"Suicide Behaviour of the Japanese and Implications for Modern Suicidology: Reflections of a Suicidologist"

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Introduction

No other domain of scientific inquiry has been so studded with myths and misconceptions as that of Suicidology, and Japan's suicide behaviour has been no exception to this dictum.[1] For Japan has been always "perceived" to be a nation characterized by very high rates. Such wide-spread perception has further been reinforced by stories of suicide due to "examination hell", "ijime (bullying at school)", overwork (Karoshi), pressure-cooker lifestyle, fierce competition, population density, overcrowdedness, a historically tolerant attitude towards death in general and to suicide in particular, etc. Yet in fact, Japan's suicide rate, though the highest in Asia, has never been one of the "top ten" in the world except once — 1957. It is the express intent of the present paper to shed some light on the common characteristics of suicide which Japan shares with many other countries as well as some unique differences. Delineation of such common characteristics and unique differences will hopefully render long-awaited and necessary assistance in re-examining the prevailing assumptions and findings in the West about suicide in Japan. These assumptions have been primarily derived from the limited data from Euro-American societies, which represent at best merely 25% of the world population. Herein lies one of the important reasons for studying Japanese behaviour that includes suicide.

A word of explanation is in order for the field of Suicidology.[2] It refers to a systematic, scientific, and multidisciplinary study of suicide, both attempted and completed. It includes three principal areas: (1) epidemiology (i. e., distribution of suicide rates in socio-demographic variables), (2) theory construction, and (3) praxis (i. e., prevention, intervention and postvention). People involved in these areas of suicidology are psychologists, sociologists, psychiatrists, nurses, social workers, psychotherapists and other mental-health professionals, religious practitioners, police officers, school counselors, coroners and medical examiners, and trained volunteers in crisis centres, etc., as shown in Transparency - 1.

Trends, Patterns and Characteristics of Suicide in Japan: An Overview

(1) Etymology of "Suicide": A Cross-cultural Comparison

Derived from Latin — "sui" (of itself, him-/herself) and "cidaere" (to cut, hence to kill) — the word "suicide" in all Indo-European languages connotes self-mutilation and self-murder. It is "suicide" in French and English, "suicidio" in Italian and Spanish, and "selbstmord" in German: *They all mean self-murder* as shown in Transparency - 2. "Suicide" was first introduced into the lexicon of the English language in the Oxford Dictionary in 1651. It is no doubt due to the influence and impact of Judaeo- Christian religions that all these Indo- European languages reveal the *evaluative, ethico-moral* and *condemnatory* stance. For, in these religions, the ultimate human destiny of life and death is in the hands of the Creator: "God giveth and God taketh."

By contrast, there are more than 30 expressions in Japanese that denote "suicide", yet all of them are free from moral-judgmental connotations as in Indo-European languages. Instead, as shown in Transparency - 3, all these expressions of "suicide" in Japanese merely *describe* the motives, means, the number of people involved, and the type of relationship revealed among the deceased, etc.[3] Some of the examples are: *ishi* (suicide by hanging), *toshin* (jumping from high places), *nyusui* (drowning), *Seppuku* (self-disembowelment), *shoshin* (self-immolation), *joshi* (love suicide pact), *ikka shinju* (family suicide pact), *boshi-shinju* (mother-child suicide) *fushi-shinju* (father-child suicide pact), *jiketsu* (soldier's suicide), *ichimonji-bara* (horizontal slitting of the belly in seppuku), *jumonji-bara* (seppuku by horizontal and vertical slitting of the belly), *gyokusai* (soldiers' mass suicide), etc.

(2) Trends in Suicide Rates

Almost all the high-suicide rate countries of the world have been central, northern and western European countries (i. e., Hungary, Finland, the Federal Republic of Germany, Austria, ex- Czechoslovakia, Denmark, Switzerland, Belgium, etc.).[4] In the context of the world-wide rates, then, Japan's rates had been quite high in 1920's and 1930's (and some years after W. W. II), then they began to decline since 1958 more or less continually. Today Japan ranks in the middle[5] between the afore-mentioned, high-rate countries of Europe and the much lower-rate countries of the non-Western world in Latin America, Asia and the Middle-East.

In Japan, suicide statistics traditionally come from two official sources: the demographic statistics (jinko dotai tokei) of the Ministry of Health and Welfare, and from the Suicide Statistics of the National Police Agency. The former is compiled on the basis of the information contained in the death certificate, the latter relies on the information from police reports. Hence, the mode and type of suicide data in Japan is identical to that of other Euro-American countries.

