Aging, Dying, and Bereavement in Contemporary Japan

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For people studying aging and bereavement, Japan occasions unique interest. Throughout the centuries, Japan was justifiably famous for its strong attitudes towards aging and dying. In contrast to the "cult of youth" popular in the West, Japan traditionally revered its elders. Ceremonies of Tea, Flowers, Meditation, Calligraphy, Aikidō, and many similar arts were precisely the kind of "Paths" in which the cultured sensibilities of maturity could find expression; people became potentially more, rather than less, valuable through age. Moreover, ideas of reciprocal obligation and interdependence dictated that elders be cared for, not because they might again contribute to society, but because they had already contributed to those now in a position to repay that obligation. Living in three-generational families, honoring their ancestors at family altars, Japanese ostensibly epitomized a culture conscious of its continuity with the past and its indebtedness to its forefathers.

In terms of dying, too, the suicides of countless samurai warriors, kamikaze pilots, and twentieth-century literati surprised the Western world with the reminder that classical civilizations lauded honor over life. While Japanese retain liberal attitudes on abortion, they do not acknowledge organ transplantation from brain-dead infants. Such apparent perplexi-

ties are in fact quite consistent within the Japanese worldview, but its fundamental disparity from the Anglo-European view confronts it with the throes of radical change.

Social change and the greying of japan

The Confucian notion that elders are universally to be cared for and respected (Holmes 1987) is rapidly growing outdated. To provide more future caregivers for its top-heavy elderly population, Japan's Ministry of Health has tried to stimulate the birth rate. Obviously what is needed is not merely more children, but more children who want to care for their elders—and such children are not in evidence. Since Japan, along with Holland, Bangladesh, and Java (Indonesia), has one of the densest populations on earth and can no longer feed itself without massive imports of food and energy, a higher birthrate is no solution to anything.

Japanese presently enjoy the longest life-spans in the world, averaging 79 for men and 86 for women, and longer for those who neither smoke nor otherwise suicide before that age (Japan National Institute 2005). As of 2006, about 20% of the Japanese population are over 65; by 2015, 25% will be over 65 (and in mandatory retirement; see Ezrati 1997). One generation from now, by 2040, over 33% of Japanese will be over 65, making Japan one of the most top-heavy populations in the world. In fact, most Japanese who survive into their 70's are likely to live well into their 90's, because the averages are weighted by a number of earlier-dying groups (Robine and Saito 2003).

The long life-span of Japanese poses severe economic challenges for the country. Japan prides itself on universal health care and pension plans that assure that no one goes without medical care. However, most medical expenses are incurred in the last years of life, so the more top-heavy the population pyramid, the larger the medical expenses for the population. Moreover, the Japanese mandatory retirement age, fixed over half a century ago when the average male life-span was about 66, still hovers between 60 and 62. Public pensions are generally provided from age 65. 50 years ago, the average pensioner collected social security for three

years before dying; today, the average pensioner collects for 15, and his widow for 25! The pension burden could be partially relieved by allowing people to work as long as they have the desire and ability, so that they are making contributions to the national tax and insurance base instead of withdrawing from it. Yet this alone will not make up for the ever-increasing costs of end-of-life care for ever-increasing numbers of seniors, including tens of thousands of centenarians unable to care for themselves.

Interestingly, elder Japanese do not aspire to the active, self-determined lifestyle that Americans idealize. In an extensive survey of "successful aging," Matsubayashi (2006) found the Japanese prioritized simply "living a long time in fair health" as a top ideal, as opposed to American elders' prioritizing of "staying involved, influencing others, making my own choices, meeting my own needs, and coping with my own problems." This supports the author's personal findings in both cultures that people with lower personal achievement ideals age more gracefully than those whose high ideals become frustrated by their gradual loss of influence, mobility, or mental agility.

Japanese living in three-generation households clearly have longer average life-spans than those living in newer "nuclear" families (Lester 1993), but the very phenomenon of three-generation households is fading from the scene. Young people are not content to work on farms in the countryside, and the price of land within commuting distance of metropolitan employers frustrates their acquisition of housing adequate for three generations under one roof. Thus the urbanization and "nuclearization" of Japanese families also takes its toll on the aging population.

