute for Mental Health and Neuro Sciences, Bangalore.

To return to the major theme of Indian identity: the attitudes toward psychoanalysis of some major leaders of the psychiatric community are very significant. Indian psychiatrists commonly use various forms of Western therapies first introduced into India by the British: the current armementarium of drugs,[4] electric shock treatment, psychiatric history-taking and diagnosis, and certain forms of psychotherapy usually of a more supportive and directive type, when time allows. A variety of techniques and theories originating from the West are thus utilized in a nonconflictual way. Psychoanalysis, however, has been something of a fishbone in their throats. Some of the negative attitudes toward psychoanalysis can certainly be laid at the doorstep of a common psychiatric ambivalence toward psychoanalysis. A more penetrating analysis of these psychiatrists' writings (Neki 1973, 1975, 1976a, 1976b, 1977; Pande 1968; Surya 1966; Surya and Jayaram 1964), however, brings to light fundamental conflicts and integrations of Westernizing/modernizing influences in an Indian mental health professional's identity.

The central issue is that, unlike other Western forms of therapy, psychoanalysis is a *Weltanschauung*, with a whole value-laden sociocultural orientation. An important aspect of this orientation is the ideal of rational man (Meltzer 1978), and correspondingly negative attitudes toward religion. With but rare exceptions, psychoanalysts have approached religion and religious experience unrelentingly in terms of compensations and psychopathology. Any type of spiritual experience has usually been reduced either to problems of the oedipal stage or, more usually to a reliving of the original infant-mother relationship—originally called the oceanic feeling and now in more contemporary, sophisticated terms, symbiosis (Masson 1980). Some of the major leaders of psychiatry who most vociferously reject psychoanalysis are profoundly involved in the Indian spiritual tradition and in their own meditation. It is clear that the religious factor involved in the realization of the spiritual self is for them a central issue. Rejection of psychoanalysis in many Indians' professional identity can thus be seen as echoing a strong need to reassert a basic Indian identity around the spiritual self, in contrast to Western values antagonistic to their own—a variation on the theme of the reassertion of Hindu identity and culture vis-à-vis the British.

But the issues involving psychoanalysis in India are far more complex and profound than this simple conflict between religious and antireligious viewpoints. Central to the psychoanalytic value system, especially

[4] It should be noted that although tranquilizers have largely been developed in the West, the original tranquilizer, reserpine, first came from India, where Buddhist monks were known to have used it for centuries.

in the United States, is the stress laid on a mental-health model of individual autonomy, of highly developed intrapsychic structures in which the individual develops a strong inner separation from others and sharply differentiates between inner images of self and other, of norms of self-reliance, self-assertion, self-actualization, and a high degree of relatively open, verbal self-expression. In the American urban middle and upper-middle classes, it is usually expected that a youth will develop the intrapsychic structures and integrated identity necessary to function independently in a variety of social groups and situations apart from the family, eventually leaving the family nest.

Many Indian psychiatric leaders view these mental health norms as inappropriate to Indian psychological development and functioning in the extended family and culture, and thus as not at all universal (Neki 1976a; Surya 1966). They rather emphasize the emotional bonding of kinship that enables the Indian person to live in emotionally close and responsibly interdependent relationships, where the sense of self is deeply involved with others, where relationships are governed by reciprocal hierarchical principles, and where there is a constant need for approval to maintain and enhance self-regard. Their ideal of mental health is not a rational, socially autonomous and self-actualizing person, but rather that of a person centered in a spiritual consciousness and being, so that there is an inner calm amid the stresses and pulls of close familial and other group hierarchical relationships. They view the psychoanalytic values inherent in the individualized self of the West, therefore, as profoundly out of tune with an Indian milieu, particularly a traditional one.

Further contributing to their rejection of psychoanalysis as an unsuitable Western import is the theoretical emphasis, or in Indian terms overemphasis, that a Western classical psychoanalyst puts on the curative nature of cognitive processes such as interpretation, to the detriment of the real relationship, as distinguished from the transference relationship, between analyst and analysand. To be sure, there are notable rumblings of dissent within the Western psychoanalytic community on this issue (Alexander 1950; Greenson and Wexsler 1969; Menaker 1942; Roland 1967; Szaz 1957), but the Indians are responding to the dominant model of the traditional psychoanalytic relationship. As many Indian therapists have noted, an Indian patient usually relates to a therapist as to a family elder, or possibly a guru, but always expects a real involvement from the therapist.

If these psychiatric leaders represent one end of a continuum in their rejection of the ideology of psychoanalysis in their professional identity, then the other end is occupied by a number of Bombay psychoanalysts—

a few of them also important psychiatrists—who closely identify with psychoanalytic values around the individualized self.[5] Closely associated with Westernizing/modernizing values, they tend to see Indian child rearing and familial hierarchical relationships as implicitly opposed to modernization (Bassa 1978). Such analysts relate to the Indian psyche and relationships through the lens of their more Westernized psychoanalytic framework.

The culture hero of the Bombay psychoanalytic group is W. Bion (1977), undoubtedly the most mystically oriented of any Western Freudian psychoanalyst, and possibly the only Western analyst who grew up in India. Many of these analysts seem best able to approach Indian spiritual life through identifying with a Westerner like Bion, who partially embodies it; simultaneously they have profound ambivalence toward indigenous Indian religious culture. A study of a number of analysands in Bombay, many of whom are in the arts, shows that although almost all felt they were appreciably helped by their analysis, a minority were quite angry over the rejecting attitudes of the Bombay psychoanalysts toward their spiritual aspirations (N. Seth 1980). A couple of analysts, like a number of other highly educated urbanites, have high regard for the late J. Krishnamurti. He was a major Indian spiritual leader to be sure, but one who emphasized an unusual degree of autonomy and independence in the spiritual search, and thus was more in tune with Westernized values of the individualized self than is the usual Indian guru.

In summary, these analysts try to synthesize a professional psychoanalytic identity around more Westernized values of the individualized self with an ambivalent orientation to the spiritual self. This type of identity synthesis in part confirms Singer's (1972) observations in Madras of cultural changes in religious orientation accommodating more modernizing practices. Undoubtedly, these analysts mirror aspects of the current sociocultural milieu of Bombay, the most cosmopolitan of Indian cities, with a window wide open to the flow of Western influences.

The middle ground of the continuum is occupied by a very small group of psychoanalysts and psychoanalytically oriented psychiatrists and psychologists who have endeavored to work out a different type of professional and personal identity synthesis. They have on the whole been trained in the West—in contrast to most Indian analysts and psychiatrists—and have struggled with their own inner identity integra-

[5] I am omitting from this discussion the psychoanalysts in Calcutta, as I am not sufficiently familiar with their attitudes on these issues.

tions. Well versed in contemporary psychoanalytic theory, they are trying to understand the Indian psyche on its own ground, evolving theoretical constructs to describe it and modified modes of psychoanalytic therapy to render assistance to the Indian patient. This is not to say that other Indian psychoanalysts are not of considerable help to their patients; but my impression is that their therapeutic methods and their understanding of Indian psychological makeup and modes of relationship are informal, and may at times be considerably different from their formal theoretical framework.

The analysts of the middle ground are frequently similar to several psychologists and social scientists in that they are well trained in excellent Western graduate programs. They see the need to evolve new theoretical paradigms for psychology and the social sciences in India, ones more related to the data of Indian society. These psychoanalysts, psychologists, and social scientists are also trying to integrate a new professional identity around Westernizing influences on theory and practice, but largely within the frameworks of Indian cultural and social patterns, and the familial and spiritual selves.

