Kokoro no Kenko: Understanding Mental Health Beliefs from a Culturally Grounded Perspective Using a Mixed-Methods Approach in Japan and Canada

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ABSTRACT

***Kokoro no Kenko*: Understanding Mental Health Beliefs from a Culturally Grounded Perspective Using a Mixed-Methods Approach in Japan and Canada**

Momoka Watanabe, Ph.D.
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Culture plays a crucial role in shaping how people perceive, interpret, and navigate psychological suffering. This dissertation examines cultural variations in mental health beliefs within Japan and Canada, utilizing two mixed-methods research designs. The overarching objective is to engage in interdisciplinary and culturally grounded research practices, driven by the need to address the lack of diversity, inclusion, and global perspectives in psychological science, commonly referred to as the "WEIRD" problem. These research practices entail critically reflecting on the generalizability of Western biomedical models, conducting literature reviews in Japanese, and fostering collaborations with Japanese researchers.

Manuscript 1 examines the differences in causal and help-seeking beliefs about mental illnesses between Japanese and Euro-Canadian students. In this study, content analysis revealed themes related to social-contextualization and unique cultural perspectives, such as filial piety and resting. Statistical analysis showed group differences in the endorsement of explanatory models across various conditions, including depression, autism spectrum disorder, schizophrenia, alcohol use disorder, and hikikomori. Overall, Japanese students tended to psychologize and recommend social support, whereas Euro-Canadian students tended to medicalize and recommend medication and self-care.

Manuscripts 2 and 3 apply cultural consensus theory to explore shared beliefs about mental health, depression, and therapeutic alliance among Japanese clinical psychologists. Using a two-phase sequential mixed-methods design, cultural domain analysis identified salient terms reflecting mental health issues and changes in licensure within Japan's socio-cultural and historical context. Cultural consensus analysis demonstrated shared models for most domains, with exceptions in for beliefs about an incompetent clinician, a difficult client, and external barriers.

This dissertation makes a valuable contribution by exploring culturally distinctive mental

health beliefs and advocating for the benefits of mixed-methods approaches. It addresses the limitations of the contemporary psychological literature, which predominantly relies on theories, sampling, and methods prevalent in Western (i.e., "WEIRD") contexts. These studies are proposed as an initial stride towards developing culturally grounded models for clinical assessment and care, catering to the needs of people from non-Western cultural backgrounds. The findings carry important implications for mental health research, policy, community care, practice, and education, especially in multicultural contexts.

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I am extremely grateful to Sasaki-sensei for enabling my data collection, analysis, and a deeper understanding of the Japanese community, even while I was physically away from Japan. Your mentorship, patience, and kindness throughout the process have been invaluable. I would also like to express my deep appreciation to the members and alumni of Sasaki-sensei's lab, including Seiji Muranaka, Nanami Suzuki, and Akane Nishimura, for their tremendous support in my projects. Additionally, I would like to extend a special thanks to Sakamoto-sensei from Nihon University and Mizuki Horiuchi for assisting me with the data collection and analysis. Without Sonora Kogo, none of my studies would have been accomplished. Your sharp insights, dedication, and commitment have been invaluable to me. I cannot thank you enough for your work in every single study I conducted during my graduate studies.

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DEDICATION

In loving memory of my dear late grandfather, your love for gardening symbolized perseverance, growth, and opportunities. As I hold the seeds you once planted, I carry the values you instilled in me. I am determined to pass on the seeds of hope, equality, and empowerment, to my beloved baby niece Haru, so they may take root and flourish for a brighter future. To those battling mental illness and dedicated mental health professionals, may this work sow seeds of light, understanding, and resilience.

CONTRIBUTION OF AUTHORS

This dissertation consists of three manuscripts that were jointly conceptualized and developed by Momoka Watanabe (Sunohara), Dr. Andrew Ryder, and Dr. Jun Sasaki. The development of materials, such as surveys, interview protocols, and recruitment procedures, as well as the data collections and analyses, were conducted by Momoka Watanabe with the help of several research assistants and research collaborators; the process was supervised by Dr. Andrew Ryder and Dr. Jun Sasaki.

The three manuscripts as well as contributions of authors according to the Contributor Role Taxonomy (CRediT) are as follows:

Manuscript 1 (CHAPTER 2; consisting of one study)

Sunohara, M., Sasaki, J., Kogo, S., Yamaguchi, S., Muranaka, S., Sakamoto, S., Thériault, A. M., Horiguchi, M., Suzuki, M., & Ryder, A. G. (under review). A cross-cultural comparison of beliefs about mental illness: A mixed-methods study of explanatory models among Japanese and Euro-Canadian students.

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M.S.: Conceptualization; Funding Acquisition; Project Administration; Resources; Investigation; Methodology; Data Curation; Formal Analysis; Visualization; Writing –Original Draft Preparation; Writing – Review & Editing

J.S.: Conceptualization; Supervision; Resources; Investigation; Methodology; Data Curation; Writing – Review & Editing

S.K.: Conceptualization; Resources; Investigation; Methodology; Data Curation; Formal Analysis; Writing – Review & Editing

S.Y.: Conceptualization; Resources; Investigation; Methodology; Data Curation; Formal Analysis; Writing – Review & Editing

S.M.: Conceptualization; Formal Analysis; Writing – Review & Editing

S.S.: Investigation; Data Curation; Writing – Review & Editing

A.M.T.: Data Curation; Formal Analysis

M.H: Data Curation; Formal Analysis; Writing – Review & Editing

N.S.: Data Curation; Formal Analysis
A.G.R.: Conceptualization; Supervision; Writing – Review & Editing

Manuscript 2 (CHAPTER 3; consisting of two studies)

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M.S.: Conceptualization; Funding Acquisition; Project Administration; Resources; Investigation; Methodology; Data Curation; Formal Analysis; Visualization; Writing –Original Draft Preparation; Writing – Review & Editing
J.S.: Conceptualization; Supervision; Resources; Investigation; Methodology; Writing – Review & Editing
S.K.: Conceptualization; Funding Acquisition; Resources; Investigation; Methodology; Data Curation; Formal Analysis; Writing – Review & Editing
A.N.: Data curation; Writing – Review & Editing
A.G.R.: Conceptualization; Supervision; Writing – Review & Editing

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CHAPTER 1: GENERAL INTRODUCTION

The ways in which people explain, experience, and adapt to mental illness are intricately intertwined with their sociocultural worldviews. However, the existing discourse and psychological research on mental health have predominantly originated from the Western perspectives of biomedically-oriented experts, employing quantitative measures developed within these specific cultural contexts. Consequently, non-Western or non-expert models of mental health have been largely overlooked and undervalued in the literature (Kirmayer, 2006; Kleinman, 1980). Previous studies in anthropology, sociology, and history have consistently emphasized the diverse cultural differences in causal beliefs, socio-moral implications, and healing practices pertaining to mental health (Kleinman 1986, 1995, 1999). These insights challenge the notion of Western biomedical model as the standard, underscoring the need to recognize and explore the diverse cultural landscapes of mental health.

This dissertation aims to explore beliefs about mental health through a cultural lens, utilizing a mixed-methods approach to explore the specific beliefs held by different cultural groups and communities. The three manuscripts examined mental health beliefs between Japanese and Euro-Canadian university students and explored the consensus beliefs among Japanese clinical psychologists. Moreover, this dissertation strives to synthesize theoretical perspectives, empirical research findings, and multifaceted insights from social, political, and historical contexts of Japan. I conducted a literature review in the Japanese language, delving into a wide range of scholarly sources that are all but unknown to the English-language scholarly community. Furthermore, this dissertation aimed to actively embrace research practices that fostered diversity, inclusion, and global perspectives by establishing cross-cultural collaborations with Japanese researchers, thereby addressing the "WEIRD" problem.

In Chapter 1, I will first discuss the lack of diversity and inherent biases in theory development, sampling, and methodology within psychological science, a pressing problem commonly referred to as the "WEIRD" problem. Then, I will discuss the relevance of mixed-methods to psychology, especially to the cultural-clinical psychology theoretical framework guiding this dissertation. I will conclude with a review of relevant literature on mental health beliefs in the Japanese cultural context.

In Chapter 2 (Manuscript 1), I will present the results of my investigation of cross-cultural

differences in causal and help-seeking beliefs about psychological disorders between Japanese and Euro-Canadian university students by conducting culturally grounded content analysis. In Chapter 3 (Manuscript 2), I will present an application of cultural consensus theory to investigate the presence of consensus beliefs about mental health among Japanese clinical psychologists, particularly their beliefs about the sources of mental health beliefs of the public and changes need to promote better mental healthcare system in Japan. In Chapter 4 (Manuscript 3), building upon Chapter 4, I will explore consensus beliefs about depression and therapeutic alliance among Japanese clinical psychologists. Finally, in Chapter 5, I will present a general discussion of the results from the three manuscripts, describing limitations and potential avenues for future studies.

1.1 Psychology's WEIRD Problem

Is your research 'WEIRD'? Every psychologist should be proactively asking themselves this question when conceiving their research, from the literature review to who they study to the origins of the theories on which we rely. Psychological science is overwhelmingly WEIRD—*Western*, *Educated*, *Industrialized*, *Rich*, and *Democratic* (Henrich et al., 2010). In their comprehensive review of studies published in the psychological science between 2003 and 2007, the researchers reported a long overdue realization that 96% of study participants were sampled from WEIRD cultural contexts, whereas the WEIRD population comprises a mere 12% of the global population (Arnett, 2008; Henrich et al., 2010). The United States alone provided almost 70% of these participants. Furthermore, the majority of the North American samples are undergraduate students, who are disproportionally middle class and White (e.g., Arnett, 2008; Graham, 1970; Sears, 1986).

A decade later, the WEIRD sampling problem has not changed much (e.g., Apicella et al., 2020; Henrich, 2020; Rad et al., 2018). Researchers analyzed papers published in the last three issues of *Psychological Science* in 2017 and found that more than 70% of the studies relied on samples from Western countries, fewer than 7% of the samples were drawn from East Asia, and not a single study included participants from Africa, the Middle East, or Latin America (Rad et al., 2018). The authors further noted that the most disturbing result of their analysis was the lack of sample descriptions in these studies. Only 10% of abstracts mentioned sample characteristics, 20% addressed sample context, and many assumed generalizability of their findings to other cultures. The authors strongly advocate for the prioritization of studies with non-WEIRD samples by editors

of psychology journals, considering them as novel and more deserving of publication.

Psychology's WEIRD problem extends beyond sampling biases. Diversifying samples alone does not make the WEIRD problem go away. The WEIRD problem is deeply embedded in theory development and testing, methods, and institutions. WEIRD methods have predominantly been experimental and used surveys and measures developed in English based on the theories derived from WEIRD samples and researchers' understanding of psychological mechanisms. Most psychological studies have tested theoretical assumptions of WEIRD cultural values and norms, such as individualism and universalism. These assumptions can essentially be traced back to the influential religious power and beliefs rooted in the West (Henrich, 2020).

Leading journals and textbooks in psychology consistently presents studies claiming generalizability of findings based on WEIRD undergraduate samples. However, a small fraction of studies has contributed to challenging the WEIRD-centric understanding of psychological phenomena. For example, researchers challenged the universality of Müller-Lyer illusion effect and demonstrated that it is a carpentered-culture specific hypothesis by showing substantial cultural differences in visual perception and spatial factors between the American undergraduates and South African-European samples (Segall et al., 1963). Markus and Kitayama (1991) expanded the concept of collectivism and individualism to understand how people from different cultural contexts view themselves, referred to as their self-construal. They posited that people from collectivistic, non-Western cultural contexts are more likely to endorse an interdependent self, whereas people from individualistic, Western societies tend to endorse an independent self. The authors further noted that the differences in self-construal have broader implications on cultural variations in cognition, emotion, and motivation.

Lastly, psychological science not only lacks diversity in participants, theories, and methods, but also in researchers who design, conduct, interpret, and publish studies. For instance, of 1691 articles in developmental psychology journals, 61% (n=1029) of the first authors were affiliated with US institutions, 20% (n=341) from English-speaking countries, 15% (n=251) from non-English speaking European countries, 4% from Asia and Israel, only 2 studies had a first author based in Central or South America, and no studies at all had first authors from the Middle East or Africa (Nielsen et al., 2017). More recently, a study investigated who was producing more papers or publishing at a faster pace about the COVID-19 in psychological science (Puthillam, 2023). The author found that in the first two months since COVID-19 was announced as a

pandemic, 65 studies were conducted by authors and samples mostly from WEIRD countries, and by March 2021, nearly 90% of the authors of the published papers were affiliated with WEIRD institutions. Furthermore, preprints with first authors from WEIRD countries also had higher median citations and were later published in higher impact factor journals than those from non-WEIRD countries. Research articles are also often published in English and are disproportionally authored by native English speakers, particularly in North America, and by Dutch researchers using English, who exhibit higher publication rates, entailing lower resource, time, and effort requirements (IJzerman et al., 2020). These findings suggest that the publication speed in psychological science is indicative of the persistent inequality in access to resources for researchers from non-WEIRD countries, particularly the Global South during periods of global crisis. This disparity in research opportunities and productivity further reinforces the systemic disadvantages faced by non-WEIRD researchers (Puthillam, 2023).

Psychological science has largely continued to ignore this issue, persisting in the use of WEIRD samples, theories, and methods without much reflection (e.g., Rad et al., 2018). To mitigate the persisting WEIRD problems in psychological science, several recommendations have been put forth for researchers to consider and implement. Rad and colleagues (2018) assert that researchers should prioritize diversifying their samples and, if not feasible, provide explicit descriptions, justifications, and contextualization for the sample. Additionally, they recommend that researchers should engage in thorough analysis of the results and carefully consider the generalizability of their findings. Furthermore, the American Psychological Association (APA) provides guidelines that promote research practices encompassing diverse and global perspectives (American Psychological Association, 2017). These guidelines recommend diversifying research methods, including qualitative or mixed-methods approaches, and considering theories and perspectives from non-WEIRD cultural contexts.

This dissertation aims to enhance sample diversity across the three manuscripts, focusing on the exploration of mental health beliefs within Japanese cultural contexts. It employs a mixed-methods approach and incorporates culturally grounded theories and perspectives by conducting a comprehensive review of relevant literature written in both Japanese and English. The subsequent sections will first examine the mixed-methods approach in psychological science. This will be followed by a comprehensive review of the literature on culture and mental health beliefs. Finally, a specific focus will be placed on exploring mental health beliefs within the Japanese cultural

context.

1.2 Mixed-Methods Research in Psychological Research

Mixed-methods research has emerged as a third methodological paradigm that seeks to reconcile the tension between quantitative and qualitative research methodologies (Tashakkori & Teddlie, 2010). Despite concerns about the potential resistance of journal editors, reviewers, research supervisors, students, and psychology departments to mixed methods, there is a growing recognition that mixed-methods research presents a valuable approach for addressing complex research objectives and inquiries. Relying exclusively on quantitative methods can have negative consequences for marginalized and minoritized communities, as it may result in the systematic dismissal of insights and findings derived from qualitative research. These qualitative approaches are crucial for gaining a deeper understanding and effectively addressing the needs of these communities (Arellano, 2022). Advocates of mixed-methods contend that researchers can benefit from "*the best of both worlds*" by leveraging the capabilities of both quantitative and qualitative methods.

1.2.1 Definitions of Mixed-Methods

Mixed-methods research is defined as, "research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry " (Creswell & Tashakkori, 2007, p. 4). The philosophical standpoint most associated with mixed-methods is pragmatism (Onwuegbuzie & Leech, 2015; Tashakkori & Teddlie, 2010). Pragmatism in the context of mixed-methods, as a deconstructive and pluralistic paradigm, challenges the notions of 'truth' and 'reality' and emphasizes the practicality of "what works" in addressing research questions (Creswell & Plano Clark, 2017; Tashakkori & Teddlie, 2010). Pragmatism rejects the rigid dichotomy often observed in paradigm wars, instead endorsing the use of mixed-methods as well as acknowledging the influence of researchers' values on interpreting research findings (Teddlie & Tashakkori, 2009).

Mixed-methods researchers recognize that different research methods are appropriate for different types of research questions. Qualitative methods, for instance, are well-suited for exploring new phenomena or engaging with understudied groups and communities. Qualitative

methods seek to capture multiple realities through descriptive reports or transcripts and to ask open-ended inquiries like "*why*" and "*how*". Quantitative methods, on the other hand, excel in testing statistical validity and reliability, as well as establishing generalizability and replicability of results, relying on numerical data under the assumption of an objective truth. Quantitative methods involve identifying patterns, relationships, and probabilities, focusing on "*what*" is happening in the data. That said, researchers can adopt a mixed-methods approach by integrating the two methods. The mixed-methods approach complements the results obtained from one method by incorporating the results from the other method to expand the range and breadth of the research inquiry.

1.2.2 Historical Context of Mixed-Methods in Psychology

Historically, psychology research has favored quantitative methods and analysis of numerical data, driven by the influence of positivism, a philosophical perspective introduced by Auguste Comte in the mid-19th century. Positivists assert that true knowledge is derived from observable data or sensory information, known as empirical evidence. In psychology, the positivist starting point is the assumption that one can predict human behavior by identifying antecedents and causal factors (Tashakkori et al., 2013). Qualitative methods, on the other hand, collect, analyze, and interpret narrative data to understand the subjective meaning and contextual complexities. Qualitative approaches offer an alternative approach to the narrowness of quantitative methods, emphasizing inductive and iterative thinking in the research process. Some researchers argue that relying solely on quantitative methods can be harmful to marginalized and minoritized communities when they systematically reject inquiries and findings from qualitative research can help understand and serve these communities better. However, despite their potential value, qualitative methods have long endured a marginalized position within the field of psychology, often overshadowed by the dominance and prestige of quantitative methods since the early 20th century (Karasz & Singelis, 2009).

Furthermore, the reluctance of North American psychologists relative to European psychologists to appreciate qualitative approaches is remarkable (Krahn & Eisert, 2000). For instance, the APA once rejected a proposal to establish a new division specifically dedicated to qualitative research in 2007. The influence of the positivist paradigm within psychology has historically discouraged the utilization of introspection and intuitive knowledge, thus shaping the

choice of methods in the field. Since the 1980s, however, there has been a growing recognition among post-positivist psychology researchers of the potential advantages of diversifying research methods, specifically through the incorporation of qualitative methods (Creswell & Poth, 2014). However, quantitative and qualitative research methods have often been perceived as mutually exclusive and incompatible in psychological science. This has led to a paradigmatic divide and a contentious debate between proponents of each method, known as the "paradigm war" (Tashakkori et al., 2013). In response to this dichotomy, some methodologists have advocated for "*the best of both worlds*" approach, aiming to reconcile the tension and enhance the understanding of understudied research topics. This emergence of the compatibility model promotes reasoned dialogue and utilization of both methods, namely, mixed-methods approach. For instance, Sechrest and Sidani (1995) argue that good science should welcome methodological pluralism. Miles et al. (2014) also note, "the careful measurement, generalizable samples, experimental control, and statistical tools of good quantitative studies are precious assets. When they are combined with the up-close, deep, credible understanding of complex real-world contexts that characterize good qualitative studies, we have a very powerful mix" (p., 43).

1.2.3 Prevalence of Mixed-Methods in Psychology

In psychology, there is a tendency to select methods based on convenience rather than aligning them with research questions. The mixed-methods approach addresses the issue of method-driven research in psychology by prioritizing research questions over the choice of data collection and analysis methods. Additionally, existing publication biases and institutional practices favor complex statistical analyses, laboratory experiments, and larger sample sizes; the analysis of subjective narratives, smaller sample sizes, and simpler research designs employed in qualitative research are often undervalued. The effects of these biases and pressure are evident at various levels of psychology knowledge production and diffusion, including journal publications, academic departments, professional organizations, funding opportunities, teaching models, and research training programs (Richardson, 1996). For example, while 95% of counseling programs in the U.S. allowed the use of qualitative methods in dissertations, only 5% of graduate students took advantage of this opportunity (Azar, 2008).

A study conducted in 2010 reported that only 7% of the articles published in top-tier APA journals utilized mixed-methods research designs (Alise & Teddlie, 2010). Furthermore, a more

recent study conducted in 2019 found 797 articles reporting the use of mixed-methods across 95 high impact journals in 10 social science disciplines over the period 1992-2016 (out of a total of 241,521 articles). According to their findings, the prevalence rate for psychology was one of the lowest (22 articles, 3%) compared to nursing (332 articles, 42%) and education (224 articles, 28%), and family studies (79 articles, 10%) (Timans et al., 2019).

Despite the initial low prevalence and slow adoption of mixed methods in psychological research, its usage has been steadily increasing in the field. In 2018, the American Psychological Association published its first-ever guidelines for journal reporting standards for qualitative and mixed-methods research (Levitt et al., 2018). Following this significant milestone, an increasing number of journal editors have shown a receptivity to and appreciation for mixed methods (Creamer & Reeping, 2020). For example, editors of prominent psychological journals, such as *Frontiers in Psychology*, assert that the use of mixed methods is now "*obligatory*" for research in psychology and across all branches of the social sciences (Anguera et al., 2020).

1.3 Understanding Mental Health Beliefs from a Cultural Perspective

Culture plays a pivotal role in shaping people's beliefs about mental health. The way in which people perceive, interpret, and navigate their experience of psychological suffering vary considerably across diverse cultural contexts (Bhui & Dinos, 2008; Kirmayer & Ryder, 2016; Kleinman, 1988; J. Lee & Sue, 2001; Marsella & Yamada, 2007; Tanaka-Matsumi & Draguns, 1997). To examine mental health beliefs from a culturally grounded standpoint, I have adopted an interdisciplinary and integrative framework known as cultural-clinical psychology. Cultural-clinical psychology serves as an amalgamation of cultural psychology and clinical psychology, providing an integrative lens through which to explore the intersection of culture and mental health. In the next section, the theoretical underpinnings of the framework will be discussed, followed by a rationale for adopting this framework to guide and inform the present dissertation.

1.3.1 Clinical Psychology

Researchers and theoreticians in the field of clinical psychology have primarily directed their attention towards the conceptualization and classification of mental illnesses and the assessment of mental health outcomes from its own cultural perspective. Despite the primary aim of clinical psychology being to understand, explain, and alleviate the experiences of suffering

situated within the person's social-cultural context, the existing research, available assessment tools, and treatment approaches have been WEIRD-centric. More specifically, clinical psychology has been dominated by pragmatic, reductionist, and essentialist perspectives, largely shaped by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) over the decades (Brick et al., 2022; Kirmayer & Ban, 2013). This process of labeling, categorizing, and reducing the individual experiences of suffering into symptomatology has undermined the exploration of underlying mechanisms and contextual explanations of mental illness and mental health beliefs. Moreover, clinical psychology's inclination to conceptualize mental health at the symptom level of analysis reflects the broader medicalization of the discipline's own beliefs about mental health, wherein the experiences of suffering are inherently attributed to biomedical causes. Kahn and Eisert (2002) claim that American clinical psychology is heavily influenced by a specific socio-political power, notably the pharmaceutical industry. The researchers further emphasize that the medicalization of mental health represents the beliefs endorsed by the pharmaceutical industry, which has a significant impact on research funding, academic departments, and research institutions. Thus, the biomedical model of mental health beliefs exerts a profound influence on the conceptualization of mental health, the selection of research methods and participants in the United States.

Considering our increasingly globalized and multicultural world, researchers in clinical psychology have progressively acknowledged and demonstrated the critical role of cultural context in understanding, evaluating, and delivering mental health care for ethnoculturally diverse populations (e.g., Huey et al., 2014; Sue et al., 1991; Whaley & Davis, 2007). Cultural competence is a recent example of clinical psychology's efforts in incorporating cultural contexts into its practices (Frisby & O'Donohue, 2018). Cultural competence has been recognized as necessary training and skill set for all mental health professionals working with ethnocultural minorities. However, the current body of cultural competence research often simplifies culture as a matter of group membership, focusing on categorizing people into different ethnocultural blocs, without thoroughly exploring the specific cultural meanings and practices that contribute to the diverse patterns of mental health beliefs (Chentsova-Dutton & Ryder, 2019; Kirmayer, 2012).

1.3.2 Cultural Psychology

Cultural psychology, on the other hand, has made significant progress in unpacking the mechanisms underlying ethnoracial, cultural, or national differences in psychological functioning

(Cole, 1998; Heine & Ruby, 2010; Markus & Kitayama, 1991; Shweder, 1991) Cultural psychologists have transcended the mere cataloguing of cultural groups and the descriptions of cultural differences within the confines of WEIRD-centric theories and psychological constructs. Instead, they have embarked on a quest to challenge the universalist approach in psychological science and unveil the intricate interplay between culturally relative practices and shared beliefs about the human mind. The core principle of cultural psychology is that culture and mind are inseparable and mutually constitutive (Shweder, 1991). Cultural psychology distinguishes "culture" from cultural group identity labels (e.g., "Asian-Americans", "Latinx"). Culture can be understood as a meaning system of behaviors, practices, and beliefs people attribute meaning to within a specific context. Furthermore, "culture" can be understood at the level of the individual person, "*in the head*"—"*in the world*", as beliefs, values, and norms that are widely distributed, shared, and observed by others. This means that "culture" is dynamic, general, and context-dependent (Kashima, 2016). The contributions of cultural psychologists have been profound, expanding our understanding of the complex interplay between culture and the human mind including self-concept (Markus & Kitayama, 1991, 2010), thinking styles (e.g., Choi et al., 1999; Peng & Nisbett, 1999), perceptions (e.g., Masuda et al., 2008), values (e.g., Triandis & Gelfand, 1998), and emotions (e.g., Tsai et al., 2006; Uchida et al., 2004). Unfortunately, cultural psychologists rarely engage with clinical or mental health issues. The majority of research engaging in cultural psychology rooted in the tradition of social and experimental psychology, reflecting the historical evolution of the discipline (P. B. Smith & Bond, 2022).

1.3.3 Cultural-Clinical Psychology

More recently, Ryder and colleagues (2011) have proposed to bridge cultural psychology and clinical psychology to better understand the interplay between culture and mental health. According to the researchers, this integration involves incorporating the brain into the original mutual constitution of culture-mind framework. From this perspective, culture, mind, and brain form an inseparable, multilevel system, and psychopathology should be viewed as an emergent property of this dynamic system. Similar to the well-known biopsychosocial model, the cultural-clinical psychology perspective recognizes the contributions of culture, mind, and brain to mental health. Furthermore, this framework argues that each level (culture, mind, and brain) cannot be reduced or fully explained by the other. Instead, it emphasizes the mutual influence and

interconnected roles of the three entities in shaping mental health.

Chentsova-Dutton and Ryder (2020) have further posited that the concept of *cultural models* can help deepen our understanding of cultural shaping of psychopathology and mental health. *Cultural models*, as defined in cognitive anthropology, refer to a set of beliefs, norms, and values that are widely shared by the members of a group, community, or society (Quinn & Holland, 1987). They are taken-for-granted models of the particular context, serving as cognitive frameworks that guide and shape the behavior of people in that context as well as their understanding of the context. Cultural models, therefore, can be understood and investigated as internalized beliefs, norms, and values held by a person or people, and as observable behaviors and cultural artifacts manifested within a specific social context or community (Chentsova-Dutton & Ryder, 2020). Cultural models that are "*in the head*" or "*personal*" mental models typically align with the consensual versions of shared beliefs, knowledge, or "*conventional*" mental models "*in the world*" (Shore, 1996).

Cultural-clinical psychology views cultural models of psychopathology as the conceptual lenses used by the person suffering from mental illness or their communities. Cultural-clinical psychologists are interested in cultural models both *in the head* and *in the world* (Chentsova-Dutton & Ryder, 2020). Cultural models of psychopathology are determined and understood by what is deemed to be pathological (models of deviancy) or normal (models of normalcy). For example, people from Western cultural contexts tend to draw upon symptoms and concepts delineated in the DSM as culturally consensual beliefs about mental illness when making sense of experiences of suffering.

1.3.4 Examples of Mixed-Methods Studies Considering Culture

Despite the potential of psychological science in integrating clinical and cultural perspectives on mental health, substantial body of research on culture and mental health has primarily been conducted by anthropologists and transcultural psychiatrists who often devote themselves to the use of qualitative research methods such as ethnography and participatory community research (Doucerain et al., 2016; Ryder et al., 2021; Ryder & Dere, 2010). Although clinical psychologists are trained in qualitative techniques as clinicians, such as clinical interviews, direct observations, and case studies, the vast majority of them tend to conform to the hypothesis-testing driven "science-practitioner" model when conducting research, transforming their clinical

insights into linear and quantifiable forms (Krahn & Eisert, 2000). Similarly, cultural psychology has historically prioritized quantitative methods such as in-lab experiments and large-scale surveys (e.g., Mturks), due to its close association with experimental psychology and a growing interest in quantitative-heavy areas such as neuroscience and business research.

To study culture and mental health, cultural-clinical psychologists have advocated for the adoption of mixed-methods research, recognizing the dual nature of culture as existing both *in the head* and *in the world* as well as the complex relationship between culture and mental health. Doucerain et al. (2016) notes, "[cultural-clinical psychology] researchers will need to engage seriously with quantitative, qualitative, and mixed-methods approaches. Sole reliance on one or the other will give us an incomplete, even flawed, picture" (p.13). The use of mixed-methods approaches in the psychological literature on culture and mental health is still in its early stages and remains relatively limited in scope. Whereas Doucerain and colleagues (2016) conducted a comprehensive review of eight selected mixed-methods studies published in psychological literature on mental health in non-WEIRD samples between 2007 and 2011, I present a selection of recently published studies.

Yu and colleagues (2023) employed a mixed-methods approach to examine the associations between social network, friendship, and psychological well-being among Chinese elderly immigrants living in the U.S. during the COVID-19 pandemic A triangulation mixed-methods study design was chosen to analyze data from multiple sources pertaining to the same topic, enabling a more comprehensive interpretation of the phenomena. Semi-structured interviews and surveys on geriatric depression and loneliness were conducted with 26 participants in California. Data collection was carried out in Mandarin or Cantonese. The quantitative data examined the structure and size of social networks among Chinese older immigrants, including the methods of communication with family and friends. It also explored how social networks influenced levels of depression and loneliness and showed that participants reported decreased social contact and social network interaction patterns specific to immigrants. Maintaining close relationships and frequent contact with others after the onset of COVID-19 predicted lower levels of depressive symptoms. Thematic content analysis identified resilience themes such as religious beliefs, neighbors serving as role models, and wisdom derived from past experiences. The utilization of a mixed-methods design was deemed appropriate due to the general lack of research on foreign-born elderly immigrants and their specific challenges during the pandemic, such as

limited English proficiency, reduced social participation, and restricted travel to their home countries.

Lee and Ryu (2018) compared the experiences of older adults living in low-income areas in South Korea and in the U.S. Specifically they investigated the effect of the content and intensity of self-conscious emotions (regrets and pride) on geriatric depression scores between Korean and American older adult samples. The authors collected survey and semi-structured interview data concurrently. They conducted theme-based qualitative coding as well as regression analysis. Their quantitative results showed that Koreans reported higher intensity of regret compared to Americans. Culture-specific themes pertaining to self-conscious emotions emerged from their qualitative analysis. For example, Koreans nominated poverty, hunger, Korean war in their youth, and conflicts with in-laws as main content of their regret, whereas American participants mentioned experiences of abuse, neglect, their children's alcohol use, and estrangement due to familial conflict. The study also identified similarities between Koreans and Americans, as both cultural groups reported experiencing a sense of pride related to family and personal growth. This particular type of pride was perceived to be associated with generating more positive thoughts and emotions compared to other forms of pride regardless of culture. The comparative mixed-methods research design used in this study elucidated both similarities and differences between Koreans and Americans, while providing an in-depth analysis of the understudied communities in both cultural contexts.

Measurement invariance research in pre- and post-testing has been a highly productive area within the mixed-methods framework for survey development. For example, Benítez and Padilla (2014) utilized a two-phase sequential explanatory mixed-methods design to investigate the presence of survey item invariance and identify sources of invariance between two linguistic and cultural groups. The researchers conducted differential item functioning (DIF) analysis, a regression-based item invariance evaluation, followed by cognitive interviewing (CI), a qualitative technique. The goal of their study was to assess the cross-cultural and cross-linguistic equivalence of attitudinal items in the Student Questionnaire of the Programme for International Student Assessment (PISA) between Spanish-speaking students from Spain and English-speaking American students. DIF analysis revealed significant invariance issues in items related to "advances in science and technology." CI analysis further revealed that American and Spanish students endorsed different temporal frameworks when responding to the questions. Spanish

students interpreted the term “advances” in the context of daily aspects such as mobile phones or the Internet, relating to situations closer to short-term academic contexts. Conversely, American students associated the term “advances” with ideas of evolution or improvement, such as drug development, which pertained to situations in the longer-term future, especially within work-related contexts. The study effectively used a mixed-methods approach by combining statistical DIF results with qualitative data obtained from in-depth interviews. This approach allowed for a comprehensive understanding of the respondents’ thinking processes and the underlying causes of DIF, which were shaped by the participants’ socio-cultural and linguistic backgrounds.

In summary, mixed-methods research offers flexibility, combining quantitative and qualitative approaches to enhance both robust and nuanced understanding of complex psychological phenomena. It allows for triangulation, validation, and capturing of both numerical data, and rich, contextualized narratives. This approach also facilitates the exploration of participants’ subjective experiences, perspectives, and meanings, which may not be adequately captured by quantitative methods alone. Furthermore, mixed-methods approach fosters interdisciplinary collaboration and provides a more robust understanding of the research topic. Mixed-methods designs can be applied within a single cultural group or community, as well as across multiple groups.

1.4 Mental Health Beliefs in Japanese

1.4.1 A Brief History of Beliefs about Mental Health

Japan has been often presented as an intriguing non-Western case example of rapid modernization and successful capitalist system. The social, cultural, and historical trajectory of mental health in Japan is marked by a series of cultural breakthroughs, from its ancient traditions and spiritual belief systems to the adoption of Western concepts and practices into their contemporary *cultural models* of mental health.

During the early modern period, a time known as the Edo period or the “Last Samurai” era in Japan, the notion of mental illness was absent. What we now conceptualize as mental illness was attributed to madness resulting from the possession of one’s body by evil spirits or ghosts. These malevolent spirits would seize control of a person’s body, causing them to experience illness, suffering, or even death. These spirits were known as *mononoke*, which

could transform into shape-shifting fox-spirits called *kitsune*. In the absence of a medical understanding of mental illness, Buddhist monks and exorcists (*onmyoji*) were regarded as efficacious healers. They employed diverse methods, including hydrotherapy (sitting beneath waterfalls), Chinese herbal remedies, and meditation. These healers enjoyed significantly greater respect and authority from the Samurai government compared to medical doctors did (Hyodo, 2008; Nakamura, 2013).

After the Edo period, Japan underwent a significant period of modernization, and Westernization as the Meiji Restoration began in 1868. Japan then started to adopt Western theories of mind, diagnostic frameworks, and treatments. Japanese psychiatrists embraced the mind-body frameworks proposed by German medical practices especially Kraepelin tradition of neuropsychiatry and Freudian psychoanalysis. By the early 1900s, psychiatry was established as an independent medical discipline in Japan (Nishimura, 2019).

Amidst resistance from Japanese academic psychiatrists against American psychodynamic theories during the 1960s, Western models encountered substantial challenges posed by clinically oriented psychiatrists like Morita Masatake, the founder of Morita therapy (Kasai, 2009; Nishimura, 2019). Morita therapy draws upon the principles of Zen Buddhism, which encourages clients to accept emotions, thoughts, and difficult situations as they are rather than trying to change or eliminate them (Morita, 1998). Morita therapy views the source of psychopathology as a natural response stemming from the desire for life. The primary goals of Morita therapy are to emphasize a holistic and experiential approach, aiming to reorient clients' experiences of suffering. This approach differs from psychodynamic approaches, which primarily focus on understanding unconscious conflicts as a means of achieving psychological change, symptom reduction, and control. The second homegrown therapy, known as Naikan therapy, also emerged around this time. The Naikan method was derived from a common sect of Japanese Buddhism, Jodo-Shinshu. The Naikan therapist aims to help the client shift their focus away from themselves and to dissolve their self-centric perspective by promoting understanding of others' feelings and thoughts, and by encouraging acceptance of significant others as they are.

As the late twentieth century approached, clinical psychology gained prominence in Japan, incorporating American traditions of psychiatry and clinical psychology such as the DSM and Rorschach. In the post-war period, clinical psychology in Japan underwent a rapid

process of Americanization, particularly adopting Rogerian principles, which appealed to many Japanese psychologists who were drawn to a counseling approach that values empathy, acceptance, and non-directive support. As clinical psychology developed as its own discipline and psychotherapy diversified its methods in Japan, an internal conflict arose among clinical psychologists. This conflict led a group of Jungian psychologists, notably Kawai Hayao, to establish the Association of Japanese Clinical Psychology (AJCP) in 1982 with the aim of implementing a clinical licensure system within Japan. Kawai incorporated a model of Japanese ego development and relationship, particularly the matriarchal consciousness based on the traditional values and mythology into his Jungian approach (Kitanaka, 2003; Sato, 2007). In the late 1980s, cognitive behavioral therapy (CBT) was introduced to Japan. The majority of psychotherapists in Japan practice in an eclectic manner, blending psychoanalytic and client-centered approaches (Takasugi, 2022).

Despite the significant presence and advancement of psychiatry and clinical psychology in Japan, laypeople generally do not actively seek psychopharmacology or psychotherapy (Kirmayer, 2002; Lock, 1981; Norbeck & Lock, 1987). Psychiatry is often reserved for people with severe mental illnesses, while clinical psychology and psychotherapy are viewed as highly psychologized, individualistic, and otherwise Western in ways that do not align well with Japanese cultural values and norms. For example, there is a higher stigma and shame associated with the term "psychotherapy", compared to "counseling" which is perceived as seeking advice, consultation, and suggestions (Kasai, 2009). The term "psychotherapy" is often accompanied by shinri-ryoho (The term "counseling" in Japan is also frequently used to refer to various consultation-oriented professions beyond mental health, contributing to its wider acceptance).

A "middle ground" approach that prioritizes the psychosomatic understanding of mental health is prevalent. It is common for Japanese people to seek care for psychosomatic complaints (e.g., headaches, stomach and digestive problems, sleep problems, skin conditions, and musculoskeletal pain) encompassing anxiety and depression at outpatient hospital units or local clinics specialized in psychosomatic medicine (*shinryo-aika,* 心療内科). It is also common for psychosomatic doctors to prescribe Chinese herbal medicine (*kanpo*) to patients, and patients to seek non-medicalized healing practices such as hot/cold bathing, acupuncture, massages, hypnosis, breathing exercises, physical exercises, prayers, and suggestions (e.g.,

fortune tellers). These practices are viewed as therapeutic and are widely used alongside visits to specialized clinics and Buddhist temples that offer services related to diet and rest (Norbeck & Lock, 1987).

1.4.2 Mind, Self, and Others in Japanese Cultural Context

In order to better grasp how people view mental health, it is important to examine the *cultural models* of mind, self, and the relationship with others. Furthermore, how cultural values including religious and philosophical teachings from different cultural contexts define and emphasize the relationship between the self and others have implications for people's understandings of psychological well-being. These values serve as a *cultural model* to guide members within a society on how to lead a virtuous life or make sense of the departure from the model. These cultural values, therefore, aid us in exploring more nuanced interpretations of what constitutes psychologically ill, normal, and well people in Japanese cultural context.

In cultural psychology, the notion of the interdependent self-construal in the context of Japanese culture has been extensively discussed and researched, as described earlier. The interdependent self-construal refers to the extent to which people understand the self as being fundamentally connected to other people, as opposed to the independent self-construal in which people view themselves as an autonomous, unique, and authentic self (Markus & Kitayama, 1991). The researchers found that Japanese people are more likely to endorse an interdependent self, compared to people from WEIRD cultural contexts, which also predicts differing ways of conceptualizing well-being across cultural contexts (Markus & Kitayama, 1991, 2010). When discussing the self-concept and its relation to people's beliefs about mental health, the history goes back to teachings by Buddha and Confucius.

The term for the interdependent self, as found in the psychological literature, is as *sogo-kyocho-teki-jikokan* (相互強調的自己観). However, scholars in anthropology, history, and religious studies often interpret it through the Buddhist doctrine of *dependent origination*, or *engi* (縁起, Sanskrit: Pratītyasamutpāda), which posits that all aspects of the universe are physically and mentally interconnected within intricate chains of causes, conditions, and consequences. Additionally, *kokoro*, a term embodying an array of meanings akin to mind, spirit, will, or heart in English, is the "heart" of Japanese cultural insight into the self and mind. *Kokoro* is seen as a

separate entity from the social self, articulated in everyday interactions, and is perceived as inaccessible, inexpressible, and unattainable, even to the person themselves. This viewpoint contrasts significantly with Western conceptions of the self and mind, which typically seek to unearth and actualize the inner-self to foster psychological well-being. In contrast, the Japanese approach to achieving psychological well-being leans towards accepting the elusive nature of the inner-self, acknowledging its inherent unattainability (D. K. Kondo, 1990; Lebra, 1976, 1992).

Confucianism imported from China have also influenced Japanese conceptions of the self and others. Notably, Confucianism promotes group and interpersonal harmony and collective well-being. In this philosophy, individual members of a group or society are seen as inseparably interconnected and ascribed to specific roles, positions, and responsibilities. Consequently, the expectations placed on a person are largely oriented towards prioritizing the needs and well-being of the collective over personal desires. A key aspect of this socio-cultural ethos is the concept of filial piety, which is deeply ingrained in the Japanese understanding of the self and its relation to others, especially family (Ikeda, 2006, 2010). This principle foregrounds the moral obligation of people to exhibit respect, obedience, and care towards their parents, familial units, and ancestors. The pursuit of filial piety often calls for the honor and fulfillment of one's familial duties to promote the welfare and harmony of the family, even if such commitment necessitates the sacrifice of personal needs and well-being (Yeh, 2003).

1.4.3 Mental Health Related Issues in Modern-Day Japan

In recent years, various issues encompassing mental health, socio-political and economic issues have garnered attention including social withdrawal (*hikikomori,* ひきこもり), nonattendance at school (*futokou,* 不登校), and death from overwork (*karoshi,* 過労死) in Japan. These concepts, while significant in the Japanese context, do not appear in Western diagnostic or assessment systems. None of these terms are formally categorized or labeled as a mental illness or psychiatric diagnosis, even within Japan. These concepts illustrate the limitations of applying Western biomedical and reductionist models to non-Western contexts. The Japanese beliefs surrounding these phenomena are not isolated but rather are deeply interconnected with biomedical models, socio-cultural-political motivations, and interpersonal dynamics. They also highlight the existence of multiple, sometimes conflicting interpretations of these phenomena, the dominance

of which may depend on who is conceptualizing the problem and who stands to benefit from a particular conceptualization.

Hikikomori is a term that has emerged to describe both the phenomenon and the person suffering from it. Hikikomori is defined as a phenomenon in which a person becomes a recluse in their own home, avoiding various social situations for at least six months. They may go out of their bedrooms, but they do not make any social contact with others (Ministry of Health, Labour, and Welfare of Japan, 2010; Saito, 1998). The lifetime prevalence of hikikomori in Japan was estimated to be 1.2% and was more common in males (Koyama et al., 2010). Since the 1990s, hikikomori has been the focus of considerable attention as one of the most prominent social and youth problems in Japan. Hikikomori has entered the vocabulary of researchers, policy-makers, and laypeople alike. The term hikikomori made its way into the *Oxford English Dictionary* in 2010. Since then, the term has been consistently translated as social withdrawal and it has been assumed to be culturally unique to Japan (Takahata, 2003). Nevertheless, there is disagreement regarding every aspect of hikikomori from the interpretation of its etiology to the meaning of its cultural significance among the scholars and policy-makers.

Hikikomori is not a clinical or psychiatric diagnosis, although diagnostic studies conducted by psychiatrists have reported a strong pattern of comorbidity with multiple existing DSM defined psychiatric disorders among the sufferers (N. Kondo et al., 2013; Koyama et al., 2010; Tateno et al., 2012). There is an important ongoing debate over whether hikikomori is a psychological or social pathology. Some cultural and social psychologists argue that hikikomori is a normative, socially valid response to the challenges of globalization, industrialization, and socioeconomic marginalization faced by young people, while others view it as a psychological disorder primarily situated at the individual level (Norasakkunkit et al., 2012; Norasakkunkit & Uchida, 2014; Tajan, 2015). The etiology, defining cases, and intervention clauses of hikikomori are still under speculation.

Nonattendance at school (futokou) refers to a behavior pattern where a child consistently avoids school and usually stays at home with their parents' knowledge. This differs from truancy, where the child is also absent from home. *Futokou* is closely linked to hikikomori. A child may become hikikomori due a past traumatic experience at school, including academic failure, interpersonal problem, or bullying (*ijime,* いじめ) (Kato et al., 2018). The problem has been prominent in Japan since the late 1990s. In 1998 over 127,000 cases of *futoko* were reported

(MEXT, 2007). The rise of this issue has also led the Japanese government to implement a school counselor system. To ensure a high standard of care, school counselors are required to hold a certified clinical psychology license, although the license was not government-regulated at that point in time. Some experts attributed this trend to societal and familial changes in Japan, such as the shift towards “fatherless families,” where fathers are often absent due to work commitments. They argue that this has led to an imbalance in family dynamics, which in turn affects children’s emotional, psychological, and interpersonal functioning (Ando et al., 2005; Treml, 2001).

Recent data paints a worrying picture of the extent of school nonattendance and related issues in Japan. The government reported nearly 245,000 cases of *futokou* in children between the ages of 6 and 15 and over 500,000 children reported experiences of bullying (MEXT, 2022). Despite a general decrease in suicide rate until 2020, suicide rates among children and youth have been increasing, culminating to a record of 514 child suicides in 2022 (Okamura et al., 2021; Ono et al., 2008). Researchers, school educators, and policy-makers are all vigorously working to understand the cause-effect relationship of bullying (e.g., mental health aspects of both the bully and the victim) and to devise effective interventions (e.g., rehabilitative vs. punitive).

Karoshi refers to death from overwork. Initially conceptualized in the early 1980s, it referred to death resulting from severe health deterioration and physical illnesses like cardiovascular disease due to long working hours (Hosokawa et al., 1982; Kanai, 2009). Over time, the definition has broadened to include both natural cause death and suicide stemming from work-related psychological distress, such as fatigue, burnout, harassment, or bullying (Ito & Aruga, 2018; Ministry of Health, Labour, and Welfare of Japan, 2014, 2016). This expansion of the definition has sparked debates. As a result, in 2020, the Japanese government compensated approximately 250 cases annually as *karoshi*, demonstrating its significant societal impact (Japan Ministry of Health, Labour, and Welfare, 2020).

Understanding depression in the context of *karoshi* in Japan is a multifaceted task. The Japanese government, partly influenced by left-wing lawyers and psychiatrists who observed the limitations of antidepressants in treating depression, redefined depression associated with *karoshi* as the society’s *collective* vulnerability. This led to the implementation of nationwide psychological stress checks at the workplace. However, medical anthropologist Kitanaka (2008, 2016) critiques this shift, arguing that it reflects a growing demand for bio-psychological self-governance and public surveillance, underpinned by the "positive mental health" movement.

According to Kitanaka, the government holds two conflicting perspectives on depression in the context of *karoshi*: one seeing depression as a biomedical condition within the individual, who is thus responsible for their own mental health, and the other viewing it as a natural response to a detrimental work environment, the responsibility for which lies with employers and the government. This analysis indicates that within a society, there can exist multiple, sometimes competing, cultural models of mental illness and health.

1.5 Dissertation Research Objectives

Beliefs about mental health are shaped by the local social and cultural milieu. Therefore, there are various cultural models of mental health across cultural contexts around the globe. However, the existing psychological research on mental health is overwhelmingly WEIRD, lacking diversity in sampling, theoretical frameworks, and methods being used. Specifically, the universalist, Western biomedical conceptualization of mental health undermines the understanding of non-Western perspectives. Cultural-clinical psychology perspective, an interdisciplinary approach study mental health allows us to explore mental health beliefs of non-Western cultural contexts. This dissertation seeks to demonstrate examples of conducting culturally grounded psychology research to advance our understanding of cultural shaping of mental health beliefs through three main objectives.

The first objective is to demonstrate the utility of mixed-methods research design to conduct culturally grounded mental health research. In this dissertation, two types of mixed-methods approaches are demonstrated as case studies: qualitative content analysis and cultural consensus theory approaches.

The second objective is to examine cultural differences in beliefs about mental illness between Japanese and Euro-Canadian university students. In Chapter 2, I present an investigation of beliefs about causes and help-seeking pertaining to five different psychological disorders (i.e., depression, autism spectrum disorder, schizophrenia, alcohol use disorder, and hikikomori), and tested as to whether the pattern of beliefs differs across cultural groups. I conducted a qualitative content analysis followed by a series of statistical analysis as a mixed-methods research approach in this study, allowing for culturally relevant themes to emerge from the qualitative data in the first phase, and then highlighting group differences.

The third objective is to investigate Japanese clinical psychologists' consensus beliefs

about mental health in Japan. Specifically, in Chapter 3 and 4, I applied cultural consensus theory to explore consensus beliefs shared by Japanese clinicians, utilizing a two-phased sequential exploratory mixed-methods design. In the qualitative phase, cultural domain analysis was conducted to elicit culturally salient beliefs. In the quantitative phase, cultural consensus analysis was performed to estimate the degree of consensus among the participants to evaluate the presence of consensus. Chapter 3 focuses on Japanese clinical psychologists' beliefs about (1) the sources of the public's beliefs about mental health; and (2) changes necessary for the mental healthcare in Japan. Building on the study presented in Chapter 3, Chapter 4 focuses on clinicians' two main cultural domains: depression and therapeutic alliance. For depression, beliefs about (1) causes, (2) effects, and (3) treatment were explored. For therapeutic alliance, characteristics of (1) incompetent clinician, (2) difficult client, (3) external barriers, and (4) problem were explored.

