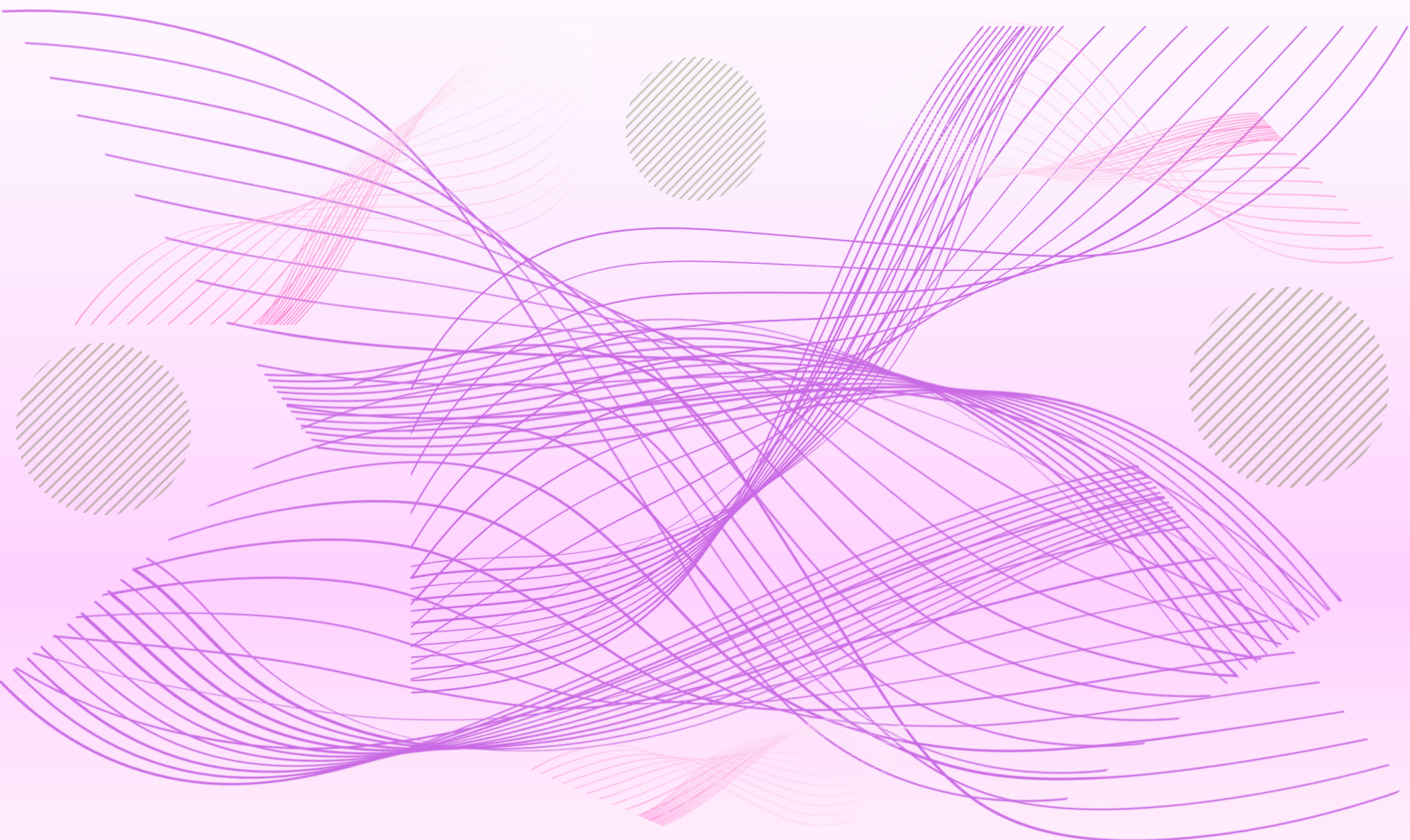


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E-mail journal@jscp.or.jp

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Original article

AI or Human Support for Suicide Prevention? Examining Help-Seeking Intention in Suicidal Crisis

Daisuke Nakamura^{1,2}, Hajime Sueki³, Jiro Ito¹

Abstract

Background: Chat-based crisis support is a common strategy for suicide prevention, and artificial intelligence (AI) chatbots may improve low response rates. Although AI chatbots are technically feasible for crisis support, it remains unclear whether individuals experiencing suicidal ideation intend to use them. This study aimed to examine the intentions of adults with severe psychological distress to use chat-based crisis support (human vs AI) when feeling suicidal.

Method: A cross-sectional web-based survey was performed, recruiting participants aged 18–69 years with a Kessler-6 score ≥ 13 who were registered as monitors with an internet research company in Japan. They completed a questionnaire on their intention to use chat-based crisis support when feeling suicidal. Participants were categorized into four groups: (1) both human and AI chat, (2) AI chat only, (3) human chat only, and (4) neither.

Results: Overall, 1,024 participants completed the survey; 19.5% intended to use AI-based chat and 21.3% intended to use human-based chat. The proportions of participants who intended to use both human and AI chat, AI chat only, human chat only, and neither option were 15.6%, 3.9%, 5.7%, and 74.8%, respectively. Significant differences were observed in gender ($p = 0.028$), history of crisis support use ($p < 0.001$), and current issues (financial problems [$p = 0.002$] and sexuality-related concerns [$p = 0.006$]) across the groups.

Conclusion: In this web-based survey, 74.8% of individuals with severe psychological distress did not intend to use either human- or AI-based chat support when feeling suicidal, whereas 19.5% intended to use AI-based chat and 21.3% intended to use human-based chat.

Keywords: Suicide, Suicidal ideation, Artificial intelligence, Crisis intervention, Help-seeking behaviour

1. Introduction

Suicide is a serious social issue, and preventing it is a global priority. Annually, over 700,000 people die by suicide¹. The World Health Organization (WHO) has set a goal to achieve a one-third reduction in the suicide rate by 2030² and recommends utilizing technology for suicide

prevention³.

One type of crisis support is a technology-based suicide prevention method that uses chat and text messages. Chat-based crisis support has shown positive experiences⁴ and effects on mental health outcomes⁵ and suicidal ideation⁶ among users. Text-based crisis support has a

¹) Specified Nonprofit Corporation OVA, Tokyo, Japan

²) Department of Health Informatics, School of Public Health, Graduate School of Medicine, Kyoto University, Kyoto, Japan

³) Department of Psychology and Education, Faculty of Human Sciences, Wako University, Tokyo, Japan

promising impact on users' suicidal ideation 1 month following consultation⁷. However, low response rates from counselors remain a serious problem, at 30% for chat-based support and 56% for text-based support⁸.

Artificial intelligence (AI) chatbots have emerged as a promising solution for overcoming the limitations of text- and chat-based crisis support. A meta-analysis showed that AI chatbots, such as Woebot and Wysa, reduced depressive and anxiety symptoms⁹. Counseling through AI chatbots has the potential to contribute to suicide prevention among internet users at risk of suicide¹⁰. Furthermore, AI has been reported to help counselors provide crisis support in Hong Kong¹¹, and a meta-analysis depicted good accuracy in predicting suicide risk behavior¹². In addition, ChatGPT-4 has a higher social intelligence score than psychologists with doctoral degrees¹³. A systematic review demonstrated that large language models achieved higher empathy scores than humans¹⁴. Thus, AI chatbots may have the advantage of accurately predicting suicide risk and delivering empathetic responses, while having a high social intelligence 24 hours a day.

Although an AI chatbot may improve the response rate to crisis support, it remains unclear whether citizens will choose to use AI-based crisis support. Among crisis support users and the general public, approximately one-third opposed using AI and automation to personalize crisis support, and over half avoided the service if such technology was implemented¹⁵. People prefer human counselors to AI¹⁶, and human responses are preferred to AI-generated responses for sensitive discussions, such as suicidal thoughts¹⁷. However, considering the rapid pace of technological developments in AI, these trends may evolve over time.

Furthermore, intentions to use AI chatbots vary according to demographic factors; for instance, younger individuals¹⁸ and men¹⁶ tend to accept AI, as they reduce barriers related to cost, time¹⁶, and stigma¹⁹ compared to traditional services. Additionally, in situations where individuals experience suicidal ideation, they may seek help from any available source,

including an AI chatbot.

This study aimed to investigate the intention of adults with severe psychological distress to use chat-based crisis support provided by humans or AI when feeling suicidal. Clarifying these intentions is crucial when designing crisis support that reflects help seekers' perspectives. Furthermore, we explored the associations between these intentions and background characteristics to determine which types of individuals intend to use chat-based crisis support.

2. Methods

2.1. Study design and settings

This study was a cross-sectional web-based survey conducted through an internet research company (Cross Marketing Inc.) in Japan. Participants were recruited from the general internet users registered as monitors with the research company from November 7 to 10, 2023, approximately 1 year following ChatGPT's release.

2.2. Study participants

This study aimed to recruit 1,000 men and women aged 18 to 69 years. The research company randomly distributed questionnaires to potential respondents via a secure website that they accessed with unique IDs and passwords. Respondents who met all inclusion criteria and none of the exclusion criteria were included as study participants. The inclusion criteria were: (1) men and women aged 18–69 years who were registered with the research company and (2) individuals who scored ≥ 13 on the Kessler-6 (K6). The K6 is a six-item questionnaire that screens for psychological distress, and its Japanese version has established reliability and validity²⁰. In a Japanese study, a cut-off of 13 or higher had high specificity for mood and anxiety disorders²¹. The exclusion criteria were (1) incomplete questionnaire responses and (2) failure to pass the attention check item (e.g., “mark the third option to this question”). Participants were equally divided into 10 groups categorized by gender (men and women) and age (18–29, 30–39, 40–49, 50–59, and 60–69), with

100 adults per group. Following research company regulations, incentives were provided to the participants.

2.3. Measurements (outcome)

The primary outcome was the intention to use the chat-based crisis support provided by a human (professional counselor) and AI in three situations: feeling suicidal, experiencing an immediate personal crisis, and having difficulty coping with events in daily life. As no standardized measures exist for evaluating the intention to use chat-based crisis support, we adapted and modified questions from previous studies^{15,22}. These questions were further developed through discussions with a crisis support professional and a suicide researcher to suit the context of this study. Participants responded to binary questions for this measure (Supplementary Material 1). Human-based chat was described as a free service in which well-trained professionals, such as clinical psychologists, accurately assessed users' risk levels and manually provided empathetic responses and referrals to relevant medical institutions or local government services. AI-based chat was described as a free service in which AI accurately assessed users' risk levels based on data from real consultations handled by professionals, such as clinical psychologists, and automatically provided empathetic responses and referrals to relevant medical institutions or local government services. The human- and AI-based chats were completely idealized services. The description of the AI-based service focused on its functions and did not specify the underlying technology, such as a rule-based system or a large language model. To avoid order effects, the presentation order of the questions about human- and AI-based chats was randomized.

2.4. Measurements (exposures)

The participants were asked about their history of suicide attempts, crisis support usage, suicidal ideation, current concerns and issues, and sociodemographic characteristics (age, gender, marital status, household income, and employment status). Suicidal ideation was assessed using a suicidal ideation scale that

confirmed internal consistency, test-retest reliability, and validity in the Japanese population²³. Current concerns and issues were selected from a multiple-choice list of suicide-related factors (i.e., financial problems/multiple debts, unemployment/job dismissal, drug addiction, alcohol addiction, gambling addiction, sexual violence, domestic violence, sexuality-related concerns, and others). This list was adapted and modified from previous studies^{22,24} through discussions with a crisis-support professional and suicide researcher.

2.5. Statistical analysis

The proportion of intentions for using AI chat and human chat was calculated respectively.

Participants were categorized into four groups based on their intention to use chat-based crisis support: (1) Both options: participants who intended to use both human- and AI-based chats; (2) AI chat only: participants who intended to use only AI-based chat; (3) Human chat only: participants who intended to use only human-based chat; and (4) Neither option: participants who did not intend to use either human- or AI-based chat. The proportion of participants in each group was calculated.

Chi-square tests were used to compare the proportions of categorical variables (e.g., sex), and the Kruskal–Wallis test was used to compare continuous variables (e.g., age) that did not follow a normal distribution across the groups. Adjusted residuals were calculated for categorical variables to identify specific differences between groups. Analyses about gender were restricted to male and female participants due to zero frequencies in the "other" category. Current concerns and issues were analyzed using Fisher's exact test when cells had zero frequencies or >20% had five or fewer expected frequencies. A p-value of <.05 was considered significant in all statistical tests. This study was exploratory. We reported p-values in addition to adjusted residuals. Caution was warranted in the interpretation of the results. All statistical analyses were performed using R version 4.4.2.

2.6. Ethics

The Ethics Committee of Wako University (2023_0926) approved this study. Informed consent was obtained from all participants before the survey.

3. Results

3.1. Study participants selection

Figure 1 illustrates the participant selection process. The research company chose 159,970 potential respondents, and 17,793 responses were obtained. Among these respondents, 15,992 did not meet the inclusion criterion of K6 score ≥ 13 . Of the 1,801 respondents, 616 were excluded for failing an attention check, and 161 were excluded for providing incomplete responses. Overall, 1,024 participants completed the survey.

