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

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Part Three — Adapting CBT for Japanese Culture

第３部要約

第３部では，第１部と第２部の議論を受け，日本の臨床心理学にエビデンスベイストアプローチおよび認知行動療法を適切に導入する方法について検討する。欧米の先進国から近代産業社会を積極的に導入してきた日本が，なぜ臨床心理学に限っては近代的な心理療法の導入に積極的ではなかったのかという疑問を出発点として考察を進める。伝統社会，近代社会，そしてポストモダン社会という文化の移行過程に心理療法の発展を位置づけ，日本における伝統的深層文化と近代的産業社会との二重性に由来する葛藤に注目する。そして，明治時代以降，その二重性の葛藤を抱えてしまった日本人の意識の発展史の観点から森田療法の意義を明らかにするとともに，森田療法と新世代の認知行動療法の異同を手掛かりとして日本における認知行動療法の適切な発展の道筋を示唆する。

I Considerations on how best to introduce CBT into Japanese society

The first two parts of this series of papers have argued that introducing a Western evidence- based therapy like Cognitive Behaviour Therapy (CBT) might well be useful for Japan and for Japanese clinical psychology, but that CBT needs some adaptations for such an initiative to be truly effective. This final paper opens with consideration of some underpinning professional, cultural and historical issues, followed by a brief examination of whether Morita Therapy can suggest a way forward in adapting CBT for Japan. The paper concludes with some proposals regarding the development and adaptation of CBT techniques which may be needed to fit better within the Japanese context, and which could be of benefit

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both to people in Japan with mental health needs, and to the profession of Japanese clinical psychology.

II Possible professional reasons for the limited impact of CBT within Japan

In recent years it has become very clear that although some CBT-based practices have been introduced to a limited extent into Japanese Clinical Psychology (Shimoyama, 2011), evidence-based practice has not yet really flourished or become naturalized in Japan. In addition to the cultural issues described in the two earlier parts of this series (and also discussed below), there are three key professional reasons why this may be the case. First, clinical psychology in Japan (which might otherwise have been responsible for introducing CBT) has unfortunately not yet been officially recognised as a mental health profession, and therefore has had comparatively little influence in agreeing its terrain and implementing its own standards. Second, the profession is still suffering from identity confusion within the discipline, being involved in numerous interdisciplinary conflicts. This is mainly because there is disagreement about precisely what clinical psychology, psychotherapy and counselling each mean or could do in Japan, leading to many of the problems regarding both internal integration and in gaining recognition outside. By contrast, British Clinical Psychology has already established its distinction and consistency as a discipline and profession, defining the discipline in terms of (a) the basic science of psychology and (b) its application to the understanding and resolution of human distress. The dominant underlying model underpinning British Clinical Psychology is, first and foremost, that of the "scientist-practitioner" (Hall & Llewelyn, 2006), whilst Japanese Clinical Psychology contains a number of ambiguous overlaps between clinical psychology, psychotherapy and counselling, and cannot even define itself as a discipline. This ambiguity means that Japanese Clinical Psychology has unfortunately been subject to theory-based sectionalism, and since each branch of psychotherapy tends to adhere to its own theory, it is almost inevitable that clinical psychology, led by a group of disparate and disagreeing psychotherapists, finds it almost impossible to progress beyond sectionalism towards integration.

The third key difficulty is a split between theoretical teaching and clinical practice. Psychodynamic (especially Jungian) theory has maintained its influence so strongly that, for many influential psychologists, purely intra-psychic psychotherapy remains the ideal model in teaching and clinical practice. However, this ideal, intra-psychic model is actually so complex and specialized that most clinical psychologists in practice are unable to master it competently. In addition, since many of the problems that clinical psychologists are now expected to deal with are concerned with social behaviours in daily life (such as school refusal and bullying), such kinds of intensive psychotherapy are of limited immediate practical use. As a result, leaders of the profession set high standards and propose complex treatment methods that are familiar to psychodynamic (analytical) psychotherapists, whilst the larger body of psychologists, who are not fully qualified to practice in this way, function in effect as counsellors. Consequently there are very few Japanese clinical psychologists who could be called clinical psychologists as described by the British definition, and links with academic psychology and evidence-based practice are regrettably weak. Perhaps not surprisingly this sectionalism and split between practice and evidence has hampered Japanese Clinical Psychology in accepting or promoting CBT as an important or unifying approach, despite the evidence of the significant contribution that it has made elsewhere (and could potentially make in Japan) to the reduction of mental health distress.

