✣ 短期連載

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

Susan Llewelyn* and Haruhiko Shimoyama**

Part Two — Japanese Society and Culture : Implications for Mental Health

第２部要約

第２部では，まず西洋文化圏と非西洋文化圏では心理学的問題のあり方が異なっていることを，具体的な障害を例として説明する。そこでは，個人主義と集団主義といった文化の違いに注目することの意義が示される。次に，“いじめ”や“引きこもり”といった日本の特有な心理的問題を取り上げる。そして，そのような問題の背景にある日本文化の特徴を表す概念として，曖昧，沈黙，腹芸，（非）個人主義，恥，家族構造を取り上げ，それとの関連で西洋文化に基づく認知行動療法をそのまま導入することの難しさを論じる。さらに，日本の文化に根差した森田療法と，認知行動療法の最前線ともいえる ACT（Acceptance and Commitment Therapy）の類似について検討し，日本への認知行動療法導入の可能性を探る。

I Cultural difference and psychological problems

Most comparative psychiatrists and psychologists have suggested that the way in which personal distress presents itself is shaped by culture, and by the available structures that respond to that distress (Rathod & Kingdom, 2009). So for example Kirmayer (2001) has suggested that : “the clinical presentation of depression and anxiety is a function not only of patients’ ethno-cultural backgrounds, but of the structure of the healthcare system they find themselves in and the diagnostic categories and concepts they encounter in mass media and in dialogue with family, friends and clinicians” (Kirmayer, 2001, p.27). It may therefore be that what is known in the West as PTSD or depression, for example, are features of a Western culture, whereas in Japan, some states of melancholy, for example, are not considered illnesses

*Professor of Clinical Psychology, Oxford University, and Course Director / Oxford Doctoral Course in Clinical Psychology
**Professor of Clinical Psychology Course, Graduate School of Education, the University of Tokyo

: "Indeed, the experience of prolonged, deep sadness was often considered to be a Jibyo, a personal hardship that builds character" (Watters, 2008).

Further, different societies have different dominant assumptions about human relationships, for example Japan has a more collectivist culture than the USA or the UK. The culture's notion of the individuated self is important : in the West, concepts of the self tend to be organised around being distinct, whereas in non-Western cultures, they tend to be around belonging and being a useful member of a group. In the West, negative affect is linked to low self-esteem and negative self beliefs, whereas in non-Western cultures it is linked to not fitting in. Koenig (1997) notes that depression in the West is manifest through cognitive/motivational systems/despair/suicidal ideation, which is linked to the dominant cultural "self-way", i.e., characteristic ways of engaging in the social world : "a pattern that establishes or strengthens certain kinds of self-concepts" (Neisser, 1997, p.5), which guides what people notice, think about, find meaningful, decide to do etc. Experiences which are typically relevant here are how distinct individuals uniquely make judgements, think or attribute, and unsurprisingly, these are often the focus of Western (for example CBT) psychological treatment. Kitayama, Takagi and Matsumoto (1995) by contrast suggest that in Japan, individuals explain actions in terms of situational factors, and that actions are likely to be understood largely as a function of group membership. For instance, with respect to eating disorders, Cooper (2002) suggests that in Western cultures, causal attributions are that everyone should have a healthy weight and if they don't, they have only themselves to blame, but in non-Western cultures, being thin or fat is isn't seen as saying something about an individual, but is understood in relation to one's social context. As a consequence, in Japan distress may be expressed in terms of dysfunctional relationships with groups, or with the wider society, rather than as a result of faulty cognitions or internalised emotional conflicts.

II Psychological problems in Japan

The importance of seeing distress in relational terms can also be seen in the widespread problems of bullying and school refusal (Shimoyama, 2002). An individualistic therapeutic approach such as CBT which primarily addresses the individual thought processes of the distressed child, risks misunderstanding the underlying social nature of these problems in Japan. Perhaps because group membership is so important in childhood as elsewhere in Japanese society, the need for group cohesion and the processes of group identity formation is critical. It follows that it is probably of great value to the group, when seeking to establish itself, to exclude others in order to strengthen in-group identity (see the work on in-group identity formation and scape-goating by Taijfel, 1982). The process of creating outsiders is rewarding to the in-group ; hence bullying and excluding others is endemic, and may unfortunately be almost inevitable. Further, given the strengths of groups and their need to keep themselves boundaried, the bullied child may have nowhere else to go but home (which in Japan is traditionally supportive and indulgent via a process known as amae, see below) ; hence the child only feels safe at home and school refusal develops as a major social problem. It may also be culturally disloyal to the bullying group to report on this, so it is very hard for teachers or parents to detect and address. There are additional links culturally to the importance of silence, since besides conveying thoughtfulness, silence as a social virtue in Japan can also be a way of ignoring others, or excluding others further.

