A Cross-Cultural Analysis of Help-Seeking for Symptoms of Depression in Japanese Primary School Teachers

Ethnicity, Self-Construal, and Subjective Perception

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ABSTRACT

A CROSS-CULTURAL ANALYSIS OF HELP-SEEKING FOR DEPRESSION IN JAPANESE PRIMARY SCHOOL TEACHERS: ETHNICITY, SELF-CONSTRUAL, AND SUBJECTIVE PERCEPTION

ELIJAH WADE BULLARD

This cross-cultural study investigates help-seeking for depression among Japanese primary school teachers. Help-seeking for depressive symptoms is examined quantitatively by administering the Help-Seeking Scale for Depression among participants. In addition, this study qualitatively examines the help-seeking pathways of participants according to Kleinman's explanatory model of help-seeking. The objective of the study was to determine possible motivators for Japanese and other Asian people to seek professional help for symptoms of mental illness.

The participants consisted of 71 Japanese school teachers from four primary schools located in the Kansai region of Japan. Participants' conceptualizations of depression were assessed using the Help-Seeking Scale for Depression (HSSD) after reading a vignette describing depressive symptoms. Participants' perceived severity of depressive symptoms (hypothesis 1) and prior therapy/counseling experience (hypothesis 2) significantly predicted professional help-seeking. The prevalence of depression was significantly higher in female participants (hypothesis 3); results indicating prevalence were non-significant for males. Hypotheses 1 and 2 were supported at $p < .05$; Hypothesis 3 was supported at $p < .05$ for females, but not males.

Additional open-ended questions were evaluated according to content analysis methods suggested by Kleinman (1980) and Kawamoto (2004). Certain implications for mental healthcare services in both Japan and western cultures were discussed, including reasons for the underutilization of professional mental health services among Japanese people and other Asian groups.

DEDICATION

この博士論文は私の師であり親友である石井潤一氏に捧ぐ。

This monograph is dedicated to my mentor and best friend,

Junichi Ishii

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"In every human being there is a wish to ameliorate his [or her] own condition."

–Thomas B. Macaulay (Porter, 1913)

CHAPTER I
INTRODUCTION

Depression is a phenomenon recognized cross-culturally and documented over many centuries. However, the ways people experience, perceive, and seek help for depression vary across cultures and have constituted a strong focus of interest among cross-cultural psychologists and anthropologists. Although the efforts of research psychologists reveal great emphasis on pinpointing universally human behaviors, emotions, and cognitions, many researchers aim to discern ethnic and sociocultural differences that are fundamentally disparate across cultures. Therefore, *emic* and *etic* approaches to cross-cultural psychology have become important considerations when investigating psychological research questions (Berry, Poortinga, & Pandey, 1997; Brislin, 1983; Kawamoto, 2004).

The terms, *emic* and *ethic,* were first introduced by Pike (1967) as derivatives of the linguistic terms, *phonemic* and *phonetic. Phonemic* means *culturally specific* whereas *phonetic* means *universal or culturally general.* Kleinman (1980) describes the ways people conceptualize symptoms of mental illness from an emic perspective; he expounds how people make help-seeking decisions within the context of various sociocultural frameworks. Kleinman asserts that disease and illness are dichotomous; disease refers to a malfunctioning that involves universal biological and psychological processes, whereas illness describes an individual's psychosocial and cultural responses to a disease. Moreover, Kleinman notes that:

> Illness involves processes of attention, perception, affective response, cognition, and evaluation directed at the disease and its manifestations (i.e., symptoms, role impairment, etc.). But

> also included in the idea of illness are communication and interpersonal interaction, particularly within the context of the family and social network. (p. 72)

Indeed, the ways individuals conceptualize symptoms and relate to others within individual, sociocultural frameworks are essential components to consider when investigating help-seeking pathways. Markus and Kitayama (1997) posit that the processes involved in human thinking, feeling, wanting, and doing are guided by each individual's construal of the self in relation to others—these processes cannot be understood separately from sociocultural contexts.

