

Suicide: A Unique Epidemic in Japan

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Japan, a country with a long life expectancy, strong economy and stable political system seems like an unlikely place to encounter a deadly global epidemic. Yet, the unique history and culture of Japan, including its religion, media, and economy, create a setting in which rates of suicide are reaching unprecedented levels. The culture of Japan combined with the peculiar nature of suicide, which allows it to evade clear classification as a disease, creates an intriguing public health challenge for Japan in tackling this epidemic.

A high GDP, a literacy rate of 99 percent, a healthy life expectancy of 72-78 years, and a health budget of 1660 international dollars per capita (World Health Organization 2005) are not the features typically associated with a country suffering from one of the worst outbreaks of a deadly global epidemic. Then again, nothing is really typical about the suicide epidemic in Japan. In general, suicide is a growing public health problem globally, with international suicide rates increasing 60 percent in the last 45 years (World Health Organization 2009). More specifically, Southeastern and the Western Pacific regions of Asia are disproportionately affected, representing 60% of the world's suicides (Suicide Prevention International 2008). Within this region of Asia, the suicide epidemic is particularly devastating in Japan, a country that has seen at least 30,000 deaths from suicide annually since 1998 (Hidaka, et al. 2008, 752). In Japan, suicide is inextricably tied to nearly every facet of society, including its history, religion, media, and economy, creating an intriguing public health challenge for Japan in tackling this epidemic.

Historical Context

Suicide is a dark thread that weaves through centuries of Japanese history as an integral part of culture and society, manifesting itself in various forms over the years. Fusé (1980) investigated one of the primary manifestations of suicide in Japanese culture, *seppuku*, which is “a ritualized form of suicide by disembowelment” (57). This form of suicide first appeared in 716 AD in the story of Harima, a young goddess who slit her stomach after fighting with her god-husband. After such appearances in literature and mythology, *seppuku* spread to the samurai military aristocracy during their rise to power in the 12th century as a form preserving one's honor from the indignity of capture by the enemy. Acts of *seppuku* then peaked during the Mongol invasion in the 13th century, when the military conflict gave the samurai myriad opportunities to use *seppuku* as a show of their valor. After the war, the samurai switched to

performing a form of *seppuku* more appropriate for times of peace, *junshi* or “suicide to follow one's lord to the grave,” (59) as an outlet for expressing their valor and dedication to their lord. *Seppuku* emerged yet again in a slightly different form in the 17th century Japanese legal system as a somewhat more dignified alternative to the death penalty. Throughout the next two hundred years, *seppuku* remained central to Japanese society in its various forms until Japan began to modernize during the Meiji period in the late 1800s and early 1900s. During this time, the Japanese government attempted to adopt a more Western view on suicide and banned *seppuku* as a form of death penalty (Fusé 1980, 59). Despite the ban on *seppuku* in official and political contexts, it continued to be used as a form of voluntary suicide into the mid 1900s. One of the best examples of this is the suicide of 350 military officers following Hirohito's announcement of surrender during World War II (Gordon 2009, 225). While incidences of *seppuku* have since become rare, as Fusé states, “[*seppuku*] remains as a ‘romantic’ tradition deep in the Japanese psyche” (59).

Another manifestation of suicide in Japanese history that may be more memorable to the Western world is the Kamikaze pilots that were used by the Japanese during World War II. While the images of suicide bombers flying into Allied armies strikes only chords of horror in American minds, the kamikaze pilots are viewed very differently in Japan, shown in the words of Japanese Captain Okamura when he referred to the kamikaze pilots as a swarm of bees which die after they have stung (Axell and Kase 2002, 35). This comparison between Kamikaze pilots and bees shows that for the Japanese, being a Kamikaze pilot is a natural role in society, just as it is natural for a bee to sting its enemy and die in the hopes that the sting will protect its fellow bees. Axell and Kase further this idea, explaining that the many Japanese youth recruited to be Kamikaze pilots were viewed as *eirei*, or guardian spirits, of the country, a position held in high honor (2002:35). The honor of the *eirei*

position made it easy to recruit young Japanese and thus, as the war went on, additional suicide weapons were developed such as the *ohka* (human bombs), and *kaiten* (manned torpedoes) (Axell and Kase 2002). In stark contrast to the American view of a suicide mission as unfathomable, the Japanese see the use of suicide weapons as strategic and the many men who died piloting these weapons as respectable soldiers who chose a commendable method of serving their country (Axell and Kase 2002).