Psychoanalytic Therapy in India

We are still left with the substantive question as to the goals and practice of psychoanalytic therapy in India. If there is any legitimacy to the assertion of certain major psychiatrists that Western normative goals of psychoanalysis around autonomy, and separation are profoundly incompatible with the ability to function within the Indian extended family, then how suitable is psychoanalysis for India? Is it simply a Western import incongruously imitated by a miniscule group of analysts and patients whose identity is highly Westernized; or is it rather a Western innovation that can be altered and integrated within the framework of Indian culture and society? To answer these questions is to delve into the nature of the psychoanalytic relationship and process in India and to reexamine the essentials of psychoanalytic therapy.

In the contemporary United States, when a young urban adult who comes for analysis is living in a family situation fraught with difficulties, the psychoanalyst frequently works initially on emotional difficulties that keep this person tied to pathological familial relationships. However, the real crux of psychoanalytic therapy emerges later when, through the transferences the patient makes onto the analyst and others, the deeply internalized patterns of familial relationships from childhood and ado-

lescence are gradually relived, understood, and resolved, or developmental deficits are repaired. At that point, the patient is able to relate to current family members and others in a more dispassionate, appropriate way, without being disturbed or overwhelmed by them. It is thus the working out or working through of past internalized relationships with their concommitant defenses in the patient's psyche, through reexperiencing them in the transference and/or having a transference that repairs deficits in structure, that constitute the essence of psychoanalysis.

In the Indian setting, the fundamental goal for a man who remains in his parents' family or for a woman with basic responsibilities to her in-laws is to enable each to function in a less disturbed and more fulfilling way, freer of anxiety and other symptoms, within the context of the complex interdependencies and reciprocal responsibilities of the extended family and other hierarchical relationships. This frequently means to understand and resolve transference reactions within extended family relationships, which then enables the patient to handle current relationships in a more appropriate and happier way. I have found, for instance, in the case of Saida (see Chapter Five) that even where realistic difficulties with a mother-in-law are considerable, by resolving transference reactions displaced from her original family relationships and unconsciously projected onto the mother-in-law, the daughter-in-law can handle her much better and be far more content. There is obviously room in extended family relationships for very different kinds of psychological functioning: hierarchical relationships and responsibilities can be responded to and fulfilled in many different ways depending on the inner state of mind of the person. In effect, an inner autonomy develops through self-understanding, enabling the person to function well within the rich interdependencies of the extended family, rather than effecting any physical separation or leading to a more self-reliant, Western life style.

Even if the essential goals of psychoanalysis are consonant with functioning in an Indian milieu, other important objections have been raised over the supposed unsuitability of Indian patients for psychoanalytic therapy, as well as over the very nature of the psychoanalytic relationship and process for Indians. Some psychiatrists have asserted that a patient relates to the therapist as a family elder or guru, and therefore expects advice and guidance rather than self-exploration; that free-association—a sine qua non of psychoanalytic therapy—is impossible in certain cultures of India that restrain personal self-expression, particularly verbal expression. Further, the classical psychoanalytic relationship is viewed as being far too distant and uninvolved for an Indian, with

patients put too much on their own, and with therapists relying too greatly on cognitive curative elements (such as interpretation) rather than ones using relationship (Pande 1968). They also assert that important secrets within the family relevant to a patient's state of disturbance are rarely communicated to outsiders because of the need to maintain family honor and reputation (Neki 1976b).

The psychoanalytic relationship in India is set up by the patient according to the psychosocial dimensions of extended family hierarchical relationships. Thus, the psychoanalyst is related to as the superior in the hierarchical relationship—which is usually modeled after a relationship with a parent or other extended family elder—in which patients initially expect their analyst to take care of them, solve their problems, tell them what to do and how to become a better person. In these hierarchical relationships there is an unspoken, subtle emotional exchange of dependency needs on the patient's part with narcissistic gratification in the analyst for fulfilling the ego-ideal of the superior who responsibly helps the subordinate. Although some actual giving of advice in the early phases of the therapy may sometimes be called for to establish a working alliance, since Indian patients are so accustomed to guidance, it is usually not difficult to get Indian patients to begin speaking rather freely. When the therapist conveys an attitude of genuine interest in what is on the patient's mind, of empathic receptivity to what is being conveyed, of emotional support to the patient, and of strict confidentiality, Indian patients, in my experience and Indian analysts', usually become quite open and expressive. Often there has been a precedent, some family member, more often a woman than a man, with whom the patient has been able to talk freely in the past. It is only when the Indian therapist responds as a typical elder in constantly giving advice and guidance that the patient will continue to ask for it.

Beneath the observance of an overt etiquette of deference, loyalty, and subordination, Indians keep a very private self that contains all kinds of feelings and fantasies that will not be revealed in the usual hierarchical relationship with an elder. In a psychoanalytic relationship, however, where the Indian patient feels that the therapist is empathic and receptive, and where strict confidentiality of communication is assured, the floodgates of feelings can open up widely. In effect, Indians are highly sensitive to the qualities of the superior in the psychoanalytic relationship as well as in other hierarchical ones. My distinct impression is that once one gets beyond the normal social reserve and etiquette of Indians, they tend to reveal their inner life more openly, and even to be more in touch with it, than most American patients I have worked with.

There are still other aspects to the relationship of Indian patients with their analyst as an extended family elder. Dr. Ramanujam (1980a) comments that Indian patients tend to come for therapy when all available family elders and mentors have let them down. They therefore expect the therapist to fulfill some of the responsibilities not attended to by the various parental figures. Ramanujam sees their view of the therapist not so much as a transference projection as a real part of the psychoanalytic relationship in India that must be given due weight. If these interpersonal needs of Indians are ignored, then little work can be accomplished on intrapsychic conflicts. This real dimension may well continue beyond the termination of the therapy, so that an analyst may be invited to a wedding, birth ceremony, or such.

In the case of Veena, the woman who had attained a high position as a professional and was now trying to arrange her own marriage, I wondered over a number of sessions why she was continuing to see me for therapy. She was making her arrangements in as sensible a way as possible, manifesting little in the way of either inner conflict or emotional deficit. It was only later that I realized that she had consulted me because her father was dead, her elder brothers were doing little to help her find a mate, and in any case they and her mother and other family elders were in a distant part of India. I was in effect a stand-in for the usual family elder at the time of arranging a marriage. More technically, I was an empathic selfobject that she could use as a sounding board to express her various efforts, not out of emotional deficit as is present with the patients Kohut presents (1971, 1977) but rather out of the need and expectation that a family elder of some kind be present to help her. As one Indian woman succinctly expressed it to me in a session in New York City, "We were not brought up to be independent." Thus, to whatever extent the analyst may be involved in Indian patients' transferences, the analyst also stands in for a real hierarchical superior, usually modeled after the extended family elders.

If one major aspect of the psychoanalytic relationship as related to hierarchical relationships is that of the responsible elder, another involves a central psychosocial dimension—what I have come to term the qualitative mode of the hierarchical relationship. The qualitative mode involves the close emotional involvement that Indians frequently expect in their hierarchical relationships—though these may vary considerably at different stages of the life cycle—with a warm, caring, and smiling supportiveness. This affective nature of Indian intimacy relationships is carried over to the analytic relationship with an expectation of much greater emotional connectedness than the typical American patient has,

and correspondingly less emotional distance between patient and analyst. If the analyst does not respond appropriately to these patients' emotional intimacy needs, a working alliance cannot be established (Ramanujam 1980a). This closeness need not necessarily be verbalized, but can often be conveyed simply by a glance or smile—reflecting the strong nonverbal communication of emotion in Indian relationships (pers. com. Udayan Patel).

