CHAPTER CITATION:

Ryff, C. D., Love, G. D., Miyamoto, Y., Markus, H. R., Curhan, K. B., Kitayama, S., Park, J., Kawakami, N., Kan, C., & Karasawa, M. (2014). Culture and the promotion of well-being in East and West: Understanding varieties of attunement to the surrounding context. In G. A. Fava & C. Ruini (Eds.), *Increasing psychological well-being in clinical and education settings: Interventions and cultural contexts*. New York: Springer. doi:10.1007/978-94-017-8669-0

Cross-Cultural Advancements in Positive Psychology

Volume 8

Series Editor:

ANTONELLA DELLE FAVE
Università degli studi di Milano, Italy

Editorial Board:

MARTIN E.P. SELIGMAN
Positive Psychology Center, University of Pennsylvania, USA
MIHALY CSIKSZENTMIHALYI
Quality of Life Research Center, Claremont Graduate University, USA
BARBARA L. FREDRICKSON
University of North Carolina at Chapel Hill, USA
ALAN WATERMAN
The College of New Jersey, USA
ROBERT A. EMMONS
University of California, Davis, USA

The aim of the *Cross Cultural Advancements in Positive Psychology* book series is to spread a universal and culture-fair perspective on good life promotion. The series will advance a deeper understanding of the cross-cultural differences in well-being conceptualization. A deeper understanding can affect psychological theories, interventions and social policies in various domains, from health to education, from work to leisure. Books in the series will investigate such issues as enhanced mobility of people across nations, ethnic conflicts and the challenges faced by traditional communities due to the pervasive spreading of modernization trends. New instruments and models will be proposed to identify the crucial components of well-being in the process of acculturation. This series will also explore dimensions and components of happiness that are currently overlooked because happiness research is grounded in the Western tradition, and these dimensions do not belong to the Western cultural frame of mind and values.

For further volumes:
http://www.springer.com/series/8420

Giovanni Andrea Fava • Chiara Ruini
Editors

Increasing Psychological Well-being in Clinical and Educational Settings

Interventions and Cultural Contexts

Editors
Giovanni Andrea Fava
Department of Psychology
University of Bologna
Bologna, Italy

Chiara Ruini
Department of Psychology
University of Bologna
Bologna, Italy

ISSN 2210-5417 ISSN 2210-5425 (electronic)
ISBN 978-94-017-8668-3 ISBN 978-94-017-8669-0 (eBook)
DOI 10.1007/978-94-017-8669-0
Springer Dordrecht Heidelberg New York London

Library of Congress Control Number: 2014933803

© Springer Science+Business Media Dordrecht 2014
This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed. Exempted from this legal reservation are brief excerpts in connection with reviews or scholarly analysis or material supplied specifically for the purpose of being entered and executed on a computer system, for exclusive use by the purchaser of the work. Duplication of this publication or parts thereof is permitted only under the provisions of the Copyright Law of the Publisher's location, in its current version, and permission for use must always be obtained from Springer. Permissions for use may be obtained through RightsLink at the Copyright Clearance Center. Violations are liable to prosecution under the respective Copyright Law.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
While the advice and information in this book are believed to be true and accurate at the date of publication, neither the authors nor the editors nor the publisher can accept any legal responsibility for any errors or omissions that may be made. The publisher makes no warranty, express or implied, with respect to the material contained herein.

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Foreword

In the past decades, psychological well-being has achieved a prominent role in the biopsychosocial consideration of the dynamic balance between health and disease. Early pioneers were physicians and scientists embracing the psychosomatic approach. George Engel defined etiologic factors as "factors which either place a burden on, or limit the capacity of systems concerned with growth, development or adaptation" (Engel 1960, p. 473). In 1987, Aaron Antonovsky introduced the salutogenic approach, which called for a focus on resources for health and health-promoting processes. He described a state of health and well-being, characterized by the presence of competence, internal and external resources and active use of coping strategies. The Ottawa Charter (1986) declared that health promotion is the process of enabling the individuals to increase control over and to improve their health, in order to reach a state of complete physical, mental and social well-being. This means that individuals all over the world should be able to identify and realize aspirations, as well as to satisfy needs and cope with their environment. Ryff and Singer (1998) proposed the concept of 'positive human health', which refers to a comprehensive – holistic – consideration of health, where stressors but also positive resources are taken into account. Accordingly, health is maintained by good health habits (i.e. good nutrition, regular physical activity, no smoking, nor use of drugs and other risky habits) and by the presence of emotional and psychological well-being.

Psychological well-being, by a biological viewpoint, was found to display a protective role as to the vulnerability to illness. By a psychological viewpoint, the growing awareness of the limited degree of remission that current symptom-oriented therapeutic strategies of mental disorders entail, has underscored the need of shifting the emphasis on increasing the positive. By a social viewpoint, the role of psychological well-being in determining the true wealth of a nation and in addressing disparities in health risks has emerged.

All these issues converged inside the Positive Psychology movement, founded by Martin Seligman in 2000. As President of the American Psychological Association, he declared that the future mission for psychology research was the scientific study of all factors in human existence that contribute to, and are

9 **Well-being and Resilience in School Settings** 135
Toni Noble and Helen McGrath

10 **Strength Based Resilience: Integrating Risk and Resources Towards Holistic Well-being** 153
Tayyab Rashid, Afroze Anjum, Ron Chu, Suzanna Stevanovski, Anosha Zanjani, and Carolyn Lennox

11 **School Programs for the Prevention of Mental Health Problems and the Promotion of Psychological Well-being in Children** 177
Dalila Visani, Elisa Albieri, and Chiara Ruini

12 **The Promotion of Hope in Children and Youth** 187
Susana C. Marques and Shane J. Lopez

13 **Life Satisfaction in Youth** 199
Carmel Proctor and P. Alex Linley

Chapter 1
Culture and the Promotion of Well-being in East and West: Understanding Varieties of Attunement to the Surrounding Context

Carol D. Ryff, Gayle D. Love, Yuri Miyamoto, Hazel Rose Markus, Katherine B. Curhan, Shinobu Kitayama, Jiyoung Park, Norito Kawakami, Chiemi Kan, and Mayumi Karasawa

1.1 Introduction

The purpose of this chapter is to examine scientific findings on cultural differences in the experience of psychological well-being, as gleaned from a series of studies comparing adults from Japan and the U.S. These investigations, drawn primarily from our own prior work, point to notably distinct cultural formulations in what constitutes well-being, accompanied by differences in the factors thought to promote it. We then provide a brief summary of differences between Japan and the U.S. in

C.D. Ryff (✉)
Institute on Aging/Department of Psychology, University of Wisconsin-Madison, Madison, WI, USA
e-mail: cryff@wisc.edu

G.D. Love
Institute on Aging, University of Wisconsin-Madison, Madison, WI, USA

Y. Miyamoto
Institute on Aging, University of Wisconsin-Madison, Madison, WI, USA

H.R. Markus • K.B. Curhan
Department of Psychology, Stanford University, Stanford, CA, USA

