Suicide and Diverse Communities:
Cultural Considerations in Support for Multicultural Individuals in Japan

Andrea CARLSON

1. Introduction

We are not yet a society in which diversity is widely understood, accepted, and normalized. This, of course, has ramifications for how members of minority groups are treated in schools, the workplace, and the community, and the ways in which bullying, discrimination, and marginalizing behavior and practices negatively impact the emotional wellbeing and mental health of children and adults with diverse backgrounds (Kirmayer, 2012). And, critically, although the importance of school and community-based mental health literacy and suicide education programs and opportunities to learn about issues related to diversity, tolerance, and inclusion are widely recognized, actual implementation of such initiatives is still relatively rare (Ojio et al., 2012). A continued lack of awareness, then, results in minority communities being unfairly burdened by stressors resulting from marginalizing behavior. In this research note I will consider issues related to the availability of mental health support and suicide prevention for the diverse multicultural community in Japan.

2. Diverse multicultural communities and mental health needs

Diverse multicultural communities in Japan are an example of groups in which stressors such as racism and marginalizing behaviors may have serious implications with regard to adverse mental health outcomes, and the need for support for these communities is significant for both groups which have been in Japan for a relatively long time, and for those who are newer and perhaps more transitory in nature. For instance, between 2012 to 2016,

the suicide rate for Korean women in Japan was 2.46 higher than that of Japanese women (Gilmore et al., 2019), regardless of age, which was higher than that of Korean women living in Korea. Although the suicide rate for Korean men has decreased in recent years, as of 2015 it was double that of Japanese men (Ueda et al., 2019). As 66% of Korean residents of Japan were born in this country, it is therefore unlikely that language is a major barrier to medical and mental health support. The high suicide rate among Korean residents is framed, however, by a greater degree of financial hardship than that of Japanese residents, as well as by an increase in racism and hate speech (Gilmore et al., 2019), marginalizing behavior which places an unacceptable burden on members of the Korean community in Japan.

Perhaps especially for newer foreign residents in Japan, such as international students, interns, short-term and longer-term foreign workers and their families, access to mental health provision and crisis prevention is made more challenging by a lack of easily-accessible information about local resources for support, and by a range of potential linguistic and cultural barriers to accessing treatment and therapy—increasing the risk that some groups may not receive psychological first aid in the event of a natural disaster or protection or mental health support should they be a victim of an act of violence. Particularly for children and youth, this may have profound ramifications in terms of both mental health and safety. In a survey of 1,895 middle and high school students attending international schools in the Tokyo area, 4.9% reported that they *always* worry about suicide and 6% answered that they *always* worry about depression (TELL, 2008). Children and youth attending non-traditional educational settings in Japan, such as Brazilian schools, home schools, or international schools, may be somewhat at risk of being isolated from a range of psychological and social support services in the local community due to their ages and possible lack of Japanese language ability, and due to the school's own possible lack of relationships with community mental health and social service professionals (Inman et al., 2009). The potential for isolation and a lack of necessary psychosocial support (Borg and Pålshaugen, 2009) is also evident at the university level with respect to international students (Sakagami et al., 2014), such as in the

recent deaths by suicide of international students and interns from Asian countries, including Nepal and Vietnam. These tragic deaths highlight the urgent need for professionals to continually work in a joined up manner to provide support and gatekeeping for individuals who may be at particular risk due to emotional distress caused by isolation, fatigue, harassment, and financial concerns.

The expected increase in foreign residents in coming years will require a corresponding increase in psychosocial support. Yet, in terms of policy on a national level, the Basic Act for Suicide Prevention does not yet include any interventions or initiatives specifically targeting marginalized groups (Gilmore et al., 2019).

3. Diversity-sensitive mental health support may be out of reach

The above exists against a backdrop of a range of factors which may contribute to keeping mental health support out of reach for many in the diverse multicultural communities. This is strikingly important as, according to the Japan Medical Association Mental Health Committee (2013), "… measures against depression are positioned as the most important challenge in combating suicide".

One factor which may contribute to diverse communities not receiving psychological support is the somewhat transitory period that Japan is in with respect to how psychological support is regarded. For instance, what has been seen to be a medicalized approach to mental health support may be shifting to include a greater appreciation of the need for psychotherapeutic approaches to support. However, as counseling is still relatively new in Japan, there remains some ambiguity among the public regarding the role and value of psychotherapy in treatment for mental health issues, such as depression and anxiety (Kitanaka, 2012). For instance, an individual who feels depressed may initially visit his or her family doctor, perhaps wishing to avoid the stigma of seeking mental health support from a specialist or perhaps due to lack of understanding about mental health issues and possible resources in the local community. The role of the primary care physician as a gatekeeper

is critical, therefore, in these instances. According to the Japan Medical Association Mental Health Committee:

> *Regarding the relationship between depression and medical institutions, depression patients often start by going to see an internist or other primary care physician, not a psychiatrist or other specialist, complaining about physical symptoms such as insomnia, loss of appetite, and general malaise. For that reason, even Outlines for Comprehensive Measures to Prevent Suicides approved in a Cabinet meeting stress the importance of the role played by primary care physicians as the gatekeeper in dealing with depression at an early stage.*
>
> (Japan Medical Association Mental Health Committee, 2013, web)

And, although mental health professionals, such as clinical psychologists and mental health social workers, undergo extensive training and are required to pass extremely rigorous licensing examinations, there is currently no law in place regarding who may or may not work independently as a counselor or psychotherapist. This lack of clarity, alongside a paucity of literacy about mental health generally, may contribute to difficulty of finding a qualified mental health professional who can provide psychotherapy, let alone an individual who has training in delivering diversity-sensitive support. Added to this is a financial burden as while insurance will pay for consultations with psychiatrists and for medications, such as antidepressants, which may be prescribed, it does not always pay for psychotherapy delivered by mental health professionals, such as clinical psychologists. This disparity is another factor which may put psychotherapy as a form of support out of reach of many individuals.

In considering the effects of marginalizing behavior, it is also important to recognize that as humans we are diverse in our diversity, and we may well belong to more than one community and have a range of aspects to our identity. A multicultural Brazilian-Japanese student, for instance, might identify as being female to male (FtM) transgender or a cis-gender Japanese female artist who grew up in South Africa and now lives in Japan may be on

the autistic spectrum. Identities are therefore rich and complex, and it has been well established that support from a mental health professional who can provide diversity-sensitive counseling and other forms of therapy can be particularly important for individuals from minority or marginalized groups (Kirmayer, 2012). There exists, however, an inconsistency in preparedness to provide diversity-sensitive mental health support, both in Japan and elsewhere. This can be seen, for instance, in a lack of training in Japan and abroad, of school counselors regarding support for LGBTQ+ students in schools and universities or of mental health professionals who have had in their graduate level training coursework specific to support for individuals with ethnically diverse backgrounds. As marginalizing behavior, such as bullying and harassment, are serious issues in schools, this is an issue which urgently needs to be addressed (Kase, 2016).

An additional issue is that in Japan where diversity-competent mental health support exists, it tends to be most available and accessible in Tokyo. That is, although social and mental health support networks for minority groups exist in major urban settings in Japan, they are far less present in rural areas. For instance, there are at least two major mental health clinics with psychiatrists and psychotherapists on staff who have extensive background in supporting the mental health needs of members of the multicultural LGBTQ+ community in Tokyo, both offering consultations and psychotherapy in both Japanese and English. However, these clinics may well of course be inconvenient for people living outside the greater Tokyo area and, due to the significant need for their services, individuals wishing to receive mental health support at these clinics may not be able to make an appointment immediately.

Beyond being most widely available in Tokyo, multilingual mental health support, such as psychotherapy, tends to be in English more often than in other languages, this despite the greater number of Asian residents in Japan than those from English-speaking countries. In Tokyo, for example, there is one major mental health clinic providing support in a wide range of languages. Also in Tokyo, there are also mental health clinics and counseling centers providing English or English and Japanese therapy. While clinics,

counseling centers, and licensed psychotherapists in private practice offer support in English in other parts of Japan, a quick internet search shows that they are far fewer than in the greater Tokyo area, at least among those which have an internet presence. Regional organizations, such as international centers, may provide counseling in various languages. However, there may be a limit to the number of counseling sessions an individual may have and there may be other limitations, such as the counseling room being adjacent to busy areas of the center, thus making it possible for others to overhear what should be a private conversation between therapist and client.

Even when mental health support is available and accessible, research in countries with ethnically and culturally diverse populations has shown that people with diverse backgrounds are often in acute stages of psychological distress when they visit a mental health professional as they are reluctant, and therefor slower, to seek mental health support (Gopalkrishnan, 2018). Similarly, young people often delay their first visit to a mental health professional, again increasing the risk of psychological crisis. In both cases, stigma, lack of knowledge about mental illness, and lack of information about the types of resources that are available in the local community are thought to contribute to the delay in these two groups seeking support (Zachrisson, 2006).

Together, the factors described above inform how effectively medical and community models of support can be integrated to support individuals from diverse groups who are experiencing challenges to their mental health, and without appropriate mental health support may become at risk of dying by suicide.