(3) Suicide By Age

In terms of the age patterns, suicide rates in the world as registered with the World Health Organization (W. H. O.) may be grouped into three discernible patterns: the "Hungarian" pattern, the "North American" pattern, and the "East Asian" pattern as shown in

Transparency - 4. The Hungarian model, which includes most countries of Europe and elsewhere, is distinguished by a steady increase in rates with advancing age, especially after retirement around 60-65. In the North American pattern, (including the U. S., Canada, the United Kingdom, Australia, New Zealand and Scandinavian countries), suicide rates register a slow increase or slight decline or stability after age 65. The third model, the so-called East Asian pattern, has been characterized by a bi-modal trend — *i. e.,* one small peak usually among youths (15-25) and very sharp increase after the retirement age. Japan used to fit into the East Asian model with two demographic peaks, but since 1979 it has been approximating the Hungarian model. It is significant to note, however, that in both Europe and Japan, the suicide rate soars right after the retirement age, suggesting a serious psychological and life crisis, especially for men, to whom retirement seems to mean dislocation and withdrawal from a productive life, which has defined their place in society as well as meaning for life. Contrary to a popular perception, the highest suicide rates have always been observed everywhere among the elderly, as shown in Transparency - 5. Yet they receive little attention either from the public or from suicide prevention activities anywhere.

In the case of Japan, the highest rate of suicide has been observed among the elderly who live in three-generation households with their married children and their grandchildren, followed in rank order by the elderly who live with their married children, and then by the elderly who live by themselves.[6] This observation, first made by the Metropolitan Medical Examiner's Office in Tokyo in the mid-1980's, has been confirmed in many othere cities and prefectures thoughout Japan.[7] Such observations are a serious challenge to a long-cherished, idyllic and over-romanticized view of the elderly "living happily" within the warm bosom of the legendary three-generation household. Some serious rethinking of social policies for the elderly is certainly in order in light of such observations.

(4) Suicide by Occupation

Physicians as a group have registered one of the highest rates of suicide both in Europe & North American, and it is interesting to note that psychiatrists seem to show the very highest rate, followed by other specialties as shown in Transparency - 6.[8] In Japan, however, physicians have shown one of the lowest rates for a long time. High rates have been historically observed among those *who have been outside the mainstream of society* such as the unemployed and low-skilled workers in steadily declining industries (e. g., fishing, farming, mining, etc.) as shown in Transparency - 7.

(5) Sex Ratio

The sex ratio refers to the number of female suicide per 100 male suicides. One of the hallmarks of suicide in Japan has historically been the high rate of suicide among women — a trait Japan shares with women in the rest of Asia and the Middle East, in comparison to North America and Europe, as shown in Transparency - 8. Such consistently high rates among women in non-Western countries including Japan may suggest the pervading presence of stress and tension women have to go through in such countries where the burdens of life and family and marital life often fall on the female sex far more than in Euro-American societies.[9]

(6) Plural Suicide

Japan has been well known historically for plural suicide such as dual, love suicide pact (joshi) as well as family suicide pact (ikka shinju). After W. W. II, however, the family suicide as a homicide-suicide combination has become more prevalent than double suicide. Typically it involves a young urban mother in a nuclear family who kills her child(ren) then herself, as shown in Transparency - 9. In North America, the typical pattern is reversed: a distraught man (husband-father) kills his estranged wife, at times his child(ren) also, then turns the gun on himself, as shown in Transparency - 10.

(7) Marital States and Suicide

For both males and females, suicide rates are generally lower for the married than for those without spouses. The rank order, from the highest to the lowest, is as follows: 1. the divorced, 2. the separated, 3. widowers and widows, 4. the single, and 5. the married. Evidently, the loss of one's spouse in death, divorce or separation (i. e., "object loss") seems to be highly correlated to higher suicide rates. In this trend, then, Japan is quite comparable to the rest of the world. Divorce and separation seems to have a great impact on the young adults in their 30's, especially among males. For the middle-aged group in their 40's and 50's, the impact of separation or marriage breakdown seems to be far more devastating than the death of a spouse, again especially for men.[10]

(8) Suicide by Region

In Japan, higher suicide rates have generally been observed in areas which are characterized by less population density. With the index of the national average as 100, high population density areas such as Chiba Prefecture & Tokyo Metropolitan Region have consistently registered a suicide index less than 80.[11] It is interesting to note that such high suicide rates in rural and less densely populated areas have also been observed in Hungary and France.[12] As a matter of fact, Paris and the Parisian Region have historically shown lower suicide rates than other areas of France.[13]

(9) Suicide Landmarks

People in different countries show a preference for certain national landmarks as a site of suicide — e. g., the Eiffel Tower in France, the Golden Gate Bridge, etc. As for the Japanese, there has been a definite preference for certain famous mountains, such as Mt. Mihara before W. W. II, and Mt. Fuji after the war, as shown in Transparency - 11.