The problem of culturally valuing both silence and having respect for seniors, together with a fear of being an outsider, exists more widely in Japanese schools : children who are thoughtful and conscious of their own feelings, may stay silent until their emotions overflow and cannot easily be controlled. The result may be sudden unexpected violence towards the self or towards others. Again this may be linked to there being no refuge

to go, psychologically or practically, when bullied. If the family is absent or dysfunctional, the only option may appear to be self-harm or even suicide, which is a serious and growing problem amongst young people in Japan. Understanding these concepts, and those of shame (see below), may also help when trying to understand the problems presented by the probably uniquely Japanese phenomenon of hikikomori (Nakata, 2008 ; Ricci, 2010), whereby otherwise healthy individuals (often young men) withdraw into their own homes or bedrooms from any social contact whatsoever, and become dependent on their families just for food, delivered on trays, sometimes for many years or decades on end.

Japan is currently undergoing many rapid social changes as it develops into a more Western, less traditional society. This has brought many challenges including those for the mental health of its citizens : for example Ricci (2010) comments: "what is happening now is that the values, the meanings incorporated by people clash with the constant metamorphosis of a globalized social reality in which the rate of change often allows neither comprehension nor adaptation to the change itself " (p.27). Levels of depression, anxiety and suicide are increasing, particularly amongst children, and services are struggling to respond appropriately. There are also high levels of stigma surrounding mental health problems, and many issues are kept secret until families are no longer able to cope. This also means that many problems are well entrenched and reach chronic levels before they come to the attention of services.

Given its prevalence, success and influence in the West, it is perhaps unsurprising that, as noted in the first paper in this series, CBT is now being introduced into countries such as Japan, in order to improve the mental health of its citizens. We have previously argued that its utility will depend on how far it is able to adapt to the different understandings and complexities of the culture. We argue here that, despite the experience of those who tried to use exposure-based CBT with earthquake survivors in 2011, there is good potential for CBT to be able to address some of the mental health problems experienced in Japan, especially given the recent expansion of some CBT models to include more Eastern ideas, such as mindfulness (Williams, Teasdale, Segal & Kabat-Zinn, 2008) (this will be discussed below). No matter what form is applied, modifications will be needed, through paying increased attention to the need for sensitivity to cultural norms and cultural beliefs about causes of distress and the importance of the group ; by being aware of the difficulty Japanese patients may have in achieving a collaborative relationship with the therapist ; and by making a move beyond verbal reasoning about symptoms as being the central component of treatment. Hence we consider that, in order for Japanese people to gain from CBT, considerable adaptation will be needed too. Practitioners will need to be aware, for example, of many of the unspoken subtler forms of Japanese communication which may otherwise undermine the effectiveness of CBT. These are now described below in some detail.

III Significant features of Japanese culture and their implications for the practice of CBT

Drawing on the work by Davies and Ikeno (2002), as well as from descriptions from many other observers of Japanese society, there appear to be a number of features or concepts that characterise Japanese culture which may present challenges for the individualistic model or techniques often used in conventional CBT, as practiced in the West. All of these may affect how CBT is understood and will probably impact on its fit and utility. Hence practitioners of CBT in Japan may need to consider the implications of the following :

(i) **Aimai** : In Japanese interactions, many communications have more than one meaning. There is value in ambiguity and keeping things vague, which is seen as a virtue, since it helps Wa, or natural communication without words. This is helpful in a

close and crowded society where people need to feel they belong. Words carry a range of meanings, and people should not criticise or disagree with each other openly ; hence meaning should be negotiated and interpreted by the listener. In this sense, ambiguity has the quality of compromise, and being aware of each others' feelings, as if by instinct. The Japanese carefully weigh the atmosphere between them ; hence ambiguity is effectively a social lubricant. To express oneself clearly implies the other knows nothing, which would be impolite, just as to be definitive is to assert superiority. Even if they disagree the Japanese will wait their turn to speak and will listen with an air of agreement, and disagree in a roundabout way. This may present difficulties in CBT if the therapist is attempting to uncover how the client "really" thinks about a particular issue.