It should be noted, that, although not specific to professional mental health provision, there are some multicultural and multilingual peer support groups throughout Japan related to a range of themes including cultural diversity, parenting children who are on the Autistic spectrum, topics relevant to the LGBTQ+ community, being a third culture kid, among others. And, although not yet accessible to all, another resource for limited proficiency Japanese speakers is medical interpreting, which is available through some large hospitals, international centers, and regional organizations (Kawauchi

and Ogasawara, 2015). The International Medical Information Center, for example, helps patients navigate the health care system by providing telephone support in several languages, and helping users find medical facilities which have staff who can provide support in the patient's own language (AMDA, web).

In addition, there is some support available to individuals though lifelines and helplines. For instance, TELL, formerly Tokyo English Lifeline, provides anonymous and confidential support to Japan's English-speaking community every day of the year. In 2017, TELL launched a chat support service to operate in collaboration with its telephone lifeline. Of chat users, 60% have identified as being actively suicidal, compared with 8% of telephone users. 71% of the chat users report being in their 20s or younger (TELL, 2018). TELL estimates that at least half its users are non-native English speakers. Inochinodenwa, although most generally used by Japanese speakers, also provides counseling in English and some other languages. However, this provision varies by region and is available on a more limited basis. Both TELL and Inochinodenwa provide rigourous training to all prospective volvunteer counselors, and include diversity-sensitive support as part of this training.

4. Conclusion

There are a number of ways in which mental health support for diverse groups in Japan can be developed and made more inclusive. A top priority should be working to ensure that the most vulnerable members of society have access to a range of support. Central to this is finding avenues through which diverse children and young people are able to tell appropriate adults about their concerns and about threats to their safety and wellbeing, such as abuse, bullying, or about their fear of disclosing their sexual orientation or gender identity. At the same time, developing multilingual mental health literacy programs in non-traditional schools and their wider communities is critical, as is making available forums for the sharing of information and resources regarding best practices in mental health support among

Japanese, Brazilian, international, and other types of schools. Related to this, programs providing information and training in being allies to people of all ages should be developed and implemented in schools, the workplace, and wider counities. Finally, an online multilingual database with up-to-date information and contact details for organizations and individuals providing support for a variety of issues, including suicide, abuse, harassment, sexual violence, bullying, and LGBTQ+ related topics, should be developed and made available through easy-to-access locations.

References

Borg, E. & Pålshaugen, Ø. (2018). Promoting Students' Mental Health: A Study of Inter-professional Team Collaboration Functioning in Norwegian Schools. *School Mental Health*, 1–13.

Gilmour, S., Hoshino, H., & Dhungel, B. (2019). Suicide Mortality in Foreign Residents of Japan. *International Journal of Environmental Research and Public Health*, 16(17), 3013. doi:10.3390/ijerph16173013

Inman, A., Ngoubene-Atioky, A., Ladany, N., & Mack, T. (2009). School counselors in international schools: Critical issues and challenges. *International Journal for the Advancement of Counselling*, 31, 80–99.

International Medical Information Center. (Web). http://eng.amda-imic.com. Retrieved September 16, 2019.

Japan Medical Association Mental Health Committee. (2013). Depression and suicide countermeasures in Japan. *Japan Medical Association Journal*, 56(3), 129–142.

Kase, M. (2016). Sexual and gender minorities and bullying in Japan. In S. T. Russell and S. S. Horn (Eds.), *Sexual Orientation, Gender Identity, and Schooling*. Oxford: Oxford University Press. 185–192.

Kawauchi, K. & Ogasawara, M. (2015). The language barrier in healthcare settings in regional Japan: Assessing the need for trained medical interpreters. *Kyushu Communication Studies*, 13, 98–113.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, 75, 249–256.

Kitanaka, J. (2012). *Depression in Japan: Psychiatric Cures for a Society in Distress*. Princeton, NJ: Princeton University Press.

Ojio, Y., Ohnuma, K., Miki, T., & Sasaki, T. (2015). Development of a Mental Health

Literacy Program for Secondary School Students in Japan. *School Mental Health Global Challenges and Opportunities*, 139–150.

Sakagami, Y., Uwatoko, T., & Takeuchi, J. (2014). International Students' Mental Health Issues at Kyoto University: A Retrospective Cohort Study. *Journal of International Student Advisors and Educators*, 17, 7–18.

TELL. (2008). Tokyo English Lifeline School Awareness Program Annual Report.

TELL. (2018). Private Communication with the Lifeline Director.

Ueda, M., Yoshikawa, K., & Matsubayashi, T. (2019). Suicide by persons with foreign background in Japan. PloS one, 14(2), e0211867. doi:10.1371/journal.pone.0211867

Zachrisson, H. D., Rödje, K., & Mykletun, A. (2006). Utilization of health services in relation to mental health problems in adolescents: a population based survey. *BMC Public Health*, 6, 34. doi:10.1186/1471-2458-6-34