

Working with CBT across Cultures in Clinical Psychology with Particular Reference to Japanese Clinical Psychology

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シリーズ要約

近年、臨床心理学は、世界規模で専門的なメンタルヘルスの活動として発展してきている。しかし、その発展の在り方は、国や文化によって異なっている。欧米では、エビデンスベーストアプローチと、それと関連の深い認知行動療法の導入が大きな原動力となって臨床心理学が社会的に認められ、大きな発展を遂げてきた。日本においても、臨床心理学のさらなる発展に向けて認知行動療法の導入が求められている。しかし、欧米文化の産物である認知行動療法を、文化の異なる日本にそのまま当てはめても有効な結果を得ることは難しいと考えられる。それだけでなく、日本人の心性に悪影響を与えることもあり得る。

そこで、認知行動療法の導入に当たっては、日本の文化や社会の在り方に即した修正や改善を加えての適用が望まれる。本論文は、文化的観点を踏まえ、エビデンスベーストアプローチと認知行動療法が発展している英国との比較を通して、日本における認知行動療法の活用の可能性について検討するものである。

本論文は全体として3部から構成されるシリーズとなっている。第1部は、東日本大震災の被災地支援の経験も踏まえて日本と英国の臨床心理学の現状を比較する。第2部では日本の文化の特徴と明らかにし、認知行動療法の導入の進め方を議論する。その際、日本固有の心理療法である森田療法と、認知行動療法の最前線であるマインドフルネス認知療法やACTなどとの比較も併せて行う。第3部では、それまでの議論を受けて、日本の文化に適した認知行動療法の発展の方向性について社会の近代化の過程と関連させて議論する。

The aim of this series of papers

Since its inception as a discipline, the development and practice of Clinical Psychology has differed widely

across countries and between cultures, although the profession's expansion has been prompted by widespread and growing social need for psychological help, and many common features are recognisable across cultures.

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In response to rapid development and growing social demand, clinical psychologists everywhere have had to develop the scope of their clinical psychological practice and to develop locally appropriate and responsive services. It is an urgent task for the discipline today to provide helpful models for clinical psychologists to apply wherever they work, and to develop organizational structures for clinical practice and training programmes, although these may well need to vary according to each culture's own social systems and traditions.

As a contribution to these developments and in order to promote the growth and usefulness of clinical psychology across many differing cultures, we argue that it would be helpful as a starting point to review patterns of development which have been successful within some countries, particularly the West, and to compare these with development in non-Western countries where the profession has not as yet had equal impact. Few comparative studies of clinical psychology's development in terms of cultural differences have been published to date, but these three serial papers aim to build on earlier work by Shimoyama (2011) which has examined the examples of clinical psychology in the UK and in Japan, and the relationship of these professional groupings with their respective cultures, and to see what might be usefully learned from these experiences.

A key focus of our examination in these papers will be the role of Cognitive Behaviour Therapy (CBT) in the development and position of the profession. The most obvious comparison between British clinical psychology, which has largely employed a scientist-practitioner approach (most recently by using CBT as a core model), and Japan, has been that British clinical psychology has established reasonable consistency as a discipline and is officially recognised as a core mental health profession, whilst Japanese clinical psychology, which has employed mainly psychodynamic approaches, is still experiencing confusion within the discipline, and is involved in considerable internal conflict. This difference suggests that

taking an evidence based approach (in this case CBT) may have been one of the important factors affecting the two differing professional trajectories. Based on this argument, it could be concluded that introducing CBT could facilitate Japanese clinical psychology's ambition to become a more widely recognised and effective profession. However CBT is a product of Western culture, and in these papers we will also argue that Japanese psychological therapists should consider how Western conceptualisations risk inappropriately violating non-Western cultural assumptions, which might well lead to negative consequences for patients and the profession in the long run. Modifications for the application of CBT by clinical psychologists working in the East will therefore also be suggested.