S. Kitayama • J. Park
Department of Psychology, University of Michigan, Ann Arbor, MI, USA

N. Kawakami • C. Kan
Graduate School of Medicine, University of Tokyo, Hongo, Bunkyo, Tokyo, Japan

M. Karasawa
Department of Communications, Tokyo Women's Christian University, Zenpukuji, Suginami, Tokyo, Japan

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8, DOI 10.1007/978-94-017-8669-0_1, © Springer Science+Business Media Dordrecht 2014

what comprises psychological ill-being; that is, the nature of mental illness occurring in both contexts. Emphasis is given to cultural differences in prevalence of major psychological disorders. These contrasting formulations of well-being and ill-being provide the background for considering clinical practices intended to treat emotional distress in the two cultural contexts. We examine a limited number of intervention strategies to illustrate differences between Eastern and Western approaches to helping people regain emotional well-being. A conclusion emerging from this work is that positive and negative emotions are construed in notably distinct ways in Japan and the U.S. Not surprisingly, such differences shape the goals and practices of clinicians seeking to promote optimal functioning. The larger message emerging from our research as a whole is that cultural contexts shape ideal formulations of human well-being as well as the practices designed to promote them. We offer several closing observations, including the need to foster greater communication and interplay between these domains and disciplines, which do not often intersect enough with each other, and the hope that cultures might learn more from each other based on in-depth understanding of their respective strengths and weaknesses.

1.2 Culture and Well-being in East and West

1.2.1 Guiding Conceptions

Over the last decade extensive scientific attention has been devoted to the question of whether and how the experience of well-being differs across cultures (Diener and Suh 2000; Kitayama and Markus 2000). Going back several decades, a U.S. review of the correlates of happiness emphasized a variety of qualities including being young, educated, healthy, wealthy, optimistic, intelligent and having self-esteem (Wilson 1967). Kitayama and Markus (2000) questioned the relevance of these findings for other cultural contexts. Drawing on distinctions between two different models of self and social relationships, they underscored that well-being is likely to be enhanced by *attunement to one's surrounding cultural context.* In the West, where the individual is viewed as an active, independent agent influencing other people, well-being is viewed as personal and individual in scope and thus is associated with self-esteem and the pursuit of one's own happiness. This formulation was contrasted with an Eastern conception of well-being that is more relational, intersubjective and collective in scope. The person in the latter context is as an interdependent agent who must adjust to other people in both a proactive and contingent manner. Well-being is thus related to self-criticism and personal discipline, both of which give rise to feelings of sympathy to and from others.

In the West, the individual is commonly viewed as an active, independent agent who is relatively separate from both the physical and social environment. This independence is realized by expressing and promoting one's interests and goals, often through influencing others. Well-being from this perspective is understood as

a personal project and is manifest in subjective, positive feelings about the self. In the East, the individual is more commonly understood as a relational and socially responsive agent who is connected with both the physical and social environment. This interdependence is realized by fitting in and by adjusting to the expectations of others and role requirements in specific situations, both of which require a capacity for self-criticism. Well-being from this perspective is thus less a subjective or personal project and depends more on meeting objective or consensually held standards and is thus manifest in maintaining the sympathy and respect of others with whom one is interconnected.

Distinctions between self-enhancement in the U.S. and self-criticism in Japan (Heine et al. 1999), in turn, influence how people describe themselves. In the U.S., self-descriptions are primarily positive, whereas in Japan they tend to be more negative. Similarly, maximizing personal happiness is an avowed goal in the U.S., whereas finding balance and moderation are the ideal objectives in Japan. These contrasting stances underlie the documented differences in the degrees of positivity that are empirically evident among U.S. and Japanese respondents. In contrast to the more honorific self-evaluations in the U.S., self-critical attitudes are prerequisites for well-being in Japan, where sympathy, compassion, adjustment and orientation to others are valued modes of being.

These ideas were elaborated by Uchida et al. (2004). Because happiness in the West is construed as a personal achievement, it requires autonomy and independence, which fuel personal achievements and self-esteem. Individuals reared and living in this cultural and societal context are motivated to maximize their feelings of positive affect. In the East Asian context, happiness is construed in terms of interpersonal connectedness with more embedding of the self in social relationships. It is thus commitment to social roles, social obligations, and readiness to respond to social expectations that are primary. Emotional experience and emotional ideals are, in sum, saturated with cultural meaning.

1.2.2 Minimalist Well-being in Japan

Considering culturally unique meanings of well-being, Kan et al. (2009) put forth a Japanese conception known as "minimalist well-being." The work was motivated by the observation that despite dramatic economic growth in the last half century in East Asian societies – Japan is sometimes referred to as the economic miracle – the country nonetheless seemed to lag far behind other advanced technological societies in psychological health and well-being. Inglehart and Welzel (2005) reported that Japan was the 3rd largest economy in the world at that time, but its mean life satisfaction score was 42nd among 50 countries tested.

One possible explanation for the apparent unhappiness of the Japanese was the possibility of cultural bias in existing instruments for measuring happiness and well-being, most having been developed in the West. For example, Kan et al. (2009) suggested a different conceptualization of well-being derived from

minimalist virtues embedded in a distinct perspective on reality – namely, that it is fundamentally fluid, transitory, and possibly incomprehensible nature. As conveyed by a Japanese respondent, "happiness is something that never lasts long." This formulation of reality gives rise to a different kind of well-being in which one is deeply grateful for the mere fact of existence. Happiness in this construal does not reside in the self, or personal achievements, but in immersion of the self in nothingness, which can lead to feelings of gratitude, calmness and peacefulness (Tsai 2007). These types of low arousal positive emotions are commonly considered ideal affective states in East Asian contexts (in contrast to high arousal positive states like cheerfulness and excitement that are commonly considered ideal affect status in the U.S.) (Tsai 2007).

A further component of Japanese well-being, linked to its historical merger of distinctly Asian philosophical and religious traditions (Confucianism, Taoism, Bushido, Buddhism, Shintoism) is that happiness cannot be accumulated. Additionally, embedded within this perspective are inherent negatives, such as the jealousy of others, or the failure to pay attention to others when one is consumed with happiness. Their minimalist formulation serves as the basis for generating two alternative indicators of well-being. One dimension, labeled gratitude, was measured with items designed to assess appreciation of the mere fact of living, and another, labeled peaceful disengagement, was measured with a focus on finding pleasure and satisfaction in disengaging from a constantly changing, constraining, and confusing world.