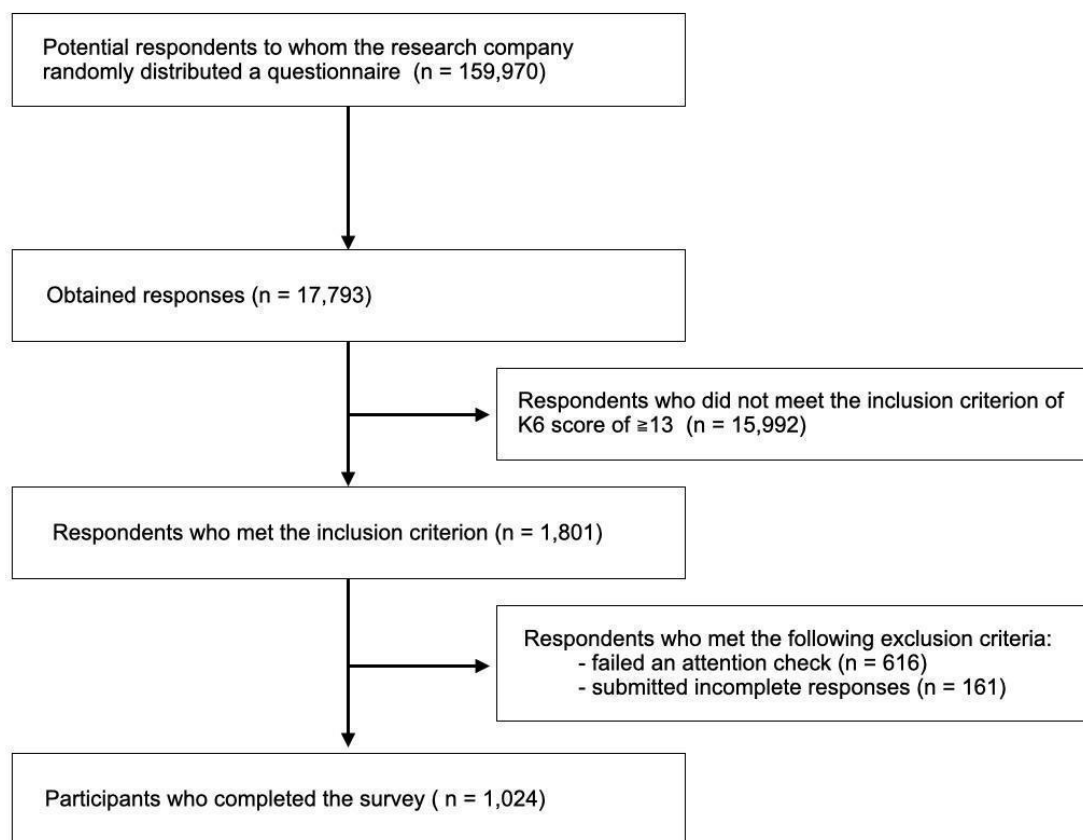


Figure 1 Participant selection process

3.2. Intention to use chat-based crisis support

Table 1 presents the distribution of intentions to use chat-based crisis support when feeling suicidal: 19.5% intended to use AI-based chat, and 21.3% intended to use human-based chat.

Table 2 lists the distribution of intentions to use chat-based crisis support across three situations. When feeling suicidal, the proportions of

participants were 15.6%, 3.9%, 5.7%, and 74.8% for both options, AI chat only, human chat only, and neither, respectively.

3.3. Comparison of sociodemographic and suicide-related characteristics among the four groups

Table 3 presents a comparison of sociodemographic and suicide-related

characteristics among the four groups when feeling suicidal. The Kruskal–Wallis tests showed no significant differences among the four groups in age, K6 score, and suicidal ideation. The chi-square tests showed no significant differences in marital status, employment status, household income, and history of suicide attempts. Women were significantly more likely to be in the human chat only group, and men were significantly less likely to be in that group (adjusted residuals = 1.993 and -2.008 , respectively; $p = 0.028$). Participants with a history of crisis support use were significantly more likely to be in the groups of both options or human chat only and significantly less likely to have no intention for either option (adjusted residuals = 5.084, 4.942, and -3.334 ; $p < 0.001$).

Table 4 lists a comparison of current concerns and issues among the four groups when feeling suicidal. Significant differences were found among the four groups in terms of financial problems/multiple debts ($p = 0.002$), sexuality-related concerns ($p = 0.006$), and others ($p =$

0.015). Participants with financial problems/multiple debts were more likely to have no intention for either option (65.2%) or intention for both options (26.7%) compared to AI chat only (2.2%) or human chat only (5.9%). Those with sexuality-related concerns also showed higher proportions of no intention for either option (60.9%) and for both (34.8%) than in the AI chat only (0%) or human chat only (4.3%). For “others,” which included various uncategorized issues, fewer participants were in the AI chat only (4.9%) compared to the neither option (68.0%), both options (17.2%), or human chat only (9.9%). Although not significant ($p = 0.087$), more participants with unemployment/job dismissal had no intention for the neither (67.3%) or both options (19.9%) than for the AI (4.7%) or human chat only (8.2%). Supplementary material 2 shows a comparison of sociodemographic and suicide-related characteristics among the four groups that experienced an immediate personal crisis and had difficulty coping with events in their daily lives.

Table 1. Distribution of intentions to use chat-based crisis support when feeling suicidal

	Yes	No
AI chat	200 (19.5%)	824 (80.5%)
Human chat	218 (21.3%)	806 (78.7%)

Table 2. Distribution of intentions to use chat-based crisis support

	Intention for both Options	AI Chat only	Human Chat only	No Intention for either option
When feeling suicidal	160 (15.6%)	40 (3.9%)	58 (5.7%)	766 (74.8%)
When experiencing an immediate personal crisis	176 (17.2%)	32 (3.1%)	71 (6.9%)	745 (72.8%)
When having difficulty coping with events in daily life	176 (17.2%)	47 (4.6%)	61 (6.0%)	740 (72.3%)

Table 3. Comparison of sociodemographic and suicide-related characteristics among groups when feeling suicidal (1/2)

	Intention for both Options	AI Chat only	Human Chat only	No Intention for either Option	p-value
Age	48.0 ^a [33.0–59.0] ^b	41.0 [28.0–56.3]	48.5 [35.5–59.5]	45.0 [32.0–55.0]	.338
Gender					
Women (n = 513)	82 ^c (16.0) ^d	21 (4.1)	40 (7.8)	370 (72.1)	.028
Adjusted residuals	0.209	0.188	1.993	-0.689	
Men (n = 505)	77 (15.2)	19 (3.8)	18 (3.6)	391 (77.4)	
Adjusted residuals	-0.211	-0.189	-2.008	0.694	
Other (n = 6)	1 (16.7)	0 (0)	0 (0)	5 (83.3)	.*
Marital status					
Married (n = 349)	60 (17.2)	11 (3.2)	20 (5.7)	258 (73.9)	.107
Adjusted residuals	0.741	-0.713	0.052	-0.190	
Separated, Widowed (n = 120)	27 (22.5)	3 (2.5)	9 (7.5)	81 (67.5)	
Adjusted residuals	1.905	-0.779	0.845	-0.925	
Unmarried (n = 555)	73 (13.2)	26 (4.7)	29 (5.2)	427 (76.9)	.133
Adjusted residuals	-1.473	0.928	-0.435	0.581	
Employment status					
Regular employment (n = 364)	62 (17.0)	15 (4.1)	14 (3.8)	273 (75.0)	.133
Adjusted residuals	0.680	0.207	-1.457	0.043	
Non-regular employment (n = 207)	41 (19.8)	6 (2.9)	15 (7.2)	145 (70.0)	
Adjusted residuals	1.522	-0.734	0.957	-0.791	
Self-employment (n = 57)	10 (17.5)	3 (5.3)	2 (3.5)	42 (73.7)	.133
Adjusted residuals	0.366	0.518	-0.684	-0.098	
Unemployment (n = 223)	28 (12.6)	6 (2.7)	12 (5.4)	177 (79.4)	
Adjusted residuals	-1.159	-0.919	-0.178	0.789	
Other (n = 173)	19 (11.0)	10 (5.8)	15 (8.7)	129 (74.6)	.133
Adjusted residuals	-1.545	1.247	1.662	-0.036	

Table 3. Comparison of sociodemographic and suicide-related characteristics among groups when feeling suicidal (2/2)

	Intention for both Options	AI Chat only	Human Chat only	No Intention for either Option	p-value
Household income					
< 4 million yen ^c (n = 603)	86 (14.3)	27 (4.5)	34 (5.6)	456 (75.6)	
Adjusted residuals	-0.847	0.710	-0.026	0.232	
4-6 million yen (n = 228)	42 (18.4)	8 (3.5)	14 (6.1)	164 (71.9)	.688
Adjusted residuals	1.068	-0.304	0.302	-0.502	
≥ 6 million yen (n = 193)	32 (16.6)	5 (2.6)	10 (5.2)	146 (75.6)	
Adjusted residuals	0.336	-0.925	-0.282	0.336	
History of crisis support use					
Yes (n = 105)	37 (35.2)	1 (1.0)	18 (17.1)	49 (46.7)	
Adjusted residuals	5.084	-1.531	4.942	-3.334	<.001
No (n = 919)	123 (13.4)	39 (4.2)	40 (4.4)	717 (78.0)	
Adjusted residuals	-1.719	0.518	-1.671	1.127	
History of suicide attempts					
Yes (n = 213)	39 (18.3)	12 (5.6)	11 (5.2)	151 (70.9)	
Adjusted residuals	0.991	1.276	-0.306	-0.660	.265
No (n = 811)	121 (14.9)	28 (3.5)	47 (5.8)	615 (75.8)	
Adjusted residuals	-0.508	-0.654	0.157	0.338	
K6	16.0 [14.0–19.0]	16.5 [14.0–19.3]	17.0 [15.0–20.8]	17.0 [14.0–20.0]	.636
Suicidal ideation scale	5.0 [2.0–7.0]	7.0 [3.8–9.3]	5.0 [3.0–6.0]	5.0 [2.0–8.0]	.160

a Median.

b Interquartile range.

c Number of participants.

d Proportion.

e One US dollar is roughly equivalent to 150 yen.

*Cells with a frequency of zero were excluded from the analysis.

Table 4. Comparison of current concerns and issues among groups when feeling suicidal

	Intention for both Options	AI Chat only	Human Chat only	No Intention for either Option	p-value
Financial problems / Multiple debts (n = 135)	36 ^a (26.7) ^b	3 (2.2)	8 (5.9)	88 (65.2)	.002
Unemployment / Job dismissal (n = 171)	34 (19.9)	8 (4.7)	14 (8.2)	115 (67.3)	.087
Drug addiction (n = 18)	5 (27.8)	0 (0.0)	0 (0.0)	13 (72.2)	.458
Alcohol addiction (n = 38)	9 (23.7)	2 (5.3)	1 (2.6)	26 (68.4)	.391
Gambling addiction (n = 27)	7 (25.9)	1 (3.7)	0 (0.0)	19 (70.4)	.321
Sexual violence (n = 18)	4 (22.2)	1 (5.6)	0 (0.0)	13 (72.2)	.564
Domestic violence (n = 25)	5 (20.0)	0 (0.0)	4 (16.0)	16 (64.0)	.102
Sexuality-related concerns (n = 46)	16 (34.8)	0 (0.0)	2 (4.3)	28 (60.9)	.006
Others (n = 203)	35 (17.2)	10 (4.9)	20 (9.9)	138 (68.0)	.015
None (n = 561)	68 (12.1)	19 (3.4)	23 (4.1)	451 (80.4)	<.001

^a Number of participants.^b Proportion.

4. Discussion

4.1. Main findings

This online survey examined the intentions of adults with severe psychological distress to use chat-based crisis support provided by either humans or AI. Of the participants, 74.8% did not intend to use either option when feeling suicidal. The proportions intending to use AI-based and human-based chat were 19.5% and 21.3%, respectively. Men (3.6%) were less likely than women (7.8%) to intend to use only human-based chat. Intentions to use human- or AI-provided chat-based crisis support differed according to participants' current concerns and issues.

Of the participants, 766 (74.8%) did not intend to use chat-based crisis support provided by either humans or AI when feeling suicidal.

People prefer different sources of support when facing a suicidal or mental health crisis, such as crisis lines, mental health professionals, and friends or family²⁵. Therefore, some participants may have preferred other sources or non-chat forms of crisis support. Systematic reviews have also shown that stigma is a barrier to help-seeking²⁶ and that privacy concerns are a barrier to engagement with digital mental health interventions²⁷. Future studies could explore why participants chose neither option and whether they preferred other forms of crisis support.

4.2. Implications

Of the participants, 40 (3.9%) intended to use only AI-based chat when feeling suicidal. Men (3.6%) were less likely than women (7.8%) to intend to use only human-based chat when feeling suicidal. Despite their high risk of suicide,

men are less likely to use crisis support⁵. Traditional masculine norms²⁸ and stigma²⁹ may contribute to lower help-seeking among men. A judgment-free AI chatbot may help reduce these psychological barriers³⁰, as demonstrated in a previous study showing that implementing a self-referral AI chatbot increased referrals to mental healthcare services, with particularly pronounced increases among minority groups experiencing high stigma³¹. These findings imply that diversifying communication channels for crisis support, including AI chatbots, might expand opportunities for help-seeking, especially among men.