These expectations can be very strong. Veena, for example, complained to me in a session in India that when she was in the United States working on her doctorate, she called up her American woman therapist at 2:30 A.M., having just learned that her mother had cancer, and the therapist responded somewhat abruptly, asking her to call back after 7 A.M. Veena felt extremely hurt that her therapist would not spend time with her then when she was so intensely upset. Another patient whom I saw in New York City also complained that her therapist, a woman, was more preoccupied with her house upstate than with her. Upon investigation, I sensed that her real hurt was that the therapist was insufficiently involved and unresponsive to her in terms of her inner expectations. These are just two simple examples of what I sense to be very real differences in inner expectations of emotional involvement in the psychoanalytic relationship between Indian and American patients.

How consonant, then, is the psychoanalytic relationship in India, structured as it is by different facets of Indian hierarchical relationships, with the accepted principles of psychoanalysis as it has developed in the West? This question must be followed with another: is a Western-style, classical psychoanalytic relationship in which the analyst remains a relatively distant, neutral, and uninvolved figure fundamental to the psychoanalytic process? Many analysts would obviously firmly assent to this. On the other hand, it can and has been strongly argued that for psychoanalytic therapy to proceed, a working or therapeutic alliance must be developed (Greenson 1967), and that for this to happen, real aspects of the patient-analyst relationship must sometimes be taken into account and worked with by the analyst. As some have also asserted, a reparative experience is sometimes fundamental to the effective interpretation and resolution of certain deep-seated transferences and resistances (Alexander 1950; Menaker 1942; Roland 1967). More recently, Kohut's (1984) work on the self emphasizes the reparative experiences that occur when the analyst functions as a selfobject for certain kinds of idealization and as an empathic, responsive person for patients' needs for mirroring. Even the classical psychoanalytic relationship intrinsically calls for the psychoanalyst to be realistically reliable, empathic, concerned, and nonjudgmental in his or her way of relating to the patient—minimal aspects of the real relationship. It seems reasonable to argue, then, that once the real relationship and working alliance are taken as fundamental to the psychoanalytic process, it is possible to conceptualize variations of the psychoanalytic relationship in India and the West without seeing these variations as deviations, psychopathology, parameters, or even nonpsychoanalytic practices.

To understand how the psychoanalytic process occurs in India, it is essential to take into account how resistance, transference, and countertransference are influenced by social and cultural factors. Psychoanalysts have from the beginning recognized that patients enter treatment with strong resistances to self-exploration and the resolution of their problems, and that the therapeutic handling of these resistances is essential to psychoanalytic work. Some resistances are idiosyncratic to the unconscious defensive structure of a person, to his or her superego, and to particular internalized imagoes from familial relationships; other resistances are far more related to various cultural norms incorporated into the person's ego-ideal, as well as to predominant modes of relating in the prevailing social patterns. An American who comes from a northern European ethnic background that emphasizes a high degree of self-reliance, suppression of dependency needs, and noncommunication of feelings or problems with anyone, will initially manifest strong resistances even to coming for therapeutic assistance, not to mention to free-associating. These resistances, related to prevailing cultural norms, must be aired and analyzed for the therapy to proceed.

In the Indian milieu, patients' resistances related to sociocultural phenomena involve certain aspects of the familial self and familial hierarchical relationships. There is first the considerable circumspection in what one says in any hierarchical relationship, especially as the subordinate. Inner thoughts and feelings of a private self will only be revealed when there is some trust that the other will be receptive and empathic, and that confidentiality will be kept. I have found Indian patients to have far more secrets, and to keep major ones more easily, than American patients—constituting a potentially powerful resistance. One woman, Shakuntala, reported that her two most important inner struggles had been kept secret over a prolonged period of psychoanalytic therapy because she felt her analyst wouldn't be receptive (see Chapter Five). The same is true for the internalized cultural norm of not communicating any family secrets and disturbances to outsiders lest they damage family reputation and social standing. Once trust is reasonably estab-

Although many countertransference reactions of Indian psychoanalysts obviously derive from personal sources within the therapist, other such reactions are also influenced by social and cultural factors that are internalized—as they are in the West as well, although they are generally unacknowledged. In India, for example, psychoanalysts may give the advice and guidance that is expected of them in their roles as family elders. On a more subtle level, when a patient comes to sessions anxious or distraught, the immediate reaction of an Indian therapist is to react as would a member of the extended family, by doing everything possible to relieve the patient's stress (pers. com. Udayan Patel). In either case, the analyst's reaction can circumvent the necessary exploration of what is actually causing the patient's problems, and must be controlled.

Social and cultural influences in both patients' resistances and psychoanalysts' countertransference reactions in psychoanalytic therapy have as yet been insufficiently explored. These factors are frequently as profoundly internalized in both patient and analyst as other ones from their more idiosyncratic family relationships and experiences. Cultural and social patterns are not simply "out there."

With regard to transference, I was obviously not involved in doing psychoanalytic therapy for a long enough period of time to comment extensively on social and cultural influences. There are, however, two aspects of transference that are distinctly different within an Indian psychoanalytic relationship from those in a Western one. It is extremely difficult for an Indian to express anger openly and directly to a hierarchical superior, and this is carried over into the psychoanalytic relationship. Thus an Indian patient will almost never express anger or other ambivalent feelings directly to his or her therapist, although blisteringly angry feelings may be expressed toward another hierarchical figure. Ambivalence and dissatisfaction with the therapist come out only indirectly: the patient wants to terminate therapy, does not come to sessions, fails at what he or she is doing, unconsciously displaces anger from the therapist to someone else, and so forth (pers. com. B. K. Ramanujam). The Indian therapist becomes highly sensitive to these indirect expressions of anger.

Another aspect of transference relates to termination. It is generally expected in Western psychoanalytic circles that through the resolution of the transference by the termination of analysis, the patient will become independent of the analyst, and will have little to do with the latter. In India, on the other hand, B. K. Ramanujam (1980a) writes that with the profound cultural emphasis on idealizations of and identifications with respected persons, at the conclusion of therapy the analyst still frequently remains an idealized hierarchical figure to be closely identified with, in a relationship like other important hierarchical relationships where respect predominates over deference. It is not that this process of postanalytic idealization is entirely absent in American analytic relationships, but there it seems to go on much more covertly because of the American emphasis on relative autonomous and egalitarian relationships as the ideal.

I have taken some time here to delineate carefully the adaptation of psychoanalysis, a Western import, within the Indian milieu. By delving into the essential nature of the goals of psychoanalysis, and of the psychoanalytic relationship and process, it should be clearer how psychoanalysis is actually adopted and adapted within a completely different social and cultural setting from the one in which it originated. The Indian psychoanalytic therapist naturally takes into account these social and cultural influences. Simultaneously, by making explicit various facets of the psychoanalytic relationship and the psychoanalytic process in India, a Western analyst can throw further light on the psychosocial dimensions of hierarchical relationships and of intrapsychic functioning within these relationships. I strongly suspect that such an analysis of the psychoanalytic relationship and process in America would also throw light on the psychosocial dimensions of American-style individualism with its congruent intrapsychic makeup. This, however, would necessitate a cross-civilizational experience.