III Possible cultural reasons for the limited impact of CBT within Japan

As already discussed in the first two parts of this series, there are also a number of cultural and historical reasons

Table 1 Brief Cultural History (adapted from McLeod, 1997 by Shimoyama)

Traditional	Modern	Post-modern
Collective way of life	Individualistic way of life	Contextual way of life
(Localized community)	(National state)	(Global village)
Self defined in terms of external factors	Bounded self controlled by himself or herself	Relational self saturated with given information
Belief in religion and myth	Belief in science	Belief that knowledge is socially constructed
Agricultural work	Industrial work	Information-processing work

for the slow acceptance in Japan of evidence-based therapeutic practice such as CBT. As noted in part 1, this has been most obviously demonstrated in the recent attempts to help victims of the earthquake disaster. Although CBT, especially Exposure, has been widely reported as an effective intervention for traumatized people, Japanese survivors have largely rejected CBT, and instead tried to accept the tragedy collectively. Personal therapeutic exposure to traumatic events was seen as intrusive not only to individuals but also to the community. Why might this have occurred and what is the place of psychotherapeutic help in such a cultural context?

IV Evolution and development of psychotherapy in cultural history

To answer these questions, it is necessary to understand the wider Japanese context, and in particular the history of psychotherapy from a cultural viewpoint. To start, we need to consider the development of psychotherapy as a social response to mental distress, understood in terms of cultural history (see Table 1 for a brief outline of cultural history, adapted from McLeod, 1997). From a historical and functional perspective, psychotherapy can be seen to have evolved as a response to the needs of people and cultures to complete the transition from traditional society to modern society, and as a way of reducing distress experienced by individuals resulting from the many challenges of modern life. More precisely, the transition has been from a religious to a scientific framework of thinking, and from a collective way of life to an individualistic, un-connected self. Different forms of psychotherapy have evolved all over the developed world in response to the need for rapid social transition, whereby people in distress are enabled to manage that distress by using techniques that make some cultural sense to them and to their existing society. In this respect, psychoanalysis was an early manifestation of psychotherapy, being essentially a compromise between religion (belief) and science, evolving at the end of the 18th century in Europe. Given its reliance on belief and the irrational or unconscious, rather than on scientific evidence and individual cognition, it is perhaps not surprising that its influence in modern times has diminished in many Western countries. By contrast, CBT represents a more recent device, providing a scientific framework for understanding the rational and individualistic self, which are both vital elements of modern society. It is therefore probably understandable that CBT should nowadays play a more important role than psychoanalysis in the development of clinical psychology today, in most parts of the developed world.

This formulation can also shed light on the current confusing situation of Japanese Clinical Psychology. Within most Western countries which have evolved comparatively regularly and incrementally, and where political, social and religious systems and beliefs have adapted and co-exist in relative harmony, CBT fits in quite well and provides compatible assistance for those

people who need some help to adapt to the demands of modern times. However, this is not the case in Japan. Psychoanalysis and in particular Jungian ideas (a pre-scientific approach) still dominate and thrive, rather than CBT. This suggests that psychoanalysis and Jungian therapy are currently functioning to facilitate the social transition between religion and science, whereas CBT, as a more modern technique which aims to provide a scientific framework and works with the individualistic self, has not as yet become culturally embedded or personally acceptable. In other words, current forms of CBT appear not to successfully help patients in the process of integration and transition in modern Japanese life, at least in part for cultural reasons.