In a related effort, Uchida and Kitayama (2009) examined "folk models of emotion" via spontaneously generated descriptions of happiness and unhappiness among Japanese and U.S. respondents. The goal was to probe cultural differences in what people do to attain happiness and avoid unhappiness. Most cultures, they note, prescribe ways of coping with unhappiness, including how people deal with failure and personal problems. This analysis of folk models supported the previously described distinctions between happiness in the U.S., which is regarded primarily as a personal achievement, and happiness in Japan, which is formulated as the realization of social harmony. Consistent with Confucian beliefs in yin and yang, in which positives (happiness) contain negatives (envy, jealousy) within themselves, and also that negatives (unhappiness) contain positives (sympathy, motivation for self-improvement) within themselves, they also found that the Japanese respondents were more likely than Americans to mention social disruption and transcendental reappraisal (avoiding reality, elusive) as features of happiness. When confronted with unhappiness, Americans focused on externalizing behavior (anger, aggression), whereas Japanese were more likely to highlight transcendental reappraisal and self-improvement.

1.2.3 *Dialectical Emotions*

Cultural influences are also prominent in how emotions are experienced and expressed. In the West, Bradburn's (1969) seminal work on positive and negative

affect launched decades of U.S. studies that probed relationships between the two types of affect as well as examining their correlates, antecedents, and consequents. Whether positive and negative emotional experiences are construed similarly across cultures was not part of these early queries, but is a relevant question. If happiness is perceived to be a transitory state and is seen to encompass not only positive but also negative feelings in Japan, people in that context may seek *balance* between the two types of affect rather than try to maximize only one. Stated otherwise, whereas positive and negative emotions are seen as contradictory in U.S. and European cultures, and indeed, are known to be inversely correlated (Schimmack et al. 2002), in East Asian cultures, they are seen as complementary (Kitayama et al. 2000; Peng and Nisbett 1999). The balance between positive and negative emotions seems to have a peculiar role also in clinical settings, as described in details in Chap. 2 of this book.

Building on these ideas, Miyamoto and Ryff (2011) investigated the idea of "dialectical" (i.e., feeling positive *and* negative emotions with similar frequency) and "non-dialectical" (i.e., feeling predominantly positive *or* negative emotion) emotion styles in Japan and the U.S. In dialectical formulations, reality is constantly changing and contradiction is tolerated. This leads to an inclination to find the middle way; that is, to experience balance in positive and negative emotions. They summarized prior literature showing that Westerners show a stronger polarity (inverse correlation) between positive and negative emotions. East Asians, in contrast, are more likely to show the dialectical emotional style (reporting both positive and negative emotions). Their findings clarified that the most common emotional styles in the U.S. was the mostly positive non-dialectical type, followed by the mostly negative non-dialectical type, whereas in Japan, the two most common emotional types were the moderate dialectical type and the mostly positive non-dialectical type. Importantly, these reported profiles were linked to health: the moderate dialectical type was associated with fewer health symptoms in Japan compared to the U.S.

Miyamoto and Ma (2011) extended ideas of dialectical versus non-dialectical cultural scripts via examination of East/West differences in how individuals regulate positive emotion. Such regulation can occur via efforts to increase (up-regulate), maintain, or decrease (down-regulate) positive hedonic emotional experiences. The guiding prediction was that Westerners are more inclined to *savor and augment* (i.e., up-regulate, maintain) positive emotions whereas Easterners are more likely to *dampen* (i.e., down regulate) positive emotions. The findings showed that although most people want to savor rather than dampen their positive emotions, this pattern was less pronounced for East Asian compared to European American respondents. For example, when recalling a positive event, Asians engaged in less savoring than European Americans. In addition, respondents' dialectical beliefs about emotions were found to mediate cultural differences in the regulation of positive emotions. Finally, via examination of on-line reports of emotion regulation strategies, Asians reported feeling less positive compared to negative emotion on the day after a positive event compared to Americans, with these differences also linked to dialectical beliefs about emotional experience. The significance of such findings for broader efforts to promote well-being across cultures is the recognition that the up-regulation or maintenance of positive emotion is not universally endorsed – in some contexts where

cultural beliefs construe happiness and misery as wrapped inextricably to each other, there is less interest in promoting and sustaining exclusively positive feelings.

1.3 Within the West: Hedonic and Eudaimonic Conceptions

The above studies illustrate East-west cultural differences, via comparative data from Japan and the U.S. with regard to what well-being is and how one achieves it. Such broad contrasts, anchored in notably distinct cultural contexts, are accompanied by varying conceptions of well-being *within the Western context.* In the U.S., there is increasing recognition of the distinction between hedonic aspects of well-being (Kahneman et al. 1999), which emphasize feeling good (positive affect, life satisfaction), and eudaimonic conceptions of well-being (Ryan and Deci 2001), which address existential tasks, such as being purposefully engaged in life and experiencing personal growth (Ryff 1989). These broad distinctions are traceable to the ancient Greeks, as evident in differing formulations of positive functioning articulated by Epicurus and Aristotle (see Ryff and Singer 2008).

Current evidence supports the empirical distinction between these two types of well-being (Keyes et al. 2002), each of which has been linked to diverse indices of health (Boehm and Kubzansky 2012; Morozink et al. 2010; Pressman and Cohen 2005; Steptoe et al. 2006). Age differences in both types of well-being have also been documented in Japan and the U.S. (Karasawa et al. 2011). Cross-sectional data revealed age increments, from midlife to old age, in personal growth in Japan, whereas age decrements were evident in the U.S. Adults in both cultures showed an age-related decline in purpose in life, accompanied by age increments in positive affect. As predicted, interpersonal well-being was rated significantly higher, relative to overall well-being, in Japan compared to the U.S.

Overall, the above literatures draw attention to cultural differences in core elements of psychological well-being. Numerous findings, based on comparative samples from Japan and the U.S., underscore the distinction between happiness as an experience of personal achievement and self-esteem in the West, contrasted with happiness as social harmony tied to self-criticism, discipline, and adjusting to others in the East. Minimalist conceptions of well-being in Japan underscore the transitory nature of happiness as well as the gratitude, calm, and peacefulness that can come from immersing oneself in nothingness. A further Eastern theme is the intertwining of positive and negative emotions – that each is embedded within the other. Dialectical emotions, which involve a balanced experience of positive and negative emotions, was emphasized in Eastern contexts, in contrast to the more common bipolar pattern in the West wherein positive and negative affect are inversely related. Finally, in the West, there is growing distinction between hedonic (feeling good) well-being and eudaimonic (striving, pursing goals, making the most of personal talents) aspects of well-being, with both showing linkages to health. In the section below, we address cultural differences in the counterpoint question: namely, what constitutes psychological ill-being. These literatures on well-being and ill-being differ primarily in the valence of the psychological phenomena of interest. Rarely do these two realms intersect.

1.4 Mental Distress: Comparisons Between East and West

Our guiding assumption is that the upside and downside of psychological functioning – that is, distinctions between mental health and mental illness – are inextricably connected. Indeed, when we examine intervention strategies in a subsequent section, we emphasize that efforts to treat psychological disorders are guided, implicitly or explicitly, by what is construed as well-being or good mental health. Before considering such issues, here we examine cultural differences in the nature of psychological disorders, giving primary emphasis to psychiatric epidemiology, as examined across cultural contexts. We maintain our emphasis on Japanese-U.S. comparisons in this review, focusing on the types and prevalence of major mental disorders in the two countries.