The Discussion section (Chapter 5) explores how the contributions of each manuscript inform and complement one another to promote a deeper understanding of mental health beliefs from a Japanese cultural perspective. From this broader scope, I discuss the importance of integrating social and cultural contexts into the study of mental health beliefs as well as the utilization of mixed-methods research. Overall, this dissertation endeavors to showcase concrete research practices that prioritize cultural diversity, inclusion, and equity, with the goal of tackling the challenges associated with the WEIRD problem and propelling the field of psychological science forward.

1.6 Author's positionality

Before I present and discuss the findings of the studies in this dissertation, and in the spirit of self-reflexivity, I acknowledge both my ascribed and acquired identities, lived experiences, personal worldviews, and the intersections thereof have influenced the way I perceive and approach the research topics of this dissertation. As such, this positionality statement is an attempt to become aware of and to be transparent about my own biases and privileges to the extent that I am able.

I am a cis-woman, abled-bodied, visible minority and a first-generation international graduate student currently living in Canada. I was born and raised in Japan as a citizen, where I had the privilege of growing up in a comfortable middle-class family. Additionally, I have been fortunate to have international travel experiences during my childhood due to a family member

living and working for an international organization abroad as well as my able-bodiedness and my Japanese passport.

I lived and studied at a small private liberal arts college in Southern Virginia, U.S. I spent my first two years of undergraduate education in a predominantly White, evangelical Christian community, where I learnt a great deal about the local culture of the Appalachia as well as the complex relationship between the White and Black communities, mental health beliefs, and financial and educational barriers people were facing in the region. Afterward, I completed my studies in psychology and sociology at a large public university in Baltimore, Maryland, where the school and surrounding community were predominantly Black. Through my undergraduate studies and internship experiences, I gained insights into the inner-city Black community of Baltimore, especially the mental health beliefs of adolescents and emerging youths in the community. Upon completing my undergraduate studies, I returned to Japan and worked for a public policy research institute for three years. There, I learned about issues pertaining to earthquake and disaster needs, gender inequality, and nursing home development in Japan.

I then arrived in Montreal, Canada, a city renowned for its multiculturalism as well as linguistic diversity and tensions, to pursue my master's degree in transcultural psychiatry at McGill University ten years ago. A few years later, I began my doctoral studies in psychology at Concordia University. These experiences deepened my understanding of both the variations between and within cultural groups and communities, as well as the complexities of racial and cultural tensions and diversity, socio-political, and historical differences in mental health professions and healthcare systems, and the importance of mental health research and conversations.

I gained all my formal educational experiences in the field of mental health in U.S. and Canada, although I have been involved in cross-cultural research collaborations with Japanese colleagues. Throughout my career, I have not received formal clinical training. I have been away from home in Japan and Japanese cultural context for a decade. From a global standpoint, this dissertation may still be seen as situated within the WEIRD cultural context as I am completing a doctoral degree at a Canadian university and conducting my research in the English language. I also acknowledge the historical, economic, and religious context of Japan, including its past imperialism, high-income status, and the coexistence of multiple religions and spiritual traditions. These contextual elements may have had an impact on my perspectives and privileges in various ways. Having said that, my educational, research, and personal experiences position

me both as an insider and an outsider within the Japanese community. Moreover, my journey as a minoritized psychology student in the US and Canada has fostered a deep awareness and appreciation for the experiences of Japanese people. This has motivated me to actively explore and understand their narratives in their own language in my research.

CHAPTER 2 (MANUSCRIPT 1)

A Cross-Cultural Comparison of Beliefs about Mental Illness: A Mixed-Methods Study of Explanatory Models among Japanese and Euro-Canadian Students

Submitted to *Journal of Cross-Cultural Psychology*

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Abstract (English)

Beliefs held by the public about mental illness often differ from those of professionals and scholars. Moreover, beliefs about causes and help-seeking may vary across cultural contexts. Understanding explanatory models (EMs) held by non-experts and those from non-Western cultural contexts is crucial in developing and providing culturally sensitive mental health care. In Western cultural contexts, three types of EMs of mental illness (i.e., medicalizing, moralizing, and psychologizing) have been proposed as commonly held by laypeople; however, culturally unique EMs regarding causes and help-seeking should be carefully examined. The aim of the present study was to employ mixed-methods approach to (1) explore culturally unique EMs about causes and help-seeking through the analysis of open-ended responses without imposing existing models and measures developed in the West; (2) examine cultural variations in the EMs between Japan and Canada across five mental health conditions (i.e., depression, ASD, schizophrenia, AUD, and Hikikomori).

178 Japanese and 189 Euro-Canadian university students provided their causal explanation and help-seeking recommendations using vignettes. Content analysis allowed both deductive coding to classify the EMs and inductive coding to discover new and culturally unique themes. We then conducted multivariate generalized linear models to test cultural differences.

Qualitative results uncovered social-contextualization of causes and social-contextual responsibility as help-seeking beliefs that were not captured by the existing theories and models. Quantitative results showed that overall, Japanese students were more likely to psychologize and suggest social support, whereas Euro-Canadians were more likely to medicalize and suggest medication and self-care. There were also variations in EMs between cultural group and five conditions.

The findings suggest that Japanese and Euro-Canadian students endorsed differing beliefs about mental illness that are more complex and holistic than previously thought. Content analysis of our qualitative data allowed us to uncover culturally unique explanations and themes that are not captured by the EMs theorized and derived in the West.

Keywords: explanatory models, mental illness, mixed-methods, causal attribution, help-seeking, Japanese

Abstract (Japanese)

精神疾患の説明モデルの文化比較:日本人とヨーロッパ系カナダ人大学生を対象とした原因帰属と援助要請に関する価値観の混合法研究

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世間一般の人びとはそれぞれ精神疾患をどのように解釈するのかについての“説明モデル”を保有しており、患者のモデルの「病い」は、専門家の「疾患」モデルとは異なっている。人々は病因を心の問題、生物医学的な問題、個人の責任の問題であると捉える「心理化」、「医療化」、「モラル化」の３説明モデルを保有しているといわれている。しかし、これらは欧米文化圏で提唱された理論枠組みであり、日本でのこれらの概念に関する実践研究例はほとんどない。また、これらのモデルは内的帰属に偏っており、社会や日本文化特有な概念が欧米文化発祥のモデルの中に含まれていない。日本と欧米では文化的価値観が異なることから、日本とカナダで説明モデルの文化差があることが予想される。本研究では説明モデルの日加文化比較を行った。日本

人（178名）とヨーロッパ系カナダ人（189名）大学生にうつ病、発達障害、統合失調症、アルコール依存症、ひきこもりの５つの精神疾患の架空症例を提示し、病因・援助要請についての自由回答記述を求め、データを内容分析した。質的データ解析からは、“家族の責任”や“教育制度や経済状況の問題”など既存の説明モデルに当てはまらない、「社会的要因」や「社会的責任」に相当する回答も複数抽出された。統計解析では日本とカナダ、また疾患別で文化差が示された。日本人はより心理化、ソーシャル・サポートと回答する傾向が高く、ヨーロッパ系カナダ人は医療化、投薬治療、セルフ・ケアと回答する傾向が高くみられた。また文化に関わらず、一般の人びとは複数の説明モデルを保有しており、従来考えれているよりも専門家ではない人びとの病の語りは複雑で包括的であることが示唆された。

キーワード

説明モデル，精神疾患，混合法，原因帰属，援助要請，日本

A Cross-Cultural Comparison of Beliefs about Mental Illness: A Mixed-Methods Study of Explanatory Models among Japanese and Euro-Canadian Students

2.1 Introduction

Public beliefs about mental illness have been examined in research areas such as mental health literacy, stigma, and health service utilization. However, most of the existing psychological literature in these areas adopts a Western biomedical model of mental illness, employing the concepts and measures predominantly developed in the West. Moreover, Euro-American and Judeo-Christian values, norms, and beliefs have profoundly shaped the present psychiatric nosology, theory development, research practices, and healthcare policy formulation (e.g., Fernando, 2014; Kirmayer, 2006). Prior cross-cultural studies, however, have consistently shown that the Western biomedical model is just one model among many around the globe, and diverse cultural differences exist in the understanding of mental illness within non-Western cultural contexts. People living in these contexts endorse different epistemological models such as mind-body holism, religious faith, spirituality, traditional healing, social morals, and relationships, to appraise what constitutes the nature of mental illness, identify its causes, and alleviate suffering. This pluralistic perspective stands in contrast to the singular focus on the biomedical model. Hence the interpretation, understanding, and treatment of mental illness, are shaped by the local socio-cultural context and are expected to vary across cultures.

Nevertheless, non-Western cultural models of mental illness have been largely excluded from the psychological literature. Much of the work examining and documenting non-Western cultural models of mental illness has been conducted by anthropologists who have attempted to deconstruct and decolonize Western, biomedical, and Eurocentric theories of mental illness as well as technoscientific, quantitative methodologies. Their efforts aim to deepen our understanding of cultural variations and promote culturally affirming practices in the field.

Another critique of the predominance in the use of the Western biomedical model in mental health research within psychology is that its overreliance on a dualistic, reductionist, and essentialist approach may overlook beliefs and experiences that are salient to non-expert or non-professional communities, including patients, their caregivers, and the general public (Kvaale et al., 2013; Lebowitz & Appelbaum, 2019; Schomerus et al., 2012). Researchers and mental health

professionals operating within the Western biomedical paradigm can be viewed as just another context or community. Beliefs about mental illness held by non-experts or the public often diverge from those of researchers and clinicians. Moreover, there is limited evidence suggesting that the Western biomedical model, or what is commonly referred to as the scientific understanding of mental illness, has effectively reduced stigma among the general public. Several review studies, for instance, have reported that anti-stigma campaigns and intervention programs promoting biogenetic explanations have failed to enhance public acceptance of mental disorders (Rusch et al., 2010; Schomerus et al., 2012). Instead, such efforts have been associated with increased stigma, including aversion, perceptions of dangerousness, and pessimism about recovery (Baek et al., 2023; Loughman & Haslam, 2018), while exacerbating othering and distancing from those with mental illness (Walsh & Foster, 2021) among the general public. Moreover, these initiatives have predicted higher levels of prognostic pessimism/chronicity, self-blame, fear, and lower levels of empathy toward those with mental illness among mental health professionals (Larkings & Brown, 2018). However, mainstream psychologists seldom have focused on the narratives and perspectives held by the public, as well as the roles they play in fostering mental healthcare. Gaining insights into the public's worldview, *explanatory models* of mental illness is crucial for understanding their attitudes toward sufferers and their help-seeking decisions.

The theoretical framework for explanatory models of mental illness was first developed by medical anthropologist Arthur Kleinman (Kleinman, 1980). Explanatory models propose that individuals, groups, or communities may develop their own unique sets of ideas and beliefs about the causes and treatment of mental illness. The majority of studies exploring this framework have been conducted by anthropologists and applied health researchers. These scholars have aimed to investigate perspectives of people with mental illness and the dynamics of patient-practitioner relationships through in-depth qualitative interviews and observations conducted in clinical settings. Their focus has been on how the explanatory models are shaped by their local socio-cultural world. In contrast, mainstream psychologists have primarily focused on examining aggregated data regarding people's perceptions and beliefs about the Western biomedical model of mental illness. This line of research is often done in the context of mental health literacy and public health, using conventional quantitative approaches such as epidemiological studies and self-reported surveys. In these quantitative studies, the underlying premise is that the general public

lacks recognition of professional or Western biomedical definitions of mental illnesses, resulting in limited knowledge about the causes of mental illness and underutilization of appropriate help-seeking resources (e.g., Angermeyer et al., 2006; Jorm et al., 1997). These studies typically highlight discrepancies between the biomedical knowledge about mental illness held by professionals and by the public, concluding that the latter perform poorly on, "mental health literacy tests," suggesting the need for increased education and awareness of the "correct" answers (e.g., Jorm, 2000).

Moreover, researchers conducting cross-cultural studies often claim that, compared to people from non-Western cultural contexts, Westerners perform better on these literacy and knowledge tests, as along with reporting lesser stigma and greater compassion toward those with mental illness. However, these claims often neglect to consider cultural specificity and appropriateness, instead conveniently imposing Western biomedical models and standards such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) as universal benchmarks. Consequently, this body of scholarship tends to perpetuate a Eurocentric and expert-centric perspective that portrays non-Western cultures and non-experts as less developed and inferior. Such perspective implies that individuals, communities, and cultures should strive to become more "literate" and "correct" by adopting the Western biomedical model.

2.1.1 The Folk Psychiatry Model

Research on mental health literacy within psychology also has predominantly focused on descriptive and correlational approaches, often lacking a solid theoretical foundation to understand the psychological processes through which the general public explain non-normative behavior or experience. Social psychologists, drawing from attribution theory, have made significant contributions to this field of research in Western cultural contexts. Haslam (2003) developed the *folk psychiatry model*, which provides a theoretical framework to examine how the public attributes causes to mental illness. The model acknowledges that non-experts hold well-developed theories or models of their own to understand psychological abnormality and deviance, even if they do not use the biomedical terminology to label or articulate mental illnesses.

The folk psychiatry model proposes that non-experts employ specific cognitive processes and four attributional dimensions— *pathologizing*, *moralizing*, *medicalizing*, and *psychologizing*

—to distinguish and evaluate different mental illnesses. According to the model, pathologizing is the initial step, where non-experts perceive behavior or the person exhibiting the behavior as abnormal, deviant, unexpected, or difficult to comprehend. This pathologizing judgment creates an explanatory gap or puzzle, where the behavior is deemed significant and deserving of attention yet challenging to understand. Subsequently, people employ one of the remaining dimensions to provide alternative explanatory frameworks that fill the gap and offer explanations for the behavior.

2.1.1.1 Moralizing

Moralizing is the process of interpreting behavior as a moral violation, attributing moral responsibility to the person engaging in the behavior. In this dimension, the perceiver judges that the behavior reflects the person's immoral intentions, desires, or failure to exercise self-restraint, thereby violating societal norms. When behavior is moralized, it is perceived as intentional and undesirable, leading to the belief that the actor is blameworthy. In the context of mental disorders, moralizing occurs when a perceiver believes that abnormal behavior or the condition reflects the person's weak character, personality flaw, or lack of self-control (e.g., viewing a person with depression as lazy or lacking personal effort). While the actor may be seen as deviating from societal norms, they are still considered a member of the shared moral community and held accountable for their actions and the undesirable consequences that may arise. Consequently, they may be subject to punishment or expected to conform to the shared norms of the community. Moralizing involves the perceiver's assessment of the actor's reasons and intentions underlying the behavior.

2.1.1.2 Medicalizing

The medicalizing framework represents the belief that the abnormal behavior stems from inherent biomedical malfunctions such as genetic, hormonal, or neurochemical abnormalities in the brain. According to this perspective, the abnormal behavior is perceived as beyond the control of the person exhibiting it. Medicalization, as an explanatory model, has become dominant in modern psychiatry and originated primarily in Western cultural contexts. Laypeople, particularly

those within Western cultural contexts, may have embraced the medicalization of mental disorders in response to the widespread influence of psychiatry and biomedicine in society.

2.1.1.3 Psychologizing

The psychologizing framework involves interpreting the causes of behavior based on the historical reasons and influences that shape the actor's behavior, rather than intentional motives. In this framework, behavior is attributed to non-intentional causes, and explanations are sought in psychological states, processes, or structures. Laypeople tend to explain psychological abnormality by referencing the actor's life history and non-conscious cognitive processes, rather than intentional reasons. While the actor's current behavior may be intentional, it is understood to be influenced by their past actions and unconscious cognitive processes, of which the actor may not be fully aware. Psychologizing explanations incorporate elements of both moralizing and medicalizing explanations. Like moralizing, they involve considering mental states, but with a diminished degree of intentionality and responsibility, similar to medicalizing explanations. For example, a moralizing explanation for a person with depression who is disengaged in daily activities may attribute it to laziness or a failure to control their mood. In contrast, a medicalizing explanation might attribute it to a deficiency of neurotransmitters in the brain. A psychologizing explanation recognizes the meaningfulness of the symptoms of depression and takes the person's life history into account, such as traumatic and social learning experiences.

2.1.2 Cultural Variations in Explanatory Models of Mental Illness

Previous research has demonstrated cultural variations in beliefs about the causes of mental illness and help-seeking. Different cultural communities endorse their own explanatory models with varying emphases based on their prevalent values. For instance, Romanians were more likely to endorse medicalization whereas Brazilians were more likely to endorse moralizing when explaining the causes of mental illness (Giosan et al., 2001). Brazilians displayed a lower tendency to psychologize compared to Americans (Giosan et al., 2001). However, increased American acculturation among Brazilians living in the US was associated with increased tendency to psychologize (Glovsky & Haslam, 2003).

Researchers have further investigated the role of cultural values in shaping causal beliefs and pathologizing tendencies. For example, a study by Ban and colleagues (2010) found that Euro-Australians were less likely to pathologize and moralize Major Depressive Disorder and Antisocial Personality Disorder when provided with a causal explanation for the abnormal behavior. However, this "normalizing" effect was not observed among Chinese-Singaporeans. The tendency to pathologize these mental illnesses was not influenced by the presence of a causal explanation or familiarity with the disorders. The study also revealed that adherence to traditional Chinese values, such as self-discipline, obedience, and social order partially predicted moralization among Chinese-Singaporeans. In sum, the acknowledgement or comprehension of the underlying cause of abnormal behavior did not impact the degree to which Chinese-Singaporeans perceive the behavior as pathological, but rather resulted in increased moralization and stigmatization. Similarly, Vargas and colleagues (2019) found that Chinese-Canadians were more likely to pathologize and moralize depression, whereas Euro-Canadians were more likely to psychologize it. Chinese-Canadians' tendency to moralize depression was also predicted by their vertical collectivism. These findings suggest that group differences in beliefs about psychological deviancy may be shaped by social and cultural values between Western and East Asian cultural contexts.

A substantial body of research in cultural psychology demonstrates that people from East Asian cultural contexts tend to construe the self as interdependent, whereby they tend to perceive and define themselves in relation to external qualities and socially defined identities (e.g., student, son, good listener). Conversely, people from Western cultural contexts are more likely to endorse an independent self-construal and typically prioritize internal traits and private descriptions as the most defining aspects of themselves (e.g., smart, likes books, good in math) (Markus & Kitayama, 1991; Norenzayan et al., 2002; Rhee et al., 1995). There is also considerable evidence suggesting that cultural differences in self-construal influence socio-cognitive and psychological processes including beliefs regarding the causal attribution of abnormal behavior. Therefore, it is plausible to consider that there would be cultural differences in explanatory models of mental illness between East Asian and Western cultural contexts.

The three dimensions of the folk psychiatry explanatory framework presuppose that the cause of mental illness lies within the sufferer. We argue that such an assumption is primarily derived from the emphasis on the individual or the allocentric understanding of the self in Western

cultural context. These three dimensions fail to capture the broader social and contextual dimensions surrounding the sufferer, which people from non-Western cultural contexts may consider holding greater importance depending on the circumstances. Earlier studies found that East Asians are inclined to use more external or situational attributions to make sense of others' behaviors as opposed to internal or dispositional attributions favored by those from Western cultural contexts (Choi et al., 1999; Mason & Morris, 2010; Miyamoto & Kitayama, 2002; Norenzayan et al., 2002). These studies suggest that, in East Asian cultural contexts, people tend to prioritize social considerations and group harmony over individual uniqueness or private needs, leading them to perceive external, situational, and contextual influences as playing a greater role in the etiology of socially deviating behaviors.

In contrast, other studies showed inversed patterns between East Asians and European Americans. For example, Crystal and colleagues found that Japanese participants endorsed more internal attributions and moralized the actor to protect the group, whereas European American participants endorsed external attributions to prioritize the actor's self-enhancement (Crystal, 2000; Crystal et al., 2001). Similarly, Hui (2001) found that although both Chinese students and teachers endorsed both internal and external attributions to explain mental health and school related difficulties and concerns held by students at school, they gave more weight to their internal deficiencies rather than external, dispositional influences. The seemingly contradictory findings from these studies suggest that East Asians tend to attribute behavior to a complex interplay of *both* dispositional and situational-contextual determinants, rather than exclusively relying on one or the other. Dispositional attribution is not completely absent among East Asians. This worldview aligns with the prevalent dialectical principle of holism in Asian cultural contexts, as described in theoretical and empirical literature exploring the relationship between the mind and body (Conrad & Pacquiao, 2005; Kleinman, 1988; Leong et al., 2001; Norenzayan et al., 2002; Ryder et al., 2002; Spencer-Rodgers et al., 2012). Therefore, we argue that non-experts, particularly those in East Asian cultural contexts, are likely to endorse more holistic and pluralistic explanatory models of mental illness than previously assumed a monolithic model.

Like causal beliefs, help-seeking beliefs and actions are determined by the local, social, and cultural contexts in which people are situated (Arnault, 2009; Pescosolido, 1992; Saint Arnault & Woo, 2018). The majority of research examining beliefs about help-seeking has primarily

focused on seeking professional help, frequently asserting that lack of mental health awareness and literacy and the presence of stigma, as factors contributing to the underutilization of mental health services among non-experts and people from non-Western cultural contexts. However, studies have shown that those experiencing symptoms of mental illness also perceives various informal support as valuable sources for their recovery (e.g., Tata & Leong, 1994; Ten Have et al., 2010). Furthermore, previous cross-cultural research has found that East Asians, Asian Canadians, and Asian Americans seek social support from their close others and professional help less often compared to European Canadians and European Americans (Chen & Mak, 2008; Jung et al., 2017; Kuo et al., 2006; Tse & Haslam, 2021). Similarly, in surveys comparing mental health literacy, Australians were more likely to report that their general practitioner is helpful, while Japanese indicated a preference for seeking help from family members or managing the problem themselves. Furthermore, both Australians and Japanese held similar beliefs regarding the usefulness of private resources such as books and the internet. (Jorm et al., 2005; Nakane et al., 2005).

The authors argue that these cultural differences reflect the differences in the mental health care system that Australian mental health care places more emphasis on community care and more common disorders such as depression, whereas the Japanese system tends to prioritize hospitalization or institutionalization for more severe conditions such as psychotic disorders (Mizuno & Murakami, 2002). Similarly, mental health professionals and researchers endorsing culturally sensitive care for Asians and Asian Americans argue that people from Asian cultural contexts place less value on Western-invented psychotherapy or talk therapy, which emphasizes openly expressing emotions and individual needs and seeking help outside of one's social network. This preference aligns with the interdependent and collectivistic norms prevalent in Asian cultural contexts. People from Asian cultural contexts may prefer to seek indirect coping styles compared Western cultural contexts, such as accepting difficult situations, holding others accountable for change and recovery, and placing less emphasis on direct coping strategies such as changing or removing the source of stress by seeking professional support (Kim et al., 2001; Kim-Mozeleski et al., 2018; Wong et al., 2010).

The public's beliefs about mental illnesses are also expected to differ across different disorders because sociocultural norms shape what is considered normal or pathological (Angermeyer et al., 2004; Angermeyer & Dietrich, 2006; Chentsova-Dutton & Ryder, 2020;

Schomerus et al., 2012). However, many studies examining the general public's perceptions of mental illness have often narrowed their focus on a specific disorder or aggregated different disorders into a single concept of mental illness. The reliance on broad categories or specific selection of disorders may overlook the diverse and nuanced nature of various mental disorders, as well as the way in which the public's beliefs are shaped by unique cultural and social values and norms. Consequently, it may lead to oversimplifications and potentially inaccurate conclusions (Angermeyer & Dietrich, 2006). Nevertheless, some studies found variations in the public's beliefs based on the specific types of disorders under consideration. For instance, population-based surveys conducted in the US have revealed more negative attitudes, stigma, or moralization towards substance abuse problems compared with depression or schizophrenia (Schnittker, 2008; Schnittker et al., 2000). Additionally, Schnittker (2008) found an increased trend towards public use of genetic explanations for both schizophrenia and depression between 1996 and 2006. However, the function of the genetic explanations differed for these two disorders. For schizophrenia, genetic explanations are associated with higher levels of perceived dangerousness, heightening concerns about potential violence and threats. In contrast, genetic explanations for depression are linked to reduced levels of moralization and increased acceptance.

Although direct comparisons of explanatory models across disorders and cultural contexts were not conducted, Angermeyer et al. (2011) conducted a systematic review of 33 population studies on public beliefs about mental illness. It revealed differences in moralization across disorders and countries. The review found that moralization of schizophrenia was infrequently endorsed in all 30 national surveys conducted in European countries (European Commission, 2006). However, two studies conducted in Malaysia and Japan showed higher levels of moralization for general mental illness and schizophrenia (Griffiths et al., 2006; Yeap & Low, 2009). For depression, studies from Great Britain, Australia, and Canada indicated lower prevalence of moralizing compared to Germany, Japan, Brazil, and India (Angermeyer & Matschinger, 2003; Crisp et al., 2000, 2005; Griffiths et al., 2006; Kermode et al., 2009; Link et al., 1999; E. T. P. Peluso et al., 2008; E. T. P. Peluso & Blay, 2009; Yeap & Low, 2009). For alcohol dependence, another review of population studies conducted by Schomerus et al. (2011) reported that across the 17 surveys located in Europe, North America, New Zealand, Brazil and Ethiopia, alcohol dependence was much more moralized than depression and schizophrenia or

other, substance-unrelated mental disorders such as panic attacks, eating disorders, and Alzheimer's disease(Blay & Peluso, 2008; Crisp et al., 2000; Link et al., 1999; E. T. P. Peluso & Blay, 2008; E. T. P. Peluso et al., 2008; Pescosolido et al., 2010). These results suggest that cultural differences are likely, and particularly alcohol dependence is highly moralized compared to other mental illnesses.

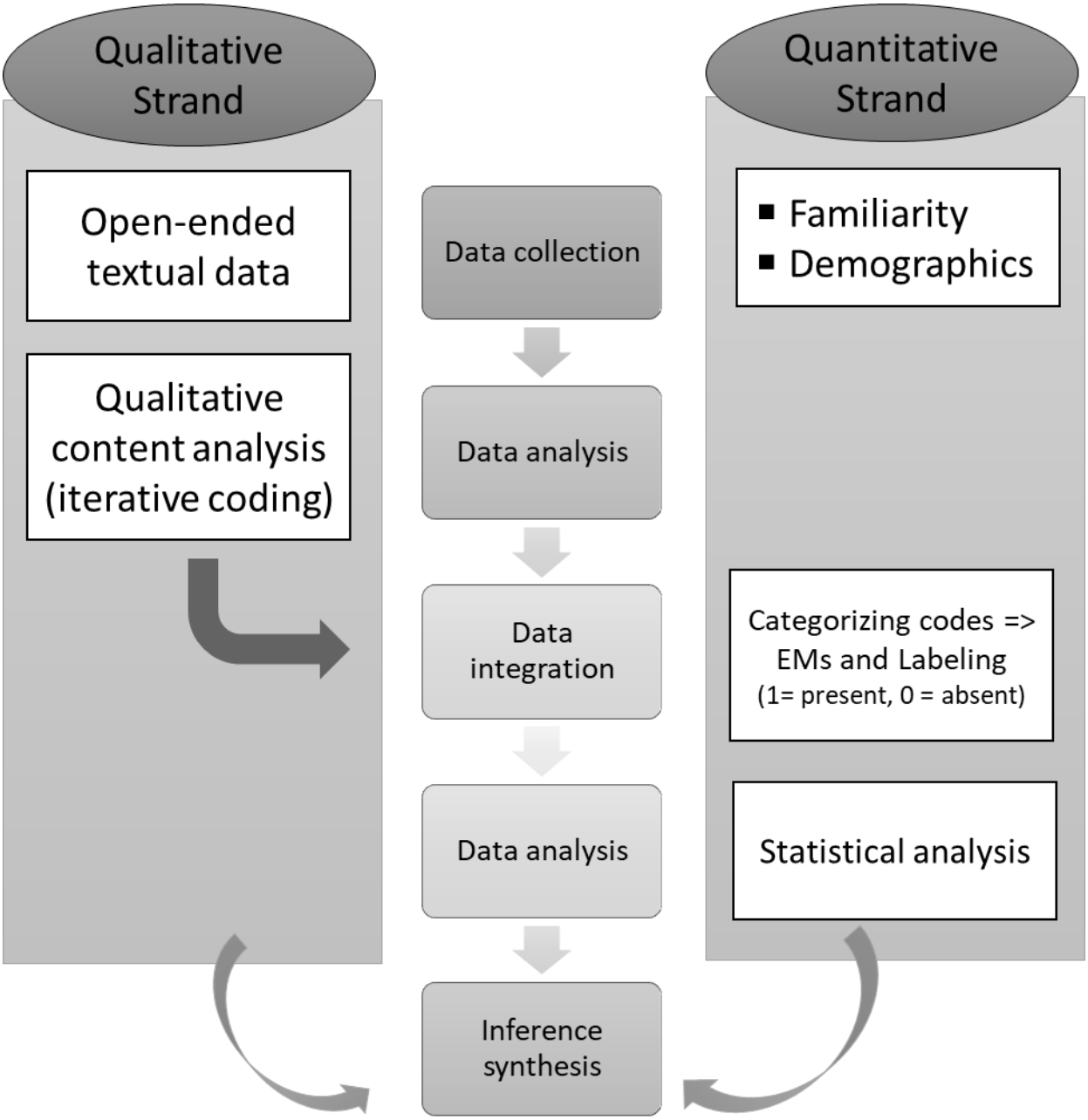
2.2 Present Study

The goal of the present study was to employ a mixed-method research (MMR) approach to investigate cultural variations in explanatory models of non-experts in Japan and Canada. We implemented a mono-strand conversion design (Teddlie & Tashakkori, 2009). The study design is displayed in Figure 1. First, the qualitative phase aimed to explore a wide range of participants' narratives pertaining to causes and help-seeking across five disorders: depression, autism spectrum disorder, schizophrenia, alcohol use disorder, and hikikomori without imposing pre-existing frameworks. Specifically, we conducted content analysis to elicit various themes that were not captured by the three existing folk psychiatry models, survey items, and help-seeking models in the existing literature.

Second, building on the results from the qualitative phase, the quantitative phase aimed to investigate cultural variations in explanatory models of five disorders between Japanese and Euro-Canadian students. An MMR approach allows researchers to identify a diverse range of beliefs that not only reflect local cultural contexts but also retain some level of generalizability to be tested across different contexts by integrating qualitative and quantitative research methods (Creswell, 2013; Doucerain et al., 2016; Karasz & Singelis, 2009).

An MMR approach is particularly suitable for the present study for two main reasons. Firstly, previous research on beliefs about causes and help-seeking has predominantly relied on quantitative methods only. Secondly, most studies in this field have been conducted on samples that are Western, Educated, Industrialized, Rich, and Democratic (WEIRD), by researchers of WEIRD background (Henrich et al., 2010). Therefore, it is crucial to first engage in a thorough qualitative research inquiry to understand the local cultural, non-expert beliefs without imposing existing Western biomedical theories, and then proceed to the confirmatory research phase using quantitative approaches.

Figure 1 *A Mono-Strand Conversion Mixed-Methods Research Design used in the Present Study*



2.3 Methods

We conducted a mono-strand mixed-method research design first to (1) examine explanatory models of causes and help-seeking inductively in the qualitative phase and (2) statistically analyze cultural differences in explanatory models between Japanese and Euro-Canadian students in the quantitative phase. We aimed to integrate both inductive and deductive approaches in our methodology and data analysis to conduct hypothesis testing while allowing culturally unique explanatory models to emerge from the data. To this end, we conducted content analysis to collect, code, and analyze the qualitative data in the phase 1. Content analysis allowed us to elicit open-ended responses to capture diverse explanatory models and nuances rather than imposing an existing framework on them. Doing so then allowed us to subsequently quantify and statistically analyze the relationships among the variables of interest in phase 2.

2.3.1 Participants

For the Japanese sample, a total of 178 (117 cis-women, 57 cis-men, four identified as other, mean age = 20.37, *SD* = 3.41) undergraduate students enrolled in psychology courses at Osaka University and Nihon University in Japan participated in the study. Japanese participants were all born in Japan and self-identified as having Japanese heritage. For our Euro-Canadian sample, we analyzed data from 189 undergraduate psychology students (163 cis-women, 25 cis-men, one identified as other, mean age = 22.70, *SD* = 4.88) at Concordia University, Montreal, Canada. Euro-Canadian participants were either born in Canada or moved to Canada before the age of six, attended schools at an English-language school board for all levels of education, and self-identified as White with European ancestry. Participants at both sites were recruited using purposive sampling within a convenience sampling frame. The data were collected during 2017-2019.

2.3.2 Procedures

Participants filled out a paper-and-pencil survey packet that included informed consent, demographic information, the levels of familiarity with each vignette condition, and five vignettes followed by open-ended questions pertaining to their beliefs. Participants were asked to read each vignette, rate their familiarity with the disorder, and provide their responses to the two open-ended

questions: (1) why does this person behave the way they do? (*Causal beliefs*) and (2) How could this person recover (*Help-seeking beliefs*). All the materials were translated, reviewed, and evaluated following the team-based translation approach (Harkness, 2003).

2.3.3 Vignettes

We developed five vignettes depicting a person meeting the criteria for hikikomori defined by the Japanese Ministry of Health, Labor, and Welfare, and four DSM-5 defined mental disorders: Major Depressive Disorder (depression); Autism Spectrum Disorder (ASD), schizophrenia; and Alcohol Use Disorder (AUD). The order of the presentation of the vignettes was counterbalanced. Disorders were unlabeled in the vignettes and developed with consultation from a clinical psychologist from each site (see Appendix A for an example).

2.3.4 Measures

Familiarity. The level of familiarity with mental illness may offer an alternative explanation for differences in explanatory style, therefore, we administered the Level of Contact Report (Holmes et al., 1999), a 12-item questionnaire assessing the level of familiarity with people with each of the mental disorders depicted in the vignettes. Example items include, "I have observed a person like this frequently", "I have worked with a person like this", and "My relative is like this". Participants rated items on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). We administered the Japanese version of the measure previously translated and validated by Kashihara (2016). Participants responded to the 12-item measure for each disorder type. Cronbach's alphas ranged from .60 to .80.

2.3.5 Coding Scheme Development

For explanatory styles, we adopted content analysis to qualitatively code the open-ended responses using an integrative approach that involves both deductive and inductive coding. Inductive coding allowed us to explore and reveal new or unique statements that were not captured by the three explanatory styles. Through a deductive process, on the other hand, the open-ended responses were classified into existing theory (i.e., medicalizing, psychologizing, moralizing) to examine the alignment of the data with the existing explanatory style. Additionally, any mention

of clinical or psychiatric diagnosis names was coded as 'labeling'. Our coding development involved the iterative process of extracting new information, developing new codes, and reassigning the codes to the data. The coding scheme was developed and finalized by two English-Japanese bilingual researchers (the third and fourth authors) in consultation with the first author who is also bilingual. The two coders have lived in both Japan and Canada and have good understanding of norms and values of both cultural contexts.

Coding of explanatory styles was performed by the seventh author, who is a native English-speaking Euro-Canadian coder and the eighth author, a native Japanese-speaking Japanese coder, each of whom coded the data in their respective first language. They were joined by the aforementioned two bilingual coders, who each coded half of the Japanese and half of the English data. The four coders were trained and mediated by the first author throughout the coding process. To train the coders in the use of the coding scheme, we first selected random 10% participants from each cultural group in our sample and they independently coded the responses. Second, we compared the set of codes each coder assigned to the responses of each participant and discussed discrepancies for each case. The next step was to confirm that all the four coders could independently replicate the other's work using the same coding scheme. The two coders coded the remaining 90% of the responses in the sample. Intercoder reliability coefficients exceeded Kappa = .85 (Landis & Koch, 1977). Disagreements between coders were resolved through discussion among the coders and the first author.

2.4 Results

2.4.1 Phase 1: Qualitative Analysis

Our analysis of labeling indicated that while Euro-Canadian participants provided psychiatric diagnosis and mental illness labels consistent with the condition described in vignette cases, general labeling (e.g., "*the person suffers from some kind of mental illness*"), or widely known disorders such as anxiety. However, we also discovered responses representing uncertainty about the hikikomori condition in our Euro-Canadian data (e.g., "*I have never heard of these symptoms*", "*I am not a clinical psychologist to give a diagnosis about this condition, and I don't think it's possible to explain definitely without more information*."). We also observed responses labeling hikikomori as a personality disorder (e.g., antisocial, avoidant, and schizotypal) and

schizophrenia in our Euro-Canadian data. In our Japanese data, we found the labeling of hikikomori and Taijin Kyofusho; there was no labeling of a personality disorder.

2.4.1.1 Causal Beliefs

We developed two separate coding schemes for causal and help-seeking beliefs. For causal beliefs, we adopted a coding manual developed by Wong (2010) while allowing new codes to emerge from our own data. Our final coding scheme included a total of 15 codes by merging some of the existing codes defined in the manual and generating a few new ones to fit with our study purpose (as shown in Table 1). We then aggregated the codes and classified them into one of the three folk psychiatry models according to the theoretical conceptualization. Across the five disorders examined, Japanese participants provided 262 examples (30%) of codable text representing medicalization, 135 examples (15%) representing moralization, and 653 examples (73%) representing psychologization. Euro-Canadian participants generated 747 examples (79%) of codable responses representing medicalization, 78 examples (8%) representing moralization, and 318 examples (34%) representing psychologization.

Our data also uncovered beliefs and thematic patterns that involved attributing causes of mental illness to macro-level societal factors, or cultural pressures. These themes included the non-fulfillment of filial piety, the failure of family members or caregivers to fulfill their parenting obligations (moralization of the family, rather than the person experiencing the suffering), and external factors such as misfortune or unfavorable circumstances. These themes could have been categorized as psychologizing according to the original folk psychiatry theory. However, we argue that these themes deserve their own model because they strongly reflect crucial aspects of Japanese cultural norms and values. We also argue that such macro-level explanations or contextualization should be differentiated from micro-level or the person-focused explanations such as psychodynamic attributions often accompanied by psychologization endorsed by people from Western cultural contexts. We, therefore, created and labeled a new explanatory model as *social-contextualization*. We conceptualized the newly emerged *social-contextualization* as an explanatory model in which respondents strongly externalized and sought explanations for the causes of mental illness outside the sufferer, but in a larger social-contextual world.

For social-contextualization, Japanese participants generated 32 instances (3.60%) of codable text, and Euro-Canadian participants provided a total of 24 codable texts (2.54%). Specific examples representing social-contextualization in our Japanese data were "*the family members are indulging their child and enabling the problematic behaviors* (親が甘やかしており、過保護だから今の生活で不自由なく暮らせるため、外に出ていく必要性も感じていない。)," "*the parents failed to provide appropriate support that the child needs to recover for the hikikomori condition* (両親が問題解決しようとすることをしなかったから。)," and "*the parents are reinforcing the child to avoid interpersonal interactions and creating an environment where they can live without confronting problems* (両親が人との接触を拒むような行動を許容してしまっており、問題に向き合わずとも生きていけるような状況をつくっている。)." Similarly, Japanese participants attributed the emotional and psychological difficulties of the hikikomori sufferer to their failure to fulfill filial piety, which is distinctively different from attributing to moral violation (e.g. "親不孝や親への罪悪感を感じているから。"). We also found examples in our data from Japanese participants that reflect beliefs about bad luck and misfortune, "*the person just had a bad luck* (運が悪かった。)" and "*Unfortunately, the person experienced bad timing in their life* (残念なことに人生のタイミングがただ悪かった。)." In our Euro-Canadian data, "*lack of societal and structural support being responsible for the suffering of the person with ASD*," "*the parents indulge his lazy behavior, encouraging it to continue*," and "*the parents themselves are anxious beings, causing him to lack social skills. They did not properly teach him how to process certain emotions*" were examples representing social-contextualization.

In summary, both Japanese and Euro-Canadian participants provided social-contextualization of causal attribution, which are not captured by the existing folk psychiatry models. This underscores the importance of including social-contextualization in the conceptualization of explanatory models for mental illness.

Table 1 *Codebook for Causal Beliefs*

Explanatory Model	Code English (E)	Japanese (J)	Response Examples
Medicalization **医療化**	Biomedical	生物医学	(E) "*Genetic predisposition, or deregulation of hormones or neurotransmitters*." (J) "脳内化学物質のバランスが崩れたから。"
Moralization **モラル化**	Behavioral	行動	(E) "*They use alcohol to self-medicate themselves*." (J) "悪い習慣から抜け出せないから。"
	Moral	道徳規範	(E) "*They avoid facing their problems and takes the easy way out.*" (J) "元から心が弱い人間だから。"
Psychologization **心理化**	Existential	実存・存在	(E) "*They have low self-esteem and self-worth.*" (J) "自分の人生にやる気や生きがいが感じられないから。"
	Cognitive	認知	(E) "*They cannot see the "good" in things.*" (J) "人間関係を築くことが苦手だと思い込んでいるから。"
	Psychodynamic	サイコダイナミック	(E) "*They have experienced a traumatic event as a child.*" (J) "幼少期の親との関係に起点しているから。"
	Situational/ Environmental	状況・環境	(E) "*They are experiencing stressful life transitions.*" (J) "大学で高校と違った新しい環境に馴染めなかったから。"
	Interpersonal	対人関係	(E) "*Disputes in relationships.*" (J) "職場の人と人間関係のトラブルがあったから。"
	Sense of belonging/ Network Skills	居場所・ネットワーク	(E) "*They never had any sense of inclusion.*" (J) "コミュニティの中で自我を出せる場面が無かったから。"
		スキル	(E) "*They have poor social skills.*" (J) "コミュニケーションを取るのが苦手だから。"

	Emotion	感情	(E) "*They feel pressured and scared.*" (J) "人と関わることに恐怖を覚えてしまったから。"
	Traits/Character	特性・性格	(E) "*It's their unique personality.*" (J) "もともと責任感の強い性格だから。"
Social-Contextualization **社会化**	Family-Blaming/ Responsibility	親の責任	(E) "*Their family indulges their lazy behavior.*" (J) "親が甘やかしており、過保護だから。"
	Societal factors/pressures	社会的要因・プレッシャー	(E) "*Our society is not adapted for individuals with autism" That's the main problem*." (J) "教育制度や経済状況が良くないから。"
	Misfortune/ Bad Timing	運・タイミング	(E) N/A (J) "タイミングや運が悪かったから。"
	Failure to fulfill filial piety	親不孝	(E) N/A (J) "親不孝や親への罪悪感を感じているから。"

Note. NOS = Not Otherwise Specified. N/A = No response reported.

2.4.1.2 Help-Seeking Beliefs

Table 2 presents a list of codes for help-seeking beliefs. We developed a coding scheme both deductively and inductively. We identified a total of 19 codes and reduced the codes to six categories partially adopting the categorization done in previous studies (e.g., Erdal et al., 2011; Lauber et al., 2005; Markova & Sandal, 2016). Japanese participants generated 123 examples (14%) of codable text representing medication, 272 examples (31%) representing professional support, 251 examples (28%) representing social support, and 294 examples (33%) representing self-care. Euro-Canadian participants provided 437 instances (46%) of codable text representing medication, 618 instances (65%) recommending professional support, 196 (21%) instances representing social support, and 427 (45%) instances for self-care.

We identified two new distinctive help-seeking beliefs; (1) *social-contextual responsibility*, and (2) *prognostic pessimism* that are not captured by the categorizations done in the existing studies mentioned above. For social-contextual responsibility, Japanese participants generated 125 instances (14%) of codable text, and Euro-Canadian participants provided a total of 27 codable text (3%). For prognostic pessimism, Japanese participants provided 8 examples (1%) of codable text, whereas Euro-Canadian participants provided 40 examples (4%) of codable text representing the belief.

Most interestingly, we found beliefs about collective responsibility of recovery process. Specifically, we identified a belief that the sufferers themselves were not necessarily the only ones responsible for seeking help. Instead, participants' perception of collective responsibility involved attributing accountability to family members, friends, and caregivers of the person who is suffering. They believed that people surrounding the sufferer play a significant role in facilitating changes in the sufferer's thinking or behavior, which could potentially help them overcome problematic behaviors or emotional difficulties. Example responses from our Euro-Canadian data, "*the parents should see a therapist to work on their cognitive distortions*, " and from our Japanese data, "*the parents should educate themselves about the illness, stop spoiling their child, or actively search for a job for their son with hikikomori to recover from the condition* (親が過保護をやめ、病気の理解を深め、仕事を探してあげる。)" allowed us to identify social-contextual responsibility.

Responses representing prognostic pessimism or denying the presence of the problem were observed through pessimistic and negative statements such as "*The person doesn't deserve help*", "*The problem doesn't exist*", "*The problem will go away*", or "*There is no help or cure*". For this type of help-seeking belief, Japanese participants provided 8 (0.9%) examples and Euro-Canadian participants provided 40 (4.23%) examples in the data.

To account for cultural differences in beliefs about seeking help from mental health professions, we incorporated a Japanese-specific code that includes "seeing a psychosomatic doctor (*shinryo-naikai*;心療内科医) as one of the professional support codes. Psychosomatic doctors in Japan are highly sought-after specialists who often serve as the initial point of contact and medical professionals for those who present with psychological, emotional, and physical symptoms. Importantly, seeking the help of a psychosomatic doctor is generally less stigmatized than seeing other mental health professionals such as psychiatrists or psychotherapists in Japan.

Although self-care is not a newly emerged category in help-seeking literature, we developed a new code, *resting* under self-care. *Resting* was specific to Japanese respondents. *Resting* code includes taking a leave of absence from work or school. There was no Euro-Canadian participants mentioned *resting*. Relatedly, in our analysis of the Japanese data, we observed specific responses pertained to work-related themes. For instance, the need for seeking social support from the boss or colleagues at work, as well as the potential benefits of changing the sufferer's work environment, such as requesting a department or division transfer as an important "environmental change" (code labeled as *environmental change*). In contrast, we did not observe any work-related responses or themes in the Euro-Canadian data. This suggests a cultural distinction in the importance placed on work-related stress and support when it comes to beliefs about mental illness and seeking support for Japanese participants. Figure 2 and Figure 3 show the percentage of participants who endorsed each of the explanatory models for causal beliefs and help-seeking beliefs, respectively.

Table 2 *Codebook for Help-Seeking Beliefs*

Explanatory Model	Code English (E)	Japanese (J)	Response Examples
Medication **投薬**	Medication	投薬	(E) "*SSRIs.*" (J) "ホルモンバランスを調べて、投薬治療を行う。"
Professional Help **専門家**	See a therapist	セラピストにみてもらう	(E) "*Cognitive Behavioral Therapy*." (J) "セラピストと一緒に原因の整理をする。"
	See a psychiatrist	精神科医にみてもらう	(E) *"See a psychiatrist."* (J) "精神科で早期に治療を開始する。"
	See a counselor	カウンセラーにみてもらう	(E) *"Seek out some counselling to better understand themselves."* (J) "カウンセラーの援助で自分の状態について知る事が必要。"
	See a psychosomatic doctor	心療内科に行く	(E) N/A (J) "心療内科で適切な治療を受ける。"
	See a doctor (e.g., GP, FD)	病院に行く（精神・心療内科以外）	(E) "*See a doctor to get a medical checkup.*" (J) "医療機関を受診する。"
	See a professional (NOS/Other)	専門家にみてもらう（上記以外）	(E) "*Go to a rehabilitation institution.*" (J) "アルコール依存治療の専門機関に行く。"
Self-Care **セルフケア**	Cognitive change	考え方を変える	(E) "*Recognize their negative thoughts and replace them with positive ones.*" (J) "自分のミスを客観的に把握して苦手意識を無くす。"
	Behavioral change	行動を変える	(E) "*Change habits and establish a healthy routine.*" (J) "禁酒して、生活にメリハリをつける。"

	Engage in Healthy Networking/ Interpersonal Relationships	より良い人付き合い・人間関係を築く	(E) "*Find a community and support group to be part of.*" (J) "SNS で同じ状況から立ち直った人と交流する。"
	Recreational activities	趣味・リクリエーション	(E) "*Cultivate an interest or hobby (e.g., gardening, cooking).*" (J) "旅行や音楽などの自分の趣味に没頭する。"
	Palliative coping	心身のリラクゼーション・バランスを整える	(E) "*Exercise, meditate, and eat healthy.*" (J) "運動、睡眠、食事を健康的にする。"
	Rest	休みを取る・休息する	(E) N/A (J) "仕事を一旦休んでゆっくり静養する。"
	Environmental change	環境を変える・整える	(E) "*Get out of their bedroom*." (J) "職場や部署を変える。"
Social Support **周囲からの支援**	Support from friends	友人のサポート	(E) "*Talk to a group of supportive friends*." (J) "友人に忘れ物のチェック、好きなことを一緒にしてもらえるように依頼する。"
	Support from family	家族のサポート	(E) "*Talk about their feelings with an understanding family member.*" (J) "家族と話し合う機会を作り、イライラする理由を伝えて、理解してもらう。"
	Support from others (NOS)	他者のサポート（友人・家族以外）	(E) "*Ongoing and strong support system.*" (J) "会社の上司に相談する。"

Social-Contextual Responsibility **社会的責任**	Others' responsibility	他者（家族など周囲）の責任	(E) "*Their parents should change their beliefs and attitudes first to stop their behavior and give them some guidance and a push.*" (J) "親が過保護をやめ、病気の理解を深め、仕事を探してあげる。"
Prognostic Pessimism **予後悲観**	The person doesn't deserve help. Problem doesn't exit. It will go away. There's no help/cure.	回復や予後に悲観的	(E) "*They won't be able to recover. There is not a cure.*" (J) "もう諦めていると思う。本人の意志が変わらぬ限り変化はない。"

Note. NOS = Not Otherwise Specified. N/A = No response reported.

