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be valuable to collect evidence on the impact of the intervention on the behavioural responses of gatekeepers and on any individuals they identify as at risk and refer for treatment even if there is no demonstrable change in the rates of attempted and completed suicide.

Optimizing the potential of gatekeepers as suicide prevention agents

Educating gatekeepers is an important addition to the full complement of suicide prevention strategies available in Asian countries. The role of these gatekeepers will vary, depending on the specialist resources that are available in the given country (or region within the country). Where psychiatrists and other dedicated mental health care workers are available, the role of gatekeepers will be one of acting as a channel for those at heightened risk of suicide, and training should therefore focus on assessment and referral skills. The same may be true in circumstances where primary care providers with particular expertise in mental health care are on hand to provide appropriate interventions. In countries like China and India where there are large rural populations and the specialist mental health workforce is thinly spread, however, there may be more of a blurring of the role of gatekeepers as referrers and gatekeepers as direct service providers. By necessity, gatekeepers in these countries are required to offer some degree of intervention themselves, and require additional education in keeping the individual safe, active listening, problem-solving and so on.

Optimizing the potential of gatekeepers as suicide prevention agents in Asian countries will require careful consideration of their role in given locations. The content of training for gatekeepers will vary accordingly, as may the intensity of the training (e.g., the number and duration of training sessions). Modes of delivery may also differ, depending on the target audience(s). At present, little guidance is available regarding the sort of training that may be best for given gatekeeper groups because of the dearth of solid evaluative evidence in this area. For this reason, careful needs analysis will have to be conducted in order to identify the exact requirements of any training. The processes, impacts, and outcomes of such training should be carefully monitored via sound evaluations that are conducted as rigorously as possible.

Summary and conclusion

Educating gatekeepers in suicide prevention shows promise as a means of reducing the suicide rate in Asian countries, provided that due consideration is given to the context in

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which these gatekeepers are operating. Participating countries have put in place a range of gatekeeper education programmes in an effort to improve the assessment, referral, and (in some cases) direct intervention skills of individuals who regularly come into contact with vulnerable members of the community by virtue of their responsibilities. There is as yet no consensus on the core components of gatekeeper training, and it is likely that the nature and structure of the training will desirably vary, depending on the particular gatekeeper group in question and their role in the community relative to the role of others who might be involved in suicide prevention. Improved evaluation efforts are required.

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Table 5: Key gatekeeper education activities in participating countries *

Country	Identifying actor	Gatekeeper group	Activities	Evaluation
AUSTRALIA	Department of Health and Ageing and Department of Education, Science and Training	Teachers and other school staff	MindMatters programme, which provides training in building resilience and identifying and working with students at high risk	Evaluated
	Wesley Mission	Volunteers and lay people	LifeForce Suicide Prevention Program, which aims to equip community members to deal with a suicidal crisis in an appropriate manner	Not evaluated
CHINA	Beijing Suicide Research and Prevention Center, supporting the Women's Federation	Tertiary education personnel	Several university-based, small area projects	No evaluation
	National School Health Training Centers, established by the Chinese Ministry of Education	School health workers and social workers	Intensive training in mental health and suicide prevention	Evaluated
	Hong Kong Jockey Club Centre for Suicide Research and Prevention	Teachers, social workers and related professionals, mixed groups	Training programmes for various frontline staff	Most programmes have been evaluated
INDIA	Education and Manpower Bureau Quality Education Fund	Teachers	Training in provision of onsite support to students - e.g., the Student Psychological Resilience and Emotional Intelligence Enhancement (SPREE) Project	Evaluated
	SNEHA	Teachers and police	Awareness programmes	Not evaluated
JAPAN	Ministry of Health, Labour and Welfare, in co-operation with the Japanese Medical Association	Mixed groups	Education in basic suicide prevention skills	Evaluation planned
	Ministry of Health	Mixed groups	Education delivered as part of the Japanese Multimodal Intervention Trials for Suicide Prevention	Evaluation planned
MALAYSIA			No non-medical gatekeeper education activities	

NEW ZEALAND	Ministries of Education, Health and Youth Development	Teachers and other school personnel	Resources outlining the roles and responsibilities of school personnel in suicide prevention, and offering guidance about best practice in suicide prevention	Reviewed
	Department of Child, Youth and Family Services	Family members and qualified caregivers	Training on identifying young people at risk and prevention and intervention techniques	Ongoing evaluation
	Department of Corrections	Prison staff	Training focusing on suicide awareness and prevention	Not evaluated
PAKISTAN			No non-medical gatekeeper education activities	
REPUBLIC OF KOREA (THE)	Sponsored by Community Chest of Korea and implemented by the Korean Association for Suicide Prevention	Teachers	Education programme and resources providing basic knowledge about youth suicide and depression and their treatment and prevention, as well as practical skills	N/A
SINGAPORE	Samaritans of Singapore	Counsellors and welfare workers, police officers	Training on identifying signs of distress and reacting appropriately	Not evaluated
SRI LANKA	Ministry of Health	Teachers	Training in identifying children who have behavioural and other problems	Not evaluated
THAILAND	Ministry of Public Health	Youth leaders, volunteers and community leaders	Training in recognizing depression, providing preliminary assistance, and developing referral networks	Not evaluated
	Bureau of Mental Health Technical Development, Department of Mental Health, Chang Mai District Public Health Centre	Buddhist monks	Education on applying Buddhist dharma to assist suicidal individuals and training in specific counselling skills	Not evaluated
VIET NAM			No non-medical gatekeeper education activities	