1.4.1 Psychiatric Epidemiology: East/West Perspectives

Due to advances in international collaboration, the last decade witnessed novel efforts to assess mental illness around the globe. This inquiry emerged from a universally adopted formulation of mental disorders as described below. Thus, in contrast to the preceding inquiries on culture and well-being, which explicitly addressed how formulations of positive functioning differ by cultural context, scientific research on the prevalence distribution of mental illness across countries has been less attuned to whether the guiding conceptions of emotional distress are themselves culturally-infused, and therefore, potentially distinct, depending on the culture considered. We note, however, some prior consideration given to how cultural context might influence the expression of affective disorders (Kleinman and Good 1985). For example, in collectivist societies, adults may be more likely to express emotional distress through bodily symptoms (somatization) because so doing is less disruptive of social harmony (Kleinman and Kleinman 1985). This earlier anthropologically oriented work is largely absent in more recent efforts to examine psychiatric epidemiology across nations.

Using standardized criteria (developed in the West) to assess mental disorders, we examine below rates of mental disorders in Japan and the U.S. Such findings show higher prevalence of mental disorders in the U.S. compared to Japan. Second, we address other types of mental disorders that may be unique to Japan.

1.4.2 Prevalence of Emotional Disorders in Japan and the U.S.

Kawakami et al. (2005) reported on the 12-month prevalence, severity, and treatment of common mental disorders in Japan, based on face-to-face household surveys conducted in four community populations. Using the World Health Organization

(WHO) Composite International Diagnostic Interview (WMH-CIDI), they found that the prevalence of any disorder in the prior year was 8.8 %, of which 17 % of cases were severe and 47 % were moderate. The most prevalent disorders were anxiety disorders (4.8 %), mood disorders (which includes major depression) (3.1 %), and substance use disorders (1.7 %). Only 19 % of serious or moderate cases received medical treatment in the 12 months before the interview. Overall, greater risk was evident among older and unmarried individuals. Those with higher educational levels were more likely to seek treatment. The findings confirmed the prevalence of mental disorders as equal to that observed in other Asian countries (Beijing, Shanghai), but were lower than seen in Western countries (WHO 2000).

Kessler et al. (2005) generated comparable data from the National Comorbidity Survey in the U.S. They reported the prevalence of any disorder to be 26.2 %, of which 22.3 % were classified as serious and 37.3 % as moderate. The most prevalent disorders were anxiety disorders (18.1 %), mood disorders (which included major depression) (9.5 %), impulse control (8.9 %) and substance use disorders (3.8 %). Thus, at the level of DSM-IV disorders (Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.), the U.S. population has nearly three times as many mental disorders as were reported in Japan, with comparable or greater differences in specific disorders across the two nations.

Interpreting these differences requires taking into account the stigma of mental illness in Japan (Desapriya and Nobutada 2002). Loss of mental control in that cultural context is seen as something over which a person should be able to exercise will power. Thus, Japanese adults may be more likely to feel shame if they lack this power, which may explain why approximately two-thirds of Japanese sufferers are not thought to seek help from professionals. In an attempt to address the problem, the Japanese Society of Psychiatry and Neurology recently changed the name of schizophrenia to help dispel prejudice against people who have the illness, from *seishi bunretsu byo* (split-mind disorder) to *togo shiccho sho* (loss of coordination disorder), according to the 2002 World Congress of Psychology. Framing mental illness in a broader health context, Desapriya and Nobutada (2002) emphasized that mental health disorders are among the leading causes of disease and death in the current world. Specifically, depressive disorders were ranked as the fourth leading cause of global disease burden (Murray and Lopez 1997), with the expectation that they will be ranked second by 2020, only behind ischaemic heart disease.

1.4.3 Other Disorders in Japan

Hikikomori (severe social withdrawal) constitutes another mental health concern in Japan (Kato et al. (2011)), particularly in young people. It has been referred to as "modern-type depression" and is characterized by a shift in values from collectivism to individualism, distress and reluctance to accept prevailing social norms, a vague sense of omnipotence, and avoidance of effort and strenuous work. It seems

to have affected those born after 1970, the generation growing up with high economic growth and many technological and computer resources, including video games. Young people with this type of disorder have trouble adapting to work or school, or participating in the labor market. However, recent epidemiological research shows a low lifetime prevalence of hikikomori (1 %) among Japanese adults (Koyama et al. 2010). Similar cases have been noted in Oman, Korea, and Spain, raising questions as to whether it is a culture-bound syndrome specific to Japan or a new form of maladjustment linked to modernization. Some suggest it may be a form of personal addiction to the attractive features of internet resources and services, which may be an easier alternative to engaging in the rigors of daily life and traditional societal demands.

Suicide is also a relevant topic for consideration of mental health in Japan. In 2008, more than 30,000 people killed themselves in Japan (McCurry 2008), which translates to one person every 15 min. This number has increased each year for 10 years in a row. Seven of ten suicides in 2006 were male and about a third were aged 60 or older. Japanese men are seen as particularly at risk because they are expected to keep their feelings to themselves and not show signs of personal weakness. The biggest catalysts for suicide are thought to be poor health and financial worries. The government has approved measures for better counseling and the installation of barriers at rail and subway stations (common locations for suicide). National health insurance, however, does not cover counseling, and sessions are thought to be too expensive for many.

The cultural context is again relevant – Buddhist teachings, for example, offer no clear message on the moral rightness or wrongness of taking one's life, unlike the prohibition against suicide in most Western religions. Suicide also has a central place in the samurai code of honor. For many Japanese individuals confronted with the stigma of mental illness, or failure in personal or professional life, death may seem the only acceptable means of escape. Yuzo Kato, Director of the Tokyo Suicide Prevention Center, stated that "the most common factor behind suicide in Japan is depression caused by a failure to cope with the pressure to play a part in society, either because of poverty or the demands of work." He noted that number of people who committed suicide or attempted to due to work-related stress has doubled in the past 5 years.

To summarize, epidemiological studies show that mental disorders, assessed with formulations conceived in the West, are far more common in the U.S. than Japan, with many more receiving treatment as well. Part of the differences may be due to the stigma of mental illness in Japan, which probably also results in some under-reporting. Other syndromes, such as hikikomori, may be more culture specific. Whether the prevalence will increase with the aging of the current generation of young people for whom such problems seem to be more common is an important future question. Despite the lower prevalence of most mental disorders in Japan, there is a notably high rate of suicide. Interpretations of these patterns are challenging. If expressing emotional distress is construed as a personal failing, higher suicide rates could indicate many who need treatment are not receiving it. Alternatively, higher suicide rates may also be tied to the view that taking one's life is less explicitly prohibited by philosophical and religious beliefs in Japan.

Having summarized cultural differences in the rates and types of emotional disorders, we now examine cultural differences in approaches to the treatment of psychological disorders. Such contrasts underscore notable distinctions in what constitutes the target of treatment (i.e., promoting good mental health), thus invoking our earlier discussion of culture influences on well-being.