Depending on the concerns and issues experienced by individuals, intentions to use chat-based crisis support differed between human- and AI-provided services. These findings suggest that the issues people face may be related to whether they intend to use human- or AI-provided chat-based crisis support. However, these analyses were exploratory and hypothesis-generating. Future studies could directly assess the reasons for participants' responses and conduct prespecified subgroup analyses using multivariable models to examine associations between intentions and sociodemographic characteristics, suicide-related characteristics, and types of concerns.

The WHO has published warnings regarding the ethical concerns and risks of inadequate support when using AI in crises, citing a case in Belgium wherein an individual died by suicide after interacting with an AI chatbot³². AI-based mental health interventions can trigger past traumatic experiences and lead to symptom exacerbation³³ in addition to generating inappropriate responses³⁴. Organizations deploying AI-based crisis support must assess potential user issues and understand the associated risks in advance.

4.3. Limitations

The present study had several limitations. First, this study assessed intentions rather than actual behaviors. The items measuring "intention to use chat-based crisis support" were adapted from previous research but they are not standardized

scales. In addition, the binary response format could not distinguish between participants who strongly intended to use chat-based crisis support and those who were hesitant. Second, all data were self-reported, limiting response accuracy, and we conducted an attention check to improve data quality. Third, participants were recruited from a single internet survey company in Japan. Their suicidal ideation scores were lower than those of actual crisis support users³⁵, suggesting that their help-seeking intentions may have been underestimated. Thus, it is unclear whether these findings apply to people in more severe suicidal crises or at imminent risk of suicide. Fourth, this survey was conducted in November 2023. Public attitudes toward AI may change quickly as the technology rapidly evolves. The intentions reported in this study reflect the situation at that time. Finally, it is unclear how broadly the present findings can be generalized to populations other than the Japanese participants in this study, considering the cultural differences in help-seeking³⁶.

5. Conclusion

Our web-based survey suggests that 74.8% of individuals with severe psychological distress did not intend to use chat-based crisis support when feeling suicidal, whether provided by a human or an AI. The proportions intending to use AI-based and human-based chat were 19.5% and 21.3%, respectively. Therefore, diversifying communication channels for crisis support may expand opportunities for help-seeking.

Declarations

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Conflict of interests

Hajime Sueki declares honoraria from Specified Nonprofit Corporation OVA related to the subject matter of this manuscript. The other authors declare no conflict of interest.

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Ethics approval

The Ethics Committee of Wako University (2023_0926) approved this study.

Consent to participate

Informed consent was obtained from all individual participants included in the study.

Data availability

All data produced in the present study are available upon reasonable request to the corresponding author.

Authors' contributions

Daisuke Nakamura: conceptualization, data curation, formal analysis, project administration, validation, visualization, writing – original draft, writing – review & editing.

Hajime Sueki: conceptualization, formal analysis, supervision, writing – review & editing.

Jiro Ito: conceptualization, project administration, writing – review & editing. All authors approved the final version of the article.

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Commentary

Changes in Family Structures and the Reality of Social Isolation: Considering the Relationship Between Isolation and Suicide

Katsuhiko Fujimori¹⁾

Abstract

Japan's long-standing reliance on the family as a core welfare unit is increasingly strained by changes in household composition, particularly the rapid rise of single-person households. Individuals living alone lack intra-household mutual assistance, resulting in vulnerabilities, including elevated suicide risk. This paper examines suicide statistics from the Ministry of Health, Labour and Welfare (MHLW) and finds that more than half of all suicide deaths in 2025 occurred among people living alone; suicide mortality rate in this population is several times higher than that for multi-person households, with an especially pronounced risk among older men (≥ 80 years) and middle-aged women (40–59 years). While suicides explicitly attributed to loneliness represent a small proportion of cases, loneliness is likely underreported due to its latent nature, and living alone significantly increases suicide mortality linked to loneliness. Long-term demographic trends project a sharp rise in the number of older adults living alone, accompanied by a substantial increase in never-married individuals without family ties. These shifts heighten the likelihood of social isolation. Indicators such as “lack of conversation,” “lack of someone to rely on,” and “lack of someone to help” reveal particularly high rates of social isolation among older men living alone. Finally, the paper evaluates current support systems and identifies key policy priorities: strengthening accompaniment-based support, building community-based support networks, and creating places of belonging to prevent isolation. These measures are essential for constructing a society in which older adults can live dignified lives even without family.

Keywords: Single-person households, Suicide mortality, Social isolation, Loneliness, Older individuals without family, Accompaniment-based support, Never-married older persons, Places of belonging

Introduction

Japan is generally known as a family-dependent welfare state, where the family plays a central role in the provision of everyday social and economic support. However, household composition changes—in particular the rapid growth in single-person households—have weakened the traditional function of the family as

a primary support system. Individuals who live alone lack intra-household mutual assistance, and this generates a range of social and practical challenges.

Among the most concerning issues is the elevated suicide risk among those who live alone. Recent studies, such as the one by Narita et al.¹, find that persistently living alone is associated

¹⁾ Nihon Fukushi University, Mihama-cho, Aichi, Japan

with an increased risk of suicide death as well as non-suicide death and all-cause mortality¹. The prevalence of social isolation is particularly high among older adults. In the final stages of life, individuals often require assistance with daily activities, including hospital accompaniment, shopping, and administrative procedures. They might also need guarantors for housing or hospitalization, and after death, someone must manage the funeral arrangements for them and dispose of their personal belongings. Traditionally, family members have taken care of these responsibilities. For older adults who have no family or close relatives these tasks pose significant challenges.

This paper examines the reality of suicide among single-person households relative to its incidence in multi-person households. It then analyzes trends in the increase in older adults living alone, followed by an overview of the phenomena of social isolation. The paper concludes with a discussion of the current state of support for older adults who have no close relatives and identifying key policy issues for the future.

1. The Reality of Suicide Among Single-Person Households

In this section, drawing on MHLW's website *Suicide Statistics*², we provide an overview of the state of suicide in Japan and then review the reality of suicide in older individuals living alone². After reviewing trends in the number of deaths by suicide in Japan and the background factors influencing these trends, we outline the factors associated with suicide deaths in 2025 data. With respect to the suicide deaths recorded in 2025, we analyze the incidence rates of suicide and other indicators, distinguishing between people in single-person households (living alone) and those in larger households of two or more persons (living with others).

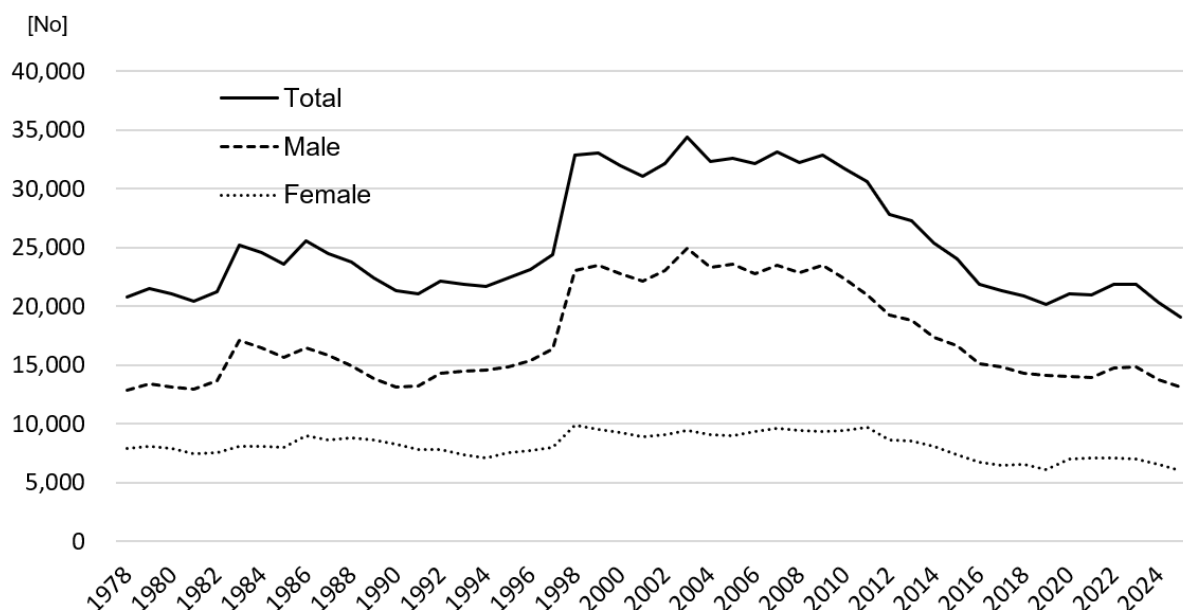
1.1 Trends in the Number of Suicide Deaths in Japan and Their Background

The collection of statistical data in Japan using *The Suicide Statistics Original Form*, a unified nationwide data-collection instrument, began in 1978³. Over the period from 1978 to 1997, the annual number of suicide deaths generally ranged between 20,000 and 25,000 (Figure 1). However, due to worsening economic conditions, including such as the economic downturn following the collapse of the bubble economy, the Asian currency crisis, and increasing corporate bankruptcies, the number of deaths by suicide exceeded 30,000 in 1998. This high rate was stable through 2011, with more than 30,000 suicide deaths annually. During this period, suicide deaths among middle-aged and older men were particularly prominent, and work-related, economic, and health problems were identified as major contributing factors.

The number of suicide deaths began to decline gradually around 2009, likely due in part to strengthened community-based measures and expanded consultation services under *the Basic Act on Suicide Countermeasures*, which came into force in 2006. In 2012 and going forward, the annual number was below 30,000, in a downward trend continuing until 2019.

In 2020, however, the number began to rise again, due to the spread of COVID-19. Social isolation, employment insecurity, and household stress had complex and compounding effects, which led to an increase in suicide deaths, particularly among women and younger people³. Higher numbers continued to be recorded through 2023, and the number of suicide deaths among elementary, junior high, and high school students reached extremely high levels even when viewed against the long term.

In 2024 and the following year, the overall number of suicide deaths again declined.



Source: Compiled by the author based on *The Situation of Suicide in 2025* (March 27, 2026), published by the Suicide Prevention Office, Ministry of Labour, and the Community Safety Planning Division, Community Safety Bureau, National Police Agency.

Figure 1. Annual Trend in Number of Suicide Deaths

According to the Ministry of Health, Labour and Welfare, there were 19,188 deaths by suicide in 2025, falling below 20,000 for the first time since statistics began in 1978—for the lowest level ever recorded. The number of suicide deaths among elementary, junior high, and high school students, in contrast, reached record highs for two consecutive years: 529 in 2024 and 538 in 2025. While the total number of suicide deaths in Japanese society has decreased, measures targeting children and young people remain among the most critical issues³.

1.2 Causes and Motives of Suicide Deaths in 2025

Of the deaths by suicide in 2025, 13,176 were men, and 6,012 were women. The Ministry of Health, Labour and Welfare's *Statistics on Suicide* are compiled from cases where prefectural police have determined suicide as the cause of death according to standardized criteria, recorded on *The Suicide Statistics Original Form*. The Ministry receives these data, which are aggregated by the National Police Agency, and it publishes information on the causes and motives for suicide on its website as basic reference materials³.

With respect to the causes and motives of

suicide, *The Suicide Statistics Original Form* contains 75 detailed related observation items. Prefectural police can record up to 4 of 75 applicable detailed items per suicide case, based on such materials as suicide notes or other evidence of the person's behavior before death, along with testimony from family members when relevant³.

There were 26,496 applicable items recorded for the 19,188 suicide deaths in 2025 (an average of approximately 1.38 items per person). The seven major categories for these were Health problems (42.9%), Economic and living problems (20.3%), Family problems (15.9%), Work-related problems (9.0%), Other (6.7%), Relationship problems (3.3%), and School-related problems (2.0%) (Table 1).

Among the 75 observation items, the top 10 by proportion of total applicable items (26,496) for 2025 were as follows, in descending order: 1) Distress or impact related to illness (depression): 14.9%, 2) Distress related to illness (other physical diseases): 9.6%, 3) Distress related to illness (other mental disorders): 6.8%, 4) Financial hardship: 6.5%, 5) Debt (multiple debts): 3.6%, 6) Distress or impact related to illness (schizophrenia): 3.2%, 7) Marital discord

(other causes): 3.0%, 8) Debt (other): 2.6%,

Table 1. Trends in the Major Categories of Causes of and Motives for Suicide

Year	No. of Suicide Deaths	No. of applicable cases and the proportion of the aggregated No. of such cases							Total No. of applicable causes	Average No. of applicable causes per suicide case
		Health problems	Economic/ living problems	Family problems	Work-related problems	Other	Relationship problems	School-related problems		
2022	21,881	12,774	4,697	4,775	2,968	1,734	828	579	28,355	1.30
		45.1%	16.6%	16.8%	10.5%	6.1%	2.9%	2.0%	100%	
2023	21,837	12,403	5,181	4,708	2,875	1,776	877	524	28,344	1.30
		43.8%	18.3%	16.6%	10.1%	6.3%	3.1%	1.8%	100%	
2024	20,320	12,029	5,092	4,297	2,564	1,704	868	572	27,126	1.33
		44.3%	18.8%	15.8%	9.5%	6.3%	3.2%	2.1%	100%	
2025	19,188	11,355	5,387	4,201	2,390	1,764	875	524	26,496	1.38
		42.9%	20.3%	15.9%	9.0%	6.7%	3.3%	2.0%	100%	
Change from 2022		-2.2%	3.8%	-1.0%	-1.4%	0.5%	0.4%	-0.1%	-1,859	0.08

Source : Ministry of Health, Labour and Welfare, Suicide Prevention Office; National Police Agency, Community Safety Planning Division (2026).