(ii) **Chinmoku** : Silence is seen as a virtue in Japanese communication, as a skill, linked to dominance of group consciousness. What is true will often exist in silence not words, since the inner is considered to be true, and the outer (words, expressions) false. This is probably linked to traditional ideas from Zen Buddhism. Silence is also linked to mastery. Further, it is conventionally considered rude for a subordinate to speak out to a person of higher rank. Silence indicates thoughtfulness and may indicate self-screening for anything that might cause hurt or offence to the other. Again this may be difficult for the practice of a brief verbal psychotherapy such as CBT, in which active discussion of different perspectives, and some disagreement is routine and expected. The position of the therapist as "expert" may further encourage passivity in the patient.

(iii) **Haragei** : This is a deliberately implicit way of communicating thoughts and feelings, (Hara means belly, which is assumed to be the seat of the soul, while gei means art, which involves reading other people's minds). For example a person may say "yes" hesitantly hoping that the other understands that one actually means "no". In communicating, the Japanese person needs to keep a balance between their true self and not wanting to hurt the other. Much of the information lies in the context or the people involved (Japan is a high context culture), not as much in what is said. Haragei means that you understand without or despite words. The use of implicit communication is clearly a challenge for an essentially verbal form of psychotherapy, although it may be possible for the therapist to use the limited context of therapy to explore otherwise challenging material.

(iv) **Individualism** : A common saying in Japan is "the nail that sticks out will be hammered down", also known as the "tall poppy syndrome". Japanese society strongly values group cohesion such that anyone who is very different or stands out from others may be rejected and punished. Hence the notion of discovering the "true self" in opposition to the group, does not have any effective meaning ; instead the client may be seeking more effective re-integration or more harmonious relationships with others. Much Western psychotherapy aims to facilitate the client to express their uniqueness, this is not seen as such a virtue in Japan, although low self confidence and not knowing what one "really" wants or who one "really" is, is a widespread difficulty.

(v) **Haji** : One key requirement in CBT and most western psychotherapies is to talk openly about hidden issues. Yet Haji or shame is central to Japanese culture (and may have developed as a mechanism for keeping control in a small tightly knit and crowded society). Besides being endemic, shame in Japan is said to be situational, topographic,

and describes keeping inner matters hidden and private, not being revealed. If the hidden is forceably revealed, this can lead to shame and may be catastrophic (see Kitayama, Takagi & Matsumoto, 1995). The therapist may need to avoid suddenly opening up what the client considers to be shameful issues, although this may be a key component of some forms of exposure treatment, as noted above

(vi) **Families and hierarchies** : Relationships in families and small group are complex, since in Japan, seniority rules are critical. Everything can be classified by vertical and horizontal hierarchies : hence a younger person (Kohai) must be respectful to Sempai : a senior person. This also applies to employees in companies, students in universities, children in secondary schools, men and women in marriage. (This is probably culturally linked to Confucianism, and the Shogunate, which stresses the virtue of loyalty Cho-ko, and filial piety.) The collaborative practice of CBT may present further challenges. According to Nippoda (2002), there are likely to be difficulties for the patient in being able to assert a clear sense of self or do anything to challenge the hierarchical relationship with the therapist as an expert. At the same time Japanese society is changing rapidly so it is not clear which approaches may fit best in which type of situation. There are obvious implications here for the practice of family therapy, or work related problems, where for example a challenge to existing structures which might be seen as helpful in a Western family or workplace, may be culturally inappropriate. There are also implications for the therapist-client relationship.

Understanding these features of Japanese culture is vital for the effective delivery of treatment, as shown by the difficulties experienced by those attempting to introduce the benefits of CBT to Japanese survivors following the earthquake and tsunami as described in Part One of this 3-part series. However, and on a very positive note, although a hallmark of CBT has been the attentive demonstration of the specific CBT related components of effective practice (for example Bennett-Levy et al., 2004) and its insistence on using scientific evidence, one of its other strengths has also been adaptability and willingness to take new ideas on board, and in fact to incorporate concepts whose origins seem highly disparate from the original cognitive or behavioural foundations. Hence CBT now incorporates many ideas which, it could be argued, are not traditionally seen as cognitive or scientific, such as Mindfulnesss (Kabat-Zinn, Segal, Williams & Teasdale, 2002) ; compassionate mind training (Gilbert & Procter, 2006) ; and solution-focussed psychology (Berg & deShazer, 1993). This adaptability has facilitated its spread and appeal to many practitioners and to the general public, and we will argue in the next paper of this series that this has considerable implications for its potential in Japan.