In Japan, the prevalence of depression has been considered low when compared to the U.S.; however, more recent epidemiological studies have demonstrated that the prevalence rates of depression in both countries are similar. Moreover, depression is currently the most prevalent mental illness in the U.S. and Japan (Kessler et al., 1994; Kitamura, 1998). In addition, Kessler and colleagues found that less than 40% of people having mental illnesses in the U.S. sought professional help. Although 40% may seem low in the U.S., the report on utilization of psychological services in Japan has shown that both civilian and student populations do not seek help for depression (Kitayama, 1998; Tomoda, Mori, Kimura, Takahashi & Kitamura, 2000). Furthermore, people with depression in Japan often remain underrepresented and untreated (Ballenger, Davidson, Lecrubier, & Nutt, 2001; Kitamura, 1998). Because of this, there is invaluable need to investigate help-seeking behaviors in the U.S. and Japan. The aim of the current study is to reveal possible motivations for increasing the rates of help-seeking for depression in Japanese people living in the U.S. and Japan.

Numerous researchers have found that East Asian people are more likely than Caucasian Americans to seek help from others that are close them, such as friends and family (Atkinson & Gim, 1989; Center for Mental Health Services, 2000; Kawamoto, 2004; Sue & Kirk, 1975; Sue & Sue, 1974). Conversely, individuals who

demonstrate a great measure of western values and attitudes were found more likely to go to mental health practitioners for help with psychological distress (Kawamoto, 2004). Consistent with the findings of Kawamoto (2004), concepts of independence and interdependence (*self-construals*), which were developed by Markus & Kitayama (1991) to explain the sociocultural differences between Caucasian and Japanese Americans, are applied in order to better understand participants' cultural alignments in the current study. Thus, the current study utilizes several possible sources of help-seeking and open-ended questions as means to determine likely motivational factors for increasing the utilization rates of professional mental health services by Japanese people within the U.S. and Japan.

The current study investigates help-seeking behavior for depression among contemporary Japanese primary school teachers living and working in suburban areas of Japan. In collaboration with Kawamoto's (2004) research, individuals' conceptualizations of depression and depressive symptoms are examined quantitatively and qualitatively. Depression in the present study constitutes a clinically significant psychological condition that occurs for more than two weeks and with symptoms such as fatigue, loss of appetite, depressed mood, sleep disturbance, anhedonia, and an inability to concentrate that greatly disturb an individual's daily functioning.

The quantitative sections of this study aim to predict professional help-seeking for depression in Japanese primary school teachers, and to determine the prevalence of depressive symptoms among participants relative to the general Japanese population. Professional help-seeking in this study incorporates two help-seeking sources, namely: therapists/counselors and medical doctors. In prior research studies (Kawamoto, 2004; Ying, 1990), university professors were included in the assessments of professional help-seeking in university students. However, the current study omits "professor" as a help-seeking source in the assessment of professional help-seeking because it is an unlikely help-seeking source for middle-aged, Japanese school teachers. In order to pre-

dict professional help-seeking among the participants in this study, two independent variables were examined that have been considered likely predictors of professional help-seeking according to the findings of past researchers: Severity (Kawamoto, 2004; Sue & McKinney; Sue, Nakamura, et al., 1994) and Therapy/Counseling Experience (Hirai, 2005; Kawamoto, 2004; Masuda, Suzumura, et al., 2005; Yeh & Wang, 2002). The present study examines the predictability of professional help-seeking in Japanese primary school teachers in Hypotheses 1 and 2.

In addition, Hypothesis 3 examines the mean score of participants on the *Center for Epidemiologic Studies Depression* (CES-D) scale in order to determine whether the prevalence of depression in Japanese primary school teachers is significantly higher than that of the general Japanese population, which Shima (2002) found to be 9.6. Following the quantitative analyses, the current study addresses two exploratory research questions that aim to uncover how Japanese primary school teachers perceive depressive symptoms and take actions to alleviate such symptoms. The present study qualitatively examines exploratory research questions according to Kleinman's (1980) explanatory model of help-seeking.