"Suicide Situation in 2025" (March 27, 2026, p.28). Extracted by the author. <https://www.mhlw.go.jp/content/001680736.pdf>

9) Death of a family member: 2.4%, and 10) Feelings of loneliness: 2.3%⁴.

Examination of the trends in the proportions for the major categories since 2022, when the criteria for causes and motives were revised, we find that in 2025, the proportion for Health problems decreased by 2.2 percentage points compared with 2022, and the share for Economic and livelihood problems increased by 3.8 percentage points (Table 1, repeated). This likely reflects the recent increase in prices and the increasing severity of financial hardship³. Further, the average number of applicable items per suicide case was 1.30 in 2022 and 2023, 1.33 in 2024, and 1.38 in 2025. The causes and motives of suicide are showing an increasing rate of complexity.

1.3 Single-Person Households and Suicide

Here, we compare individuals living alone (single-person households) and those living with others (multi-person households) in relation to the number of suicide deaths in 2025ⁱ (Table 2).

Overall, more than half of suicide deaths occur in single-person households among both men and women. In particular, among the 13,117 male suicide deaths, 59.1% were in single-person households, totaling 7,756 individuals. Among women, 69.6% of the 5,980 suicide deaths occurred in single-person households, totaling 4,160 individuals⁵. While the number of suicide deaths among single men is higher than that among single women, the proportion of suicide deaths that are accounted for by single-person households is greater among women than among men.

Next, a comparison between single-person and multi-person households, the suicide mortality rate is markedly higher in among single-person households. Specifically, the suicide mortality rate for men in single-person households was 66.0 per 100,000, approximately 5.9 times higher than the rate of 11.1 for men in multi-person households. For women, the suicide mortality rate in single-person households was 37.1, which is approximately 10.6 times higher than the rate of 3.5 for women in multi-person households

ⁱ Because only provisional figures have been released for the "number of suicide deaths by presence or absence of cohabitants," this analysis uses the provisional figures. The term "provisional figures" refers to the number of suicide deaths reported in the early part of the following month, published around mid-month. In contrast, "final figures" refer to the confirmed number of suicide deaths for a given year, published around March of the following year. Notably, the provisional figure for the total number of suicide deaths in fiscal year 2025 (19,097) is only 91 cases (approximately 0.5%) lower than the final figure (19,188), indicating that the difference is minimal.

(Table 2, Repeated).

The suicide mortality rate for single-person households was more than twice as high as that for cohabiting households in every age group for both men and women. Notably, the suicide mortality rate for men aged 80 and above was 10.5 times higher in single-person households, and for women aged 40–49 (28.5 times), 50–59 (18.1 times), and 60–69 (11.8 times), the rate for was more than 10 times greater. Therefore, regardless of sex or age, living alone is a significant risk factor for suicide mortality.

Next, we examine the characteristics of single-person households by sex and age group. First, among single men, the age group with the highest absolute number suicide deaths was 50–59 years, with 1,525 individuals. The proportion of single-person male households among all male suicide deaths was 59.1%, and across age groups, this proportion generally ranged from 50% to 60%. Furthermore, among single men, the highest rate per 100,000 population was found among those

aged 80 and above, at 118.7. The next highest rates were among those aged 40–49 years (84.5) and 50–59 years (74.3) (Table 2, Repeated).

Among single women, the age group having the highest number of suicide deaths was 50–59 years, with 775 individuals. The proportion of single women among all female suicide deaths was 69.6%, or 10 percentage points higher than the proportion for men. Across age groups, the proportion of single women among female suicide deaths was approximately 70%–80% for those aged 30–69 years. Then, the suicide mortality rate per 100,000 population was 70.1 among single women aged 40–49 years and 59.9 among single women aged 50–59 years, both of which were higher than those observed in other age groups. Furthermore, the ratio of suicide mortality rates between single-person households and multi-person households exceeds tenfold for women aged 40–69 years. Among single women, suicide mortality is higher in the middle-aged years relative to women in multi-person households.

Table 2. Comparison of Number of Suicide Deaths in 2025: Single-Person Households vs. Multi-Person Households

		Total		Single-person households			Multi-person households		
		No. of Suicide	Suicide Mortality Rate(SMR*)	No. of Suicide	% of Single-person Households in Total Suicide No.	SMR(a)	No. of Suicide	SMR(b)	Ratio of SMR(a)/(b)
Male (Age Grps)	Total	13,117	21.9	7,756	59.1%	66.0	5,361	11.1	5.9
	20~29	1,561	24.5	890	57.0%	36.8	671	16.9	2.2
	30~39	1,610	23.9	943	58.6%	52.8	667	13.5	3.9
	40~49	2,180	27.0	1,329	61.0%	84.5	851	13.1	6.4
	50~59	2,696	29.1	1,525	56.6%	74.3	1,171	16.3	4.6
	60~69	1,692	23.0	876	51.8%	55.3	816	14.2	3.9
	70~79	1,564	20.8	900	57.5%	64.6	664	10.9	5.9
	80~	1,382	28.6	923	66.8%	118.7	459	11.3	10.5
Female (Age Grps)	Total	5,980	9.4	4,160	69.6%	37.1	1,820	3.5	10.6
	20~29	844	13.9	518	61.3%	26.8	326	7.9	3.4
	30~39	672	10.5	464	69.0%	43.3	208	7.3	5.9
	40~49	771	9.8	599	77.6%	70.1	172	2.5	28.5
	50~59	1,036	11.3	775	74.9%	59.9	261	3.3	18.1
	60~69	696	9.2	496	71.3%	37.5	200	3.2	11.8
	70~79	759	8.7	471	62.0%	23.5	288	4.3	5.5
	80~	772	9.3	454	58.8%	17.6	318	5.6	3.2

Notes:

*SMR: Suicide Mortality Rate (per 100k population)

- Shaded areas in the SMR indicate rates exceeding 70.

- Shaded areas in the ratio of SMR (a)/(b) indicate ratios exceeding double digits.

- For both males and females, the total numbers include individuals aged 19 and below as well as those of unknown age.

- For Single-person and Multi-person households, individuals with unknown cohabitation status were proportionally allocated.

As a result, the figures do not match those in the "Suicide Statistics (detailed below)"

Sources:

-Data on the suicide death numbers were obtained from the Ministry of Health, Labour and Welfare website, "Suicide Statistics: Annual Situation ([2025 Provisional Values – Date Found] Sex × Age Group × Cohabitation Status, etc.).

-SMRs were calculated based on the estimated 2025 population by sex and age group, as well as the estimated number of single-person households, from the National Institute of Population and Social Security Research publications: "Population Projections for Japan (2023 Projection)" and "Household Projections for Japan (2024 Projection)."

Thus, although the absolute suicide mortality rate for single women is lower than it is for single men, the ratio of suicide mortality rates in single-person to multi-person households is much higher for single women than it is for single men. Moreover, the rate of suicide incidence in single-person households is higher than that among multi-person households across all age groups, with risk that is particularly elevated among single men aged 80 and above and single women in middle age (40–59 years). Almost more than 60 % of suicide deaths take place in single-person households, which suggests a strong association between living alone and suicide risk.

1.4 Suicide Attributed to Feelings of Loneliness

As noted earlier, the website of the Ministry of Health, Labour and Welfare (2026b) lists 75 detailed items discussing the causes and motives

of suicide, among which is "feelings of loneliness." In 2025, 607 suicide deaths were attributed to loneliness (394 men and 213 women)⁴. This accounted for 3.2% of all suicide deaths (19,188 individuals overall: 13,176 men and 6,012 women), with men at 3.0% and women at 3.5%. Relative to the total number of suicide deaths, the proportion of 3.2% is relatively low. Moreover, the suicide mortality rate attributed to loneliness (per 100,000 population) was also low, at 0.66 for men and 0.34 for women (Table 3).

One reason for this could be that suicide statistics have not fully captured cases where loneliness was the underlying cause. In particular, prefectural police could record up to four applicable items per suicide case, based on materials such as suicide notes or other evidence of the person's behavior prior to death, as well as on testimony from the members of the family.

Table 3. Number of Suicide Deaths Attributed to Loneliness in 2025

		No. of Suicide Deaths (Total)	No. of SDAL		
			Total	% of SDAL among All Suicide Deaths	SMR* attributed to Loneliness
Male (Age Grps)	Total	13,117	394	3.0%	0.66
	20~29	1,561	45	2.9%	0.71
	30~39	1,610	41	2.5%	0.61
	40~49	2,180	52	2.4%	0.64
	50~59	2,696	70	2.6%	0.76
	60~69	1,692	56	3.3%	0.76
	70~79	1,564	51	3.3%	0.68
	80~	1,382	68	4.9%	1.41
Female (Age Grps)	Total	5,980	213	3.6%	0.34
	20~29	844	26	3.1%	0.43
	30~39	672	11	1.6%	0.17
	40~49	771	25	3.2%	0.32
	50~59	1,036	22	2.1%	0.24
	60~69	696	21	3.0%	0.28
	70~79	759	38	5.0%	0.44
	80~	772	56	7.3%	0.68

Notes:

*SMR: Suicide Mortality Rate (per 100k population)

-For both males and females, each total includes individuals aged 19 and below as well as those of unknown age.

-Shaded areas indicate the highest values for each sex.

Sources:

-Data on the suicide numbers were obtained from the Ministry of Health, Labour and Welfare website, "Suicide Statistics: Annual Situation ([2025 Provisional Values – Date Found] Sex × Age Group × Cohabitation Status, etc.)."

-SMRs were calculated based on the estimated 2025 population by sex and age group, as well as the estimated number of single-person households, from the National Institute of Population and Social Security Research publications: "Population Projections for Japan (2023 Projection)" and "Household Projections for Japan (2024 Projection)."

However, because feelings of loneliness tend to remain latent, it is difficult to grasp them from sources such as wills or family statements, and it is presumed that their actual prevalence could be underestimated. Among the 75 detailed items, those that are considered to be related to loneliness and with more than 100 applicable cases include the following: Distress or impact related to illness (depression) (3,958 cases), Death of a family member (637 cases), Workplace interpersonal relations (other) (476 cases), and Romantic breakup (392 cases)⁴.

Due to statistical limitations, it was not possible to analyze loneliness-based suicide for this paper by distinguishing between single-person and multi-person households. However, earlier research provides insights here. Hiramitsu⁶ who had access to specially tabulated data from The Suicide Statistics Original Forms compiled by the Cabinet Office, analyzed the

relationship between the living arrangements (presence or absence of cohabitants) and suicide that were attributed to loneliness according to sex and age group⁶. The study defined suicide due to loneliness cases as those for which feelings of loneliness were selected as a cause or motive in The Suicide Statistics Original Form, based on data from 2009 to 2011. The suicide mortality rate due to loneliness (per 100,000 population) was 2.7 for men living alone and 0.3 for men living with others, and it was 1.3 for women living alone and 0.2 for women living with others. That study⁶ concluded that living alone is a risk factor for suicide due to loneliness irrespective of regardless of sex or age, and the impact may be greater for men than for women among those aged 70 and above⁶.

2. Trends in the Increase in Single-Person Households

As noted, single-person households have a higher suicide risk than multi-person households. This leads us to examine how the proportion of single-person households has changed over time and what trends are projected for the future.

2.1 Trends in the Rate of Single-Person Households

In 2020, there were 21.15 million single-

person households in Japan, or 38.0% of all households. Because single-person households are people living alone, the rate of people living alone relative to the total population is 16.8% (Figure 2). With respect to trends over time, both the proportion of single-person households among all households and the proportion of people living alone within the total population have exhibited a gradual upward trend since 1985.