1.5 Interventions for Treating of Mental Disorders: Cultural Comparisons

Psychotherapy and clinical interventions come in many varieties. Our objective herein is not to provide a comprehensive overview of what exists in the realm of practice, either in Japan or the U.S. Instead, we highlight select therapeutic interventions, one in the West and two in the East, to illustrate how strategies to improve mental health are themselves culturally constituted. As such, they differ in how mental health problems are construed as well as in what needs to be done to alleviate them. Our contrast focuses on *well-being therapy*, as developed and practiced in the West and further described in Chap. 2 of this book, and *Morita and Naikan therapies*, as developed and practiced in Japan.

1.5.1 Well-being Therapy

Created by practicing clinicians from the University of Bologna in Italy, well-being therapy (Fava et al. 1998) was initially designed for the residual phase of treatment among individuals suffering from recurrent major depression. During this phase, most debilitating symptoms have subsided, but the client remains at risk for relapse. The guiding idea is that during this period it is critically important to have positive psychological experiences, both for their impact on subjective experience, but also in terms of underlying neural processes. The core assumption is that the *absence of well-being* creates vulnerabilities to risk of relapse.

As described in details in Chap. 2, Well-being therapy itself reflects a cognitive behavioral approach and consists of a short-term strategy (8 weeks) during which the client is required to keep a daily diary of positive experiences. Events and feelings recorded in the diary become the focus of weekly sessions with the therapist (Fava and Ruini 2003). In the initial sessions, the focus is on helping clients identify positive experiences from daily life. The therapy builds around these experiences and focuses on identifying thoughts and beliefs that lead to the premature interruption of well-being. For example, the client may feel unworthy or uncomfortable having positive emotions, given the rarity of such experiences. Or, the client may worry that that such good feelings are not going to last. Additional sessions link self-generated positive experiences to existing dimensions of well-being, as derived from the multidimensional model of well-being developed by Ryff (1989). The intent is to enrich clients' thinking about what constitutes types of well-being, such as experiencing positive self-regard, having good relationships with others, feeling a sense of mastery and purpose in daily life, and seeing growth and development in one's capabilities.

The first empirical assessment of well-being therapy (Fava et al. 1998) showed strong differences in remission profiles for those receiving the treatment compared to standard clinical management (antidepressant medication, minimal psychotherapy). A subsequent follow-up showed that these benefits persisted over a 6-year period (Fava et al. 2004). Additional work extended the approach to treatment for generalized anxiety disorders (Ruini and Fava 2009). Recent endeavors have taken the approach beyond the clinic to interventions in the community. Ruini et al. (2009) implemented a high school program to promote psychological well-being. Compared to an attention placebo group, the intervention group showed improvements in adolescents' psychological well-being, along with reductions in distress, particularly anxiety and somatization. Additional efforts in school settings have examined the differential effects of well-being therapy (WBT) with anxiety management strategies (AM) (Tomba et al. 2010) and found that WBT, by facilitating a progression toward positive and optimal functioning, integrates symptom-centered strategies. Further details on these WB enhancing school interventions in the Western cultures are addressed in Chap. 11 of this book.

From a cultural perspective, it is useful to reflect on the thinking that underlies well-being therapy. Central to the enterprise is a basic question in the treatment of psychological disorders – namely, what constitutes recovery? Fava et al. (2007) clarify that traditional conceptions in the treatment of major depression (e.g., Frank et al. 1991) define recovery as reduced and less severe symptoms that persist over a specified period of time. In contrast, they offer a more expansive formulation of recovery, which includes: (a) remaining free of symptoms despite discontinuation of treatment, (b) if subclinical symptoms are present, they do not interfere with everyday life and social adjustment, (c) the patient reports well-being in at least one of six areas (Ryff 1989), and (d) there is normalization of altered biomarkers, which may have been abnormal in the acute phase of illness. Of particular significance herein is the emphasis on experiencing well-being as a component of recovery. Such a requirement necessitates having a clear conception of what well-being is in order for the goal to be attained. As emphasized in our opening section above, there is good reason to believe such conceptions vary across cultural contexts. As evident from the examples below, therapies indigenous to Japan begin with notably different assumptions about what constitutes well-being.

1.5.2 Morita Therapy

Developed in the early 1900s by Dr. Shoma Morita, a psychiatrist at the Jikei University School of Medicine in Tokyo, Morita therapy blends ideas from Buddhist thought with ideas from Western psychotherapies (Reynolds 1982). Its aim is to

build character so that the person can take action in life, regardless of symptoms, fears, or wishes. Character is believed to be cultivated by mindfulness, one part of which involves knowing what is controllable and what is not. A further emphasis is on doing, in contrast to what one is feeling. The cure is thus not defined by the alleviation of emotional discomfort, or the attainment of some ideal feeling state, but by being able to take constructive action in one's life – i.e., being able to live a full and meaningful existence, rather than be ruled by passing emotions.

Professor Morita, in fact, felt that trying to control emotions was like trying to return the water of a river back upstream. Moods and feelings are recognized as part of the human experience, but they are viewed as largely outside what one can control and therefore beyond the scope of personal responsibility. What can be controlled, however, is what one does. At all times and under all conditions, emphasis thus needs to be on what one is doing. Successful therapy means learning to accept internal fluctuations in thought and feelings, while maintaining a strong focus on personal action and behavior.

Morita therapy is divided into four areas of treatment. The first, known as the "rest phase," typically means 1 week of isolated bed rest. During this period, the individual is separated from the usual intrusions of daily life. It is a time of solitude intended to have the client encounter him or herself with minimal distractions. Clients are told to accept whatever thoughts and feelings bubble up into awareness. These experiential observations are meant to illustrate that emotions come and go without conscious control. A further function of the rest phase is to teach that withdrawal from social interaction is unnatural and eventually uncomfortable. Boredom typically ensues during the last days of this period.

The second phase may last from 3 days to a week and involves doing light manual tasks – i.e., monotonous work that is conducted in silence. The client remains largely isolated from others, but is allowed to read or write in a journal. Attention is directed toward completing small tasks (cooking, heating a bath, walking outside). In the third phase, lasting from 3 days to 1 week, the patient remains restricted from associating freely with others or participating in entertainment, but there is a shift toward hard physical work (chopping wood, gardening, farming, carpentry). Reading is allowed, but the emphasis is on completing work irrespective of how one feels. Joy may be experienced in finishing tasks.

The fourth phase, called the "life-training period," is when the patient is sent outside the hospital or clinical setting. This is when s/he learns to integrate what has been learned into a new lifestyle of meditation, physical activity, clear thinking, ordered living, and renewed ties with the natural world. Re-integration means bringing one's new practices into daily life.

In contrast to Western psychotherapies, anxiety, which may be the cause for seeking treatment, is not, in itself, a focus of the treatment. There is no goal of trying to erase anxiety and bring the patient back to a "normal" state. Rather, the aim is to cultivate a different approach to living wherein doing is elevated over feeling, and emotions (good or bad) are accepted as transitory and not conducive to conscious control.