CHAPTER II
BACKGROUND

Prevalence of Depression

Current epidemiological research shows that depression is not limited to specific areas, countries, or cultures. Indeed, depression is a condition that appears worldwide. Furthermore, depression impinges onerous individual, societal, and economic burden on the U.S. and Japan, which are manifested in individuals taking sick-leave from work due to inimical effects on one's mental, physical, and social well-being (Greenberg & Stiglin, 1990; Kroenke, 2001; Spitzer et al., 1995). In fact, the annual economic cost for depression in each country has reached several billion U.S. dollars (over $40 billion in the U.S. and $32 billion in Japan) (World Health Organization, 2009). Such burden paired with the favorable treatability of depressive disorders prompts for action (Rubenstein, Jackson-Triche, Unutzer, et al., 1999; Simon, 1998).

However, there is notable disparity in the rates of depression reported by different researchers. This is due to several factors involved in assessing the prevalence of depression, including sampling procedures, the population being assessed (clinical or community), psychological measurements and the criteria researchers use, investigative duration, and cross-cultural variations in the manifestations and conceptualizations of depression. The following summarizes current data about the prevalence rates of depression; however, because of the aforementioned confounding issues simple interpretation and comparisons of rates between the U.S. and Japan cannot be made (Kawamoto, 2004).

Prevalence of Depression in the U.S.

The lifetime prevalence rate for major depressive disorder, which is a risk probability to suffer from the illness throughout an individual's lifetime, lies within the ranges of 10% to 20% for women and 5% to 12% for men according to the *Diagnostic and Statistical Manual of Mental Disorder-4th edition* (DSM-IV). The probability of people

who meet the criteria for the disorder at one point in time, known as the point prevalence rate, ranges from 5% to 9% for women and 2% to 3% for men in community samples (American Psychiatric Association, 1994). According to the National Survey of Drug Use and Health (NSDUH) (2007), an annual average of 7.0% of full-time workers aged 18 to 64 experienced a major depressive episode between 2004 and 2006, inclusive. Among different countries in the world, the one-year prevalence rate of unipolar depression, which constitutes the probability of people who meet the criteria for the illness for the duration of one year, ranges from 4% to 10% (Higuchi & Motohashi, 2000). In the U.S., the most commonly diagnosed psychological disorders are depressive disorders; indeed, the most recurrent complaint of patients seeking outpatient treatment is depression (Center for Mental Health Services, 2000). Furthermore, according to the national comorbidity survey, which is the first comprehensive investigation on the prevalence of mental illnesses, depression is the most frequently occurring mental illness in the U.S. with one-year and lifetime prevalence rates of 10% and 12%, respectively (Kessler et al., 1994). Additionally, the majority of people meeting the criteria for mental illness in Kessler et al.'s investigation had never received mental health treatment. The researchers' findings also indicate that the prevalence rates of affective disorders are higher among Hispanics than Caucasians and African Americans. The following expounds past research on ethnic differences in the utilization of mental health services.

The percentage of people who seek professional help for psychological problems among clinical populations is higher for Caucasian Americans and lower for Asian Americans than other ethnic groups (Atkinson & Gim, 1989; Center for Mental Health Services, 2000; Sue & Kirk, 1975; Sue & Sue, 1974). The underutilization of mental health services by Asian Americans introduces the question of whether the prevalence of depression is lower among Asian Americans than other ethnic groups or that many clinically depressed Asian Americans do not seek professional help. The majority of epidemiological research investigating differences

in prevalence rates of mental illnesses based on ethnicity examines clinical populations with access to mental health facilities. However, a number of researchers doubt the generalizability of the results due to overly restrictive clinical populations (Kleinman, 1985; Kuo, 1984).