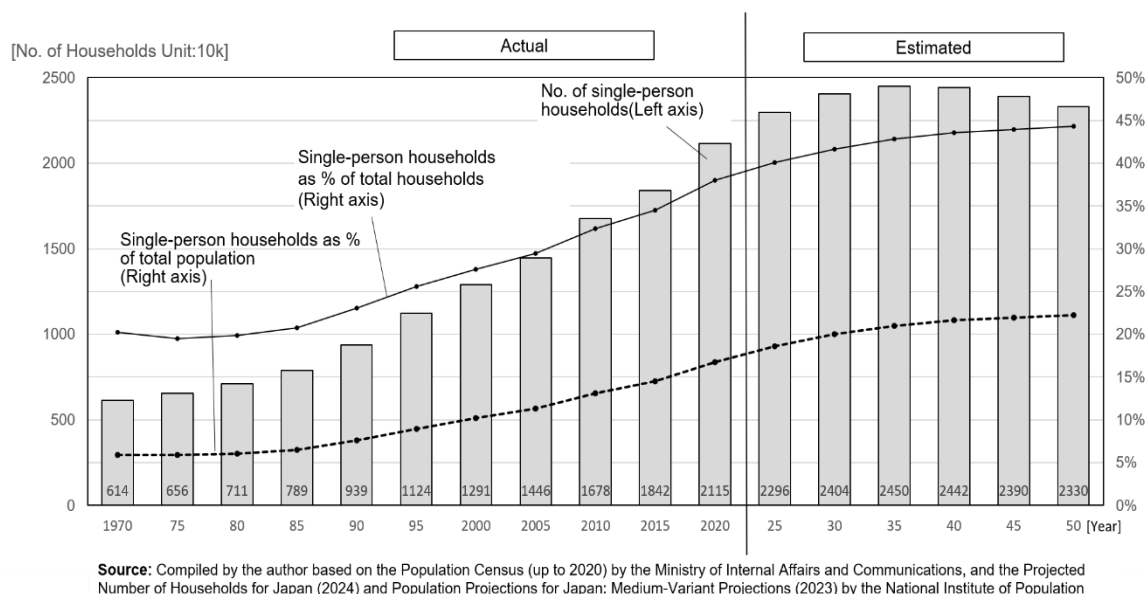


Figure 2. Overall Trends in Single-Person Households
—Long-Term Changes Since 1970 (Values up to 2020)

Projections by the National Institute of Population and Social Security Research indicate that the number of single-person households (in solitary living) is expected to begin decreasing around 2035. This is because the total population has been declining since around 2008, and single-person households are expected to be affected by this trend. However, the proportion of people living alone to the total population is projected to rise to 22.3% by 2050. Furthermore, the share of single-person households in all households is expected to continue increasing after 2035, reaching 44.3% in 2050.

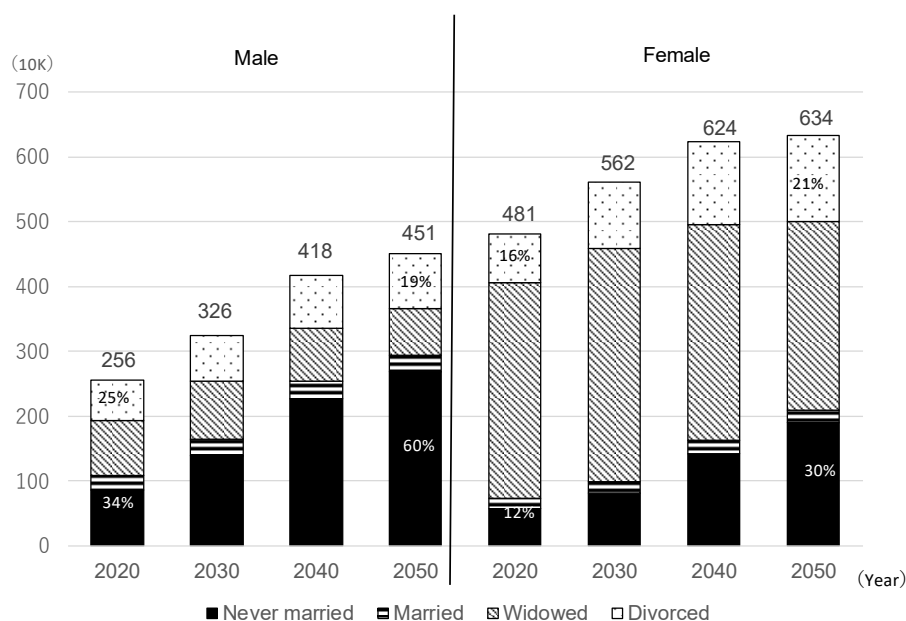
2.2 Future Marital Status of Older Individuals Living Alone

According to *Household Projections for Japan: 2020–2050* provided by the National Institute of Population and Social Security Research, there were 7.38 million older adults were living alone in 2020, which is projected to

increase by approximately 1.5 times, reaching 10.84 million in 2050. The proportion of single-person households among the population of those aged 65 and over is also projected to grow from 20% in 2020 to 28% in 2050.

A notable point here is the growing proportion

can be understood as referring to (1) individuals



Source: National Institute of Population and Social Security Research (2024), “Household Projections for Japan (National Projection)”, p. 14

of individuals who have never been married among the older people living alone. Among older men living alone, the rate of those who have never married are expected to increase from 34% in 2020 to 60% in 2050 (Figure 3). Among older women living alone, the rate of those who have never married is projected to rise from 12% in 2020 to 30% in 2050. The increase in the never-married older individuals living alone suggests that many in this group have neither spouses nor children, which implies a rise in older people without family ties. It will become increasingly difficult to rely on one’s family for support in old age. Additionally, having no relatives to rely on

who have no family or relatives; (2) individuals who have family or relatives but are unable to contact them; and (3) individuals who have family or relatives but cannot obtain support from them. A survey that was conducted among Community General Support Centers in the Tokai region found that among older adults living alone without family to rely on, category (1) accounted for approximately 20%, category (2) for approximately 30%, and category (3) for approximately 50%, indicating a high proportion of those who have family or relatives but cannot depend on them⁷.

Figure 3. Projected Percentages of Single-Person Households Aged 65 and Over by Marital Status (2020–2050)

3. Single-Person Households and Social Isolation

3.1 Definition and Actual Conditions of Social Isolation

Single-person households are more likely to fall into social isolation. Social isolation is an objective condition in which an individual has little or no contact with family or community⁸. Note that the related concept of loneliness refers to subjective feelings such as being all alone and is therefore to be distinguished from social isolation.

We therefore examine the proportion of individuals who are subject to social isolation by household type. There is no universally established measure of isolation, but prior studies identified indicators such as the following: 1) Lack of conversation, 2) Lack of someone to rely on, and 3) Lack of someone to help. Notably, lack of someone to help is a key indicator of isolation. Preventing isolation requires having someone to rely on and having opportunities to help others.

Here, we determine the proportion of individuals who are experiencing isolation by

household type, using the following three indicators: lack of conversation, lack of someone to rely on, and lack of someone to help. For all of the indicators, the proportion of socially isolated individuals is highest among older men living

alone. In particular, regarding lack of conversation, the proportion of individuals who converse once every two weeks or less” is 2.2% overall, but it increases to 15.0% among older men living alone (Table 4).

Table 4. Conditions of Social Isolation According to Household Type

			Conversation frequency: Once every 2 weeks or less	Isolation due to	
				Lack of someone to rely on	Lack of someone to help
Single-person household (Age groups)	Elderly (65+)	Male	15.0	11.1	17.4
		Female	5.2	4.2	9.7
	Non-Elderly (0-64)	Male	8.4	6.9	9.4
		Female	4.4	1.7	2.2
Couple-only household	Both elderly		2.3	1.7	3.4
	Both non-elderly		1.1	1.5	1.3
Three-generation households (with children)			0.5	0.5	2.5
Two-generation households (with children)			0.6	0.5	0.9
Single-parent households			1.8	8.7	0.5
Total			2.2	1.7	3.2

Notes:

-“Children” refers to household members under the age of 20.

-Shaded areas indicate values that exceed the total ratio by 5 percentage points or more.

Source:

Prepared based on Mizuho Research & Technologies (2021), “Research Report on the Actual Conditions and Factors of Social Isolation” (FY2020 Social Welfare Promotion Project, Ministry of Health, Labour and Welfare), p.29.

A person experiencing a lack of someone to rely on is one who has responded no one to rely on for all nine items, including caregiving or nursing, consultation on important matters, and minor daily assistance. The rate of this indicator in the overall proportion is 1.7%, but this rises to 11.1% among older men living alone.

In addition, lack of someone to help applies to those who indicated that they do not provide help for all seven items when asked whether they would provide assistance to family/relatives,

friends/acquaintances, neighbors, and coworkers for seven of the nine items. The overall proportion of those with this indicator is 3.2%, but it rises to 17.4% among older men living alone and 9.7% among older women who are living alone. For this indicator, even older women who are living alone have a high level of isolation.

Even among older individuals living alone, the proportion falling into isolation is lower among women than among men. This may be because

women tend to be full-time homemakers or part-time workers during their working years, providing them with stronger ties to their neighbors than men. In contrast, men tend to have workplace-centered relationships that are active during their working years while not forming strong ties with local communities.

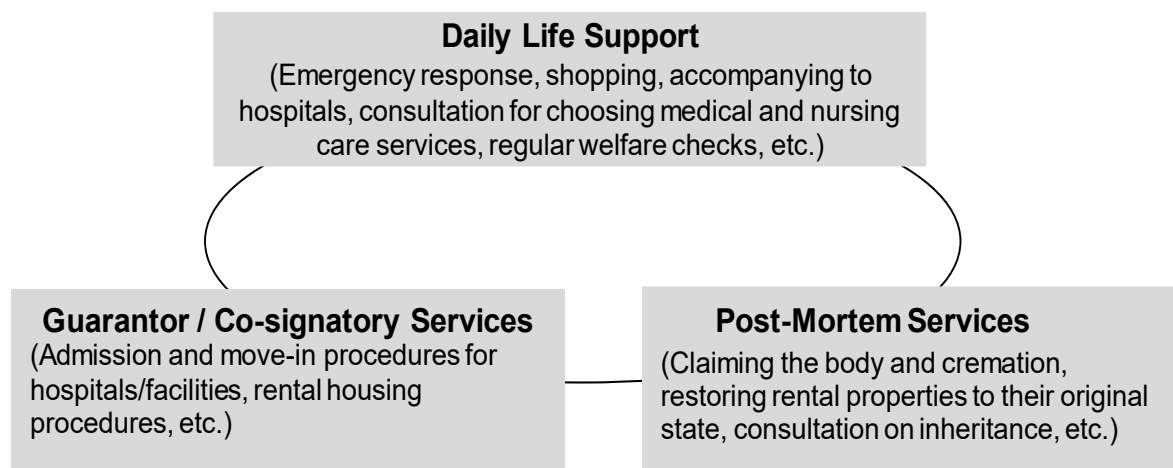
3.2 What Is Problematic About Social Isolation?

Let us clearly establish what is problematic about social isolation? First, it is difficult for someone in social isolation to receive necessary support in daily life and in emergencies (Figure 4). As noted, in the last stages of life, people often require assistance with their activities daily living, personal guarantor services, and postmortem procedures. An individual who lives with his or her family members can have the family handle

these matters; however, older adults who have no relatives have no family they can rely on.

Second, the absence of relationships with others can reduce the will to live and impair self-esteem. People who are socially isolated tend to have lower self-esteem and tend to view themselves as “worthless” (Table 5). This is often because the will to live and self-esteem tends to be fostered through relationships with others.

Third, when poverty is compounded by social isolation, the severity of economic hardship increases. Isolated people have no one to turn to when they fall into financial distress. This causes their economic hardship tends to worsen further, and they become more likely to fall into severe situations such as homelessness.



Source: Prepared by the author.

Figure 4. Problem of Social Isolation: Lack of Support in Daily Life

Table 5. Relationship Between Isolation Type and Subjective Health, Motivation for Living, and Self-Esteem

	Conversation Frequency: once every 2 weeks or less		Isolation due to: Lack of someone to rely on		Isolation due to: Lack of someone to help	
	Isolated	Non-isolated	Isolated	Non-isolated	Isolated	Non-isolated
Feeling too apathetic to do anything	14.7	4.0	13.6	4.0	14	3.9
I feel like I am worthless	14.0	2.1	13.1	2.1	8.2	2.1

Notes:

Shaded areas indicate values of 10 percent or higher.

Source:

Based on Mizuho Research & Technologies (2021), "Research Report on the Actual Conditions and Factors of Social Isolation," FY2020 Social Welfare Promotion Project, Ministry of Health, Labour and Welfare. Data are derived from National Institute of Population and Social Security Research (2018), "Summary of the 2017 National Survey on Social Security and Population Issues: Survey Results on Living and Mutual Support."

4. Current Status of Support for Older Individuals Living Alone Without Family

4.1 Current Status and Challenges of Support Provided by Municipalities and Regional Comprehensive Support Center

The question of how to respond to the needs of older individuals living alone without their family—such as identity guarantees, daily life support, and postmortem arrangements—is already apparent. For example, when an individual has insufficient decision-making capacity, an adult guardian can be appointed. Although the guardian does not function as a guarantor, the presence of a legally authorized representative provides hospitals and long-term care facilities with individuals who can make decisions on the person's behalf, thereby facilitating treatment or long-term care⁹. However, among older adults without family members, those who retain decision-making capacity cannot obtain such representation through the adult guardianship system. As a result, hospitals and long-term care facilities often decline admission to such individuals as no guarantor is available. Legally, hospitals and care facilities are not allowed to refuse admission solely on the grounds that an individual lacks an identity guarantor. Nevertheless, the need for debt guarantees or the retrieval of the deceased's remains necessitates the involvement of identity

guarantors¹⁰. Meanwhile, public institutions cannot serve as guarantors of identity, and in some municipalities, staff members have been reported to write their names in as emergency contacts.