Psychoanalysis in Japan

George DeVos (1980) in an "Afterword" in David Reynold's book, *The Quiet Therapies,* raises some fundamental issues as to why psychoanalysis has not become as popular in Japan as it has in the West, concluding that psychoanalysis is emotionally unsuitable for the Japanese. His arguments are remarkably similar to those of major Indian psychiatrists I have cited earlier (Neki 1975; Surya and Jayaram 1964), who also view psychoanalysis as wholly inappropriate for Indians. DeVos's basic point is that psychoanalysis is intrinsically connected with Western individualism and is profoundly oriented toward the autonomy of the individual, who creates meaning in his or her own life and becomes free from the family. This contrasts and conflicts fundamentally with basic Japanese cultural values and social patterns, in which persons remain

deeply embedded throughout life within family and group relationships, parental figures are greatly respected, and major and even minor life decisions are made through the guidance of the hierarchical superior. If Japanese should become aware of their intense negative feelings toward their mothers or other family members, as they would in psychoanalysis, DeVos argues, this would seriously disrupt family cohesion and become highly destructive. DeVos further intimates that cognitive and linguistic processes would also interfere with psychoanalysis in Japan, since Japanese are not oriented toward the analytic discursive reasoning and talk of Westerners. Rather, they express themselves in visual-spatial metaphorical language, and have a cultural ideal toward more verbal restraint than self-expression and the free association of psychoanalysis.

Is DeVos correct that psychoanalysis is unsuitable for Japan? Or is it more accurate to say that psychoanalysis is slowly growing and expanding in Japan, as it is in India, as a Western therapeutic paradigm that can be profoundly adapted, transformed, and incorporated within Japanese society? And as it becomes harmonious with Japanese social, cultural, and psychological patterns, psychoanalysis simultaneously introduces a greater degree of individualization.

In Japan, as in India, psychoanalysis is clearly a Western import ushering in heterogenetic change.[8] But psychoanalysis can also be seen as a case study of the Japanese assimilation of a Western sociocultural product and process. To see how psychoanalysis has become assimilated in Japan, I shall first briefly delineate Japanese hierarchical group structures to provide a framework for comprehending the development of psychoanalysis and its current institutionalization in Japan. I shall focus on the psychosocial dimensions of family and group hierarchical relationships so as to understand the nature of the psychoanalytic relationship in Japan, and culturally related resistances.

Japanese society is oriented around specific group or institutional units—household, corporation, bureaucracy, business, educational or social institution, or village—rather than around occupational skills. These groups have very firm, clear-cut boundaries and are structured within each unit in a well-defined, pyramidal vertical hierarchy (Nakane 1970). Japanese usually become deeply emotionally involved and loyal to one group only, and make long-term commitments to the purposes and unity of the group. For women it is most often the family or occupational household; for

[8]The concept of heterogenetic change was formulated by the social anthropologist Robert Redfield to denote social change in a civilization that is introduced by influences from outside rather than being generated from within (Singer 1972, 609).

rural persons, it has traditionally been the village or hamlet;[9] for students it is the class at school or in college, and a specific activity subgroup from the class; and for urban men, a work group, which might include in certain cases a household involved in a particular occupation or business. Apart from family and friends, group involvement becomes all-consuming and there is little opportunity or urge for middle-class men to form outside relationships.[10] Even after-hour socializing is usually with associates from work, which reinforces group cohesion. This is in contrast to Indians, who although also emotionally enmeshed in the extended family, community (caste), and other groups, are nevertheless far freer to become involved with others outside the family and community, bringing them into the extended family.

Japanese are profoundly identified with their group and its reputation. Middle-class men's sense of esteem is far more involved with the particular school, college, and work group (corporation, bureaucracy, profession, or business) they are associated with than in the amount of money they earn. The group they are in reflects first on the esteem of their own mothers and family—something of considerable importance to a Japanese son—and then on their wives.[11] Like Indian marriages, Japanese ones are not simply between individuals but also between families, so that the importance of an alliance with a family of suitable background and reputation is still central to a husband's and wife's esteem.

Within a particular work group, Japanese men—and women too if they are present—are intensely emotionally enmeshed with the group as a whole and with each other in a series of vertical hierarchical relationships based primarily on seniority in the group rather than age or accomplishment. There are also horizontal relationships with those who have entered the group at approximately the same time. The group assumes a pyramidal form with only one person at the very top of the hierarchy; everyone has a distinct position (*za*) within this hierarchy by seniority, the position gradually changing with increased seniority. A variety of tasks, however, may be performed according to the overall needs of the group. The flexibility of assuming different tasks regardless of one's position in the group is a distinctive hallmark of Japanese group

[9]In Japanese society today, rural persons frequently have considerable contact in urban areas, one or more family members commuting to work, so that the traditional village group is not nearly as circumscribed as previously.

[10]In the lower middle-class artisan and subcontracting groups, men are frequently involved in voluntary community service groups (Wagatsuma and Devos 1984, 28–29).

[11]Wives of salaried men in a corporation, for instance, will relate to each other hierarchically in terms of their husband's position.

functioning, as is the decision-making process wherein the group gradually comes to a consensus under the guidance of its leader (*nemawashii*).

Integral to the hierarchical relationships within the group are basic familial values of a strong emotional interdependence between senior and junior, and unquestioning loyalty, compliance, and dependence by the junior with full expectations for nurturance, protection, and responsibility by the senior. The latter also carefully consults his subordinates on a number of decisions, and may take a somewhat retiring stance to let his subordinates participate more fully. No step is taken by anyone without the approval of the immediate hierarchical superior, who in turn looks to his senior for guidance; the subordinate may also look to another superior as a mentor or benefactor. Even more than Indians, Japanese have brought the full range of familial mutual reciprocities, loyalties, and obligations to the work group (Hsu 1985, 41–44; DeVos 1985, 157–158)—which is part of the genius of successful Japanese group functioning.

This hierarchy by seniority is frequently in a dialectic with a subtle hierarchy by quality, in which the leader of the group will gradually get the sanction and cooperation of his followers to promote someone of unusual abilities to do more responsible tasks than he or she would ordinarily do according to seniority and position. But even here, the junior person thus promoted must observe the proper respect to those senior to him—regardless of who they are—who occupy a superior position in the group. Or conversely, a person more senior but lacking the requisite abilities will be honored for his position but be given less responsible tasks. And in some cases, a powerful figure who is not most senior may actually be running the group indirectly (pers. com. Moses Burg). Thus, the kind of influence a person has in the group will depend not only on position but on personal attributes that can expand or contract the nature of that position.

Within any given institution—whether corporation, bureaucracy, university, or profession—there is usually a variety of these pyramidal hierarchies or factions. Although there is extremely close group feeling within a particular faction, the relationship between factions is frequently one of competition if not conflict, even within the same company or institution.

Institutionally, Japanese psychoanalysis revolves around hierarchical, closely bonded groups led by important professors of psychiatry and psychology who are psychoanalytically trained. They, in turn, train members who come through their departments, or other professionals

who come to them for training and become part of their group. The power and influence of these leaders is reflected in the size and significance of the following they have built up. Psychoanalysis in Japan has thus become completely assimilated to Japanese hierarchical social structure in contrast to Western and even Indian institutionalization, where there are specific working psychoanalytic societies that train new members. In Japan, there is no psychoanalytic training institute that cuts across these well-defined factions with their particular leaders. One remains part of a group throughout life, loyal to and dependent on the professor, who assumes responsibility in guiding the junior member to different positions in the field. No job can be switched or psychoanalytic training abroad pursued without the express approval and support of the leader or mentor. In turn, junior members in their hospital, clinic, or university position begin to build up a following, who in turn are dependent on them—the size and quality of the following depending on the personal attributes of this member.