The families that do feel social pressure and personal responsibility to care for their elders nonetheless face problems of burnout, of inadequate training, and of an environment lacking the barrier-free improvements required for comfortable and competent care of the increasingly handicapped (Harris 1993). There are far too few nursing home facilities to care for all of Japan's elderly, and the elderly may decline to apply to them in any case, out of shame for not having adequately "filial" children. Moreover, low levels of nursing home care lead to rapid deterioration in communication skills as well as to physical disabilities, even in patients exhibiting no other signs of senility (Nagatomo 1988). Many

Japanese elders prefer hospitalization as more "honorable" than applying for community welfare services (NODA 1991). All too often, hospitalization which begins for a cold, a sprained ankle, or an arthritic hand is prolonged until the patient dies of pneumonia years later (UEDA 1990).

Japanese face wide-ranging problems in adjusting to their own aging. While healthy elders optimistically respond to questionnaires that they can take care of themselves (WOLF 1985), this attitude changes rapidly when health declines. The fact that pneumonia is still the leading cause of death in elderly rural populations demonstrates that many lack basic care when faced with sickness. When an elderly rural person becomes unable to raise her own food, she may face real crisis if she has no one to purvey it. The depopulated rural areas show far greater rates of bedridden elderly, depression, and consequent decline in mental and physical health (UEDA 1990).

Urban port populations, and those near to power plants and refineries face severe rates of lung cancer (MINOWA 1981), as do the mostly male chain smokers in the population. Chronic alcoholism also contributes to an early mortality, both through disease and traffic accidents (IMAIZUMI 1986). The government has been reluctant to publicize the harms of tobacco and alcohol because of the strong lobbies of those industries and the high surcharges that the government collects on both. Yet the cost to the country demonstrably outweighs the tax returns which these industries produce (NAKAMURA 1993).

For a range of social and psychoneuro-immunological reasons, single persons in Japan tend to die 15 to 20 years younger than married persons (HU 1993)! On the one hand, the above-mentioned exceptions make it all the more amazing that the average life-span remains so long. On the other hand, an increasing number of elders dread the prospect of living thirty years beyond the typical retirement age of 60. This is made graphically clear by the voluminous research on Japanese suicide.

JAPANESE SUICIDE

Perhaps because Japan is renowned as a society that does not condemn suicide for religious reasons, cross-cultural research on suicide

almost invariably tries to include Japan. An inordinate number of studies are available on the subject of suicide in Japan, although many lack linguistic competence or cultural sensitivity. While not the primary focus of this paper, these studies illuminate some Japanese attitudes towards death, so it is useful to grant them an overview here. In traditional Japanese society, suicide was permitted to samurai to escape shame and defeat, and to commoners as a chance to be reborn in a healthier world than this one of sickness and poverty. In the past decade, and without the benefit of handguns (strictly illegal in Japan), Japanese suicides have led the world, averaging over 30,000 reported every year since the year 2000 (compared to America's 29,000 out of a population 2.5 times as large as Japan's).

Japanese suicide patterns today must be divided into three broad age groups: students and young adults, the middle-aged, and the elderly. Traditionally there were two peak age groups: students who either failed university entrance exams or failed somehow in college, and elderly widows. My own Kyoto University is infamous for having one of the leading suicide rates in the country. This has bred a spate of studies indicating that from youth, Japanese students tend to think of suicide as a "right" and as normal and acceptable behavior (Takahashi 1991). Youth are less concerned than their seniors with the effects of their suicides on others; their suicides tend to be more intensely personal and "performance-oriented." It has repeatedly been observed that media publicity of one suicide tends to give rise to a wave of subsequent suicides in the pre-adult age group (Ishii 1991).

In the past decade, a national reduction of university entrance requirements and a proliferation of universities have made college entrance examinations less competitive; at the same time, the restructuring of the Japanese economy has put thousands of middle-aged Japanese men out of work. Middle-aged Japanese men suicide more than women today, their suicides being almost entirely provoked by unemployment (Snyder 1990), bankruptcy, or financial crises (Araki 1986, 1987). As in Western countries, poor social support is another major predictor of middle-aged male suicide (Berger 1993). Significantly, suicide among mature males was extremely low during the war years (Yamamoto 1984) and rose drastically after the war, showing that a loss of sense of "purpose"

was a major factor in reducing the will to live (KITAHARA 1984). Some Japanese scholars have gone so far as to call suicide an "institutionalized adjustment mechanism" to the limitation of economic and social resources (IGA 1981). In middle age, Japanese females showed high suicide rates until the 1960s, the result of the conflict of their desires for success with their resourcelessness and vulnerability (IGA 1975). As the economic status of women has improved, those with access to economic independence suicide less than the norm (IGA 1978). Ironically, the increase of females in the work force has also led to the suicides of overworked women, and of men who have lost their sense of superiority (LESTER 1992).