This view also suggests that the difficulties faced by CBT in gaining acceptance in Japan is closely related to complicated attitudes toward science and modernization. Shimoyama (2011) suggests that a critical role is played by the contrast between Japanese people's general attitudes to science and modernity on one hand, and their personal attitudes on the other, which have been shaped by culture and history, and which are reflected in the ambivalence that many Japanese people (including clinical psychologists themselves) feel towards an approach such as CBT. Within almost all social, industrial and economic domains, Japan has relatively recently and very successfully imported and developed science-based techniques and other Western ideas or products, such that Japan has rapidly become one of the leading economies of the world. Since the Meiji Restoration, which started at 1868, the Japanese government commenced the modernization of Japanese society by importing a selection of Western ideas, concepts, approaches and technologies, such as industrialization and the applications of scientific research. After the defeat of the Second World War, key aspects of American culture such as democracy and individualism were also introduced. As a result Japanese society seems very rapidly to have been highly modernized and industrialized along Western lines. Especially in cities such as Tokyo, people live in a modern hyper-industrialized society surrounded by numerous modern high-tech devices and processes, affecting all aspects of their everyday lives.

Importantly however Japanese people are also regulated psychologically and socially by traditional social and religious customs which have not evolved in the same way. People simultaneously lead a traditional, interpersonally attuned way of life which emphasises the collective, as well as the modern way of life, which often prioritizes the individualistic self. Traditional culture still lingers on and influences Japanese people psychologically, so that any therapy that aims to address psychological problems, must work with this psychological reality, which is essentially pre-scientific and collectivist. Although the Meiji Restoration led to the import of a number of modern social systems from the West, the government also restored a traditional monarchy and provided support for traditional religions. So in Japan it is not the case that a traditional society quickly and straightforwardly evolved into a modern society. Instead, traditional culture and modern social systems were set up to co-exist. Since modern social systems were in effect artificially and rapidly grafted onto traditional communities during the Meiji era, and that these are essentially contradictory traditional systems, it is probably inevitable that people struggle over how to achieve psychological integration between modern individualistic ways of thinking, and their traditional collectivist culture.

These contradictions may be able to help explain why, in contrast to so many other fields of endeavor, Japanese clinical psychology has not warmly embraced the modern ideas of science, and evidence-based practice, including CBT. Japan has not simply followed the cultural transition path shown in Table1, because Japan did not evolve smoothly and gradually from a traditional society

into a modern society. Instead, these two types of societies can be seen to overlap, and co-exist simultaneously as mutually contradictory layers.

V An alternative: Morita therapy

It was in the climate of the Meiji Restoration that Morita therapy emerged, as an early Japanese form of psychotherapy. Masatake Morita, the founder of Morita therapy, suffered neurosis with symptoms of excessive self-consciousness, which can be understood as deriving from the contradictory situation outlined above, during the Meiji Era. While in the process of curing himself of this neurosis, Morita realized that inappropriate cognitive efforts to control self by Ego actually brought about neuroses such OCD and Panic disorder. On the basis of this insight, he developed Morita Therapy, which can be understood not as a psychotherapy developed to aid the transition from traditional culture to modern society, like psychoanalysis or CBT, but instead as a therapy designed to balance the contradiction between traditional cultures and modern society, and to resolve the contradiction between the collective way of life and the individualistic self. From this viewpoint, Morita therapy can be said to be an appropriate, locally derived device to balance the particularly Japanese current contradiction between traditional society and modern society, or between the co-existing collective self and the individualistic self. Later in this paper we will return to this indigenous therapy to see what can be learned from it, as a possible link to CBT.

VI Addressing cultural and professional reasons for the limited impact of CBT within Japan

The behaviour of Japanese people in the disaster-stricken areas following the 2011 earthquake and tsunami can perhaps offer a clue as to why Japanese Clinical psychology is as yet apparently un-modernized. The disaster, which hit so suddenly and so dramatically, effectively removed the surface layer of social systems and revealed the underling structure of people's lives and their core beliefs, making the local, personal culture tangible. What was described in earlier sections of this three-part series with reference to reticence, Haji and shame, was starkly evident amongst the earthquake survivors: they did not overtly express their feelings such as anxiety and depression, but instead manifested various symptoms of somatoform disorder, together with stoicism, respect for others and patience. Symptoms of PTSD were not articulated by either adults or children, especially to the mental health professionals who came from outside of their areas. Despite the magnitude of this traumatic situation, there seemed to be an awareness that if the hidden was forcibly revealed (including the expression of trauma), this could lead to overwhelming shame, and could be catastrophic. Hence there was a refusal to engage with the type of therapies offered by well-meaning Western therapists, who could only point to evidence that their approaches had been helpful elsewhere, but who were not welcomed or even invited in to help, despite the evident need.