Figure 2 *Proportions (%) of Explanatory Models by Culture for Causal Beliefs*

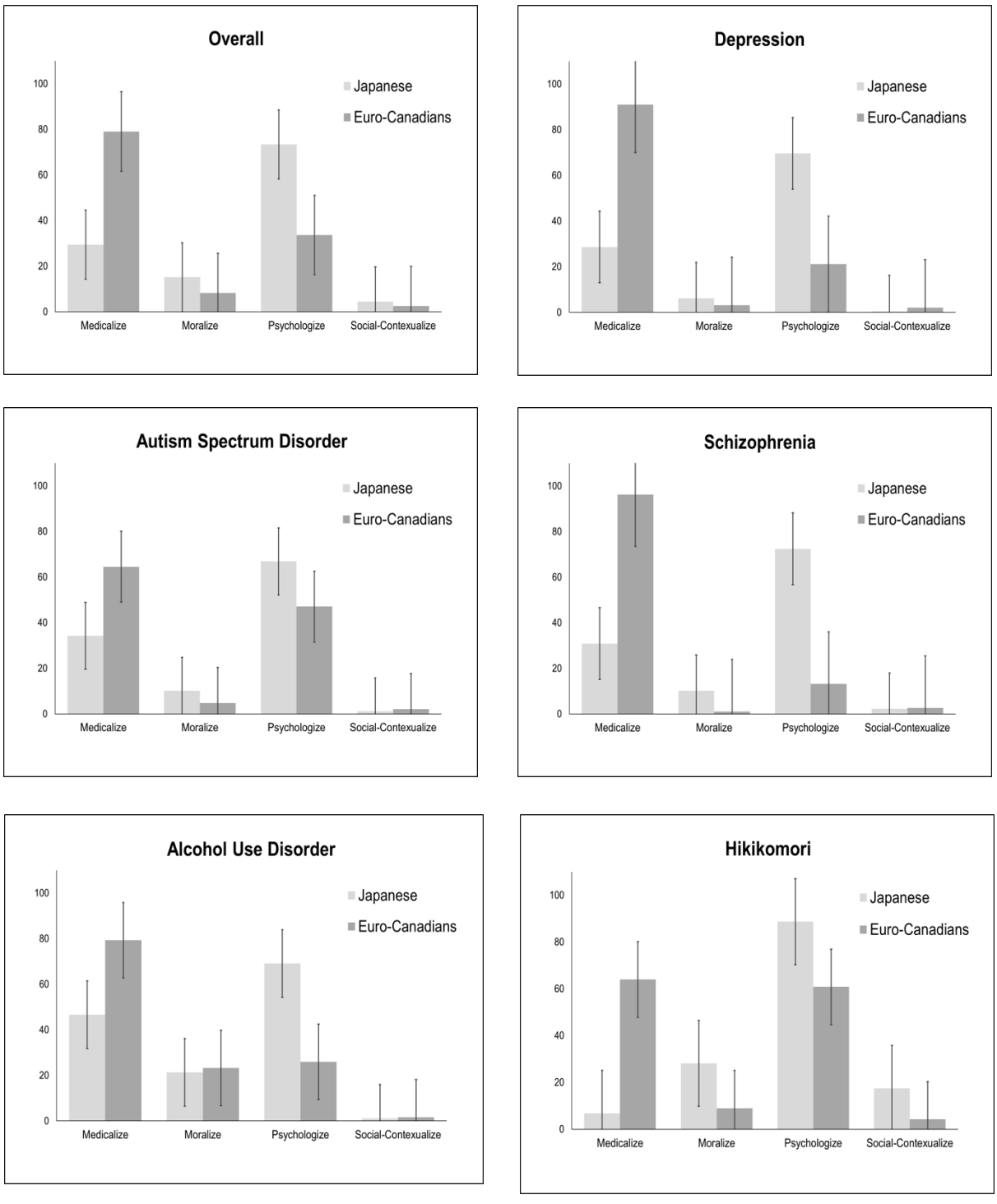
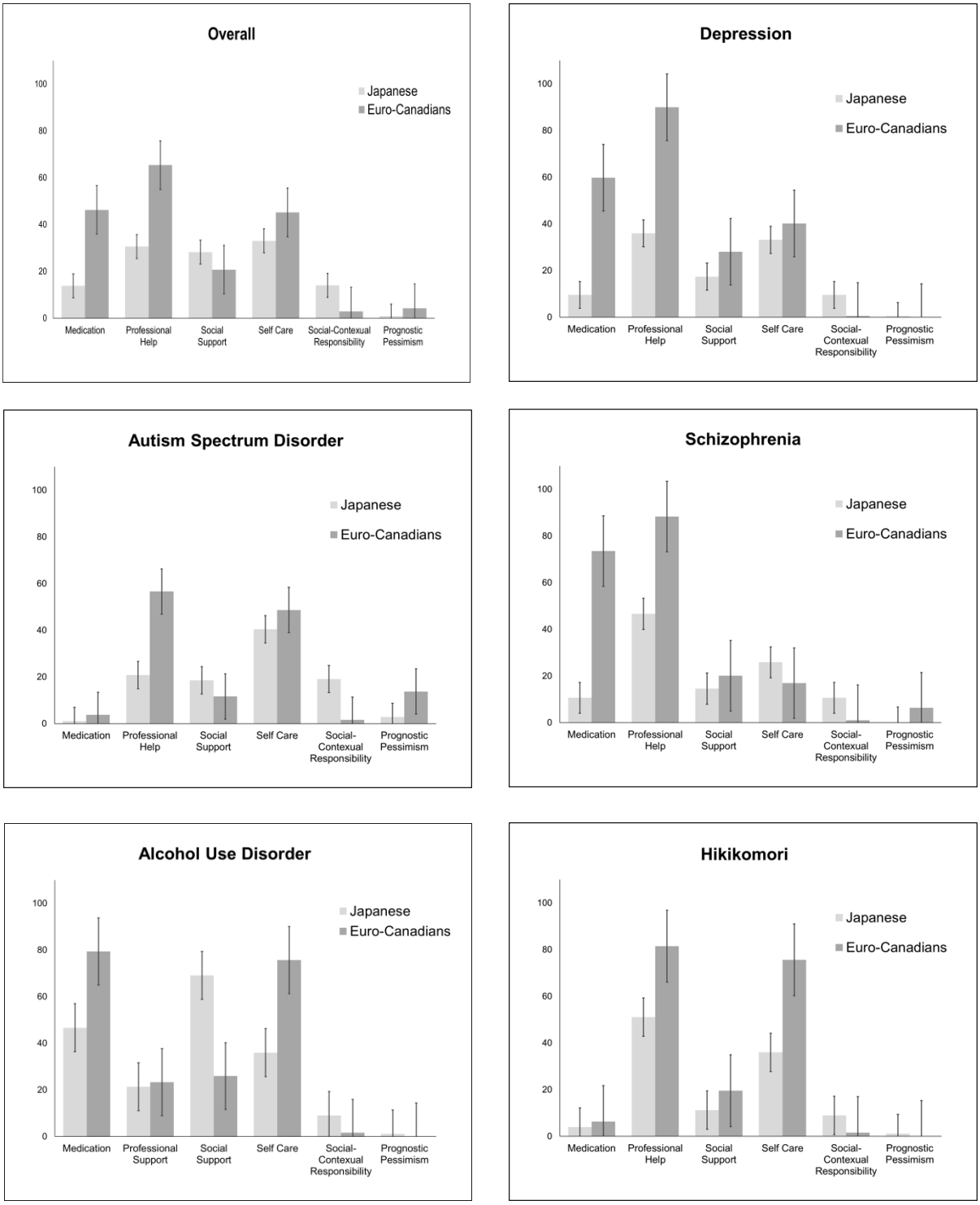


Figure 3 *Proportions (%) of Explanatory Models by Culture for Help-Seeking Beliefs*



2.4.2 Phase 2: Quantitative Analysis

The present study aims to examine cultural differences in the endorsement of EMs between Japanese and Euro-Canadian students. We generated the following hypotheses:

For causal beliefs:

H1 = The endorsement of EMs will differ between cultural groups, with Euro-Canadians medicalizing and psychologizing more and Japanese moralizing and social-contextualizing more.

For help-seeking beliefs:

H2 = The endorsement of EMs will differ between cultural groups, with Euro-Canadians suggesting medications, professional help, and self-care more and Japanese suggesting social support and social-contextual responsibility more.

Our theoretical interest was to compare cultural differences in the patterns of EMs. Therefore, as an additional research question, we explored the following:

RQ: Do the patterns of EMs across five disorders differ between Japanese and Euro-Canadians?

2.4.2.1 Preliminary Analysis

Qualitative data coded in the first phase was converted to a numeric value to represent the endorsement of the EMs and labeling (1= present, 0 = absent). We then conducted missing data analysis for the familiarity variable for each disorder by cultural group. We found that the missing data was less than 1% of the data and completely at random by passing the Little's Missing Completely At Random (LMCAR) tests. To identify and handle outliers on familiarity, we standardized the scores and winsorized the values outside $z = \pm 3.00$. Shapiro-Wilk tests showed that familiarity scores were not normally distributed ($p < .05$).

Therefore, we conducted a series of non-parametric tests, Mann-Whitney U tests to examine the cultural differences in the levels of familiarity. We then conducted Chi-square tests of independence to examine the cultural differences in the frequencies of labeling across the five disorders. Our results showed that compared with the Japanese participants, Euro-Canadian participants had higher scores on the measures of familiarity with depression ($U = 6344.50$, $p < .001$, $r = -.62$), schizophrenia ($U = 13439.00$, $p = .001$, $r = -.20$), and AUD ($U = 9873.50$, p

< .001, r = -.42), whereas the Japanese participants reported greater familiarity with hikikomori (U = 554.00, p = .004, r = -.42) than was shown by Euro-Canadian participants. There was no statistically significant group difference for ASD (U = 292.00, p = .147, r = .09) (See Table 3 for means and standard deviations).

For labeling, we found that compared to Japanese participants, Euro-Canadian participants were more likely to provide a lable for all the disorder types: depression. (χ^2 (1, N = 367) = 149.89, p < .001, φ = .64), ASD (χ^2 (1, N = 367) = 32.63, p < .001, φ = .30), schizophrenia (χ^2 (1, N = 367) = 153.05, p < .001, φ = .65), AUD (χ^2 (1, N = 367) = 43.71, p < .001, φ = .35), and hikikomori (χ^2 (1, N = 367) = 127.26, p < .001, φ = .59) (See Table 3 for frequencies and percentages).

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Table 3 *Group Differences in Familiarity and Labeling between Japanese and Euro-Canadians*

Variables	Culture					
	Japan	**Canada**				
	M (*SD*)	*M* (*SD*)	*U*	*p*	*r*	*E.S. CI* [*LL, UL*]
Familiarity						
Depression	2.30 (0.71)	**3.35** (0.93)	6344.50	<.001***	-.62	[-0.69, -0.55]
Autism Spectrum Disorder	2.66 (0.83)	2.55 (0.87)	18292.00	.147	.09	[-0.03, 0.20]
Schizophrenia	2.04 (0.53)	**2.27** (0.68)	13439.00	.001**	-.20	[-0.31, -0.08]
Alcohol Use Disorder	2.36 (0.61)	**2.92** (0.82)	9873.50	<.001***	-.42	[-0.51, -0.32]
Hikikomori	**2.36** (0.55)	2.20 (0.75)	19554.00	.004**	-.18	[0.06, -0.29]
	n (%)	*n* (%)	χ^2	*p*	φ	*E.S. CI* [*LL, UL*]
Labeling						
Depression	46 (25.84)	**168** (88.89)	149.89	<.001***	.64	[0.56, 0.72]
Autism Spectrum Disorder	59 (33.15)	**119** (62.96)	32.63	<.001***	.30	[0.20, 0.40]
Schizophrenia	52 (29.21)	**174** (92.06)	153.05	<.001***	.65	[0.56, 0.73]
Alcohol Use Disorder	82 (46.07)	**150** (79.37)	43.71	<.001***	.35	[0.25, 0.44]
Hikikomori	11 (6.18)	**118** (62.43)	127.26	<.001***	.59	[0.50, 0.68]

Note. *$p < .05$, ** $p < .01$, *** $p < .001$. Mann-Whitney *U* test was conducted for Familiarity. *r* = rank-biserial correlation measured as an effect size (E.S.). Chi-Square Test of Independence was conducted for Labeling. φ = phi correlation measured as an effect size (E.S.).

Boldfaced values indicate statistically significantly higher values. CI [*LL*, *UL*] indicates the lower and upper limits of 95% confidence interval.

2.4.2.2 Analytical Strategy for Cultural Differences in Explanatory Models (EMs)

To examine the effect of culture in the endorsement of different EMs across disorders, we conducted multivariate (multiple response) generalized linear models (MGLMs) using the packages *mcglm* (v0.8.0; Bonat, 2018) and *htmcglm* (v0.0.1; de Freitas & Bonat, 2022) in *R*. The use of MGLMs implemented in the *mcglm* and *htmcglm* packages provides an extension of traditional Multivariate Analysis of Variance (MANOVA) methods. The MGLMs allow for the analysis of non-normal, multivariate, and repeated measures data without making assumptions about the independence of observations or the normality of the data.

We conducted MGLMs separately for causal beliefs and help-seeking beliefs. Each of our dependent variables, or the endorsement of EMs was binary (i.e., 1= present, 0 = absent), in which the data followed Bernoulli distributions. The observations in the data were not considered independent as each participant was allowed to provide multiple responses (repeated measures). Due to the low occurrence of social-contextualization for causal beliefs and social-contextual responsibility for help-seeking beliefs, we made the decision not to include these newly emerged explanatory models in our statistical analysis. Therefore, we entered the three *EM*s (i.e., *medicalization*, *moralization*, and *psychologization*) for causal beliefs, and the four *EM*s (i.e., *medication*, *professional support*, *social support*, *self-care*) for help-seeking beliefs as our multiple response dependent variables. Our predictor variables were *Culture* (Japanese vs Euro-Canadian), *Disorder* (Depression, ASD, Schizophrenia, AUD, Hikikomori), and an interaction effect of *Culture*Disorder*. We entered *Familiarity* (Low vs. High) as a covariate. We then conducted a series of multivariate and univariate multiple comparison tests by means of Bonferroni corrections utilizing the *htmcglm* package.

2.4.2.3 Causal Beliefs

***Multivariate Interaction Effects*.** Results from the MANOVA revealed a significant interaction effect between *Culture* and *Disorder* all the three EMs, $\chi^2(12) = 90.11$, $p < .001$. This pattern suggests that the likelihood of endorsing causal beliefs EMs altogether varied across disorders and cultural groups (See Table 4).

***Multivariate Main Effects*.** Results from the MANOVA revealed a statistically significant main effect of *Culture*, $\chi^2(15) = 341.87$, $p < .001$, *Disorder*, $\chi^2(24) = 318.75$, $p < .001$, and

Familiarity, $\chi^2(3) = 13.83$, $p = .003$. Multivariate Generalized Linear Model (MGLM) regression revealed a statistically significant multivariate effect of culture on medicalization and psychologization. Specifically, compared to Euro-Canadian students, Japanese students were significantly less likely to medicalize, $OR = 0.23$, $p < .001$, and significantly more likely to psychologize, $OR = 6.35$, $p < .001$. There was no significant multivariate main effect of *Culture* on the endorsement of moralization, $OR = 0.88$, $p = .550$. Compared to participants who were high in familiarity, participants in low familiarity group were statistically significantly less likely to medicalize, $OR = 0.52$, $p = .001$ (See Table 4 and 5).

Univariate Analysis and Multiple Comparison Post Hoc Tests. Given the significant multivariate interaction effect of *Culture* and *Disorder*, we proceeded to conduct a series of univariate analyses (ANOVAs) to examine the univariate main effects of *Culture* and *Disorder*, as well as their interaction effects, on each of EMs prior to conducting a series of multiple comparison post hoc tests (see Table 6). There was a significant univariate main effect of *Culture* for medicalization, moralization, and psychologization: $\chi^2(5) = 206.32$, $p < .001$, $\chi^2(5) = 33.58$, $p < .001$, $\chi^2(5) = 210.65$, $p < .001$, respectively. There was a significant univariate effect of *Disorder* for all three EMs: $\chi^2(8) = 161.01$, $p < .001$, $\chi^2(8) = 64.05$, $p < .001$, and $\chi^2(8) = 152.09$, $p < .001$, respectively. The univariate interaction effect between *Culture* and *Disorder* was significant for all three EM, $\chi^2(4) = 48.81$, $p < .001$, $\chi^2(4) = 21.63$, $p < .001$, $\chi^2(4) = 34.46$, $p < .001$, respectively. Therefore, we conducted multiple comparison tests for medicalization, moralization, and psychologization.

Table 7 shows all possible pairwise comparisons using Bonferroni correction among *Culture* and *Disorder*. Overall, Euro-Canadians were significantly more likely to medicalize all the disorders compared to Japanese in all disorder conditions except one pair, Euro-Canadian x hikikomori and Japanese x AUD. For the Japanese x depression pair, Euro-Canadians were significantly more likely to moralize AUD, while Japanese were more likely to moralize AUD than Euro-Canadians did for depression, ASD, schizophrenia. Japanese were also more likely to moralize hikikomori than Euro-Canadians did for depression, ASD, schizophrenia, and hikikomori. Japanese psychologized more than Euro-Canadians for most pairs except Japanese x ASD and Euro-Canadian x ASD, Japanese x ASD and Euro-Canadian x hikikomori, Japanese x schizophrenia and Euro-Canadian x hikikomori pairs, respectively.

Table 4 *Results of Multivariate Analysis of Variance Exploring Cultural Differences in Explanatory Models across Disorders for Causal Beliefs*

Variable	*df*	χ^2	*p*
(Intercept)	3	65.22	<.001***
Culture	15	341.87	<.001***
Disorder	24	318.75	<.001***
Culture*Disorder	12	90.11	<.001***
Familiarity	3	13.83	.003**

Note. $*p < .05$, $** p < .01$, $*** p < .001$. Wald test statistics (Type II).

Table 5 *Results of Multivariate Generalized Linear Models Exploring Cultural Differences in Explanatory Models across Disorders for Causal Beliefs*

Variables	Medicalize		Moralize		Psychologize	
	OR	*p*	*OR*	*p*	*OR*	*p*
(Intercept)	7.34	<.001***	0.35	.008**	0.35	<.001***
Culture	0.23	<.001***	0.88	.550	6.35	<.001***
Depression	1.37	.330	0.09	<.001***	0.78	.411
ASD	0.46	<.001***	0.16	<.001***	2.55	<.001***
Schizophrenia	3.43	.005**	0.03	<.001***	0.44	.012*
Hikikomori	0.29	<.001***	0.29	.001**	4.51	<.001***
Familiarity	0.52	.001**	0.87	.616	1.01	.913
Culture*Depression	0.20	<.001***	2.42	.129	1.37	.336
Culture*ASD	0.73	.333	2.35	.112	0.36	.003**
Culture*Schizophrenia	0.08	<.001***	12.07	.002**	2.85	.002**
Culture*Hikikomori	0.23	<.001***	5.01	<.001***	0.80	.512
Observations	1804		1804		1804	

Note. $*p < .05$, $**p < .01$, $***p < .001$. *OR* = Odds Ratio (exponential value of unstandardized B). Reference category for Culture (0 = Japan), Disorder (Alcohol Use Disorder = 0), Familiarity (Low = 0), respectively.

Table 6 *Results of Univariate Analysis of Variance Between Culture and Disorders for all Explanatory Models for Causal Beliefs*

		Medicalize		Moralize		Psychologize	
Variables	*df*	χ^2	*p*	χ^2	*p*	χ^2	*p*
(Intercept)	1	57.55	<.001***	10.35	.001**	17.25	<.001***
Culture	5	206.32	<.001***	33.58	<.001***	210.65	<.001***
Disorder	8	161.01	<.001***	64.05	<.001***	152.09	<.001***
Culture*Disorder	4	48.81	<.001***	21.63	<.001***	34.46	<.001***
Familiarity	1	11.45	.001**	0.26	.613	0.00	.946

Note. $*p < .05$, $** p < .01$, $*** p < .001$. Wald test statistics (Type II).

Table 7 *Results of Multiple Comparisons Between Culture and Disorders for Explanatory Models for Causal Beliefs*

Comparison		Medicalize		Moralize		Psychologize	
		χ^2	*p*	χ^2	*p*	χ^2	*p*
Culture x Disorder Japanese	Euro-Canadian						
Depression							
	Depression	100.76	<.001***	2.02	1.000	75.08	**<.001*****
	ASD	56.04	<.001***	0.15	1.000	14.78	**.005****
	Schizophrenia	84.66	<.001***	5.42	.897	93.46	**<.001*****
	AUD	93.03	<.001***	15.40	.004**	49.57	**<.001*****
	Hikikomori	47.64	<.001***	0.92	1.000	3.35	1.000
ASD							
	Depression	92.58	<.001***	6.84	.402	69.01	**<.001*****
	ASD	42.76	<.001***	2.25	1.000	9.41	.097
	Schizophrenia	78.41	<.001***	9.53	.091	87.44	**<.001*****
	AUD	75.66	<.001***	7.74	.243	37.73	**<.001*****
	Hikikomori	37.37	<.001***	0.15	1.000	1.33	1.000
Schizophrenia							
	Depression	106.32	<.001***	6.56	.469	87.52	**<.001*****
	ASD	49.04	<.001***	1.95	1.000	15.37	**.004****
	Schizophrenia	87.42	<.001***	9.32	.102	105.63	**<.001*****
	AUD	81.90	<.001***	7.38	.296	45.55	**<.001*****
	Hikikomori	47.71	<.001***	0.09	1.000	5.86	.697

AUD							
	Depression	26.51	<.001***	17.43	**.001****	46.12	**<.001*****
	ASD	11.49	.031*	18.45	**.001****	17.47	**.001****
	Schizophrenia	34.00	<.001***	17.31	**.001****	62.91	**<.001*****
	AUD	41.90	<.001***	0.27	1.000	63.04	**<.001*****
	Hikikomori	1.10	1.000	8.50	.160	1.74	1.000
Hikikomori							
	Depression	111.38	<.001***	27.27	**<.001*****	96.95	**<.001*****
	ASD	91.97	<.001***	28.75	**<.001*****	57.15	**<.001*****
	Schizophrenia	106.04	<.001***	22.76	**<.001*****	115.13	**<.001*****
	AUD	128.41	<.001***	1.06	1.000	106.94	**<.001*****
	Hikikomori	68.83	<.001***	19.12	**.001****	28.03	**<.001*****

Note. $*p < .05$, $** p < .01$, $*** p < .001$. Degrees of freedom = 1. Bonferroni corrections were applied. Multiple comparisons were reported only for EMs with significant Culture x Disorder interactions found in univariate analysis. Boldfaced values indicate Japanese group scoring higher values.

2.4.2.4 Help-Seeking Beliefs

Multivariate Interaction Effects. Results from the MANOVA revealed a significant multivariate interaction effect between *Culture* and *Disorder* for all the four EMs, $\chi^2(16) = 185.23$, $p < .001$. This suggests that the likelihood of help-seeking EMs altogether varied across disorders and cultural groups (See Table 8).

Multivariate Main Effects. Results from an MANOVA and MGLM regression and revealed a statistically significant main effect of *Culture*, $\chi^2(20) = 584.67$, $p < .001$. Overall, compared to Euro-Canadian students, Japanese students were significantly less likely to suggest medication, $OR = 0.23$, $p < .001$, self-care, $OR = 0.19$, $p < .001$, and significantly more likely to suggest social support, $OR = 6.36$, $p < .001$. However, there was not a significant main multivariate effect of *Culture* on the likelihood of suggesting professional support, $OR = 0.88$, $p = .606$. There was a statistically significant multivariate main effect of *Disorder*, $\chi^2(32) = 722.38$, $p < .001$. The multivariate main effect of *Familiarity* was not statistically significant, $\chi^2(4) = 8.61$, $p = .072$. Compared to participants who were high in familiarity, participants in low familiarity group were significantly more likely to suggest social support, $OR = 1.69$, $p = .018$ (See Table 8 and 9).

Univariate Analysis and Multiple Comparison Post-Hoc Tests. We conducted a series of ANOVAs to examine the univariate main effects of *Culture* and *Disorder*, as well as their interaction effects, on each of the help-seeking EMs (see Table 10). There was a significant univariate main effect of *Culture* for four EMs, medication, professional support, social support, self-care: $\chi^2(5) = 211.09$, $p < .001$, $\chi^2(5) = 207.97$, $p < .001$, $\chi^2(5) = 81.79$, $p < .001$, $\chi^2(5) = 68.36$, $p < .001$, respectively. There was a significant univariate effect of *Disorder* for all four EMs: $\chi^2(8) = 321.50$, $p < .001$, $\chi^2(8) = 137.28$, $p < .001$, $\chi^2(8) = 144.04$, $p < .001$, $\chi^2(8) = 92.81$, $p < .001$, respectively. The univariate interaction effect between *Culture* and *Disorder* was also significant for all four EMs, $\chi^2(4) = 21.53$, $p < .001$, $\chi^2(4) = 55.09$, $p < .001$, $\chi^2(4) = 70.61$, $p < .001$, $\chi^2(8) = 45.91$, $p < .001$, respectively. Therefore, we conducted multiple-comparison tests for medications, professional support, social support, and self-care.

Table 11 shows all possible pairwise comparisons using Bonferroni correction among *Culture* and *Disorder*. Overall, Euro-Canadians were significantly more likely to suggest medications except the following pairs, Japanese x depression and Euro-Canadian x ASD, Japanese x ASD and Euro-Canadian x ASD, Japanese x schizophrenia and Euro-Canadian x

ASD/Hikikomori, Japanese x AUD and Euro-Canadian x schizophrenia, and Japanese x hikikomori and Euro-Canadian x ASD/hikikomori. Euro-Canadians were more likely to suggest professional support except the following pairs, Japan x Depression and Euro-Canadian x AUD, Japanese x ASD and Euro-Canadian x AUD, Japanese x schizophrenia and Euro-Canadian x ASD/AUD/hikikomori, Japanese x AUD and Euro-Canadian x AUD, and Japanese x hikikomori and Euro-Canadian x AUD. For social support, there were significant differences only for Japanese x AUD pair. Social support was strongly endorsed by Japanese participants in relation to AUD. Overall, Euro-Canadians were more likely to recommend self-care for AUD compared to the likelihood of Japanese participants recommending self-care for depression. Similarly, Euro-Canadians showed a higher likelihood of endorsing self-care for the following pairs of disorder x culture: Japanese x ASD and Euro-Canadian x ASD/AUD, Japanese x schizophrenia and Euro-Canadian x AUD/hikikomori, Japanese x hikikomori and Euro-Canadian x ASD/AUD. Japanese participants were more likely to recommend self-care for depression than Euro-Canadians for schizophrenia.

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Table 8 *Results of Multivariate Analysis of Variance Exploring Cultural Differences in Explanatory Models across Disorders for Help-Seeking Beliefs*

Variable	*df*	χ^2	*p*
(Intercept)	4	78.55	<.001***
Culture	20	584.67	<.001***
Disorder	32	722.38	<.001***
Culture*Disorder	16	185.23	<.001***
Familiarity	4	8.61	.072

Note. *$p < .05$, *$p < .01$, ***$p < .001$. Wald test statistics (Type II).

Table 9 *Results of Generalized Linear Models Exploring Cultural Differences across Explanatory Models for Help-Seeking Beliefs*

Variables	Medication		Professional Support		Social Support		Self-Care	
	OR	*p*	*OR*	*p*	*OR*	*p*	*OR*	*p*
(Intercept)	7.27	<.001***	0.38	<.001***	0.21	<.001***	2.80	<.001***
Culture	0.23	<.001***	0.88	.606	6.36	<.001***	0.19	<.001***
Depression	0.20	<.001***	23.52	<.001***	1.88	.046*	0.24	<.001***
ASD	0.01	<.001***	4.18	<.001***	0.38	.001**	0.31	<.001***
Schizophrenia	0.40	.040*	18.40	<.001***	1.21	.556	0.07	<.001***
Hikikomori	0.03	<.001***	6.16	<.001***	0.89	.690	0.28	<.001***
Familiarity	0.53	.090	0.81	.259	1.69	.018*	1.10	.588
Culture* Depression	0.37	.009**	0.08	<.001***	0.07	<.001***	3.99	<.001***
Culture* ASD	0.76	.779	0.20	<.001***	0.44	.046*	4.16	<.001***
Culture* Schizophrenia	0.19	<.001***	0.14	<.001***	0.11	<.001***	9.56	<.001***
Culture* Hikikomori	0.41	.295	0.23	<.001***	0.15	<.001***	2.71	.003**
Observations	1802		1802		1802		1802	

Note. *p< .05, ** p<.01, *** p<.001. *OR* = Odds Ratio (exponential value of unstandardized B). Reference category for Culture (0 = Japan), Disorder (Alcohol Use Disorder = 0), Familiarity (Low = 0), respectively.

Table 10 *Results of Univariate Analysis of Variance Between Culture and Disorders for all Explanatory Models for Help-Seeking Beliefs*

		Medications		Professional Support		Social Support		Self-Care	
Variables	*df*	χ^2	*p*	χ^2	*p*	χ^2	*p*	χ^2	*p*
(Intercept)	1	22.53	<.001***	14.41	<.001***	31.94	<.001***	17.02	<.001***
Culture	5	211.09	<.001***	207.97	<.001***	81.79	<.001***	68.37	<.001***
Disorder	8	321.50	<.001***	137.28	<.001***	144.04	<.001***	92.81	<.001***
Culture* Disorder	4	21.53	<.001***	55.09	<.001***	70.61	<.001***	45.91	<.001***
Familiarity	1	2.87	.010*	1.28	.259	5.62	.018*	0.29	.588

Note. * $p < .05$, ** $p < .01$, *** $p < .001$. Wald test statistics (Type II).

Table 11 *Results of Multiple Comparisons Between Culture and Disorders for all Explanatory Models for Help-Seeking Beliefs*

Comparison	Medications		Professional Support		Social Support		Self-Care	
	χ^2	*p*	χ^2	*p*	χ^2	*p*	χ^2	*p*
Culture x Disorder Japanese Euro-Canadian								
Depression								
Depression	67.66	<.001***	78.61	<.001***	6.91	.385	1.81	1.000
ASD	0.79	1.000	13.25	.012**	7.04	.360	5.01	1.000
Schizophrenia	101.22	<.001***	72.74	<.001***	0.90	1.000	11.03	**.040***
AUD	87.66	<.001***	3.61	1.000	0.06	1.000	42.15	<.001***
Hikikomori	2.92	1.000	34.04	<.001***	0.02	1.000	4.66	1.000
ASD								
Depression	38.25	<.001***	120.99	<.001***	3.98	1.000	0.00	1.000
ASD	3.87	1.000	35.03	<.001***	9.53	.158	1.02	1.000
Schizophrenia	49.11	<.001***	116.03	<.001***	0.07	1.000	20.71	<.001***
AUD	55.58	<.001***	0.77	1.000	0.16	1.000	26.59	<.001***
Hikikomori	12.98	.014*	70.71	<.001***	0.75	1.000	0.69	1.000
Schizophrenia								
Depression	77.41	<.001***	61.60	<.001***	8.28	.180	7.05	.357
ASD	0.72	1.000	4.01	1.000	4.45	1.000	9.09	.116
Schizophrenia	114.82	<.001***	55.54	<.001***	1.45	1.000	4.57	1.000
AUD	72.48	<.001***	8.52	.158	0.17	1.000	45.07	<.001***
Hikikomori	2.91	1.000	17.32	<.001***	0.01	1.000	11.01	.041*

AUD								
Depression	0.02	1.000	78.99	<.001***	15.50	**.004****	0.79	1.000
ASD	52.46	<.001***	39.73	<.001***	100.51	**<.001*****	5.44	.884
Schizophrenia	1.92	1.000	72.82	<.001***	26.08	**<.001*****	8.75	.139
AUD	43.29	<.001***	0.06	1.000	65.73	**<.001*****	52.38	<.001***
Hikikomori	26.40	<.001***	46.11	<.001***	47.67	**<.001*****	2.77	1.000
Hikikomori								
Depression	29.72	<.001***	74.19	<.001***	5.40	.904	3.86	1.000
ASD	2.53	1.000	26.01	<.001***	8.63	.149	12.02	.024*
Schizophrenia	39.14	<.001***	68.03	<.001***	0.76	1.000	4.77	.883
AUD	58.42	<.001***	1.28	1.000	0.11	1.000	65.39	<.001***
Hikikomori	9.17	.111	38.41	<.001***	0.01	1.000	8.19	.190

Note. $*p < .05$, $** p < .01$, $*** p < .001$. Degrees of freedom = 1. Bonferroni corrections were applied. Boldfaced values indicate Japanese group scoring statistically significantly higher values.

2.5 Discussion

Our qualitative analysis revealed attributions and themes related to explanatory models of causes and help-seeking that were not included in folk psychiatry model and existing help-seeking literature for five different disorders between Japanese and Euro- Canadian students. Specifically, social-contextualization of causes and the endorsement of social-contextual responsibility for beliefs about help-seeking emerged, which were not previously addressed in the folk psychiatry model and mainstream help-seeking literature. In addition to the endorsement of EMs focused on the self, our participants perceived macro-level and broader social-contextualizing themes and experiences to have a direct relationship with mental illness. Most notably, a unique theme that emerged from both the Euro-Canadian and Japanese data was the perception that family and caregivers have their responsibility to change themselves and seek help. Participants who endorsed these themes perceived that family play a crucial role in the recovery of the person suffering from mental illness, thereby placing a great emphasis on moralization of the family or caregivers. However, this belief encompassing collective responsibility, wherein help is not only seen as necessary but also actively sought after by the sufferers themselves, as well as their family and caregivers, has not been extensively examined in the existing literature.

Our analysis of the narratives from Japanese participants revealed culturally unique themes that encompassed the importance placed on familial roles. These themes included the failure to fulfill parental responsibilities and filial piety. Additionally, themes pertaining to the influence of people from work such as bosses/colleagues, the impact of work and school culture, and external and uncontrollable forces (e.g., societal pressure, misfortune/ bad timing) also emerged from the data. For help-seeking beliefs, Japanese specific codes emerged (e.g., seeing a psychosomatic medicine doctor, resting from work or school, seeking support from their bosses/colleagues, or changing environment at work).

The greater emphasis placed by Japanese participants on well-being at work and school can be explained by the ongoing crisis in the country such as *karoshi* (death by overwork) and youth suicide. Karoshi was initially conceptualized as a potentially fatal syndrome in which long working hours leads to death due to intense health deterioration and physical illness such as cardiovascular disease in the early 1980s (Hosokawa et al., 1982; Kanai, 2009). Although the definition and conceptualization of karoshi have been a controversial debate among Japanese scholars and policy makers, now the definition of karoshi includes both natural cause death and

suicide due to psychological distress from fatigue, burnout, harassment, or bullying at work (Ito & Aruga, 2018; Ministry of Health, Labour, and Welfare of Japan, 2014, 2016). Japanese government reported that approximately 250 death cases are compensated annually as karoshi (Ministry of Health, Labour, and Welfare of Japan, 2020).

Japan's overall suicide rate has been declining in recent years, however, the suicide rate among the youth and children is on the rise (Okamura et al., 2021; Ono et al., 2008). Similar to the concept of karoshi, death resulting from *ijime*, school bullying lacks a universally accepted definition. However, the association between youth suicide and ijime has been the subject of much debate and has frequently been sensationalized by the media, as well as extensively studied by the academic community (e.g., Ando et al., 2005; e.g., Ogura et al., 2012; Treml, 2001). Both karoshi and youth suicide due to ijime have not been categorized as mental illnesses. Nevertheless, the consistent reporting of work or school-related themes by the Japanese participants in our data indicates their association with the mental illnesses represented in the vignettes. This finding underscores the manifestation of culturally specific social phenomena that are relevant to Japanese participants.

Our quantitative analysis revealed cultural differences in EMs as well as differential endorsement of EMs across five disorders. Specifically, for causal beliefs, Japanese students psychologize more frequently, whereas Euro-Canadian students medicalized more frequently. Despite the non-significant multivariate effect of culture on moralization and the higher levels of familiarity with hikikomori reported by Japanese group, overall Japanese students moralized hikikomori much more often than Euro-Canadian students moralized depression, ASD, schizophrenia, and hikikomori. Furthermore, interestingly despite Euro-Canadians reporting lower levels of familiarity with hikikomori, they were significantly more likely to provide a diagnostic label such as personality disorder and schizophrenia. No Euro-Canadian participants labeled it as hikikomori.

The greater tendency of Japanese students to psychologize compared to Euro-Canadian students may be explained by shifting cultural values and mental health education in Japan. In our data, Euro-Canadians primarily endorsed medicalization, while Japanese students preferred psychologization as their primary explanatory model. This trend suggests a shift away from moralization for both cultural groups. Previous studies that documented Westerner's greater tendency to psychologize than non-Westerners, also based on undergraduate samples, were

conducted approximately 10-15 years prior to our data collection (e.g., Ban et al., 2010; Giosan et al., 2001; Haslam et al., 2007). Japanese undergraduate students may have increasingly adopted psychologization beliefs, potentially influenced by exposure to Western media, mental health literacy education, and psychological theories taught in academic settings. In contrast, Euro-Canadians may have increasingly emphasized medicalization, biogenetic, and neurological explanations over the past few decades, aligning with trends reported in Germany (Angermeyer & Matschinger).

For help-seeking beliefs, Japanese students were more likely to suggest social support, whereas Euro-Canadian students were more likely to suggest medication and self-care. While we did not directly examine the relationships between causal beliefs and help-seeking beliefs in this study, it is noteworthy that the Euro-Canadian participants' tendency to medicalization aligns with their preference for medication, as well as their tendency to provide diagnostic labels. These findings are consistent with existing literature suggesting that non-experts from Asian cultural contexts tend to prioritize social support, while non-experts from the Western cultural contexts more frequently endorse labeling, medicalization, and seeking medication and professional help (Angermeyer et al., 2004; Cheng et al., 2013; Griffiths et al., 2006; Jorm et al., 2005; Jung et al., 2017; Kuo et al., 2006; Li & Wong, 2015; Loo et al., 2012; Nakane et al., 2005; Schnittker, 2008; Tse & Haslam, 2021). Similarly, although not subjected to statistical testing, it is plausible to assume that there may exist an intuitive relationship between moralization and social-contextual responsibility, which are often endorsed by Japanese students for hikikomori, compared to Euro-Canadian students. These findings are consistent with the reported beliefs about hikikomori held by non-experts from Japan and Western countries, while the specific beliefs of Euro-Canadian non-experts remain unknown. For example, DeVylder et al. (2020) found that the need for clinical treatment was less frequently endorsed for hikikomori in comparison to schizophrenia and depression among Japanese adults. In a study analyzing tweets in five Western languages (Catalan, English, French, Italian, and Spanish) on Twitter, researchers investigated perceptions of hikikomori outside Japan. The findings revealed that a majority of the discussions portrayed hikikomori as a problem (Pereira-Sanchez et al., 2019). Furthermore, among the tweets that considered hikikomori as a problem, there was a higher prevalence of medical-related content compared to anecdotes or social explanations across all the languages examined. This suggests

that the discourse surrounding hikikomori in these Western languages tends to emphasize medicalization rather than social explanations or personal experiences.

Lastly, our novel approach of employing MGLMs and MANOVAs to analyze EMs as a multiple response model provides support for our assertion that multiple EMs coexist within both cultural groups, albeit with potential variations in the ratios of attributions to the individual versus the social context differed between Japanese and Euro-Canadian cultural groups. These findings also highlight that Japanese and Euro-Canadian non-experts' understanding of mental illness does not differ in complexity, suggesting an underlying universal psychological propensity to interpret and explain behaviors and experiences through multiple lenses.

2.5.1 Limitations

The present study has several limitations. First, it remains unclear whether both Japanese and Euro-Canadian students perceived the conditions depicted in the vignettes as indicative of psychopathology or as deviations from the norm within their respective cultural contexts. It is possible that the meanings attributed to the disorders, conditions, or symptoms presented in this study vary between Japan and Canada, and the extent to which each of these symptoms is considered a psychological abnormality depends on the cultural context. The vignette cases presented symptom constellations defined by the DSM-5 diagnostic criteria, which inherently reflects a cultural bias of its own. While the current study analyzed the frequency of labeling, the central focus was not on whether students provided a "correct answer" in terms of diagnostic labels. However, Euro-Canadian students were much more inclined to provide labels in general, and even attempted to diagnose hikikomori as personality disorders or schizophrenia based solely on their knowledge derived from DSM-5. The Japanese understanding of hikikomori has increasingly diversified and may not necessarily be perceived as a youth problem or pathology by lay people or even by non-mental health professionals. Some scholars, particularly social psychologists, argue that hikikomori is a consequence of social pathology, rather than individual psychopathology, challenging the biomedical and reductionist model and conceptualization of hikikomori offered by psychiatrists and clinical psychologists (Norasakkunkit & Uchida, 2014; Toivonen et al., 2011). The discrepancies and controversies in the conceptualization of hikikomori among different experts and disciplines suggest variations in explanatory models of hikikomori even within the

scholarly community. Therefore, it is also possible that Japanese students may not have pathologized hikikomori in our study.

Another example illustrating the limitations of the universal application of DSM from a Japanese cultural perspective is *shin-gata utsu*, also known as new or modern type depression (MTD), which has been observed and conceptualized by Japanese scholars and mental health professionals since around 2000. This specific type of depression does not align with the symptoms defined for Major Depressive Disorder in the DSM-5. Despite the lack of consensus on its construct validity, diagnostic criteria, and treatment, MTD is regarded as a culture-specific phenomenon. MTD is characterized by situation-dependent depressive states, attributing blame to others, and exhibiting strong avoidance tendencies, such as absenteeism from work or school, while functioning relatively well in other situations and contexts (Kato et al., 2011).

The second limitation is that our study did not directly investigate predictors or underlying cultural differences in causal and help-seeking beliefs, despite controlling for familiarity as a covariate. Additionally, we did not examine the relationship between causal beliefs and help-seeking beliefs, nor did we explore potential patterns or correlations. There is little doubt that beliefs about causes guide people in determining who and what are suitable sources for receiving help to recover from mental illness. While it is evident that the EMs held by students from both Japan and Canada are more multidimensional and pluralistic rather than being unidimensional and discrete as previously theorized, the factor structure of the EMs derived from qualitative data was not statistically tested in the current study. Future studies could explore statistical validity of the newly emerged EMs and potential mediators such as cultural values and self-construal to better understand the determinants of cultural differences in beliefs and conceptualizations of psychological abnormality and mental illness between Japan and Canada.

We acknowledge that our study sample consisted of undergraduate psychology students from both cultural contexts. Our participants are more likely to be familiar with psychopathology theories and textbook knowledge compared to the public without a psychology background. Psychology students may also tend to provide more psychologically oriented explanatory models, potentially exaggerating similarities across cultural contexts. Furthermore, the limited number of responses regarding social-contextualization and social-contextual responsibility EMs hindered our ability to conduct the statistical analyses to examine the group differences, despite these EMs emerging from the qualitative data. Consequently, caution should be exercised when interpreting

the results. Future research is needed to include and should aim to include larger and more diverse samples, such as patients, caregivers, clinicians, and people from the general community, to examine belief variations across different cultural contexts. The construct validity of social-contextualization and social-contextual responsibility remains to be investigated in future studies.

2.5.2 Conclusion

In sum, the utilization of a mixed-method approach in our study enabled the identification of beliefs about causes and help-seeking that emerged from the qualitative data, followed by the subsequent statistical analysis to examine group differences.

Our overall conclusions are:

(1) Both Japanese and Euro-Canadian students reported the endorsement of social-contextualization and social-contextual responsibility as their beliefs regarding the causes of mental illness and help-seeking. As these two emerging explanatory models have not yet received extensive attention in mainstream psychological literature, it is imperative that they are integrated into future research in the field.

(2) Japanese and Euro-Canadian students possess diverse beliefs about causes and help-seeking that varied across mental health conditions. This suggests that multiple EMs may co-exist, and EMs held by non-experts across cultural contexts are more complex and holistic than previously recognized.

These findings are consistent with our epistemological standpoint, which acknowledges the existence of sophisticated and nuanced explanatory models of mental illness among non-experts and people from non-Western cultural contexts. Our intention was to refrain from imposing experts or Western biomedical definitions of mental illness, often derived from the WEIRD literature and quantitative studies. Instead, we sought to explore the understanding of mental illness from the perspectives of non-experts and students in Japan, utilizing a mixed-methods approach. As non-experts, both Japanese and Euro-Canadian students in our sample possess their own understanding of the interplay between culture, mind, and the brain when making sense of mental illness. This has clinical implications. Western concepts of pathologizing and mental illness should not be blindly applied or exported to the rest of the globe. Educational and intervention programs must be tailored to align with the beliefs and practices embedded in the healing and coping traditions of specific groups, communities, and cultural contexts. (Kidron & Kirmayer, 2019).

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CHAPTER3: (MANUSCRIPT 2)

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Abstract (English)

This study applied a two-phase mixed-methods research design using the Cultural Consensus Theory (CCT) approach to examine shared beliefs about mental health held by Japanese clinical psychologists (CPs). In CCT, qualitative methods are first used to identify culturally salient elements of a domain; factor analysis is then used to quantify the degree of sharedness, using an approach known as cultural consensus analysis (CCA). First, we conducted a free-listing technique with 16 Japanese CPs to elicit salient terms for the two domains: (a) how members of the general public acquire beliefs about mental health; and (b) how Japanese mental healthcare ought to be reformed. In the second phase, we conducted CCA through a survey completed by 100 CPs. Our free-listing analysis generated 21 and 23 culturally salient terms for the two domains. Then, CCA demonstrated that the two domains could each be characterized as a single cultural model with a high degree of consensus. CCT provides a systematic mixed-methods approach that is particularly well-suited to investigating culturally grounded shared beliefs held by people in a specific cultural context.

Keywords: Cultural Consensus Analysis, Cultural-Clinical Psychology, Mental Health Beliefs, Japanese Clinicians, Mixed-Methods Research.

Abstract (Japanese)

臨床心理士のメンタルヘルスに関する信念の合意度の検討：カルチュラル・コンセンサス・セオリーを用いた混合法研究

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キーワード：カルチュラル・コンセンサス、文化臨床心理学、混合法

カルチュラル・コンセンサス・セオリー（Cultural Consensus Theory: CCT）とは、知識や文化、心理面に関する混合法研究の枠組みとして近年認知人類学で注目されている理論・方法論である。 CCT では、特定のグループに属する一員は重要な情報提供者“インフォーマント”であり、信念、知識、価値観はインフォーマント達によって「共有された情報のかたまり」と捉え、グループの間主観性や合意の内容を質的研究法によって明らかにしたのち、統計解析によりその合意度を推測することが可能である。本研究では CCT に基づいた 2 フェーズ混合法デザインを用いて、臨床心理士の①一般の人のメンタルヘルスに関する考えに影響を与えているもの、② 日本社会におけるメンタルヘルスケアの改善すべき点に関する信念の合意度を検討した。第 1 フェーズでは 16 名の臨床心理士にフリーリスティング法でインタビュー調査を行い、質的分析を行った。第 2 フェーズでは日本人臨床心理士 100 名を対象に質問紙調査を行い、因子分析を応用したコンセンサス解析を行った。その結果、臨床心理士らの考える日本社会におけるメンタルヘルスに関する信念について高い合意が確認された。CCT を用いた研究分野横断的なアプローチにより、複雑な社会現象や人々の心理・認知のリアリティに迫る知見が得られることが示唆された。

Japanese Clinical Psychologists' Consensus Beliefs about Mental Health: A Mixed-Methods Approach

3.1 Introduction

How do we study people's beliefs about mental health in a particular cultural context? Is there a set of shared understandings of mental health among mental health clinicians? Our study was undertaken to answer these questions, applying cultural consensus theory to demonstrate a methodology suitable for investigating intersubjective beliefs about mental health and the larger society shared by Japanese mental health clinicians. Despite the sizable literature documenting the general public's beliefs about mental health, the beliefs of mental health clinicians have not been given the same attention. How the concept of mental health is construed by treatment providers can have a significant impact on patients' recovery process and treatment outcomes (Cohen & Cohen, 1984; Schulze, 2007). Furthermore, mental health clinicians play a significant role as opinion leaders who may influence education, advocacy, and policy making with respect to mental health matters in the society. It is important, then, to better understand clinicians' beliefs about mental health and the extent to which clinicians share these beliefs among themselves.

Our overview of the psychological research database suggests not only that more research is needed to include clinicians in the picture, but also that there is a need to include cultural groups who are not from "Western" cultural contexts. Therefore, we argue that psychological science needs a new theoretical and methodological foundations to shift from simply measuring and averaging subjective and personal beliefs to carefully examining beliefs shared by people when taking understudied cultural groups into consideration. We argue that culture is usefully understood by conceptualizing it as intersubjective representations held *between* people, rather than as personal beliefs. The goal of the current study is to allow cultural consensus theory to guide us in conceptualizing the intersection of cultural context and shared beliefs. This approach allows us to examine the content of intersubjective beliefs shared by Japanese clinical psychologists. Furthermore, this methodology, rarely used by psychologists, challenges the conventional reliance on self-report surveys to study personal beliefs as the aggregate of individual items.

We chose Japanese clinical psychologists for three reasons. First, historically, Japanese clinical psychologists have been marked as marginalized mental healthcare professionals under the dominance of psychiatry and medical professionals in Japan (Horiguchi, 2019). Second, there

has been a drastic change in the licensure accreditation over the past few years, which may have affected Japanese clinical psychologists' professional identity as well as views about the local mental healthcare system (Imada & Tanaka-Matsumi, 2016; Iwakabe, 2008; Iwakabe & Enns, 2013). Third, cultural values, norms, and priorities about the relationship between sense of self and the society, which further shapes common beliefs about mental health in Japan, are profoundly different from Western societies (Markus & Kitayama, 1991). Specifically, we sought to investigate Japanese clinical psychologists' shared beliefs about mental healthcare and the general public's understanding of mental health.