While *seppuku* and the Kamikaze soldiers represent the historical and militaristic traditions of suicide in Japan, there are other cultural factors that have added to the current Japanese perspective towards suicide. Religion is one such factor. As discussed in the World Health Organization's report on suicide in Asia, Vijayakumar (2002) has shown that "religion may be protective against suicide, both at the individual and societal level, and this effect may be mediated by the degree to which a given religion sanctions suicide" (Hendin, et al. 2008, 24). This may be particularly true in Japan, which has a unique mix of religions, where 83.9% of the population is Shinto and 71.4% of the population is Buddhist, with many people falling in both categories (CIA World Factbook 2005). Buddhism views suicide as "an empty, act, which will lead to unpleasant consequences such as the loss of a child in the next rebirth" (Hendin, et al. 2008, 25). While this view does not promote suicide, it also does not condemn suicide as strongly as many other religions. Possibly more important, then, is the Shinto view of suicide, which "has little or no concept of the sanctity of human life as this idea is understood in Western Christianity... and [permits] withdrawal from this life through suicide for a wide variety of reasons," including both religious and purely personal reasons ranging from patriotism to romance to philosophy to despair (Barry 1994, 57-58). The combination of the Buddhist and Shinto view of suicide does little to sanction suicide and thus, according to Vijayakumar's findings, likely has little protective effect against suicide. In this way religion plays a role in the suicide epidemic in Japan.

The historical traditions of ritual or militaristic suicide and the religious views towards suicide are vitally important to the present day study of suicide in Japan because they give indispensable insight into the Japanese perspective on suicide. The historical and religious context helps to explain why the Japanese view suicide not as a sin, but almost as a virtue

(Wiseman 2008). Understanding of this perspective is necessary in order to control the suicide epidemic because consideration of the uniquely Japanese view towards suicide will undoubtedly need to be a central part of any public health measures targeting suicide rates in Japan. Also, one must recognize the other cultural factors that do not necessarily affect perspective on suicide, but rather directly affect the rates of suicide. Two such factors are the media and the economy of Japan.

The Media and the Economy

In 2000 Malcolm Gladwell shook up popular notions about the spread of ideas when he introduced the concept of the tipping point, the small event that serves as the pathogen in social epidemics. One example he used to explain this concept was that highly publicized suicides could serve as the tipping point in suicide epidemics, citing one study that found that media coverage of suicides predicts higher rates of traffic fatalities, which are often indirect and less public forms of suicide (Gladwell 2000, 224). This idea that media coverage of suicides increases suicide rates, something called the imitation effect, has been reported in numerous studies, many of which also add the idea that the effect of the media depends upon how receptive the audience is (Chiu, Ko and Wu 2007, 585). Stack looked at the effect of media coverage of suicides on suicide rates in Japan in particular from 1955-1985 and found similar results to previous studies done Western cultures. That is, only stories of state citizens have an imitation effect; news stories of foreigners' suicides have no imitation effect on the Japanese (Stack 1996, 139). Additionally, he found that the imitation effect was not greater in Japan than it was in the United States (1996:140). Though Stack had predicted a greater effect in Japan due to increased receptiveness to suicide in Japanese society, he instead found that the factors affecting the extent of the imitation effect are unclear. In general, there appears to be a substantial effect of media coverage on suicide rates in general and in Japanese society, something that should be considered when constructing public health prevention measures for suicide.