To summarise : this series of papers will explore how effectively Western psychological approaches (specifically CBT) can be applied outside the normal comfort zone of Western society, specifically in Japan. They propose that although it may have much to offer, both therapeutically and professionally, an evidence-based therapy such as CBT will need to be modified ; that we need to ask questions about how helpful the Western ways of working can be in non-Western cultures ; and that effective components are not universal. The first paper opens with an example from accounts of recent interventions for victims affected by the 2011 Japanese earthquake and tsunami, where CBT-based interventions, guided by well-intentioned offers of help from the West, were not in fact enthusiastically welcomed.

This series comprises three parts. The first describes today's situation and background around CBT and clinical psychology in both countries. The second explores features of Japanese culture and briefly considers one of its indigenous psychotherapies, Morita Therapy, in comparison with advanced methods of CBT. The third considers how best CBT could be introduced into Japanese society.

Part One — Introduction : CBT and Clinical Psychology in Culture

第1部要約

以下、本号では、日本と英国の臨床心理学の現状の違いを明らかにする第1部を掲載する。2011年に起きた東日本大震災においては、多くの人々がトラウマ体験をしていると考えられる。エビデンスベーストアプローチにおいては、トラウマに対しては認知行動療法の有効性が実証されている。しかし、日本では、多くの被害者は、認知行動療法による心理支援を求めることはしない。むしろ、そのようなものには拒否的である。このような心理的問題への対応の違いには文化的な違いがあると考えられる。第1部は、そのような文化的違いを糸口にして日英の臨床心理学の現状の違いを検討する。

I Can therapies such as CBT derived from Western clinical psychology be of help in Japan?

On 11th March 2011, an earthquake of enormous magnitude hit the east part of Japan, leading to a huge tsunami overwhelming the coast and inland areas, followed by a series of very serious nuclear accidents. The death toll had risen after nine months to 15,841 and in addition the number of people left missing by the Tsunami remains over 13,493. Probably many of the missing bodies were lost at sea, meaning that many survivors not only lost all their relatives, but that this happened almost instantaneously without warning, leaving no traces whatsoever. It is a major tragedy that many children, who survived because they were at school at the time that the earthquake hit, lost both their parents and often grandparents without saying good-bye to them. Several cities and villages were literally wiped out : in a matter of moments, these communities and the people living in them all vanished completely. The number of refugees including those from the nuclear plant accidents had by the middle of 2011 risen to 240,000. All the survivors of some cities and villages had to move as a group to other locations remote from their own towns, meaning that these survivors had lost not only many of their relatives, but also their home towns with everything that was fa-

miliar to them. In addition, the radioactive contamination was a further, terrifying threat to the survivors and those who came to help.

This unprecedented and overwhelming disaster is highly likely to have been experienced as traumatic, and hence it would (to most observers) have seemed likely that amongst some of the survivors there would post-traumatic symptoms and grief responses typical of post-traumatic stress disorder (together with the effects of multiple bereavement) such as fear, avoidance, numbing, withdrawal and depression. Whilst it was clear that meeting physical needs and restoring physical safety had to be the first priority, it was also felt that the population's psycho-social needs after a traumatic event of this sort should also be addressed. Many nations offered help and advice as to appropriate interventions to assist with the psychological sequelae, and in particular there were offers of treatments which are empirically supported such as those derived from CBT, including psycho-education and exposure-based interventions.

Yet the response of many Japanese people was to resist these offers of help, and to behave in ways distinctively characteristic of the Japanese. They were very patient and non-assertive, and as local communities, insisted on remaining traditionally and culturally intact, resisting the contributions of others, even if those others were professionals. Many of the survivors did not overtly express

their feelings such as anxiety and depression, although various symptoms of somatoform disorder were manifested. The symptoms of PTSD were only rarely articulated by adults or by children, especially to mental health professionals. At some refugee sites, notices were erected, firmly announcing that psychologists and counsellors should keep out. Instead, the local people tried to accept the tragedy collectively and to take care of each other, rejecting any attempts to utilise personal therapeutic attempts such as controlled re-exposure to the traumatic events (which have formed part of treatment packages applied in previous traumatic circumstances, see for example Ehlers, Clark, Hackmann, McManus & Fennell, 2005). Instead these were seen as intrusive not only to individuals but also to the whole community.