Diaries may be included in the therapy. Reynold's (1982) examples of diary entries, along with annotated responses from the therapist, illustrate the emphasis on directing energy toward controllable behaviors rather than on how one feels. To illustrate, one diary entry was about sitting in a seminar and trying to be interested. The therapist's response was that interest, or lack of interest should not be the focus; rather, the focus should be on paying attention, taking notes, and sitting erectly. Such behaviors may, or may not, lead to interest. Another entry was about neglecting to write in the diary because of feeling unhappy. The therapist's response was first to question whether it is better to feel happy than unhappy. A further message was to learn how to handle happiness and unhappiness with equanimity, by evaluating life in terms of what one is accomplishing in each moment.

Reynolds (1976) summarized a number of studies using Morita therapy, which reported rates of cured and improved patients in the 90 % range. Suzuki and Suzuki (1977) surveyed over 1,200 patients treated at a Morita Clinic, finding that among those who returned their questionnaires (71 %), responses indicated notable improvement in daily life, including reductions, or elimination of neurotic tendencies and worries, evident years after treatment began. Fully incorporating the principles of the therapy into one's daily life may take years, however. Morita therapy is seen as particularly effective in treating *shinkeishitsu* neuroses, which are considered largely anxiety disorders characterized by over-sensitivity to others, shyness, and feelings of inferiority. Many of the treated patients are young adults.

1.5.3 Naikan Therapy

Also known as "introspection" therapy, Naikan therapy is a structured method of self-reflection developed by Yoshimoto Ishin in the 1950s (Reynolds 1982). Mr. Ishin was a business man and devout Jodo Shinshu Buddhist who had engaged in ascetic contrition (dwelling in a dark cave without food, water or sleep) as a young man. He developed Naikan therapy to make introspection available to others. The practice of self-reflection is part of multiple spiritual traditions, including adherents among Christian hermits and Japanese samurai.

The practice is based on three questions posed to the client: (1) what have you received from person X (typically, it begins with a focus on one's mother)? (2) What have you given to person X? (3) What troubles, inconveniences, deceit and pettiness have you caused person X? The question of what troubles and difficulties person X may have contributed to the client's life is purposefully ignored. The assumption is that much misery in daily life is rooted in focusing on how one has been treated badly by others.

The typical practice involves 1-week at a Naikan retreat. Reinterpretation of the past is a key feature of the practice. The work begins by focusing on the above three questions, beginning with the client's relationship with his/her mother. Questions are then expanded outward to other relationships (fathers, siblings, teacher, spouse, employer). Most clients soon evolve progressively into reporting having received a

great deal, returned little, and caused a great deal of trouble to the person on whom they are reflecting. Self-aggrandizement and complaints about treatment one has received from others are viewed as self-centered and improper.

Deep emotions may be stirred by the process; tears are common. Clients are known to pass through a number of stages as the week progress (Takeuchi 1965; Kitsuse 1964). Initial difficulties in concentrating and feeling bitterness toward others tend to gradually be replaced by feelings of regret, guilt, and sorry over how one has treated significant others. This awareness prompts repentance and the desire to serve and repay them. The underlying objective is to prompt gratitude from within, while getting beyond the view that others are there to satisfy personal needs. Self-centeredness is seen as a problem to be recognized. So doing should prompt self-reproach, guilt, and lowered self-esteem. Failure to make progress is interpreted as failure of the client, not the method, therapist, or society.

Like Morita therapy, the emphasis of Naikan therapy is not on providing symptom relief, but on promoting character development. It was initially conceived by Mr. Yoshimoto as a means to treat prison inmates. Since the 1950s, numerous (nearly 60 %) adult prison facilities tried the therapy at one time or another (Reynolds 1982) and reported improved rates among *naikansha* (client) prisoners compared to prisoners who did not undergo the therapy. In addition, thousands of clients have been treated at more than 40 Nara centers in Japan over the past four decades. It has been used for mental health counseling and treatment for addictions. Clients tend to be more male than female. With regard to effectiveness, Yamamoto (1972) reported decreased self-evaluation and increased evaluation of others in postnaikan subjects. Ishida (1969) reported over 90 % effectiveness in treating neurotic and psychosomatic patients with Naikan alone or in conjunction with other therapies.

Both treatments considered above represent prior eras of psychotherapy in Japan, but they nonetheless offer notable contrasts to Western approaches, such as well-being therapy. A more modern and distinctly Japanese mode of therapy is called *shinrin-yoku* or 'forest-bathing therapy', which focuses on reconnecting the person with nature and inner harmony by promoting personal mindfulness through walks in the woods and mountains (Tsunetsugu et al. 2010). Viewed from these Eastern perspective, Western approaches have generally tended to ignore, not only the surrounding natural environment, but also that individual well-being is fundamentally tied to commitment and service to others. In addition, Western therapies overemphasizing feeling states, which are seen as fleeting and beyond one's control. Viewed from the Western perspective, Eastern treatment approaches, in turn, give inadequate attention to experience of emotional distress and how it both influences and is influenced by patterns of thought and behavior.

1.6 Integration and Summary Reflections

Our objective in this chapter was to utilize ongoing programs of research in Japan and the U.S. to examine cultural differences in what constitutes psychological well-being and the treatment and response to ill-being. Drawing on multiple sources of

evidence, we emphasized that Japanese conceptions of well-being give greater emphasis to social harmony and related capacities of self-criticism, discipline, and adjustment to others, whereas U.S. conceptions place greater emphasis on self-esteem, happiness, and realization of personal talents and capacities. The interplay between positive and negative emotions also reveals cultural differences. In the West, they are construed as opposites and in empirical studies tend to be inversely related, whereas in the East are seen an inherently tied to, if not embedded with each other. As such, Japanese adults show moderate levels of both. Qualitative studies in Japan point to minimalist well-being, which involves feeling calm, at peace, and grateful for one's existence.

Our brief examination of mental distress emerged from standardized assessments (developed in the U.S.) that have been used to assess prevalence rates of psychiatric problems across countries. Population-based comparisons show notably higher rates of depression and anxiety in the U.S. relative to Japan. Given the stigma that is attached to mental illness in Japan, some degree of under reporting may be involved. Another Japanese-specific disorder pertains to severe social withdrawal (*hikikomori*), which occurs primarily among contemporary young adults. Some see the problem as possibly linked to shifting values from collectivism to individualism. The high rate of suicide in Japan relative to other countries was noted. Interpreting this difference requires attending to cultural differences in views on taking one's own life.