These pyramidal hierarchies are generally passed down in a pattern similar to that of the traditional *ie* family structure—the main house and its branches—which is more or less institutionalized in Japanese work groups. It is remarkably easy to trace the different group hierarchies or factions within psychoanalysis in Japan, since there is such a clear-cut mentor-disciple continuity. I could easily see this process at work in the Hiroshima group of psychoanalytic therapists with whom I was associated for a month. This group of thirty to forty persons was under the leadership of Dr. Mikihachiro Tatara, then professor of clinical psychology in the graduate school of Hiroshima University. The others consisted of therapists with positions in universities, hospitals, and clinics in various cities around the Inland Sea, and of Dr. Tatara's present and past graduate students. Two of the more experienced therapists had their own followers.

The historical development of psychoanalysis in Japan must be set against the background of German psychiatry previously ensconced in Japan, with its emphasis on diagnosis and pharmacology rather than psychotherapy; and indigenous mental health healers, as well as specifically Japanese forms of psychotherapy, such as Morita Therapy (Reynolds 1976) developed by Professor Morita, a psychiatrist, and Naikan Therapy with its strong roots in Buddhism (Reynolds 1983). Psychoanalysis is a major departure from both Germanic psychiatry and indigenous Japanese ways of dealing with emotional problems and symptoms.

The main hierarchical progression started with Professor Marui of

Tohoku University in Sendai, who initiated a course in psychoanalytic psychiatry in 1918.[12] Of the students he then trained in Japan, the best known ones are Drs. M. Yamamura and H. Kosawa. The former is now head of psychiatry at Gifu University. The latter was trained in Vienna in the early 1930s and opened a psychoanalytic clinic in Tokyo; he became the dean of Japanese psychoanalysis and the first president of the Japanese Branch of the International Psychoanalytic Association (I.P.A.) when it was officially formed in 1954; even now, though he is deceased, he is accorded considerable deference in Japanese psychoanalysis. Dr. Kosawa trained a number of students, the most important and well-known ones being Drs. Takeo Doi, Masahisa Nishizono, Keigo Okonogi, and Shigeharu Maeda.[13] These four students of Dr. Kosawa, plus Dr. Yamamura, are currently the five official training analysts of the Japanese Branch of the I.P.A. To become a member of this branch, it is considered essential to train with one of these analysts, regardless of one's training abroad, and to become a member of his group.

However, the complexion of psychoanalysis in Japan is considerably more complicated than this direct line of descent from Professor Marui to Dr. Kosawa to their disciples, the current training analysts with their own groups. The other factions and their interrelationships in Japan reflect the political shape of psychoanalysis in the West, particularly in the United States—the Japanese being tremendously influenced since the Occupation by American ideas and institutions. In the United States two important groups of psychoanalysts have thus far been excluded from the I.P.A. by the American Psychoanalytic Association: psychoanalysts of neo-Freudian training and persuasion, who may be either psychiatrists or psychologists; and psychoanalysts who come from a variety of

[12] In the 1920s he went to Johns Hopkins University in Baltimore for five years training in psychiatry, becoming further exposed to psychoanalysis.

[13] Dr. Takeo Doi was originally at Tokyo University and then at International Christian University and St. Luke's International Hospital; currently, he is director of the National Institute of Mental Health. He was trained at the Menninger Foundation in the 1950s and later at the San Francisco Psychoanalytic Institute. Dr. Nishizono is dean of the Medical School and head of the department of psychiatry at Fukuoka University in Kyushu, and is considered a powerful and influential head of an important group of psychoanalytic psychiatrists. He has published a couple of papers in English (1969, 1980). Dr. Okonogi, a psychiatrist at Keio University in Tokyo, is an influential leader of another important group of psychiatrists and has done more than any other analyst in explaining psychoanalysis to the public. He also has published a few papers in English (1978a, 1978b, 1979). Dr. Maeda is a psychiatrist at Kyushu University in Fukuoka, and seems to be affiliated with Dr. Nishizono. I unfortunately know little about his following or work.

disciplines and do not have a medical degree, the vast majority of whom are Freudian in orientation.

For example, a Japanese psychologist, Dr. Ohtsuki, also went to Vienna for psychoanalytic training in the 1930s, and returned to form an interdisciplinary group of psychoanalytic therapists, including many schoolteachers. Although this group is no longer functioning, one of its important members, Professor Moses Burg, an American psychologist who stayed on after the Occupation, has his own group of psychoanalytic therapists who work mainly with schizophrenic patients at various mental hospitals.[14] Because of their nonmedical status as well as Burg's neo-Freudian training, neither Dr. Ohtsuki nor Professor Burg, not to mention any of their students, has been admitted to the Japanese Branch of the I.P.A.

Three other major psychoanalytic groups have been started by Japanese psychiatrists and psychologists who went to the United States after World War II for psychoanalytic training; because of a neo-Freudian or eclectic orientation, they and their students have also been excluded from the Japanese Branch of the I.P.A. The earliest was Dr. Akihisa Kondo (1975), a highly respected clinician of the same age and seniority as the main training analysts of the Japanese Branch of the I.P.A., who introduced Zen Buddhism to Karen Horney and Erich Fromm.[15] Dr. Mikihachiro Tatara (1974, 1982) also did not have a close relationship with the Freudian training analysts because of his neo-Freudian background until he spent two years in Freudian training at the Austen Riggs Foundation. The third, Dr. Kenzo Sorai, trained at the Postgraduate Center for Mental Health in New York City, and then started the Sanno Institute in Tokyo with a broad eclectic psychoanalytic orientation that includes Jungian perspectives.

In more recent years, in the 1970s and 1980s, younger persons have gone abroad to the United States and England for training in psychoanalysis and have generally joined one or another of the groups I have cited above. The particular group they join depends on whether their

[14] Professor Burg (1960, 1969, 1980) is professor of clinical psychology at Toyo University and is director of the Orient-Occident Mental Health Research Center there. This center was started by Dr. Harold Kelman of the Karen Horney Institute, with whom Burg had further psychoanalytic training.

[15] Dr. Kondo trained in the late 1940s and early 1950s at the Karen Horney Institute in New York City. He introduced Erich Fromm to D. T. Suzuki, a renowned teacher of Zen; the latter two collaborated on a book about psychoanalysis and Zen Buddhism (Fromm and Suzuki 1970).

psychoanalytic orientation is neo-Freudian or Freudian. There are now American-trained psychoanalytic therapists in the groups of Drs. Nishizono, Okonogi, and Tatara, as well as two British-trained ones in Dr. Okonogi's group. This gives these groups far more opportunity for direct communication in English with other psychoanalysts from the I.P.A. and the West, as well as the ability to report new developments in psychoanalysis. Four Japanese have gone abroad for psychoanalytic training and have remained abroad.[16]

There are currently two psychoanalytic societies in Japan. One is the Japanese Branch of the I.P.A., with some twenty-four members. The other is the Japanese Psychoanalytic Association, which now has over a thousand members, 80 percent of them psychiatrists, with others coming from a variety of disciplines. All of these latter are interested in psychoanalysis, but only a limited number have actual psychoanalytic training. Notably absent from both associations are such senior psychoanalysts as Dr. Kondo and Professor Burg.

