

Research to Practice



Overwork Suicide in Japan: A National Crisis

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INTRODUCTION

I recently attended an international conference on affective disorders held in Tokyo and learned about the high rate of suicide in Korea and Japan. Currently, Korea has the highest annual suicide rate in the world. It is noteworthy that the increasing suicide rate is directly correlated with the annual increase in Korea's gross national product. Japan has the third highest rate of annual suicide (after Hungary) and has witnessed a staggering 30,000 deaths per year for the past decade related in part to the sustained

economic recession. It has not been easy for these proud and tradition-based cultures to acknowledge the relationship between suicide and depression, but the enormous social and economic consequences of the deaths have fostered an unusual partnership between the government and psychiatry to confront this urgent bio-psycho-social issue. Whereas suicide was once "normalized" by many Japanese as an act of free will, the alarmingly high suicide rates have contributed to a new conceptualization of suicide as a genuine mental illness and a

new category called "overwork" suicide to describe people who take their lives simply because of working too hard. Although overwork suicide represents only a small fraction of the total suicides in Japan, this new category has had a marked social and political impact in the country.

During the conference, I met Junko Kitanaka, PhD, a medical anthropologist trained at the University of Chicago and McGill University and currently an Associate Professor in the Department of Human Sciences at Keio University (Tokyo). She has researched depression in Japan and written extensively about overwork suicide and the responses taken by both the government and psychiatrists to deal with this dilemma. Here, she presents some of her compelling research work and perspective on overwork suicide.

Dr. Kitanaka, how is suicide conceptualized in Japan?

Dr. Kitanaka: Actually, the Japanese concept of suicide has been changing. For over 100 years, the Japanese have tended to normalize suicide as if it were an act of individual freedom. There is a popular expression, *kakugo no jisatsu*, or suicide of resolve, that essentially romanticizes the act as a way of creating meaning through one's own death. Until fairly recently, newspaper articles and popular literature frequently associated suicidal acts with taking responsibility for one's actions or protesting against social injustice. However, as the suicide rate has skyrocketed in the past decade, these concepts have been challenged. Today, a new concept has emerged that suggests that suicide results from tremendous social pressure and depression. In fact, romantic or idealistic ideas

about suicide in Japan are being replaced by a broad-scale social medicalization of suicide.

What do you mean by “medicalization?”

Dr. Kitanaka: Medicalization is a process whereby a problem of living is redefined as pathology of individual biology. Durkheim’s sociological theories challenged the medicalized concept of suicide by arguing that societal forces rather than a diseased brain are the underlying basis for suicide. Alternatively, for many years, some prominent Japanese psychiatrists emphasized biological causes rather than social factors contributing to suicide. In my opinion, this view has reversed such that Japanese psychiatry is now caught up in a “socializing” form of medicalization by suggesting that suicide may be a consequence of the Japanese work ethic. In fact, a new category has been coined called *overwork suicide* that emphasizes a worker’s social and biological victimhood.¹

What is *overwork suicide*?

Dr. Kitanaka: It has been well documented that some middle-aged workers in Japan are committing suicide in part due to work-related stress as well as the economic recession. The term *karo jisatsu*, or *overwork suicide*, refers to people who are driven to take their own lives after excessive overwork. Although the actual number of Japanese who commit *overwork suicide* is small, its importance lies in its political and symbolic impact. Increased awareness about *overwork suicide* heightened in the year 2000 when the Japanese Supreme Court ordered a large Japanese company to compensate the family of a deceased man who allegedly committed suicide because

of long and excessive overwork. After this precedent setting verdict, there were several similar legal outcomes that eventually legitimized the concept of *overwork suicide*. Hence, the concept of social causality of suicide has been promoted to confront the *suicide crisis*.²

What has been the role of the government in dealing with this crisis?

Dr. Kitanaka: The government intervened because of the enormity of the crisis. There is an undeniable impact caused by the high suicide rate on social, political, and economic affairs in the country. To understand the context of the crisis, there have been 3 to 5 times more annual suicides in Japan than of people who die in traffic accidents. So, the Ministry of Labour (now integrated into the Ministry of Health, Welfare, and Labor) began to implement important policy changes in the workplace as early as 1999 and the government passed a law on suicide countermeasures in 2006. Essentially, the new “legal” definition of suicide highlights the idea that individuals who kill themselves from work stress are not free-will agents of their own deaths but rather mentally ill victims of their social circumstances. Today, workers are eligible for workers’ compensation if they develop a mental illness caused by overwork.

What has been the role of Japanese psychiatry in dealing with this crisis?

Dr. Kitanaka: In my opinion, Japanese psychiatry was used to establish this new “social” cause for suicide and to legitimize worker’s suffering by way of a psychiatric diagnosis. Of course, the *suicide crisis* has facilitated the

acknowledgement and recognition of depression as a problem in Japan as well. For many years, most Japanese assumed that depression was a rarity in Japan, and some psychiatrists even debated whether suicide of resolve was acceptable within the culture. Consequently, the recent conceptual shift toward describing suicide as a product of mental illness, albeit of social etiology, has introduced the potential for diagnosis and effective treatment of depressive disorders. Through this process, psychiatrists may be overcoming the long-held resistance to psychiatry in Japan.

Do Japanese psychiatrists recognize a biopsychosocial model for suicide?