In may be argued that a need to make public statement as well as a need to externally demonstrate one's aggression (and probably narcissistic exhibitionism) does play a part in jumping off tall buildings and bridges. The Japanese penchant for choosing the dense forest at the foot of Mt. Fuji, however, seems to hint a different need: *a passive need for escaping rather than for an outright expression of hostility and aggression* unlike the afore-mentioned cases of the Eiffel Tower and some famous bridges in the United States. Japanese suicide attempters simply wade into the dense forest (called "Jukai" or "Sea of Trees") with little hope of being discovered: they simply wish to disappear into oblivion without any hope of being traced. If the French and American preferences mentioned above fit into the "wish-to-kill" motif of Karl

Menninger's theory, Japanese example may suggest a more passive "wish-to-die"[14].

(10) "Role Narcissism" in Japanese Suicide

In other parts of the world, suicide is often reported to be clinically related to personal breakdown, depression and hopelessness, extreme isolation, etc. To wit, suicide is related to manifestations of personal crisis and psycho-social pathology. In Japan, however, some types of suicide such as Seppuku (or ritual self-disembowelment, also known as "hara-kiri") have historically and traditionally been related to a very strong sense of honour and responsibility. In other words, the type of people who are well intergrated into their social groups in general may be particularly prone to suicide in extreme situations that call for assuming responsibility. Such propensity is still very much observable in Japan even today. Such "role narcissim" seems to be deeply ingrained in the inner psyche of the Japanese, probably due to extraordinary cohesion and integration of members into their own social groups[15]. A prevalence of suicide during and after major scandals involving officials and persons of responsibility in organizations may also demonstrate the relevance of such role narcissism.

In North America, there has been a definite separation between *legal* and *moral* responsibility in the ethico-legal concept. In face of any infraction of the law, therefore, one is primarily concerned with fulfilling one's *legal* responsibility and obligations — e. g., restitution and/or serving time in prison, etc. Once such *legal* obligations are fulfilled, one is released from any legal debts to society: one is a free citizen again and is thus able to get on with life once again.[16] For the Japanese, however, *legal* and *moral* responsibility has been fused and *not* separated in the eyes of the ego or the public. Mere fulfillment of legal obligations does not automatically lead to *moral* exoneration. Hence, legal and financial compensation to the surviving families of the crash victims in 1985 on the part of Japan Airlines was considered a fulfillment of *legal* but not *moral* responsibility. Someone must atone for *moral* responsibility in the form of an apology to the surviving families and to the deceased. Hence, an executive for customer relations and the supervisor for plane repair and maintenance at Japan Airlines committed suicide in fulfillment of their *moral* responsibility, as shown in Transparency - 12.

Japanese dedication to group is a well known trait and requires no explanation here. Welfare, integrity, survival and continuity of a group one belongs to have been considered *sine qua non* in Japanese social behaviour and values, and must be preserved at all cost.

The above examples could be subsumed in a theory of "role narcissism", in relation to such suicide behaviour in Japan. Role narcissism, in the afore-mentioned examples, is a response to a sudden frustration of a continual need for social recognition, resulting from a narcissistic preoccupation of the self in respect to one's social role and status in group life and society. Many Japanese tend to become excessively involved with their social role, which has often become the ultimate meaning for life. Such individuals are often vulnerable to social disturbances in a hierarchical group or personal mistakes that may bring about suicide, in order to preserve the honour and continuity of the group he/she belongs. Such excessive concern and involvement with one's social role and status in one's group (i. e., role

narcissism), combined with the fusion of legal and moral reponsibility, provides a powerful fuel for self-destructive behaviour in the name of the collective,[17] as shown in Transparency - 13.