What this example clearly demonstrated is that exactly how and in what form evidence-based interventions, such as CBT, are introduced to a culture such as Japan, is critical. Although the need was great, and existing evidence implies that an approach such as CBT for trauma might have been useful in the face of this tragedy, nonetheless this experience shows that precedents from other countries might not apply in Japan, largely because they may not fit well with cultural understandings and the traditional behaviours and beliefs of the sufferers.

II Clinical psychology in the UK

Mental health problems are undoubtedly present in some form or another in all human societies. In the West in particular the profession of clinical psychology has in recent times successfully developed a number of models, practices and therapies in an attempt to understand mental health difficulties, and as a profession, has grown hugely in size and influence, probably because its underlying models and theories have been found to be scientifically useful in generating effective solutions to clinical problems. Indeed it is arguable that a key explanation for the success of Western clinical psychol-

ogy has been the good use made of theoretical concepts, models, approaches and insights from psychology as an underlying academic discipline (Beinart, Kennedy & Llewelyn, 2009), which offer a coherent alternative to psychiatry. In many Western countries, like the UK, this has in effect meant the endorsement and development of evidence based practice, which in recent years has tended to mean CBT. Although they have also used other approaches, many clinical psychologists have developed and delivered effective CBT treatments for children and adults based on cognitive models for specific clinical conditions such as anxiety, panic, depression, PTSD, OCD, the symptoms of psychosis, and for challenging behaviour and developmental disorders (Rathod & Kingdom, 2009). The link between the successful application of evidence based interventions and the growth of clinical psychology has been particularly clear in the UK but has also been evident elsewhere (Hall & Llewelyn, 2006). Throughout the West, and in the UK in particular, CBT practitioners have been diligent in demonstrating the effectiveness of CBT, based on the publication of the results of numerous research trials and clinical investigations. As a consequence, CBT has been widely endorsed by government guidelines and by investment in clinical services and training (Roth & Fonagy, 2004). Hence for example in the UK, CBT has been recommended as the treatment of choice for many clinical conditions from panic to bulimia, and is required in the training of most mental health professionals including clinical psychology.

III Clinical psychology in Japan

By contrast, mental health problems in Japan have for many decades been understood and treated primarily by psychiatrists, and unlike British clinical psychologists, Japanese clinical psychologists have not presented a clear alternative which commands the support of either the profession or the government. Currently most clinical psychologists and psychotherapists in Japan tend to base their work on Jungian or Rogerian approaches,

and do not make much use of either academic psychology or evidence based approaches such as CBT (see Shimoyama, 2000). Jungian and Rogerian therapies are both therapeutic approaches which appear to fit reasonably synchronously within Japanese culture, and have evidently been helpful to many patients, but few would claim they are supported by large scale outcome studies normally understood as being “scientific”. Japanese Clinical Psychology has also effectively kept itself apart from science-based academic psychology so that the two psychologies have had almost no connection with each other. Moreover, since clinical psychology trainers have begun to make use of some of the physical space that academic psychologists used to occupy in the universities, serious conflicts between the two psychologies have occurred. This has reached the unfortunate position that one of the societies to which academic psychologies belong has expressed its formal objections to Japanese Clinical Psychology.

In effect, Japanese Clinical Psychology has split between practice and research, which has resulted in an alienation of practical application from research findings. Psychodynamic psychotherapy particularly tends to direct exclusive attention to its own intra-psychic theory and aetiology, such that it does not consider evidence-based scientific thinking to have anything very helpful to contribute. As a result, Japanese Clinical Psychology has not paid much attention to psychological evidence and the findings of psychological research. In addition, unlike in the UK, the discipline has also been divided between training courses in universities and clinical practice in the community. Psychodynamic psychotherapy taught in university settings has tended to focus on the training of skills such as dream analysis, transference analysis, sand play techniques for the individual, and the delivery of intra-psychic psychotherapy in closed settings, and there have been few attempts to develop training systems in placements. In turn, practitioners in the field have tended not to trust training courses in the university be-

cause such individual and intra-psychic psychotherapies are not easily applied in the community.

Another conflict is with psychiatry. The Japanese Association of Psychiatrists has declared that it strongly objects to legitimatising the qualifications of clinical psychologists, as long as clinical psychology does not accept the condition of working only under the control of psychiatry. As a result, the activities of clinical psychologists are greatly limited not only in the medical setting but also in mental health fields. In effect the professional role of clinical psychologists has become confined to that of counsellors in the educational context.