Furthermore, the scope of support for daily living that has traditionally been provided by family members is exceptionally broad. For example, if an older adult who is hospitalized leaves their dentures in their apartment, a family member can easily retrieve them. However, in the absence of family members, a support worker may be required to obtain a key from the landlord and enter the individual's apartment in their absence. In such circumstances, it is not necessarily clear whether locating and retrieving the dentures falls within the formal scope of the worker's responsibilities, and the provision of such assistance may require the establishment of complex administrative procedures. Considering that without the dentures, the individual may be unable to eat adequately, some support workers provide this type of assistance based on their own judgment and discretion.

4.2 Older Support Service Providers

In response to this state of affairs, businesses providing identity guarantees as part of lifelong support services for older individuals (hereafter, "support service providers") have grown in

recent years. A survey by the Ministry of Internal Affairs and Communications¹¹ found that there are approximately 400 such providers nationwide. This increase is driven by the reality that older individuals without family often cannot be hospitalized or admitted to facilities without the support of such providers. Many support service providers provide both identity guarantees and postmortem arrangements and daily life support, provided that their fees are paid. Moreover, unlike public systems, there are no restrictions on who may use their services.

However, several issues have been identified regarding the services that are provided by support service providers. First, they are often insufficiently reliable. For example, for older individuals without family, there is no one to verify that contractual obligations are fulfilled following the death of the individual concerned. In addition, because barriers to entry are low, some providers could lack sufficient experience or expertise. Furthermore, contractual terms are often complex, and fee structures are unclear, leading to consumer harm.

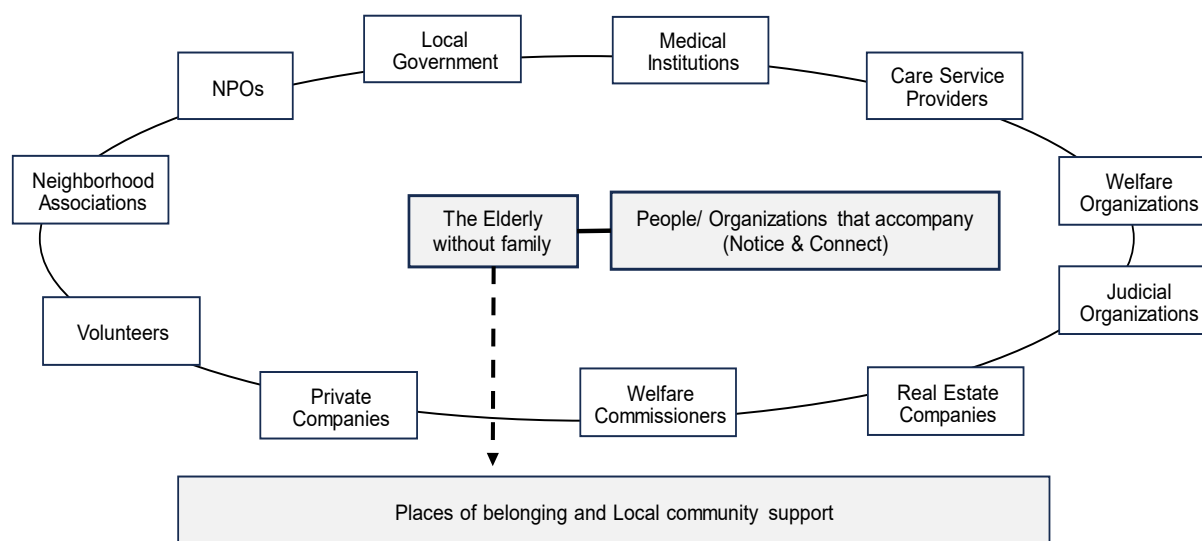
In response, the government, recognizing the need for consumer protection, released its *Guidelines for Lifelong Support Service Providers for Older Individuals* in June 2024, which was jointly issued by nine ministries¹².

However, it continues to be the case that no single ministry has jurisdiction. To ensure the reliability of support service providers, a licensing system and mechanisms to identify high-quality providers are necessary.

Second, the fees for such organizations are high, making it difficult for low-income individuals to take advantage of their services. The fees vary by provider, but according to the Ministry of Internal Affairs and Communications, an examination of four providers found that initial costs exceeded 1 million yen¹¹. Service provision is generally limited to regions where the operations are financially viable, meaning that services are not available everywhere.

5. Key Points for Supporting Older Individuals Living Alone Without Family

The national and local governments closely examine support measures for older individuals who are living alone without their family. The author considers the following three points essential in terms of support as the number of solitary older individuals increases: 1) A accompaniment-based support function that is based on noticing and connecting; 2) Networks of supporters within communities; and 3) Creating places of belonging and community spaces (Figure 5). Each of these points is discussed below.



Source: Prepared by the author.

Figure 5. Key Points for Supporting Older Individuals Without Family

5.1 Accompaniment-Based Support Function

First, the coordination function must accompany older individuals without family, notice their necessary support, and connect them to welfare services and other assistance. This could be described as accompaniment-based support¹³. In cases where family members are present, living together allows them to observe health and other changes, notice necessary support, and connect the older person to various services available in the community. Family members can also perform simple tasks needed by older individuals, such as changing light bulbs.

However, older individuals who are socially isolated tend to have difficulty receiving such support. As a socialization of family functions, it becomes necessary to accompany older individuals who have no family, notice their needs, and connect them to appropriate support. In particular, this involves regularly visiting older individuals who are without family, speaking with them, checking on their well-being, and providing consultation and assistance when issues arise.

Several government initiatives are investigating the establishment of coordinators and supporters. For example, in October 2025, the Ministry of Land, Infrastructure, Transport and Tourism introduced Housing with Residential Support Services (Kyoju Sapoto Jutaku), a certified housing scheme that combines rental housing with monitoring and residential support services provided through collaboration between landlords and residential support organizations¹⁴. In these residences, prefectures designate real estate companies or welfare organizations as residential support organizations, whose support staff can accompany older individuals living alone without family and assist them in securing housing prior to move-in. After move-in, supporters can conduct safety checks and monitoring and connect residents to the welfare services they may need. This supported housing model incorporates a mechanism by which support staff notice changes in residents through regular visits and connect them to necessary assistance, essentially fulfilling the role previously played

by family members. This system socially supports the functions traditionally carried out by families, serving an extremely important role for older individuals who are living alone without family. Such socialization of family functions will have significant value.

Some residential support organizations were already providing supportive housing before the establishment of Housing with Residential Support Services. The National Council of Residential Support Organizations (General Incorporated Association) surveyed three such residential support organizations to examine the type of support their staff provide and the time that they spend on these activities¹⁵.

Survey data showed that more than 40% of residents received five or more visits per month from support staff. Although Housing with Residential Support Services requires at least one visit per month, the actual needs of the beneficiaries far exceed this minimum. Support staff also reported that casual conversation during visits was particularly important. Through casual conversation, trust is built, and residents are more willing to talk about changes in their health or problems that they are experiencing. Such everyday conversations can help restore the will to live, especially among individuals who have been isolated, and can contribute to preventing isolation. Even where problem-solving is extremely difficult, accompaniment-based support—which serves as a reason for maintaining an ongoing connection—is essential.

The organization that should take the lead in providing accompaniment-based support will vary depending on local circumstances. However, to ensure reliability, national and local governments must establish the necessary foundational systems.

5.2 Building Support Networks Within the Community

Second, it is essential to build networks of supporters in communities so that the necessary support can be provided to older individuals living alone without family. In other words, this is a network of service providers serving as

connection points.

In the final stages of life, multiple issues may arise simultaneously, including daily life support, identity guarantees, and postmortem arrangements. To respond to these, municipalities, welfare organizations, medical institutions, long-term care providers, legal professionals, and private companies must establish cooperative frameworks in advance.

Several regions have created support guidelines. Their objectives include the following: 1) Ensuring that older individuals who are living alone without family can smoothly access medical, long-term care, and welfare services and 2) Reducing the uneven burden placed on support organizations¹⁶. Going forward, such initiatives need to be expanded nationwide.

5.3 Creating Places of Belonging

Third, it is important to establish places of belonging in communities. As the number of older individuals living alone without any family is on the increase due to trends such as rising rates of never-married individuals, places of belonging can be spaces to prevent isolation. The presence of familiar faces at such places can help restore the energy to live and foster mutual watching-over and care. Even in the absence of relationships with family or relatives, social isolation can be prevented if informal connections can be built with friends, acquaintances, or neighbors.

The number of socially isolated older adults is expected to increase, a likewise, a shortage of professionals who can provide accompaniment-based support may also arise. Where belonging can be created to prevent isolation, the number of socially isolated individuals can be reduced. That is, accompaniment-based support provided by professionals can be focused primarily on high-risk groups who are particularly prone to isolation.

Even in accompaniment-based support, professionals need to connect with isolated older individuals, but eventually it will be necessary to transition to a stage where these individuals are connected with local residents at places of

belonging, and professionals shift to a more relaxed monitoring role. When various institutions and residents come to be involved in addressing the difficulties faced by older individuals without family, the relationships expand, creating communities where residents care for one another and can prevent isolation. The development of relationships among residents—including older individuals who are living alone without family—contributes to community building. No matter how well the systems are developed, gaps must inevitably remain, but many issues can be resolved through relationships with trusted friends and neighbors.

6. Conclusion

The first challenge to be faced is securing financial resources for coordination organizations providing accompaniment-based support. Accompanying older individuals in the absence of family naturally requires personnel costs. Currently, support for older individuals living alone without family often relies on the financial burden of various support organizations, but this is not sustainable. Moreover, low-income older individuals without a family may be unable to pay for the welfare services they need. Securing financial resources is therefore essential to address these challenges.

Second, securing places of belonging remains in the exploratory stage. Instead of gathering for a specific purpose, it is desirable to have places in daily life where people can engage in casual conversation and feel comfortable being themselves. The connections that are formed in such comfortable spaces enrich life.

Third, it is necessary to push forward research on suicide that is associated with feelings of loneliness. Suicides that are attributable to loneliness are difficult to identify because such cases are less likely to be visible. However, it is not difficult to imagine a pathway in which, in hardships, such as concerns about illness, financial distress or debt, marital discord, or the death of a family member, individuals can experience isolation—such as having no one to consult—and that this isolation leads to feelings

of loneliness. Moreover, among the difficulties that people face, many are not easily resolved. In such situations, accompaniment-based support, which aims not at solving problems but at maintaining an ongoing connection, is likely to be effective.

Even in the absence of family, having high-quality relationships with friends, neighbors, and other close individuals is sufficient. We must embrace the creation of a new society that does not rely solely on family and build a society in which people can live dignified lives in old age even without family.

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Commentary

Suicide Prevention in Australia: A Person-Centred and Whole-of-Community Approach

Nicholas Procter¹, Joshua McDonough¹, Mark Loughhead¹

Abstract

Suicide prevention in Australia is conducted under the guidance of National Suicide Prevention Office's, the 'National Suicide Prevention Strategy'. This is a 10-year Strategy that aims to embed suicide prevention activities across all levels of government and expand further than just health departments. In this commentary the authors outline the key principle of the Strategy, why it is necessary, and how the latest theories, research, and practice relate to its implementation. Central principles of this Strategy include embedding lived experience of suicide in the design and delivery of suicide prevention activities, applying person-centred care principles, and drawing upon the elements of safety planning to reduce future levels of suicidal thoughts and behaviours. It was created under the belief that through consistent and genuine focus, suicide is preventable. This article discusses these major themes alongside the role of compassion in the suicide prevention strategy, emphasising the importance of human connection in reducing hopelessness. It is hoped that through genuine multi-sector leadership, suicidal distress can be reduced in the Australian population.

Keywords: Suicide prevention, Policy, Safety planning, Lived experience, Person-centred care

The Context

Australia's current national policy settings for suicide prevention are guided by the landmark document titled, *The National Suicide Prevention Strategy 2025–2035* (the Strategy).¹ This is Australia's ten-year plan to significantly reduce suicide deaths, attempts, and the conditions that lead to suicidal thoughts and behaviour. Developed by the National Suicide Prevention Office (NSPO), the Strategy marks a major shift in national policy, positioning suicide prevention as a whole-of-government and whole-of-community responsibility.

Approximately 3,000 Australians end their lives each year (about 8 people a day). Australia loses more people to suicide than die in motor vehicle accidents each year. Suicide is the leading cause of premature death from injury or disease, and the main cause of death among people aged 15-49 years.²

Prevention of suicide efforts are directed throughout the life course, and across settings and contexts. Until recently, suicide was conceptualised as a purely mental health issue. Contemporary thinking recognises that suicide is impacted by several factors, rather than a single cause. Suicide is considered a public health

¹ Mental Health and Suicide Prevention Research and Education Group, Adelaide University, Australia

priority and the result of a complex interplay between social determinants and individual factors that give rise to people being vulnerable to suicide. This means that the prevention of suicide is not something that sits simply within the domain or responsibility of health and human service workers or the health system. Suicide and its precipitants, drivers, and prevention sit within and across all areas of government, social care, and civil society. This approach is grounded in both the pervasiveness and persistence of suicide and self-harm (with an estimated 150 suicide attempts per day) and the various touch points to interrupt an individual's trajectory toward suicide.

Against this background Australia has adopted a whole of government and whole of sector Strategy to prevent suicide. The Strategy incorporates the voices of thousands of people with lived and living experience of suicide, aligns with contemporary research, and includes Aboriginal and Torres Strait Islander frameworks of social and emotional wellbeing. The Strategy is noteworthy for being structured around two core domains – the prevention of suicidal distress and support for people experiencing suicidal thoughts and behaviours.