(11) Depression and Suicide in Japan

It has been found that depression (especially expressed as "hopelessness") is closely related to suicide ideation and eventually to the suicide act.[18] Some research and clinical findings suggest, however, that there are some crucial differences in the expression, content and forms of depression *cross-culturally.* An examination of some cross-cultural clinical data reveals that North Americans and Europeans are likely to express dysphoria in emotional and internal referents such as emotional dysphoria, guilt and loss of self-esteem, but Asians and Africans, including some Japanese, are more likely to express their dysphoria in terms of such external referents as physical complaints, bad weather's effects, etc. — to wit, in somatization as opposed to psychologization[19], as shown in Transparency - 14. Kleinman of Harvard hypothesizes that (1) such interiorization of dysphoria may be due to a particular way of internalizing feelings since the rise of Protestantism in the West as suggested by Max Weber, and that (2) it may be a result of the widening influence of Victorian mentality which frowned upon somatization and favoured internalization of somatic conditions.[20]

There is a tendency in North America and Europe to call somatization "masked depression", but in view of the fact that Asians and Africans represent almost 75% of humanity, it may be argued that somatization may be the standard form depression and that "psychologization" of depression is an aberration and idiosyncracy inherent in Western civilization. At any rate, further accumulation of data is certainly in order.

Such caution and warning against easy psychopathologization of suicide as practised in the West has been raised by the present writer in his study of Seppuku.[21] For Seppuku has been a time-honoured practise among the Samurai and Japan's military which has been in tune with the norms and expectations of Japanese society. Hence it has been an expected "normal" behaviour in Japan's culture; and as such, there has been little evidence of psychopathology. A collection of suicide poems, usually composed hours or days prior to the act of self-disembowelment by the Samurai and military officers, reveal calmness, presence of mind, deep affection for the country, the lord, family members, etc., completely devoid of emotional disturbance, depression, self-pity and psychopathology.

(12) Suicide Prevention Centres

Though Japan's culture has been tolerant of death in general and of suicide in particular, Japan has lagged behind North America in developing an effective helping system for those in distress and crisis. In fact, there is no crisis intervention centre as is generally known in North America, either within or outside the hospital in Japan.[22] As for telephone emergency services, the first hotline called "INOCHI- NO- DENWA" (Lifeline) was introduced for operation, October 1, 1971, and the phone has been ringing ever since at more than 31 Lifeline Centres throughout Japan, as shown in Transparency - 15.

Conclusion: Implications for Modern Suicidology and Psychiatry

It is clear from the above discussion that in spite of some basic similarities in epidemiology (age, sex, marital status, etc.), Japan does offer some fundamental differences in suicide behaviour that merit attention. In summary, it is argued that (1) despite its non-condemnatory values in Japan, Japan lacks any significant suicide prevention and intervention programme at this point in time, (2) Japan's consistently high elderly suicide rate has been most pronounced among the three-generation household, shattering a comfortable popular myth, (3) very high rates among those who fall off from the mainstream of society are exposed to extreme life stress, the fact of which suggests a society that is extremely warm and favourable to the elite and the successful but very bruta Ito those who are "failing"and have fallen off the conveyer belt of societal success, (such as the elderly, women, the unemployed, marginalized farm-hands, especially in sparsely populated areas, employees of tiny businesses, etc.), (4) relatively non-aggressive, passive suicide in preference for suicide sites, (5) evidence of "role narcissism", as opposed to the Western pattern of an on-going process of the breakdown of the individual's coping ability, may suggest a necessary corrective to the Western temptation to automatically link suicidality to psychopathology.

This last point may suggest that our North American psychiatry is an *ethno-science* and is *culture-bound.* It cannot generalize, on the basis of the patterns of North Americans who account for merely 2% of humanity in the world, for human behaviour in suicide. In addition it may be informative to compare the Freudian theory of Oedipus Complex with the Buddhist-based Ajase Complex in psychotherapy.