Recently however the increasing need for clinical psychology services, and the growing awareness of the potential benefits of a briefer, evidence-based approach as seen in the West, has increased the interest of Japanese clinical psychology in developing CBT (Shimoyama, 2002). Hence there is an urgent need to consider how far CBT may be applicable outside the West and how it might require adaption for this different culture. Although cultural assumptions are not often questioned when working inside a particular culture, such questions become central when considering how applicable a treatment might be when transposed to another culture.

IV The importance of culture

When assessing the possibility of introducing a treatment developed in one cultural context into another, it is important to consider what is meant by “culture”. Haviland (1977), a cultural anthropologist, has defined culture as “...the abstract values, beliefs and perceptions of the world that lie behind people’s behaviour and which are reflected in their behaviour” (p.345); a definition that suggests that culture is itself a highly psychological phenomenon. A clear implication of this view is that if a therapist is going to try to understand a person’s behaviour, thoughts and feelings, the therapist will also need to understand that person’s culture. In

turn this also implies that psychological therapy, which inevitably addresses people's values, beliefs and perceptions, is bound to be affected by, and would need to be adapted to that culture. A useful notion here is that of "schema". Ulrich Neisser, a central figure in cognitive psychology, defines a schema (a key concept in CBT) as "a cognitive structure that represents knowledge about a concept or type of stimulus including its attributes and the relations among those attributes" (Neisser, 1967). If we want to understand someone, therefore, we need to understand their schemas, that is, how they understand the things and people (stimuli) around them, and how these stimuli relate to one another. By implication this suggests the importance of culture, since knowledge inevitably comes from inside a given culture, which again suggests the need for some form of cultural fit for any therapeutic approach. So in order to understand and therefore potentially help a person in therapy, a therapist will first need to understand their culture using culturally sensitive approaches. Fiske and Taylor (1991), as experimental social psychologists, also point out that cultural forces may influence the existence of emotionally toned schemas, structure and associated processes. If these are negative, they could contribute to the development of mood disorders, or related problems. For example, negative cultural schemas about the worth of older people in a youth-oriented society may play a significant role in the development of low self-esteem in individual elderly people, but may be protective in a culture where older people are venerated.

Given the importance of cultural considerations, this series of papers argues that simply using CBT as developed and delivered in the West is likely to be sub-optimal, and risks being either insensitive at best, or irrelevant at worst. This indeed was exactly what was seen in the rejection of CBT by the communities affected by the 2011 earthquake, as described above. To further emphasise this, in his seminal work on psychological

therapies across both cultures and time, Frank (1974) points to the centrality of shared but culturally specific features in how psychotherapy works, i.e., the presence of a culturally approved socially sanctioned healer working in a prestigious setting ; engagement of the "patient" in an emotionally arousing process or ritual ; provision by the healer of an explanatory framework which makes sense ; and provision of some success experience for the "patient". Frank suggests that all of the above features engage hope, and promote change in the sufferer, according to the local culture. This again clearly implies that effective psychotherapy needs to be solidly based within its host culture, in order to be meaningful to its practitioners and patients, and thereby to enable beneficial change to take place.

To conclude this first paper, we have argued that, because it is evidence-based and closely linked to research conducted by academic psychology as well as by clinical psychology, CBT or similar approaches may have much to offer those with mental health problems in Japan. It may also be the case that adopting these models could also have huge positive benefits for Japanese clinical psychology, increasing its influence, effectiveness and status. But even a preliminary look at how people's understanding of the world is intimately linked to which form of therapy may be meaningful for them, suggests that CBT must be adapted in order for this to be effective. The experience of the 2011 earthquake and tsunami survivors provides a clear example of this. The next paper in this series will discuss some of the key concepts in Japanese culture which present a challenge to CBT which is based on Western-centric views of the world, and will also discuss one indigenous form of Japanese psychotherapy, Morita therapy, which intriguingly might offer a possible link between West and East.

References

References of all three parts will be gathered and placed at the end of part three.