3.1.1 Cultural-Clinical Psychology

Scholars concerned with a lack of cultural diversity in the psychological sciences advocate reassessing theories derived from 'Western' research. Henrich, Heine, and Norenzayan (2010) argued that existing psychology studies are based on perspectives and samples that are disproportionally WEIRD—that is, Western, Educated, Industrialized, Rich, and Democratic. They concluded that it is vital to take cultural context into account when studying psychological mechanisms of people around the world, as cultural context profoundly shapes human psychology, including emotion, motivation, and cognition (Markus & Kitayama, 1991). Cultural psychology has progressively challenged the WEIRD bias, uncovering cultural variations in psychological mechanisms through rigorous quantitative methods and research designs originating in social and experimental psychology.

Cultural psychologists only occasionally engage with the mental health implications of their research findings. Clinical psychologists, on the other hand, combine the study of mental health with training in its assessment and treatment. In North American clinical psychology, the so-called scientist-practitioner model advocated by the American Psychological Association since the 1940s, promotes an active and ongoing integration of science and practice. Clinical psychology has also gone beyond the academic context, working closely with patients, caregivers, communities, and policy makers; however, it has lagged behind in addressing cultural diversity in both research and clinical practice as the discipline was founded in North America. As such, the discipline's conceptualization of mental health has developed predominantly within WEIRD cultural contexts.

Cultural-clinical psychologists have applied this perspective to mental health, especially to the

cultural shaping of mental illness beliefs, assessment, symptoms, and treatment (Chentsova-Dutton & Ryder, 2019; Ryder et al., 2011). This subdiscipline emerged as an integration of cultural psychology and clinical psychology following earlier integrative work by, for example, Draguns (1980), Marsella and Yamada (2007), and Tanaka-Matsumi and Draguns (1997). Importantly, cultural-clinical psychology incorporates the growing influence of clinical neuroscience, rather than insisting that culture must exclude biology. For example, Ryder et al. (2011) argue that culture, mind, and brain are best understood as a single system. The three levels of culture, mind, and brain, moreover mutually constitute one another: one cannot properly understand one of these levels without reference to the other two. Mental health and disorder are, in this view, best understood as properties of this system rather than residing at a particular level. This holistic and systemic perspective also points towards multi-disciplinary and multi-method ways of studying the relation between culture and mental health.

More recently, Chentsova-Dutton and Ryder (2020) have discussed the vital role of cultural models in cultural-clinical psychology research, an approach developed by cognitive anthropologists who are concerned with both local cultural contexts and the psychological functioning of individual people, as well as their mutual relation (D'Andrade, 1995). Cultural models refer to understandings of the local sociomoral world that are widely shared by the majority members of a society shaping the beliefs, norms, and values as well as guiding their behavior (Quinn & Holland, 1987). The cultural models approach allows us to understand how different cultural groups assign different consensual meanings to the same mental health concept. Cultural models exist both "in the head" as personal beliefs, norms, and values internalized by each member of the society and "in the world" as pervasive historically derived behaviors, public representations, and cultural products (e.g., media, creative arts).

Cultural models are presupposed as the taken-for-granted models of *knowledge* about the local cultural context. For example, a person's own beliefs about mental health, along with depictions of mental illness shown in media or books to the general public, may represent the culturally shared and consensual knowledge about mental health among the members of the cultural context or group in which the person is situated. Cultural models can also be revealed by measuring people's beliefs about other people's beliefs, or intersubjective beliefs perceived to be widespread in their cultural context at the intermediate level between "in the head" and "in the world". The presence of cultural models can be confirmed when intersubjective perceptions can

be measured under the assumption that members of a particular cultural group have general agreement or consensus on the degree of importance of beliefs about certain topic or core values (Wan et al., 2007). People then use the consensus knowledge to cognitively represent their cultural values. There is also evidence that intersubjective perceptions are the better predictor of conformity and traditional behaviors than are personal beliefs (Fischer, 2006). In (cross-) cultural psychology, research on culture as "*in the head*" and "*in the world*" has been conducted quite extensively; however, intersubjective perceptions are comparatively understudied.

A mixed-methods research (MMR) design is particularly useful for capturing elements of shared knowledge at different levels of articulation (e.g., personal beliefs vs. beliefs shared by the larger cultural context). MMR allows researchers to identify a pool of people's beliefs that can simultaneously reflect local sociocultural worlds and retain some level of common language beyond these worlds by integrating quantitative and qualitative research methods (e.g., Doucerain et al., 2015). The defining features of MMR are (a) data collection and analysis of both qualitative and quantitative data sources, and (b) the integration of results and drawing inferences based on qualitative, quantitative, and mixed-methods findings (Creswell, 2013). Furthermore, taking an MMR approach in mental health research when taking culture into account is particularly suitable for at least two reasons. First, existing research on beliefs about mental health among mental health professionals have been predominantly quantitative. Second, the vast majority of studies in this area have been conducted on WEIRD samples, by WEIRD researchers. It is, therefore, crucial to first engage in a careful qualitative research inquiry to understand the local cultural perspective on mental health without imposing existing Western theories, and then move onto the confirmatory research phase through quantitative approach.

3.1.2 Cultural Consensus Theory

Cultural consensus theory was first developed by cognitive anthropologists as a theoretical framework to study cultural models. This framework provides a collection of methodological techniques designed to elicit culturally grounded cognitive models and identify the degree of consensus around the models in a given sociocultural group, with three primary objectives (Romney et al., 1986).

First, cultural consensus theory posits that cognitive models are culturally constructed and shared by the group, not by researchers, and those "culturally correct" answers should be studied

without assuming or imposing the existing "answers". For example, the general public's model of "mental health" comprises what they believe to be shared among themselves, not the existing definition provided by researchers or scholars studying mental health. In this sense, the actual "experts" local beliefs about mental health are the local people themselves; as such, they are commonly described as "informants". Cultural consensus theory is not concerned with measuring how well or poorly the general public know about "mental health" as defined by researchers, in contrast to conventional surveys assessing the general public's "mental health literacy" with already-established answer keys (for a critique of this latter approach in East Asian contexts, see: Na, Ryder, & Kirmayer, 2016).

Second, the qualitative methods in cultural consensus theory allow researchers to inductively discover salient aspects of the model or domain. This exploratory analytical step is called cultural domain analysis (Borgatti, 1994). The goal of cultural domain analysis is to generate a collection of local understandings of the domain of interest by eliciting terms that remain true to the daily language used by the informants.

Third, cultural consensus theory proposes an innovative statistical model, namely cultural consensus analysis (CCA), to identify a consensually shared cognitive model pertaining to a specific domain within a given sociocultural group. CCA estimates participants' knowledge of culturally-shared intersubjective beliefs using levels of agreement among them. In other words, this approach examines the extent to which individual participants know the consensus answers from their own group, irrespective of their personal beliefs and preferences. Furthermore, CCA allows researchers to quantify *cultural competence*, the relationship between each participant's individual knowledge of the cultural domain and the aggregate knowledge of this domain.

CCA accomplishes these ends through the application of factor analysis (Romney et al., 1986). The goal of CCA is reliability testing, but not in the conventional way where survey items are assessed through comparing scores across participants. CCA seeks to test reliability of participants themselves, rather than of survey items. In other words, the concern here is with how each participant responds to each item and how the responses across items agree with or differ from the overall aggregated pattern of other participant responses. The factor loadings are measures of the extent to which participants know the culturally correct answers or consensus and are defined as "competence scores".

Another notable feature of CCA is that it requires a relatively small sample size to obtain

valid estimates of the correct answers if there is high level of agreement in the responses. Although the suggested criteria for determining the rows-to-columns ratio have been inconsistent in the existing literature, conventional factor analysis requires at least 5:1 in which rows represent the number of participants and columns represent the number of items. In CCA, the standard usages of rows and columns are reversed, so that rows represent the number of items and columns represent the sample size. The reliability and validity of the aggregated responses increases with the number of participants and/or the level of agreement among people. Thus, the sample size estimation is formalized based on the average Pearson correlation coefficient between all pairs of participants, or the average cultural competence score and the validity of the aggregated responses (expressed as the correlation between the estimated answers and the true answers).

Those with higher cultural competence scores are thought to be more "competent" or "expert" about the knowledge and agree with each other more frequently. Conventionally, researchers should obtain an average cultural competence ≥ 0.50 to claim that there is sufficient agreement and at least a sample size of thirty to correctly classify 95% of the answers (0.95 validity) at the 0.99 confidence level (i.e., Bayesian posteriori probability of > 0.99) (Weller, 2007). Overall, cultural consensus theory allows researchers to utilize qualitative methods to inductively elicit culturally grounded and salient ideas, beliefs, and norms about a domain and apply robust statistical methods to estimate the social distribution of the knowledge, the cultural model constructed and possessed by members of a given sociocultural group.

Studies aiming to understand health beliefs commonly held within understudied communities utilizing cultural consensus theory have been published over the past quarter-century. For example, Dressler, Balieiro, and Dos Santos (1997, 1998) examined shared beliefs about lifestyle and social support in urban Brazil and identified salient items in their cultural domain analysis, capturing better terms representing participants' experience-near beliefs than the theoretical definition of social class and social integration. Their research team also obtained similar results with African Americans in the Southern U.S. (Dressler & Bindon, 2000). Barg et al. (2006) studied both the overlapping and diverging beliefs about depression held by older American adults and showed that loneliness among the participants was highly salient. Their structured clinical interviews revealed that participants' beliefs about symptoms of depression were highly associated with their understanding of loneliness. Smith et al. (2004) used CCA to show that patients, faculty, and residents at a clinic in a Western region in the U.S. did not share

the same cultural model concerning values about clinic function (e.g., patient-doctor relationship), suggesting that the large value discrepancy between the three target groups can inform solutions to improve clinical interventions. Ratanasuwan et al. (2005) reported that there was not a single shared health belief about diabetics in many parts of Thailand despite its high prevalence. The lack of a shared model in their study seems uninformative at first, but these results also indicate lack of health understanding and knowledge about diabetes among the general public, suggesting the need to bridge the information gap between health professionals and patients.

Overall, cultural consensus theory offers a methodological framework to support research on cultural models of mental health beliefs held by understudied cultural groups while integrating qualitative and quantitative approaches. Researchers may therefore start with their emic, inductive inquiry to reveal detailed accounts of a cultural model provided by the informants, and then quantify the degree of agreement in the model among the informants to learn about the social distribution of knowledge within the specific cultural context. The integration of both perspectives and methods are not yet widely used in mainstream psychology research designs thus far. Our present study aims to demonstrate the utility of cultural consensus theory from a cultural-clinical perspective. Specifically, we seek to understand the shared cultural models of Japanese clinical psychologists on (a) how the general public acquire beliefs about mental health and (b) how Japanese mental healthcare ought to be reformed.

3.1.3 Mental Health Beliefs and Clinical Psychologists in Japan

The development of professional credentials for clinical psychologists in Japan have undergone turbulent trajectories, which may have influenced their beliefs about the mental healthcare system in Japan. Clinical psychologists have long struggled to gain recognition of their professional identity both within psychology and with neighboring disciplines such as psychiatry. Therefore, their beliefs about mental health in general as well as the system in Japan may differ from those of other mental health professionals. After they failed to establish their professional status within the Japanese Psychological Association (JPA), the oldest professional psychology organization in Japan (founded in 1927), a group of clinical psychologists departed from the JPA and founded the Association of Japanese Clinical Psychology (AJCP) in 1982. The AJCP has then become the largest professional psychology association in Japan (AJCP, 2018). In 1988, the Japanese Certification Board for Clinical Psychologists (JCBCP) was founded by the AJCP to

issue its first certification of what is now referred to as the certified clinical psychologist [Rinshou-Shinrishi, 臨床心理士]. While this certification has been the most powerful credential for applied psychologists working in the clinical field, it is not a national licensure regulated by the government. The JCBCP established three criteria to earn the certification: (a) completion of two years of a master's program in clinical psychology; (b) participation in supervised clinical practice for a minimum of 1 year; and (c) passing an examination. The JCBCP began its accreditation system for Master's programs in clinical psychology in 1996 offering a highly structured curriculum focusing heavily on course work and practical skills in counseling and psychotherapy, assessment and interviewing, and research methods (Imada & Tanaka-Matsumi, 2016; Iwakabe, 2008; Iwakabe & Enns, 2013).

In 1995, Ministry of Education, Culture, Sports, Science and Technology (MEXT) approved the JBCP certificate in clinical psychology as the requirement for school counselors when they implemented the school counselor system in response to increasing school refusal, bullying, and violence issues (Iwakabe, 2008). Meanwhile the Japanese Ministry of Health, Labor and Welfare (MHLW) and the Japanese Medical Association strongly opposed to the MEXT's decision to approve the JBCP accredited clinical psychology in school counseling. Consequently, to reconcile the lack of national licensure for applied psychologists, the MHLW proposed to develop a national licensure, namely the designation of "health and medical psychologist" [Iryou-Shinrishi, 医療心理師]; however, the proposal failed due to opposition from medical professional associations such as the Japanese Medical Association and the Japanese Society of Psychiatry and Neurology.

Despite these setbacks, clinical psychologists continued to advocate for their recognition by the government, and more recently, MEXT and MHLW jointly established the Certified Public Psychologist [Kounin-Shinrishi, 公認心理師] Act as the first, centralized, national licensure system for clinical psychologists in Japan in 2017. While there are differences in training requirements between the JBCP certified license and the government certified license, the most striking difference is the relationship between physicians and psychologists. In theory, those who are certified clinical psychologists maintain their independence from physicians in terms of decision making, whereas physicians endorse greater decision-making power over certified public psychologists as they are required to follow direction from the physicians. As such, the licensure

transition between the two competing licenses has led to confusion and ongoing debate among mental health stakeholders.

The roles of clinical psychologists in the context of Japanese mental healthcare overlap with that of counselling psychology, community psychology, school psychology, and social work (Shimoyama, 2001). The training programs place a strong emphasis on projective testing, psychoeducation, and community intervention; however, they offer limited practicum and field experiences compared with counseling and clinical programs in the United States (Kudo Grabosky et al., 2012). According to a survey conducted by the Japanese Society of Certified Clinical Psychologists (2016), 77.7% of 10,321 respondents were female, and most certified clinical psychologists work in the health and medical fields (41.9%), followed by schools (36.0%), academic and post-secondary institutions (25.3%), companies and industrial organizations (8.3%), private clinics (8.2%), and the justice system and police (3.7%). Most of them engage in psychotherapy and counseling (86.2%), followed by assessment (79.9%), and community support work such as liaison for referral to other professionals (64%). School counselor is the most common profession among certified clinical psychologists, but they often work part-time at several places on one-year contracts (Horiguchi, 2019). The employment situations for certified clinical psychologists have thus far been extremely challenging. For example, more than half of the respondents reported their earnings were less than the national average and approximately half of them were employed as only a part-time position.

We selected Japanese clinical psychologists as our informants because they are an understudied and marginalized "cultural subgroup" among mental health professionals in Japan even as they mediate between the professional world and the non-professional community. They are immersed in diverse elements of society from education to medicine and face-to-face interactions with patients to community level engagement. Moreover, clinical psychologists' beliefs influence and are influenced by those of clients because the nature of psychotherapy is an exchange of perceptions, beliefs, and values between a clinical psychologist and a client, which is much more rarely experienced by other mental health professionals. Therefore, we posited that beliefs held by clinical psychologists are important to understanding the status of mental healthcare in Japan. Furthermore, Japanese practitioners have challenged the existing Western approaches and have attempted to make approaches more culturally appropriate and effective with Japanese patients (Kudo Grabosky et al., 2012; Kudo Grabosky et al., 2015). For example, Hakoniwa,

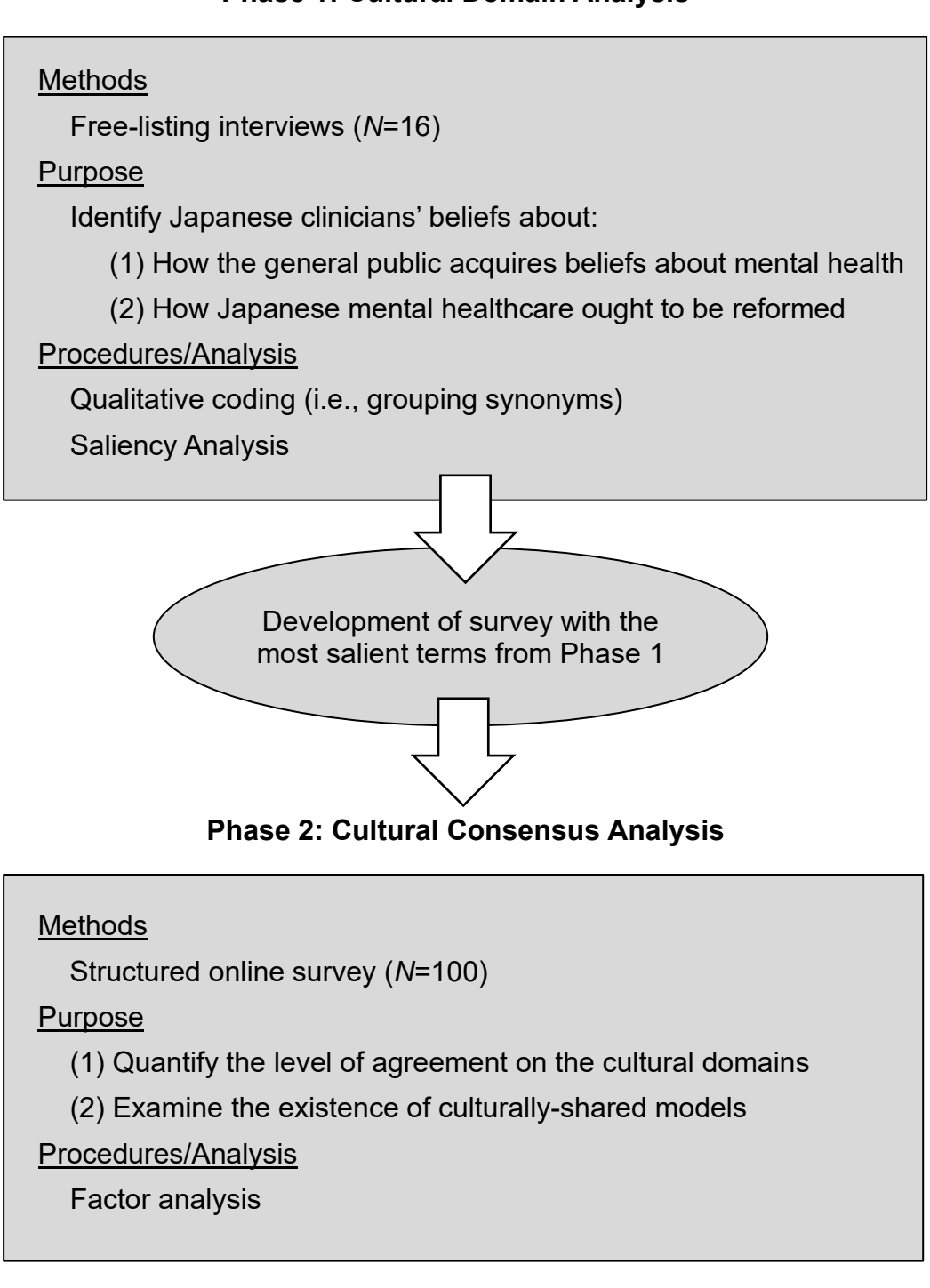
known as Sandplay therapy in the West, has emerged as a form of psychotherapy adapting both Jungian traditions viewing the Sandplay as a way for clients to explore and express their intrapersonal worlds in a symbolic way and Japanese traditions integrating art expressions, Buddhist perspectives, Japanese personality, symbolism, and mythology (Enns & Kasai, 2003; Kasai, 2009). Hakoniwa has been a very popular psychotherapy method used with both children and adults in Japan. While most Western psychotherapies assume the client as an individual in isolation, verbal and direct expression of emotion, a direct cause-effect thinking orientation to the world, and clear separation of mind and body, Hakoniwa encourages the expression of the individual in context through both nonverbal and verbal communication, nonlinear holism, and interconnectedness of physical and mental well-being (Kirmayer, 2007; Lee & Sue, 2001). Moreover, we sought to investigate clinical psychologists' intersubjective beliefs about how members of the general public acquire mental health beliefs to better understand where such beliefs are exposed, learned, and transmitted from one another in the community. We argue that clinical psychologists are better able to locate and articulate the sources contributing to the general public's beliefs and values as they have often spent considerable time exploring them with their clients in their therapy sessions, in addition to interactions with caregivers and people in the community.

The sociocultural and political background behind the development of clinical psychology as a mental health profession discussed earlier, as well as the emergence of these culturally-adapted approaches, suggests that Japanese clinical psychologists hold a strong knowledge of both professional and non-professional needs and beliefs about mental health in Japan. Again, it was our purpose to explore beliefs about the mental health and care system embedded in the society through the perspective of clinical psychologists.

3.2 Methods

We conducted a two-phase mixed-methods research design; specifically, cultural domain analysis using qualitative method in the first phase to inform our cultural consensus analysis as our confirmatory, quantitative method in the second phase. A schematic of the research phases is presented in Figure 1. This two-phase approach has been one of the most common methods of choice for extracting culturally relevant items about the domain of interest and the subsequent survey development and implementation in cultural consensus theory studies (e.g., Weller et al., 2002). Our study was approved by the Osaka University Institutional Review Board and informed consent was obtained from all participants.

Figure 1 *A Schematic of the Two-Phase Cultural Consensus Theory Research Design*



3.2.1 Phase 1: Cultural Domain Analysis (CDA)

We conducted a semi-structured interview technique of free-listing with five clinical psychologists practicing in the greater Osaka region and eight clinical psychologists practicing in the greater Tokyo region, along with a group interview with three doctoral students enrolled in clinical psychology program at Osaka University. Then, we collected the data from a purposive and convenient sample of key informant clinicians. Criteria for the interviewee included: holding a certified clinical psychology license [Rinshou-Shinrishi, 臨床心理士] and having practiced as a clinician for at least three years excluding the years spent for clinical training during their master's program. Unlike the conventional approach emphasizing individual-level data collection and random sampling, the data collection of cultural knowledge requires purposive convenience sampling (Handwerker & Wozniak, 1997). Key informants were recruited through the authors' network and the informants' acquaintances who they believed to offer a good understanding of Japanese clinical psychologists' beliefs. Participants were compensated for their participation with a gift card valued at 3,000 yen.

Free-listing is a commonly used qualitative method to elicit culturally salient themes of a domain in which a respondent is asked to list words and phrases that represent elements in the domain of interest. The technique allows researchers to gather emic content pertaining to a given domain from participants' point of view rather than relying on the researcher's presumptions and preexisting theories as commonly done in traditional psychological measurement (Bayliss, 2003). In our study, participants were asked to name (a) sources of health beliefs among the Japanese general public [一般の人のメンタルヘルスに関する考えに影響を与えているもの] and (b) changes needed to improve mental health care [日本社会におけるメンタルヘルスケアの改善すべき点].

The research team reviewed the free-listing responses and standardized them (e.g., by combining synonyms). For example, responses such as "stigma", "reducing stigma", and "negative attitude" were combined as a single item "reducing stigma". We then used *AnthroTools*, a package in R to analyze the salience of each item by accounting for the most frequently and spontaneously mentioned items among the participants (v0.8; Purzycki & Jamieson-Lane, 2017). An item salience score was calculated for each item, and this was done by considering the order in which

an item was elicited from each participant, inversely assigning a score to the order number and dividing this value by the total number of items listed by the participant. Next, we calculated Smith's *S*, a salience index using the formula:

$$S = ((\sum(L\text{-}R_j+1))/L)/N$$

where L is the length of each list, R_j is the rank of item J in the list, and N is the number of lists in the sample (Borgatti, 1999). Smith's *S* captures items that prototypically represent the domain of interest accounting for both the frequency and rank of the term on the list across all participants (Winkielman et al., 2006).

3.2.2 Phase 2: Cultural Consensus Analysis (CCA)

In the second phase, we developed a structured online survey to assess the shared beliefs about the two domains examined in the first phase among Japanese clinical psychologists. In developing our questionnaire, we included all the items elicited by clinical psychologists through qualitative free-listing in the first phase. The study recruitment was advertised among various clinician community groups through the authors' networks. Eligibility criteria were the same as phase 1. Participants completed a survey online to rate the extent to which they agree that clinical psychologists *in general* believe using a visual analogue scale (VAS) ranging from 0 to 100 (from very untrue to very true). For example, we asked participants, "Here are some statements or phrases about what clinical psychologists in general might believe. Please indicate to what extent you think each statement or phrase is a belief held by clinical psychologists in general. Please remember to think about what clinical psychologists in general would believe when rating each statement or phrase. It is NOT about your own personal beliefs or opinions" [ここからは、多くの臨床心理士が一般的に思っていること、または常識として認識している事柄についてあなたのご意見をお聞きします。あなたの個人的な意見ではありません。あくまで世間一般のほとんどの臨床心理士が思うことかどうかについてスライドを利用して程度を示してください]. Participants were compensated for their participation with a gift card with a value of 1,500 yen.

To determine whether there are shared consensus models, responses were subjected to CCA. One hundred ten clinical psychologists participated in our study. We excluded 10

participants who did not meet our inclusion criteria, resulting in a final sample of one hundred participants. We used the *psych* package in R (v.2.1.3; Revelle, 2021) to run the formal CCA. Following the statistical procedure recommended by Weller (2007), exploratory factor analysis using the iterated principal factor analysis without rotation was performed to minimize the variance accounted for by the first factor. We performed a 5,000 bootstrapping resampling method to randomly select subsets of four participants (row-to-columns ratio of 5:1) following the procedure described by (2016). The analysis follows sequential steps as follows: (a) examining the presence of a consistent response pattern using goodness-of-fit criteria by determining whether the ratios of the first to the second eigenvalues are ≥ 3:1 (Weller, 2007); (b) estimating individual knowledge from the agreement between participants by examining the factor scores on the first factor; and finally (c) estimating the culturally correct answers by weighing the responses of each participant by their competence score and aggregating responses across participants. The eigenvalue for each factor indicates the amount of variance accounted for by the factor. If the eigenvalue for the first factor is three times larger than the second factor, this means that there is a unidimensional factor, which indicates the presence of a shared model. According to cultural consensus theory, factor loadings represent the correlation between the shared model and the respondents on which the factor analysis is performed. Factor loadings are used to weigh the responses of each respondent and are aggregated to identify the most culturally relevant items (components) of the shared model of underlying construct of interest.

3.3 Results

3.3.1 Phase 1: Cultural Domain Analysis (CDA)

A total of 16 Japanese clinical psychologists completed the free-list questions. Table 1 shows participant characteristics. After we completed qualitative coding, we generated a total of 21 terms for how the general public acquire beliefs about mental health and 23 terms for how Japanese mental healthcare ought to be reformed; both were above the recommended minimum of 20 items (Weller, 2007). In our study, we included all the terms provided by the participants. Tables 2 and 3 provide the frequency, the proportion of participants who listed the item, and Smith's *S* values. The most salient terms (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants) for how the general public acquire beliefs about mental health were *mass media*, *beliefs taught and learnt at home*, *social media*, *creative and visual arts, beliefs held*

by school teachers and boss at work, historical and cultural values, beliefs held by people who are close such as friends, but not family members. Participants listed *promote mental health education and awareness from a young age (both through compulsory education and at home), extend health insurance coverage, improve clinicians' quality, skills, and training, improve information literacy, improve mental health literacy* to most frequently and spontaneously to describe how Japanese mental healthcare ought to be reformed from all possible items, words, and phrases and not from a list of options provided by researchers, unlike in conventional surveys.

Table 1 *Sample Characteristics of participants in Phase 1 and Phase 2*

Characteristics	Phase 1 (N = 16) M (SD) or n (%)	Phase 2 (N = 100) M (SD) or n (%)
Age in years	31.56 (6.55)	35.87 (7.85)
Gender (women)	7 (43.75)	70 (70.00)
Years of experience as a clinician	5.63 (4.99)	9.36 (6.84)
Education level		
Junior college	0 (0.00)	1 (1.00)
Bachelor's degree	3 (18.75)	4 (4.00)
Master's degree	11 (68.75)	90 (90.00)
Doctoral degree	2 (12.50)	5 (5.00)
Primary work area		
Medical/Health	5 (31.25)	42 (42.00)
Education/School	3 (18.75)	18 (18.00)
Social services	2 (12.50)	16 (16.00)
Industry/Company	1 (6.25)	8 (8.00)
Private clinic	1 (6.25)	6 (6.00)
Academic/Post-secondary institutions	3 (18.75)	5 (5.00)
Judicial system/Police	1 (6.25)	5 (5.00)
Orientation		
Client-centered therapy	4 (25.00)	36 (36.00)
Cognitive behavioral therapy	4 (25.00)	31 (31.00)
Psychodynamic therapy	1 (6.25)	10 (10.00)
Family therapy	2 (12.50)	3 (3.00)
Play therapy	1 (6.25)	3 (3.00)
Eclectic/Integrative therapy	1 (6.25)	3 (3.00)
Morita therapy	0 (0.00)	2 (2.00)
Trauma therapy	1 (6.25)	2 (2.00)
Solution focused brief therapy	1 (6.25)	2 (2.00)
Art therapy	0 (0.00)	1 (1.00)
Dream analysis	1 (6.25)	1 (1.00)
No specific orientation	0 (0.00)	6 (6.00)
Clinical work type		
Psychotherapy/Counseling	12 (75.00)	69 (69.00)
Assessment	1 (6.25)	22 (22.00)
Community support work	2 (12.50)	8 (8.00)
Research	1 (6.25)	1 (1.00)
Target patient group		
Adults	9 (56.25)	58 (58.00)
Children	0 (0.00)	22 (22.00)
Adolescents	7 (43.75)	12 (12.00)
Infants	0 (0.00)	4 (4.00)
Older adults	0 (0.00)	1 (1.00)
All age groups	0 (0.00)	3 (3.00)
Practicing Region		
Greater Tokyo area	8 (50.00)	43 (43.00)
Greater Osaka Area	8 (50.00)	20 (20.00)

Other	N/A	37 (37.00)

Note. SD = standard deviation.

Table 2 *Frequency, respondents who listed the term (%), Smith's S for how laypeople acquire beliefs about mental health*

Term	*n*	%	Smith's *S*
マスメディア報道（新聞・テレビ・ラジオ・Web メディアなど） Mass media (e.g., newspaper, TV, radio, web media)	10	62.50	0.50
家庭での考え・教育 Beliefs taught and learnt at home	15	93.75	0.40
ソーシャルメディア（各種 SNS、YouTube など） Social media (e.g., SNS, YouTube)	10	62.50	0.40
創作物や視覚芸術（本・ドラマ・映画・マンガなど） Creative and visual arts (e.g., books, dramas, movies, manga)	13	81.25	0.32
教師や上司の考え Beliefs held by school teachers and boss at work	9	56.25	0.31
歴史・文化観 Historical and cultural values	4	25.00	0.13
友人など家族以外の身近な人の考え Beliefs held by people who are close such as friends, but not family members	4	25.00	0.13
広告（製薬会社などの） Commercial advertisement (e.g., pharmaceutical ads)	2	12.50	0.10
政府・政策・制度 Government, policy, and public system	3	18.75	0.07
世俗的な心理学または学術的ではない情報（自己啓発本など） Pop psychology or non-academic information (e.g., self-help books)	3	18.75	0.06
メンタルヘルスに関する経験・習慣の有無 Level of experience or routines related to mental health	2	12.50	0.06
メンタルヘルス不調者との接触経験の有無 Level of experience with people with mental illness	3	18.75	0.06
専門家からの情報発信・教育（職場・学校などで） Disseminated information or education by professionals (e.g., at work or school)	2	12.50	0.04
経済的格差 Economic inequality	1	6.25	0.04
代替医療・民間療法（東洋医学、ヨガ、ピラティスなど） Alternative or traditional medicine (e.g., Asian, Yoga, Pilates)	3	18.75	0.03
職場・会社など組織での考え Beliefs and values held by an organization (e.g., company)	1	6.25	0.03
宗教的な考え Religious beliefs	2	12.50	0.03
情報の格差 Information and digital literacy inequality	1	6.25	0.03

医療制度 Healthcare system	1	6.25	0.02
教育の格差 Education inequality	1	6.25	0.02
精神科病院の役割･イメージ The role and image of psychiatric hospitals	1	6.25	0.01

Note. *n* = frequency and % represents proportion of participants who listed the term.

Table 3 *Frequency, respondents who listed the term (%), Smith's S for how Japanese mental health care ought to be reformed*

Term	*n*	%	Smith's *S*
義務教育・小さい頃からの教育・啓発 Promote mental health education and awareness from a young age (both through compulsory education and at home)	8	50.00	0.34
保険適用の拡大 Extend health insurance coverage	8	50.00	0.30
心理士の質・技術力・トレーニングの向上 Improve clinicians' quality, skills, training	9	56.25	0.25
情報リテラシーの向上 Improve information literacy	4	25.00	0.17
メンタルヘルスリテラシーの向上 Improve mental health literacy	9	56.25	0.15
スティグマの軽減活動 Partake in anti-stigma efforts	3	18.75	0.14
心理士の地位の向上・雇用の安定化 Improve clinicians' social status and secure employment stability	5	31.25	0.10
行政サービスやカウンセリング機関の充実 Expand social service and mental healthcare facilities	5	31.25	0.09
多職種連携の推奨(医師・ソーシャルワーカーなどとの) Encourage multidisciplinary collaboration (e.g., with doctors, social workers)	3	18.75	0.09
心理職の増員 Increase mental health professionals	2	12.50	0.08
大学等の教育の場での専門家の活用 Place professionals in schools/educational institutions	3	18.75	0.07
企業教育の推進 Promote corporate training for mental health	2	12.50	0.07
精神障害者への雇用・経済支援 Provide financial and employment support to people with mental illness	2	12.50	0.05
いじめ対策の強化 Enhance anti-bullying policies and prevention programs	1	6.25	0.05
患者団体へのクローズアップ Engage with patient groups	1	6.25	0.05
児童虐待対策の強化 Enhance anti-child abuse and neglect policies and prevention programs	1	6.25	0.04
貧困対策の強化 Enhance anti-poverty policies and prevention programs	1	6.25	0.04
地域格差の是正 Reduce regional inequality and gap	1	6.25	0.04

診療費用・効果に関する研究の増進 Increase research on care effectiveness and cost performance	1	6.25	0.03
教師への教育・負担感の軽減 Reduce burdens and labor of school teachers	1	6.25	0.02
海外動向の発信拡充 Disseminate programs and approaches from abroad	1	6.25	0.01
ルールの明確化（診断、診療名） Clarify and centralize the guidelines (diagnosis, treatment labels)	1	6.25	0.01
一般向け研究情報の発信拡充 Disseminate research knowledge to the public	1	6.25	0.01

Note. *n* = frequency and % represents proportion of participants who listed the term.

3.3.2 Phase 2: Cultural Consensus Analysis (CCA)

CCA revealed that a single, shared set of beliefs about how the general public acquire beliefs about mental health and how Japanese mental healthcare ought to be reformed was identifiable among Japanese clinical psychologists. We obtained a first to second eigenvalues ratio of 5.81 (1.32 to 0.23) for the first domain and 6.95 (1.44 to 0.21) for the second domain, respectively, which showed an adequate fit to the data following the standard recommendations of a ratio > 3.0 (Weller, 2007a). These eigenvalue ratios indicate a single factor representing the consensus among study participants. The average competence score was 0.46 for the first domain and 0.50 for the second domain, respectively, demonstrating acceptable factor loadings according to the conventional rule of thumb. Weller (2007) recommends scores above 0.5 average; those below 0.3 are deemed to indicate a poor fit (lower level of consensus). Table 1 shows participant characteristics.

3.4 Discussion

To the best of our knowledge, this is the first study to utilize cultural consensus theory for studying shared beliefs about mental health among Japanese clinical psychologists. The two-phase MMR approach used in our study allowed us to investigate the following: (a) culturally salient terms Japanese clinical psychologists use to characterize how the general public acquire beliefs about mental health; and how Japanese mental healthcare ought to be reformed in our cultural domain analysis phase; and (b) evidence of a shared cultural model of the two domains by conducting CCA.

Our cultural domain analysis in the first phase showed that overall, there were 21 items to describe how the general public acquire beliefs about mental health and 23 items to describe how Japanese mental healthcare ought to be reformed, respectively. The most salient items mentioned for how the general public acquire beliefs about mental health were *mass media, beliefs taught and learnt at home, social media, creative and visual arts, beliefs held by school teachers and boss at work, historical and cultural values, beliefs held by people who are close such as friends, but not family members*, and for how Japanese mental healthcare ought to be reformed were *promote mental health education and awareness from a young age (both through compulsory education and at home), extend health insurance coverage, improve clinicians' quality, skills, and training,*

improve information literacy, improve mental health literacy. The terms emerged in the first phase informed the second phase to examine the level of agreement among the clinical psychologists about the two domains. Our CCA results showed consensus regarding how the general public acquire beliefs about mental health and an even stronger consensus regarding how Japanese mental healthcare ought to be reformed.

Most clinical psychologists in our study perceived the largest contributions to the mental health beliefs of the general public are non-professional learning or knowledge dissemination outlets that people encounter on a regular basis. Although *religious beliefs* are found to be one of the most influential factors shaping people's mental health beliefs in the West (e.g., Koenig & Larson, 2001), it was one of the least salient items in our study. This finding is consistent with studies reporting lower levels of religiosity in Japan compared to the Western countries (e.g., Kobayashi et al., 2020).

Participants rated extend *health insurance coverage* as the second most salient term for how Japanese mental healthcare ought to be reformed, reflecting the limitations of current Japanese health insurance coverage. Currently, psychotherapy or counseling is not covered by the government-funded national health insurance unless it is deemed necessary treatment by physicians. Services provided by clinical psychologists, which are not supervised by physicians are not covered by the health insurance. Thus, extending the coverage would benefit both patients and clinical psychologists given the increased patient access to mental healthcare as well as employment opportunities for clinical psychologists. Participants also rated *improve clinicians' quality, skills, and training* as one of the most salient terms, which may also reflect their concern with the current professional status and disciplinary boundary conflict with medicine and medical professionals in Japanese mental healthcare. We also observed that the salient terms listed for the two cultural models share some themes in common in that clinical psychologists' strong emphasis on the need for improving education, literacy, and awareness in mental health reflect the suggested solutions that may work through non-professional learning and knowledge dissemination outlets.

3.4.1 Limitations

The results of our study are limited by its exploratory approach rather than a hypothesis-testing approach. While we found shared models of mental health beliefs among all the clinical psychologists in the sample, we did not closely examine the distribution of cultural competence

among them. Future research should investigate characteristics of clinical psychologists endorsing consensual vs. diverging beliefs about mental health. It is possible that there may be subgroups or people with certain characteristics within our sample, which may predict cultural competence (e.g., gender, age, theoretical orientation). The extent to which personal beliefs held by the participants in our study map onto the shared cultural models detected by CCA is also unknown. Dressler and Bindon (2000) proposed a theory of 'cultural consonance' to study further the relationship between the identified cultural models and the endorsement of personal beliefs. Cultural consonance is defined as the degree to which people place or fail to place culturally shared models of beliefs into their own practices and lives. Lower levels of cultural consonance were associated with poorer health outcomes. For example, higher cultural consonance in lifestyle and social support domains predicted lower blood pressure among urban Brazilians while controlling for demographic variables (i.e., age, sex, and socioeconomic status) (Dressler et al., 1997, 1998). Although CCA does not require a large sample size, we relied on snow-ball sampling for our free-listing phase and an online professional community forum for our recruitment for our CCA phase, which limited us to examining within-group differences such as different therapeutic orientations, age, gender, and years of experience. Finally, future studies should seek to investigate the cultural models of patients, other mental health professionals, or clinical psychologists in other cultural contexts to examine the presence of intergroup variations or similarities in shared beliefs about mental health.

3.4.2 Conclusion

Cultural consensus theory, as used in this study, is a promising methodological framework that could be applied much more widely, especially to cultural psychology but indeed to the psychology of beliefs more generally. More generally, MMR designs are well-suited for exploring underexplored cultural domains and/or understudied cultural groups, where a hypothesis-testing approach would be premature. Our study contributes to this literature by demonstrating a case example of how cultural consensus theory can be used to advance mental health research in non-WEIRD cultural contexts along with how an MMR approach can be applied to psychological research.

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CHAPTER 4: (MANUSCRIPT 3)

"What do you think other clinicians think?": Examining Japanese Clinical Psychologists' Shared Beliefs about Depression and Therapeutic Alliance Using Cultural Consensus Theory

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Abstract (English)

Cultural consensus theory (CCT) proposes a comprehensive theoretical, methodological, and statistical framework aimed to identify shared beliefs held by a particular group. The current study employed a two-phase sequential exploratory mixed-methods research design using CCT to examine the collective beliefs about depression and therapeutic alliance shared by Japanese clinical psychologists (CPs). Within CCT, qualitative methodologies are first conducted to identify culturally salient themes of a particular knowledge domain; factor analysis is subsequently performed to quantify the level of consensus through a technique known as cultural consensus analysis (CCA). Firstly, we conducted a cultural domain analysis (CDA) utilizing a free-listing interviewing technique with 16 Japanese CPs to elicit salient terms for depression: (1) causes, (2) effects, (3) treatment; therapeutic alliance (1) an incompetent clinician, (2) a difficult client; (3) external barriers, and (4) problem-solving in the therapeutic alliance. The identified terms were then subjected to qualitative coding and used to develop a survey to be tested for cultural consensus analysis (CCA) in the quantitative phase. Subsequently, 100 CPs completed the survey, and CCA was performed. CDA results allowed us to develop lists of 19-20 salient terms generated by the participants. The results of our CCA showed a significant level of consensus across the four domains: causes, effects and treatment regarding depression, and problem-solving domain therapeutic alliance. We did not find strong shared models for incompetent clinician, difficult client, and external barriers. CCT emerges as a comprehensive mixed-methods approach adept at exploring culturally informed collective beliefs shared by a specific cultural group.

Keywords: Cultural Consensus Analysis, Cultural-Clinical Psychology, Beliefs about Depression, Japanese Clinicians, Mixed-Methods Research.

Abstract (Japanese)

”世間一般の心理士はどう考えるていると思うか？”- 日本人臨床心理士のうつ病と治療同盟共通認識の合意度の検討：カルチュラル・コンセンサスを用いた混合法研究

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キーワード：カルチュラル・コンセンサス、文化臨床心理学、混合法

本研究は著書ら(Sunohara et al., 2022)によるカルチュラル・コンセンサス・セオリー（Cultural Consensus Theory: CCT）を用いた日本の心理士のメンタルヘルスに関する価値観についての先行研究の第二弾である。CCTとは、認知人類学で発展してきた人びとの知識や文化的価値観を検討するための理論・方法論的枠組みである。CCTでは、文化的価値観や知識について、特定のグループに属する人たちの間で形成され、互いに認識されている「共有された情報のかたまり」と位置づける。CCTではまず質的研究法を用いてグループの間主観性または合意の内容を明らかにしたのち、統計解析を用いてその合意度を定量化する。本研究では CCTに基づいた2フェーズ混合法デザインを用いて、日本人臨床心理士のうつ病（①原因帰属，②症状・影響，③治療）と治療同盟（①力量不足の心理士、②対応が難しいと感じるクライエント、③障壁、④課題解決）に関する信念の合意度を検討した。質的研究フェーズの研究 I では16名の臨

床心理士を対象にフリーリスティング法によるインタビュー調査を行った。研究２の量的研究フェーズでは臨床心理士100名を対象に質問紙調査を行い、因子分析を応用したコンセンサス解析を行った。その結果、”力量不足の心理士”,対応が難しいと感じるクライエント、障壁以外の４つの項目において、心理士の間でうつ病と治療同盟について高い合意があることが確認された。 CCTは研究方法論として分野横断的なアプローチであり、欧米・英語圏文化の中で発展してきた心理学的理論を標準とする応用するのではなく、非欧米圏やマイノリティの文化・コミュニティの心理・価値観を考慮し帰納的に検討する混合法研究としての有用性が期待される。

"What do you think other clinicians think?": Examining Japanese Clinical Psychologists' Shared Beliefs about Depression and Therapeutic Alliance Using Cultural Consensus Theory

4.1 Introduction

Practicing mental health clinicians often encounter a broad range of experiences within the context of the therapeutic alliance, encompassing both rewarding moments and challenging situations. Therapeutic alliance, a central ingredient of psychotherapy, is defined as a collaborative relationship and dynamic process that unfolds between a clinician and a client and has consistently been shown to predict positive therapeutic outcomes (Ardito & Rabellino, 2011; Bordin, 1979; Dobkin & Lucena, 2015; Horvath & Symonds, 1991). Clinicians adeptly navigate the intricate intersections between client's experiences of suffering, psychological well-being, and social recovery, all while also managing and fostering their therapeutic alliance with their clients.

The emotional demands, hardships, and difficulties that clinicians experience in the process of providing care and cultivating a strong therapeutic alliance are profound and often underestimated (Rønnestad & Skovholt, 2003; Schröder & Davis, 2004; Skovholt & Rønnestad, 2003). Furthermore, working closely with persons suffering from mental illnesses, mental health clinicians often develop a distinct set of beliefs about mental illness, which can diverge from those held by their clients or the general public within community (e.g., Ahn et al., 2009; Flanagan & Blashfield, 2008; Larkings & Brown, 2018; Lauber et al., 2006; Montgomery & Fahey, 2001; Rønnestad Oren et al., 2021; Schulze, 2007; Stuber et al., 2014). These beliefs pertaining to how people from different cultural groups and communities (including mental health care providers) perceive, explain, and respond to mental illness, are conceptualized as explanatory models of mental illness (Kleinman, 1980, 1988). According to Kleinman, explanatory models are culturally shaped, and reflect the cultural norms, values, and consensus of the context in which people are situated.

Mental health clinicians hold a distinct professional position within society, as they operate at the intersections of medical and health care system, education, public policy, and advocacy. Their role places them in a unique cultural group or community of their own, characterized by their shared professional identity and the specific challenges and responsibilities they face in their work. The existing literature on explanatory models in the field of mental health has primarily

focused on the beliefs and narratives of clients, leaving a gap in our understanding of the explanatory models and therapeutic alliance as perceived and shared by practicing mental health clinicians. While some scholars argue that the client's perception of the therapeutic alliance carries more weight, it is crucial to acknowledge the pivotal role played by the clinician's beliefs in the overall dynamic of care provision (Nissen-Lie et al., 2010, 2013). Clinicians' explanatory models and beliefs about the therapeutic alliance contribute to the interplay between the explanatory models of clients, caregivers, and other mental health professionals.

Although empirical research on clinicians' beliefs and explanatory models is limited, some studies have shed light on the challenges experienced by clinicians in therapeutic relationships. For example, Davis and colleagues (1987) proposed a taxonomy to categorize difficulties reported by British psychotherapists. In another line of research, Nissen-Lie et al. (2013, 2017) examined the associations between coping strategies and interpersonal distress among Norwegian psychotherapists. Schröder and Davis (2004) conducted qualitative analysis of the narratives of British and German psychotherapists, exploring their experiences of difficulty in therapeutic alliances. In contrast, Skovholt, an American counseling psychologist and Rønnestad, a Norwegian clinical psychologist (2003), noted that there is lack of consensus among clinical psychologists regarding effective strategies for managing obstacles in the therapeutic alliances, partly due to the ambiguity and uncertainty surrounding their professional responsibilities.

Despite the heterogeneity in the methodologies, sample characteristics, and operational definitions employed in these studies, these authors have not adequately addressed the cultural specificity of their findings. Moreover, although the existing literature on beliefs and perspectives of clinicians has offered useful insight, most of these studies have primarily focused on Western cultural contexts, resulting in a limited understanding of non-Western cultural perspectives (Flückiger et al., 2018; Pelling, 2004; Tanaka-Matsumi, 2022). For instance, Flückiger and colleagues (2018) conducted a comprehensive meta-analysis of 295 independent studies published between 2011-2017, investigating the effect of therapeutic alliance on treatment outcome in adult psychotherapy. The study reported that 70% of the study samples were from North America; in contrast, 7% were from other English-speaking countries, and 22% were from European countries.

In a review of case studies from various countries, Wedding (2007) highlights the immense diversity in the experiences and social-cultural shaping of practicing psychologists worldwide. The qualitative studies mentioned in the review provide insight into the education, training,

professional experience, and legal and social status of psychologists in various non-Western countries, which can differ significantly from the American context. For example, in Argentina, there is a growing emphasis on time-limited cognitive behavioral therapy (CBT) approaches and a noticeable feminization of psychology, with a majority (85%) of psychotherapists being women (Gómez, 2007). In Brunei Darussalam, Kumaraswamy (2007)describes how Muslim values shape the public's understanding of mental illness. However, most mental health providers in the country have received training in Western universities, thereby resulting in a cultural conflict between patients and clinicians. In Iran, there is a clear professional distinction between psychotherapy and counseling, where psychologists with doctoral degrees are recognized as clinicians specializing in psychotherapy, whereas those with master's degrees are regarded as counselors (Khodayarifard et al., 2007). Note the clear distinction in this last case, especially when compared to the more ambiguous differentiation between counselors and psychotherapists in the U.S., as highlighted by Wedding (2007). In South Africa, the opportunities for participation in the psychotherapy profession are deeply intertwined with the country's history of racial tension and segregation. Notably, a significant majority (80%) of licensed psychologists in South Africa are white, despite the white population constituting less than 10% of the total population (Cooper, 2007). It is apparent that further research is needed to explore the diverse and culturally unique understanding of beliefs held by mental health clinicians practicing in non-Western cultural contexts.

This paper aims to adopt a mixed-methods approach grounded in cultural consensus theory as a framework to examine mental health beliefs shared by Japanese clinical psychologists. By integrating culturally informed qualitative methods and rigorous statistical analysis, this approach allows for exploration of a deeper understanding of the beliefs shared by an understudied cultural group or community. In this study, our objective was to explore the diverse range of beliefs and explanatory models of depression and the therapeutic alliance among Japanese clinical psychologists, thereby providing a lens into the perspectives of a non-Western cultural group. The deliberate selection of Japanese clinical psychologists stems from three primary rationales. Firstly, they have historically been considered marginalized within the mental healthcare system in Japan, often overshadowed by medical disciplines such as psychiatry and psychosomatic medicine (Horiguchi, 2019; Sato, 2007). Secondly, recent years have witnessed profound shifts in licensure practices in Japan, with remarkable implications to their professional identity and views on mental health (Imada & Tanaka-Matsumi, 2016; Iwakabe, 2008; Iwakabe & Enns, 2013). Lastly, Japan's

cultural values, norms, and societal priorities diverge significantly from those of Western societies (Markus & Kitayama, 1991), influencing the prevailing beliefs about mental health (Horiguchi, 2019; Narikiyo & Kameoka, 1992; Sato, 2007).