* Responses to the questionnaire by STOPS country representatives

CHAPTER 9

Addressing in Asia the Problems of Survivors of Suicide

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Abstract

In any given year, around 12 million people in Asia may be actively experiencing the aftermath of a suicide. The associated grief and loss may be severe and children who have lost a parent are among the most deeply affected. Because of the disproportionately high rate of suicide in China and India among young married women, large numbers of children have lost their mothers to suicide. Despite this, few services for survivors are available in the Asian countries participating in the Strategies to Prevent Suicide (STOPS) project; only six of the countries have any survivors support groups and only two of these have more than a few groups. In some countries cultural, religious and political factors that shape taboos about suicide contribute to the problem. There is a clear imperative to raise awareness of the needs of survivors among religious and political leaders, and among the general public. There is a need to strengthen and expand service provision in this area; Suicide Prevention International (SPI) is beginning to address that need.

People bereaved by suicide (termed 'survivors' in the current chapter) often experience significant emotional sequelae as a result of their loss. Clark and Goldney (2000) and Wong et al. (2007) discuss the kinds of grief reactions that may be experienced by survivors, acknowledging that different people will respond differently. Some may experience shock, disbelief or horror. Others may feel the need to seek explanations of how and why the suicide occurred. Guilt, blame and shame are also common reactions, with many feeling responsible for not having 'seen the signs' and prevented the death. These feelings are often accompanied by feelings of stigma, loss of trust and social isolation. Rejection and anger are also experienced by many. Some may experience some sort of relief or feeling that the person is no longer in emotional distress, particularly in circumstances where the suicide has been preceded by depression or other mental illness. Alternatively, the suicide may be viewed as a wasted life or as a family disaster. Survivors often experience suicidal thoughts themselves, either as a result of their wanting to join the deceased or because of depression and grief.

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Children are particularly vulnerable not only to the loss of a parent and the weakened economic viability of the household but to the fact that a traumatized surviving parent may be functioning less well as a parent than previously. In addition there is a genetic vulnerability to suicide, and the child, unless adopted, has a genetic link to the deceased parent.

The current chapter examines the emotional support available to survivors of suicide in the countries participating in the Strategies to Prevent Suicide (STOPS) project. It describes the services available for survivors in these countries, and considers some of the impediments to service delivery. It also makes reference to current research and evaluation efforts in this area. Finally, it makes some suggestions regarding future steps that might be taken to strengthen the assistance and support available to survivors of suicide in Asia.

Issues for survivors of suicide in Asia

Clark and Goldney (2000) note that an average of six people experience grief and loss as the result of any given suicide, and that their level of grief may remain high for up to four years. Given that there are around half a million suicides in Asia in any given year (see Chapter 1), this translates to 12 million people actively experiencing loss and grief as a result of suicide at any particular time. In fact, this estimate is probably conservative, given that nuclear families are larger in most Asian countries than in Europe and the United States and there is a greater tendency for people to live in joint and extended family systems.

The issues for survivors of suicide in Asia may be amplified by cultural and religious norms which influence attitudes towards suicide (see Chapter 2). In countries like Pakistan, for example, suicide is strongly condemned on religious grounds and considered a criminal offence. According to Islam, suicide is a sin which results in refusal of entry to heaven. Families in which suicide has occurred may be ostracized and isolated, and the marriage prospects of sisters and daughters of people who die by suicide may be marred (Khan and Prince, 2003). These attitudes may impact the way people respond to survivors and the likelihood that survivors seek help or identify themselves as having been bereaved by suicide.

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Services for survivors of suicide in Asia

The above attitudinal problems are further compounded by the fact that very few formal services are provided for survivors of suicide in Asia. According to the country questionnaires completed by the Asian representatives in the STOPS project, few of the participating countries have initiatives in place to address survivors' needs (see Table 6). A number of countries (e.g., Malaysia, Pakistan, Thailand, Viet Nam) have no services in place at all. Examples of professional bereavement support and/or response services for survivors are rare in Asia; only Australia and New Zealand have committed resources in this area, via specific projects and initiatives. These countries have also developed information and support packs for survivors. Hong Kong SAR, however, has initiated a number of pilot projects designed to help survivors.

Although not shown in Table 6, most of the limited services for survivors available are provided by non-professional groups. For example, the Ashinaga Foundation in Japan provides emotional and financial support to children who have lost a parent to suicide. Sri Lankan church organizations provide memorial services and religious ceremonies. The Singapore Local Outreach to Suicide Survivors (LOSS) programme is informed by police when a suicide occurs, and they dispatch a team of two Samaritans to attend the survivors.