In contrast to Western countries, Japan shows lower female suicide rates after divorce than in marriage, indicating that some Japanese females are more likely to suffer silently until suiciding than to seek divorce (LESTER 1992, 1995). By contrast, males are more likely to suicide after divorce, whether from shame, loss of face, or the inability to care for themselves (MOTOHASHI 1991, 1992). Dual suicides of single parents and their children remain a striking feature, again with economic hardship the main predicting factor (SAKUTA 1995). Regardless of sex or age group, living in depopulating rural regions, losing social support, insufficient income, and a sudden decline in physical condition are the main indicators of suicide in Japan (ARAKI 1986). Sadly, these indicators are all expected to rise rapidly in the foreseeable future, leading to major increases in elderly suicides in the future (OHARA 1994).

Among the elderly, physical disease and incapacitation are major causes of suicide (TATAI 1991). This is particularly evident among rural families whose children move away to the cities (FUSE 1980, LESTER 1993). Feelings of "alienation," or of being unable to keep up with rapidly changing times, also lead Japanese elderly to suicide (TRAVIS 1990). On the surface, male suicides slightly outnumber female even in the elderly age bracket. However, a sharp increase in "unintentional drownings" is reported among Japanese females over the age of 55, reaching an incredible 15 times the comparison rates by age 75, indicating that a great number of elderly female suicides are reported as "unintentional drownings," presumably for the family members to save face (ROCKETT 1993). While the national average in Japan is about 24 suicides per 10,000 people per

year, in the over-85 year-old population, the ratio is double, or 47–48 per 10,000—and that is of reported suicides alone (Takahashi 1998).

On all levels, suicide is deliberately under-reported. Universities report their students' suicides as sickness or accidents to protect their own reputations and those of the students' advisors, who might otherwise be pressured to resign. Corporations report their workers' suicides as accidents, lest they be sued for overworking their employees, and widows generally ask their doctors and police investigators to do the same, since their insurance benefits are greatly decreased if their husbands die from suicide rather than by accident. The unintentional drowning data for elderly widows also underscore that while individual suicides are not *morally* condemned, their families nonetheless feel great grief at the loss, and social shame for not having been able to save their relatives from this last desperate step.

There is some debate about the rural-urban prevalence of suicide in Japan. In most advanced countries where metropolitan life is hectic and impersonal, suicides are higher in urban than rural areas. However, Japan has particularly high suicide rates in its northern rural prefectures, afflicted with Seasonal Affective Disorder and heavy alcoholism (like Scandinavia), and relatively lower suicide rates in some of its youthful cities. Some have argued that rural residence is "the major factor in age-adjusted male suicide mortality" (Otsu et al. 2004). Others have held that high elderly rural suicide rates are due not only to loneliness or isolation, but also to interfamilial conflict—especially the inability of elders to understand their juniors, and their desire not to impose on them (Traphagan 2004).

If families are somehow more important to the Japanese than to their Western counterparts, then the loss occasioned by the death in such families may be expected to be a more serious blow to the bereaved than where independence is touted as a virtue from youth, and families frequently are scattered across continents. Indeed, studies show that Japanese mortality is directly related to social support, the quality of human relations, and the presence of children (Sugisawa 1994, Cornell 1992). But the Japanese have adapted their own Morita-style of meditative therapy to assist them in facing their own mortality (Ishiyama 1990). While wives often panic and fall into mental instability immediately following

their husband's deaths, their family activities are instrumental in helping them recuperate and take a more forward-looking view, and after a few years, not a small percentage go on to take an active part in counseling and consoling other recently bereaved wives (HENMI 1995).