Kuo (1984) found that Asian Americans actually experience depression rates similar to those of Caucasian Americans by examining the prevalence of depression among Asian Americans in a community population. Furthermore, Abe and Zane (1990) probed college students and found that Asian immigrants and Asian Americans suffer from psychological distress more than Caucasian Americans even after controlling for confounding variables. Kuo (1984), however, speculates that such results may be due to the short period of time that many Asian Americans reside in the U.S. As supported by the literature, the fact remains that depression is a common phenomenon among different ethnic groups even with the underutilization of mental health services (Kawamoto, 2004).

Prevalence of Depression in Japan

As of October, 2010, there is no published data that indicates the prevalence of depression in Japan. However, statistics derived from the total population of people who utilized Japanese hospitals and clinics in 2008 indicate the prevalence rate of depression in Japan to be extremely low as compared to the United States (approx. 0.001) (Ministry of Health, Labour and Welfare, 2008); the data includes people suffering from post-traumatic stress disorder. In the past prevalence rates of depression have been considered much lower in Japan than in the U.S. (Tseng, 2001). Depression has been seldom reported in Japan and has been viewed as an illness afflicting western cultures (Nakane, Ohta, & Radford, 1991). More recently and contrary to previous findings, however, prevalence rates of depression have increased. The research conducted by Nakane et al. (1991) indicates that the one-year prevalence rates of depression among clinical populations in Japan,

China, and Korea ranges from 20% to 30% in each country. Moreover, the researchers point out that prevalence rates of depression have increased in all three countries and that prevalence rates are similar in the U.S. and Europe. Using the *International Classification of Diseases, 9th Revision* (ICD-9), the Japanese Ministry of Health, Labour and Welfare also reports that the prevalence of depression in Japan is increasing and that the number of people meeting the criteria for mood disorders has increased from 97,000 in 1984 to 433,000 in 1996 (Kawamoto, 2004).

There is a paucity of epidemiological research on depression in community populations in Japan. The findings of a study conducted on a community population by Kitamura (1998) indicate that the lifetime prevalence rate of having a major depressive episode is 19% among middle-aged individuals, and that women are two times more likely to be depressed than men. Furthermore, Kitamura (1998) notes that younger individuals in the community population experience higher prevalence rates of depression and that the rates are more balanced between male (24%) and female (23%) adolescents.

Depression and Suicide

The fact that depression is considered a risk factor for suicide may help to determine why people suffering from depression are often underreported and frequently left untreated by looking at suicide rates. Depressed individuals commonly report suicidal ideation and experience suicide rates 30 times greater than those of the normal population (Kawamoto, 2004). Depression is deemed responsible for a high percentage of suicides and attempted suicides (Ohhara, 1986; Yoshimasu, Sugahara, Tokunaga, et al., 2006). According to the American Psychiatric Association (1994), 15% of people suffering from severe depression commit suicide. Among patients who attempt suicide and are subsequently hospitalized in Japan, around 50% meet criteria for reactive depression and 34% meet criteria for clinical depression (Ohhara, 1986). Ohhara suggests that suicide rates should be higher among patients with depression

than among patients with other mental illnesses because depressed individuals are at high risk for suicide. As expected, Ohhara's study of hospitalized patients for attempted suicide shows that 29.7% are patients with depression, 6.8% with schizophrenia, 6.3% with epilepsy, and 5.2% with alcohol dependence.

Suicide is the causing factor of a high percentage of deaths in both Japan and the United States. Mortality probabilities are expressed differently in each country. In Japan, mortality rates refer to the probability that an individual at birth will die from a specific cause of death in the future. In the U.S., suicide statistics take into account different age groups to determine leading causes of death. Suicide is the sixth highest cause of death for men and the seventh highest cause of death for women in Japan (Ministry of Health, Labour and Welfare, 2000). In the U.S., suicide is the 11th leading cause of death for all ages inclusive, and the third leading cause of death between the ages of 15 and 24 (Center for Disease Control and Prevention, 2002).