The information provided in Table 6 suggests that because of the lack of formal services in most participating countries, there is a reliance on small, local survivor self-help groups and other types of support groups. Table 7 profiles these survivor support groups. Six of the Asian participating countries have survivor support groups (Australia, China, China, Hong Kong Special Administrative Region (Hong Kong SAR), Japan, New Zealand, and Singapore), mostly with formal organizational support of some sort. These are the only services available for survivors in China, Hong Kong SAR, Japan, and Singapore. Most of these countries have only a limited number of such support groups, but Australia and Japan report 'more than a dozen'. They tend to meet at least once a month; occasionally more frequently for the recently bereaved. They tend to be located in cities and suburban areas. Few include a mental health professional, or even offer referral for psychiatric consultation or treatment if it seems indicated. Some of these groups have difficulty reaching out to survivors because of the stigma associated with suicide. The majority of those countries without existing survivor support groups have some potential to start such groups, sponsored by a local organizing body.

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According to participants' questionnaire responses, there are some common barriers to the provision of services for survivors in Asian countries. There is a lack of awareness that the aftermath of suicide can be significant and last for some time, and that suicide survivors represent a significant at-risk group. Even in circumstances where there is some awareness, there is often a lack of financial and human resources (e.g., few trained professionals are available to conduct programmes for survivors) and/or a lack of organizational governance of programmes. Perhaps most importantly, however, the cultural, religious and sometimes even political influences on attitudes towards suicide render it a taboo subject. As a consequence, family members are reluctant to identify themselves as having been directly affected by suicide, and are reticent to talk about the topic to strangers. The fact that family members of those who attempt or complete suicide often want this information kept secret means that even when services such as support groups are available, attendance is often poor.

Research and evaluation

Research and evaluation activities in the area of survivor programmes have been limited in participating countries, with a few notable exceptions. In Hong Kong SAR, for example, research is being undertaken into the incidence of and risk factors for posttraumatic stress disorder among suicide survivors. In Thailand, a study considering the impact of a suicide by a patient on Thai psychiatrists has been completed (Thomyangkoon and Leenaars, 2007). In Australia, evaluations are being conducted alongside the development of support and information packs and the delivery of professional bereavement services. In India, efforts were made to evaluate the single survivor support group that previously existed (run by a nongovernmental organization) using a range of mental health outcome measures, but the sample size was too small to draw firm conclusions. In New Zealand, one study has explored the impact of suicide on family members; another study has examined the training and experience of volunteers who provide support to bereaved families. An evaluation is planned of a new national postvention initiative in which clinical psychologists who specialize in suicide prevention train, supervise, and monitor volunteers who provide support for survivors.

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Next steps

There is a clear need to raise awareness about the needs of survivors of suicide in many participating Asian countries, and to remove barriers to their seeking support. This is not a simple task, and will involve a multi-faceted approach. Raising awareness among religious leaders is vital, and may help to address the religious censure that prevents many people coming forward to seek help, particularly if churches and mosques give their imprimatur to survivor programmes. Lobbying political leaders is also important, particularly in Asian countries where suicide is still considered a crime, in order that survivors can seek help without fear of being condemned as accomplices. Improving the knowledge and attitudes of the general public (e.g., via print and electronic media) is also crucial, and may help to reduce the stigma experienced by survivors.

Beyond raising awareness, there is a need to strengthen existing efforts to address the needs of survivors. Services should be culturally sensitive in order to address the reluctance of many survivors to discuss suicide and its emotional consequences. Current services should be expanded, and new services developed.

Suicide Prevention International (SPI) is attempting to fill this need by partnering with LOSS, a model programme in the United States for survivors of suicide in Chicago, in training qualified mental health professionals from Asia to organize and run survivor support groups and programmes.

LOSS (Loving Outreach for Survivors of Suicide) has an organized plan for individual treatment for survivors, weekly support groups of ten sessions for the recently bereaved, and ongoing monthly support groups. Started as a single group over 20 years ago, the programme's success led to demand for its services so there are now ten linked groups in the city. All of their programmes are led by trained professionals, have an effective plan for providing help, and central oversight to ensure that guidelines are followed. They have developed evaluation criteria for the individual treatment of survivors that they are now adapting for the weekly bereavement groups.

SPI and LOSS are training mental health professionals representing organizations from a few countries in Asia in effective methods of helping children and family members deal with the impact of suicide. The goal is for those trained not only to develop survivor support programs in their own cities but in time to serve as resources and become centres for training professionals and volunteers from other regions in

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their own countries, and possibly from other Asian countries. It will not be possible to have professionals in groups in all regions but the objective then will be to select and train group leaders. This initiative will be discussed in Chapter 10.

Summary and conclusions

The problems of survivors of suicide in Asian countries are under-recognized and under-addressed. In most Asian countries, few or no services are provided for survivors in any systematic way. Cultural, religious, and political factors underpin this picture; taboos about suicide militate against services being provided for survivors and make it difficult for survivors to approach the few services that do exist. There is a clear imperative to raise awareness of the needs of survivors among religious and political leaders, and among the general public. Since the need to expand service provision in this area is so evident it is encouraging that representatives of all participating countries are confident that survivor support groups could be started in their countries and that there would be organizations that would support these efforts. This augurs well for the efforts of SPI in addressing this need.