While the link between the media and suicide rates is a recent discovery, Morselli drew a link between poor economic conditions and a rise in suicide rates as early as 1882 (as cited in Chang, Gunnell, Sterne, Lu & Cheng, 2009, p. 1323). Chang et al showed this link again in 2009 in a study of the

effects of the economic crisis of 1997 and 1998 on suicide rates in a number of countries in East and Southeast Asia, including Japan. They found that the economic crisis “was associated with an excess of around 10,000 suicides in Japan, Hong Kong and Korea” (1330). Moreover, of the socio-economic variables studied, “changes in unemployment rates were most closely associated with rises in suicide after the Asian economic crisis” (1330). As a result, working-age men were the group that was most affected (p. 1330). Such information shows that the economy is an important risk factor for public health officials to watch when monitoring suicide rates; and, should economic turmoil occur, the working-age men are the target risk group to watch.

The above discussion serves to explain through cultural influences why the suicide epidemic in Japan is different from the epidemic in other countries. The discussion also attempts to tease out the extent to which global risk factors such as the media and the economy affect Japan in particular. As Bertolote & Fleishmann explain:

Global figures and statistics are very suitable for giving a broad view of a problem, raising awareness about it and providing a means of comparison with other problems. However, they hide important regional and local characteristics and cannot replace a sound local system of monitoring suicide trends, including sociodemographic, psychiatric and psychological variables. (2002, 8)

Analyzing the differences in the effect of global risk factors between countries is one step towards finding the local characteristics that are hidden within broad international data. Japan is unique because, unlike many other Asian countries, local data is available due to the country’s strict system of reporting detailed information about all suicides (Hendin, et al. 2008, 8). Because the infrastructure is already in place, Japan currently has a better chance than many of its Asian neighbors to discover the sociodemographic, psychiatric, and psychological variables that Bertolote & Fleishmann emphasize.

An Epidemiological Perspective

Understanding all of these variables requires the consideration of suicide from an epidemiological perspective. Unfortunately, viewing suicide from an epidemiological perspective is a lot like wearing sunglasses indoors; nothing is as clear as it could be. Suicide fits somewhere in the grey areas between the

traditional epidemiological concept of communicable and noncommunicable disease. The classification of an epidemic as communicable or noncommunicable is significant because it determines how the epidemic is treated and which prevention measures are employed. If suicide were classified as a communicable disease, each outbreak could be treated as a uniform event with one common cause and thus one common prevention measure. If, on the other hand, suicide were considered more like a noncommunicable disease, prevention would focus more on encouraging lifestyle changes.

In some ways suicide resembles a communicable disease, which is defined as:

An illness due to a specific infection agent or its toxic products that arises through transmission of that agent or its products from an infected person animal or reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment. (Porta 2008, 46-47)

Suicide fits this definition because it can be transmitted between people, as seen in the effects of the media on suicide rates. However, there is no clear infection agent or toxic product that causes the infection, placing suicide outside the previously stated definition of a communicable disease. In other ways, suicide resembles the non-communicable diseases, which are defined as, “chronic conditions that do not result from an acute infection process...[They] cause death, dysfunction, or impairment in the quality of life and the usually develop over relatively long periods - at first without causing symptoms” (Noncommunicable Disease Control 2002). Also, according to Breslow & Cengage, injuries are included as a form of noncommunicable disease (2002). Suicide fits in the given context of a noncommunicable disease in a couple of ways. In a majority of cases, suicide fits in the context of mental illness, a traditionally recognized noncommunicable disease (Noncommunicable Disease Control 2002). In fact, “90% of people who commit suicide have one or more diagnosable mental illness” (Conwell and Brent 1995). The other 10% of suicides that are not preceded by mental illness can also be in the category of noncommunicable diseases, but in the context of injury instead of mental illness. However, because suicide itself is neither a mental illness nor an injury, per sé, it once again falls outside traditional epidemiological definitions. Because suicide cannot

be clearly categorized, prevention measures, at least in Asia, resemble those from both categories.