The Strategy is deliberately and strategically designed to guide federal, state, territory, and local governments, non-government organisations, community groups, educators, employers, health services, and individuals. It emphasises that suicide is preventable through focussed effort and attention, systemic reform, cultural change in the way that systems and services operate, and long-term collaboration.

Embedded Lived Experience

The Strategy embeds lived experience of suicide in both design and practice. In Australia, lived experience peer support workforces are expanding, making it one of the fastest growing emerging disciplines in transdisciplinary mental health and suicide prevention settings.³ It is essential that service and system leaders value and support lived experience through a

supportive organisational culture. This means having a workplace culture with foundations to support and promote person-centred suicide prevention efforts. Building lived experience capability requires necessary infrastructure, financial and social investment. This means adequate remuneration, support, mentoring and development and inclusive recruitment.⁴ Australia's national policy settings promote the importance of clear roles and responsibilities, governance frameworks and co-produced outcomes measurement.

Tensions can and do exist in health care settings. Progressive concepts such as person-centred care shape the way mental health and suicide prevention is conceived, delivered, experienced and evaluated. Person-centred care aims to redistribute knowledge and power between healthcare providers and consumers to ensure that healthcare is meeting the needs of consumers. However, despite many years of Australian services attempting to deliver person-centred care, multiple reviews and inquiries into services find these attempts failing. Person-centred care challenges the traditional ways in which mental health and suicide prevention care have been conceived and delivered, reflecting tensions in the mental healthcare system. Tensions can be theoretical, legislative and cultural.⁵

Understanding Suicide to Prevent Suicide

One way to understand suicidal thoughts and behaviours is the Interpersonal Theory of Suicide.⁶ This theory is based on the premise that interpersonal processes influence thoughts and actions towards the likelihood of suicide: thwarted belongingness (perception of loneliness and absence of reciprocal relationships), perceived burdensomeness (feelings of being a burden to oneself and others), and capability for suicide. A person experiencing all three processes may be prone to attempting suicide. Individuals may move between states of experiencing suicidal thoughts and behaviours and not. These fluctuations in states can be driven by personal

circumstances, such as responses to trauma and changes in social determinants of health. Important in this discussion are the ways in which suicidal thoughts and behaviours fluctuate and can rapidly intensify. This highlights suicide as a complex phenomenon. Recently, thinking about suicide risk has shifted away from an over-reliance on risk assessment tools towards narrative and relationship-based engagement and care.

The Strategy adopts a broad definition of suicidal distress: a human response to unbearable suffering, shaped by an interaction between social determinants such as financial stress and income, employment, education, housing stability, access to healthcare, social inclusion, discrimination, community safety, experiences of violence, trauma, or systemic inequity. There is also an emphasis on distress caused by unexpected or unsupported life transitions impacted by social and cultural factors.

An example of a social determinant of mental health that has been a focus in recent times has been ex-serving Australian Defence Force members. This population is known to be at a higher risk of death by suicide than nonveterans. Ex-serving males and ex-serving females are, respectively, 26% and 100% more likely to take their own life than Australian males and females. Veterans who leave the Australian Defence Force for involuntary medical reasons are two and three times (females and males respectively) as likely to take their own life than those who leave voluntarily.

A recent shift is to bring together perspectives of lived experience/peer work, clinical, government and non-government sectors to advance compassionate trauma informed support and care for people experiencing suicide-related distress and their loved ones. Australia's national suicide prevention policy settings view compassion as kindness, with a deep awareness of and connection to the suffering of oneself and others, along with desire and effort to relieve it.⁷ The consensus thinking brought to education and

training of workers is guided by this belief. For clinicians the focus is on personalised, compassionate inquiry into the drivers of suicidal suffering. This means helping a person come to know and understand: their personal distress triggers for suicidal thoughts, intentions and actions; their personal warning signs; and how they can be safe in future suicidal crisis.

A practical example of this is understanding how for some individuals trauma, fear and suicidal intentions are related to specific dates and anniversaries helping family members, clinicians, and supportive community understand when someone may need greater care and support.⁸ For frontline clinicians the suicide assessment and engagement inquiry should (a) not be based solely on a 'tick-a-box' checklist; (b) involve staff who are properly trained to ask questions and value the answers given; (c) focus on suicidal thoughts and associated feelings states, i.e. encourage staff to enter into a person's conceptualisation of distress, at the same time confidently tackling difficult questions and nuanced conversations; and (d) involve carers and family members where this is possible and permissible.

So, the priority of how to understand and make meaning through suicide becomes just as critical as 'what to assess'. Humanising compassionate engagement also embraces psychological safety for people. Psychological safety is a concept informed by psychoanalytic notions of secure attachment and containment within relationships. It also includes practical utility of establishing and maintaining trust, interpersonal security within interactions, and being able to be curious in interpersonal interactions.

This is done by addressing person specific needs with an emphasis on (a) modifiable factors; (b) validation of and response to what they say are the causes of their life distress and stressors; and (c) individualised assessment which informs evidence-based service and care experienced 'as care'. This recognises that there is something for everyone who has contact with a service provider.

Implications for Suicide Prevention Education and Training

The authors of this article work in suicide prevention research and education. Given shifts in Australia's national policy settings, the structure, content, and approach to education and training programs incorporate co-design with staff who are representatives of future training participants. In one recent example the authors worked with a government organisation supporting military veterans receiving support for mental health and suicide related challenges. The service provider employees taking part in the co-design process represented peer workers, clinicians, and administrative staff. Each engaged in three 90-minute co-design sessions with led by a lived experience leader. The purpose of the co-design was to collaborate within and between staff on the work they do, and how evidence based a suicide prevention training program could be shaped to best meet their needs.

In this example, administrative staff play a potentially important role in the therapeutic environment.⁹ The interactions they have with people in distress and their family members can be both meaningful and important. Administrative staff support people in distress in ways that are not typically defined as therapeutic. This is consistent with Australia's national policy settings. It recognises and values the contribution made by administrative staff as client facing staff who provide an extension of the positive overall care experience generated by clinicians and peer workers. For many people, administrative staff are the first and frequent point of contact as people in distress make physical contact with a service or make contact by email or phone.

Similarly, peer workers contribute to the organisational environment and through direct client contact. Through peer support, clients come into conversation with a person who has similar life experiences of distress and help seeking, which can affirm and validate many of difficult experiences of the client, promote connection and personhood. Individuals with

lived and living experience of mental health or suicide related distress, who are bereaved or have supported a person who has experienced suicidal crisis, can be our teachers. This is reflected in the steadily accumulating evidence in support of contributions made by lived experience and peer support work within government and on-government sector mental health services.^{10, 11}

Peer workers are widely considered essential in suicide prevention, mental health recovery, and system reform. It is expect that national mental health action plans and policy include consumers in all levels of mental health service development and delivery.⁴ Changes to Australia's national policy settings has brought increased focus to implementing lived experience expertise in services provided by government and non-government sectors, sharing greater awareness and support for peer workforces through initial integration and ongoing role support.

A core theme and binding element across all these actions is listening 'to listen' rather than listening to respond to people in distress. For clinicians, administrative staff and peer workers, it can sometimes be hard to find the right words during critical moments. However, what we know from many people in distress is that it is less about the words and more about being genuinely engaged and compassionate. It is the intent that sits behind the words that matters most. So go gently, go slowly when responding to people in distress.¹²

Careful listening and probing further into the drivers of distress aligns with contemporary developments in relational practice and clinical suicidology. Suicidal thinking is not a fixed state. It can both diminish and rapidly intensify. This brings us closer to understanding intensity and variability of suicidal thoughts as it applies to people who contact services.⁷ At the same time the risk factors for suicide also vary. They range from social determinants to medical and biological factors in the life of a client.¹³

Person-Centred Safety Planning

The above considerations guide current evidence to best prevent suicidal distress and support people during the onset or worsening of suicidal thoughts and behaviour. The Stanley & Brown safety planning intervention is a well-established indicated intervention for general adult populations experiencing suicide related distress, primarily in face-to-face, community and clinical settings.¹⁴ It is a brief intervention taking 20–45 minutes to complete, in which the worker and the client collaborate to identify reasons for living, individualised distress triggers and internal feeling states that occur during the onset or worsening of a suicidal thoughts and behaviour.

A safety plan is quite literally a plan for ‘future safety’.¹⁵ Safety planning is designed to interrupt the trajectory towards suicide. It is best communicated as a compassionate conversation between the client and worker with clear person-specific actions to increase safety. A typical safety plan includes six components:

- (1) recognising individual warning signs and distress triggers;
- (2) identifying and employing internal coping strategies;
- (3) using trusted networks, social supports and connections as distractions;
- (4) contacting trusted family or friends to help;
- (5) contacting specific mental health services; and
- (6) reducing access to/use of lethal means.

Some conversations about safety planning with people in distress may begin by identifying reasons for living. Suicidologists report that when we have reasons for living, living a life with meaning and purpose, we are less likely to take action that threaten that motive.¹⁶ Reasons for living can also encourage hope for the future and

establish a rationale for the safety plan. These reasons can be returned to if/when the person is having difficulty implementing their plan.

Sample questions include: *“What has helped you get through difficult times in the past?”* and *“When everything else seems unendurable or hopeless, what keeps you going?”*

A sample question to help a client recognise individual warning signs and personal distress triggers is: *“What do you experience inside (your internal states) when you start to think about suicide?”*

The purpose of identifying activities to engage in without contacting other people (both established and new activities) in safety planning is to identify and act upon internal coping and self-support activities. This might include distractions, calming activities, and activities that lift the individual’s mood.

Sample questions include: *“What can you do on your own if you become suicidal again, to help you not to act on your thoughts?”* and *“What activities can you do to help take your mind off the feeling state you have at the time?”*

It is critical to discuss the likelihood of the client using the identified self-management strategies and to identify any possible barriers or hesitations along with possible solutions.

Sample questions include: *“How likely do you think it is you’ll be able to use these support and coping strategies in a crisis?”* and *“Can you think of anything that might stop you from thinking about these activities, or doing these activities even after you’ve thought of them?”*

The purpose of facilitating the client to identify social connections and supports is to distract and bring comfort when internal coping and support strategies are not effective. This can include family, friends, groups or social settings. It is recommended that specific names, contact details

and locations of individuals and groups are listed in the plan.

Sample questions include: *“Who helps you feel safe/good when you spend time with them?”*, *“Who helps you to take your mind off your difficulties/troubles/problems?”* and *“Where can you go to be around people in a safe environment?”* It is critical to avoid social connections that might exacerbate the person’s uncomfortable thoughts or internal feeling states. Interaction as a form of social support and settings it occurs in should be safe environments.

Trusted networks, family and friends that the person can inform at the onset or worsening of crisis and when in need of support should be listed in detail on the plan. Specific names and contact details should be listed in the plan.

Sample questions include: *“Of your family, friends, network or community, who do you think you could contact for help during a crisis?”*, *“Of your family, friends, network or community, who is supportive of you in times like these?”* and *“Of your family, friends, network or community, who you feel you can talk to when you are reaching a difficult situation – including crisis?”* Sample responses include spouse/partner, parent, uncle, aunt, sibling, close friend, or religious figure such as a chaplain (all named groups and individuals are agreed and confirmed in advance).

Next is to help the person to identify professional support when the previous strategies are not effective, as well as how to access these supports. This can include existing and new support. The safety plan should include specific names (agreed in advance), contact details, locations and opening hours.

Sample questions include: *“Who are the professionals you turn to for support?”* and

“Who are the mental health professionals that should be listed on your plan?”

It is also important to discuss potential barriers to accessing professional support. Some individuals may be reluctant to access support for fear of reprisal, punishment, stigma, or previous experience. These concerns should be discussed along with potential solutions, such as asking a friend or family member to assist with making the initial contact.

When discussing lethal means, research and consensus opinion in clinical suicidology suggests that the term ‘means safety’ can be more acceptable to people than ‘means restriction’. Means restriction can be experienced by people in distress as a negative consequence, can sound punitive and permanent, and can limit autonomy.¹⁷ The language change is important for firearms. The behavioural goal is to safely store lethal means until the client recovers. Storing firearms away from the home temporarily is regarded by many as the safest choice.

A recent study¹⁸ has suggested peers as effective in lethal means counselling when using conversational and non-confrontational style approaches that are aligned with a person’s value system. This finding is consistent with the intent of Australia’s national Strategy. Research suggests that firearm owners prefer to engage in conversations about firearm safety with credible messengers from within firearm culture (e.g., police officer or military veteran) or with those whom they have established a trusting relationship (e.g., family member) rather than a clinician.

At a deeper level of analysis, the way that safety planning is enhanced by inclusion of support persons and peer workers.¹⁹ This acknowledges that:

- Peer workers may have different language and ways of talking about supports, practices and meanings that are also discussed in safety planning.