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Table 6: Services for survivors of suicide in participating countries*

	Australia	China	China, Hong Kong SAR	India	Japan	Malaysia	New Zealand	Pakistan	Republic of Korea (the)	Singapore	Sri Lanka	Thailand	Viet Nam
Information and support packs	Yes	No	No	No	No	No	Yes	No	Not available	Not available	No	No	No
Professional bereavement support and/or response services	Yes	No	No	No	No	No	Yes	No	Not available	Not available	No	No	No
Survivors support groups	Yes	Yes	Yes	No	Yes	No	Yes	No	No	Yes	Not available	No	No

* Information supplied by STOPS country representatives via questionnaire

Table 7: Survivors support groups in participating countries*

	Australia	China	China, Hong Kong SAR	India	Japan	Malaysia	New Zealand	Pakistan	Republic of Korea (the)	Singapore	Sri Lanka	Thailand	Viet Nam
Are there currently survivors of suicide support groups in your country (i.e., groups of survivors that meet at least once a month to discuss their problems)?	Yes	Yes	Yes	None, though there had been one	Yes	No	Yes	No	No	Yes	Not available	No	No
If so, estimate how many there are.	More than a dozen	A few	A few	Not applicable	More than a dozen	Not applicable	A few	Not applicable	Not applicable	One	Not available	Not applicable	Not applicable
Where are they located?	In large cities, suburban areas and rural areas	In large cities	In large cities	Not applicable	In large cities	Not applicable	In suburban areas	Not applicable	Not applicable	Not available	Not available	Not applicable	Not applicable

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	Australia	China	China, Hong Kong SAR	India	Japan	Malaysia	New Zealand	Pakistan	Republic of Korea (the)	Singapore	Sri Lanka	Thailand	Viet Nam
Do any of the groups include a mental health professional?	Don't know	Most	Some	Not applicable	Some	Not applicable	None	Not applicable	Not applicable	None	Not available	Not applicable	Not applicable
Are there support groups meeting weekly for 10 weeks for the recently bereaved?	Don't know	Yes	Don't know	Not applicable	No	Not applicable	No	Not applicable	Not applicable	Yes	Not available	Not applicable	Not applicable
If yes, do they include a mental health professional?	Don't know	Yes	Yes	Not applicable	Not available	Not applicable	Not applicable	Not applicable	Not applicable	No	Not available	Not applicable	Not applicable
Is there organizational support for the survivors groups?	Yes	Yes	Yes	Not applicable	Yes	Not applicable	Not yet	Not applicable	Not applicable	Yes	Not available	Not applicable	Not applicable
Is psychiatric consultation or treatment available if it seems indicated?	Yes	Yes	Don't know	Not applicable	Yes	Not applicable	Not in a co-ordinated way	Not applicable	Not applicable	Yes	Not available	Not applicable	Not applicable
Do you think it would be possible to start survivors groups in your country?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not available	Not available	Yes
If yes, is there an organization in the country that would support them?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not available	Not available	Yes
If you don't think it possible to start such groups, why not?	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not available	Not available	Not applicable

* Information supplied by STOPS country representatives via questionnaire

Takahashi, Y.: Japan. In Yip, P.S. (Ed.) *Suicide in Asia: Causes and Prevention*. pp.7-17, Hong Kong: Hong Kong University Press, 2008.

Japan

Yoshitomo Takahashi

This chapter provides an epidemiological profile of suicide in Japan, which has one of the highest suicide rates in Asia. Suicide rates in Japan have increased significantly over the past decade, with a rate of 23.1 per 100,000 in 2003. Suicide rates have increased with age. The gender (male and female) ratio was about 2.6 to 1. Rural areas have a higher rate than that of urban areas. Depression is commonly found to be present among those who commit suicide and has been shown to be work related. Some implemented measures for suicide prevention are discussed.

Introduction

The average annual number of suicides for a ten-year-period between 1988 and 1997 was 22,410. However, the number became 32,863 in 1998, an increase of more than 10,000 in one year. Ever since then, the total number of suicides for each year has remained in the 30,000s. It even reached the record high of 34,427 in 2003. This means that about 90 people per day and about four people per hour end their life in Japan, (Figure 1). This situation should be considered as a grave crisis for mental health in Japan.