Dr. Kitanaka: Certainly. In my experience, psychiatrists are extremely careful not to reduce suicide to a mere biological problem. When patients resist medicalization and insist that their suicide attempt was an existential act, psychiatrists generally say that they are only trying to treat the underlying depression. Many even say that as doctors they have no right to intrude into the irresolvable aspects of patients’ lives.

However, the critical awareness about the social aspects of suicide has created dilemmas. Psychiatrists working in suicide prevention programs are often distressed by the growing gap between the government’s grand vision of prevention and their daily practices that may not always bring immediate results. Some experts working in economically depressed areas of Japan lamented to me that what they really needed to stop people from committing suicide was a few thousand dollars to help them pay off debts rather than a medical consultation or even

antidepressants. Although they certainly hope that treating depression is a step toward preventing suicide, psychiatrists are keenly aware of the social and political problems associated with suicide as well.³

Are Japanese workers really more susceptible to suicide than other groups?

Dr. Kitanaka: They might be. It has long been recognized that the “model” employee in Japan may also be the person most susceptible to depression. In the 1930s, Shimoda Mitsuzo, a professor of psychiatry noted that many of his depressed (melancholic) patients were otherwise socially adaptive people who were enthusiastic about work, meticulous, thorough, honest, punctual, and had a strong sense of justice, duty, and responsibility. Clearly, these were the kind of people who were praised by others and seen as reliable and trustworthy. Recently, it has been suggested that Japanese society rewards these “ideal” behaviors that create “model” employees but ultimately yield a melancholic premorbid personality. The rise of industrialization and isolation from family reinforced the importance of the workplace for these “model” employees. These socially reinforced individuals often define themselves by their work success that requires over-responsibility, perfectionism, and sustained social pressure to outperform. Ultimately, the armor of some of these “model” employees crack and they become depressed because they cannot meet these work expectations. Many of the depressed people I have met seem to find positive meaning in depression as a retreat from social engagements and obligations that are cornering them.

What is the view of suicide in other population groups in Japan? For instance, does gender matter in the Japanese view of suicide?

Dr. Kitanaka: Interestingly, the new conceptualization of suicide seems more reserved for male workers and thus minimizes the importance and possible under-reporting of depression in women or unemployed individuals. Although Japanese male workers may be at most risk, they have also been the primary focus of suicide concern in Japan at the expense of other population groups.

Many American workers work long hours and are praised for exceeding expectations. Do you think American workers are at risk for overwork suicide?

Dr. Kitanaka: There is certainly plenty of stress in the American workplace. But I think there may be less risk for overwork suicide because of the American culture. Americans do not suffer as much over-responsibility and are quicker to express their frustration rather than keep it inside until they crack. In addition, I think that nature of the American employment system makes a difference for minimizing the risk of overwork suicide. American workers can switch jobs when they are under excessive pressure, unlike their Japanese counterparts who have often been bound to their companies via lifetime employment, which can be either bliss or a curse.

In your view, what other differences have you observed between American and Japanese work ethics?

Dr. Kitanaka: Actually, I’ve noticed increasing similarities rather than differences where workers everywhere face the same increasing

uncertainty about their place in the work force. Jonathan Metzl (2003) describes a “productivity narrative,” (the Prozac narrative) that urges people to take pills, to bring out their assertiveness and competitiveness, and possibly enhance their ability even beyond their true limits in order to take control of their lives.⁴ The likelihood of lifetime employment has begun to crumble not just in Japan but also in Europe. Indeed, the young worker’s experience of depression in Japan seems intricately intertwined with the question of his or her professional identity. He or she may adopt a psychiatric diagnosis of depression in order to get care and to get recognition about his or her suffering, but remain uncertain about the kind of “cure” this will ultimately bring.

Given the new conceptualization of suicide in Japan, will there be long-term social effects in this tradition-based country?

Dr. Kitanaka: I can envision three important long-term social changes in Japan.

First, Japanese psychiatrists are helping to reconceptualize the meaning of vulnerability in mental illness. Psychiatrists reason that vulnerability to depression can be rooted in socialization as much as it is in genetics and might only manifest itself as pathology when vulnerable individuals are placed in an unaccommodating environment or at a time of social change. In other words, vulnerability is no longer conceptualized as static and frozen in time but rather something that is collective, relational, and even historical. Following Rose,⁵ I think this signals a fundamental change in Japanese psychiatry from the era of “absolute geneticism” to

the age of “susceptibility,” or the realization that we all carry “genomic vulnerabilities” of some sort.

Secondly, the increasing awareness of overwork depression is becoming institutionalized as a public language and clinicians who call attention to the hazards of psychological labor.⁶ A new historical sensibility is emerging for the Japanese who are beginning to talk about the burden of psychological and affective labor as well as physical labor. Psychological and affective labor has been largely unrecognized. For instance, Japanese workers are told to sell their “smile” for free at a McDonald’s or to use their imagination to “empathize” with a customer who is unjustifiably rude. This form of psychological labor has long been justified and naturalized as a virtue, even aestheticized as part of “Japanese culture.” By telling people how depression tends to afflict those who work too hard, the new psychiatric language of depression may begin to work as an antidote against this hegemonic cultural discourse.

Thirdly, some depressed people are opening up in public to speak about their depression. They are asking what it means to be depressed. This change can be seen in the number of publications, websites, and support groups related to depression that have mushroomed in the past decade. Through such media, they are beginning to talk about how depression is not simply a biological defect or a distortion in cognition. The psychiatric language of depression may ultimately help people to address a fundamental question of modernity: Is a relentless quest for personal advancement really the way to pursue happiness?

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