4.1.1 Mixed-Methods Approach for Culturally Informed Psychological Research on Mental Health

The use of the mixed-methods research (MMR) approach is particularly advantageous in investigating understudied subjects and communities in the realm of psychological research (Bartholomew & Brown, 2012; Creamer & Reeping, 2020). MMR involves the collection and analysis of both qualitative and quantitative data, as well as the integration of findings from these different data sources (Creswell, 2013; Creswell & Poth, 2014). This comprehensive approach facilitates a more profound understanding of shared beliefs within specific groups and communities. MMR concurrently captures the nuanced elements of their local sociocultural contexts through qualitative methods driven by an inductive inquiry, while also maintaining a degree of universality and generalizability through quantitative methods (Doucerain et al., 2016; Tashakkori et al., 2012). Furthermore, employing an MMR approach in psychological research on mental health particularly when considering cultural perspectives is beneficial for two key reasons. Firstly, a clear limitation in psychological science research has been the neglect of non-Western cultural perspectives, primarily relying on undergraduate student samples from Western cultural contexts and conducted by researchers of Western cultural background. Secondly, the existing literature on beliefs about mental health has been dominated by quantitative methodologies, often aggregating individual's responses and the testing of hypotheses designed and interpreted by Western researchers, rather than exploring the perspectives and beliefs driven by the group or non-expert community.

Psychological research has faced criticism for its limited cultural diversity and applicability in various aspects, including theory development, sampling, and methodologies. This issue is conceptualized as the WEIRD problem, which stands for Western, Educated, Industrialized, Rich, and Democratic research biases (Henrich et al., 2010). Heinrich, Heine, and Norenzayan (2010) documented that mainstream psychological studies have predominantly drawn undergraduate student participants and theoretical frameworks from WERID cultural contexts thus reflecting cultural norms and values specific to those contexts. Moreover, these studies have heavily relied

on quantitative methodologies and used measurements such as self-report surveys that have been developed within the WEIRD cultural perspectives and languages.

Cultural psychology has emerged as a response to address the limitations of the WEIRD dominated mainstream psychology by adopting more relativistic perspectives. Cultural psychologists have consistently demonstrated that theories previously assumed to be universally applicable (but based on WEIRD sampling and theory development) may not hold true in different cultural contexts. These discrepancies have been observed in various areas of psychology including emotion, motivation, and cognition (e.g., Markus & Kitayama, 1991). Nonetheless, cultural psychology has also favored quantitative research designs, such as self-report surveys and lab-based experiments, often using undergraduate student samples commonly used in social psychology. Additionally, the field has expanded its scope by conducting large-scale comparative surveys to investigate cross-national differences in values (Hofstede, 1980; Inglehart & Baker, 2000; Shwartz, 1994). Nevertheless, research in the field of mental health and clinical psychology has shown limited engagement with these findings.

Clinical psychology has indeed followed a different disciplinary trajectory compared to cultural psychology. Historically, compared to cultural psychologists, clinical psychologists have engaged directly with patients, caregivers, communities, and policy makers, alongside scientific research. However, the discipline has been slower in addressing cultural diversity in both research and clinical practice, given its origins in North America (J. Lee & Sue, 2001). Methodologically, while clinical psychology has traditionally emphasized qualitative research methods, such as case studies, there has been a notable shift towards embracing the integration of clinical practice and scientific research through the scientist-practitioner model. Consequently, there has been an increasing preference for quantitative approaches within the field, including randomized controlled trials, neuroimaging studies, and epidemiological surveys.

Cultural-clinical psychology has emerged as an integration of cultural psychology and clinical psychology. (Chentsova-Dutton & Ryder, 2019; Marsella & Yamada, 2007; Ryder et al., 2011; Tanaka-Matsumi & Draguns, 1997). The discipline has been a strong advocate for the use of MMR to better understand the influence of culture on mental health, including explanatory models, diagnostic systems, symptom presentations, and help-seeking behaviors. Specifically, Ryder et al. (2011) posit that culture, mind, and brain are interconnected and mutually influence each other. In this framework, clinicians' beliefs about mental illness should be examined under

the assumption that they are properties of the interconnected system of culture, mind, and brain, rather than being restricted to a single level analysis. This holistic perspective emphasizes the importance of adopting interdisciplinary approaches and differing philosophical assumptions to study the relationship between culture and mental health, which can be facilitated through the utilization of MMR.

4.1.2 Cultural Models and Cultural Consensus Theory

The interdisciplinary approach to epistemology and methodology concerning the study of culture advocated by cultural-clinical psychology sharply diverges from the traditional approaches upheld by either clinical psychology or cultural psychology. Chentsova-Dutton and Ryder (2019, 2020) have recently adapted a *cultural models* approach, a theoretical model originally emerged from cognitive anthropology, which itself markedly differs from the foundations of mainstream anthropology. Cognitive anthropology conceptualizes cultural models as the prevailing beliefs, knowledge, or cognitive models that are widely distributed and shared among members of a particular cultural group or community (D'Andrade, 1995). The fundamental premise of cultural models is that the underlying social and psychological construct should be understood at a collective cultural or group level, rather than solely residing at the individual level as hypothesized by many mainstream psychologists. This approach aims to deconstruct researcher or expert-centered understandings of psychological and social phenomena, and instead investigates and embraces how members from various groups assign and construct their own interpretations and "models" for specific concepts or knowledge. This approach contrasts with mainstream psychology's focus on demonstrating deviations from WEIRD or researcher-imposed models among people from non-WEIRD cultural groups or non-expert communities. In addition to the traditional ethnographic methods used in anthropology, cognitive anthropology has also incorporated statistical models to enhance the study of culture. This MMR approach, adopted in the study of cultural models proposed by cognitive anthropology, aligns well with the goals of cultural-clinical psychology.

4.1.3 Cultural Consensus Theory as a Two-Phase Mixed-Methods Approach

Cultural models can be examined by identifying the beliefs and perceptions held by members within a specific group, and subsequently estimating the extent of consensus among

group members. This approach, known as cultural consensus theory (CCT), was developed as a theoretical, methodological, and statistical framework to guide researchers to study cultural models (Romney et al., 1986, 1987). The CCT driven research program often follows a two-phase sequential mixed-methods design, where the qualitative phase provides insights and informs the subsequent quantitative phase. The three principles of CCT are: (1) cultural models are constructed and shared by the group, rather than by researchers or those outside of the group; (2) the study of cultural models should first be undertaken by careful qualitative approaches, allowing participants to actively define and conceptualize specific cultural models in their own words; (3) the ultimate goal of studying cultural model is to statistically test the presence or absence of consensus among the members of the group regarding the cultural model (Borgatti, 1999; Dressler, 2017; Romney et al., 1986).

The first principle of CCT may be particularly novel to psychologists who often carry out their research based on a priori definitions of beliefs, values, or knowledge to engage in hypothesis driven, deductive research. For example, conventional quantitative survey studies examining public beliefs about mental illness have focused on measuring the discrepancies between researcher-driven, academic definition of psychiatric diagnoses and the way non-experts in the community define those diagnoses/conditions/symptoms (e.g., Jorm, 2000; Kermode et al., 2009; Reavley et al., 2014). These studies often present results of their hypothesis that show that general public is more likely to fail to provide researcher-defined correct answers and lack experts' knowledge. In contrast, CCT emphasizes the importance of deconstructing researcher or expert-centered conceptualizations. The first phase of CCT is theory building and exploratory research in nature.

4.1.3.1 Qualitative Phase: Cultural Domain Analysis (CDA)

In CCT, members of a particular cultural group or community are regarded as the true "experts" of knowledge and are referred to as informants, representing the cultural models of their local socio-cultural world. To this end, researchers may carry out cultural domain analysis (CDA) as the initial qualitative step in CCT, using free-listing interviews and saliency analysis (Borgatti, 1994). CDA aims to elicit culturally relevant and salient ideas by generating a list of terms that aligns with the informant's specific cultural knowledge area, known as the cultural domain. In the free-listing task, participants engage in a simple, low-demanding task of listing words or short

phrases that come to mind easily related to the domain (Fiks et al., 2011; Schrauf & Sanchez, 2008). One can then compute an item's salience index called Smith's *S* accounting for the order and frequency of the term mentioned across participants (J. Smith & Borgatti, 1998). Smith's *S* helps determine which terms should be retained for further quantitative analysis in subsequent stages of the study. The detailed procedure of CDA is outlined in the methods section of this paper.

4.1.3.2 Quantitative Phase: Cultural Consensus Analysis (CCA)

Lastly, one of the defining features of CCT is the application of cultural consensus analysis (CCA), a statistical model performed to evaluate the presence of a shared cultural model. CCA utilizes factor analysis to measure the degree of agreement or consensus among respondents on a cultural model, represented by a statistically derived factor (Romney, 1999; Romney et al., 1986, 1987). As with conventional factor analysis, CCA computes eigenvalues for the first and second factors. By examining the ratio of the first to second eigenvalues, researchers can determine the presence of a shared cultural model, with a threshold typically set at 3:1 (Romney et al., 1986). CCA is like reliability testing where survey items load onto a factor by comparing scores across participants. However, CCA examines each participant's performance relative to culturally shared knowledge or consensus among the participants. Therefore, it estimates reliability of participants themselves and provides insights into the level of each participant's knowledge about shared knowledge indicated by factor loadings. In this context, factor loadings are referred to as cultural competence scores. The detailed statistical procedure of CCA is outlined in the methods section of this paper.

The application of CCT in psychology has been scarce. Therefore, we present several studies conducted over the past thirty years that have applied CCT to examine shared beliefs about health more generally among understudied cultural groups and communities across various disciplines in the social and health sciences. One of the pioneering studies in the application of CCT to health beliefs was conducted by a research group led by Dressler, an American biocultural medical anthropologist, and colleagues (Dressler et al., 1997, 1998). The researchers investigated cultural models of lifestyle and social support among urban residents in Brazil. The study employed a comprehensive multi-year, multi-cite CCT research design. These studies included in-depth ethnographic interviews and data collection from various communities across different socioeconomic statuses and neighborhoods to ensure a comprehensive understanding of the

cultural models in this context. Specifically, they have identified and confirmed the presence of cultural models of the successful lifestyle among the communities. In another study, Dressler and colleagues replicated the methodology and found similar results with African American communities in the Southern U.S. (Dressler, 1991; Dressler & Bindon, 2000).

Other researchers compared cultural models of different groups and examined the implications of the divergence or convergence within and across different groups. For instance, Barg and colleagues (2006) first identified the presence of a shared cultural model of depressive symptoms among older American adults in which the themes related to loneliness were found to be highly salient. They subsequently conducted structured clinical interviews and discovered that participants' understanding of depressive symptoms was conceptually closely linked to their beliefs about loneliness rather than aligning with the experts' definition of depressive symptoms. Smith (2004) studied three different cultural groups at a same medical clinic and found that patients, faculty, and medical residents at the clinic in a Western region in the U.S. did not share the same cultural model concerning the values about the quality of the service and care provided by the clinic. Similarly, Fisk and colleagues (2011) demonstrated disparities in cultural models of conceptualization of ADHD and its treatment between pediatricians and caregivers of children with ADHD in Philadelphia, U.S. They identified that themes related to school were central to beliefs held by clinicians, whereas the effects of the ADHD condition on the child and family were more salient for the parents. Moreover, variations in cultural models were observed among different subgroups of parents, with parental education level dividing parents into distinct groups with differing cultural models.

Petty and colleagues (2019) showed that subgroups differentiated by personal experience of dementia caregiving and years of professional experience showed distinct patterns of cultural models in their responses to emotional distress of the patients and priorities in patient care at a hospital in the UK. The findings of these studies suggest that discrepancies or similarities in cultural models have clinical implications for enhancing patient care and the quality of the patient-clinician relationship. In some cases, the absence of a shared cultural model can provide valuable information and insights. When researchers studied beliefs about diabetics in certain parts of Thailand, no single cultural model emerged despite the high prevalence of the condition (Ratanasuwan et al., 2005). This suggests a lack of consensus or shared understanding among the

community regarding diabetes, which can have implications for healthcare interventions and education in this context.

4.1.4 Brief History of the Professional Development of Clinical Psychologists in Japan

Readers should recall that the landscape of clinical psychology as a mental health profession and the practice of psychotherapy in Japan are significantly distinct from North America. Therefore, understanding the beliefs of Japanese clinical psychologists requires considering the historical and political trajectories, as well as educational and credential requirements that have shaped the establishment of the profession in Japan. Over the years, the profession has undergone significant transformations, facing various challenges and witnessing advancements not only within the field of clinical psychology but also in relation to neighboring disciplines such as medicine (Imada & Tanaka-Matsumi, 2016; Iwakabe, 2008; Iwata, 2023; Kasai, 2009; K. Maruyama, 2016; Nozue, 2018; Sato, 2007; Takasugi, 2022).

The ongoing controversy surrounding the professionalization of clinical psychologists' centers on the jurisdiction of their role as a "mental health" profession within the Japanese society. Specifically, the debate is the fundamental question of whether they should be officially classified as a "medical" profession within the broader medical care system and entitled to a national qualification akin to other medical professions like nursing. Establishing national qualification entails a trade-off for clinical psychologists, as it could relinquish their professional autonomy and identity by restricting their decision-making authority to the discretion of physicians and confine their practice primarily to the medical and healthcare domains. While some demanded the immediate establishment of national qualification, others strongly opposed the proposal, whether through a non-government or government regulation. Their stance derives from the belief that clinical psychology and its specialized knowledge should not be subjected to regulation or monopolization by any particular entity, as this could potentially lead to objectification, exploitation, and oppression of the clients and sufferers seeking help.

Consequently, the Japanese Psychological Association (JPA), founded in 1927, initially resisted professionalizing clinical psychologists, leading to a group of clinical psychologists departing from JPA and forming the Association of Japanese Clinical Psychology (AJCP) in 1982. The AJCP has since become the largest professional psychology association in Japan, surpassing

the membership of the JPA. In 1988, the Japanese Certification Board for Clinical Psychologists (JCBCP) was established by the AJCP to issue the certification for clinical psychologists, known as the certified clinical psychologist or *rinshou-shinrishi* [臨床心理士] in Japanese. This certification is considered the most prestigious among those working in the field of mental health. However, it is important to note that this certification is not a national or government-regulated "medical" licensure. Nurses are permitted to provide psychotherapy and counseling if supervised and directed by physicians, and it is considered a medical treatment. Conversely, while certified clinical psychologists maintain a certain degree of professional autonomy within the medical and healthcare system, the care they provide is not officially recognized as a medical and therefore are not covered by national health insurance for the clients and patients. The JCBCP has set three criteria for certification, including the completion of a two-year master's level training in clinical psychology at an accredited program (note that undergraduate degree in psychology is not required), a minimum of one year of supervised clinical practice, and successful completion of a certification examination. Starting in 1996, the JCBCP began accrediting master's programs in clinical psychology, which offer a highly structured curriculum focusing on counselling, psychotherapy, assessment and interviewing, and research methods (Imada & Tanaka-Matsumi, 2016; Iwakabe, 2008; Iwakabe & Enns, 2013; K. Maruyama, 2016; Takasugi, 2022).

During the late 1990s, the endeavor to professionalize clinical psychologists and attain societal recognition in Japan persisted, this time intersecting with the field of medicine (K. Maruyama, 2016). In 1995, the Ministry of Education, Culture, Sports, Science and Technology (MEXT) acknowledged the certification of JCBCP in clinical psychology and mandated that school counsellors acquire this certification to address the escalating social issues of school nonattendance, bullying, and violence. Nonetheless, the Japanese Medical Association quickly opposed MEXT's decision and exerted pressure on the Ministry of Health, Labor and Welfare (MHLW) and government officials to establish a national qualification known as the "health and medical psychologist," or *iryou-shinrishi* [医療心理師] in Japanese. Initially, the proposed *iryou-shinrishi* qualification exhibited more restrictive and narrower criteria compared to the existing *iryou-shinrishi* certification. Notably, its approved work domains were restricted to medical, health, and social welfare, whereas *iryou-shinrishi* covered a broader and more multidisciplinary areas such as education, judiciary system, and industrial/organizational settings. Furthermore, *iryou-shinrishi* necessitated only a bachelor's level of training, thereby limiting their professional

autonomy, as they were required to operate under the authority of physicians. However, in 2006, amidst a change in Prime Minister, the proposed bill to establish *iryou-shinrishi* as the first national qualification in Japan was not passed, and ultimately suspended due to opposition from influential medical professional associations such as the Japanese Medical Association and the Japanese Society of Psychiatry and Neurology (Iwata, 2023; K. Maruyama, 2016).

Despite facing obstacles along the way, clinical psychologists in Japan persisted in their efforts to gain official recognition from the government. After a half century of effort, a significant milestone was reached in 2017, when the MEXT and MHLW finally collaborated and established Certified Public Psychologist [*kounin-shinrishi*, 公認心理師] Act, marking the inception of the first centralized and national licensure for psychologists in the country. The extent to which certified public psychologists would be authorized to offer psychotherapy independently, without the discretion or supervision of physicians, remains uncertain (Takasugi, 2022). Consequently, this licensure transition has sparked ongoing debates and generated a sense of perplexity among key stakeholders within the mental health field.

4.1.5 Clinical Psychologists in Practice in Japan

Clinical psychologists in Japan fulfill a diverse range of roles within the sphere of mental healthcare domains, such as counselling psychology, community psychology, school psychology, and social work (Shimoyama, 2002, 2011). The training programs for clinical psychologists in Japan place a considerable emphasis on projective testing, psychoeducation, and community intervention. However, in comparison to counseling and clinical programs in the United States, they provide limited opportunities for practicum and field experiences (Kudo Grabosky et al., 2012, 2015). As of 2020, approximately 70% of the certified public psychologists hold the certified clinical psychology license (Ministry of Health, Labour, Welfare, 2021). A survey conducted in 2016 reported that the majority of certified clinical psychologists work in the health and medical areas (41.9%), followed by schools (36.0%), academic and post-secondary institutions (25.3%), companies and industrial organizations (8.3%), private clinics (8.2%), and the justice system and police (3.7%) (Japanese Society of Certified Clinical Psychologists, 2016). Most of them provide psychotherapy and counseling (86.2%), followed by assessment (79.9%), and community support work such as liaison for referral to other professionals (64%). A study conducted by Horiguchi (2019) revealed more than half of the respondents reported earning less than the national average

income, and approximately half of them were employed only on a part-time basis. This highlights the need for improved job opportunities and financial support for clinical psychologists in Japan.

Japanese clinicians have actively questioned and sought to enhance the cultural appropriateness and efficacy of Western approaches when working with Japanese patients (Kudo Grabosky et al., 2012, 2015). Both homegrown approaches and Western-derived approaches have been founded. The first homegrown therapeutic approach is Morita therapy established in 1919. Originating in Buddhism, Morita therapy is founded on the principle of gaining an insight of arugamama or embracing the context, and feelings and problems of the self and those of others as they are. Resting is a major part of Morita therapy. Clients are encouraged to transcend their fears and worries, and instead, actively engage in meaningful work, social integration, and contribute to the community as a constructive member of Japanese society (Iwakabe, 2008; Kasai, 2009). The second Buddhism inspired homegrown therapy is Naikan therapy. Originated in 1940s, the Naikan therapy focuses on *mishirabe* (self-reflection) and *naikan* (introspection). In this approach, clients are guided to re-evaluate their past relationships with others and understand the world from the perspectives of others. The goal is to bring awareness to one's self-centered tendencies and develop empathic skills. Another example is Hakoniwa, also known as Sandplay therapy in the West, which integrates Jungian traditions of utilizing Sandplay as a symbolic exploration of clients' inner worlds with Japanese traditions that incorporate art expressions, Buddhist perspectives, Japanese personality, symbolism, and mythology (Enns & Kasai, 2003; Kasai, 2009). Hakoniwa has been a highly favored therapeutic approach used with both children and adults in Japan. In contrast to many Western psychotherapies that focus on the individual in isolation, emphasizing verbal and direct emotional expression, linear cause-effect thinking, and a clear delineation between mind and body, Hakoniwa promotes the holistic expression of the individual within their context. It encourages the use of both nonverbal and verbal communication, embracing nonlinear perspectives and recognizing the interconnectedness of physical and mental well-being. Japanese clinicians have also been drawn to the humanistic approaches and the principles of psychoanalysis, incorporating elements of these therapeutic modalities into their practice. Currently, the majority of Japanese clinicians use Western therapeutic models rather than the homegrown models such as Morita and Naikan therapy. However, there is no single prevailing approach among clinical psychologists in Japan. Many of them use a combination of psychoanalytic and client-centered approaches with a growing interest in CBT (Takasugi, 2022).

4.2 Present Study

This paper presents the second part of a larger study exploring the shared beliefs about mental health among Japanese clinical psychologists. The previous research focused on Japanese clinical psychologists' consensus beliefs about (1) sources of mental health beliefs among the Japanese general public and (2) changes needed to improve mental healthcare in Japan (Sunohara et al., 2022). We discovered shared cultural models for the two domains, with an even stronger consensus for how Japanese mental healthcare ought to be reformed. Notably, clinicians expressed a strong belief in "improving clinician's quality, skills, and training" as a crucial aspect of reform. This finding suggests the existence of self-awareness regarding the role psychologists, as a community, play in the broader mental healthcare promotion in Japan given the historical, political, and sociocultural background of the profession. Thus, Japanese clinical psychologists are likely to hold a unique set of shared beliefs about mental health and mental illness within the context of their own clinical practices and professional experiences.

The Japanese literature on Japanese clinician's beliefs and perceptions is extremely limited. In a review study conducted by Kimura and Kimura (2017), the authors reported that there were only sixteen qualitative studies including five unpublished master's theses aiming to elucidate Japanese clinicians' perceptions of therapist difficulties. The findings from these studies are heterogenous in their results, methods (e.g., KJ-methods, Critical Incident interviewing, Trajectory Equinity Approach), and sample characteristics (e.g., clinical psychologists, counselors, nurses). Indeed, 70% of the samples focused on convenient sampling of novice therapists including student trainees who do not hold licenses. In recent years, online platforms and social media communities like Twitter, Instagram, and Facebook have witnessed a growing presence of Japanese clinical psychologists who utilize these platforms to share their professional experiences and engage in discussions with each other. While clinicians actively express their beliefs and perspectives online, whether there is a consensus or shared agreement about their clinical practices among clinicians as a collective community and a cultural group has not been empirically studied.

We applied CCT to conduct a sequential exploratory mixed-methods research design to explore Japanese clinical psychologists' shared beliefs about depression and therapeutic alliance. The research was carried out in two consecutive studies in which the quantitative phase of data collection and analysis builds on the qualitative phase of data collection and analysis.

4.3 Study 1: Cultural Domain Analysis (CDA)

The first study was a cultural domain analysis (CDA), consisting of several steps. The goal of the CDA is to identify culturally salient and relevant terms for the two main domains: beliefs about *depression* and *therapeutic alliance* among Japanese clinical psychologists. The first step of the CDA is to collect free lists of terms elicited by the participants. The second step is to conduct a qualitative coding of the terms. The third step is to perform a saliency analysis to generate a final list of salient terms defining each cultural domain of interest. Specifically, we were interested in to identifying culturally salient themes pertaining to seven subdomains of the clinicians' beliefs about depression: (1) causes, (2) effects, (3) treatment; and therapeutic alliance: (1) an incompetent clinician, (2) a difficult client, (3) external barriers; and (4) problem solving.

4.3.1 Methods

4.3.1.1 Participants

The first author conducted semi-structured face-to-face interviews, utilizing purposive, convenient, and snowball sampling methods to select sixteen key informant clinicians in December 2019. The sample consisted of five clinical psychologists practicing in the greater Osaka region, eight clinical psychologists practicing in the greater Tokyo region, and three doctoral students enrolled in a clinical psychology program at Osaka University. The sample consisted of seven cis-women and nine cis-men with a mean age of 31.56 years (*SD*=6.55). Out of the total sixteen participants, thirteen clinicians participated in individual interviews, while the remaining three doctoral students participated in a group interview. The eligibility criteria for key informant clinicians included possession of a certified clinical psychology license [*rinshou-shinrishi*, 臨床心理士] and a minimum of three years of clinical practice experience, excluding any supervised clinical training during their master's program. Demographic characteristics of participants are presented in Table 1 and Figures 1-4. In contrast to the random sampling commonly employed in quantitative methods for population generalization, the sampling method used in our study specifically aimed to gain a deeper understanding of the beliefs held by Japanese clinicians. Initially through the authors' network, we were able to access hard-to-reach and understudied clinicians who were believed to possess valuable insights. This method was deemed crucial and

necessary to capture the nuanced cultural knowledge and beliefs of the targeted community (Handwerker & Wozniak, 1997). Participants received a 3,000 yen gift card as compensation for their participation. This first study and the following survey study received institutional approval and informed consent was obtained from all participants.

Table 1 *Sample Characteristics of participants in Study 1 and Study 2*

Characteristics	Study 1 ($N = 16$) *n* (%)	Study 2 ($N = 100$) *n* (%)
Age in years	31.56 (6.55)	35.87 (7.85)
Years of experience as a clinician	5.63 (4.99)	9.36 (6.84)
Gender (cis-women)	7 (43.75)	70(70.00)
Education level		
Junior college	0 (0.00)	1 (1.00)
Bachelor's degree	3 (18.75)	4 (4.00)
Master's degree	11(68.75)	90 (90.00)
Doctoral degree	2 (12.50)	5 (5.00)

Note. (standard deviation) for age and years of experiences as a clinician.

Figure 1 *Therapeutic Orientations of Participants in Study 1 and Study 2*

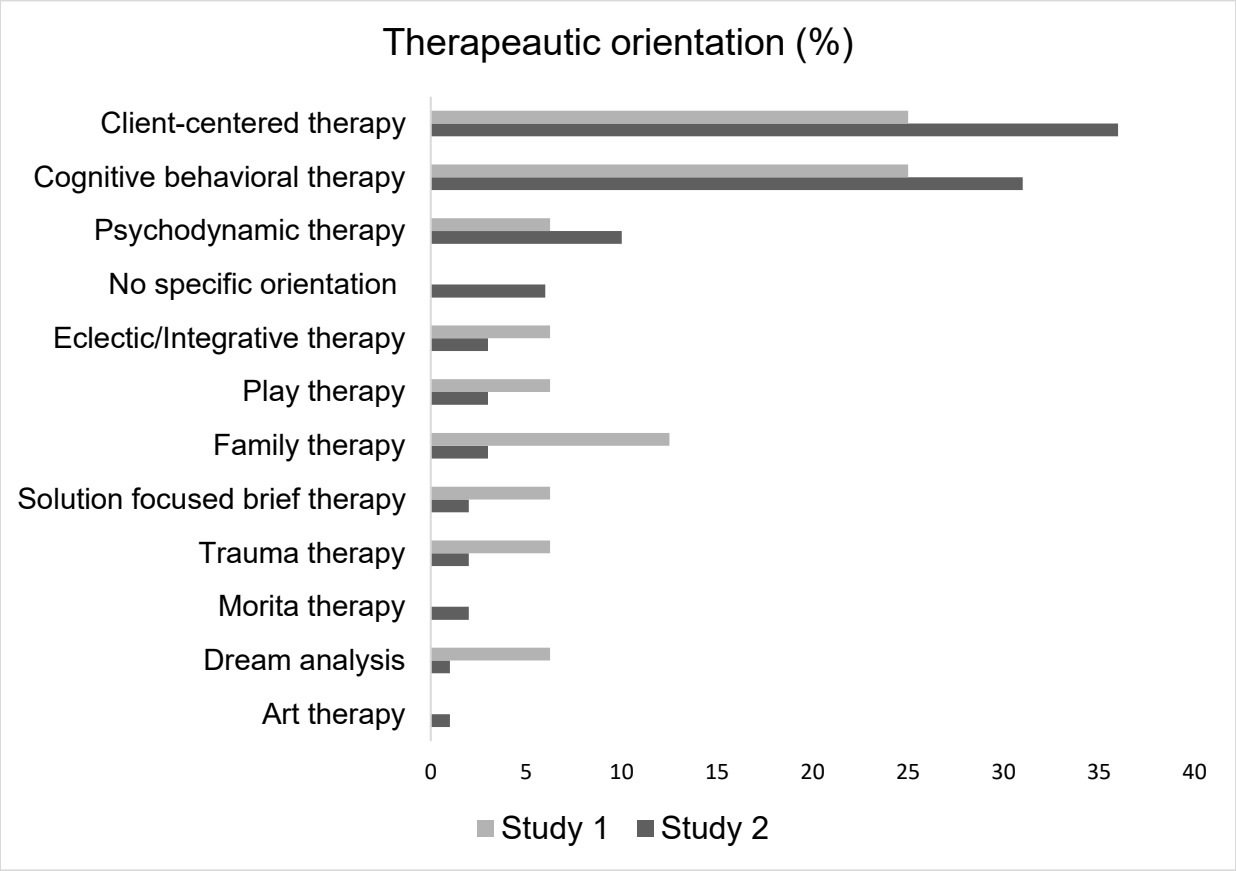


Figure 2 *Primary Work Areas of Participants in Study 1 and Study 2*

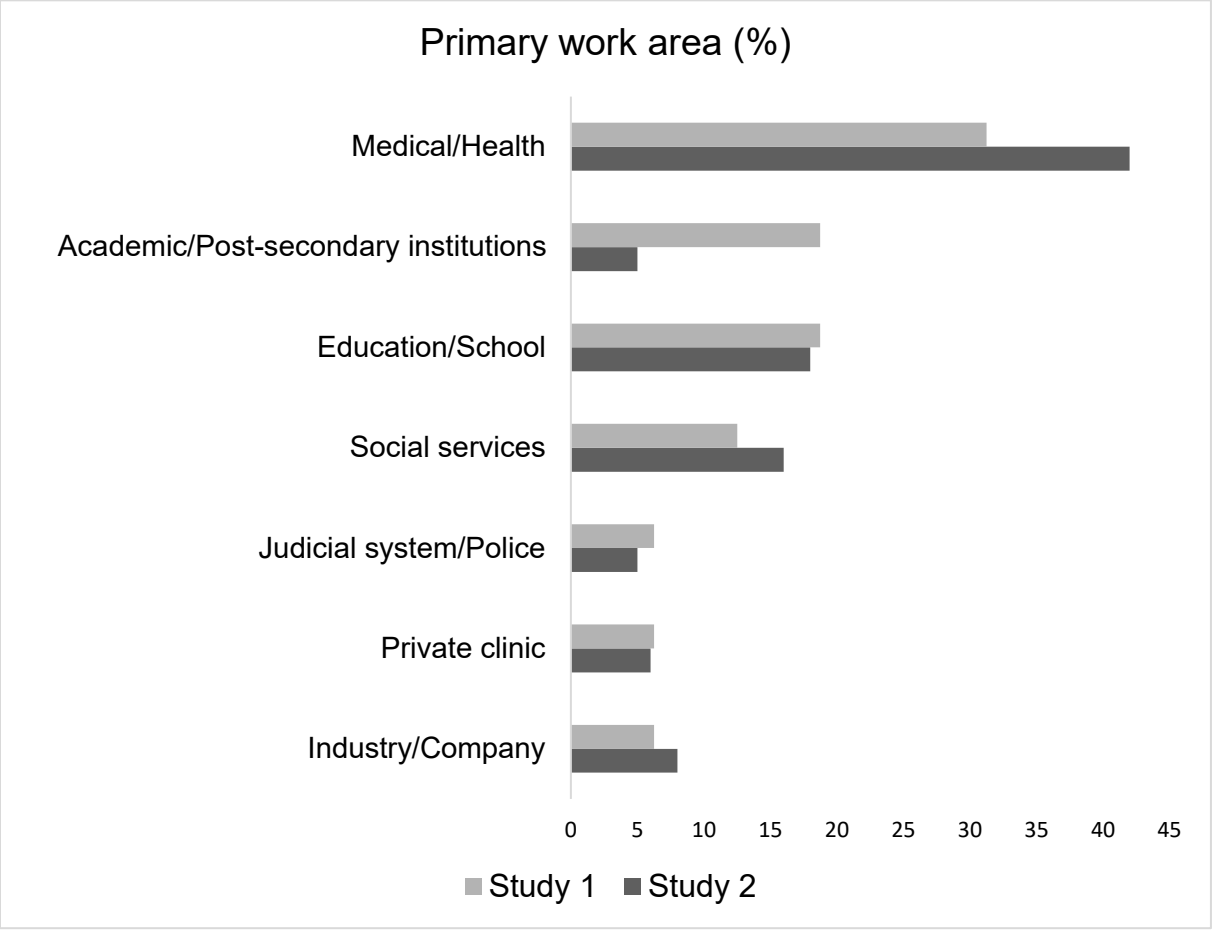


Figure 3 *Clinical Work Types of Participants in Study 1 and Study 2*

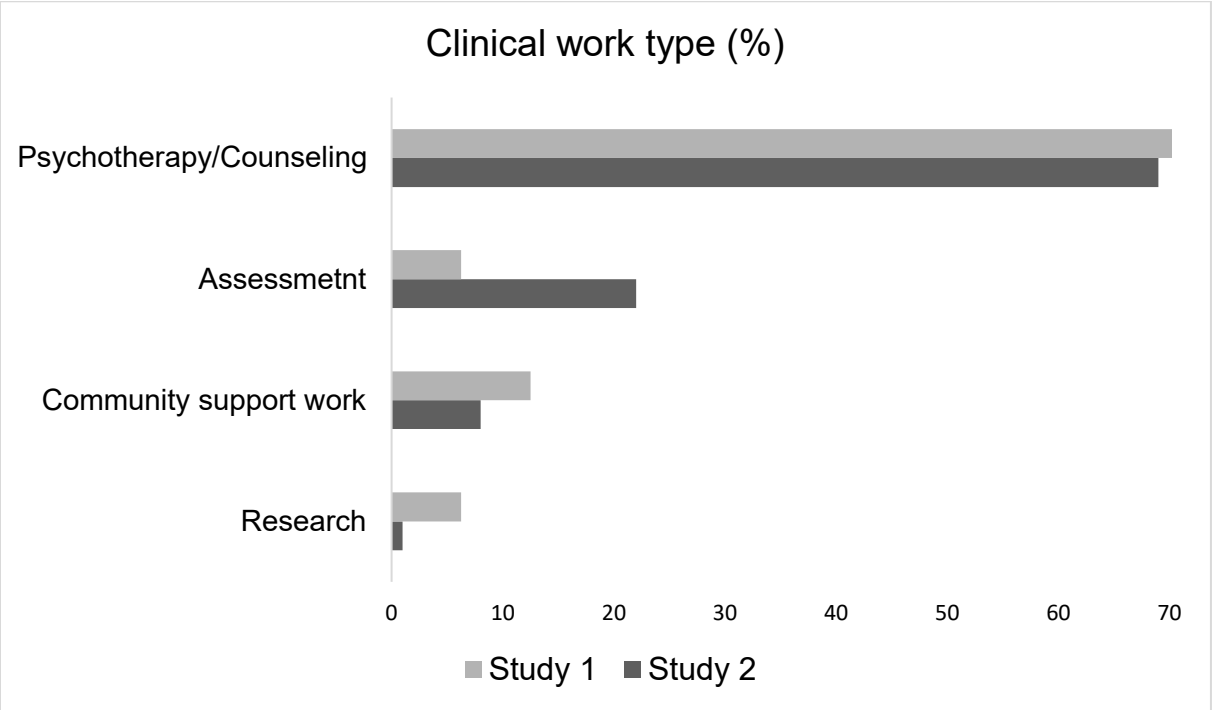
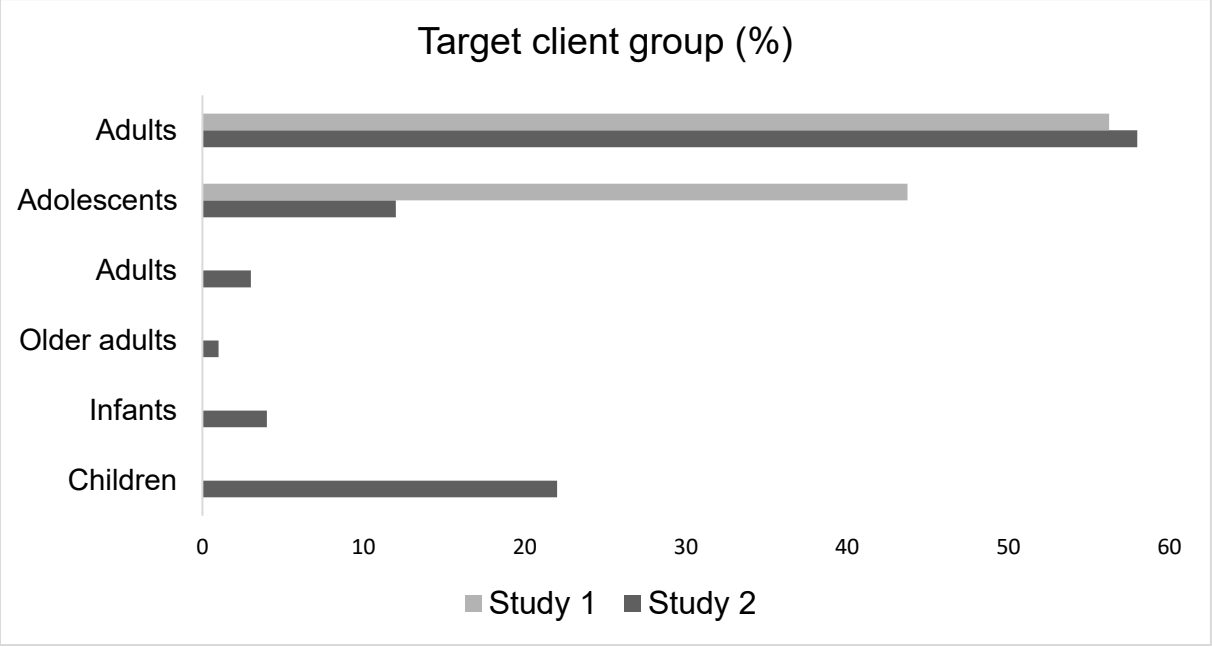


Figure 4. 4 *Target Client Groups of Participants in Study 1 and Study 2*



4.3.1.2 Procedure

During the free-listing part of the interview, participants were asked to reflect their beliefs about two main areas: (a) depression and (b) therapeutic alliance. They were firstly instructed to list words and terms that they regard as important to describe relevant to the first domain including (1) causes of depression, (2) effects of depression, and (3) treatment for depression. For the second domain regarding the therapeutic alliance, they were prompted to provide terms related to characteristics of (1) an incompetent clinician, (2) a difficult client; (3) external barriers; and (4) problem-solving solutions impacting the quality of their therapeutic alliance. Upon completion of free-listing, follow-up interviews were conducted to further refine and clarify the terms provided by the participants.

The first and third authors and a research assistant conducted a primary coding of all the terms listed by the participants and developed the final list, which was reviewed by the third author. We consolidated or split the terms based on the follow-up interviews accompanying the free-listing task (e.g., combining synonyms). This process allowed us to create a more comprehensive and accurate representation of the participants' beliefs and perspectives. For instance, responses such as “neurotransmitter deficiency”, “lack of dopamine”, “chemical imbalances in the brain”, and “genetic predispositions” were all combined as a single item “biogenetic causes”. Responses such as “problem with family and upbringing” were collapsed into two items as (1) problem with family at present; and (2) problem with family in the past.

The final list of free-lists was analyzed using *AnthroTools*, an *R* package specifically designed to assess the salience of items in free-listing data (v0.8; Purzycki & Jamieson-Lane, 2017). This package allows researchers to calculate a salience index, known as Smith’s *S*, for each item by accounting for both the frequency and the order in which terms were mentioned by participants. Smith's *S* enables researchers to identify items that represent prototypes within a given domain (Borgatti, 1994; Schrauf & Sanchez, 2008; J. Smith & Borgatti, 1998).

Smith’s *S* is calculated by:

$$S = [(\sum(L\text{-}R_j+1))/L]/N$$

The above formula inversely assigns a score to the order number and divides this value by the total number of items listed by the participants, where L denotes the length of each list, R_j denotes the rank of item *J* in the list, and *N* is the number of lists in the sample (Borgatti, 1999). Smith’s *S* ranges from 0 to 1. A lower value would indicate lower ranking and frequency (i.e., the item was

mentioned later and less frequently), while a higher value indicates higher ranking and frequency (i.e., the item was mentioned earlier and more frequently).

4.3.2 Results

Our analysis of the free-listing data resulted in a range of 19 to 21 items for each of the seven subdomains examined. We retained only the items that were mentioned by at least 10% of the sample to be examined for our quantitative analysis. The final list yielded 19 items for the external barriers in the therapeutic alliance domain, which falls slightly below the recommended minimum of 20 items suggested by Weller (2007). Tables 2-8 present the frequency, the proportion of participants who listed the item, and Smith's *S* salience index values. The most salient terms were identified based on Smith's *S* value of 0.1 or above and being mentioned by at least 50% of the participants (Weller, 2007).

4.3.2.1 Domain 1: Depression

The most salient terms were identified for the four subdomains in beliefs about depression. *Stress* (81.25%, *S* =.426), *work/overwork* (56.25, *S* =364), *cognitive distortion/thinking style* (87.50, *S* =.345), and *interpersonal problems* (62%, *S* =.311) were reported as the most salient for causes of depression. *Sleep problems* (81.25%, *S* =.656), *decreased standard of living* (62.50%, *S* =.471), *appetite problems* (68.75%, *S* =.463), *social withdrawal* (absence from work/school) (68.75%, *S* = .390), *negative thinking/decreased self-esteem/decreased self-confidence* (75.00%, *S* =.353), *suicidal ideation* (62.50%, *S* =.293), *self-blame/guilt* (62.50%, *S* =.220), *irritability/anger/aggression* (68.75%, *S* =.217), and *fatigue/tiredness* (68.75%, *S* =.211) were believed to be the most distinctive effects of depression. Finally, *resting* (68.75%, *S* =.635), *social support (from family and work)* (56.25%, *S* =.424), and *working on cognitive distortions* (68.75%, *S* =.322) were reported as the most salient treatment options for depression.

4.3.2.2 Domain 2: Therapeutic Alliance

Imposing personal values onto the client (68.75%, *S* =.518), *negative emotions towards the client* (56.25%, *S* =.406), *poor choice of words or negative attitude towards the client (e.g., intimidating demeanor)* (100%, *S* =.322), *unease and discomfort related to client's attributes (e.g., gender, age)* (68.75%, *S* =.177), and *anxiety about lack of structure and imposing a structure onto*

the client (75.00%, *S* =.117) were found to be the most salient characteristics for an incompetent clinician. The two most salient characteristics of a difficult client were those *placing unrealistic expectations on the clinician* (87.5%, *S* = .459), (56.25%, *S* =.401). and showing *a lack of trust in the clinician's ability to protect confidentiality* (56.25%, *S* =.401). *Lack of understanding and inadequate support from others (family, work, friends)* (93.75%, *S* =.748) and *environmental barriers* (e.g., *location, facilities, noise, smell, receptionists' services)* (93.75%m *S* =.395) were perceived to be the most problematic external barriers hindering their therapeutic alliance. Finally; clinicians reported that they *make efforts to understand client's situation (e.g., listening, asking questions)* (56.25%, *S* =.377), *re-establish goals and sharing the process of non-achievement* (56.25%, *S* =.272), *check-in with client's needs* (50.00%, *S* =.247), *re-provide resources about the treatment* (56.25%, *S* =.242), and *engage in self-disclosure (e.g., communicating clinician's feelings and understanding to the client)* (50.00%, *S* =.123) when they encountered problems in therapeutic alliance.