The degree of severity of the current situation of suicide incidents becomes more obvious when compared with traffic accident fatalities. People used to call this a "traffic war," and annual traffic fatalities reached 17,000 at their worst in the 1970s. However, as a result of long-term countermeasures, the annual traffic fatalities in 2003 decreased to 7,702. Although it may seem questionable to make a simple comparison between these two figures, since traffic fatalities only include people who die within 24 hours after the accident, the fact that the number of

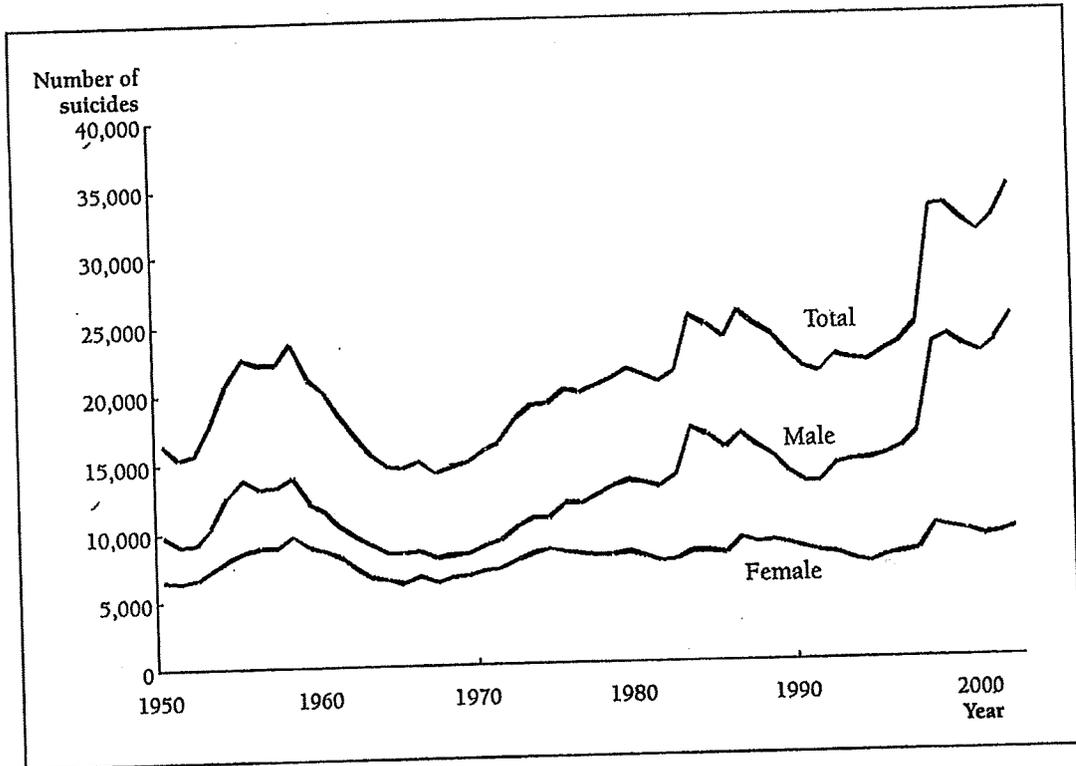


Figure 1 Annual number of suicide in Japan (NPA 2004).

suicide incidents is 4.5 times greater than the traffic fatalities in Japan remains striking.

The national statistics on suicide are made public, both by the National Policy Agency (NPA) and the Ministry of Health, Labor, and Welfare (MHLW). According to the Population Survey Report by the MHLW, the number of suicide incidents in 2003 was reported to be 32,082, which is approximately 2,000 fewer than the number announced by the NPA. The figure by the MHLW has been 1,000 to 2,000 fewer than the figure by the NPA every year. This might be due to the fact that a family doctor who knows well the deceased person and his/her family tends to avoid recording "suicide" as the clear cause of death on the death certificate.

Gender

In 2003, male suicide incidents were 24,963, and female suicide incidents were 9,464. The male-female ratio of accomplished suicides was 2.6 to 1. Although there are a few exceptions (e.g., Peoples' Republic China), completed suicide is more common among men worldwide.

There is no such great gender difference in the morbidity of mental disorders that are closely associated with suicide. Therefore, the question naturally arises

of how this gender difference in suicide incidents can be explained. There are a few interpretations for this (Takahashi 1992).

- (1) Females are biologically superior to males in their ability to control impulsiveness. Males tend to use more hostile, impulsive, and aggressive behavior in a problem-solving situation.
- (2) In relation to (1), males tend to take more lethal measures when trying to commit suicide.
- (3) Females have less resistance consulting with others when faced with problems and tend to take a candid attitude toward them.

Social expectations or norms, such as "Men should be strong," "Men should not show weakness to others," and "Men should not cry," are so strong that men cannot easily consult with others when they have a problem. It is obvious that men tend to bear problems by themselves. Biological and social factors, such as the ones described above, are thought to contribute to the outstanding gender difference in accomplished suicide incidents.

Age

Figure 2 shows the age distribution of suicide, in both males and females, in Japan. Elderly people have always been in the high-risk group. In 2003, 33.5% of suicide incidents occurred in the population of 60-year-olds and older. This phenomenon of the elderly population showing a higher suicide rate than the younger generation is not limited to Japan but is a general characteristic among developed countries.