This response to the disaster thereby also revealed the underling traditional culture of Japan. Historically people in Japan have lived in wooden houses that were easily burnt down, and have also experienced frequent natural disasters caused by volcanoes, natural explosions, earthquakes, and tsunami, which have the capacity to destroy everything instantly. These experiences have contributed significantly to both Japanese culture and to its collective society. Indeed some senses of beauty in Japanese culture are related to this kind of inevitable process of losing and changing. In the earthquake-hit areas, once the modern way of life (which had been the unquestioned assumption of most people's daily lives) was broken or damaged, the survivors quickly drew upon their cultural recognition that compassion and collaboration in family and in community were really the most essential aspects of life. Suddenly aware that all things are mutable and that individuals are helpless in the face of powerful natural

forces, these Japanese people relied on religion and social cohesion for survival. Such traditional collective ways of life and values seemed indispensable in the fragile communities, and scientific ideas such as those proposed by CBT made no sense.

What also appears to underlie this situation is that the concept of self may well be significantly different between Western culture and Japanese culture. Self-control and self-regulation as an individual are not so important in Japan as in Western countries. Self is always understood in context and as a part of social relationships. In other words, "self" in Japan, as the Japanese call it, is not "self" in a Western sense. Encouraging development of aspects of the Western, more individuated self (for example by asking someone to express or pursue their own feelings and ambitions), might well be threatening for the Japanese self in terms of undermining that person's harmony within his or her social context. Instead, achieving a reconciliation of self with others is often how Japanese people become more comfortable with themselves. It is a contradiction, but true to the Japanese, that giving up self leads to gaining self.

Japanese clinical psychologists, who attempt to help individuals psychologically with their mental health problems, may therefore find that the people that they try to help are unwilling or unable to engage with the methods and approaches that evidence-based practice suggests ought to work. Given this, most Japanese clinical psychologists (who of course also share similar understandings of "self" with their patients) will understandably choose to depend on what makes sense to them culturally, not what science from another culture tells them "ought" to work. This is perhaps why psychoanalysis, which was a compromise between the traditional society and modern society, lingers on in Japan. So Japanese clinical psychologists find themselves unable to make use of the benefits of scientific research and approaches such as CBT, and in addition also feel alienated from and rejected by academic, scientific psychology for their "failure" to do so. They may also find themselves enmeshed in sectional debates about the discipline (where more culturally-attuned approaches such as Jungian therapies are dominant) and are therefore unable to contribute as effectively to meeting large-scale social need as they might be, if only they could find a way of using CBT techniques more appropriately.

VII What about the future of CBT in Japan?

Evidence from empirical studies of psychotherapy suggests that therapies like CBT can have a significant role in supporting people in transition from traditional society to modern, science-based society (as it has in Europe and the USA for example). So does this also mean that Japanese Clinical Psychology is underdeveloped and should immediately accept the ideas and practices of CBT in order to grow into a modern evidence-based profession? Alternatively, should Japanese Clinical Psychology have confidence in its own culturally evolved approaches such as Morita therapy? Or is there another path here, which is to broaden and develop CBT, so that it is also appropriate for the next stage of cultural evolution, by becoming a therapy suitable for the post-modern age, whilst also being sensitive to the particular cultural contradictions in Japan?

Interestingly there are already signs that this is happening in CBT anyway. Mindfulness cognitive therapy (Williams et al., 2008 ; and Acceptance and Commitment Therapy (ACT), Hayes, Strasahl & Wilson, 2003), which are increasingly at the forefront of the CBT movement, in fact have many elements in common with Morita therapy, which emerged in Japan in 1919, a long time before CBT had been developed in the West. This was shown in Part 2 of this 3-part series of papers. Because the individualistic self of the modern society and the relational self of the post-modern society are also contradictory, it is perhaps predictable that CBT has recently added in ideas such as Mindfulness-based cognitive therapy and ACT in

order to start to manage the contradiction. So it could be argued that Japanese Clinical Psychology, far from being underdeveloped, has in fact been responding creatively to the unique process of Japanese cultural history.