Table 2 *Frequency, % of respondents, Smith's S for Beliefs about Causes of Depression*

Term in Japanese (English translation)	*n*	%	Smith's *S*
1. ストレス **Stress**	**13**	**81.25**	**.426**
2. 性格・気質 Personality and temperament	5	31.25	.411
3. 仕事・過労 **Work and overwork**	**9**	**56.25**	**.364**
4. 認知の歪み・思考パターン **Cognitive distortions/thinking style**	**14**	**87.50**	**.345**
5. 環境 Environment	5	31.25	.325
6. 対人関係 **Interpersonal problems**	**10**	**62.50**	**.311**
7. 過去の家族関係・生い立ち Past family relationships and upbringing	5	31.25	.244
8. 神経伝達物質 Neurotransmitters	4	25.00	.237
9. 生活習慣の乱れ（睡眠・栄養） Disrupted lifestyle (e.g., sleep, diet)	6	37.50	.235
10. 喪失・トラウマ Loss and trauma	6	37.50	.207
11. 遺伝 Genetics	3	18.75	.131
12. 身体的病気 Physical illness	4	25.00	.131
13. 現在の家族関係	6	37.50	.108

Family relationship problems			
14. 経済的困難 Financial difficulties	4	25.00	.084
15. ストレスフルなライフイベント Stressful life event	3	18.75	.081
16. 頑張りすぎ・自責 Burnout and Self-blame	2	12.50	.065
17. 薬の副作用 Side effects of medication	3	18.75	.060
18. 身体的感覚への鈍感さ Numbness to physical sensations	2	12.50	.054
19. タイミング・運の悪さ Poor timing/misfortune	2	12.50	.038
20. 離婚 Divorce	2	12.50	.031
21. 他人の責任（ハラスメント、周囲の無理解など） Inflicted by others (e.g., harassment, lack of understanding from others)	2	12.50	.031

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

Table 3 *Frequency, % of respondents, Smith's S for Beliefs about Effects of Depression*

Term in Japanese (English translation)	*n*	%	Smith's *S*
1. 睡眠障害（不眠・過眠） Sleep problems	**13**	**81.25**	**.656**
2. 対人関係のトラブル Interpersonal problems	6	37.50	.497
3. 生活水準の低下 Decreased standard of living	**10**	**62.50**	**.471**
4. 意欲低下・無気力 Lack of motivation and energy	4	25.00	.468
5. 食欲の増減 Appetite problems	**11**	**68.75**	**.463**
6. 社会活動の参加困難（休職・不登校） Social withdrawal (absence from work/school)	**11**	**68.75**	**.390**
7. 経済的損失 Financial difficulties	5	31.25	.365
8. ネガティブ思考・自尊心・自己肯定感の低下 Negative thinking/decreased self-esteem/decreased self-confidence	**12**	**75.00**	**.353**
9. 希死念慮 Suicidal ideation	**10**	**62.50**	**.293**
10. 気分の落ち込み Depressed mood	7	43.75	.222
11. 自責感・罪悪感 Self-blame and guilt	**10**	**62.50**	**.220**
12. イライラ・怒り・攻撃的 Irritability, anger, aggression	**10**	**62.50**	**.217**
13. だるさ・倦怠感	**11**	**68.75**	**.211**

Fatigue and tiredness			
14. パフォーマンス・集中力の低下 Decreased performance and difficulty concentrating	8	50.00	.193
15. 妄想（貧困・微小・被害など） Delusions (e.g., poverty, unworthiness, persecution)	6	37.50	.125
16. 家族・周囲への負担 Burden on family and others	3	18.75	.124
17. 身体的苦痛 Physical pain and discomfort	6	37.50	.093
18. 処方薬による影響（精神的な依存や副作用） Side effects of medication (e.g., psychological dependence)	4	25.00	.093
19. 社会的評価・立場の低下 Poorer social status and evaluation	3	18.75	.087
20. 社会・人との関わりの減少 Social withdrawal (e.g., decreased social activities and interpersonal interactions)	3	18.75	.063

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

Table 4 *Frequency, % of respondents, Smith's S for Beliefs about Treatment for Depression*

Term in Japanese (English translation)	*n*	%	Smith's *S*
1. 休養 **Resting**	**11**	**68.75**	**.635**
2. 服薬 Medication	5	31.25	.426
3. 周囲の支え（家族・職場など） **Social support (family, work)**	**9**	**56.25**	**.424**
4. 認知の歪みの改善 **Working on cognitive distortions**	**11**	**68.75**	**.322**
5. 生活リズムを整える Healthy daily routine	7	43.75	.316
6. 環境調整 Supportive and nurturing environment	7	43.75	.196
7. ストレス軽減 Stress reduction	6	37.50	.186
8. 行動活性化 Behavioral activation	4	25.00	.150
9. 安心感を得る・不安を取り除く Cultivating a sense of security and alleviating anxiety	3	18.75	.129
10. 睡眠 Better quality sleep	6	37.50	.124
11. うつ病の原因を理解する Understanding the causes of depression	6	37.50	.113
12. 運動 Physical exercise	4	25.00	.104

13. クライエントが社会福祉的なリソースを増やす（行政の援助を受ける、など） Increasing the client's social welfare resources (e.g., seeking public assistance)	3	18.75	.101
14. 受診・診断・通院 Seeing a medical doctor (e.g., diagnosis)	4	25.00	.093
15. 人生や生きる意味を見出す Finding meaning in life	3	18.75	.092
16. 心理療法・カウンセリング Psychotherapy and counselling	7	43.75	.085
17. 食事 Healthy diet	3	18.75	.076
18. 好きなことをする Engaging in enjoyable activities	3	18.75	.068
19. 自己受容・自分を信じる Self-acceptance and believing in self	5	31.25	.063
20. 経済的支援 Financial support	3	18.75	.062

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

Table 5 *Frequency, % of respondents, Smith's S for Beliefs about "Incompetent Clinician" in Therapeutic Alliance*

Term in Japanese (English translation)	*n*	%	Smith's S
1. クライエントに価値観を押し付ける	**11**	**68.75**	**.518**
Imposing personal values upon the client			
2. クライエントに対して無関心・共感的態度がないことがある	7	43.75	.417
Lack of empathy or feeling indifferent			
3. クライエントへの陰性感情	**9**	**56.25**	**.406**
Negative emotions towards the client			
4. クライエントに対する言葉遣いや態度が悪い（威圧的な態度など）	**16**	**100.00**	**.322**
Poor choice of words or negative attitude towards the client (e.g., intimidating demeanor)			
5. 話を聞くだけ・アドバイスをしない	5	31.25	.256
Merely listening/Not giving advice			
6. 期待感の無さ（クライエントは無力・どうせ良くならないなどの考え）	7	43.75	.243
Lack of positive expectations (e.g., "client is powerless", "improvement is unlikely").			
7. 心理士の治療観	4	25.00	.223
Clinician's therapeutic orientation			
8. 救世主願望（よくしてあげようという願望）	7	43.75	.214
Savior complex (e.g., desire to "save" the client)			
9. クライエントの属性に対する苦手意識（性別・年齢等の一致・不一致）	**11**	**68.75**	**.177**
Unease and discomfort related to client's attributes (e.g., gender, age)			
10. 心理士の自信の無さ・コンプレックス	7	43.75	.161
Clinician's lack of confidence or personal insecurities			
11. 返答・アドバイスが的外れ	4	25.00	.156
Irrelevant or misguided responses and advice			
12. 見通し・ゴールを立てない	3	18.75	.151
Failure to establish clear vision and goals			

13. 心理士による逆転移・投影 Client's countertransference and projection	7	43.75	.124
14. エビデンスや合理的解決の過剰な重視 Overemphasis on evidence and rational problem-solving thinking	3	18.75	.118
15. 枠が無い事への不安・プログラムにのせようとする **Anxiety about lack of structure and imposing a structure upon the client**	**12**	**75.00**	**.117**
16. 心理士の力量・経験不足 Lack of experience and skills	4	25.00	.088
17. 心理士の見た目・におい・清潔感（服装が派手、香水がきつい、など） Clinician's physical appearance, odor, or lack of hygiene (e.g., inappropriate attire, strong perfume)	4	25.00	.086
18. 万能感（心理士は常に適切な対応をしなければならない、一人で解決しなければならない、共感しなければならない、など） Omniscient attitude (e.g., "clinician must always provide appropriate response, resolve issues alone, empathize at all times")	9	56.25	.086
19. やる気がない Lack of motivation	1	6.25	.063
20. これまでのケース・患者との経験からのトラウマ Trauma from previous cases or negative experiences with clients	3	18.75	.031

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

Table 6 *Frequency, % of respondents, Smith's S for Beliefs about "Difficult Client" in Therapeutic Alliance*

Term in Japanese (English translation)	*n*	%	Smith's *S*
1. 心理士に対する過度の期待（全部お任せ、この人が救ってくれる、など） **Placing unrealistic expectations on the clinician. (e.g., completely relying on the clinician. "This person will save me")**	**14**	**87.50**	**.459**
2. 治療への不信感（治療を希望していない、心理士に話しても無駄、お金の無駄、など） Lack of trust in treatment (e.g., not wanting a treatment, "talking to a therapist is useless or waste of money")	7	43.75	.435
3. 心理士に対して不信感がある（どうせわかってくれない、経験や能力を疑う、など） Lack of trust in the clinician (e.g., "they won't understand" or doubting their experience or abilities)	5	31.25	.435
4. 守秘義務に関する心理士への不信感・不安 **Lack of trust in the clinician's ability to protect confidentiality**	**9**	**56.25**	**.401**
5. クライエントが自身のニーズと心理士が提供できるものの違いを理解していない Lack of understanding of the difference between the client's needs and what the clinician can provide	7	43.75	.371
6. 動機・モチベーションが低い・主体性がない Low motivation or lack of initiative	5	31.25	.271
7. 自己開示への抵抗感（弱みを見せたくない、人に相談するのは恥、など） Resistance to self-disclosure (e.g., "I don't want to show vulnerability", "It's a shame to seek help")	7	43.75	.25
8. 治療が自分の意志・希望でない Lack of their own will or desire to seek treatment	4	25.00	.167
9. 認知の歪み・過度の一般化 Cognitive distortions and overgeneralization	3	18.75	.134
10. 心理士に対する個人的な負の感情がある（妬み、気に入らない、気が合わないと感じる、など） Negative feelings toward the clinician (e.g., envy, dislike, feeling incompatible)	6	37.50	.126
11. 心理士の属性（性別・年齢・見た目など）で合わないと判断する Judging the clinician based on personal attributes (e.g., gender, age, appearance)	5	31.25	.112

12. 心理士に対する個人的な好意的感情がある（恋愛感情や強い関心など） Inappropriate feelings toward the clinician (e.g., romantic feelings, strong interest)	2	12.50	.094
13. 劇的・急な変化の期待 Expecting dramatic rapid changes	2	12.50	.085
14. 金銭面での不安・懸念 Financial concerns and anxieties	2	12.50	.083
15. 治療内容に関して不信感がある Distrust regarding the treatment approach/content	3	18.75	.076
16. 治療への抵抗感（スティグマ・恥の感覚） Resistance to treatment (e.g., stigma, shame):	2	12.50	.063
17. クライエントがやるべきことを果たさない（ホームワークをやらない、提案を無視など） Not fulfilling their responsibilities (e.g., not doing homework, dismissing suggestions, etc.)	3	18.75	.059
18. 過去の心理士とのネガティブな経験・トラウマ Negative past experiences or traumas with previous clinicians	2	12.50	.047
19. 治療に関する知識のなさ（治療の目的／プロセスがわからない） Lack of knowledge about treatment (e.g., about the purpose or the process)	3	18.75	.021
20. 疾患・治療に関する間違った知識や認識 Misinformation or misconceptions about mental illness or treatment	3	18.75	.016

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

Table 7 *Frequency, % of respondents, Smith's S for Beliefs about External Barriers in Therapeutic Alliance*

Term in Japanese (English translation)	*n*	%	Smith's *S*
1. クライエントの周囲の人の無理解や適切なサポートがないこと（家族・職場・友人など） **Lack of understanding and inadequate support from others (family, work, friends)**	**15**	**93.75**	**.748**
2. 来談の際の環境的な障壁（施設の立地、部屋の設備、雑音、におい、受付等の他スタッフの対応など） **Environmental barriers (e.g., location, facilities, noise, smell, receptionists' services)**	**15**	**93.75**	**.395**
3. 他の援助職（医師など）や機関による介入 Intervention by other mental health professionals (e.g., physicians) or parties	7	43.75	.378
4. クライエントの家族が問題や困難を抱えている Problems or challenges client's family is having	3	18.75	.313
5. クライエントにプレッシャー・ストレスのかかる環境 Environment that puts pressure or stress on client	6	37.50	.241
6. クライエントが多忙・過労 Overwork and busy schedule	4	25.00	.226
7. 金銭的要因 Financial difficulties	7	43.75	.172
8. 心理士の異動（退職・妊娠・病気等による） Terminating due to clinician's personal reasons (e.g., retirement, pregnancy, illness)	4	25.00	.151
9. 行政的サポート・社会の保障不足 Lack of support from the government, public sectors, and social services	4	25.00	.151
10. クライエントの未解決のトラウマやネガティブな過去の経験 Unresolved trauma or negative past experiences of the client	4	25.00	.120
11. 薬が効かないこと Medication's ineffectiveness	3	18.75	.109
12. メディアや世俗的心理学などの誤情報 Misinformation from media or popular psychology	2	12.50	.094

13. 医師の不適切な投薬・診断 Inappropriate medication or diagnosis by physicians	5	31.25	.064
14. 来談の継続性がない（多忙、定期的に子供を連れてこられない親、事故による中断など） Lack of continuity in sessions (e.g., due to busyness, inability to bring children regularly, interruption due to accidents)	2	12.50	.056
15. タイムリミットがある（休職期間など） Time limitations (e.g., constrained by the limited sick leave time period)	2	12.50	.052
16. クライエントの身体的不調（病気・けが、体調が悪いなど） Physical health (e.g., illness, injury, feeling unwell physically)	2	12.50	.052
17. 会社や学校など社会におけるスティグマ Societal Stigma (e.g., at work, school)	2	12.50	.033
18. 心理士のコントロール外の守秘義務の不安定さ Concerns about Confidentiality outside of clinician's control	2	12.50	.028
19. 施設外でのクライエントとの接触 Accidental encounter with the client outside of the session or the facility	2	12.50	.025

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

Table 8 *Frequency, % of respondents, Smith's S for Beliefs about problem-solving in Therapeutic Alliance*

Term in Japanese (English translation)	*n*	%	Smith's *S*
1. クライエントの状況を理解するように努力する（話を聞く、質問する） Make efforts to understand client's situation (e.g., listening, asking questions)	**9**	**56.25**	**.377**
2. 目標の再設定・不実施のプロセスを共有する Re-establish goals and informing the client about areas of improvement	**9**	**56.25**	**.272**
3. クライエントのニーズの確認 Check-in with client's needs	**8**	**50.00**	**.247**
4. 治療についての情報提供を再度する Re-provide resources	**9**	**56.25**	**.242**
5. 適切な支援機関にリファーする Refer to appropriate parties that can provide support	6	37.5	.236
6. クライエントができないことなどを受容する Accept client's limitations and difficulties	5	31.25	.206
7. クライエントの理解度に合わせた伝え方をする（表現などを単純化する） Communicate in a way that matches the client's level of understanding (e.g., use simpler language)	4	25.00	.198
8. 心理士が自己分析をする・自分の課題を分析する Self-analyze and assess personal challenges	5	31.25	.141
9. 心理士が適切なアセスメント・方向修正をする Conduct appropriate assessments and adjust therapy directions and goals	7	43.75	.126
10. 心理的な自己開示をする（心理士の気持ち・理解をクライエントに伝える） Engage in self-disclosure (e.g., communicating clinician's feelings and understanding to the client)	**8**	**50.00**	**.123**
11. 心理士がスーパービジョンを受ける Receive supervision	5	31.25	.097
12. 他の心理職のスタッフ・友人に相談する Consult with other mental health professionals, colleagues, or friends	3	18.75	.066

13. 他の心理士にリファーする Refer to another clinician	3	18.75	.063
14. 医師に相談する Consult with a physician	1	6.25	.050
15. 言語以外の関わりを試す Explore non-verbal communication	2	12.50	.047
16. できることと、できないことを再度確認する Reconfirm what clinician/therapy can and cannot do	8	50.00	.028
17. 心理教育・情報提供を行う Provide psychoeducation and resources	2	12.50	.013
18. 心理士が他機関・第三者からのアドバイスを考慮する Consider advice from other parties	2	12.50	.013
19. 文献を探す Conduct literature search	2	12.50	.013
20. 過去の経験・体験から想像して対応する Respond based on experiences and knowledge from the past	2	12.50	.006

Note. *n* = frequency and % represents proportion of participants who listed word. Items considered highly salient are boldfaced (those above Smith's *S* value of 0.1 and mentioned by at least 50% of the participants).

4.4 Study 2: Cultural Consensus Analysis (CCA)

In study 2, the goal of the study was to statistically examine the presence of consensus beliefs pertaining to the seven subdomains among the clinicians. The second study was carried out by developing a survey, collecting quantitative data, and performing a series of cultural consensus analysis (CCA). The results from the saliency analysis in study 1 informed study 2 to generated a final list of the salient terms to be included in the quantitative survey.

4.4.1 Methods

4.4.1.1 Participants

Participants were recruited through the authors' network and various popular online community groups for clinical psychologists and psychotherapists. Inclusion criteria were consistent with study 1. One hundred ten clinical psychologists participated in our study in April 2021. Ten participants were excluded from the analysis as they did not meet the inclusion criteria. The final sample was one hundred participants (70% cis-women; 43% from the Greater Tokyo area; 20% from the Greater Osaka area; and 37% from other areas, with a mean age of 35.87 years (*SD*=7.85)). The participant characteristics are presented in Table 1 and Figures 1-4.

4.4.1.2 Procedure

Participants completed an online survey. They were instructed to use a visual analogue scale (VAS) to rate the extent to which they agree with the items about the seven domains that are commonly held by clinical psychologists in general. The VAS ranged from 0 ("very untrue") to 100 ("very true"). A sample question is "Here are some statements or phrases about what clinical psychologists in general might believe about causes of depression. Please indicate to what extent you think each statement or phrase is a belief held by clinical psychologists in general. Please remember to think about what clinical psychologists in general would believe when rating each statement or phrase. It is NOT about your own personal beliefs or opinions" [ここからは、多くの臨床心理士が一般的に思っていること、または常識として認識している事柄についてあなたのご意見をお聞きします。あなたの個人的な意見ではありません。あくまで世間

一般のほとんどの臨床心理士が思うことかどうかについてスライドを利用して程度を示してください]. Participants received a 1,500 yen gift card as compensation for their participation.

4.4.1.2 Cultural Consensus Analysis (CCA)

We performed CCA to examine the presence of shared consensus beliefs for seven cultural domains. We used the *psych* package in *R* to run a series of factor analyses following the CCA procedure (v2.1.6; Revelle, 2021). The conventional factor analysis typically requires sample size-to-number of items ratio of at least 5:1. However, in the context of CCA, the rows and columns are reversed (Weller, 2007b). In CCA, rows represent the number of items, and columns represent the sample size. Higher cultural competence scores suggest that participants have a better understanding of the shared beliefs, indicating their expertise in the cultural models. These "experts" are more likely to agree with each other frequently. An average cultural competence score of ≥ 0.50 is considered the minimum threshold to support the presence of agreement.

We followed the statistical procedure described by Weller (2007) and conducted a series of exploratory factor analysis using the iterated principal factor analysis without rotation to minimize the variance accounted for by the first factor. We first applied bootstrapping procedures with 5,000 iterations to randomly select subset of four participants (row-to-column ratio of 5:1) based on the procedure demonstrated by Segalowitz (2016). We then calculated the following scores in sequential steps: (1) the ratios of the first to the second eigenvalues; (2) individual cultural competence scores from the agreement between the participants by evaluating the factor scores on the first factor; and (3) weighing the response of each participant by their competence scores and aggregating responses across participants to estimate the culturally correct answers. According to CCA, to determine whether there is a presence of a shared cultural model, the ratios of the first to the second eigenvalues must be larger than 3:1 (Weller, 2007). A higher ratio indicates stronger evidence for the presence of a unidimensional factor, suggesting the presence of a shared cultural model among the participants. Factor loadings represent the strength of the relationship between the shared model and the responses provided by the participants. These loadings are used to assign weights to each participant's responses and are aggregated to identify the most culturally relevant items or components of the shared model for the underlying construct of interest.

4.4.2 Results

Cultural consensus analysis showed that there are strong evidence for the presence of shared cultural models for four domains: causes of depression ($1^{st}/2^{nd}$ eigenvalue ratio = 8.96; mean cultural competence = .60, cultural competence range = -.19 to .90), effects of depression ($1^{st}/2^{nd}$ eigenvalue ratio = 8.55; mean cultural competence = .59, cultural competence range = -.32 to .89), treatment for depression ($1^{st}/2^{nd}$ eigenvalue ratio = 7.94; mean cultural competence = .57, cultural competence range = -.01 to .89), and problem-solving ($1^{st}/2^{nd}$ eigenvalue ratio = 7.83; mean cultural competence = .54, cultural competence range = -.39 to .90).

There was moderate evidence for the presence of consensus for the three domains in therapeutic alliance: incompetent clinician ($1^{st}/2^{nd}$ eigenvalue ratio = 5.48; mean cultural competence = .32, cultural competence range = -.03 to .55), difficult client ($1^{st}/2^{nd}$ eigenvalue ratio = 5.40; mean cultural competence = .35, cultural competence range = -0.12 to .63); and external barriers ($1^{st}/2^{nd}$ eigenvalue ratio = 5.30; mean cultural competence = .32, cultural competence range = .04 to .64).

4.5 General Discussion

Previous research has demonstrated that Japanese clinical psychologists share cultural models regarding mental health within broader social and cultural contexts for the two cultural domains (1) sources of mental health beliefs among the public; and (2) changes needed to improve mental healthcare in Japan (Sunohara et al., 2022). The present study aimed to delve deeper into their clinical practice and professional experiences. Following the framework of cultural consensus theory (CCT), we conducted a two-phase sequential mixed-methods design to examine the shared cultural models of Japanese clinical psychologists regarding depression and therapeutic alliance. The first study aimed to extract culturally unique and salient terms related to depression, (1) causes, (2) effects, (3) treatment; and therapeutic alliance, (1) an incompetent clinician, (2) a difficult client; (3) external barriers, and (4) problem-solving. The first phase was accomplished through the qualitative method of cultural domain analysis (CDA). Building upon findings of the first study, the second study explored the presence of shared cultural models of the seven domains utilizing the statistical modeling approach known as cultural consensus analysis (CCA).

4.5.1 Study 1: Cultural Domain Analysis (CDA)

In study 1, the results from the CDA showed that Japanese clinical psychologists elicited approximately 20 terms per domain. It is noteworthy that for the causes of depression domain, among the final list of 21 terms, situational causes such as stress, work/overwork, and interpersonal problems showed high salience, whereas there were only four biogenetic items (i.e., neurotransmitter, genetics, side effects of medication, physical illness), which did not meet the criteria to be considered highly salient in our analysis. The results suggest that the majority of elicited items were either psychological (e.g., trauma) or situational, and there was no item suggesting moralizing. Although the saliency scores and frequency were relatively low, financial difficulties, misfortune/bad timing, and responsibility of other people (e.g., harassment, lack of understanding from others) were elicited and themes of social-contextualizing or attributing to a broader context or the circumstances beyond the self. These findings are in line with the greater tendency to psychologize depression and other mental illnesses than medicalize and moralize among Japanese psychology undergraduate students, and the need to include social-contextualization of explanatory models (Sunohara et al., under review).

For the effects of depression, items covered a wide range of consequences of suffering from depression from disruptions in basic somatic and physical needs/self-care (i.e., sleep and appetite problems, decreased standard of living), emotional difficulties (e.g., self-blame/guilt, suicidal ideation), social consequences (e.g., poorer social status/evaluation, social withdrawal), and burden on family/others. Particularly, sleep, decreased standard of living, and appetite problems has been perceived as the most salient effect and symptom of depression by Japanese clinicians. This finding is consistent with the previous studies reporting that patients from East Asia compared to the Western cultural context are more likely to somatize depression (e.g., Arnault et al., 2006; Ryder et al., 2002). Clinicians' recognition of social consequences aligns with the ongoing discourse among Japanese clinical psychology researchers, advocating for the inclusion of social recovery and social functioning, such as the ability to return to work, in the assessment of recovery from depression and in psychotherapy practices (e.g., Tanoue et al., 2012, 2012b).

For treatment for depression, the items spanned from self-care (e.g., resting, healthy daily routine) to social support (e.g., from family and friends) and professional help (e.g., medication, seeing a medical doctor). However, it is surprising that psychotherapy/counseling was mentioned by only seven participants, and its Smith's *S* values for the term were relatively low. Since the

causes of depression themes were mostly non-biomedical, it is possible that the inclusion of suggestions for professional help and medical solutions were likely to be intended to address somatic symptoms associated with depression. Interestingly, the most salient item was resting, which appears to be the simplest form of treatment and recovery, but it makes logical sense as the treatment suggestion corresponds to stress and work/overwork as perceived as most salient and important in the causes domain.

For the "incompetent clinician" subdomain, clinicians perceived imposing personal values onto the client, negative emotions towards the client, negative emotions towards the client, poor choice of words, negative attitude towards the client (e.g., intimidating demeanor), unease and discomfort related to client's attributes (e.g., gender, age), and anxiety about lack of structure and imposing a structure onto the client being one of the most important to them. Imposing personal values onto the client and poor choice of words, negative attitude towards the client (e.g., intimidating demeanor were perceived as problematic attitudes and behaviors that clinicians should avoid. In a qualitative study conducted by Kanazawa (2020) also reported that overall, clinicians shared their self-awareness that clinician's negative behaviors and attitudes toward client and lack of clinical skills contributes to poorer quality in therapeutic alliance. Negative emotions towards the client, unease and discomfort related to client's attributes, anxiety about lack of structure and imposing a structure onto the client, lack of empathy or feeling indifferent represent challenging emotions and were also described as one of the most salient themes elicited by Japanese psychotherapists in a few qualitative studies. For example, novice psychotherapists commonly experience psychological stress and emotional labor during the therapy sessions, which can lead to their anxiety about lacking directions and making mistakes (Aoki, 2010; Ueno, 2010), have difficulties displaying empathy (Ishitani, 2008), and become excessively sensitive to their clients (Kamikura et al., 2016).

For the "difficult client" subdomain, the most salient item, placing unrealistic expectations on the clinician and lack of understanding of the difference between the client's needs and what clinician can provide items may well capture Japanese cultural values influencing the client's beliefs about psychotherapy. This finding suggests that clinicians may face challenges in navigating the hierarchical client-therapist relationship that is inherent in Japanese culture. It implies that clients may exhibit passivity, dependence, or even obedience towards professional authorities, potentially hindering effective therapeutic engagement (Kida & Uchisawa, 2006;

Nippoda, 2012; Takasugi, 2022). For example, Nippoda (2012) describes that in contrast to clients from Western cultural contexts, Japanese clients tend to give authority to the therapist as a sign of respect in the client-therapist relationship, even when receiving therapy in the UK. However, the author also noted that Japanese clients were often perceived as lacking agency, being passive, needy, and repressed by English therapists. Japanese clients may have high expectations for clinicians, viewing them as responsible for resolving their issues, rather than fostering a sense of personal agency and accountability for self-improvement. Although the extent of exposure to Western cultural values among the participants in our study is unknown, it is possible that they perceived the discrepancies between Japanese cultural values embedded in client's expectations and attitudes and the nature of psychotherapy as a potential hindrance in their practice. Similarly, lack of trust in the clinician's ability to protect confidentiality and lack of trust in treatment and clinician, resistance to self-disclosure may stem from stigma associated with mental illness and seeking professional help, thereby urging the clinicians to be particularly attuned to the clients' fears of breaching confidentiality and strive to ensure a truly safe space for talk therapy (Iwakabe, 2008; Iwakabe & Enns, 2013; Takasugi, 2022).

External barriers, such as lack of understanding and inadequate support from others (family, work, friends), and environmental barriers (e.g., location, facilities, noise, smell, receptionists' services) were perceived as the two most salient themes in our study. It is not surprising that the first term being the most salient, especially for clinicians who work with children and families as family members and caregivers are part of the therapeutic process. Regarding the environmental barriers, although the literature on this subject is limited, there are a few studies that have explored the impact of physical and environmental obstacles on therapeutic alliance, especially in the context of child and play therapy and counseling rooms located in school settings For instance, Sakai and colleagues (2020) conducted a qualitative study examining the advantages and limitations of the counseling room with different physical conditions (e.g., room size, furnishings, toys) by interviewing underage clients about their preferences. They concluded that tailoring the physical and environmental conditions to meet the specific needs of each client is crucial for fostering a strong therapeutic alliance (Yoshida, 2020).

Maruyama (2018) proposed the integration of environmental psychology principles into clinical psychology and school counseling to enhance the effectiveness of school counseling for junior high school students. Given that approximately 40% of our participants reported working

with adolescents, it is plausible that they are more attuned to the importance of physical and environmental conditions in their practice. Intervention by other mental health professionals or parties was also viewed as a highly salient barrier. This finding highlights the challenges associated with the multi-disciplinary work settings in which Japanese clinical psychologists often find themselves. Japanese clinical psychologists often work with physicians, nurses, pharmacists, nutritionists, occupational/physical therapists, speech therapists, and social workers. Due to unclear professional boundaries and power dynamics, interaction with other professionals can be particularly challenging and stressful for clinical psychologists. Nozue (2018) argues that clinical psychologists are encouraged to engage in active listening with clients but are now required to develop active assertion skills to effectively collaborate with other mental health professionals. Nevertheless, researchers also have reported the positive effects of multi-disciplinary team approach to mental health care especially during times of crisis (e.g., Hiwatashi et al., 2020; Okuno, 2020).

Lastly, clinicians perceived the following terms as highly salient for problem-solving: Make efforts to understand client's situation (e.g., listening, asking questions); re-establish goals and sharing the process of non-achievement; check-in with client's needs; re-provide resources about the treatment; and engage in self-disclosure (e.g., communicating clinician's feelings and understanding to the client). These findings suggest that overall, clinicians perceived better communication including active listening, empathetic interactions, clarifying the progress and specific directions and goals, and providing resources. Suzuki and Sasaki (2019) found that clinicians generally acknowledged the importance of self-disclosure, although they tended to avoid discussing practical solutions directly with the client. Instead, they preferred to engage in active listening and demonstrate empathy. On the other hand, clients had greater expectations for the clinician to discuss solutions and provide specific guidance, rather than solely focusing on active listening. These findings suggest that there may be disparities in problem-solving preferences between clients and clinicians. Interestingly, consulting with other mental health professionals, colleagues, or friends, refer to another clinician, consider advice from other parties, and consult with a physician were found to be less salient.

In another qualitative study, Satake (2017) identified two major themes emerged regarding problem-solving strategies endorsed by psychotherapists when faced with challenges in the therapeutic relationship. The first theme involved therapists responding to the needs of the client,

which included active listening, validation, and engaging in non-behavioral activities according to the client's needs and preferences. The second theme encompassed therapists taking the initiative to suggest solutions and provide feedback to the client, which included providing information and engaging in self-disclosure. These two themes align with our findings, where four terms pertained to addressing client needs and five terms focused on clinician initiatives. In terms of terms deemed to be less salient, given the perception of intervention by other mental health professionals or parties as a significant external barrier, it can be assumed that clinicians have a lesser preference for consulting with others as a problem-solving strategy.

4.5.2 Study 2: Cultural Consensus Analysis (CCA)

Our research was conducted with the assumption that Japanese clinicians, having obtained the *rinsho-shinrishi* license accreditation and received similar clinical training, would exhibit a certain degree of homogeneity and agreement in their beliefs about therapeutic alliances. Results from the CCA suggest that Japanese clinical psychologists had a single shared model for causes of depression, effects of depression, treatment for depression, and problem-solving in therapeutic alliance. On the contrary, while the eigenvalue ratios were satisfactory, the mean competence scores did not reach the recommended threshold for the three domains regarding the therapeutic alliance: incompetent clinician, difficult client, and external barriers. These findings indicate that the evidence supporting the presence of shared models for these particular domains is only partial, suggesting a greater variation of worldviews among the clinicians in our study than anticipated. One possible explanation for this variation is that differences in clinician's psychological attributes as well as demographic characteristics such as age, gender, years of experience, education level, work areas, target client population, and therapeutic orientation may explain the absence of the shared cultural models found in our study. The dynamic nature of the therapeutic relationship means that it is not a one-size-fits-all approach, but rather influenced by the unique characteristics of each client and clinician, including demographic differences, personal experiences, and expectations regarding treatment and the therapeutic relationship itself. For example, Yoshimi et al. (2010) reported that therapists' attachment styles had differing effects on the quality of therapeutic alliance evaluated by the client.

4.5.3 Limitations

The present study had several limitations. First, we did not examine the factors possibly explaining our results for weak evidence for the presence of shared cultural models for incompetent clinicians, difficult clients, and external barrier domains. Given that our sample characteristics were quite heterogenous, future research could investigate the presence of shared models among subgroups of Japanese clinical psychologists. For example, Dressler et al. (2015) developed a residual agreement analysis to study subgroup differences in their knowledge that may deviate from the overall consensus of the cultural mode. The second factor analysis would allow researchers to identify which group is agreeing more with those accounting for the overall consensus (e.g., CBT therapists with each other, client-centered therapists with each other). Similarly, we did not closely examine the distribution of cultural competence among the participants. For example, cultural competence score analysis could reveal which item is the culturally correct answer, and who is an expert (i.e., those who are agreeing) and who is not (i.e., those who are disagreeing). It is plausible that participants' attributes and characteristics may be predictors of cultural competence. In relation to sample characteristics, considering the growing number of clinical psychologists in Japan, investigating larger sample sizes with clinicians from diverse backgrounds would expand our understanding of their shared beliefs.

Second, our study did not include pile-sorting, another CDA technique, which is recommended in cultural consensus theory research to further explore the interrelationships among the emerged terms and themes after collecting free-listing data (Borgatti, 1994; Dressler, 2017; Weller, 2007b). During the pile-sorting task, participants are asked to group and sort terms based on similarities and differences in meaning. Researchers can then estimate a proximity matrix per participant to perform multidimensional scaling, cluster analysis, or correspondence analysis to statistically examine the associations among the terms and visually map them. Pile-sorting is a useful mixed-methods approach designed to detect underlying dimensions of semantic structure of the terms emerged and rated by the participants (Gravlee et al., 2018) Incorporating pile-sorting in future research utilizing cultural domain analysis would provide a more comprehensive understanding of the relationships among the cultural domains.

Furthermore, our study did not investigate the relationship between the emergent cultural models and the actual practices and behaviors endorsed by Japanese clinical psychologists. Future research should conduct follow-up studies that incorporate the analysis of cultural consonance,

which examines the extent to which individuals align their behaviors and lives with culturally shared models of beliefs (Dressler & Bindon, 2000). For example, Dressler and colleagues (2000) revealed that lower levels of cultural consonance predicted poorer health outcomes among urban Brazilian residents while adjusting for demographic variables such as age, sex, and SES. Exploring the relationship between cultural consonance and clinical practice outcomes such as dropout rates would provide valuable insights.

Lastly, future studies should aim to investigate the cultural models of mental health beliefs shared by patients, caregivers, and other mental health professionals in Japan as well as clinical psychologists from other cultural contexts. Examining potential group differences or similarities in shared beliefs about mental health would contribute to our understanding of the diverse explanatory models present in mental health literature and care.

4.5.4 Conclusion

Our study serves as a case example of utilizing cultural consensus theory and mixed-methods approach to advance mental health research from a cultural perspective. We argue that cultural consensus theory holds promise as a theoretical, methodological, and statistical framework with broader applicability, particularly in psychological research. While there have been psychological studies on beliefs about depression and therapeutic alliance among clinical psychologists, research on clinicians from non-WEIRD cultural contexts is significantly limited. Furthermore, there is a scarcity of studies that have employed a mixed-methods approach to explore *the shared beliefs* among understudied cultural groups and communities. To our knowledge, this study represents the first to utilize cultural consensus theory and mixed-methods approach to examine Japanese clinical psychologists' shared beliefs about depression and therapeutic alliance.

4.6 Acknowledgement

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CHAPTER 5: GENERAL DISCUSSION

Across three manuscripts, four different samples, and two different mixed-methods approaches, this dissertation aimed to explore beliefs about mental health from a culturally grounded perspective while addressing the lack of diversity in sampling, theory development and testing, and methods in WEIRD psychological science. Specifically, beliefs about mental health are often conceptualized and studied in the context of mental health awareness, literacy, and stigma in the current psychological literature. Such studies typically apply measures derived from Western biomedical paradigms or expert's models, aims to discern the discrepancies between groups (e.g., laypeople vs. experts or Western medicalization vs. Japanese moralization), and focus on quantifying the extent of deviation from the Western biomedical experts' models. However, these approaches potentially oversimplify and overlook the complex reality of cultural models of mental health held by different cultural groups and communities.

The first manuscript described in Chapter 2 examined cultural differences in causal and help-seeking beliefs about five different psychological disorders between Japanese and Euro-Canadian university students using content analysis. The third and fourth manuscripts discussed in Chapter 3 and 4, drew upon cultural consensus theory as a framework to examine consensus beliefs about mental health in a broader context, depression, and the therapeutic alliance held by Japanese clinical psychologists. These two manuscripts employed a two-phase sequential exploratory mixed-methods design.

In the following sections, I will first summarize the main contributions of the three manuscripts in this dissertation. Next, I will discuss the broader implications of this dissertation work, illuminating the importance of conducting mental health research from a culturally grounded perspective by diversifying theoretical framework, samples, and methods to address the challenges of the WEIRD problems in psychological science. I will then critically assess the limitations of this dissertation and provide reflections on potential future directions to enrich our understanding of beliefs about mental health in Japanese cultural contexts.

5.1 Main Contributions

This dissertation makes five main contributions, summarized as follows:

(1) Explanatory models (i.e., social-contextualization and social-contextual responsibility) and themes (e.g., filial piety, resting) that were absent in the previously proposed models of causal and help-seeking beliefs emerged from the qualitative data. Cultural differences in these beliefs were found between Japanese and Euro-Canadian samples as well as across five different disorder types (Chapter 2).

(2) Overall, Japanese clinical psychologists endorsed shared cultural models pertaining to mental health, depression, and therapeutic alliance with the exceptions of beliefs about an incompetent clinician, a difficult client, and external barriers in the therapeutic alliance. Their beliefs about mental healthcare, depression, and therapeutic alliance speak to one another, also suggesting that their cultural models of these domains reflect broader social and cultural context surrounding mental health in Japan (Chapters 3 & 4).

(3) Although direct comparisons were not made, across the samples examined in this dissertation, each cultural group or community endorsed *multiple* beliefs and themes about mental health. This means that cultural models held by people are not simple or monolithic, but more complex, wide-ranging, and holistic than generally assumed in previous psychological research on the topic. Configurations of these cultural models *depend on the context*, such as the samples and mental illness types (Theoretical contributions).

(4) The application of mixed-methods designs and interdisciplinary approaches in the studies facilitated the uncovering of culturally nuanced themes through qualitative methods (Chapters 2, 3, & 4), the presence of group differences and multiple cultural models (Chapter 2), and the existence of shared cultural models (Chapters 3 & 4), while preserving the statistical rigor typical of conventional quantitative research. This in turn enabled us to discuss the concept of mental health beliefs in a more multifaceted and detailed manner (Methodological contributions).

(5) The inclusion of non-WEIRD samples (Japanese students and clinical psychologists), coupled with the integration of the literature review in the Japanese

language, and cross-cultural and interdisciplinary collaboration, broadened the scope of our understanding of mental health beliefs and demonstrating ethical obligation towards diversity and social justice in psychological science (Equity, Diversity, and Inclusion contributions).

5.1.1 Cross-Cultural Differences in Beliefs about Mental Illness between Japanese and Euro-Canadians

In Chapter 2, I presented a study (Sunohara et al., under review) examining cultural differences in explanatory models of five mental illness conditions between Japanese and Euro-Canadian university students. The study first conducted a content analysis to allow new themes and explanatory models to emerge from the qualitative data followed by multivariate statistical modeling approach to examine the group differences. Results from the qualitative phase revealed that explanatory models that were previously not considered emerged from the data. Specifically, there were *social-contextualization* of causal beliefs and *social-contextual responsibility* for help-seeking beliefs. Beliefs about causes and help-seeking about mental illness have been conceptualized as *explanatory models* and extensively studied by anthropology (Kleinman, 1980). These studies have often focused on a specific cultural group or community using qualitative methods alone (e.g., ethnography). Folk psychiatry model was developed to categorize the causal explanatory models into three models; medicalize, moralize, and psychologize based on causal attribution theory in social psychology (Haslam, 2003). Previous research using the three dimensionalized explanatory models showed cultural differences (e.g., Giosan et al., 2001). However, it had never been tested with Japanese samples. Furthermore, I argue that the three models only include causal attribution focusing on the allocentric understanding of the self, given the theory development and sampling originating from the WEIRD cultural context. Therefore, the three models fail to capture explanatory models encompassing the broader social and contextual explanation of mental illnesses.

First, I conducted a qualitative content analysis coding to elucidate themes pertaining to beliefs about mental illnesses, combining deductive and inductive approaches to discover new themes, while allowing for the exploration of the existing EMs (i.e., medicalize, moralize, and psychologize). Qualitative data analysis revealed the presence of social-contextualizing themes and culturally unique themes (such as filial piety and resting). Statistical analysis demonstrated cultural

differences in the endorsement of explanatory models (EMs) across five different conditions (i.e., depression, autism spectrum disorder, schizophrenia, alcohol use disorder, and hikikomori). Contrary to our hypothesis, Japanese students generally exhibited a tendency to psychologize the conditions and emphasize the importance of social support in help-seeking. In contrast, Euro-Canadian students leaned towards medicalizing the conditions and suggesting medication and self-care for treatment. More research is needed to fully test the presence of social-contextualizing explanatory models as the statistical power was weak in the present study. Overall, the findings from Chapter 2 highlight that the Western biomedical model is not universal across cultural context, and applying the simplified and monolithic model undermines the complexity of people's beliefs. The effect of culture on explanatory models also varied across the five conditions. Furthermore, our findings suggests that people from both cultural contexts endorse multiple explanatory models, which also depend on the disorder conditions. The use of a mixed-methods approach in this study demonstrated its advantages in conducting culturally grounded psychological research on mental health.

5.1.2 Japanese Clinicians' Shared Beliefs about Mental Health, Depression, and Therapeutic Alliance

In Chapter 3 and 4, I presented two manuscripts drawing upon cultural consensus theory to explore consensus beliefs held by Japanese clinical psychologists. Specifically, I conducted a two-phase exploratory mixed-methods design to first conduct a cultural domain analysis through qualitative free-listing interviewing technique with a group of practicing clinicians followed by a consensus analysis to evaluate the presence of consensus for three domains: *mental health in a broader societal context*, *depression*, and *therapeutic alliance*. For the mental health domain, two subdomains were examined: (1) sources of public's beliefs about mental health; and (2) changes needed for mental healthcare reform in Japan. For the depression domain, three subdomains were examined: (1) causes; (2) effects; and (3) treatment. Lastly, for the therapeutic alliance domain, four subdomains were investigated: (1) an incompetent clinician; (2) a difficult client; (3) external barriers; and (4) problem-solving.

Most clinicians believed that non-professional learning or information outlet such as *media* and *beliefs taught at home, work, or school* to be contributing to shape the public's beliefs about mental health. Interestingly, these terms indeed overlap with some of the terms perceived as most salient for external barriers subdomains. Japanese clinicians viewed that *lack of understanding and*

inadequate support from others (family, work, friends) being the most hindering factor in the therapeutic alliance with their client. Although we did not specify what we meant by "mental health" in our free-listing interviewing, it is possible that clinicians perceived the influences of beliefs held by family members or people from work being mostly negative to the clients, thereby affecting the therapeutic alliance. Five items (e.g., improving clinician's quality, skills, training) in the subdomain: "changes needed for mental healthcare reform" represent clinicians' frustration with the radical regulation changes being in effect in the licensure and training system since 2018. Clinicians' belief that *extending health insurance coverage* was important to improve the mental healthcare system reflects the limitations of the current health care system. Currently, psychotherapy or counseling is considered medical care only if provided or supervised by physicians. This means that services provided by clinical psychologists outside the purview of physicians are not covered by the government-funded national health insurance, which may in turn limit people's access to psychotherapy or counseling. Clinicians' concern about health insurance corresponds with the *financial difficulties* and *intervention by other mental health professionals or parties* items being reported as salient for external barriers subdomain. Clinicians critically and collectively perceive that factors hindering the mental healthcare system in a broader societal context are simultaneously and directly hindering their day-to-day clinical practices and therapeutic alliances with their client.

In terms of beliefs about depression, our cultural domain analyses showed that clinicians endorsed multiple beliefs and themes encompassing Western biomedical models, psychological themes, as well as social, cultural, and well-being issues currently at stake in Japan. Notably, *stress* and *overwork* were the most salient terms for causal beliefs. As discussed in Chapters 1 and Chapter 4, an increasing number of reports of psychological stress and deaths from overwork (both natural cause death or suicide) have been viewed as ongoing social, political, economic, and psychological issues in Japan (Hosokawa et al., 1982; Japan Ministry of Health, Labour, and Welfare, 2020). These pressing issues were captured by clinician's beliefs about causes of depression. Interestingly, medicalization or biogenetic explanations (e.g., neurotransmitters, genetics, physical illnesses, side effects of medication) were not reported as salient in our analysis. Terms representing psychologization such as *personality and temperament*, *cognitive distortions/thinking styles*, *environment*, *interpersonal problems*, and *past family relationships and upbringings* were reported as moderately salient.

For the effects of depression subdomain, the most salient terms represent somatic symptoms

(e.g., sleep problems, decreased standard of living, appetite problems, fatigue/tiredness) followed by social withdrawal (i.e., absence from work/school) and psychological symptoms (e.g., negative thinking, decreased self-esteem/self-confidence, suicidal ideation, self-blame/guilt, and irritability/anger/aggression). Social and familial consequences such as *burden on family/others*, *poorer societal status/evaluation*, and *social withdrawal* were reported as moderately salient.

Clinicians' beliefs about treatment for depression also represented and corresponded with the social and mental health issues at stake in Japanese culture. Although none of the participants reported practicing Morita therapy, and the therapeutic orientations of our participants were diverse, *resting* was reported as the number one solution to alleviate depressive symptoms, followed by *medication*, *social support*, and *working on cognitive distortions*. Self-care solutions (e.g., physical exercise, engaging in enjoyable activities) were also reported as moderately salient. Most interestingly, our results showed that clinicians did not particularly perceive psychotherapy or counseling to be the most effective to treat depression. Clinicians also reported that most difficult clients to work with are those who are *placing unrealistic expectations*, *showing lack of trust in psychotherapy as a treatment*, or *clinicians' ability to protect the clients' privacy and confidentiality*, and *lack of motivation*. Clinicians also reported that clinicians' *imposing personal values upon the client* as well as *anxiety about lack of structure and imposing a structure upon the client* may hinder their therapeutic alliance. These themes may be explained by the fact that the concept of talk therapy itself is still relatively new or unfamiliar to laypeople, and clinicians are highly aware of this gap (Kasai, 2009; Nippoda, 2012; Takasugi, 2022). As discussed in Chapters 1, 3, and 4, psychotherapy was initially imported from Europe and subsequently the U.S. Although there exist culturally adapted versions of psychotherapy such as Morita or Naikan therapy, much of its theories, education, and training curriculum implemented are heavily Western. Many of the founders of schools and education systems for psychotherapy and counseling in Japan studied abroad in the West. It is, therefore, possible that clinicians perceive the gaps in the needs and recognition of psychotherapy by the general public and their own clients.

Our cultural consensus analysis in the quantitative phase showed that there were strong consensus models for the mental health, depression, and problem-solving subdomain of the therapeutic alliance domain. There was weak evidence for the presence of consensus for an incompetent clinician, a difficult client, and external barriers subdomains. The findings for lack of strong consensus models for the three subdomains suggest that there was disagreement on what it

means to be an incompetent clinician, work with a difficult client, and deal with external barriers. This could be explained by differences in clinician's characteristics, therapeutic orientation, training models, years of experiences, as well as the clinician's own ideal models of therapeutic alliance. For example, Reynolds (1987), an American anthropologist, examined psychotherapy practices in Japan. He described that there are four models of client-therapist relationship: the healing model (i.e., client seeks healing from the clinician, putting the responsibility on the clinician), the training model (e.g., client seeks guidance from clinician for psychological growth and development), the interaction model (e.g., model focused on developing a long-term sustaining, supportive relationship between client and clinician), and the salvation model (e.g., based on religious salvation, therapist helps the client worship to offer relief from mental anguish). It would be intriguing to test if the conceptualization of the four models would be replicated utilizing CCA.

Overall, clinicians endorsed complex, multiple, and holistic beliefs about mental health in a broader social context, depression, and therapeutic alliance. The terms emerged from the qualitative data showed that they represent wide-ranges of themes from Western biomedical and psychologization themes (e.g., cognitive distortion) to unique social-cultural context shaping the clinician's experiences and practices (e.g., licensure changes, relationship with the physicians) to societal issues (e.g., overwork) at stake in Japan. In conclusion, the study showcased the utility of cultural consensus theory as a valuable mixed-methods approach for conducting culturally informed research on mental health concepts within understudied cultural groups or communities.

5.2 Implications

Beyond the implications of the specific findings from the studies, this dissertation serves as a critique of the predominant research practices employed in mainstream psychological sciences, promoting a reconsideration of conceptual and methodological paradigms as well as addressing the systemic biases. There are three main broader implications of this dissertation in these three domains.

First, findings from this dissertation suggest that the overreliance on WEIRD samples and quantitative methods in psychological science may reflect its tendency to label, categorize, and dichotomize psychological and social phenomena. Irrespective of cultural groups or communities, beliefs about mental health and illnesses held by people cannot be assumed to be singular, monolithic, or essentialized (Haslam, 2000; Haslam & Ernst, 2002). Scholars concerned with

culture and mental health point out about the potential harm of essentializing clients, as it can divert the mental health professionals who are otherwise attuned to unique individual experiences of suffering (Kleinman, 1988). The results from this dissertation demonstrate that the cultural models of mental health held by people from different communities are complex, holistic, and multifaceted.

Second, to undertake a research endeavor aiming to provide a comprehensive understanding through in-depth analysis of psychological constructs or understudied groups and communities, it is imperative to consider an interdisciplinary perspective and the mixed-methods research approach. Integrating literature outside of psychology and scholarly sources published in languages other than English would also enrich our understanding the unique contributions of cultural, social, political, and historical contexts shaping beliefs about mental health and illness.

Lastly, as I addressed in Chapter 1, psychological research is WEIRD at the systemic level. In addition to authors predominantly being affiliated with WEIRD cultural contexts, Roberts and colleagues (2020) published a controversial paper documenting racial inequality in psychological research in their review paper published in *Perspectives on Psychological Science*, published by the Association for Psychological Science. The authors conducted a review of 26,000 empirical studies published between 1974 and 2018 in top tier journals in cognitive, developmental, and social psychology to investigate the prevalence of race in their research topic, race of the researchers, and the relation between the two. They found that, overall, only 5% of the studies discussed race, 93% of editors in chief were white, 63% of authors who published studies highlighting race were white, and only 23% of whom were people of color. They also found the effect of race of the authors on the race of the participants in the studies, indicating that white authors are more likely to publish with white participants, and less likely to publish with participants of color. The authors conclude that "to truly diversify psychological science, it is important for funding agencies to consist of diverse review panels, to support researchers of color, and to fund projects with diverse samples" (p.1305). The American Psychological Association, moreover, declared psychologists have *an ethical responsibility* in diversifying their research practices, partnerships, and addressing the systemic biases to solve global problems and promote new discoveries in their statement in *Resolution on Promoting Global Perspectives in U.S.* (APA Policy by APA Council of Representatives, 2017). To this end, the current dissertation aimed to build on partnerships across four universities (two from Canada, and two from Japan), involving

scholars, graduate students, and research assistants from both countries.

5.3 Limitations and Future Directions

This dissertation focusses only on cultural models of mental health in terms of deviancy and psychopathology. Cultural models of mental health indeed include normalcy or what it means to be psychologically well (Chentsova-Dutton & Ryder, 2020). There is accumulating evidence to suggest that there are cultural differences in the concept of happiness. For instance, Hitokoto and Uchida (2015) proposed a new theoretical concept of *interdependent happiness.* The researchers theorize that interdependent life goals such as respecting and contributing to group harmony and norms are salient to some cultural groups that promotes interdependent self, and this collective happiness is a missing piece in a previously hypothesized concept of happiness. The researchers then developed and validated an interdependent happiness measure by building on the culturally grounded previous work (Uchida & Kitayama, 2009). They also showed that interdependent happiness predicted both subjective well-being and interdependent self-construal among Japanese undergraduates and adults. They further demonstrated that the effect of interdependent happiness in predicting self-esteem differed among working adults from Japan, U.S., Germany, and Korea. Future studies should incorporate cultural models of happiness to gain a better picture of beliefs about mental health.

The first manuscript in this dissertation aimed to highlight cultural differences between Euro-Canadian and Japanese contexts, facilitating a cross-cultural collaboration among four universities in both countries. However, I fully acknowledge that the samples were indeed psychology undergraduates; therefore, the findings may not be generalizable to understudied samples and communities. For example, SES is shown to predict certain psychological tendencies more than race or cultural membership (Ishii & Eisen, 2020). Manuscript 2 and 3 aimed to address the sampling limitations identified in Manuscript 1. Nevertheless, Japanese clinical psychologists are also a highly educated group of people compared to the general public as well. Future studies should explore detailed demographic variables such as SES, gender, and age, as they have often been considered statistical noise to be removed and "controlled for," but can indeed provide valuable insights into psychological tendencies.

Similarly, cultural psychologists should shift away from the East-West binary comparisons and include samples and perspectives from other parts of the globe (P. B. Smith & Bond, 2022).

The researchers showed that among the 558 articles focused on self-construal, East Asia represented 39% of the studies, while only 3% were from Latin America, 1% were from Sub-Saharan Africa, and 4% were from the Middle East (Krys et al., 2022). Including Japanese samples in my dissertation has several privileges, as Japan is a high-income country that provides access to abundant resources and facilitates collaboration with Western institutions.

Cultural consensus theory and content analysis methodological frameworks used in this dissertation were still Western derived mixed-methods approaches. There are indeed non-Western derived methods such as the KJ method (Kawakita, 1967). The KJ method was developed by a Japanese geographer and cultural anthropologist, Jiro Kawakita. The KJ method, also known as the Affinity Diagram, is a qualitative research technique to organize, synthesize, and describe patterns of a large number of unstructured ideas or terms. The KJ method is a commonly used qualitative method in Japanese psychological science. It is also used for idea generation and brainstorming in non-research or academic settings. The majority of the Japanese studies on clinicians' beliefs I reviewed employed not only qualitative methods but specifically the KJ method. The KJ method is also commonly used in business and design industries and applied social science fields in Western countries. Future research should explore research methods that have been developed in Japan.

Finally, while this dissertation primarily focuses on mental health, it does not directly address the clinical applicability of the findings or their transferability to practical contexts. Future studies should seek to apply the research into practice and policymaking to better serve marginalized communities in consultation with community members. For example, in Canada, community-level effort and research-intervention programs have been proposed and put forth to bridge the cultural models of Indigenous Peoples and mental health intervention research by researchers and community members of Indigenous cultural traditions. For example, the Indigenous Cultural Responsiveness Theory (ICRT) has been developed as a decolonized pathway research design to prioritize the restoration of First Nations community-based health systems, explore the possibilities to establish a "middle ground" for and co-existence of differing perspectives between mainstream and First Nation belief systems, and adapt culturally responsive and informed research into mainstream service delivery system to better serve Indigenous Peoples in Saskatchewan (Sasakamoose et al., 2017). Thus, it is crucial to establish a connection between research and practice by fostering collaboration between researchers and the community.