How mental disorders are treated reflects cultural differences in what constitutes the problem to be resolved as well as what defines successful treatment or recovery. We contrasted well-being therapy in the West with Morita and Naikan therapies in Japan for the explicit purpose of showcasing such differences. Well-being therapy, designed initially for treatment of major depression, but subsequently extended to anxiety, seeks to free clients from the debilitating effects of these emotions. A key part of recovery involves experiencing well-being, which involves enriching clients' awareness of positives, such as good quality ties to others, purposeful engagement, self-acceptance, and personal growth. Morita therapy, in contrast, emphasizes the importance of doing over feeling, and further underscores that emotions cannot be controlled. Progress thus occurs through retraining oneself to focus on controllable behaviors, while simultaneously recognizing that positive or negative feelings are inherently fleeting. Naikan therapy emphasizes the importance of introspection, particularly as it relates to the good that one has received from significant others, along with awareness of the difficulties one has caused these others. This form of treatment is thus explicitly aligned with interdependent emphasis on Japanese well-being as detailed in our first section. That is, greater social harmony, a core component of what it means to be well in Japan, is clearly a central objective of the treatment. Again, emotional experience is secondary to the task of improving one's ties with others.

Taken as a whole, our chapter underscores the following key point: promoting well-being, whether among the general population or maladjusted individuals, is inextricably tied to cultural context. Although we have focused primarily on the contrast between Japan and the U.S., similar distinctions could have been illustrated with numerous other cultures as well. Hence, our overarching theme of attunement – the

need for a reasonable degree of fit between what one feels with surrounding norms and values. There is thus no single type of well-being to be promoted across cultures – one size does not fit all. Recognizing that cultures differ in their construal of psychological well-being is not, however, equivalent to blind relativism when it comes improving the human condition. Instead, we close with two opportunities for progress that will emerge from a more refined knowledge of well-being across cultures.

First, whatever the context, research can help clarify the impact (for individuals and for societies) of possessing different types of well-being. One way to pursue this question is to investigate the health consequences of such experiences as happiness, purposeful engagement, and social harmony. Such inquiries are increasingly underway, with evidence showing that higher levels of well-being are linked with better health profiles, measured in terms of morbidity and mortality as well as biological risk factors (e.g., Boehm and Kubzansky 2012; Boyle et al. 2009; Pressman and Cohen 2005; Ryff et al. 2006; Steptoe et al. 2005). Missing from such research to date, however, is consideration of whether such associations vary across cultural contexts (as seen in Miyamoto and Ryff 2011) and depending on the component of well-being assessed. It is an open question whether social harmony better predicts health outcomes in the East versus the West, or whether self-esteem is more strongly predictive of good health in the West compared to the East.

Second, as we achieve greater insights into our respective cultures, we may acquire a deeper understanding of what constitutes their respective strengths and weaknesses. For example, the West is often caricatured as a realm of unbridled individualism that can leave social ties neglected and may instill unrealistic expectations about achieving personal happiness and promote resistance to accepting negativity. Alternatively, Eastern social harmony and concern for meeting obligations to others can hamper opportunities for personal development and self-realization. Importantly, these questions are themselves open to scientific inquiry, to the extent that cross-cultural studies include diverse assessments of well-being (derived from both independent and interdependent formulations) and use them to predict meaningful outcomes, such as health. Thus, rather than engage in arm-chair philosophizing to resolve which kinds of well-being are most conducive to good health, questions can be adjudicated by looking at the evidence across different cultural contexts.

Such empirical evidence will serve another purpose as well – namely, to inform the world about what constitute more effective clinical treatments and interventions, which, in turn, will help in building health education programs and supportive public policies.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Boehm, J. K., & Kubzansky, L. D. (2012). The heart's content: The association between positive psychological well-being and cardiovascular health. *Psychological Bulletin*. Advance online publication. doi:10.1037/a0027448.

Boyle, P. A., Barnes, L. L., Buchman, A. S., & Bennett, D. A. (2009). Purpose in life is associated with mortality among community-dwelling older persons. *Psychosomatic Medicine, 71*(5), 574–579. doi:10.1097/PSY.0b013e3181a5a7c0.

Bradburn, N. M. (1969). *The structure of psychological well-being*. Chicago: Aldine.

Desapriya, E. B. R., & Nobutada, I. (2002). Stigma of mental illness in Japan. *The Lancet, 359*(9320), 1866. doi:10.1016/s0140-6736(02)08698-1.

Diener, E., & Suh, E. M. (2000). *Culture and subjective well-being*. Cambridge, MA: The MIT Press.

Fava, G. A., & Ruini, C. (2003). Development and characteristics of a well-being enhancing psychotherapeutic strategy: Well-being therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 34*(1), 45–63. doi:10.1016/S0005-7916(03)00019-3.

Fava, G. A., Rafanelli, C., Grandi, S., Conti, S., & Belluardo, P. (1998). Prevention of recurrent depression with cognitive behavioral therapy. *Archives of General Psychiatry, 55*, 816–821. doi:10.1001/archpsyc.55.9.816.

Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Conti, S., & Grandi, S. (2004). Six-year outcome of cognitive behavior therapy for prevention of recurrent depression. *American Journal of Psychiatry, 161*(10), 1872–1876.

Fava, G. A., Ruini, C., & Belaise, C. (2007). The concept of recovery in major depression. *Psychological Medicine, 37*(3), 307–317. doi:10.1017/s0033291706008981.

Frank, E., Prien, R. F., Jarrett, R. B., Keller, M. B., Kupfer, D. J., Lavori, P. W., Rush, A. J., & Weissman, M. M. (1991). Conceptualization and rationale for consensus definitions of terms in major depressive disorder: Remission, recovery, relapse, and recurrence. *Archives of General Psychiatry, 48*(9), 851–855. doi:10.1001/archpsyc.1991.01810330075011.

Heine, S. J., Lehman, D. R., Markus, H. R., & Kitayama, S. (1999). Is there a universal need for positive self-regard? *Psychological Review, 106*, 766–794.

Inglehart, R., & Welzel, C. (2005). *Modernization, cultural change, and democracy: The human development sequence* (pp. 13–39). New York: Cambridge University Press.

Ishida, R. (1969). Naikan analysis. *Psychologia, 12*, 81–92.

Kahneman, D., Diener, E., & Schwarz, N. (Eds.). (1999). *Well-being: The foundations of hedonic psychology*. New York: Russell Sage Foundation.

Kan, C., Karasawa, M., & Kitayama, S. (2009). Minimalist in style: Self, identity, and well-being in Japan. *Self and Identity, 8*(2/3), 300–317. doi:10.1080/15298860802505244.

Karasawa, M., Curhan, K., Markus, H., Kitayama, S., Love, G., Radler, B., & Ryff, C. (2011). Cultural perspectives on aging and well-being: A comparison of Japan and the United States. *International Journal of Aging & Human Development, 73*(1), 73–98. doi:10.2190/AG.73.1.d.

Kato, T. A., Shinfuku, N., Sartorius, N., & Kanba, S. (2011). Are Japan's hikikomori and depression in young people spreading abroad? *The Lancet, 378*(9796), 1070. doi:10.1016/s0140-6736(11)61475-x.