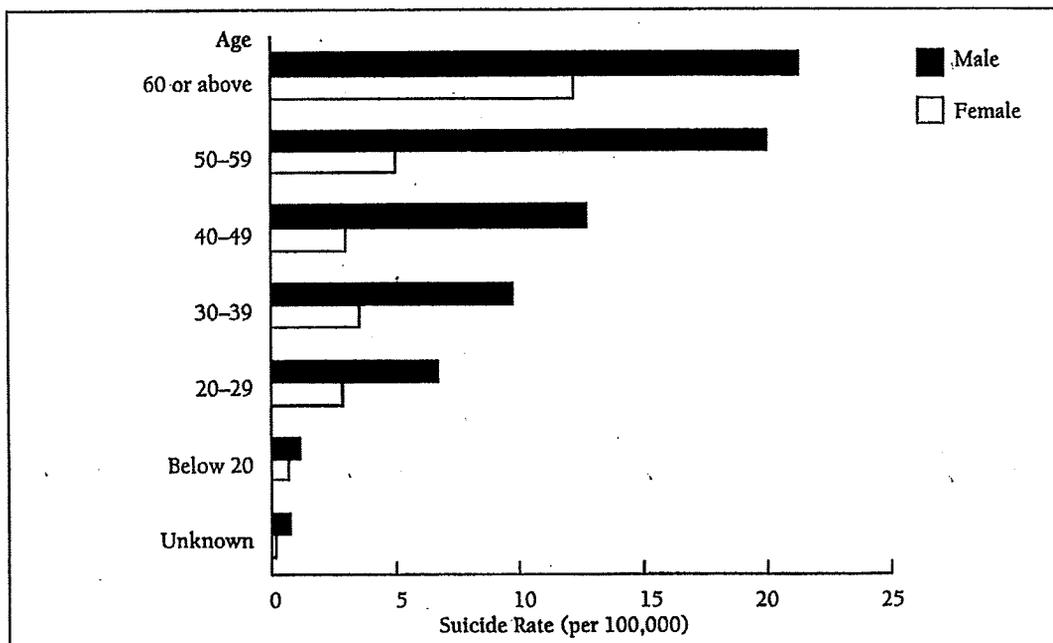


Figure 2 Age distribution of suicide in males and females.

In addition, 25% of people who committed suicide were in their 50s, and 15.7% were in their 40s. Thus, 40% of people committing suicide in Japan are in their most productive years. This also contrasts with the fact that suicide incidents among young people increased in the 1980s in many countries in Europe and the USA.

Meanwhile, the number of suicide deaths in their 30s was 4,603 in 2003, which was a 17% increase from the previous year. Although, people committing suicide in their 40s and 50s have constituted a noticeable trend since 1998, suicides among people in their 30s show an increase at this point and onwards.

Employee layoffs in the long-lasting economic recession mainly scarified people in the 40s and 50s. This tendency might impose a bigger burden to the younger generation in the work place.

Suicide Rates of Each Prefecture

The suicide rate of each prefecture is shown in Figure 3. Japan's suicide rate in 2003 was 27 per 100,000.

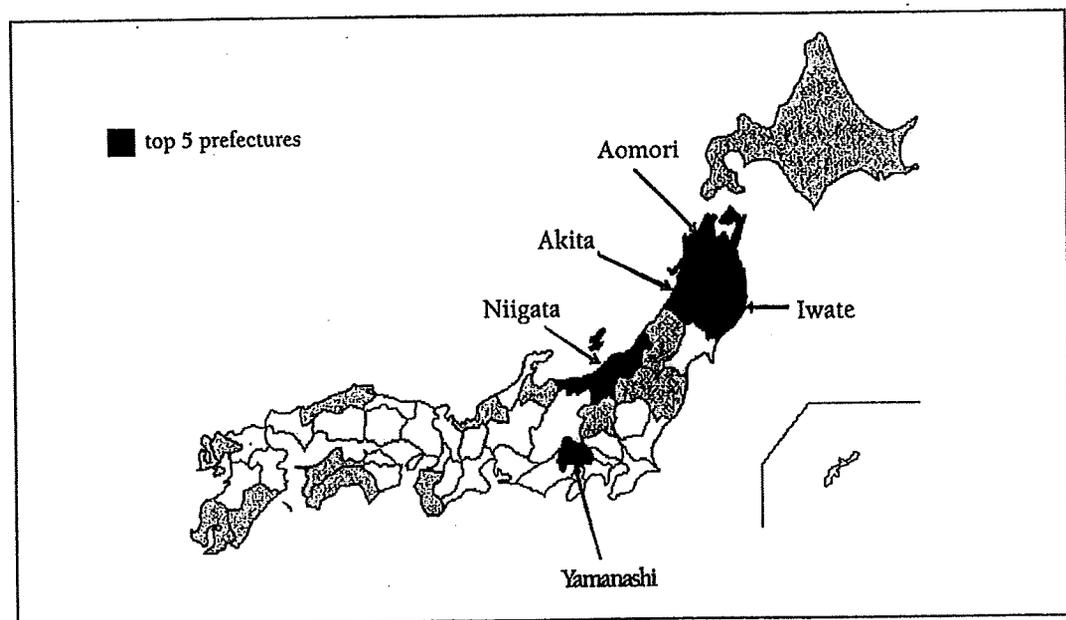


Figure 3 Suicide rate of each prefecture (above average rate).