It is striking that unlike Indian psychoanalysts, the Japanese have from the very beginning openly asserted the uniqueness of the Japanese psyche and tried to formulate relevant theories that depart significantly from Western psychoanalysis. Although Girindrasekhar Bose (1966), the father of Indian psychoanalysis, developed his own unique theory of repression and psychological functioning, like Freud and other Western analysts he posited it as universal, not as uniquely Indian. Japanese psychoanalysts, on the other hand, not being burdened by a colonial legacy with its denigration of indigenous culture, have found it much easier to assert their Japaneseness. Thus, Dr. Kosawa dismissed the Oedipus complex as not central to the Japanese psyche, and substituted the Ajase complex, taken from a Buddhist myth. Here the focus is not so much on the son-mother-father triangle, as in the Oedipus myth, but rather on the son-mother dyad, wherein the son rages over feelings of loss of his symbiotic tie with the mother, but later repents after realizing her great sacrifices for him. This is obviously of another order not only from

[16]The two who are fully certified psychoanalysts are Dr. Yasuhiko Taketomo (1982, 1983, 1984, 1985), who is equivalent to the senior training analysts in Japan, and is a member of the Association for Psychoanalytic Medicine at Columbia University and clinical associate professor of psychiatry at Albert Einstein Medical Center in New York City; and Mrs. Nobuko Meaders (1983), who is now a supervising psychoanalyst at the Postgraduate Center for Mental Health, also in New York City. The other two are Dr. Tetsuro Takahashi of the Menninger Foundation, and Dr. Nakakuki, who started training at the Colorado Psychoanalytic Institute.

the Oedipus complex, but also from the much more recent work on separation-individuation.[17]

Even more seminal in focusing on the uniqueness of the Japanese psyche is Takeo Doi's (1973) work on *amae*. Doi discards the whole Freudian theoretical framework as unworkable for understanding the Japanese psyche, and uses instead Japanese terms for a depth psychological exposition of Japanese dependency relationships. These he views as existing only in a very minor key in Western relationships, so that there is almost no Western vocabulary to describe them. As in Dr. Kosawa's work, there is an affirmation of Japanese values, patterns of relationship, and inner psychological makeup, with no sense of inferiority vis-à-vis the West. Other papers by Drs. Kondo, Nishizono, Okonogi,

[17]The Ajase myth is as follows: In the time of Buddha, there lived a king named Binbashara. His wife, Idaike, fearing the loss of her husband's love as her beauty faded, longed to have a son with which to secure the king's love for as long as she lived. Hearing of her intense wish, a sage told her that within three years a hermit living on a mountain would die a natural death and start his life afresh to become her son. However, the queen, who so deeply feared the loss of her husband's love, chose to kill the hermit before the three years had passed. She wanted to have her son as soon as possible. Soon, as the sage had said, she conceived and gave birth to a boy, Ajase. During her pregnancy, however, she had been beset with fears of being cursed by the hermit she had killed and at one time had even tried to induce a miscarriage.

Ajase grew up spending a happy youth with his parents' love centered upon him, knowing nothing of the secret of his conception. But one day after he had reached manhood, he was approached by Daibadatta, one of Buddha's enemies, who revealed to Ajase the secret of his birth. At first Ajase reacted against his father, feeling sympathy for his mother's agony and anger against his father who had so distressed his mother. He helped unseat his father and then had him imprisoned.

Ajase soon learned that his mother was feeding his imprisoned father honey which she had first rubbed onto her body. This honey saved his father from starvation. Ajase then became so angry with his mother that he tried to kill her with his sword, blaming her for the attempt to save his father, who was his enemy. He was dissuaded from slaying her by a minister who counseled that although there were some sons who tried to kill their father, there were none who attempted to kill their mother. At that moment, Ajase was attacked by severe guilt feelings and became afflicted by a terrible illness called *ruchu*—a severe skin disease charaterized by so offensive an odor that no one dared approach him. Only his mother stood by and cared for him.

Thanks to his mother's compassionate nursing, Ajase recovered from the illness and was forgiven by the mother he had intended to murder. As a result, he was awakened to a real love for his mother, discarding his grudge against her and realizing her great sacrifices for him. His mother, for her part, was able to develop a more natural maternal affection for her son beyond her original self-centered concerns for herself and attachment to him. (Much of this version of the Ajase myth can be found in Okonogi 1978b.) This depiction of the Ajase complex as the prototype of the early Japanese mother-child relationship is quite different from the description of this relationship in American society (Mahler et al. 1975).

Taketomo and Tatara all attempt to explicate Japanese psychological makeup as being significantly different from Western, but not in the least inferior. Doi has been the most influential on a number of social scientists and Japan specialists; Kondo's views have been incorporated in the recent work of Reynolds (1983).

Although solidly established in Japan, psychoanalysis remains a small but growing movement, still set against a predominant Germanic psychiatry and academic-behavior psychology on the one hand, and indigenous folkhealers and psychotherapies on the other. One can speculate both on the reasons why psychoanalysis has been accepted and on its still quite limited scope. In Japan, as in India, social and cultural communities have simply not come apart to anywhere near the extent they have in America (Rieff 1968) and France (Turkle 1978). Thus, a psychoanalytic world view that guides the person in a world of crumbling cultural and social supports is not at this point very appropriate to the Japanese.

From an historical perspective, it is evident that Japan's radical effort to modernize after the Meiji Restoration in 1868, to keep the Western powers from taking over, was accomplished through assimilating Western institutions and technology but continuing Japanese hierarchical social patterns and their associated values within these new institutional forms. It is only with the American Occupation, after the shattering defeat of World War II, that more radical changes occurred, influenced by a value system and its institutional implementation that departs at times drastically from indigenous Japanese social and cultural patterns. From the effects of the Occupation and the current influences of the media, there are two major factors that have greatly enhanced the growth of psychoanalysis in Japan.

The first is the Western ideal of individualism in terms of increased personal autonomy, independence, and individualized choices in a variety of situations, together with an ideology of equality that has been partially but increasingly incorporated by the younger generations. This is radically different from the traditional emotional enmeshment in family and group, and on the level of ideals creates a generation gap. Psychoanalysis is clearly congruent with this new thrust toward individualization.

The second factor involves a greater emphasis on the values of rationality and self-reflection in social situations. These values are manifested in psychoanalysis in its greater dependence on rational, interpretive explanations for psychological behavior than is present in indigenous psy-

chotherapies such as Morita and Naikan, which rely on more intuitive and meditative means, respectively (pers. com. Akihisa Kondo). With the introduction of foreign psychological ideals and paradigms of personal functioning into Japan, psychoanalysis is becoming established as a new therapeutic mode.

Economics significantly influence the practice of psychoanalysis in Japan. National Health Insurance pays a very small amount for psychoanalytic sessions, so that it is generally not feasible for the usual psychiatrist, or even psychologist, to live by earnings from a private practice. Psychiatrists who can see innumerable patients for a very short period in a hospital, prescribing and administering various drugs, make far more money there than they could in private practice. Another contributing factor is the economic homogeneity in Japanese society, where 90 percent of the people consider themselves to be middle-class and to be generally unable to afford to see a psychoanalytic therapist more than once a week. Many of these middle-class patients come to university psychotherapy clinics; it is only a much smaller upper-middle class that can come more frequently to an analyst in private practice.

The Psychoanalytic Relationship in Japan

As in my clinical psychoanalytic research in India, it gradually struck me that to understand the nature of the psychoanalytic relationship in Japan, the kinds of expectations patients bring to therapy, and crucial resistances that are usually present, one must take into account the major psychosocial dimensions of family and group hierarchical relationships (see Chapter Seven). As these psychosocial dimensions profoundly differ from those of Western individualism, so do various facets of psychoanalysis in Japan.