As shown in Transparency - 16 and 17, they demonstrate some crucial differences for therapy. The Freudian approach seems to stress the importance of early upbringing and of externalizing one's suppressed anger, rage, and aggression for eventual healing. "Naikan Therapy", Japan's Buddhist-based therapy, on the other hand, typically stresses the sense of gratitude one owes to one's parents (especially one's mother), and then to significant others as well. The Buddhist approach in Naikan Therapy emphasizes the crucial importance of a web of intimate human relations, especially those earlier relations with one's mother who is the chief nurturing agent for most individuals. Such a sense of gratitude, once realized and awakened by meditation and reflection in the Naikan Therapy, eventually leads to a profound sense of contrition, which in turn culminates in genuine mutual forgiveness, acceptance and reconciliation. Full reintegration of the individual into the primary social group (i. e., the family), therefore, is the central purpose of such a therapy.[23]

It is important to observe that in the Oedipal myth one of the results of the whole story is the suicide of the King's mother (Iocaste) and the wandering of Oedipus the Rex, who later gouged out his eyeballs. In the myth of Ajase, there is *full mutuality* of contrition, forgiveness and total *reconciliation.* Such fundamental differences are rich in implications in terms of the therapeutic model in cultures other than Judaeo-Christian as well as for therapy of suicide attempters.[24]

Finally, the Japanese word "to listen" illustrates the wisdom and rationale for active listening. The Japanese character for LISTENING is composed of four sub-characters: *Ear, Eyes, Undivided Attention and Heart in Unison.* As such, "listening to someone" in Japanese means that you "lend your ear, eyes and heart in undivided attention". It succinctly summarizes the spirit and essence of Active Listening as practised at every telephone crisis centre around the globe including the INOCHI-NO-DENWA in Japan.[25]

Notes and References

1 For a summary of such wide-spread myths misconceptions, see: Toyomasa Fuse, *Jisatsuno Bunka* (Suicide and Culture), (Tokyo: Shinchosha Co., Lts., 1985), pp. 35-37.

2 The word "suicidology" was coined for the first time by Dr. Edwin Shneidman, then a clinical psychologist and head of the suicide research section of the National Institute of Mental Health (NIMH) in the U. S. Contrary to popular perception, however, the founders of modern suicidology did not hail from the ranks of Clinical Psychology or Psychiatry; rather, they emerged form an incipient science of Sociology in 19th. century Europe. See: Thomas G. Masaryk (1850-1937), *Suicide and the Meaning of Civilization,* in 1881, and Emile Durkheim (1858-1917), *Suicide: A Sociological Study,* in 1884.

3 Stuart Picken, *Nipponjin no Jisatsu* (Suicide of the Japanese), (Tokyo: Simal Publishing House, 1979), pp. 18-55.

4 The only exception has been Sri Lanka, which has ranked very high in suicide rate, right next to Hungary, which has been the highest-rate country in the world, for many decades.

5 In Japan the official compilation of suicide statistics was begun in 1882, just about the time when they were beginning to be collected in Europe as well. Over the years, the rates averaged 16-20 per 100,000 in the Meiji-Taisho period (1868-1925), then began to decrease steadily during W. W. II, then to increase steadily after 1945 to an all-time high of 25.6 in 1957. Since then the rate has been decreasing to 14-17 in 1960's, and then to 18-20 in 1980's. In 1990's, the rate has shown some fluctuation, but has been stablizing around 18 per 100,000.

6 M. Uyeno, M. Shoji, S. Nagasawa, et al., "Suicide among the Elderly Based on the Records of the Tokyo Medical Examiner's Office", *Medical Journal,* Vol. 40, No. 10, 1982, pp. 1109-1119, Department of Legal Medicine, Nippon University School of Medicine.

7 Confirmed in many data and documents loaned to the author by Mr. Yukio Saito, Executive Director, Japan Federation of INOCHI-NO-DENWA, 1994.

8 H. Shigekazu, *Diagnosis of Physician Longevity,* (Tokyo: FMP Centre, 1988).

9 Kazui Fukutomi, "Statistical Characteristics of the Suicide of the Japanese", *Clinical Psychiatric Chart,* (Kokoro No Rinsho Arakarto), Vol. 11, No. 2, June, 1992, pp. 15-17; *White Paper on Suicide,* (Tokyo: National Police Agency, 1950-94).

10 K. Fukutomi, *ibid.* p. 19.

11 National Police Agency White Paper, 1950-94, *op. cit.*

12 T. Fuse, *Introduction to Suicidology. .* , op. cit., pp.

13 Jean-Claude Chenais, "Le Mesure du Suicide", Colloques Nationaux du CNRS sur l'Analyse Demographique et ses Applications, 20-22 Octobre 1975, Numero 934, Paris.