5.4 Conclusion

This dissertation aimed to explore beliefs about mental health from a culturally grounded, interdisciplinary perspective amidst the WEIRD problems in psychological sciences. The three studies presented in this dissertation aimed to address lack of diversity in theory, sampling, and methods by investigating beliefs about mental illness across Japanese and Euro-Canadian university students and shared beliefs about mental health, depression, and therapeutic alliance among Japanese clinical psychologists. Two types of mixed-methods research designs were employed to address the research questions of this dissertation.

The findings suggest that multiple and different combinations of cultural models of mental health beliefs exist, *depending on the context* (i.e., Japanese vs. Euro-Canadian undergraduates, across five mental illnesses, Japanese clinical psychologists). The use of mixed-methods allowed for this discovery. Qualitative methods allowed for the exploration of culturally nuanced themes. Quantitative methods revealed group differences and multiple cultural models, as well as the identification of shared cultural models.

Psychology researchers investigating mental health are strongly encouraged to embrace and adopt more culturally grounded, interdisciplinary research practices and collaborations. Such practices involve considering non-WEIRD perspectives and theories, diversifying the samples, and employing mixed-method approaches.

References

Ahn, W. K., Proctor, C. C., & Flanagan, E. H. (2009). Mental health clinicians' beliefs about the biological, psychological, and environmental bases of Mental disorders. *Cognitive Science*, *33*(2), 147–182. https://doi.org/10.1111/j.1551-6709.2009.01008.x

Alise, M. A., & Teddlie, C. (2010). A Continuation of the Paradigm wars? prevalence rates of methodological approaches across the social/behavioral sciences. *Journal of Mixed Methods Research*, *4*(2), 103–126. https://doi.org/10.1177/1558689809360805

American Psychological Association. (2017, February 17). *Resolution on Promoting Global Perspectives in U.S. Psychology*. APA Policy by APA Council of Representatives. https://www.apa.org/about/policy/global-perspectives

Ando, M., Asakura, T., & Simons-Morton, B. (2005). Psychosocial influences on physical, verbal, and indirect bullying among Japanese early adolescents. *The Journal of Early Adolescence*, *25*(3), 268–297. https://doi.org/10.1177/0272431605276933

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163–179. https://doi.org/10.1111/j.1600-0447.2005.00699.x

Angermeyer, M. C., & Matschinger, H. (2003). Public beliefs about schizophrenia and depression: Similarities and differences. *Social Psychiatry and Psychiatric Epidemiology*, *38*(9), 526–534. https://doi.org/10.1007/s00127-003-0676-6

Angermeyer, M. C., & Matschinger, H. (2005). Causal beliefs and attitudes to people with schizophrenia. *British Journal of Psychiatry*, *186*(4), 331–334. https://doi.org/10.1192/bjp.186.4.331

Angermeyer, M. C., Buyantugs, L., Kenzine, D. V., & Matschinger, H. (2004). Effects of labelling on public attitudes towards people with schizophrenia: Are there cultural differences? *Acta Psychiatrica Scandinavica*, *109*(6), 420–425. https://doi.org/10.1111/J.1600-0047.2004.00310.X

Angermeyer, M. C., Holzinger, A., Carta, M. G., & Schomerus, G. (2011). Biogenetic explanations and public acceptance of mental illness: Systematic review of population studies. *British Journal of Psychiatry*, *199*(5), 367–372. https://doi.org/10.1192/bjp.bp.110.085563

Aoki, S. (2010). Rinshō shinri mensetsu kēsu tantō jisshū ni kansuru ikkōsatsu [A study of training as a therapist at the counseling center of graduate school]. *Bulletin of Clinical Psychology, Tokyo Seitoku University*, *10*, 28–39.

Apicella, C., Norenzayan, A., & Henrich, J. (2020). Beyond WEIRD: A review of the last decade and a look ahead to the global laboratory of the future. *Evolution and Human Behavior*, *41*(5), 319–329. https://doi.org/10.1016/j.evolhumbehav.2020.07.015

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: Historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*(OCT). https://doi.org/10.3389/fpsyg.2011.00270

Arellano, L. (2022). Questioning the science: How quantitative methodologies perpetuate inequity in higher education. *Education Sciences*, *12*(2), 116. https://doi.org/10.3390/educsci12020116

Arnault, D. Saint, Sakamoto, S., & Moriwaki, A. (2006). Somatic and depressive symptoms in female Japanese and American students: a preliminary investigation. *Transcultural Psychiatry*, *43*(2), 275–286. https://doi.org/10.1177/1363461506064867

Arnault, D. Saint. (2009). Cultural determinants of help seeking: A model for research and practice. *Research and Theory for Nursing Practice*, *23*(4), 259–278. https://doi.org/10.1891/1541-6577.23.4.259

Arnett, J. J. (2008). The neglected 95%: Why American psychology needs to become less American. *American Psychologist*, *63*(7), 602–614. https://doi.org/10.1037/0003-066X.63.7.602

Azar, B. (2008). *Qualitative research is gaining ground and respect. Up close and personal*. American Psychological Association. http://www.apa.org/gradpsych/2008/01/upclose.aspx

Baek, C. H., Kim, H. J., Park, H. Y., Seo, H. Y., Yoo, H., & Park, J. E. (2023). Influence of Biogenetic Explanations of Mental Disorders on Stigma and Help-Seeking Behavior: A Systematic Review and Meta-Analysis. *Journal of Korean Medical Science*, *38*(3). https://doi.org/10.3346/jkms.2023.38.e25

Ban, L., Kashima, Y., & Haslam, N. (2010). Does understanding behavior make it seem normal?: Perceptions of abnormality among Euro-Australians and Chinese-Singaporeans. *Journal of Cross-Cultural Psychology*, *43*(2), 286–298.

https://doi.org/10.1177/0022022110385233

Barg, F. K., Huss-Ashmore, R., Wittink, M. N., Murray, G. F., Bogner, H. R., & Gallo, J. J. (2006). A mixed-methods approach to understanding loneliness and depression in older adults. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences*, *61*, S329–S339. https://doi.org/10.1093/geronb/61.6.S329

Bartholomew, T. T., & Brown, J. R. (2012). Mixed methods, culture, and psychology: A review of mixed methods in culture-specific psychological research. *International Perspectives in Psychology: Research, Practice, Consultation*, *1*(3), 177–190. https://doi.org/10.1037/a0029219

Bayliss, E. A., Steiner, J. F., Fernald, D. H., Crane, L. A., & Main, D. S. (2003). Descriptions of barriers to self-care by persons with comorbid chronic diseases. *Annals of Family Medicine*, *1*, 15–21. https://doi.org/10.1370/afm.4

Benítez, I., & Padilla, J.-L. (2014). Analysis of nonequivalent assessments across different linguistic groups using a mixed methods approach. *Journal of Mixed Methods Research*, *8*(1), 52–68. https://doi.org/10.1177/1558689813488245

Bhui, K., & Dinos, S. (2008). Health beliefs and culture. *Disease Management & Health Outcomes*, *16*(6), 411–419. https://doi.org/10.2165/0115677-200816060-00006

Blay, S. L., & Peluso, E. T. P. (2008). The public's ability to recognize Alzheimer disease and their beliefs about its causes. *Alzheimer Disease and Associated Disorders*, *22*(1), 79–85. https://doi.org/10.1097/WAD.0b013e31815ccd47

Bonat, W. H. (2018). mcglm: Multiple response variables regression models in R. In *Journal of Statistical Software* (Vol. 84, pp. 1–30). https://doi.org/10.18637/jss.v084.i04

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252–260. https://doi.org/https://doi.org/10.1037/h0085885

Borgatti, S. P. (1994). Cultural domain analysis. *Journal of Quantitative Anthropology*, *4*, 261–278. https://doi.org/4324/9781003092179-4

Borgatti, S. P. (1999). Cultural consensus theory. In J. Schensul (Ed.), *The ethnographic toolkit*. SAGE Publications.

Brick, C., Hood, B., Ekroll, V., & de-Wit, L. (2022). Illusory essences: A bias holding back theorizing in psychological science. *Perspectives on Psychological Science*, *17*(2), 491–

506. https://doi.org/10.1177/1745691621991838

Chen, S. X., & Mak, W. W. S. (2008). Seeking professional help: Etiology beliefs about mental illness across cultures. *Journal of Counseling Psychology*, *55*(4), 442. https://doi.org/10.1037/A0012898

Cheng, H. L., Kwan, K. L. K., & Sevig, T. (2013). Racial and ethnic minority college students' stigma associated with seeking psychological help: Examining psychocultural correlates. *Journal of Counseling Psychology*, *60*(1), 98–111. https://doi.org/10.1037/A0031169

Chentsova-Dutton, Y. E., & Ryder, A. G. (2019). Cultural-clinical psychology. In D. Cohen & S. Kitayama (Eds.), *Handbook of cultural psychology* (2nd ed., pp. 365–394). New York, NY: Guildford Press.

Chentsova-Dutton, Y. E., & Ryder, A. G. (2020). Cultural models of normalcy and deviancy. *Asian Journal of Social Psychology*, *23*(2), 187–204. https://doi.org/10.1111/ajsp.12413

Choi, I., Nisbett, R. E., & Norenzayan, A. (1999). Causal attribution across cultures: Variation and universality. *Psychological Bulletin*, *125*(1), 47–63. https://doi.org/10.1037/0033-2909.125.1.47

Cohen, P., & Cohen, J. (1984). The clinician's illusion. *Archives of General Psychiatry*, *41*, 1178–1182. https://doi.org/10.1001/archpsyc.1984.01790230064010

Cole, M. (1998). *Cultural psychology: A once and future discipline*. Harvard University Press. https://www.hup.harvard.edu/catalog.php?isbn=9780674179561

Conrad, M. M., & Pacquiao, D. F. (2005). Manifestation, attribution, and coping with depression among Asian Indians from the perspectives of health care practitioners. *Journal of Transcultural Nursing : Official Journal of the Transcultural Nursing Society*, *16*(1), 32–40. https://doi.org/10.1177/1043659604271239

Cooper, S. (2007). Psychotherapy in South Africa: The case of Mrs. A. *Journal of Clinical Psychology*, *63*(8), 773–776. https://doi.org/10.1002/jclp.20392

Creamer, E. G., & Reeping, D. (2020). Advancing mixed methods in psychological research. *Methods in Psychology*, *3*, 100035. https://doi.org/10.1016/j.metip.2020.100035

Creswell, J. W. (2013). Steps in Conducting a Scholarly Mixed Methods Study. *DBER Speaker Series*, 54. http://digitalcommons.unl.edu/dberspeakers

Creswell, J. W., & Plano Clark, V. L. (2017). *Designing and Conducting Mixed Methods Research* (3rd ed.). SAGE Publications.

Creswell, J. W., & Poth, C. N. (2014). *Qualitative inquiry & research design* (4th ed.). SAGE Publications.

Creswell, J. W., & Tashakkori, A. (2007). Editorial: differing perspectives on Mixed methods research. *Journal of Mixed Methods Research*, *1*(4), 303–308. https://doi.org/10.1177/1558689807306132

Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World Psychiatry : Official Journal of the World Psychiatric Association (WPA)*, *4*(2), 106–113. http://www.ncbi.nlm.nih.gov/pubmed/16633526

Crystal, D. S. (2000). Concepts of deviance and disturbance in children and adolescents: A comparison between the United States and Japan. *International Journal of Psychology*, *35*(5), 207–218. https://doi.org/10.1080/00207590050171148

Crystal, D. S., Parrott, W. G., Okazaki, Y., & Watanabe, H. (2001). Examining relations between shame and personality among university students in the United States and Japan: A developmental perspective. *International Journal of Behavioral Development*, *25*(2), 113–123. https://doi.org/10.1080/01650250042000177

D'Andrade, R. G. (1995). *The development of cognitive anthropology*. Cambridge, England: Cambridge University Press. https://doi.org/10.1017/CBO9781139166645

Davis, J. D., Elliott, R., Davis, M. L., Binns, M., Francis, V. M., Kelman, J. E., & Schröder, T. A. (1987). Development of a taxonomy of therapist difficulties: Initial report. *British Journal of Medical Psychology*, *60*(2), 109–119. https://doi.org/10.1111/j.2044-8341.1987.tb02720.x

de Freitas, A. L. C., & Bonat, W. H. (2022). *htmcglm: Hypothesis tests for multiple responses regression models in R*. Available at: https://cran.r-project.org/web/packages/htmcglm/htmcglm.pdf

DeVylder, J. E., Narita, Z., Horiguchi, S., Kodaka, M., Schiffman, J., Yang, L. H., & Koyanagi, A. (2020). Stigma associated with the labeling of schizophrenia, depression, and hikikomori in Japan. *Stigma and Health*, *5*(4), 472–476. https://doi.org/10.1037/sah0000215

Dobkin, P. L., & Lucena, R. J. M. (2015). Mindful medical practice and the therapeutic alliance. *The International Journal of Whole Person Care*, *3*(1).

https://doi.org/10.26443/ijwpc.v3i1.106

Doucerain, M., Vargas, S., & Ryder, A. G. (2016). Mixed-methods research: Integrating qualitative and quantitative approaches to the psychological study of culture. In N. Zene, G. Bernal, & F. T. L. Leong (Eds.), *Evidence-based psychological practice with ethnic minorities: Culturally informed research and clinical strategies.* (pp. 147–167). American Psychological Association. https://doi.org/10.1037/14940-008

Draguns, J. G. (1980). Psychological disorders of clinical severity. In H. C. Triandis & J. G. Draguns (Eds.), *Handbook of cross-cultural psychology. Vol. 6: Psychopathology* (pp. 99–174). Boston, MA: Allyn & Bacon.

Dressler, W. W. (1991). Social support, lifestyle incongruity, and arterial blood pressure in a southern black community. *Psychosomatic Medicine*, *53*(6), 608–620. https://doi.org/10.1097/00006842-199111000-00003

Dressler, W. W. (2017). Cultural Models and Cultural Consensus. In *Culture and the Individual: Theory and Method of Cultural Consonance* (pp. 53–81). Routledge. https://doi.org/10.4324/9781315164007-4

Dressler, W. W., & Bindon, J. R. (2000). The health consequences of cultural consonance: Cultural dimensions of lifestyle, social support, and arterial blood pressure in an African American community. *American Anthropologist*, *102*, 244–260. https://doi.org/10.1525/aa.2000.102.2.244

Dressler, W. W., Balieiro, M. C., & Dos Santos, J. E. (1997). The cultural construction of social support in Brazil: Associations with health outcomes. *Culture, Medicine and Psychiatry*, *21*, 303–335. https://doi.org/10.1023/A:1005394416255

Dressler, W. W., Balieiro, M. C., & Dos Santos, J. E. (1998). Culture, socioeconomic status, and physical and mental health in Brazil. *Medical Anthropology Quarterly*, *12*, 424–446. https://doi.org/10.1525/maq.1998.12.4.424

Dressler, W. W., Balieiro, M. C., & dos Santos, J. E. (2015). Finding culture change in the second factor: Stability and change in cultural consensus and residual agreement. *Field Methods*, *27*(1), 22–38. https://doi.org/10.1177/1525822X14542755

Dressler, W. W., Balieiro, M. C., & Santos, J. E. Dos. (1998). Culture, socioeconomic status, and physical and mental health in Brazil. *Medical Anthropology Quarterly*, *12*(4), 424–446. https://doi.org/10.1525/maq.1998.12.4.424

Enns, C. Z., & Kasai, M. (2003). Hakoniwa: Japanese sandplay therapy. *Counseling Psychologist*, *31*, 93–112. https://doi.org/10.1177/0011000002239403

Erdal, K., Singh, N., & Tardif, A. (2011). Attitudes about depression and its treatment among mental health professionals, lay persons and immigrants and refugees in Norway. *Journal of Affective Disorders*, *133*(3), 481–488. https://doi.org/10.1016/j.jad.2011.04.038

European Commission. (2006). *Mental Well-being. Special Eurobarometer 248/Wave 64.4*. https://ec.europa.eu/health/ph_information/documents/ebs_248_en.pdf

Fernando, S. (2014). Mental Health and Mental Illness in Non-Western Countries. In *Mental Health Worldwide: Culture, Globalization and Development* (pp. 45–62). Palgrave Macmillan UK. https://doi.org/10.1057/9781137329608_5

Fiks, A. G., Gafen, A., Hughes, C. C., Hunter, K. F., & Barg, F. K. (2011). Using freelisting to understand shared decision making in ADHD: Parents' and pediatricians' perspectives. *Patient Education and Counseling*, *84*(2), 236–244. https://doi.org/10.1016/j.pec.2010.07.035

Fischer, R. (2006). Congruence and functions of personal and cultural values: Do my values reflect my culture's values? *Personality and Social Psychology Bulletin*, *32*, 1419–1431. https://doi.org/10.1177/0146167206291425

Flanagan, E. H., & Blashfield, R. K. (2008). Clinicians' folk taxonomies of mental disorders. *Philosophy, Psychiatry, & Psychology*, *14*(3), 249–269. https://doi.org/10.1353/ppp.0.0123

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316–340. https://doi.org/10.1037/pst0000172

Frisby, C. L., & O'Donohue, W. T. (2018). Cultural competence in applied psychology: An evaluation of current status and future directions. In *Cultural Competence in Applied Psychology: An Evaluation of Current Status and Future Directions*. Springer International Publishing. https://doi.org/10.1007/978-3-319-78997-2

Giosan, C., Glovsky, V., & Haslam, N. (2001). The lay concept of 'mental disorder': A cross-cultural study. *Transcultural Psychiatry*, *38*(3), 317–332. https://doi.org/10.1177/136346150103800303

Glovsky, V., & Haslam, N. (2003). Acculturation and changing concepts of mental disorder:

Brazilians in the USA. *Transcultural Psychiatry*, *40*(1), 50–61. https://doi.org/10.1177/1363461503040001004

Gómez, B. (2007). Psychotherapy in Argentina: A clinical case from an integrative perspective. *Journal of Clinical Psychology*, *63*(8), 713–723. https://doi.org/10.1002/jclp.20386

Graham, S. (1992). "Most of the subjects were White and middle class": Trends in published research on African Americans in selected APA journals, 1970–1989. *American Psychologist*, *47*(5), 629–639. https://doi.org/10.1037/0003-066X.47.5.629

Gravlee, C. C., Maxwell, C. R., Jacobsohn, A., & Bernard, H. R. (2018). Mode effects in cultural domain analysis: comparing pile sort data collected via internet versus face-to-face interviews. *International Journal of Social Research Methodology*, *21*(2), 165–176. https://doi.org/10.1080/13645579.2017.1341187

Griffiths, K. M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry*, *6*(1), 21. https://doi.org/10.1186/1471-244X-6-21

Handwerker, W. P., & Wozniak, D. F. (1997). Sampling strategies for the collection of cultural data: An extension of Boas's answer to Galton's problem. *Current Anthropology*, *38*, 869–875. https://doi.org/10.1086/204675

Harkness, J. A. (2003). Questionnaire translation. In J. A. Harkness, F. van de Vijver, & P. Ph. Mohler (Eds.), *Cross-cultural survey methods* (pp. 35–56). John Wiley & Sons.

Haslam, N. (2000). Psychiatric categories as natural kinds: Essentialist thinking about mental disorder. *Social Research*, *67*(4), 1031–1058.

Haslam, N. (2003). Folk psychiatry: Lay thinking about mental disorder. *Social Research: An International Quarterly*, *70*(2), 621–644. https://doi.org/10.1353/sor.2003.0030

Haslam, N., & Ernst, D. (2002). Essentialist Beliefs About Mental Disorders. *Journal of Social and Clinical Psychology*, *21*(6), 628–644. https://doi.org/10.1521/jscp.21.6.628.22793

Haslam, N., Ban, L., & Kaufmann, L. (2007). Lay conceptions of mental disorder: The folk psychiatry model. *Australian Psychologist*, *42*(2), 129–137. https://doi.org/10.1080/00050060701280615

Heine, S. J., & Ruby, M. B. (2010). Cultural psychology. *WIREs Cognitive Science*, *1*(2), 254–266. https://doi.org/10.1002/wcs.7

Henrich, J. (2020). The Weirdest People in the World: how the West became psychologically

peculiar and particularly prosperous. In *History of European Ideas* (Issue 2). Farrar, Straus and Giroux. https://www.tandfonline.com/doi/full/10.1080/01916599.2022.2062900

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). The weirdest people in the world? *Behavioral and Brain Sciences*, *33*(2–3), 61–83. https://doi.org/10.1017/S0140525X0999152X

Hitokoto, H., & Uchida, Y. (2015). Interdependent happiness: Theoretical importance and measurement validity. *Journal of Happiness Studies*, *16*(1), 211–239. https://doi.org/10.1007/s10902-014-9505-8

Hiwatashi, T., Kubota, Y., Yamada, Y., Mukasa, A., Yamashita, Y., & Hayashi, M. (2020). Rinshō shinri-shi ni yoru gakkō kiki e no kinkyū shien ～ Gakkō rinshō shinri-shi kōdineitā e no chōsa kara ～ [School crisis interventions by clinical psychologists: Based on the survey of school counseling coordinators of the prefectural society of certified clinical psychologists]. *Journal of the Faculty of Human Sciences, Kyushu Sangyo University*, *2*, 10–16. https://doi.org/10.32223/hsksu.2.0_10

Hofstede, G. (1980). Culture's Consequences: International Differences in Work-Related Values. In *Administrative Science Quarterly* (Issue 4). SAGE Publications. https://doi.org/10.2307/2393017

Holmes, E. P., Corrigan, P. W., Williams, P., Canar, J., & Kubiak, M. A. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin*, *25*(3), 447–456. https://doi.org/10.1093/oxfordjournals.schbul.a033392

Horiguchi, S. (2019). Mental health and therapy in Japan. Conceptions, practices and challenges. In J. (2019). Kingston (Ed.), *Critical Issues in Contemporary Japan* (2nd ed., pp. 221–231). Routledge. https://doi.org/https://doi.org/10.4324/9781351139649

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, *38*(2), 139–149. https://doi.org/10.1037/0022-0167.38.2.139

Hosokawa, M., Tajiri, S., & Uehata, T. (1982). *Karōshi: Nō・shinzō-kei shikkan no gyōmu-jō nintei to yobō [Karoshi: Approval of Cerebral and Cardiovascular Disease as Occupational Disease and How to Prevent them]*. Rodo Keizaisha.

Huey, S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural

competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology*, *10*(1), 305–338. https://doi.org/10.1146/annurev-clinpsy-032813-153729

Hui, E. K. P. (2001). Hong Kong students' and teachers' beliefs on students' concerns and their causal explanation. *Educational Research*, *43*(3), 279–294. https://doi.org/10.1080/00131880110081044

Hyodo, A. (2008). *Seishinbyô no Nihon kindai: tsuku shinshin kara yamu shinshin e [Mental Disease and Japanese Modernity: From the Possessed Mind/Body to the Diseased Mind/Body]*. Seikyusha.

IJzerman, H., Lewis, N. A., Przybylski, A. K., Weinstein, N., DeBruine, L., Ritchie, S. J., Vazire, S., Forscher, P. S., Morey, R. D., Ivory, J. D., & Anvari, F. (2020). Use caution when applying behavioural science to policy. *Nature Human Behaviour 2020 4:11*, *4*(11), 1092–1094. https://doi.org/10.1038/s41562-020-00990-w

Ikeda, Y. (2006). Analysis of gratitude toward one's mother: Adolescents and young adults. *Journal of Japanese Association of Educational Psychology*, *54*, 487–497.

Ikeda, Y. (2010). Factors of resistance against gratitude to parents in adolescents. *Japan Society of Youth and Adolescent Psychology*, *22*, 55–67.

Imada, H., & Tanaka-Matsumi, J. (2016). Psychology in Japan. *International Journal of Psychology*, *51*, 220–231. https://doi.org/10.1002/ijop.12258

Inglehart, R., & Baker, W. E. (2000). Modernization, cultural change, and the persistence of traditional values. *American Sociological Review*, *65*(1), 19. https://doi.org/10.2307/2657288

Ishii, K., & Eisen, C. (2020). Socioeconomic status and cultural difference. In *Oxford Research Encyclopedia of Psychology*. Oxford University Press. https://doi.org/10.1093/acrefore/9780190236557.013.584

Ishitani, S. (2008). Daigakuin-sei ni yoru moki mensetsu taiken no bunseki ― Rinshō shinri-shi kōho seisei ga mensetsu bamen de ochiirigachi na konnan to rinshō kyōiku no kadai ni tsuite no ikkōsatsu [Analysis of simulated interview experience by graduate students - A study on the difficulties faced by clinical psychology trainees in interview settings and reflections on clinical education challenges]. *Bulletin of School of Human Sciences, Kobe College*, *9*, 3–18.

Ito, H., & Aruga, T. (2018). Japan imposes a legal overtime cap, but mental health issues are complex. *The Lancet Psychiatry*, *5*(8), 616–617. https://doi.org/10.1016/S2215-0366(18)30266-9

Iwakabe, S. (2008). Psychotherapy integration in Japan. *Journal of Psychotherapy Integration*, *18*, 103–125. https://doi.org/10.1037/1053-0479.18.1.103

Iwakabe, S., & Enns, C. Z. (2013). Counseling and psychotherapy in Japan: Integrating Japanese traditions and contemporary values. In R. Moodley, U. P. Gielen, & R. Wu (Eds.), *Handbook of counseling and psychotherapy in an international context* (pp. 204–214). Routledge.

Iwata, M. (2023). Shinri-shoku no kokka shikakuka o meguru keii kara miru kōnin shinri-shi seido no shakaiteki igi - “Rinshō shinrigaku-teki shakai seido-ron” no hitsuyōsei - [The social significance of the certified public psychologist system in the context of the national qualification of psychologists: The necessity of a "clinical psychological theory of social institutions]. *Bulletin of Human Sciences, Osaka University*, *22*, 84–96.

Japanese Association of Behavioral and Cognitive Therapies, *38*(1), 11–22.

Japanese Society of Certified Clinical Psychologists. (2016). *Report of the seventh survey on the trend and attitude of clinical psychologists*. Tokyo, Japan: Japanese Society of Certified Clinical Psychologists. (In Japanese, title translated by the author of this article.)

Jorm, A. F. (2000). Mental health literacy. Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, *177*(5), 396–401. https://doi.org/10.1192/bjp.177.5.396

Jorm, A. F., Korten, A. E., Jacomb, P. A., Rodgers, B., Pollitt, P., Christensen, H., & Henderson, S. (1997). Helpfulness of interventions for mental disorders: Beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, *171*(3), 233–237. https://doi.org/10.1192/bjp.171.3.233

Jorm, A. F., Nakane, Y., Christensen, H., Yoshioka, K., Griffiths, K. M., & Wata, Y. (2005). Public beliefs about treatment and outcome of mental disorders: a comparison of Australia and Japan. *BMC Medicine*, *3*(1), 12. https://doi.org/10.1186/1741-7015-3-12

Jung, H., von Sternberg, K., & Davis, K. (2017). The impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. *International Journal of Mental Health Promotion*, *19*(5), 252–267. https://doi.org/10.1080/14623730.2017.1345687

Kamikura, Y., Saito, S., Sato, M., Nomura, N., & Irikarui, E. (2016). Shinri mensetsu ni okeru shogakusha no fuan e no taisho to norikoekata oyobi seichō ― Fukusen keiro・tōshisei moderu (TEM) ni yoru bunseki― [Trainee therapists how to cope, get over their anxiety, and growth ―Analyzing with Trajectory Equifinality Model (TEM)―]. *Bulletin of Clinical Psychology, Rissho University*, *14*, 41–54.

Kanai, A. (2009). "Karoshi (Work to Death)" in Japan. *Journal of Business Ethics*, *84*(S2), 209–216. https://doi.org/10.1007/s10551-008-9701-8

Kanazawa, Y., Ueno, M., Yokozawa, N., & Nakayama, M. (2020). Rinshō shinri mensetsu ni okeru kaunserā・kuraiento kankei ni kansuru kenkyū ― Kaunserā・kuraiento ryōsha no taiken no shitsuteki bunseki― [The counselor-client relationship in psychotherapy: A qualitative analysis of counselors' and clients' experience]. *Meiji Gakuin University Bulletin of Psychology*, 13–26.

Karasz, A., & Singelis, T. M. (2009). Qualitative and mixed methods research in cross-Cultural psychology. *Journal of Cross-Cultural Psychology*, *40*(6), 909–916. https://doi.org/10.1177/0022022109349172

Kasai, M. (2009). The role of Japanese culture in psychological health. Implications for counseling and clinical psychology. In L. H. Gerstein, P. P. Heppner, S. Ægisdóttir, S.-M. A. Leung, & K. L. Norsworthy (Eds.), *International Handbook of Cross-Cultural Counseling: Cultural Assumptions and Practices Worldwide* (pp. 159–171). SAGE Publications.

Kashihara, J. (2016). Holding Prejudices Against People with Depression Affects Intentions of Personal Rejection and Supporting Behaviors : A Questionnaire-Based Experiment. *Japanese Journal of Clinical Psychology*, *16*(5), 591–599.

Kashima, Y. (2016). Cultural dynamics. *Current Opinion in Psychology*, *8*, 93–97. https://doi.org/10.1016/j.copsyc.2015.10.019

Kato, T. (2016). Hikikomori and modern-type depression in Japan. *European Psychiatry*, *33*. https://doi.org/10.1016/j.eurpsy.2016.01.835

Kato, T. A., Hashimoto, R., Hayakawa, K., Kubo, H., Watabe, M., Teo, A. R., & Kanba, S. (2016). Multidimensional anatomy of 'modern type depression' in Japan: A proposal for a different diagnostic approach to depression beyond the DSM-5. *Psychiatry and Clinical Neurosciences*, *70*(1), 7–23. https://doi.org/10.1111/pcn.12360

Kato, T. A., Shinfuku, N., Fujisawa, D., Tateno, M., Ishida, T., Akiyama, T., Sartorius, N., Teo, A. R., Choi, T. Y., Wand, A. P. F., Balhara, Y. P. S., Chang, J. P.-C., Chang, R. Y.-F., Shadloo, B., Ahmed, H. U., Lerthattasilp, T., Umene-Nakano, W., Horikawa, H., Matsumoto, R., … Kanba, S. (2011). Introducing the concept of modern depression in Japan; an international case vignette survey. *Journal of Affective Disorders*, *135*(1–3), 66–76. https://doi.org/10.1016/j.jad.2011.06.030

Kato, T., Kanba, S., & Teo, A. R. (2018). Hikikomori: experience in Japan and international relevance. *World Psychiatry*, *17*(1), 105–106. https://doi.org/10.1002/wps.20497

Kawakita, J. (1967). *Hassōhō - Sōzōsei Kaihatsu no tame ni [Methods of Ideation - For Creative Development]*. Chūō Kōronsha.

Kermode, M., Bowen, K., Arole, S., Pathare, S., & Jorm, A. F. (2009). Attitudes to people with mental disorders: a mental health literacy survey in a rural area of Maharashtra, India. *Social Psychiatry and Psychiatric Epidemiology*, *44*(12), 1087–1096. https://doi.org/10.1007/s00127-009-0031-7

Khodayarifard, M., Rehm, L. P., & Khodayarifard, S. (2007). Psychotherapy in Iran: A case study of cognitive-behavioral family therapy for Mrs. A. *Journal of Clinical Psychology*, *63*(8), 745–753. https://doi.org/10.1002/jclp.20389

Kida, Y., & Uchisawa, S. (2006). Shinri rinshō ni okeru rōrupurei jisshū no kisoteki kenkyū - Shogakusha wa, dono yō ni ikitsumaru no ka [Foundational research on role-play practicum in clinical psychology: How do novice practitioners encounter challenges?]. *Bulletin of University of Toyama School of Humanities*, *45*, 13–29.

Kim, B. S. K., Atkinson, D. R., & Umemoto, D. (2001). Asian cultural values and the counseling process. *The Counseling Psychologist*, *29*(4), 570–603. https://doi.org/10.1177/0011000001294006

Kim-Mozeleski, J. E., Tsoh, J. Y., Gildengorin, G., Cao, L. H., Ho, T., Kohli, S., Lam, H., Wong, C., Stewart, S., McPhee, S. J., & Nguyen, T. T. (2018). Preferences for depression help-seeking among Vietnamese American adults. *Community Mental Health Journal*, *54*(6), 748–756. https://doi.org/10.1007/s10597-017-0199-3

Kimura, Y., & Kimura, Y. (2017). Waga kuni no wakate shinri rinshōka ga kakaeru mensetsu bamen ni okeru konnan no genjō: Shitsuteki kenkyū ronbun no bunken kentō [The current situation of novice therapist struggles in the psychotherapy session in Japan-

Review of qualitative researches]. *Bulletin of Center of Clinical Psychology & Couseling at Ochanomizu University*, 71–80.

Kirmayer, L. J. (2002). Psychopharmacology in a globalizing world: The use of antidepressants in Japan. *Transcultural Psychiatry*, *39*(3), 295–322. https://doi.org/10.1177/136346150203900302

Kirmayer, L. J. (2006). Beyond the 'New Cross-cultural Psychiatry': Cultural biology, discursive psychology and the ironies of globalization. *Transcultural Psychiatry*, *43*(1), 126–144. https://doi.org/10.1177/1363461506061761

Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry*, *44*, 232–257. https://doi.org/10.1177/1363461506070794

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J., & Ban, L. (2013). Cultural Psychiatry: Research Strategies and Future Directions. In *Advances in Psychosomatic Medicine* (pp. 97–114). S.Karger AG. https://doi.org/10.1159/000348742

Kirmayer, L. J., & Ryder, A. G. (2016). Culture and psychopathology. *Current Opinion in Psychology*, *8*, 143–148. https://doi.org/10.1016/j.copsyc.2015.10.020

Kitanaka, J. (2003). Jungians and the rise of psychotherapy in Japan: A brief historical note. *Transcultural Psychiatry*, *40*(2), 239–247. https://doi.org/10.1177/1363461503402006

Kitanaka, J. (2008). Diagnosing suicides of resolve: psychiatric practice in contemporary Japan. *Culture, Medicine, and Psychiatry*, *32*(2), 152–176. https://doi.org/10.1007/s11013-008-9087-1

Kitanaka, J. (2016). Depression as a problem of labor: Japanese debates about Work, stress, and a new therapeutic ethos. In J. Wakefield & S. Demazeux (Eds.), *Sadness or depression?. History, Philosophy and Theory of the Life Sciences* (Vol. 15, pp. 55–67). Springer, Dordrecht. https://doi.org/https://doi.org/10.1007/978-94-017-7423-9_5

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press. https://www.ucpress.edu/book/9780520045118/patients-and-healers-in-the-context-of-culture

Kleinman, A. (1987). *Social origins of distress and disease: Depression, neurasthenia, and pain*

in modern China. Yale University Press.

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience.* Free Press.

Kleinman, A. (1995). *Writing at the margin: Discourse between anthropology and medicine*. University of California Press.

Kleinman, A. (1999). Experience and moral modes: Culture, human conditions and disorder. In *The Tanner Lectures* (pp. 357–420).

Kobayashi, D., First, M. B., Shimbo, T., Kanba, S., & Hirano, Y. (2020). Association of self-reported religiosity with the development of major depression in multireligious country Japan. *Psychiatry Clinical Neuroscience*, *74*, 535-541. https://doi.org/10.1111/pcn.13087

Koenig, H., & Larson, D. B. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry*, *13*, 67-78.

Kondo, D. K. (1990). *Crafting selves: Power, gender, and discourses of identity in a Japanese workplace.* University of Chicago Press.

Kondo, N., Sakai, M., Kuroda, Y., Kiyota, Y., Kitabata, Y., & Kurosawa, M. (2013). General condition of hikikomori (prolonged social withdrawal) in Japan: Psychiatric diagnosis and outcome in mental health welfare centres. *International Journal of Social Psychiatry*, *59*(1), 79–86. https://doi.org/10.1177/0020764011423611

Koyama, A., Miyake, Y., Kawakami, N., Tsuchiya, M., Tachimori, H., & Takeshima, T. (2010). Lifetime prevalence, psychiatric comorbidity and demographic correlates of "hikikomori" in a community population in Japan. *Psychiatry Research*, *176*(1), 69–74. https://doi.org/10.1016/j.psychres.2008.10.019

Krahn, G. L., & Eisert, D. (2000). *Qualitative methods in clinical psychology* (pp. 145–164). Springer US. https://doi.org/10.1007/978-1-4615-4165-3_7

Krys, K., Vignoles, V. L., de Almeida, I., & Uchida, Y. (2022). Outside the "Cultural Binary": Understanding why Latin American collectivist societies foster independent selves. *Perspectives on Psychological Science*, *17*(4), 1166–1187. https://doi.org/10.1177/17456916211029632

Kudo Grabosky, T., Ishii, H., & Mase, S. (2012). The development of the counseling profession in Japan: Past, present, and future. In *Journal of Counseling and Development* (Vol. 90, Issue 2, pp. 221–226). Wiley Blackwell. https://doi.org/10.1111/j.1556-

6676.2012.00027.x

Kudo Grabosky, T., Ishii, H., & Mase, S. (2015). Counseling in Japan. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling around the world: An international handbook* (pp. 97–106). Alexandria, VA: American Counseling Association. https://doi.org/10.1002/9781119222736.ch11

Kumaraswamy, N. (2007). Psychotherapy in Brunei Darussalam. *Journal of Clinical Psychology*, *63*(8), 735–744. https://doi.org/10.1002/JCLP.20388

Kuo, B. C. H. , Kwantes, C. T. , Towson, S. , & Nanson, K. M. (2006). Social beliefs as determinants of attitudes toward seeking professional psychological help among ethnically diverse university students. *Canadian Journal of Counselling and Psychotherapy*, *40*(4).

Kvaale, E. P., Gottdiener, W. H., & Haslam, N. (2013). Biogenetic explanations and stigma: A meta-analytic review of associations among laypeople. *Social Science & Medicine*, *96*, 95–103. https://doi.org/10.1016/j.socscimed.2013.07.017

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics*, *33*(1), 159–174. https://about.jstor.org/terms

Larkings, J. S., & Brown, P. M. (2018). Do biogenetic causal beliefs reduce mental illness stigma in people with mental illness and in mental health professionals? A systematic review. *International Journal of Mental Health Nursing*, *27*(3), 928–941. https://doi.org/10.1111/inm.12390

Lauber, C., Carlos, N., & Wulf, R. (2005). Lay beliefs about treatments for people with mental illness and their implications for antistigma strategies. *Canadian Journal of Psychiatry*, *50*(12), 745–752. https://doi.org/10.1177/070674370505001203

Lebowitz, M. S., & Appelbaum, P. S. (2019). Biomedical explanations of psychopathology and their implications for attitudes and beliefs about mental disorders. *Annual Review of Clinical Psychology*, *15*(1), 555–577. https://doi.org/10.1146/annurev-clinpsy-050718-095416

Lebra, T. S. (1976). *Japanese patterns of behavior.* University of Hawaii Press.

Lebra, T. S. (1992). Self in Japanese Culture. In N. R. Rosenberger (Ed.), *Japanese Sense of Self* (pp. 105–120). Cambridge University Press.

Lee, J., & Sue, S. (2001). Clinical Psychology and Culture. In D. Matsumoto (Ed.), *The*

Handbook of Culture & Psychology (pp. 287–308). Oxford University Press.

Lee, O. E., & Ryu, S. (2018). Effects of pride and Regret on geriatric depression: A Cross-cultural study with mixed-methods approaches. *The International Journal of Aging and Human Development*, *86*(2), 152–171. https://doi.org/10.1177/0091415017697726

Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research (MHSR) Mental Health Services Research*, *3*(4). https://doi.org/10.1023/a:1013177014788.

Li, T. M. H., & Wong, P. W. C. (2015). Editorial Perspective: Pathological social withdrawal during in adolescence: A culture-specific or a global phenomenon? *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *56*(10), 1039–1041. https://doi.org/10.1111/jcpp.12440

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public Health*, *89*(9), 1328–1333. https://doi.org/10.2105/AJPH.89.9.1328

Lock, M. (1981). Japanese psychotherapeutic systems: On acceptance and responsibility. *Culture, Medicine and Psychiatry*, *5*(3), 303–312. https://doi.org/10.1007/BF00050773/METRICS

Loo, P.-W., Wong, S., & Furnham, A. (2012). Mental health literacy: A cross-cultural study from Britain, Hong Kong and Malaysia. *Asia-Pacific Psychiatry*, *4*(2), 113–125. https://doi.org/10.1111/j.1758-5872.2012.00198.x

Loughman, A., & Haslam, N. (2018). Neuroscientific explanations and the stigma of mental disorder: a meta-analytic study. *Cognitive Research: Principles and Implications*, *3*(1), 1–12. https://doi.org/10.1186/S41235-018-0136-1/TABLES/3

Markova, V., & Sandal, G. M. (2016). Lay explanatory models of depression and preferred coping strategies among Somali refugees in Norway. A mixed-method Study. *Frontiers in Psychology*, *7*(SEP), 1435. https://doi.org/10.3389/fpsyg.2016.01435

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, *98*(2), 224–253. https://doi.org/10.1037/0033-295X.98.2.224

Markus, H. R., & Kitayama, S. (2010). Cultures and selves: A cycle of mutual constitution.

Perspectives on Psychological Science, *5*(4), 420–430. https://doi.org/10.1177/1745691610375557/ASSET/IMAGES/LARGE/10.1177_1745691610375557-FIG2.JPEG

Marsella, A. J., & Yamada, A. M. (2007). Culture and psychopathology: Foundations, issues, and directions. In S. Kitayama & D. Cohen (Eds.), *Handbook of Cultural Psychology* (pp. 797–818). Guilford Press.

Maruyama, H. (2018). A chūgakkō sukūru kaunseringu ni okeru seito no "hairiyasusa" to "igokochi no yosa" ni kansuru kankyō shinrigakuteki shiten de no katsudō [An Environmental Psychological Approach to Entering into and Being Comfortable in the Counseling Room of a Junior High School]. *Junshin Journal of Human Studies*, *24*, 127–136.

Maruyama, K. (2016). Kōnin shinri-shi hō no seisaku keisei・kettei katei - Nihon rinshō shinri-shi-kai no dōkō o chūshin ni - [Policy making process of the certified public psychologists act in Japan]. *Nagoya Journal of Higher Education*, *16*, 133–154.

Mason, M. F., & Morris, M. W. (2010). Culture, attribution and automaticity: a social cognitive neuroscience view. *Social Cognitive and Affective Neuroscience*, *5*(2–3), 292–306. https://doi.org/10.1093/SCAN/NSQ034

Masuda, T., Ellsworth, P. C., Mesquita, B., Leu, J., Tanida, S., & Van de Veerdonk, E. (2008). Placing the face in context: Cultural differences in the perception of facial emotion. *Journal of Personality and Social Psychology*, *94*(3), 365–381. https://doi.org/10.1037/0022-3514.94.3.365

Miles, M. B., Huberman, A. M., & Saldaña, Johnny. (2014). *Qualitative data analysis : a methods sourcebook*. SAGE Publications.

Ministry of Health, Labour, and Welfare of Japan. (2010). *Hikikomori no hyōka shien ni kansuru gaidorain [Guideline of hikikomori for their evaluations and supports]*.

Ministry of Health, Labour, and Welfare of Japan. (2014). Karōshi-tō bōshi taisaku suishin-hō [Act Promoting Measures to Prevent Death and Injury from Overwork]. In *Law No. 100 of 2014*. https://www.mhlw.go.jp/content/11200000/000509751.pdf

Ministry of Health, Labour, and Welfare of Japan. (2016). *Karōshi-tō bōshi taisaku hakusho. [White Paper on Preventive Measures against Overwork-Related Deaths]*. https://www.mhlw.go.jp/wp/hakusyo/karoushi/16/dl/16-1.pdf

Ministry of Health, Labour, and Welfare of Japan. (2020). *Karōshi-tō no rōsai hoshō jōkyō. [Status of Industrial Accident Compensation for Karoshi]*. https://www.mhlw.go.jp/stf/newpage_11975.html

Ministry of Health, Labour, and Welfare of Japan. (2021). *Kōsei-rōdō-shō Reiwa 2-nendo Shōgai-sha Sōgō Fukushi Suishin Jigyō Kōnin Shinrishinin no Katsudō Jōkyō-tō ni Kansuru Chōsa Hōkokusho [Report on the Activities and Status of Certified Public Psychologists in the Ministry of Health, Labour and Welfare's Comprehensive Disability Welfare Promotion Project for Fiscal Year 2020 (Reiwa 2)]*. Ministry of Health, Labour, Welfare.

Miyamoto, Y., & Kitayama, S. (2002). Cultural variation in correspondence bias: The critical role of attitude diagnosticity of socially constrained behavior. *Journal of Personality and Social Psychology*, *83*(5), 1239–1248. https://doi.org/10.1037/0022-3514.83.5.1239

Montgomery, A. A., & Fahey, T. (2001). How do patients' treatment preferences compare with those of clinicians? *Quality and Safety in Health Care*, *10*(Supplement 1), i39–i43. https://doi.org/10.1136/qhc.0100039

Morita, S. (1998). *Morita therapy and the true nature of anxiety-based disorders (Sehinkeishitsu)*. State University of New York Press.

Na, S, Ryder, A. G., & Kirmayer, L. J. (2016). Toward a culturally responsive model of mental health literacy: Facilitating help-seeking among East Asian immigrants to North America. *American Journal of Community Psychology*, *58*, 211-25. https://doi.org/10.1002/ajcp.12085

Nakamura, K. (2013). *A disability of the soul: An ethnography of schizophrenia and mental illness in contemporary Japan*. Cornell University Press.

Nakane, Y., Jorm, A. F., Yoshioka, K., Christensen, H., Nakane, H., & Griffiths, K. M. (2005). Public beliefs about causes and risk factors for mental disorders: a comparison of Japan and Australia. *BMC Psychiatry*, *5*(1), 33. https://doi.org/10.1186/1471-244X-5-33

Narikiyo, T. A., & Kameoka, V. A. (1992). Attributions of mental illness and judgments about help seeking among Japanese-American and White American students. *Journal of Counseling Psychology*, *39*(3), 363–369.

Nielsen, M., Haun, D., Kärtner, J., & Legare, C. H. (2017). The persistent sampling bias in developmental psychology: A call to action. *Journal of Experimental Child Psychology*,

162, 31–38. https://doi.org/10.1016/j.jecp.2017.04.017

Nippoda, Y. (2012). Japanese culture and therapeutic relationship. *Online Readings in Psychology and Culture*, *10*(3). https://doi.org/10.9707/2307-0919.1094

Nishimura, K. (2019). Psychotherapy in Japan. In M. Schouler-Ocak & M. C. Kastrup (Eds.), *Intercultural Psychotherapy: For Immigrants, Refugees, Asylum Seekers and Ethnic Minority Patients* (pp. 331–347). Springer International Publishing. https://doi.org/10.1007/978-3-030-24082-0_23

Nissen-Lie, H. A., Monsen, J. T., & Rønnestad, M. H. (2010). Therapist predictors of early patient-rated working alliance: A multilevel approach. *Psychotherapy Research*, *20*(6), 627–646. https://doi.org/10.1080/10503307.2010.497633

Nissen-Lie, H. A., Monsen, J. T., Ulleberg, P., & Rønnestad, M. H. (2013). Psychotherapists' self-reports of their interpersonal functioning and difficulties in practice as predictors of patient outcome. *Psychotherapy Research*, *23*(1), 86–104. https://doi.org/10.1080/10503307.2012.735775

Nissen-Lie, H. A., Rønnestad, M. H., Høglend, P. A., Havik, O. E., Solbakken, O. A., Stiles, T. C., & Monsen, J. T. (2017). Love Yourself as a Person, Doubt Yourself as a Therapist? *Clinical Psychology & Psychotherapy*, *24*(1), 48–60. https://doi.org/10.1002/cpp.1977

Norasakkunkit, V., & Uchida, Y. (2014). To conform or to maintain self-consistency? Hikikomori risk in Japan and the deviation from seeking harmony. *Journal of Social and Clinical Psychology*, *33*(10), 918–935. https://doi.org/10.1521/jscp.2014.33.10.918

Norasakkunkit, V., Uchida, Y., & Toivonen, T. (2012). Caught Between Culture, Society, and Globalization: Youth Marginalization in Post-industrial Japan. *Social and Personality Psychology Compass*, *6*(5), 361–378. https://doi.org/10.1111/j.1751-9004.2012.00436.x

Norbeck, E., & Lock, M. (1987). *Health, illness, and medical care in Japan: Cultural and social dimensions* (E. Norbeck & M. Lock, Eds.). University of Hawaii Press.

Norenzayan, A., Choi, I., & Nisbett, R. E. (2002). Cultural similarities and differences in social inference: Evidence from behavioral predictions and lay theories of behavior. *Personality and Social Psychology Bulletin*, *28*(1), 109–120. https://doi.org/10.1177/0146167202281010

Nozue, T. (2018). Kōnin shinri-shi no yōsei o meguru kadai - Rinshō shinri-shi to no hikaku kara - [Problems and issues around training certified professional psychologists-compared

with clinical psychologists]. *Annual Report of the Meiji Gakuin Institute for Psychological Research*, 43–48.