The final part of this series now addresses these complex issues in terms of cultural difference and history, and discusses how CBT might be further developed and implemented in non-Western cultures like Japan where individualism and self-regulation are not central. The question becomes: how such a therapy might support the transition from modern society to the post-modern society, where the relational self is at the centre.

VIII How might evidence-based practice such as CBT be modified effectively in Japan?

Within Japanese society, Japanese people live in group contexts, and rarely express their "selves" even when they may have some inner difference of views or experience. This was evidently true in the case of the aftermath of the earthquake and tsunami, but also occurs in other more domestic situations such as marital or family discord. So how should Japanese Clinical psychology best help people to adapt to the contradictions of modern Japanese society? We have argued above that Japanese society is highly modernized in commercial, industrial and academic spheres, but that traditional culture and values are still effective and powerful both interpersonally and psychologically. This kind of multiplex modernization is actually quite common amongst non-Western countries, although Japan is an outstanding example, given the extreme rapidity of its development since the Meiji restoration, and its enormous successes industrially and commercially. Since Japanese clinical psychologists are inevitably working with aspects of traditional culture in terms of people's psychology, as we have shown above it has been difficult for them to make effective use of the practices of CBT and hence to make use of the benefits of a science-based approach.

It is of course also important to ask whether it would be better, in terms of cultural fit and self-confidence, for Japanese Clinical psychology not to make efforts to introduce CBT as a main approach, but instead to emphasize a Japanese model such as Morita Therapy, which has many features in common with recently developed forms of CBT, such as mindfulness-based cognitive therapy, and ACT. Given the tough realities that many Japanese people have to face, and the need to develop a sense of self through integration, perhaps Morita Therapy could be a mediator to introduce CBT appropriately in Japan, since it makes use of traditional values and practices including meditation and acceptance. But unfortunately Morita Therapy is not particularly influential in clinical psychology or psychiatry either. Its practice is largely limited to a group of the Jikei University School of Medicine, where its author, Masatake Morita, used to be a professor. Indeed many Japanese, who perceive themselves to be modern, now consider Morita Therapy and other aspects of their traditional heritage to be obsolete, especially as many of them try to lead a contemporary way of life. Yet as we have seen in the reactions to the earthquake and tsunami, this modernity is underpinned by traditional sets of values, of which people may not be fully aware. These underpinning sets of beliefs in effect underpin and regulate aspects of their behaviour. Responses to bullying, and the phenomenon of Hikikomori (mentioned in the second paper of this series) are also associated with these contradictions. Japanese modern society requires individualism of its members, but many people have been brought up in traditional ways and their behaviour reflects this, especially when under stress. Young people who are bulled by others by being excluded, or older people who find it difficult to succeed in modern industrial society, easily withdraw into a family group and stop communicating with the outside world, or in the end may turn to suicide, rather than confronting the situation that is causing the difficulties, or seeking external help.

Therefore, even if they do not think Morita therapy

or other indigenous approaches are appropriate, clinical psychologists in Japan might helpfully take into consideration the contradiction between collectivism and individualism, in order to make effective use of CBT or other evidence-based Western therapies. If therapists simply apply unmodified CBT to Japanese people without being aware of the complexity of the self in Japanese society, this risks disregarding traditional and deep-seated aspects of Japanese psychology, and may result in their patients rejecting CBT, as happened after the earthquakes. Many Japanese people are inclined to avoid confronting challenging realities, and it also is rather difficult for them to monitor themselves, which is normally relatively unproblematic for Westerners. If therapists wish to carry out CBT effectively, they must therefore pay attention to people's hidden, traditional behaviours, values and assumptions, and take close note of the Japanese orientation towards the group context, by taking into account the patient's related self, and underpinning beliefs. Only then can therapists understand and respond effectively to contradictory attitudes and behaviours, and modify treatment approaches as needed.

Further, Japanese therapists are often expected by their patients to settle these contradictions in practice, for example by co-ordinating the patient's relationships with others, particularly within the family, while simultaneously fostering the patient's sense of self. It is often necessary to listen to the client's self-narrative empathetically to nurture his or her self or desire to live through the contradictions, while at the same time liaising with family and friends. Only then can therapies such as CBT can be applied effectively to this newly fostered self, in the context of supporting or moderating existing social relationships.