Note: Prefectures with grey color show those with above average suicide rates and prefectures with dark color show those with the five highest suicide rates

Prefectures in the northernmost part of Honshu, such as Akita, Aomori, and Iwate, plus Niigata, have been showing a certain tendency toward a relatively high suicide rate. In these areas, this reality is contemplated, and people have begun to take proactive measures to prevent suicides in the community.

Prefectures that have a rapidly aging population also show high suicide rates. For instance, Akita Prefecture currently has a demographic composition similar to the one projected for Japan in 2020. On the other hand, statistics show urban areas as having a relatively low suicide rate; this is thought to be related to the fact that the younger population constitutes a greater portion in these areas.

In addition to the rapidly aging society, there is a report suggesting that prefectures with greater alcohol consumption and a higher rate of cerebrovascular disorders have a higher suicide rate. This suggestion is worth examining since both conditions are closely associated with depressive states (Conner et al. 2003). Furthermore, some have pointed out that the social climate where people have self-accusing tendencies when they are facing problems or where the majority of people think that life has become meaningless when they get too old to work is related to the higher suicide rate (Chiu et al. 2003; Takahashi et al. 1998).

Motives

According to the 2003 report of the NPA (2004) the most common motive for suicide was "health problem" (15,416), followed by "financial or personal matter" (8,897), "domestic trouble" (2,938), and "problem at the work place" (1,878). Among these, "financial or personal matter" has increased by 12% compared to the previous year, and the mass media have covered this sensationally as an outcome of the recession. Focusing on the generation and gender of the people who committed suicide because of "financial or personal matter," males in their 50s counted as the largest portion at 34%, followed by males in their 40s (20%). In terms of the detail of the motive, "debt" constituted a predominantly large portion at 56%, followed by "hardship of life" at 15%, and "business slump" at 12%. The number of people who committed suicide due to "financial or personal matter" was 1,703 in 1978, the first year the statistics for motives were taken, and this number has stayed between 1,000 and 3,000. The percentage of the total has been between 10% and 19%. However, numbers have continued to climb every year since it reached the 6,000s in 1998, and its percentage of the total hit the record high of 26% in the latest statistics.

It goes without saying that suicide is a complicated phenomenon, stemming from a variety of causes, and is impossible to explain with a single factor. It includes a process that can be called a preparatory state. Such a state is formed by the complex intertwining of various factors, such as stresses, mental disorders, a personality that tends to take in problems, family factors, etc. *In this situation*, suicide happens when triggered by some kind of an incident (a precipitating event). The precipitating event sometimes can appear to be just a minor event to an outsider.

In order to examine the cause or motive for the suicide, both the preparatory state and the precipitating event should be explored. It is possible that someone abruptly committed suicide by a trigger of an extremely grave event. However, in reality, the majority of suicides happen after a preparatory state has gradually been formed over a long period of time.

Since this data are collected by the police, who may not have enough training or knowledge in psychiatry and psychology, chances are high that only a rather superficial factor will be identified. It is also necessary to consider that the police make a point of picking out only one motive from various factors. For example, "health problem" is currently ranked the number one cause of suicide. Although this had been further categorized, in the statistics taken from 1999, into "suffering from illness" and "mental disorders including alcohol dependence," they have been lumped together as "health problem." This means that we do not know if someone was suffering from a physical disorder or a mental disorder.

Moreover, suicide due to a "financial or personal matter," even though attracting more attention since 1998, is undeniably a reason that more people have killed themselves in this long-term harsh economic recession. However, there is a possibility that the police who have been constantly surrounded by information about the unprecedented "great depression of Heisei," like any other citizens, were affected by the information when they had to categorize motives for suicide.

As mentioned above, categorizing each suicide case by a single motive can be a big problem. Therefore, it remains highly questionable to interpret motives for suicide based only on the statistics provided by the NPA.

International Comparison of Suicide Rate

Since it is not very realistic to include the statistics of all countries, only the figures of Europe, the USA, and Japan are shown in Figure 4 (WHO 2003). Although the year the statistics were taken of each country varied, all were taken around the year 2000 and should be relevant in examining the tendencies of recent years. The suicide figure of Japan was taken in 2003.

The reality is that countries with low rates of life expectancy have not paid enough attention to the issue of suicide because many people are dying of starvation or simple infectious diseases. Given this situation, countries that submit relatively accurate statistics to the World Health Organization (WHO) are limited to Europe and the USA.

Until the mid 1990s, the suicide rate in Japan remained around 18 per 100,000 people, which was a moderate figure compared to Western countries; it had been slightly higher than that of Germany and slightly lower than France's. However,