Japan's changing attitudes towards suicide can be seen in a number of situations. When Emperor Meiji passed away in 1912, the suicide of his leading military figure, General Nogi, was seen as a natural and honorable expression of loyalty. When Japan was defeated in 1945, however, the generals were divided between those who suicided immediately, those who suicided only to avoid trial by the Allied Tribunal in Tokyo, and those who did not suicide at all. In 1988, when the Shōwa Emperor Hirohito passed away, the suicide of a few old army veterans was seen more as an anachronism than as an expression of patriotism. And when the Aum Shinrikyō plans for a coup d'etat were uncovered, the young people responsible all fled the scene and pleaded ignorance, despite the public outcry that they should suicide. So shame, apology, and loyalty are becoming less common reasons for suicide. While suicide remains a "morally acceptable" escape from poverty, social alienation, or incapacitation on the one hand, it is coming to be seen less as a protestation of "honor" or "consistency" than a simple "opting out," from which society and family should have saved the victim. The flourishing of volunteer-staffed "suicide hotlines" in Japan's major cities indicates that social sanction for suicide is declining. Not surprisingly, the hotlines have been least successful in rural areas, and most successful in the Tokyo area, where human relations are most anonymous and autonomous. The above overview of suicide patterns indicates that Japanese views of death are also changing: an orientation once death-affirming, if not otherworldly, is moving towards a more this-worldly and death-avoiding worldview.

Yet suicide is still considered a dignified way to die. In 2004, a childless octogenarian couple in Fukui Prefecture, not far from my residence, willed all their property and funds to their community and set all their affairs in order. The wife was plagued with severe senile dementia, and the husband was losing his physical abilities to care for her as he had for many years. They were known to be very devoted to each other, and were reluctant to be split up into separate eldercare institutions. The

husband loaded the local crematorium with wood, soaked it with fuel, and then persuaded his wife to join him there. Presumably he killed her first before suiciding himself, but not before he had lit their own funeral pyre. The townspeople found the crematory chamber locked from the inside, and the ashes of the old couple inextricably mingled when the chamber was finally opened. The national press criticized the town for not detecting their intentions in advance and for failing to provide adequate social services. But praise, admiration, and the expressed desire to emulate their chosen way of passing were not limited to local elders; it echoed in unsigned editorials and even academic gatherings across Japan. As in American debates about assisted suicide in cases of medical futility, who are we to say that the couple should have been forced to live on in the enforced institutional separation that the welfare state would have provided?

Ideal environments for death and dying

The social centrality of interdependence and group decision-making has ramifications for the termination of care and definition of death. In the West, it has become common to leave decisions regarding the termination of care and organ donation to the individual, who may express through a living will when she wants life-support system care terminated, when she would not like to be resuscitated, and what organs she will donate for transplantation. By contrast, in Japan, living wills are rarely respected by doctors, because the patient's family overrules them. Even when patients volunteer their organs for transplantation, it is common for the surrounding family members to oppose the transplant, thinking that it may shorten the patient's life or disfigure their corpse. Given this background, the question of brain death becomes even more complex.

In Japan, when does a person become no longer a person? Traditionally, even after a person's heart stopped beating, a number of important ceremonies were performed. Her name was called from the rooftop or from the garden well. Her favorite foods were prepared and placed by her side. Sutras were chanted and fragrant incense burned. Her body was

bathed and clothed. Families which had the time and money to do so set the body aside for several days, for a period of *mogari*. In fact, during this period of being called, fed, bathed, clothed, and rested, some people considered to be dead actually revived. The question here is: when is the person no longer a person, but a thing? The Japanese answer is: the person remains a person until finally cremated or buried, and the ashes or bones officially installed in the family altar or crypt. As long as a person has a visible body which looks like a person, one remains a person.

For being a person in Japan does not require making individual decisions or actively influencing events; being a person means being a nexus in a series of human interrelationships. When relatives gather in the hospital, even if the patient is unconscious, she remains a member of their group. Particularly at the wake and funeral, she is the center and focus of a network which connects all the people who attend. They continue to make decisions for her benefit, and if her voice could be heard, she would continue to accede to their decisions. If a person is a discrete, atomic consciousness, then when that consciousness leaves the body, the person no longer exists. But if a person is a node in a larger organic network, then as long as the network values the relationship, the person does not lose her personhood; she does not become a non-person, nor merely a thing. For the same reason, there has been great resistance in Japan to organ transplantation. In the Japanese worldview, cessation of breathing does not make the person into a thing, to be cut up. A Japanese remains a person even when comatose, brain-dead, or medically "deceased."

This is not the place to debate the rationality of these beliefs, nor is rationality the prime concern in understanding cultural practices anyway. The important thing we need to note is that viewing persons as parts of greater wholes leads to different policy implications in their health care and treatment.