IX Suggested modifications for CBT for application in Japan

The following specific points represent further examples of possible ways for CBT-oriented therapists in Japan to adapt Western-based CBT, in order to increase its utility in Japan:

1. Given the reticence of Japanese children to speak to adults and express their own ideas, it may be important for the CBT therapist to take a more directive approach than normal in the West, suggesting a choice of possible responses to children in therapy (Matsumaru, 2010, personal communication), and helping them to articulate their views.
2. The therapist may wish to pay special attention to reducing shame and increasing compassion for the self. One way of accessing and reducing shame may be to consider the language that people use when addressing themselves, and to encourage more tolerant, respectful language towards the self (see for example Gilbert & Procter, 2006).
3. The need for cultural sensitivity and adaptation is particularly acute when working within systems and families. For example, Tamura and Lau (1992) suggest that "therapists should note that the preferred direction of change for Japanese families in therapy, is toward a process of integration — how a person can be effectively integrated into the given system - rather than a process of differentiation. An authoritative therapist style, the use of individual sessions, silence, and other nonverbal techniques are relevant to bringing about the desired change toward better integration of the individual with his or her networks." (p.319).
4. Given Japanese concern for supporting others, often at the cost of self, CBT therapists may be able to explore how increasing self-efficacy is also a way of facilitating the welfare of others.
5. Introducing aspects of solution-focussed therapy (for example O'Connell, 1998), with its emphasis on finding positive ways forward, may allow therapists to focus on future goals, and not on past failure or shame which may be debilitating and

counterproductive.

6. Some interest has also been expressed in Japan for integrative ideas, such as Cognitive Analytic Therapy (CAT) (Ryle & Kerr, 2002) which may have the potential to combine the psychodynamic tradition prevalent in Japan, with more recently introduced behavioural/cognitive methods. The diologic underpinnings of CAT fit well with the more social, interpersonal focus of the culture.
7. The therapist may try to encourage acceptance and gratitude rather than to focus on symptom relief or externalising symptoms (as in ACT).
8. Therapists may also need to consider adjusting the language used in therapy, given that formal speech and the use of honorifics (which may traditionally be used in the psychologist's presence) usually reflect the desire to raise the other's standing and lower one's own, as well as to express views that are socially acceptable. This is difficult if the aim of the therapist is to uncover conventionally unacceptable emotion. It may be that an agreement on using less formal forms of speech may be helpful (Ryan, 2011, personal communication)
9. Given that Japan is a situation-based culture, it may be possible to effectively separate out the psychological consultation, as a "special place" where normal rules do not apply, and where difficult and challenging views can safely be expressed. Japanese people are also able to be much more open that Western people about some topics, for example sexuality, and this openness of discussion could be extended to consider aspects of the self.

Undoubtedly there are many other ways of developing CBT to fit more appropriately within a Japanese culture, and this should be a key task for clinical researchers and practitioners, as CBT is progressively introduced and included in the training of Japanese clinical psychologists (and other professionals). Training and academic staff in clinical psychology have a significant role here, to ensure that developments in practice are closely linked to the evidence base, through research and theoretical investigation. It is crucial however that the research undertaken is based closely in clinical reality, and pays close attention to the issues described in this paper, so that any therapeutic developments are in tune with what makes sense to Japanese people.

X Conclusion

To conclude this series of three papers, the developing practice of CBT in Japan is to be welcomed since CBT is based on a good evidence base, has an impressive record of adaptability, and in recent years has shown increasing sensitivity to concepts that are familiar to the Japanese. Unlike the currently dominant psychodynamic and counselling practice in Japan, it also places clinical psychology practice within the sphere of academic psychology, from which it is most helpfully derived, and from which it can draw sustenance and theoretical inspiration. Nonetheless there are aspects of the culture which mean that CBT, as conventionally practised in the West, does not sit easily within existing traditions of thought in Japan. Some adaptation is needed which will allow the development of a more sensitive and culturally effective form of CBT which is meaningful for practitioners and clients alike. There is a danger that CBT will promise to be all things to all people: a linked problem may be that terminology becomes confusing and theory becomes over-complex (Mansell, 2008). But modified CBT has considerable potential to reduce distress and dysfunction, and therefore offers itself as a helpful and important resource to both the clinical population, and to clinical psychology as a profession in Japan.

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