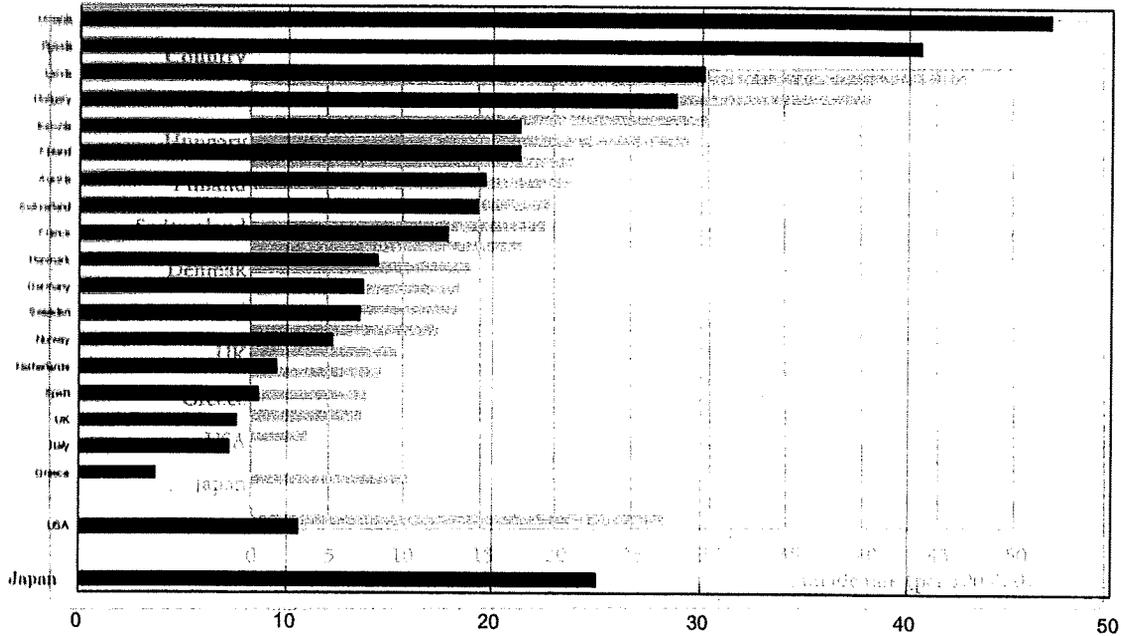


Figure 4 Suicide rates in Japan, Europe, and the USA.

Japan's suicide rate has recently increased and become about 27 in 2003. Although not only many Japanese but also non-Japanese believe that Japan has the highest suicide rate in the world, this is not true. There are countries with higher suicide rates than Japan. For instance, Lithuania and Russia have suicide rates of around 40 per 100,000 people.

As shown in Figure 4, the country with the highest suicide rate, Lithuania, is more than ten times higher than that of the lowest, Greece. What contributes to this difference? The close relation between mental disorders and suicide has been pointed out. However, even the most important morbidity of depression does not differ that much among countries.

There may be other explanations for such difference. First of all, according to the theory of Emile Durkheim (1951), an eminent sociologist in the nineteenth century, social ties could act as a preventive factor for suicide in countries where social ties still remain strong. Countries with high suicide rates also have the commonality that they have recently experienced dramatic social changes.

Furthermore, criteria used to judge suicide vary among countries. For example, in countries where social prejudice against suicide is strong, suicide without obvious evidence tends to be processed as a death with an unknown cause or an accidental death. Such a tendency has been recognized for some time.

In contrast, some countries, such as Hungary, have plenty of artistic works under the theme of suicide in its literature, theater, and music. People there take the common view that suicide is one means of problem solving that people can choose under certain circumstances. Within such a cultural sphere where people

historically have accepted suicide, they have a lower tendency to hide it. Such a situation may be reflected as a relatively high suicide rate.

Implemented Measures for Suicide Prevention

As has been identified, the number of suicides increased rapidly by the end of the 1990s and remained in the 30,000s. In addition, it cannot be denied that a series of trials of suicide induced by overwork in the 1990s forced the government to take action and implement countermeasures for preventing suicides. There is a Japanese word "karo-jisatsu," which literally means suicide due to overwork. However, the so-called "Dentsu Karo-Jisatsu Trial" deserves special mention as the landmark case because it was the first overwork-related suicide trial for the Supreme Court in Japan (Takahashi 1998, 2003).

A 24-year-old man committed suicide in August 1991. His parents asked Dentsu, which is the leading public relations firm in Japan, for a full explanation on what actually happened before their son took his life. However, the firm did not comply with their request. The parents then filled a lawsuit against Dentsu, claiming that their son committed suicide due to prolonged work hours and psychological harassment.

As the link between long working hours and suicides had been recognized, the employer's obligation in providing a safe workplace was in question. The Supreme Court clearly stated that the employer assumes an obligation for creating a safe working environment that does not exhaust employees either physically or mentally. In addition, the Supreme Court pointed out that employers should take appropriate measures at the early stages if, unfortunately, an employee has developed such a disease.

In addition to this trial, the Kawasaki Steel Corporation Trial and the Otafuku Sauce Corporation Trial were also representative.

Responding to the results of such trials, MHLW took various countermeasures, such as a thorough implementation of appropriate working hours, revision of the criteria for certifying work-related compensation about mental disorders and suicide, and promotion of mental health in the workplace.

Figure 5 shows that the number of applications and certifications for work-related compensation for mental disorders and suicide eminently increased after the criteria for certifying worker's compensation relating to mental disorders and suicide were revised in 1999.

Moreover, research on the various preventive measures against suicides and the practical efforts to prevent suicides in the community, such as the council of advisers for preventive measures against suicides, began at the initiative of the MHLW.