Japanese place a premium on dying in a natural environment. A QOD (quality of death) survey conducted at Kyoto University demonstrated that Japanese are far more concerned with dying at home or surrounded by relatives, and with seeing the sky, the trees, or the horizon from their deathbeds, and with dying in a "natural" setting, preferably on tatami mats, than are their Western counterparts (BECKER 1997). Sadly, this is becoming less and less possible as more and more Japanese die in sterile

hospital settings. The stark contrast between the Japanese ideal of dying at home surrounded by family, and the Japanese reality of dying in sterile hospital rooms surrounded by tubes, machines, monitors, and nameless masked faces, disturbs many Japanese who would like to place a higher value on the time and style of this transition (Becker 1997).

In the typical hospital situation in Japan, the patient consults a doctor because he or she is ill, ailing, or in some way in need of the doctor's care. This situation immediately constructs a vertical relationship in which the patient is the inferior—weaker, less educated, in need of another's expertise—and the doctor is the superior—stronger, better educated, presumably expert in the area in question. By the rules of Japanese hierarchy, the patient is expected to follow the doctor's orders without question. It is typical for doctors to simply write prescriptions and tell the patient what color pills to take how often, without any clear explanation of the pathogenesis or nature of the complaint, much less an analysis of the potential side-effects or complications of the drugs. This tendency is intensified by the fact that the average length of consultation is some 80-90 seconds per patient, hardly conducive to developing a deeply interactive level of interpersonal communication between each doctor and each patient. Even more than doctors in the West, Japanese doctors lack the training and interpersonal skills to deal with the fears of their patients and patients' families fears of death. The vast majority of doctors do not inform their patients that they have terminal diseases or cancer—even in national cancer centers (Uchitomi 1994). Physicians themselves want to avoid or repress discussions of death, fearing both death itself and any consequent "unprofessional" emotionalism among their clientele (Takahashi 1990).

While some 80% of patients want more information about their condition and prospects, and wish to leave the hospital in time to spend their final hours in their homes, doctors are only correct in guessing their patients' wishes in about 50% of these cases (Kai 1993). So it is not surprising to find that the majority of Japanese patients are dissatisfied with the amount and quality of time which their doctors spend with them, and with their doctors' communications skills (Kurata 1994). Nurses, who often get much closer to the patients, are viewed as "subservient housewives" by many doctors. This view deprives the doctors of the

valuable opportunity to learn about their patients' through the nurses' eyes (Takeuchi 1989). Many Japanese doctors and scholars continue to confuse "informed consent" with "pressured persuasion from those who know best" (Nagayama 1994). Both doctors and families can commit mentally "incompetent" patients to hospital or psychiatric wards without the patients' consent (Asai 1983).

Doctors who are not personally skilled at counseling may nonetheless recognize the value of liaison counseling for both patients and families in theory, but they rarely refer them to liaison or psychiatric counselors either (Glick 1991 and 1994). This is partly because such liaisons are not well reimbursed by the present national health insurance system, and partly because the public does not understand the value of psychiatric counseling (Kurosawa 1993). Not only are referrals to counselors or liaisons scarce to begin with, but many patients referred to counselors by their doctors resist the very counseling from which they might most stand to benefit (Takeuchi 1989).

In traditional towns and villages until the early years of this century, a death was not merely a family event but a community affair (as were weddings, births, coming-of-age celebrations, and other rites of passage). Neighbors and friends gathered to give solace and assist the grieving family, conduct the funeral, and dig the grave. Since funerals occasioned community solidarity, they were convivial, almost celebratory occasions, everyone so busy preparing for heavy drinking and eating that mourning was almost overshadowed by community obligations. In fact, one important definition of one's neighborhood was that of 同族 or the group of families who would share in the responsibility of funeral proceedings (Mikami 1980); similarly, the definition of one's "extended family" was largely defined by those five or six families who would participate in conducting a traditional funeral (Nakagawa 1984).

In the twentieth century, as village society began to break down, funerals first changed from village festivals to the province of the extended family who would gather for the occasion. In the postwar years of "lifetime employment" and total devotion to corporate growth, the deceased's employer or corporation gradually replaced the blood family, supplying everything from the reception tables to the master of ceremonies. In recent years, modern nuclear families turn to hired funeral

homes 90% of the time (Ikeda 1986). This transition further distanced the bereaved, not only from the communities who might help them through the transition, but also from the physical act of caring for the dead. Traditionally, the family would wash the corpse while preparing the deceased's favorite foods. Today, most Japanese die in hospitals, so nurses wipe the corpses with alcohol before shipping them to the funeral home (rather than the original residence) for the wake and funeral service. Typical apartments are too small to house the altar and sitting room required by traditional wakes. Moreover the wake itself has been shortened from a 3–4 day period to a single evening in most cases, forgiving those unable to attend.