Ogura, M., Okada, K., Hamada, S., Asaga, R., & Honjo, S. (2012). Ijime in Japan. *International Journal of Adolescent Medicine and Health*, *24*(1), 69–76. https://doi.org/10.1515/ijamh.2012.010

Okamura, K., Ikeshita, K., Kimoto, S., Makinodan, M., & Kishimoto, T. (2021). Suicide prevention in Japan: Government and community measures, and high-risk interventions. *Asia-Pacific Psychiatry*, *13*(3), e12471. https://doi.org/10.1111/APPY.12471

Okuno, M. (2020). Iryō genba ni okeru chīmu shien ni tsuite no taido keisei purosesu - Rinshō shinri-shi o taishō to shita intabyū chōsa no kentō kara - [The process through which attitude formation on support team in the clinical environment from the interview surveys toward certified clinical psychologists]. *Bulletin of Department of Humanities and Social Sciences, Iwate University*, *107*, 1–17.

Ono, Y., Awata, S., Iida, H., Ishida, Y., Ishizuka, N., Iwasa, H., Kamei, Y., Motohashi, Y., Nakagawa, A., Nakamura, J., Nishi, N., Otsuka, K., Oyama, H., Sakai, A., Sakai, H., Suzuki, Y., Tajima, M., Tanaka, E., Uda, H., … Watanabe, N. (2008). A community intervention trial of multimodal suicide prevention program in Japan: A Novel multimodal community intervention program to prevent suicide and suicide attempt in Japan, NOCOMIT-J. *BMC Public Health*, *8*. https://doi.org/10.1186/1471-2458-8-315

Onwuegbuzie, A., & Leech, N. (2015). Enhancing the interpretation of significant findings: The role of mixed methods research. *The Qualitative Report*, *9*(4), 770–792. https://doi.org/10.46743/2160-3715/2004.1913

Pelling, N. (2004). Counselling psychology: Diversity and commonalities across the Western World. *Counselling Psychology Quarterly*, *17*(3), 239–245. https://doi.org/10.1080/09515070412331317611

Peluso, E. T. P., & Blay, S. L. (2008). Public perception of alcohol dependence. *Revista Brasileira de Psiquiatria*, *30*(1), 19–24. https://doi.org/10.1590/S1516-44462008000100004

Peluso, E. T. P., & Blay, S. L. (2009). Public stigma in relation to individuals with depression. *Journal of Affective Disorders*, *115*(1–2), 201–206. https://doi.org/10.1016/j.jad.2008.08.013

Peluso, E. T. P., Cló, de A. P., & Blay, L. S. (2008). Public conceptions of schizophrenia in urban Brazil. *Social Psychiatry and Psychiatric Epidemiology*, *43*(10), 792–799. https://doi.org/10.1007/s00127-008-0372-7

Peng, K., & Nisbett, R. E. (1999). Culture, dialectics, and reasoning about contradiction. *American Psychologist*, *54*(9), 741–754. https://doi.org/10.1037/0003-066X.54.9.741

Pereira-Sanchez, V., Alvarez-Mon, M. A., Asunsolo del Barco, A., Alvarez-Mon, M., & Teo, A. (2019). Exploring the Extent of the Hikikomori phenomenon on Twitter: Mixed methods study of Western language tweets. *Journal of Medical Internet Research*, *21*(5), e14167. https://doi.org/10.2196/14167

Pescosolido, B. A. (1992). Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology*, *97*(4), 1096–1138. https://doi.org/10.1086/229863

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? a decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry*, *167*(11), 1321–1330. https://doi.org/10.1176/appi.ajp.2010.09121743

Petty, S., Dening, T., Griffiths, A., & Coleston, D. M. (2019). Importance of personal and professional experience for hospital staff in person-centred dementia care: a cross-sectional interview study using freelisting in a UK hospital ward. *BMJ Open*, *9*(4), e025655. https://doi.org/10.1136/bmjopen-2018-025655

Purzycki, B. G., & Jamieson-Lane, A. (2017). AnthroTools: An R package for cross-cultural ethnographic data analysis. *Cross-Cultural Research*, *51*, 51–74. https://doi.org/10.1177/1069397116680352

Puthillam, A. (2023). Too WEIRD, too fast? Preprints about COVID-19 in the psychological sciences. *Collabra: Psychology*, *9*(1). https://doi.org/10.1525/collabra.74331

Quinn, N., & Holland, D. (1987). Culture and cognition. In D. Holland & N. Quinn (Eds.), *Cultural models in language and thought* (pp. 3–40). Cambridge, England: Cambridge University Press. https://doi.org/10.1017/CBO9780511607660.002

Rad, M. S., Martingano, A. J., & Ginges, J. (2018). Toward a psychology of Homo sapiens : Making psychological science more representative of the human population. *Proceedings of the National Academy of Sciences*, *115*(45), 11401–11405. https://doi.org/10.1073/pnas.1721165115

Ratanasuwan, T., Indharapakdi, S., Promrerk, R., Komolviphat, T., & Thanamai, Y. (2005). Health belief model about diabetes mellitus in Thailand: The culture consensus analysis. *Journal of the Medical Association of Thailand*, *88*, 623–631.

Reavley, N. J., Mackinnon, A. J., Morgan, A. J., & Jorm, A. F. (2014). Stigmatising attitudes towards people with mental disorders: A comparison of Australian health professionals with the general community. *Australian & New Zealand Journal of Psychiatry*. https://doi.org/10.1177/0004867413500351

Revelle, M. (2021). *psych: Procedures for Psychological, Psychometric, and Personality Research*. Evanston, IL: Northwestern University. Available at: http://CRAN.R-project.org/package=psych

Rhee, E., Uleman, J. S., Lee, H. K., & Roman, R. J. (1995). Spontaneous self-descriptions and ethnic identities in individualistic and collectivistic cultures. *Journal of Personality and Social Psychology*, *69*(1), 142–152. https://doi.org/10.1037/0022-3514.69.1.142

Richardson, J. T. E. (1996). *Handbook of qualitative research methods for psychology and the social sciences.* British Psychological Society.

Roberts, S. O., Bareket-Shavit, C., Dollins, F. A., Goldie, P. D., & Mortenson, E. (2020). Racial inequality in psychological research: trends of the past and recommendations for the future. *Perspectives on Psychological Science*, *15*(6), 1295–1309. https://doi.org/10.1177/1745691620927709

Romney, A. K. (1999). Culture consensus as a statistical model. *Current Anthropology*, *40*(Supplement: Special Issue: Culture. A Second Chance?), S103. https://doi.org/10.1086/200063

Romney, A. K., Batchelder, W. H., & Weller, S. C. (1987). Recent applications of cultural consensus theory. *American Behavioral Scientist*, *31*(2), 163–177. https://doi.org/10.1177/000276487031002003

Romney, A. K., Weller, S. C., & Batchelder, W. H. (1986). Culture as consensus: A theory of culture and informant accuracy. *American Anthropologist, 88*, 313-338. https://doi.org/10.1525/aa.1986.88.2.02a00020

Rønnestad Oren, R., Roe, D., Hasson-Ohayon, I., Roth, S., Thomas, E. C., & Zisman-Ilani, Y. (2021). Beliefs about the causes of psychosis among persons with psychosis and mental health Professionals: A scoping review. *Psychiatric Services*, *72*(10), 1178–1192.

https://doi.org/10.1176/appi.ps.202000460

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development*, *30*(1), 5–44. https://doi.org/10.1177/089484530303000102

Rusch, L. C., Kanter, J. W., Brondino, M. J., Weeks, C. E., & Bowe, W. M. (2010). Biomedical stigma reduction programs produce negative but transient effects on a depressed low-income community sample. *Journal of Social and Clinical Psychology*, *29*(9), 1020–1030. https://doi.org/10.1521/jscp.2010.29.9.1020

Ryder, A. G., & Dere, J. (2010). Canadian diversity and clinical psychology: Defining and transcending "Cultural Competence." *Monitor*, *1*(35). www.cap.ab.ca.

Ryder, A. G., Ban, L. M., & Chentsova-Dutton, Y. E. (2011). Towards a cultural-clinical psychology. *Social and Personality Psychology Compass*, *5*, 960–975. https://doi.org/10.1111/j.1751-9004.2011.00404.x

Ryder, A. G., Doucerain, M. M., Zhou, B., Dere, J., Jurcik, T., & Zhou, X. (2021). On dynamic contexts and unstable categories: Steps towards a cultural-clinical psychology. In *Advances in culture and psychology* (Vol. 8). https://www.oxfordhandbooks.com/

Ryder, A. G., Yang, J., & Heine, S. J. (2002). Somatization vs. psychologization of emotional distress: A paradigmatic example for cultural psychopathology. *Online Readings in Psychology and Culture*, *10*(2). https://doi.org/10.9707/2307-0919.1080

Saint Arnault, D., & Woo, S. (2018). Testing the influence of cultural determinants on help-seeking theory. *American Journal of Orthopsychiatry*, *88*(6), 650–660. https://doi.org/10.1037/ort0000353

Saito, T. (1998). *Shakai-teki hikikomori owaranai shishunki [Hikikomori: Adolescence without End]*. PHP Shinsho.

Sakai, M., Yokoyama, K., Yoshida, S., Ide, S., & Nagata, M. (2020). Kodomo no shinri ryōhō ni okeru butsuteki kankyō no settei - Daigakuin fuzoku sōdanshitsu no jittai o fumaeta kentō - [Choosing the physical environment in child psychotherapy - A study on the actual condition of the counseling room of the graduate school -]. *Bulletin of the Graduate School of Education and Human Development, Nagoya University*, *67*, 23–35. https://doi.org/10.18999/nupsych.67.1.3

Satake, K. (2017). Rinshō shinri mensetsu ni okeru shoki no kankei keisei no tame no kakawari

ni kansuru kenkyū [A study of a therapist's behavior on initial relationship formation in psychotherapy]. *Kyusyu University Psychological Research*, *18*, 45–52. https://doi.org/10.15017/2228885

Sato, T. (2007). Rises and falls of clinical psychology in Japan: A 9erspective on the status of Japanese clinical psychology. *Ritsumeikan Journal of Human Sciences*, *13*, 133–144.

Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social Science & Medicine*, *67*(9), 1370–1381. https://doi.org/10.1016/j.socscimed.2008.07.007

Schnittker, J., Freese, J., Powell, B., Artis, W., Lutfey, K., Pavalko, E., Steelman, L., & Stryker, S. (2000). Nature, nurture, neither, nor: Black–White differences in beliefs about the causes and appropriate treatment of mental illness. *Social Forces*, *78*(3). https://doi.org/https://doi.org/10.2307/3005943

Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M. G., & Angermeyer, M. C. (2011). The stigma of alcohol dependence compared with other mental disorders: a review of population studies. *Alcohol and Alcoholism*, *46*(2), 105–112. https://doi.org/0.1093/alcalc/agq089

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *125*(6), 440–452. https://doi.org/10.1111/J.1600-0447.2012.01826.X

Schrauf, R. W., & Sanchez, J. (2008). Using freelisting to identify, assess, and characterize age differences in shared cultural domains. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *63*(6), S385–S393. https://doi.org/10.1093/geronb/63.6.S385

Schröder, T. A., & Davis, J. D. (2004). Therapists' experience of difficulty in practice. *Psychotherapy Research*, *14*(3), 328–345. https://doi.org/10.1093/ptr/kph028

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, *19*, 137–155. https://doi.org/10.1080/09540260701278929

Sears, D. O. (1986). College sophomores in the laboratory: Influences of a narrow data base on social psychology's view of human nature. *Journal of Personality and Social*

Psychology, *51*(3), 515–530. https://doi.org/10.1037/0022-3514.51.3.515

Sechrest, L., & Sidani, S. (1995). Quantitative and qualitative methods: Is there an alternative? *Evaluation and Program Planning*, *18*(1), 77–87. https://doi.org/10.1016/0149-7189(94)00051-X

Segall, M. H., Campbell, D. T., & Herskovits, M. J. (1963). Cultural Differences in the perception of geometric illusions. *Science*, *139*(3556), 769–771. https://doi.org/10.1126/science.139.3556.769

Segalowitz, N. S., Doucerain, M. M., Meuter, R. F. I., Zhao, Y., Hocking, J., & Ryder, A. G. (2016). Comprehending adverbs of doubt and certainty in health communication: A multidimensional scaling approach. *Frontiers in Psychology*, *7*, 558. https://doi.org/10.3389/fpsyg.2016.00558

Shimoyama, H. (2002). On the developmental task of clinical psychology in Japan. *Bulletin of the Graduate School of Education, the University of Tokyo*, *41*, 273–281.

Shimoyama, H. (2011). Clinical psychology in Japan: Toward integration inside and recognition from outside. In H. Shimoyama (Ed.), *An international comparison ofclinical psychology in practice: West meets east* (pp. 56–68). Kazama Publishing.

Shore, B. (1996). *Culture in mind: Cognition, culture, and the problem of meaning.* Oxford University Press.

Shwartz, S. H. (1994). Beyond individualism/collectivism: new cultural dimensions of values. In U. Kim, H. C. Triandis, Ç. Kâğitçibaşi, S.-C. Choi, & G. Yoon (Eds.), *Individualism and Collectivism: Theory, Method, and Applications* (pp. 85–119). SAGE Publications.

Shweder, R. (1991). Cultural psychology: What is it? In *Thinking through cultures* (pp. 73–110). Harvard University Press.

Skovholt, T. M., & Rønnestad, M. H. (2003). Struggles of the novice counselor and therapist. *Journal of Career Development*, *30*(1), 45–58. https://doi.org/10.1177/089484530303000103

Smith, C. S., Morris, M., Hill, W., Francovich, C., McMullin, J., Chavez, L., & Rhoads, C. (2004). Cultural consensus analysis as a tool for clinic improvements. *Journal of General Internal Medicine*, *19*, 514–518. https://doi.org/10.1111/j.1525-1497.2004.30061.x

Smith, J., & Borgatti, S. P. (1998). Salience Counts-And So Does Accuracy: Correcting and Updating a Measure for Free-List-Item Salience. *Journal of Linguistic Anthropology*,

7(2), 208–209. https://doi.org/https://doi.org/10.1525/jlin.1997.7.2.208

Smith, P. B., & Bond, M. H. (2022). Four decades of challenges by culture to mainstream psychology: finding ways forward. *Journal of Cross-Cultural Psychology*, *53*(7–8), 729–751. https://doi.org/10.1177/00220221221084041

Spencer-Rodgers, J., Williams, M. J., & Peng, K. (2012). Culturally based lay beliefs as a tool for understanding intergroup and intercultural relations. *International Journal of Intercultural Relations*, *36*(2), 169–178. https://doi.org/10.1016/j.ijintrel.2012.01.002

Stuber, J. P., Rocha, A., Christian, A., & Link, B. G. (2014). Conceptions of mental illness: Attitudes of mental health professionals and the general public. *Psychiatric Services*, *65*(4), 490–497. https://doi.org/10.1176/appi.ps.201300136

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*(4), 533–540. https://doi.org/10.1037/0022-006X.59.4.533

Sunohara, M., Sasaki, J., Kogo, S., & Ryder, A. G. (2022). Japanese clinical psychologists' consensus beliefs about mental health: A mixed-methods approach. *Japanese Psychological Research*, *64*(2), 109–126. https://doi.org/10.1111/jpr.12410

Sunohara, M., Sasaki, J., Kogo, S., Muranaka, S., Sakamoto, S., Thériault, A., Horigiuchi, M., & Ryder, A. G. (n.d.). A cross-cultural examination of explanatory models of mental illness: A mixed-methods study of causal and help-seeking beliefs among Japanese and Euro-Canadian students. (under review)

Suzuki, T., & Sasaki, J. (2019). Rinshō shinri mensetsu ni okeru kaunserā no kōkateki na jiko kaiji ― kuraiento no kitai to iu shiten kara ― [Effective self-disclosure of counselor in counseling: considering clients' expectations]. *Japanese Journal of Counseling Science*, *51*, 145156.

Tajan, N. (2015). Japanese post-modern social renouncers: An exploratory study of the narratives of Hikikomori subjects. *Subjectivity*, *8*(3), 283–304. https://doi.org/10.1057/sub.2015.11

Takahata, T. (2003). Saitama-ken ni okeru 'hikikomori' no jittai [A survey of withdrawal syndrome in Saitama Prefecture]. *Seishin Igaku* , *45*(3), 299–302.

Takasugi, H. (2022). Cognitive Behavioral Therapy in Japan. In M. Terjesen & K. Doyle (Eds.),

Cognitive Behavioral Therapy in a Global Context (pp. 327–342). Springer International Publishing. https://doi.org/10.1007/978-3-030-82555-3_21

Tanaka-Matsumi, J. (2022). Counseling across cultures: A Half-century assessment. *Journal of Cross-Cultural Psychology*, *53*(7–8), 957–975. https://doi.org/10.1177/00220221221111810

Tanaka-Matsumi, J., & Draguns, J. G. (1997). Culture and psychopathology. In J. W. Berry, M. H. Segall, & C. Kagitcßibasi (Eds.), *Handbook of Cross-Cultural Psychology: Social Behavior and Applications* (2nd ed., pp. 449–491). Allyn & Bacon.

Tanoue, A., Ito, D., Shimizu, K., Ohno, M., Shirai, M., Shimada, H., & Suzuki, S. (2012). Utsu byō kyūshoku-sha ni taisuru shinri-shoku ni yoru shūdan ninchi kōdō ryōhō no kōka ichi utsu shōjō, shakai kinō, shokuba fukki no konnankan no shiten kara ichi] Cognitive behavioral group therapy for employees on sick leave due to depression]. *Japanese Association of Behavioral and Cognitive Therapies*, *38*(3), 193–202.

Tashakkori, A., & Teddlie, C. (2010). *SAGE Handbook of Mixed Methods in Social & Behavioral Research*. SAGE Publications. https://doi.org/10.4135/9781506335193

Tashakkori, A., Teddlie, C., & Sines, M. C. (2012). Utilizing mixed methods in psychological research. In *Handbook of Psychology, Second Edition* (pp. 438–450). John Wiley & Sons, Inc. https://doi.org/10.1002/9781118133880.hop202015

Tashakkori, A., Teddlie, C., & Sines, M. C. (2013). Utilizing mixed methods in psychological research. *Handbook of Psychology, Research Methods in Psychology*, 438–450. https://doi.org/10.1002/9781118133880.hop202015

Tata, S. P., & Leong, F. T. L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counseling Psychology*, *41*(3), 280. https://doi.org/10.1037/0022-0167.41.3.280

Tateno, M., Park, T. W., Kato, T., Umene-Nakano, W., & Saito, T. (2012). Hikikomori as a possible clinical term in psychiatry: A questionnaire survey. *BMC Psychiatry*, *12*, 1. https://doi.org/10.1186/1471-244X-12-169

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research : integrating quantitative and qualitative approaches in the social and behavioral sciences*. SAGE Publications.

Ten Have, M., De Graaf, R., Ormel, J., Vilagut, G., Kovess, V., & Alonso, J. (2010). Are attitudes towards mental health help-seeking associated with service use? Results from the European study of epidemiology of mental disorders. *Social Psychiatry and Psychiatric Epidemiology*, *45*(2), 153–163. https://doi.org/10.1007/s00127-009-0050-4

The Association of Japanese Clinical Psychology. (n.d.). *What is The Association of Japanese Clinical Psychology*. (In Japanese, title translated by the author of this article.) Retrieved May 15h, 2021, from https://www.ajcp.info/?page_id=2

Timans, R., Wouters, P., & Heilbron, J. (2019). Mixed methods research: what it is and what it could be. *Theory and Society*, *48*(2), 193–216. https://doi.org/10.1007/S11186-019-09345-5/FIGURES/2

Toivonen, T., Norasakkunkit, V., & Uchida, Y. (2011). Unable to conform, unwilling to rebel? Youth, culture, and motivation in globalizing Japan. *Frontiers in Psychology*, *2*(SEP), 207. https://doi.org/10.3389/fpsyg.2011.00207

Treml, J. N. (2001). Bullying as a social malady in contemporary Japan. *International Social Work*, *44*(1), 107–117. https://doi.org/10.1177/002087280104400109

Triandis, H. C., & Gelfand, M. J. (1998). Converging measurement of horizontal and vertical individualism and collectivism. *Journal of Personality and Social Psychology*, *74*(1), 118–128. https://doi.org/10.1037/0022-3514.74.1.118

Tsai, J. L., Knutson, B., & Fung, H. H. (2006). Cultural variation in affect valuation. *Journal of Personality and Social Psychology*, *90*(2), 288–307. https://doi.org/10.1037/0022-3514.90.2.288

Tse, J. S. Y., & Haslam, N. (2021). Inclusiveness of the concept of mental disorder and differences in help-seeking between Asian and White Americans. *Frontiers in Psychology*, *12*, 3221. https://doi.org/10.3389/FPSYG.2021.699750/BIBTEX

Uchida, Y., & Kitayama, S. (2009). Happiness and unhappiness in east and west: Themes and variations. *Emotion*, *9*(4), 441–456. https://doi.org/10.1037/a0015634

Uchida, Y., Norasakkunkit, V., & Kitayama, S. (2004). Cultural constructions of happiness: theory and empirical evidence. *Journal of Happiness Studies*, *5*(3), 223–239. https://doi.org/10.1007/s10902-004-8785-9

Ueno, M. (2010). Rinshō shinri-shi no shibō dōki no chigai to shinri rinshō katsudō ni okeru taiken ni tsuite no katari to no kankei [Counseling students' motives and struggles in

practice]. *Meiji Gakuin University Graduate School Bulletin of Psychology*, *15*, 9–26.

Vargas, S. M., Dere, J., Garcia, L., & Ryder, A. G. (2019). The role of cultural values in the folk psychiatry explanatory framework: A comparison of Chinese- and Euro-Canadians. *Journal of Cross-Cultural Psychology*, *50*(5), 703–707. https://doi.org/10.1177/0022022119836517

Walsh, D. A. B., & Foster, J. L. H. (2021). A call to action. A critical review of mental health related anti-stigma campaigns. *Frontiers in Public Health*, *8*. https://doi.org/10.3389/fpubh.2020.569539

Wan, C., Chiu, C. Y., Peng, S., & Tam, K. P. (2007). Measuring cultures through intersubjective cultural norms: Implications for predicting relative identification with two or more cultures. *Journal of Cross-Cultural Psychology, 38*(2), 213–226. https://doi.org/10.1177/0022022106297300

Wedding, D. (2007). An international perspective on psychotherapy. *Journal of Clinical Psychology*, *63*(8), 785–790. https://doi.org/10.1002/jclp.20394

Weller, S. C. (2007). Cultural consensus theory: Applications and frequently asked questions. *Field Methods*, *19*, 339–368. https://doi.org/10.1177/1525822X07303502

Weller, S. C., & Baer, R. (2002). Measuring within- and between-group agreement: Identifying the proportion of shared and unique beliefs across samples. *Field Methods*, *14*, 6–25. https://doi.org/10.1177/1525822X02014001002

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services: A complementary perspective. *American Psychologist*, *62*(6), 563–574. https://doi.org/10.1037/0003-066X.62.6.563

Winkielman, P., Halberstadt, J., Fazendeiro, T., & Catty, S. (2006). Prototypes are attractive because they are easy on the mind. *Psychological science*, *17*, 799-806. https://doi.org/10.1111/j.1467-9280.2006.01785.x

Wong, Y. J., Tran, K. K., Kim, S.-H., Van Horn Kerne, V., & Calfa, N. A. (2010). Asian Americans' lay beliefs about depression and professional help seeking. *Journal of Clinical Psychology*, *66*(3), 317–332. https://doi.org/10.1002/jclp.20653

Yamauchi, T., Yoshikawa, T., Takamoto, M., Sasaki, T., Matsumoto, S., Kayashima, K., Takeshima, T., & Takahashi, M. (2017). Overwork-related disorders in Japan: recent trends and development of a national policy to promote preventive measures. *Industrial*

Health, *55*(3), 293–302. https://doi.org/10.2486/indhealth.2016-0198

Yeap, R., & Low, W. Y. (2009). Mental health knowledge, attitude and help-seeking tendency: A Malaysian context. *Singapore Medical Journal*, *50*(12), 1169.

Yeh, K.-H. (2003). The beneficial and harmful effects of filial piety: An integrative analysis. In K. Yang, K. Hwang, P. Pedersen, & I. Daibo (Eds.), *Progress in Asian Social Psychology: Conceptual and Empirical Contributions* (pp. 67–82). Praeger Publishers/Greenwood Publishing Group.

Yoshida, N. (2020). Gakusei sōdanshitsu ni okeru supīchi puraibashī no hogo ni kansuru kankyō shinrigakuteki kenkyū [Experimental study on ensuring speech privacy in student counseling rooms]. *Journal of the Faculty of Education Kogakkan University*, *3*, 99–106.

Yoshimi, M., & Kasai, M. (2010). Chiryō dōmei to mensetsu hyōka ni eikyō o oyobosu serapisuto-gawa no yōin: Gakusei serapisuto o taishō to shita naiteki sagyō moderu to kuraiento han'ō hyōtei o mochiite [Therapists' attributions with regard to therapeutic alliance and session evaluation: Based on internal working model and client response]. *Journal for the Science of Schooling at Hyogo University of Teacher Education*, *11*, 27–37. https://iss.ndl.go.jp/books/R100000002-I000000161169-00

Yu, K., Liang, J., Tung, Y. H., Zhang, M., Wu, S., & Chi, I. (2023). Social network and mental health of Chinese immigrants in affordable senior housing during the COVID-19 pandemic: a mixed-methods study. *Aging and Mental Health*. https://doi.org/10.1080/13607863.2023.2213646

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Appendix A: Materials Used for Manuscript 1

1-1-K. Please read each of the following statements carefully. After you have read the statement below, circle a number that best depicts you.

K is having great difficulty getting through each day. She has lost interest in the daily activities she used to enjoy and prefers to stay at home and be by herself. When family and friends come to visit they find her crying, dressed in her pajamas in the middle of the day. When friends ask what's wrong she says she "doesn't know"; that she "just doesn't feel so good". She has trouble sleeping, often tossing and turning throughout the night. Because of this she is constantly exhausted. When friends say she looks sad, she says that she is. She says she is sad almost all the time. When she's not sad she feels angry and irritable. She says she feels like she's a burden on her loved ones. She thinks that her loved ones would be better off without her. She can't see how her situation might improve in the future or what she might do to improve it. Her friends worry that she might try to hurt herself.

1 2 3 4 5 6 7 Totally False Neutral Exactly True	
1. I have watched a movie or television show in which a character depicted a person like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
2. My job involves providing services/treatment for persons like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
3. I have observed, in passing, a person like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
4. I have observed persons like K on a frequent basis.	1 – 2 – 3 – 4 – 5 – 6 – 7
5. I have something like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
6. I have worked with a person like K at my place of employment.	1 – 2 – 3 – 4 – 5 – 6 – 7
7. I have never observed a person like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
8. My job includes providing services to person like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
9. A friend of the family is like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
10. I have a relative like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
11. I have watched a documentary on the television about a person like K.	1 – 2 – 3 – 4 – 5 – 6 – 7
12. I live with a person like K.	1 – 2 – 3 – 4 – 5 – 6 – 7

1-2-K. Please describe your opinion for the following questions:

1. Why does K behave the way K does?

2. How could K recover and thrive?

3. How could these problems have been prevented?

2-1-T. Please read the following statements carefully. After you have read the statement below, circle a number that best depicts you.

T is a 25-year-old male living with his parents and younger sister. For the past 4 years, he has refused to see his parents and he has spent his life in his own bedroom. He went to university to study economics, but he dropped out of university when he was 21. At first, his parents thought he was sick, so they took him to see several doctors, but brain imaging and neurocognitive tests revealed no issues. He was quiet during those assessments. He spends all day in his room, eats food in a tray prepared and left by his mother outside his bedroom. When he returns the tray, he leaves a small note listing things he needs his mother to buy and deliver to his door. He sleeps during the day and wakes up in the evening. While he's awake, he spends his time surfing the internet, chatting on online bulletin boards, reading comic books, watching videos and movies, and playing online games. His academic performance was relatively good until high school, but he occasionally skipped school because he avoided interacting with his peers after an incident when he was bullied by his classmates. His parents don't know what to do about the situation, and try to support him by providing food and things he needs.

1 2 3 4 5 6 7 Totally False Neutral Exactly True	
1. I have watched a movie or television show in which a character depicted a person like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
2. My job involves providing services/treatment for persons like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
3. I have observed, in passing, a person like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
4. I have observed persons like T on a frequent basis.	1 – 2 – 3 – 4 – 5 – 6 – 7
5. I have something like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
6. I have worked with a person like T at my place of employment.	1 – 2 – 3 – 4 – 5 – 6 – 7
7. I have never observed a person like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
8. My job includes providing services to person like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
9. A friend of the family is like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
10. I have a relative like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
11. I have watched a documentary on the television about a person like T.	1 – 2 – 3 – 4 – 5 – 6 – 7
12. I live with a person like T.	1 – 2 – 3 – 4 – 5 – 6 – 7

2-2-T. Please describe your opinion for the following questions:

1. Why does T behave the way T does?

2. How could T recover and thrive?

3. How could these problems have been prevented?

3-1-C. Please read the following statements carefully. After you have read the statement below, circle a number that best depicts you.

C has become increasingly withdrawn. He is suspicious of people including family and close friends. He spends all day alone in his bedroom because he believes people are "out to get him". He rarely eats food prepared by his family because he fears that it may be poisoned. His mother often hears him talking in his room. At first she thought there must be someone in there with him but soon realised that he was alone. When asked about his behaviour he becomes angry and upset. His mother worries he may try to hurt someone. Although he confides in few people, he complains about, "the voices". He says the voices argue about him. They say that he is "queer". They say that he is "hopeless" and that his girlfriend doesn't love him. He says the music he listens to contain hidden messages just for him. The messages tell him to kill himself.

1 2 3 4 5 6 7 Totally False Neutral Exactly True	
1. I have watched a movie or television show in which a character depicted a person like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
2. My job involves providing services/treatment for persons like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
3. I have observed, in passing, a person like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
4. I have observed persons like C on a frequent basis.	1 – 2 – 3 – 4 – 5 – 6 – 7
5. I have something like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
6. I have worked with a person like C at my place of employment.	1 – 2 – 3 – 4 – 5 – 6 – 7
7. I have never observed a person like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
8. My job includes providing services to person like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
9. A friend of the family is like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
10. I have a relative like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
11. I have watched a documentary on the television about a person like C.	1 – 2 – 3 – 4 – 5 – 6 – 7
12. I live with a person like C.	1 – 2 – 3 – 4 – 5 – 6 – 7

3-2-C. Please describe your opinion for the following questions:

1. Why does C behave the way C does?

2. How could C recover and thrive?

3. How could these problems have been prevented?

4-1-O. Please read the following statements carefully. After you have read the statement below, circle a number that best depicts you.

O's behavior has changed over the last 6 months. He stopped showing up at work because he gets hangover from drinking too much and cannot get up in the morning. Although he has tried to stop drinking at first, and he thinks it's better not to drink, he feels he cannot sleep well if he does not drink alcohol. While his wife helps with the family-owned business at home during the day, he is often absent from home, but he goes out to a bar nearby to get drinks everyday. His wife has told him to stop drinking, but he's been drinking a lot more than before so he can get drunk to feel good and sleep well. Sometimes he does not even remember how he got home because he drank too much. When the alcoholic drinks run out at home, he even starts feeling anxious and agitated. He and his wife got in an argument when he tried to steal money from her wallet to buy more alcohol. His wife wants him to stay sober and go back to work.

1 2 3 4 5 6 7 Totally False Neutral Exactly True	
1. I have watched a movie or television show in which a character depicted a person like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
2. My job involves providing services/treatment for persons like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
3. I have observed, in passing, a person like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
4. I have observed persons like O on a frequent basis.	1 – 2 – 3 – 4 – 5 – 6 – 7
5. I have something like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
6. I have worked with a person like O at my place of employment.	1 – 2 – 3 – 4 – 5 – 6 – 7
7. I have never observed a person like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
8. My job includes providing services to person like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
9. A friend of the family is like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
10. I have a relative like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
11. I have watched a documentary on the television about a person like O.	1 – 2 – 3 – 4 – 5 – 6 – 7
12. I live with a person like O.	1 – 2 – 3 – 4 – 5 – 6 – 7

4-2-O. Please describe your opinion for the following questions:

1. Why does O behave the way O does?

2. How could O recover and thrive?

3. How could these problems have been prevented?

5-1-D. Please read the following statements carefully. After you have read the statement below, circle a number that best depicts you.

D feels lonely at university these days. He reports never having made friends throughout school because he can't carry a conversation with his classmates. He's always liked reading picture books about cars and traffic signs and remembered them very well ever since he was a child. He maintains relatively good grades at school, but he often forgets his belongings in lecture halls. As a child, he played only with his elder brother and a few friends, or by himself. He has often argued with his friends when they don't seem to get his jokes, and he's good at remembering the exact phrases people have said to him. He likes to dress in a somewhat old-fashioned and bizarre manner. He speaks very fast in a monotone voice, making him more difficult to understand.

1 2 3 4 5 6 7 Totally False Neutral Exactly True	
1. I have watched a movie or television show in which a character depicted a person like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
2. My job involves providing services/treatment for persons like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
3. I have observed, in passing, a person like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
4. I have observed persons like D on a frequent basis.	1 – 2 – 3 – 4 – 5 – 6 – 7
5. I have something like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
6. I have worked with a person like D at my place of employment.	1 – 2 – 3 – 4 – 5 – 6 – 7
7. I have never observed a person like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
8. My job includes providing services to person like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
9. A friend of the family is like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
10. I have a relative like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
11. I have watched a documentary on the television about a person like D.	1 – 2 – 3 – 4 – 5 – 6 – 7
12. I live with a person like D.	1 – 2 – 3 – 4 – 5 – 6 – 7

5-2-D. Please describe your opinion for the following questions:

1. Why does D behave the way D does?

2. How could D recover and thrive?

3. How could these problems have been prevented?

問題１． 以下の文章をよく読んでください。

Ｋさんは日々をやり過ごすのに大きな困難を感じている。彼女はかつて楽しいと感じていた日常の活動への興味を失い、一人で自宅にいること好んでいる。彼女の家族や友人が彼女の家を訪ねると、日中にパジャマを着たままで泣いている彼女の姿を見た。彼女の友人たちが「なにかあったの？」と尋ねると、彼女は「わからない。ただ、気分が晴れない。」と言う。彼女はなかなか寝付けず、一晩中何度も寝返りをうつ。そのため、彼女は絶えず疲れ切っている。彼女の友人たちが「なんだか悲しんでいるように見える。」と言うと、彼女は「そう、悲しい。」と答える。彼女は「ほとんどいつも悲しい。」とさえ言う。彼女が悲しいと感じていないときは、苛立ち、怒りを感じている。彼女は、自らが彼女の周りの大切な人たちの重荷になっているように感じると言う。彼女は、彼らの周りに自分がいない方が良いとさえ思っている。彼女は、今後、この状態がどのように改善されるのか、または彼女自身何をすれば改善するのか見いだせない。彼女の友人たちは、彼女が自分自身を傷付けてしまうのではないかと心配している。

問題１―１．つぎに，Ｋさんについて，以下の文章をすべてよく読んでください。すべての文章を読み終えた後，右の１～７の選択肢から当てはまるものを一つ選び，その選択肢に○をつけてください。	全くその通りだ	当てはまる	やや当てはまる	どちらとも言えない	あまり当てはまらな	当てはまらない	全く当てはまらない
１．Ｋさんのような人を描写したキャラクターが出てくる映画やテレビを見たことがある。	１―２―３―４―５―６―７						
２．Ｋさんのような人に対してサービスや治療を提供する仕事・アルバイトについている。	１―２―３―４―５―６―７						
３．Ｋさんかもしれないと思うような人を，通りがかりに見たことがある。	１―２―３―４―５―６―７						
４．Ｋさんのような人を見たことが何回もある。	１―２―３―４―５―６―７						
５．私はＫさんのようである。	１―２―３―４―５―６―７						
６．職場やアルバイト先で，Ｋさんのようになった人と働いたことがある。	１―２―３―４―５―６―７						
７．Ｋさんだと思うような人を見たことがない。	１―２―３―４―５―６―７						
８．現在おこなっている仕事やアルバイトの内容の一部には，Ｋさんのような人に対するサービスの提供が含まれている。	１―２―３―４―５―６―７						
９．家族ぐるみの友人に，Ｋさんのような人がいる。	１―２―３―４―５―６―７						
１０．親類の中に，Ｋさんのような人がいる。	１―２―３―４―５―６―７						
１１．Ｋさんのような人を扱ったドキュメンタリーをテレビで見たことがある。	１―２―３―４―５―６―７						
１２．Ｋさんのような人と一緒に生活している。	１―２―３―４―５―６―７						

問題Ⅰ―2．つぎに，Kさんについて，以下の質問に文章で記述して答えてください。

Ⅰ―2―1．Kさんはなぜこのようなふるまいをしていると思いますか？

Ⅰ―2―2．Kさんはどうすれば回復し，より健やかになると思いますか？

Ⅰ―2―3．Kさんのこのような不調は，どうしたら防げたと思いますか？

問題 2. 以下の文章をよく読んでください。

Tさんは25歳の男性だ。この４年の間、両親と顔を合わせることを拒み、自分の部屋に毎日こもって過ごして来た。彼は大学に通っていたが、２１歳のときに退学した。彼は一日中部屋にこもり、母が部屋の外に食事をお盆にのせておいてくれるのを食べて過ごしている。お盆を部屋の外に出すときには、小さなメモを残して母に買ってきてほしいものを伝える。日中は寝て過ごし、夕方起きる生活を続けている。起きている間は、ネットサーフィンをしたり、SNSを利用したり、漫画を読んだり、ビデオや映画を観賞したり、オンラインゲームをしたりして過ごす。高校までの学業成績は比較的良かったが、クラスメートによるいじめを受けて以来、彼は同級生らと関わることを避けるために、時おり学校を休んでいた。彼の両親はこの状況をどうして良いかわからず、食事や彼の欲しい物を与えることで彼をサポートしようとしている。

問題 2—1．つぎに，Tさんについて，以下の文章をすべてよく読んでください。すべての文章を読み終えた後，右の１～７の選択肢から当てはまるものを一つ選び，その選択肢に○をつけてください。	全くその通りだ	当てはまる	やや当てはまる	どちらとも言えない	あまり当てはまらな	当てはまらない	全く当てはまらない
1．Tさんのような人を描写したキャラクターが出てくる映画やテレビを見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
2．Tさんのような人に対してサービスや治療を提供する仕事・アルバイトについている。	1 — 2 — 3 — 4— 5 — 6 — 7						
3．Tさんかもしれないと思うような人を，通りがかりに見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
4．Tさんのような人を見たことが何回もある。	1 — 2 — 3 — 4— 5 — 6 — 7						
5．私はTさんのようである。	1 — 2 — 3 — 4— 5 — 6 — 7						
6．職場やアルバイト先で，Tさんのようになった人と働いたことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
7．Tさんだと思うような人を見たことがない。	1 — 2 — 3 — 4— 5 — 6 — 7						
8．現在おこなっている仕事やアルバイトの内容の一部には，Tさんのような人に対するサービスの提供が含まれている。	1 — 2 — 3 — 4— 5 — 6 — 7						
9．家族ぐるみの友人に，Tさんのような人がいる。	1 — 2 — 3 — 4— 5 — 6 — 7						
10．親類の中に，Tさんのような人がいる。	1 — 2 — 3 — 4— 5 — 6 — 7						
11．Tさんのような人を扱ったドキュメンタリーをテレビで見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
12．Tさんのような人と一緒に生活している。	1 — 2 — 3 — 4— 5 — 6 — 7						

問題 2―2．つぎに，Tさんについて，以下の質問に文章で記述して答えてください。

2―2―1．Tさんはなぜこのようなふるまいをしていると思いますか？

2―2―2．Tさんはどうすれば回復し，より健やかになると思いますか？

2―2―3．Tさんのこのような不調は，どうしたら防げたと思いますか？

問題 3. 以下の文章をよく読んでください。

Cさんはこの頃ますます引きこもるようになった。彼は、家族や親しい友人など、人という人を疑っている。彼は一日中、ひとりで自分の部屋で過ごす。というのは、“外にいる人が自分を捕まえようとしている”と信じて疑わないからだ。家族が用意した食べ物でも毒が盛られていることを恐れ、ほとんど口にしない。部屋の中で誰かと話しているのを母親は頻繁に耳にしている。最初のうちは部屋の中に誰かがいると思っていたが、すぐにひとりだということに母親は気がついた。母親が彼にそのことを尋ねると、彼は腹を立てて動揺する。母親は、彼が誰かを傷つけてしまうのではないかと心配している。彼にも信頼できる人は数人いる。しかし彼は“複数の声”について不満を言う。“複数の声”が彼に言い争いをしかけてくるのだ。声は彼のことを“変わり者だ”と言う。また、“どうしようもない人間”で、交際相手は彼のことなど愛していないと言う。彼が聞く音楽には自分だけに宛てたメッセージが隠されていると彼は語る。そのメッセージは彼に自殺せよと言っていると言う。

問題 3—1．つぎに，Cさんについて，以下の文章をすべてよく読んでください。すべての文章を読み終えた後，右の1～7の選択肢から当てはまるものを一つ選び，その選択肢に○をつけてください。	全くその通りだ	当てはまる	やや当てはまる	どちらとも言えない	あまり当てはまらな	当てはまらない	全く当てはまらない
1．Cさんのような人を描写したキャラクターが出てくる映画やテレビを見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
2．Cさんのような人に対してサービスや治療を提供する仕事・アルバイトについている。	1 — 2 — 3 — 4— 5 — 6 — 7						
3．Cさんかもしれないと思うような人を，通りがかりに見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
4．Cさんのような人を見たことが何回もある。	1 — 2 — 3 — 4— 5 — 6 — 7						
5．私はCさんのようである。	1 — 2 — 3 — 4— 5 — 6 — 7						
6．職場やアルバイト先で，Cさんのようになった人と働いたことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
7．Cさんだと思うような人を見たことがない。	1 — 2 — 3 — 4— 5 — 6 — 7						
8．現在おこなっている仕事やアルバイトの内容の一部には，Cさんのような人に対するサービスの提供が含まれている。	1 — 2 — 3 — 4— 5 — 6 — 7						
9．家族ぐるみの友人に，Cさんのような人がいる。	1 — 2 — 3 — 4— 5 — 6 — 7						
10．親類の中に，Cさんのような人がいる。	1 — 2 — 3 — 4— 5 — 6 — 7						
11．Cさんのような人を扱ったドキュメンタリーをテレビで見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
12．Cさんのような人と一緒に生活している。	1 — 2 — 3 — 4— 5 — 6 — 7						

問題 3―2．つぎに，Cさんについて，以下の質問に文章で記述して答えてください。

3―2―1．Cさんはなぜこのようなふるまいをしていると思いますか？

3―2―2．Cさんはどうすれば回復し，より健やかになると思いますか？

3―2―3．Cさんのこのような不調は，どうしたら防げたと思いますか？

問題 4. 以下の文章をよく読んでください。

Oさんの行動は、この６ヶ月で変わった。彼は飲み過ぎて二日酔いになることが増え、朝起きられず、自営業の仕事場にも行かなくなった。最初のうちはお酒を飲まないほうが良いと思い、やめようと努力していたが、飲まないと眠れないと感じるようになった。妻が昼間に仕事を手伝ってくれる間、留守にすることが多い。それどころか、近所のお店でお酒を飲んでいる。妻はお酒をやめるように言ってはいるが、うまくいっていない仕事の憂さ晴らしとよく眠るために、前よりもお酒の量が増えた。どうやって家に帰ったのかさえ覚えてないほど、大量の酒をバーで飲むことも多い。もしお酒を飲むことができないと、不安になってイライラしはじめる。妻の財布から酒を買うために金を盗もうとしたことで、言い争いになったことさえある。妻は彼が酒をやめて仕事へ復帰することを願っている。

問題 4—1．つぎに，Oさんについて，以下の文章をすべてよく読んでください。すべての文章を読み終えた後，右の１～７の選択肢から当てはまるものを一つ選び，その選択肢に○をつけてください。	全くその通りだ	当てはまる	やや当てはまる	どちらとも言えない	あまり当てはまらな	当てはまらない	全く当てはまらない
1．Oさんのような人を描写したキャラクターが出てくる映画やテレビを見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
2．Oさんのような人に対してサービスや治療を提供する仕事・アルバイトについている。	1 — 2 — 3 — 4— 5 — 6 — 7						
3．Oさんかもしれないと思うような人を，通りがかりに見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
4．Oさんのような人を見たことが何回もある。	1 — 2 — 3 — 4— 5 — 6 — 7						
5．私はOさんのようである。	1 — 2 — 3 — 4— 5 — 6 — 7						
6．職場やアルバイト先で，Oさんのようになった人と働いたことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
7．Oさんだと思うような人を見たことがない。	1 — 2 — 3 — 4— 5 — 6 — 7						
8．現在おこなっている仕事やアルバイトの内容の一部には，Oさんのような人に対するサービスの提供が含まれている。	1 — 2 — 3 — 4— 5 — 6 — 7						
9．家族ぐるみの友人に，Oさんのような人がいる。	1 — 2 — 3 — 4— 5 — 6 — 7						
10．親類の中に，Oさんのような人がいる。	1 — 2 — 3 — 4— 5 — 6 — 7						
11．Oさんのような人を扱ったドキュメンタリーをテレビで見たことがある。	1 — 2 — 3 — 4— 5 — 6 — 7						
12．Oさんのような人と一緒に生活している。	1 — 2 — 3 — 4— 5 — 6 — 7						

問題 4―2．つぎに，Oさんについて，以下の質問に文章で記述して答えてください。

4―2―1．Oさんはなぜこのようなふるまいをしていると思いますか？

4―2―2．Oさんはどうすれば回復し，より健やかになると思いますか？

4―2―3．Oさんのこのような不調は，どうしたら防げたと思いますか？

問題 5. 以下の文章をよく読んでください。

Dさんは大学生活に孤独を感じている。彼は、人付き合いが苦手で、人と会話をうまく続けられないため、今までの学校生活で友達ができたことがない、と語る。車と道路標識についての図鑑を読むことがずっと好きで、子供の頃から内容を非常に鮮明に覚えている。物事の名前を覚えたりするのは得意で、そのおかげで今まで比較的好成績を維持してきたが、彼は大学の講義室に忘れ物をしたり、授業の予定を忘れたりすることが多い。大学では周りの人に合わせるのが好きではなく、あらかじめ誰かに注意されていないと、間違ったことをしてしまったり、発言したときに“場の空気を読めない“と言われたりする。また、人の言ったことを勘違いして傷ついたり、“冗談が通じない”と言われたりすることが多い。自分はあまり人から好かれていないのでは、と彼は思っている。

問題 5—1．つぎに，Dさんについて，以下の文章をすべてよく読んでください。すべての文章を読み終えた後，右の1～7の選択肢から当てはまるものを一つ選び，その選択肢に○をつけてください。	全くその通りだ	当てはまる	やや当てはまる	どちらとも言えない	あまり当てはまらな	当てはまらない	全く当てはまらない
1．Dさんのような人を描写したキャラクターが出てくる映画やテレビを見たことがある。	1—2—3—4—5—6—7						
2．Dさんのような人に対してサービスや治療を提供する仕事・アルバイトについている。	1—2—3—4—5—6—7						
3．Dさんかもしれないと思うような人を，通りがかりに見たことがある。	1—2—3—4—5—6—7						
4．Dさんのような人を見たことが何回もある。	1—2—3—4—5—6—7						
5．私はDさんのようである。	1—2—3—4—5—6—7						
6．職場やアルバイト先で，Dさんのようになった人と働いたことがある。	1—2—3—4—5—6—7						
7．Dさんだと思うような人を見たことがない。	1—2—3—4—5—6—7						
8．現在おこなっている仕事やアルバイトの内容の一部には，Dさんのような人に対するサービスの提供が含まれている。	1—2—3—4—5—6—7						
9．家族ぐるみの友人に，Dさんのような人がいる。	1—2—3—4—5—6—7						
10．親類の中に，Dさんのような人がいる。	1—2—3—4—5—6—7						
11．Dさんのような人を扱ったドキュメンタリーをテレビで見たことがある。	1—2—3—4—5—6—7						
12．Dさんのような人と一緒に生活している。	1—2—3—4—5—6—7						

問題 5―2．つぎに，Dさんについて，以下の質問に文章で記述して答えてください。

5―2―1．Dさんはなぜこのようなふるまいをしていると思いますか？

5―2―2．Dさんはどうすれば回復し，より健やかになると思いますか？

5―2―3．Dさんのこのような不調は，どうしたら防げたと思いますか？

Appendix B: Materials Used for Manuscript 2 & 3

フリーリスト記述　（Free-listing Questions）

I.　以下の質問ではあなたの（１）**心理士として**の立場・観点からの考えを順番にお伺いします。まずはじめに、以下の項目について、６～１０個、（１）**心理士として**あなた自身の頭に浮かび上がったり、思いついた、または他の心理士が思い浮かべそうな単語やフレーズを簡潔に書き出してください。１問だいたい３分程度で回答してくだい。

A. うつ病の原因
B. うつ病による影響・症状
C. うつ病から回復するために必要なこと

II.　以下の質問では**クライエントと心理士の関係性について**お伺いします。**必ずしもあなたの個人的な考え、実際に経験したことである必要はありません。あなたがほかで見たり聞いたりした話や、ストーリーから想定される答えでもかまいません。（例えば、クライエントがシェアした過去の経験、他の心理士から聞いた話、など）。**

A. **心理士が**抱く考えや信念で、クライエントとのラポールを築く上で妨げとなるものがあるとしたら、どのようなものがありますか？
B. **クライエントが**抱く考えや信念で、心理士との共同作業で妨げとなるものはどんなものがありますか？
C. **クライエントと心理士以外の外的要因で**、クライエントと心理士間の関係にネガティブな影響を与えるものはどんなものが考えられますか？
D. 心理士とクライエントの関係の中で、ミスマッチや不一致が発生したとき、心理士ははどうやって対処しますか？

III.　以下の質問では日本社会のメンタルヘルスについてお聞きします。

A. 一般の人のメンタルヘルスに対する考えや信念に影響を与えている・及ぼしているものはなんだと思いますか？
B. 日本におけるメンタルヘルス教育、システム、関連政策に欠けている点、改革するべき点はどんなことがあると思いますか？