In the qualitative mode of hierarchical relationships, Japanese patient and therapist form a hierarchical "we" relationship with vaguely defined outer ego boundaries, especially on the patient's part. This contrasts with the individualistic "I" and "you" relationship of the Western egalitarian psychoanalytic relationship, where patient and therapist have rather well-defined, relatively self-contained outer ego boundaries. Japanese analysts report an unspoken expectation on the patient's part for a lifelong, warmly nurturing relationship, in which the therapist will completely take over and take care of the patient and solve all of his or her problems and symptoms. This can evoke a reciprocating tendency in the therapist to do this, as it is a normal part of hierarchical relationships,

with their lifelong commitments between mentor and disciple. The patient comes to the therapist not for self-exploration to deal with his or her problems, as in American society where one is far more on one's own, but rather for what the relationship itself can provide (Tatara 1982). If the therapist does take over completely, without gradually delving into the hidden aspects of a patient's problems, then a stalemate usually occurs and the patient will leave (pers. com. Keigo Okonogi).

The strong feelings of dependency (*amae*) that are rarely expressed verbally are part of a highly subtle emotional exchange and flow in Japanese hierarchical relationships whereby patients or juniors, by their dependence on and idealization of the therapist or senior, gratify the latter's own esteem in exchange for being gratified in their dependency needs (*amayakasu*). In Japanese hierarchical intimacy relationships, as in Indian ones, dependence on the other subtly enhances the latter's feelings of esteem by according him or her a superior position as the one who can gratify and guide, and helps to create a relationship of intimacy between subordinate and superior.

Another facet of the qualitative mode of hierarchical relationships is the greatly heightened concerned sensitivity (*omoiyari*) to the other's feelings, moods, and needs (pers. com. Y. Taketomo). Japanese patients expect the hierarchical superior, the therapist, to sense and know their needs and feelings—in fact their whole inner being—with only a minimum of overt verbal communication or even nonverbal cues, for Japanese are extremely restrained in facial and hand gestures. In the long-term relationships of Japanese family and group life, it is assumed that the superior, in the paradigm of the mother, will always be sensitive and nurturing to the subordinate. It is equally assumed that the subordinate will sense the superior's wishes and expectations, so that the therapist expects the patient to pick up various attitudes and even understandings with only a minimum of verbal communication. Anything really important is rarely to be communicated verbally in Japanese relationships.[18] I was startled in the supervision of five cases to see clearly therapeutic progress that could be easily understood psychodynamically, even though there was a minimum of interpretation, investigation, or even empathic reflections on the therapists' parts (Roland 1983). This strong empathic sensing obviously begins in childhood. Japanese children are raised by their mothers to be extremely sensitive and concerned with others' feelings and needs rather than with their own, which should never be expressed directly, but also to expect others, especially a hierarchical superior, to be highly sensitive to themselves. Often a person may only become aware of what he or she wants when the superior has incorrectly sensed and responded to it (pers. com. Yoshiko Idei). Needless to say, considerable anger may be generated when the hierarchical superior—mother or father or group leader or mentor—lacks sufficient empathic sensitivity, responsiveness, or responsibility.

[18] When I questioned a well-known Japanese scientist what led to his vocational choice, he related that when he was around sixteen, his father left out a book on great scientists of the world for him to read. He then assumed that his father expected him to become a scientist. There was no other communication on the subject.

I have so far emphasized diffuse outer ego boundaries, dependence and interdependence, and empathic sensitivity in hierarchical relationships as these aspects are manifested in the analytic relationship. There is still another crucial facet of the qualitative mode that enters into the psychoanalytic relationship, and particularly in the manifestation and analysis of resistances. In the intense emotional enmeshment of Japanese family and group hierarchical relationships, individuality is largely maintained by keeping a highly private self (pers. com. Akihisa Kondo). Patients feel tremendous vulnerability in a situation where their inner world may be revealed. Japanese patients only feel comfortable in a very small room, or sitting close to the therapist in a larger room, as symbolic of the need for emotional enmeshment. In both cases, patients usually try to have something between themselves and the therapist (such as a small table or footstool) as a symbolic barrier to protect their inner self from the therapist's intrusion (pers. com. Mikihachiro Tatara). This private self with its various feelings, thoughts, and ambivalences is kept quite secret, and is communicated only by indirection and innuendo verbally and by some very subtle nonverbal gestures. As patients sense that the therapist is sufficiently empathic to pick up these innuendos and clues, they will reveal somewhat more of their inner world; otherwise, whole areas will be kept secret in a way that I have not experienced with any American patients—though I have had similar experiences with my Indian ones.

I have found in both Japanese and Indians that a highly private self with a specially set inner ego boundary is intrinsic to functioning in strongly emotionally enmeshed family and group hierarchical relationships. But in the Japanese—whose outer ego boundaries seem to be more diffuse in their family and group hierarchical relationships, and whose innermost ego boundaries are less open to being aware of their own wishes, feelings, and fantasies than are those of Indians—the private self is kept even more secret and communicated more indirectly. Thus Japanese analysts must be extremely careful not to be too intrusive into this private self through investigation or interpretation. Otherwise they will

severely disrupt the warmly nurturing analytic "we" relationship, resulting in therapeutic failure. Japanese analysts who ask questions are considered stupid at best—they should sense the patient's inner world without asking—or insulting at worst for being so intrusive (pers. com. Mikihachiro Tatara).

On the other hand, Japanese therapists have also referred to many of their patients as being like onions: when you peel all the layers off, you get down to nothing (pers. com. Mikihachiro Tatara and Mishiko Fukazawa). What they mean is that many patients are brought up to be closely in touch with others' feelings, needs, and moods while being completely out of touch with their own. Simply to ask what they are feeling usually elicits no response. These therapists find it necessary to go into great detail over what happened in a particular relationship and situation to try to get at any inner experience of the patient. In this sense, therapy becomes a kind of education for the patient, to first begin to become aware of himself or herself and not adhere so strongly to what is essentially a false self. Needless to say, the existing inner psychological structure can comprise a major resistance to psychoanalytic therapy, as well as being the subject of considerable therapeutic work (see the case of Mrs. K, Chapter Five).

In addition to other resistances idiosyncratic to patients and their particular psychobiographies, there are two further social and cultural factors that significantly contribute to resistances in psychoanalytic therapy in Japan, one intrinsically related to hierarchical relationships, the other to specific Japanese cultural ideals and child rearing. In structural hierarchical relationships where reciprocal responsibilities and obligations of senior and junior are carefully observed, any direct expression of anger, particularly by the junior, is strictly forbidden, the prohibition being deeply internalized into the superego. Clinical psychoanalytic work in both Japan and India confirms the enormous anxiety attendant on any direct assertion of anger toward the hierarchical superior. Anger in the subordinate may thus be consciously contained, or unconsciously displaced toward those lower in the hierarchy or toward another group or faction; or it may be turned against oneself in the form of frequent somatic symptoms, temporary depressions, or failures in life. More particularly among the Japanese, strict superego prohibitions against anger or even grandiosity may be unconsciously projected onto others. In the analytic situation, the patient expects the analyst to be displeased with him. The patient then counters this possible interruption in their nurturing relationship by a typical social maneuver for gaining acceptance by a superior: being extremely apologetic and blaming oneself, thereby

short-circuiting any investigation by the therapist (pers. com. Mikihachiro Tatara). In social situations, this superego projection can be a major factor in the not infrequent symptom of extreme social shyness and withdrawal or anthrophobia (Kitayama 1981).