The transition from burial to cremation is another parallel consequence of the rising cost of land as well as the lack of hands to dig graves. Until the early twentieth century, burial was standard practice, except for the extremes of the priesthood, on the one hand, and the irredeemably defiled, on the other. Cremation was promoted in part to stop the spread of plagues, and in part to facilitate transporting the "remains" of soldiers from foreign wars back to their families. Today, cremation is so prevalent (99.9%) that many Japanese imagine burial to be illegal. However, burial remains the norm not only for Okinawans and remote villagers but also for the imperial family. A groundswell of interest in "natural burial," allowing a "return to mother earth," is held in check mainly by the prohibitive cost of gravesite land.

An anthropologically as well as psychologically interesting practice is that of bone-washing, now practiced only in Okinawa. The corpse is laid to rest in a large family crypt for a year or two, then removed, and the remaining flesh carefully stripped from the bones, which are washed and replaced in an urn or box. This marks a dramatic ending to the period of mourning, impressing upon the bone-washers that the deceased is very much in the other world to stay. A family feast is held outside the tomb, and the closest kin are then welcomed back from the realm of the "polluted" mourners to the realm of the living. In some such Okinawan tombs, there are three shelves for the bones of the dead. The most recently washed are placed in boxes on the lowest shelf; the previous generation on the middle shelf; those of two or three generations past on the upper shelf; and the bones of those not personally remembered by

the living are thrown in a heap behind the three-level altar. (For more on Okinawan religion and bereavement, see KONDŌ 1992.)

Such practices are unique to the southern tip of Japan, but throughout the country, the meaning of "in perpetuity" is simply "as long as someone is remembered by the living." Most cemeteries sell family gravesite packages with memorial services and gravesite maintenance guaranteed "in perpetuity." The small print makes clear that graves are maintained as long as family visit periodically, but that the ashes may be removed and the grave resold if a number of years pass with no visitation or servicing of the grave.

While not all Japanese are actively practicing Buddhists, the vast majority of funeral services are performed according to traditional Buddhist rites. Buddhist priests are summoned to chant sutras for the elevation of the soul during the wake; the guests all offer incense (sometimes flowers) on the altar in front of the portrait of the deceased. Coins are placed in the casket for the passage over the Styx-like *River Sanzu*, along with other items precious to the departed, and the family takes turns pounding in the casket nails with a rock.

The closest of kin serves as "chief mourner." He is in charge of addressing the assembled guests, of carrying the portrait of the deceased to the crematorium (in the car behind the hearse), of pushing the button that starts the combustion of the corpse, and finally of picking from the ashes a few bones to be revered in an urn on the family altar for a time before internment. Traditionally, this was the role of the first son, but increasingly wives and sisters are replacing sons as first mourners, particularly in high profile, mobile urban families (TSUBOUCHI 1980). Similarly, the attendants at funerals are shifting from patrilineal kindred to personal friends and colleagues (MIKAMI 1980).

Most important for the bereaved is the custom of family visits to the familial or custodial temple at fixed intervals after the death: one week, seven weeks, one, two three, seven, ten year, and periodic intervals thereafter, as well as holding special services at the first summer "Obon" festival. These weekly and annual services not only involve chanting of sutras commemorating and praying for the well-being of the departed, but provide an opportunity for grief-work counseling by the temple priest. The family can discuss their fears, concerns, and questions about the

afterlife, sharing their sense of loss and seeking solace from the priests who intermediate between this world and the next. While there is considerable controversy over the cost of the mandatory "offerings" to the presiding priests, this practice of repeated gathering in the name of the departed is salutary and restorative for the psyches of the survivors (cf. Savishinsky 1974). In wakes and funerals I have attended, long speeches on the character and foibles of the deceased by all the attendants helped to bring a sense of completeness and closure to the attendants' image of the deceased.

Religious belief and death anxiety

The influence of Buddhism has traditionally been one of reducing the fear of death, whether because there was a better world to go to in the hereafter (Pure Land Buddhism), or because it was important to live fearlessly in the moment (Zen).