Indeed, despite the rejection by the survivors of the earthquake and by some japanese clinical psychologists, particularly those with strong existing commitments to other models, it seems likely that the potential flexibility of CBT would also make it particularly suitable for use in different cultures, such as Japan. Intriguingly, many ideas now emerging in CBT in fact have their roots in Eastern philosophies, and have been introduced often after influential CBT exponents from the West (for example John Teasdale and Mark Williams) have experimented with the applicability of non-Western ideas, particularly when faced with challenging clinical conditions, which existing forms of CBT have so far failed to resolve effectively (for example treatment-resistant depression and long term symptoms of psychosis). Such adaptability suggests that CBT (considered broadly) has good potential, once adapted, to apply widely, and especially in non-Western countries.

This paper now concludes by looking at one indig-

enous Japanese form of psychotherapy, Morita Therapy, which can be seen to parallel some aspects of some of the newly developed CBT therapies, for example Mindfulness (Williams, Teasdale, Segal & Kabat-Zinn, 2008) and Acceptance and Commitment Therapy (ACT) (Hayes, Strasahl & Wilson, 2003), and also elements of positive, or solution-focussed psychology (O'Conell, 1998). Interestingly, in some domains, CBT is actually moving towards Eastern ways not away from them.

IV Morita Therapy and ACT

Morita Therapy (see the outline by Ishiyama, 2003) is based in a theory of mental attachment, using concepts from Buddhism, such as the unhelpfulness of Toraware (mental attachment and blocked energy, cognitive rigidity) and the importance of developing Arugamama (experiencing "as is" and embracing reality, like in the image of the willow tree bending in the wind, or as in the skilful practice of the martial arts, or as in being able to breath freely). Hence the aim of therapy is to become uncomplicated. Having anxiety is not seen as a problem per se, but being worried about it is ; likewise the belief that certain emotions are unacceptable is also considered unhelpful. Treatment broadly involves reframing anxiety into constructive desires, happiness, meaning and accomplishments. The goal is to help clients to focus on life and choose actions in spite of anxiety and other inconvenient feelings, and to re-balance, mobilising clients' inner healing capacities and spontaneous interests.

Key Morita Therapy techniques are :

(i) Noting traps and vicious cycles, and dogmatic thinking, which leads to attempts to control and entrapment
(ii) Positive re-interpretation or reframing of symptoms (for example, reframing your anxiety as showing how much you want to do something, which means that anxiety should not therefore not be repressed)
(iii) Giving up anxiety elimination as a goal (acceptance) and instead developing gratitude (Buddhist influence)
(iv) Moving away from Toraware (entrapment with self and mental preoccupations) to Arugamama, intuitive acceptance of self and the situation
(v) Some clients have imaginary internal critical audiences ; instead clients need to focus on the needs of others and the community
(vi) Therapists may apply strategic inattention to symptoms (Fumon), and will instead stress the importance of being committed to actions, no matter how simple

There are very clear parallels with recently developed forms of CBT in the West, in particular Acceptance and Commitment Therapy (ACT) which has demonstrated its utility particularly with treatment resistant clients (see an account of ACT and a review of the evidence in Hayes, Luoma, Bond, Masuda & Lillis, 2006). The Six core principles of ACT (Hayes, Strasahl & Wilson, 2003) have clear similarity with those of Morita Therapy :

(i) Acceptance of self and owning, not fighting distress e.g. anxiety, symptoms
(ii) Encouraging cognitive diffusion, that is, seeing that thoughts are just thoughts that can be watched dispassionately, or repeated until they become meaningless sounds
(iii) Being in the present, such that language just describes, and does not judge
(iv) Seeing the self as existing in context through relationships, and changing as a flow of experiences
(v) Importance of values and using these as a basis for life
(vi) Central value of being committed to action

In terms of practice, both Morita Therapy and ACT

have implications for the behaviour of the counsellor/therapist as well as the patient, for example the importance of not reinforcing symptoms and hence being able to avoid providing iatrogenic reward for problem-saturated behaviours. The aim in ACT of being able to hold oneself apart from problems and to tolerate discomfort, and to value oneself through relationships, has clear echoes of Morita Therapy.

It is impossible to know whether ACT (which developed in the USA long after Morita Therapy or not had developed in Japan) actively drew on Morita Therapy, but the parallels are clear. As noted, ACT is now being used for a variety of people in the West with mental health problems, who have previously not responded well to treatment, and with people with intractable physical health problems. The development of ACT demonstrates that there is good potential for links between Western and Japanese approaches, and that the adaptive process is in fact already underway. In the next paper of this series, we will consider whether Morita Therapy offers an effective model for the introduction of CBT ideas in Japan, and what other cultural adaptations may be needed for the effective introduction of an intervention which is based on science, such as CBT. The need for further adaptation is therefore the subject of the final part of this series.

References

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