Kawakami, N., Takeshima, T., Ono, Y., Uda, H., Hata, Y., Nakane, Y., Nakane, H., Iwata, N., Furukawa, T. A., & Kikkawa, T. (2005). Twelve-month prevalence, severity, and treatment of common mental disorders in communities in Japan: Preliminary finding from the World Mental Health Japan Survey 2002–2003. *Psychiatry and Clinical Neurosciences, 59*(4), 441–452. doi:10.1111/j.1440-1819.2005.01397.x.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627. doi:10.1001/archpsyc.62.6.617.

Keyes, C. L. M., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*(6), 1007–1022. doi:10.1037/0022-3514.82.6.1007.

Kitayama, S., & Markus, H. R. (2000). The pursuit of happiness and the realization of sympathy: Cultural patterns of self, social relations, and well-being. In E. Diener & E. M. Suh (Eds.), *Culture and subjective well-being* (pp. 113–161). Cambridge, MA: The MIT Press.

Kitayama, S., Markus, H. R., & Kurokawa, M. (2000). Culture, emotion, and well-being: Good feelings in Japan and the United States. *Cognition and Emotion, 14*(1), 93–124.

Kitsuse, J. I. (1964). *Moral treatment and reformation of inmates in Japanese prisons.* Paper presented at the First International Congress for Social Psychiatry. (Reprinted in *Psychologia* (1965), 8, 9–23).

Kleinman, A., & Good, B. (Eds.). (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.
Kleinman, A., & Kleinman, J. (1985). Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meaning of pain. In A. Kleinman & B. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 429–489). Berkeley: University of California Press.
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. doi:10.1016/j.psychres.2008.10.019.
McCurry, J. (2008). Japan to rethink suicide-prevention policies. *The Lancet, 371*(9630), 2071. doi:10.1016/s0140-6736(08)60900-9.
Miyamoto, Y., & Ma, X. (2011). Dampening or savoring positive emotions: A dialectical cultural script guides emotion regulation. *Emotion, 11*(6), 1346–1357. doi:10.1037/a0025135.
Miyamoto, Y., & Ryff, C. D. (2011). Cultural differences in the dialectical and non-dialectical emotional styles and their implications for health. *Cognition and Emotion, 25*(1), 22–39. doi:10.1080/02699931003612114.
Morozink, J. A., Friedman, E. M., Coe, C. L., & Ryff, C. D. (2010). Socioeconomic and psychosocial predictors of interleukin-6 in the MIDUS national sample. *Health Psychology, 29*(6), 626–635. doi:10.1037/a0021360.
Murray, C. J. L., & Lopez, A. D. (1997). Alternative projection of mortality and disability by cause, 1990–2020: Global Burden of Disease study. *The Lancet, 349*, 1498–1504.
Peng, K., & Nisbett, R. E. (1999). Culture, dialectics, and reasoning about contradiction. *American Psychologist, 54*(9), 741–754. doi:10.1037/0003-066x.54.9.741.
Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin, 131*(6), 925–971. doi:10.1037/0033-2909.131.6.925.
Reynolds, D. K. (1976). *Morita psychotherapy*. Berkeley: University of California Press.
Reynolds, D. K. (1982). *The quiet therapies: Japanese pathways to personal growth*. Honolulu: University of Hawaii Press.
Ruini, C., & Fava, G. A. (2009). Well-being therapy for generalized anxiety disorder. *Journal of Clinical Psychology, 65*(5), 510–519.
Ruini, C., Ottolini, F., Tomba, E., Belaise, C., Albieri, E., Visani, D., Offidani, E., Caffo, E., & Fava, G. A. (2009). School intervention for promoting psychological well-being in adolescence. *Journal of Behavior Therapy and Experimental Psychiatry, 40*(4), 522–532.
Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*, 141–166. doi:10.1146/annurev.psych.52.1.141.
Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069–1081. doi:10.1037/0022-3514.57.6.1069.
Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies, 9*(1), 13–39. doi:10.1007/s10902-006-9019-0.
Ryff, C. D., Love, G. D., Urry, H. L., Muller, D., Rosenkranz, M. A., Friedman, E. M., Davidson, R. J., & Singer, B. H. (2006). Psychological well-being and ill-being: Do they have distinct or mirrored biological correlates? *Psychotherapy and Psychosomatics, 75*, 85–95. doi:10.1159/000090892.
Schimmack, U., Oishi, S., & Diener, E. (2002). Cultural influences on the relation between pleasant emotions and unpleasant emotions: Asian dialectic philosophies or individualism-collectivism? *Cognition and Emotion, 16*(6), 705–719. doi:10.1080/02699930143000590.
Steptoe, A., Wardle, J., & Marmot, M. (2005). Positive affect and health-related neuroendocrine, cardiovascular, and inflammatory processes. *Proceedings of the National Academy of Sciences of the United States of America, 102*(18), 6508–6512. doi:10.1073/pnas.0409174102.

Steptoe, A., Gibson, E. L., Hamer, M., & Wardle, J. (2006). Neuroendocrine and cardiovascular correlates of positive affect measured by ecological momentary assessment and by questionnaire. *Psychoneuroendocrinology, 32*, 56–74. doi:10.1016/j.psyneuen.2006.10.001.
Suzuki, T., & Suzuki, R. (1977). *A follow-up of neurotics treated by Morita Therapy.* Paper presented at the 6th World Congress of Psychiatry, Honolulu.
Takeuchi, K. (1965). On *Naikan* method. *Psychologia, 8*, 2–8.
Tomba, E., Belaise, C., Ottolini, F., Ruini, C., Bravi, A., Albieri, E., Rafanelli, C., Caffo, E., & Fava, G. A. (2010). Differential effects of well-being promoting and anxiety-management strategies in a non-clinical school setting. *Journal of Anxiety Disorders, 24*(3), 326–333. doi:10.1016/j.janxdis.2010.01.005.
Tsai, J. L. (2007). Ideal affect: Cultural causes and behavioral consequences. *Perspectives on Psychological Science, 2*, 242–259.
Tsunetsugu, Y., Park, B. J., & Miyazaki, Y. (2010). Trends in research related to "Shinrin-yoku" (taking in the forest atmosphere or forest bathing) in Japan. *Environmental Health and Preventive Medicine, 15*, 27–37.
Uchida, Y., & Kitayama, S. (2009). Happiness and unhappiness in east and west: Themes and variations. *Emotion, 9*(4), 441–456.
Uchida, Y., Norasakkunit, V., & Kitayama, S. (2004). Cultural constructions of happiness: Theory and empirical evidence. *Journal of Happiness Studies, 5*(3, Special Issue), 223–239.
Wilson, W. R. (1967). Correlates of avowed happiness. *Psychological Bulletin, 67*(4), 294–306. doi:10.1037/h0024431.
WHO International Consortium in Psychiatric Epidemiology. (2000). Cross-national comparisons of the prevalences and correlates of mental disorders. *Bulletin of the World Health Organization, 78*, 413–426.
Yamamoto, H. (1972). *Naikan ryoho* [Naikan Therapy]. Tokyo: Igaku Shoin.