The Meiji Restoration of 1866 used State Shinto as a tool to overturn the Buddhist religious hegemony upon which the Tokugawa Shogunate had depended for local administrative purposes. With this turn from Buddhism to State Shinto, much of the ancestor-reverence taught by Buddhism was lost. Subsequently, MacArthur's Allied Occupation repudiated and abolished State Shinto, which had promised that souls dying for the emperor would be exalted at national shrines. So postwar Japanese went completely devoid of religious and death-related education, indeed shunning the very topic of death as polluted if not shameful. This is in some ways analogous to processes traced in the West by Aries, but intensified by desires to avoid looking back at the wartime propaganda, both by elders who do not want their beliefs falsified, and by youth who feel their grandparents simply were brainwashed into colossal mistakes.

Today, some 75-80% of Japanese claim to be Buddhists, and another 75-80% to be Shinto, but neither of these affiliations are exclusive doctrinal commitments; they are rather indicative of a mind-set shared by almost all Japanese regardless of professed religion. The Shinto worldview is optimistic and this-worldly. Death is dirty and defiling, and involves a ghostly continuation of the consciousness in or near the locale

where the person died. The ideas that a person can physically feel what happens to their corpse and will be concerned with the upkeep of their gravesite, that dead spirits can bless or curse and communicate with the living, and come back from the nether world once a year to visit the living, are originally ideas derived from a Shinto tradition of animism and spirit-worship. These ideas also militate against autopsy and organ donation. Since the passing of Japan's Brain Death and Organ Donation Law, only three to four brain-dead organ donors have been found each *year*. (Many donations are surrounded by further scandals regarding transparency, priorities, and selection of recipients.)

None of this should be taken to mean that the Japanese do not feel anxiety towards death and dying; quite to the contrary, their efforts to avoid discussing and confronting the issue belie and intensify the very fears which prompt the aversion. The long Japanese traditions of honoring elders and death rituals, and permissiveness towards suicide, would seem to imply that Japanese experience less "death anxiety" than their Western counterparts. McMordie and Kumar suggested as much in their work in the early eighties (1984).

However, more recent empirical studies (cf. Schumaker 1991) have found that Japanese scored higher than comparable Australians on Templer's Death Anxiety Scale. Counter-intuitively, Japanese men show as high death anxiety as women, unlike males in most countries (McMordie and Kumar 1984). The inconsistencies of hypotheses and conclusions about Japanese death anxiety led Misao Fujita to research Japanese and American death anxiety along a number of axes, using such instruments as Hoelter's Multidimensional Fear of Death Scale (1979). Fujita (1995) and I collected data comparing 264 American and 169 Japanese college students' death anxiety using Hoelter's MFODS. Independent T-tests on each of eight subscales found a statistically significant greater fear of dying among Japanese subjects, viz: Fear of the Dying Process, Fear of the Dead, Fear of the Unknown, Fear of Conscious Death, and Fear for the Body after Death. Further scales demonstrated that the Japanese students had lower rates of acceptance of brain-death criteria and more reluctance to admit organ transplantation, which a Pearson correlation coefficient proved was connected to their higher death anxiety. Fujita speculates that the higher anxieties of the Japanese towards death "may

indicate their less frequent use of defense mechanisms against their fear of death." The fact that Japanese males again scored as high as females in death anxiety supports earlier research findings (Schumaker 1991), and might be explicable on the basis that Japanese males respond emotionally (as women do) rather than cognitively (as Western males do) to the fears of death and dying.

Several observations arise concerning the Japanese reluctance to accept brain-death criteria and organ transplantation. Japanese respondents showed significantly higher anxieties on questions relating to "fear of conscious death," such as "I am afraid of being buried alive," and "I hope more than one doctor examines me before I am pronounced dead." Similarly, Japanese showed significantly higher anxiety concerning "fear for the body," involving such items as "I dread the thought of being embalmed," and "the thought of my body decaying scares me." Japanese subjects were more likely than their American counterparts to consider the body sacred even after death. Interestingly, fear of cremation is no longer any higher among Japanese than Americans, perhaps because cremation has become standard practice in Japan for nearly a century, and fire is considered "purifying" rather than "putrefying." There is no time nor space here to introduce and discuss all of Fujita's analyses, but our study leads to a number of important conclusions. Japanese are more rather than less anxious about death than their Western contemporaries; this anxiety is as high for men as for women; and this anxiety is also connected to their reluctance to donate organs for transplantation.