In the psychoanalytic situation, the therapist must carefully assess whether anger at others or sudden failures may be unconscious deflections from ambivalences that cannot be directly expressed to the therapist. Or the patient may show anger toward the analyst by leaving and seeing a therapist from another group or, more frequently, a folk healer.[19] There is no question that anxiety over the expression—or at times even the awareness of—anger and ambivalences toward the superior is a major facet of the unconscious superego in Japanese, as it is in Indians, and completely belies the point of view (Kakar 1978, 135–137; Muensterberger 1969) that the superego is not internalized but instead relies on the constant response of others in these societies.

The other cultural factor related to resistances involves the strong Japanese ideal of a very high level of skill, competence, and performance in everyone in both human relationships and tasks, and for achievement and success in men. Japanese mothers in particular inculcate expectations for high levels of performance (DeVos 1973). As a result, Japanese have internalized structures of strongly idealized self-images and very high ego-ideals in the areas of work, with constant tension in men between their inner idealized self-images and their actual position and influence in the group. The ego-ideal is fueled in good part by the internalization of maternal expectations, with deep feelings of gratitude and obligation to a mother who has been overwhelmingly devoted and sacrificing to her children, and with profound feelings of guilt and shame when not fulfilling maternal values. The mother in turn derives much of her own sense of esteem from her children's performance and success. These idealized self-images are further enhanced or become conflictual through identification with parental idealized self-images—particularly images and expectations of a reticent father (Taketomo 1982), or each parent's idealization or denigration of the other (pers. com. Mikihachiro Tatara). One's inner narcissistic balance thus depends a great deal on the nature of one's inner idealized self-images and how they are implemented or not in life performance and position. In subtle ways, there is a considerable mirroring in family and group relationships to maintain

[19] The point that no therapist from the same group would take on such a patient because of the insult to the initial therapist emerged during a discussion in the Hiroshima group. In American psychoanalytic circles, if a patient leaves a therapist the patient may well see another therapist from the same institute.

inner feelings of high esteem associated with these strong self-idealizations: each expects the other to reflect positively on oneself, while maintaining a position of modesty and humility (Miyamoto 1983).[20]

Just the fact of coming for psychoanalytic therapy is an admission of failure and a blow to one's self-idealizations, and immediately arouses resistance in many patients. Any questioning or interpretation by the therapist is usually experienced by the patient as a kind of criticism, and therefore interferes with the necessary nurturing atmosphere of the psychoanalytic relationship in Japan. In turn, Japanese psychoanalysts are also extremely vulnerable to criticism, and thus may sometimes not risk investigating or interpreting if they sense the patient will be critical of them.

Japanese psychoanalysts use a variety of methods to carry on the analytic process in the context of these culturally related resistances. I am most familiar with the therapeutic approaches to resistance-analysis of Dr. Tatara and his Hiroshima group of psychoanalytic therapists, as I worked most closely with them. They use several tactics to minimize their patients' vulnerability to intrusion and criticism, some not unfamiliar to a Western psychoanalyst. One approach is to assume the subordinate or inferior position with the patient when questioning or interpreting, conveying an attitude of ingenuousness or even naiveté. Or the exact opposite may sometimes be effective: taking the superior hierarchical position of the person who knows exactly what he is doing, so the patient feels a greater sense of esteem by being associated with a powerful, knowledgeable superior. Humor is still another approach, as is verbally reflecting or mirroring what the therapist senses the patient is feeling or thinking, enabling the latter to confirm or correct the therapist without feeling threatened.

At times a more direct approach is called for, and it is in this area of the occasional need for confronting a patient on a resistance that Japanese psychoanalysts seem to experience the most difficulty. Japanese psychoanalysts have confirmed their own difficulties in working with certain American patients who require a much more confrontive approach (pers. com. Akihisa Kondo and Mikihachiro Tatara). In general, however, psychoanalytic therapy in Japan works to a much greater extent by therapist and patient sensing each other's mind with a minimum of overt verbal or nonverbal communication. For example, nuances in verbal communication may be picked up in the form of subtly skewed

[20]Status anxiety can be intense in Japan. However, to balance these strivings for success, there are other cultural values for self-cultivation that transcend these strivings, and in fact view them somewhat pejoratively (pers. com. Yasuhiko Taketomo).

expressions in the respect language in various hierarchical relationships, these skewed expressions implying underlying unconscious conflicts (pers. com. Mikihachiro Tatara).

There is a still further dimension to the nature of the therapeutic relationship in Japan. In recent decades, important concepts of the therapeutic relationship have been introduced by psychoanalysts such as Winnicott (1965), Bion (1977), and Kohut (1971), such as the holding environment, the container, and the selfobject, respectively—all to convey certain therapeutic aspects of the analytic relationship as well as, at times, transference. My impression of the Japanese psychoanalytic relationship is that it is, in a sense, "free parking," to borrow an image from the game of Monopoly. In this game, as the players build houses and hotels on different properties, it is often a great relief to land on "free parking," where you will be beholden for the moment to no one. In Japanese family and group hierarchical relationships, where the person is intricately emotionally enmeshed with others, where the etiquette of hierarchical rank and obligation is meticulously observed (*giri*), and where one must be constantly sensitive to others' needs and feelings for the well-being of the group, I sense that Japanese patients can breathe a great sigh of relief to be able to explore themselves in the presence of an empathic, understanding therapist. Although all kinds of resistances and transferences emerge in psychoanalytic therapy, there is still the reality factor that the therapy relationship is a time out or free parking from strictly observed social etiquette in one's relationships.

We can now reconsider more directly DeVos's major arguments on the unsuitability of psychoanalysis for the Japanese. Psychoanalysis's emphasis in Western societies on individual autonomy and freedom from the family is not intrinsic to it. In Japan as well as in India, since the essentials of psychoanalytic therapy are to resolve inner emotional conflicts and/or deficits from the past—a kind of rearranging and reconstruction of the internal furniture—a person can be enabled through analysis to function much better within the closely emotionally enmeshed family and group hierarchical relationships.

What DeVos overlooks is that Japanese, like Indians, maintain a highly private self even when closely interconnected with others in the family and/or group; that the social self geared toward hierarchical intimacy relationships does not in the least completely define the person. When this private self is greatly conflicted from early familial relationships, the person becomes vulnerable to the inevitable frustrations, disappointed expectations, and demanding attitudes of a superior. On the other hand,

when the person resolves his or her inner conflicts and developmental deficits through the therapy relationship, he or she can function with much greater equanimity in these hierarchical relationships. Intense anger toward family members and parents may indeed surface within the psychoanalytic relationship, as it did in the case of Mrs. K (Chapter Five); but this does not mean that the person is not able to contain this anger within the private self so that it does not spill over into the familial relationships.

As to DeVos's point that Japanese verbal constraint is unsuitable for psychoanalysis, both therapists and patients are able to communicate with a minimum of verbalization. Sensing is constantly being done in the family and group hierarchical relationships, different words, phrases, and gestures being consciously used to be congruent with what one senses to be the nature of the relationship in terms of hierarchical position and degree of intimacy. This socially traditional mode of nonverbal, empathic sensing and communication is simply carried over into the psychoanalytic relationship by both patient and analyst. How is this done? I suspect that it comes from the development of capacities for an extraordinary high degree of empathic sensing of the other in long-term relationships within a society and culture where there are shared cultural meanings that have remained remarkably homogeneous over many centuries. This enables its members to sense easily how another would feel or think in any number of particular situations and relationships. Thus in psychoanalytic sessions in Japan, free associations and interpretations don't always have to be verbalized. Much, much more is communicated by innuendo.