Prevention Measures

Recently, Japan has employed a particularly notable community-based suicide prevention program in six communities around the city of Akita (Hendin, et al. 2008). This program takes a multi-faceted approach, including “raising public awareness, ...specialist training in suicide prevention, screening for depression, counselling (sic) for those who needed it, and communal activities for senior citizens to decrease isolation” (Hendin, et al. 2008, 32). One of the most unique aspects of this project is that it is “the only one of its kind to have demonstrable measures to evaluate its success” (200832). Using these evaluative measures the Japanese government found that the program was highly successful, and it is now planning to create similar programs in other communities (Hendin, et al. 2008, 32). Other Asian countries have not employed such holistic programs, but they are still taking action. Korea, New Zealand, China, Singapore, Pakistan, and Malaysia have all established strong public education and awareness campaigns to inform the population about suicide and depression (Hendin, et al. 2008, 32-34). Both these general awareness campaigns and the multi-faceted community approaches to preventing suicide resemble a non-communicable disease prevention approach as they aim to make broad lifestyle changes in the population, a technique often used when fighting obesity or cardiovascular disease (U. S. Department of Health and Human Services n.d., World Health Organization 2010).

In addition to the previously described broad public health measures, some countries are also acknowledging the communicable characteristics of the suicide epidemic and thus taking more directed, specific approaches to preventing single risk factors, such as the media’s influence on suicide rates. Australia, Malaysia, the Republic of Korea, and New Zealand have all created national guidelines for media coverage of suicides, which have been met with mixed success. Australia implemented a set of guidelines for media coverage in the country called Reporting Suicide and Mental Illness, which “have been relatively well received by the media professionals” (Hendin, et al. 2008, 41). In contrast, New Zealand tried to issue media guidelines in 1998, but did not consult enough media personnel during the construction of the guidelines and, consequently, New

Zealand’s journalists dismissed the guidelines soon after their implementation. However, the journalists were not against the guidelines as a whole, but rather only against the original format of the guidelines, demonstrated by the recent efforts of these same journalists to work with suicide prevention researchers and collaboratively establish new guidelines for the country (Hendin, et al. 2008, 42). The stories of Australia and New Zealand leave hope that through collaboration between the media and mental health groups guidelines can and will be established in many more Asian countries. Additionally, there is hope that these guidelines will, in fact, decrease suicide rates in the respective countries; but, to date none of the studies that aim to determine the effectiveness of media guidelines have been completed (Hendin, et al. 2008, 44).

Both the broad public awareness campaigns and the specific media guidelines are advantageous in their own way, one because it reaches a larger population and the other because it more thoroughly addresses one of the risk factors for suicide. When combined, as is occurring currently in many Asian countries, they may be very effective in curbing the increasing rate of suicides in many of these countries. Such combined efforts should be lauded because they require each country’s public health officials to keep in mind the unique epidemiological nature of suicide and employ creativity and flexibility when crafting public health interventions. Additionally, however, these public health professionals must remember that, as stated by the World Health Organization, “while the risk factors for suicide are universal, their importance and nature differ across countries and cultures” (Suicide prevention in different cultures 2009). That is, while risk factors may be shared across countries, epidemics still have unique manifestations in each country. For this reason public health interventions need to be individually designed to fit into each country’s cultural and epidemiological setting.

Conclusions

While this essay began by discussing the unique characteristics of suicide in Japan, it also reveals important lessons for dealing with non-traditional epidemics in a larger context, notably the immense necessity of considering the cultural context of a country and the unique characteristics of an epidemic when forming public health interventions. While globalization may be blurring the distinct

cultural lines between societies, notable differences still exist between various cultures' views on suicide. For example, at least to date, globalization has not yet erased the thousands of years of unique history in Japan that are shaping how the suicide epidemic develops in Japan.

Therefore, the field of public health must keep a flexible view of disease as it enters the 21st century. All forthcoming epidemics may not fit traditional boundaries, but this does not mean they are insurmountable. As demonstrated by this discussion of the suicide epidemic in Japan, one can delve into the history and culture of a country to understand the factors influencing an epidemic. From there, public health interventions can employ ingenuity and bend the traditional rules of epidemiology to generate suitable and successful public health measures. When we keep individuality of an epidemic and culture in mind, no epidemic is beyond the scope of our capabilities.

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