In this connection I might proffer a memorable if anecdotal case I encountered in Japan. An old gentleman wished to offer his corneas to an eye bank, and after some discussion, his family assented. His corneas were duly removed before his corpse was cremated, but a few days thereafter, his eyeless ghost was seen by several of the bereaved in their sitting room! As long as Japanese people experience, or even believe, such phenomena, mere legalization of organ banks and transplantation will by no means be sufficient to overcome the sociocultural barriers to such procedures and their psychological aftereffects (cf. Lock 1989). While most Japanese do not attend regular religious services, death is surrounded by deeply-felt beliefs, rituals, and experiences. The vast majority of Japanese taboos relate to death. For example, one may not wear a kimono

with right lapel over left, or leave chopsticks sticking in rice, for these are reserved for funereal occasions. References to death are scrupulously avoided; skyscrapers have no forty-second floor, for it is a homonym of the words "to die," and envelopes for presenting offerings to the dead may not be purchased in advance, as if they might unfortuitously occasion a premature death.

The major festival of each summer is the "Obon" ceremony, in which the spirits of the dead (especially of the most recent generation) are welcomed back with food, dancing, and merriment. Memorial services are held, and then they are again sent "back" to the other world with bonfires, torch parades, or the floating of candles out to sea. Even those Japanese who deride the notion of life after death in other seasons seem unusually wary of offending spirits in this season. Shaman-like ladies called *yuta, miko*, or *itako* enter trance possession to allow the spirits of the dead to speak through them, occasionally with uncanny likeness to the dialect and memories of the departed. Midsummer TV and popular magazines are filled with stories of ghosts and contact with the dead. Even in American settings, Japanese-Americans exhibit a consciousness of contact with the deceased (KALISH 1973).

A survey of over 4,000 highly educated doctors and nurses found that a near majority of hospital staff feel that they have experienced some sort of contact with dead spirits or haunting (KŌRI 1994). I, too, have noticed a consistent difference in attitude between religious and nonreligious patients. Those patients who have not been able to vocalize or come to terms with their conceptions of the afterlife are consistently glummer, grimmer, and gloomier than those who speak with conviction about looking forward to meeting the Buddha Amida, their relatives, or other saints in the world to come. (This is consistent with the findings of Father Deeken working in Christian hospitals in Japan; see DEEKEN 1992). Since the ninth century, Japanese Buddhists have recorded near-death experiences in richly detailed accounts in which the dying person returns to life to recount a visit to another world of flowers, light, and encountering godlike bodhisattvas or previously departed relatives. Such records continued to be kept in the countryside until Buddhism was officially denounced by the Meiji Restoration in 1866. Recent research has revealed that despite their reluctance to discuss it publicly, Japanese

continue to experience a wide range of near-death phenomena (Kōri, 1994).

In a paradigmatic case of a junior high school student hit by a car after alighting from his school bus, the lad not only saw naturalistic images of flowers and rivers, but a Buddhist guardian assigning the dead to enter gates of light and darkness according to their karma, and met his great-grandfather who had died before he was born. As in the West, such accounts tend to breed more relief than incredulity. Perhaps the day is coming when Japanese can again discuss their fears of death and hopes for the next world without seeming politically incorrect or summoning images of Emperor-reverence (Becker 1992).

Superficially, Japanese treatment of the elderly, of suicides, of hospitalization, and even of funerals, have undergone sweeping change in the half century since the war. While fashions may influence the phrasing and professions of faith, the underlying fears and hopes of Japanese patients for a "natural" death and a happy hereafter remain fundamentally unchanged. The evolution of Japanese practices and beliefs concerning death and bereavement will continue to pose challenges to medical ethicists and anthropologists as well as psychologists. For those of us living and dying in Japan, however, the gaps between Japanese ideals (of caring for elders until their natural transitions) and realities (of dying in artificial hospital situations) pose ongoing problems, not only to the social security and health insurance systems, but to the psychological care of terminal patients and bereaved families (cf. Fukui 1994). Japanese are on the whole less willing than their Western counterparts to air their feelings in public, much less to consult with psychiatric professionals. Rather than creating a new class of professional counselors, then, the revitalization of preexisting mechanisms within families and Buddhist priesthood promises the possibilities of better grief work counseling in the future.

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