Among industrialized countries Japan has one of the highest suicide rates with approximately 30,000 people committing suicide each year; many of whom suffer from major depressive disorder (Ballenger et al., 2001; Yoshimasu et al., 2006). Moreover, Japan has much higher suicide rates than the U.S. (see Table 1). Suicide rates in Japan have drastically increased during the past ten years; the Ministry of Health, Labour and Welfare (2000) reports that suicide is a major social problem in Japan and acknowledges a need to provide mental health care services for psychological problems such as depression. To account for the recent increase in suicide rates, certain researchers speculate that industrialization, greater numbers of older people, more nuclear families, and economic depression are key factors (Tajima, 2001).

The increase in longevity due to advances in medicinal technologies has an impact on suicide rates as well. Approximately 14% of the total Japanese population consisted of people older than 65 in 1993. Suicide rates within this group are high as compared to other age groups, accounting for a fourth of suicides in

1993 (Takahashi, 1997) and a third of suicides in 1997 (Tajima). Since the introduction of an economic depression in 1991, Japan has experienced an increase in suicide rates among middle-aged men and demonstrates a high, positive correlation between suicide and unemployment rates (Tajima).

Tajima (2001) points out that 30 to 50% of suicides committed by people within Japan's younger generation are attributed to mental illness. The most common mental illnesses in Japan (e.g. depressive disorders, anxiety disorders, and neurasthenia) frequently have an onset between the ages of 14 and 29 (Russel, 1989). Several researchers are hesitant to derive conclusions from these statistics, however, due to the fact that this age group is inclusive of university first-year students who undergo inordinately demanding entrance examinations that contribute significantly to a high prevalence of depressive disorders (Takahashi, 1997; Tomoda et al., 2000).

Findings of several researchers indicate gender differences in suicidal ideation, which is highly associated with depression and suicide. An investigation conducted by Yoshimasu et al. (2006) among 199 Japanese men and women suffering from depression reveals certain psychosocial factors to be significantly associated with suicidal ideation, such as self-reproach, derealization (women only), depressive mood, depersonalization, and anxiety state. Furthermore, Yoshimasu et al. note that low social/family support and depersonalization are statistically significant predictors for suicidal ideation in men. Depressive mood and anxiety state are noted to be statistically significant predictors for suicidal ideation in women (Yoshimasu et al).

Depression and Culture (in the U.S. and Japan)

Cross-cultural research acknowledges a veritable range of symptoms for depression among ethnic groups. In addition, conceptualizations of depression often vary depending on ethnicity and cultural beliefs (Hirai, 2005).

Table 1

Annual Suicide Rates per 100,000 Population in the U.S. and Japan

	U.S.	Japan
1950	11.4	19.6
1960	10.6	21.6
1970	11.6	15.3
1980	11.9	17.7
1990	12.4	16.4
1991	12.2	16.1
1992	12.0	16.9
1993	12.1	16.6
1994	12.0	16.9
1995	11.9	17.2
1996	11.7	17.8
1997	11.4	18.8
1998	11.3	25.3
1999	10.7	26.3
2005	11.0	24.2

Note. The data are obtained from "Suicide in the United States," by The Center for Disease Control and Prevention, 2002; "Figures and Facts about Suicide," by the World Health Organization, 2009; "Mental Health in Asia: Social Improvements and Challenges," by Tseng, Ebata, Kim, Krahl, et al., 2001, *The International Journal of Social Psychiatry, 47*, 8-23; "Summary of Vital Statistics of Japan," by the Ministry of Health, Labour and Welfare, 2002.

This section integrates existing literature and research findings pertaining to concepts and manifestations of depression as products of ethnicity and culture.

Symptom Manifestations

Caucasian Americans tend to express symptoms of depression in psychological terms such as sadness and anhedonia, whereas Asian Americans and Asian people frequently express symptoms in so-