14 Karl Menninger, a noted American psychiatrist, suggested that there are three fundamental wishes present in every person: (1) wish-to-kill, (2) wish-to-be-killed, and (3) wish-to-die. The "wish-to-kill" is usually expressed in aggression, hostility and hatred. As such, it is usually directed towards those in the most intimate relationship to the ego (e. g., parents, spouses, lovers, etc.). Hence, it is usually discouraged to express such feelings openly in all societies: it is thus re-directed internally against

the ego instead and is expressed in the second "wish-to-be-killed". The second wish, therefore, represents the internalization and repression of the first impulse. The third impulse, the "wish-to-die", tends to be chronic as opposed to the acute nature of the other two impulses, and is much more evident among the elderly and the chronically ill than the young. As clinically investigated in the suicide notes of Japan and the U. S., the first two, aggressive impulses were much more present in the suicide of the young, whereas the more passive, third wish is more closely related to the suicide motives of the elderly and the passive. See: Karl Menninger, *Man Against Himself,* (New York: Harcourt, Brace and the World, 1938); Toyomasa Fuse, "Theories du Suicide dans une Perpective Interdisciplenaire", *Bulletin du Psychologie,* (edition speciale sur le Suicide), Numero 401, Vol. XLIV, Mai-Juin 1991, pp. 386-390.

15 Geroge DeVos, *Socialization for Achievement,* (Berkeley: The University of California Press, 1973), pp. 438-485.

16 Hence, most Watergate culprits, once their *legal* responsibility had been fulfilled by serving time in prison, came to resume their life rather well. Some actually became financially quite well off by writing memoirs and making appearances at numerous T. V. talk shows as well as granting interviews.

17 Geroge DeVos, *op. cit.*

18 Toyomasa Fuse, "Hopelessness — an Anatomy of Despair and Suicide", a keynote address, XIII Congress of International Federation of Telephone Emergency Services, July, 1994, Jerusalem, Proceedings of the Congress, pp. 66-91.

19 For details, see: Toyomasa Fuse, *Introduction to Suicidology in Cross-cultural Perspective, op. cit.,* pp. 185-195.

20 This is why it is still frowned upon in the middle-class circles to talk about diarrhea, etc. openly. Kleinman further states that the working-class Britons are, by contrast, much more open to talk about physical conditions and sex. In this view, psychologization is a class phenomenon.

21 Toyomasa Fuse, "Seppuku as an Institutuionalized Form of Suicide: A Study in Suicide and Culture", *Social Psychiatry,* Vol. 15, 1980, pp. 9-15.

22 For example, Los Angeles Suicide Prevention Centre, and/or the Crisis Intervention Unit, Toronto East General Hospital, Self-Harm assessment Research and Education at Toronto Hospital, Suicide Unit at Clarke Institute of Psychiatry, etc.

23 Heisaku Kosawa, "Two Types of Guilt Consciousness — Ajase Complex", *Research on Psycholanalysis,* Vol. 1, No. 1, 1950, Tokyo. Ajase Complex was introduced by Professor Heisaku Kosawa, a professor of psychiatry at Keio University, Tokyo, in 1950, in a research essay entitled "Two Types of Guilt Consciousness — Introduction to Ajase Complex". Derived from some Buddhist Scriptures, this is a story of an Indian Prince named Ajase in conflict with his mother. The queen tried to conceive a male child in order to retain the fading interest of her wayward king. She kills a holy man in the mountain so that this man would be reincarnated as her son. Horrified, however, by her act, she tried to abort the child of such a curse in vain. When the son, Ajase, learns the circumstances in which he was born (i. e., he was an unwanted child, and his mother tried to kill him by abortion), he was consumed with hatred against his mother. Such intense hatred led to a terrible skin disease all over his body (evidently a psychosomatic illness), and his body emitted an unbearable odour so bad that no one would approach him, much less tend to him. It was his mother, the Queen, however, who tended to him in the spirit of contrition and repentance. Moved by her untiring care, Ajase repented, forgave his mother, who in turn forgave her son's hatred, and the two became fully reconciled. Kosawa thus pointed out the fundamental differences between Oedipus Complex and Ajase Complex.

24 Yoshihiko Miki, *Naikan Therapy — Theory and Practice,* (Osako: Sogensha Co. Ltd., 1975); Toyomasa Fuse, *Emotional Crisis and Ethnotherapy,* (Tokyo: Chuo Koronsha Ltd., 1992), pp. 169-178.

25 Toyomasa Fuse, "Suicide and Crisis: Etymology and Its Cultural Implications", *Focus on Listening,* (Ontario Association of Distress Centres), Vol. 2, No. 2, Spring 1993.

Transparencies

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