- Peer work is lived experience driven, while safety planning is theory/research driven. There are mutual learning possibilities.
- Theory of suicide and safety planning draws attention to relational safety, personal story, and finding meaning. These are also important to peer practice.
- Peer lived experience of safety and coping can draw on finding themes and practices that work for them. These maybe therapeutic practices (e.g. distress tolerance skills), or unique ideas (e.g. looking after a pet), or personal meaning (e.g. spiritual growth).
- Safety planning is focused on pathways out of patterns of crisis: other therapy supports or peer conversations can focus on longer term growth and healing (e.g. from trauma and loss).

Compassion and Relational Safety in Suicide Prevention

A compelling aspect of Australia's national approach to suicide prevention is the location of compassion being central in the prevention of suicide. At its core, the aim should be to embrace the human connection that exists between worker and client. This means being truly present in the space where someone struggles. The focus is on relational safety, an experience that comes from being together with others. When hope seems hopeless, the narrative must continue to be around relationships. This is what binds human connection and compassion as a crucial part of Australia's national policy settings to prevent suicidal suffering and death.¹ Work towards a situation where the person 'feels felt by the worker'. When human connections are absent, or when they are not felt or experienced by the person 'as intimate, authentic and relational', they may be of limited protective value.

Conclusion

In recent years Australian government policy at all levels has been directed to ensure that suicide prevention efforts are grounded in the latest

contemporary research. This includes a genuine commitment to the expertise of people with lived and living experience of suicidal thoughts and behaviours. This direction is outlined by the *National Suicide Prevention Strategy* which plans for the next decade of work in reducing suicidal distress and preventing suicide at a population health level. Through concepts of compassion, relational safety, and 'listening to listen', the Strategy acknowledges that genuine and meaningful human connection is at the centre of suicide prevention efforts. These concepts can be brought into the clinical context through safety planning, to create future safety by identifying stress triggers and strategies to reduce levels of distress. It is hoped that if the Strategy is implemented with genuine commitment, suicidal distress across the Australian population can be reduced.

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Overview

Positive Psychological Approaches to Suicide Prevention

Satoshi Shimai¹⁾, Yu Urata²⁾

Abstract

Suicide prevention policies have traditionally been grounded in a deficit-oriented medical model that emphasizes identifying high-risk individuals and reducing risk factors. Although this approach has contributed to the development of clinical and welfare systems, its application within everyday social settings remains limited. This overview examines how perspectives from positive psychology may complement existing suicide prevention strategies by strengthening psychological and social resources that support living. Drawing on theoretical, empirical and policy literature, we discuss schools, workplaces, communities, and individuals at elevated suicide risk as contexts in which resources such as meaning, hope, belonging, social participation, and reasons for living may be cultivated. Across these domains, positive psychological approaches are conceptualized not as alternatives to established medical and crisis-response interventions but as complementary strategies that promote factors supporting meaningful and fulfilling lives. Integrating suicide prevention into educational, occupational, and community systems may strengthen primary prevention and contribute to more sustainable population-based approaches to suicide prevention in Japan.

Keywords: Suicide prevention, Positive psychology, Positive education, Workplace mental health, Community resilience, Meaning in life, Japan

1. From a deficit model to a strengths-based model

Historically, suicide prevention has largely been developed within a biomedical framework, prioritizing medical approaches that focus on “deficits” and “risks,” such as psychological vulnerability and stress reactivity. Among these risks, depressive states are often identified as one of the most robust correlates¹, and experiencing excessive stress that may contribute to depression is likewise viewed as problematic². Within a deficit model, the aim is to identify individuals in crisis early and connect them to specialized

support. Timely professional intervention for at-risk individuals is widely assumed to contribute to suicide prevention; however, empirical evidence for population-level effects remains mixed.

In Japan, this deficit model has been extended from clinical settings to everyday contexts—schools, workplaces, and communities—and operationalized as population-level strategies that have largely emphasized reducing “factors that hinder living” (i.e., suicide risk factors). For children and adolescents, early detection through schools and referral to specialized care for at-risk students are emphasized. For working-age adults,

¹⁾ Kansai University of Welfare Sciences, Chiba University

²⁾ The University of Osaka

workplace stress screening and professional responses for high-stress employees have been institutionalized. For older adults, measures include identifying high-risk individuals in the community, establishing access points for consultation, and implementing gatekeeper training³. In 2024, the Act on the Promotion of Measures to Address Loneliness and Isolation came into effect, placing particular emphasis on responding to individual risk factors such as isolation and loneliness⁴.

However, suicide risk is likely shaped not only by intrapersonal factors but also through interactions with life circumstances, including everyday roles, relationships, and meaning. In recent years, large-scale meta-analyses have increasingly highlighted the limited predictive power of established risk factors and the difficulty of achieving substantial preventive effects through risk reduction alone⁵. Although deficit-model approaches narrow the locus of suicide risk to intrapersonal factors, suicide risk is more likely to emerge through interactions between individual vulnerabilities and environmental conditions, including the loss of everyday roles, relationships, and meaning in life. Notably, Japan's General Principles of Suicide Prevention Policy (2022) does not strictly adhere to a deficit model; it defines suicide prevention as “initiatives that reduce factors that hinder living while increasing factors that promote living” (p. 4) and explicitly underscores psychosocial resources such as *ikigai* (a sense that life is worth living), a sense of usefulness, and connectedness⁶. Nevertheless, these principles appear not to have been fully implemented at scale.

Furthermore, approaches centered primarily on individual risk factors face structural limitations when applied to schools, workplaces, and communities. Unlike healthcare institutions, these settings are not organized around diagnosis and treatment; rather, they are social environments in which people learn, work, build relationships, find meaning, and develop across the lifespan. Prioritizing the detection and management of risk within these contexts may create tensions with their primary functions. From the perspective of mental health professionals, identifying at-risk individuals

represents an important form of outreach⁷. At the same time, many interpersonal conflicts, challenges, and failures that occur in schools and workplaces are part of ordinary developmental and organizational processes^{8,9}. These experiences may contribute to learning, growth, and the development of personal strengths.

Against this background, the present paper proposes a strengths-based model of suicide prevention as a complementary perspective for concretizing and advancing the “factors that promote living” emphasized in Japan's national policy framework⁶. A strengths-based model conceptualizes mental health not as the absence of symptoms, but as a state of functioning characterized by the presence and utilization of positive psychological resources such as meaning, hope, relationships, and a sense of contribution. From this perspective, suicide prevention is not limited to interventions aimed at reducing risk; it also involves creating social conditions that enable individuals to experience life as meaningful and conducive to well-being.

Positive psychology may provide one theoretical framework through which the “factors that promote living” emphasized in Japanese suicide prevention policy can be conceptualized, operationalized, and implemented within everyday social settings. Although positive psychological approaches to suicide prevention have been discussed since the early 2000s, efforts to integrate theory, empirical evidence, and practice have emerged more recently¹⁰.

Table 1 summarizes the conceptual differences between deficit-based and strengths-based approaches to suicide prevention and provides the conceptual framework for the present paper.

To avoid overgeneralization of causal claims, suicide prevention is conceptualized here as a multi-layered process involving distal outcomes (suicide deaths and suicide attempts), proximal risk factors (e.g., depression, hopelessness, and social isolation), and underlying psychological and social resources (e.g., meaning in life, connectedness, and resilience). Positive psychological approaches are not assumed to directly reduce suicide outcomes; rather, they are understood as strengthening resources and influencing proximal risk factors through which

population-level suicide risk may change over time⁵.

The present paper provides an overview of positive psychological approaches relevant to suicide prevention and considers how such

approaches may complement existing suicide prevention policies in Japan. The following sections examine schools, workplaces, communities, and individuals at elevated suicide risk as contexts in which factors that promote living may be strengthened.

Table 1. Conceptual Comparison Between Deficit-Based and Strengths-Based Approaches to Suicide Prevention

Dimension	Deficit-Based Approach	Strengths-Based Approach
Goal	Reduce suicide risk factors	Promote factors that support living
View of Mental Health	Absence of symptoms	Presence of psychological and social resources
Primary Targets	Depression, hopelessness, distress	Meaning, hope, belonging, strengths
Intervention Logic	Identify and reduce risks	Cultivate protective resources
Main Actors	Mental health professionals	Schools, workplaces, communities, and professionals
Typical Outcomes	Reduced distress	Enhanced well-being and reduced proximal suicide risk factors
Policy Orientation	Crisis response and risk management	Universal prevention and resource development

2. Strengths-based positive education in schools

—Reframing suicide prevention in childhood and adolescence as the development of psychological resources

Despite an overall decline in suicides in Japan in recent years, suicides among school-aged children and adolescents remain a major concern in Japan, particularly among elementary, junior high, and high school students¹¹. Schools constitute a key context for suicide prevention in childhood and adolescence. Within suicide prevention policy, schools are expected to detect early warning signs—such as social withdrawal, marked declines in academic engagement, emotional instability, or expressions of hopelessness, and bullying—and connect students to specialized support. This approach has empirical support and plays an important role in protecting students in crisis^{12,13}.

At the same time, applying a deficit-model framework of risk-focused intervention to schools departs from schools' core functions. Schools are fundamentally social environments

that support learning, socialization, and development rather than institutions primarily designed for diagnosis and treatment. Everyday interpersonal tensions, conflicts, and failures are part of ordinary school life and should not automatically be interpreted as pathological phenomena or crises¹⁴. When schools become primarily organized around the detection and management of risk, educational functions may be de-emphasized¹⁵.

Positive education applies the strengths-based framework to school settings by cultivating resources such as meaning, belonging, strengths, and resilience¹⁶. As shown in Table 2, school-based positive psychology interventions—including SEL, positive education, strengths-based education, resilience education, and school climate interventions—have generally demonstrated small-to-moderate effects on school adjustment, subjective well-being, depression, and anxiety^{17–20}. Although these interventions are not designed to directly reduce suicide deaths or suicide attempts, they may contribute to the development of psychological resources and reductions in proximal risk factors associated with suicide risk. Importantly, positive

education is best understood not as a special suicide-prevention program but as part of schools' ordinary educational mission. By embedding emotional understanding, relationship quality, meaning in life, and self-worth into everyday educational practice, these approaches may help

create environments in which psychological resources are continuously developed, thereby addressing developmental pathways through which suicide risk may emerge among young people while remaining consistent with the educational mission of schools¹³.

Table 2. Positive Psychological Interventions in School Settings

Approach	Description	Outcomes	Key References
Social and Emotional Learning (SEL)	Development of emotional regulation and social skills	Improvements in social competence, academic performance, and reductions in emotional distress	Durlak et al. (2011) [17]
Positive Education	Integration of PERMA elements into school curricula	Improvements in well-being, engagement, and meaning in life	Seligman et al. (2009) [16]; Waters (2011) [19]
Strengths-Based Education	Identification and use of individual character strengths	Increased self-efficacy, engagement, and positive affect	Seligman et al. (2009) [16]
Resilience Education	Training in coping and adaptability skills	Reduced depressive symptoms and improved coping skills	Dray et al. (2017) [20]
School Climate / Relationships	Improvement of peer and teacher relationships	Enhanced school connectedness and reduced emotional distress	Waters (2011) [19]
Meaning / Purpose Interventions	Activities fostering life meaning and goals	Increased sense of purpose, meaning in life, and psychological well-being	Rolls & Steger (2025) [45]
Emotional Literacy Programs	Training in emotional awareness and expression	Improvements in emotional regulation and interpersonal functioning	Durlak et al. (2011) [17]

3. Reconstructing workplace stress management

—Suicide prevention for working-age adults through building positive resources

Suicide among working-age adults in Japan is often discussed in relation to work and workplace conditions. Japan's suicide rate remains higher than the OECD average²¹, and one notable characteristic is the relatively high burden among prime working-age adults²². The social consequences of suicide in this age group are substantial. Given that many adults spend a large portion of their lives at work, workplaces represent an important setting for suicide prevention. In Japan, concerns about overwork, including *karoshi* and suicide associated with

excessive work demands, have highlighted the importance of workplace conditions for mental health and suicide prevention^{23, 24}.

Traditionally, workplace suicide prevention has been embedded within occupational health systems and has primarily focused on the identification and management of risk factors. In Japan, this approach is exemplified by the Stress Check Program introduced in 2015, which aims to identify workers experiencing high levels of stress and provide opportunities for professional support²⁵. Although such efforts play an important role in preventing severe psychological distress, participation in follow-up medical consultations has remained limited²⁶, highlighting the limits of risk-focused approaches alone.

A strengths-based perspective offers a complementary framework. Work inevitably involves responsibilities, interpersonal coordination, evaluation, and role expectations, making stress a routine feature of occupational life. Consistent with the Job Demands–Resources model²⁷, occupational stress is understood as emerging from the balance between job demands and job resources rather than as a problem residing solely within individuals. Positive psychology has highlighted resources such as work engagement²⁸, psychological capital²⁹, and, more fundamentally, the experience of meaning in work. From this perspective, the workplace is not only a source of demands and stress but also a potential source of meaning, contribution, belonging, and personal growth.

As shown in Table 3, workplace-based positive psychology interventions include strengths-based training, meaning- and purpose-oriented interventions, PsyCap programs, psychological safety interventions, and job-crafting approaches.

Across outcomes such as work engagement, subjective well-being, job satisfaction, and psychological resources, these interventions generally demonstrate small-to-moderate positive effects^{30–33}.

A key implication is that positive psychology in the workplace should not be framed simply as training employees to become more resilient or productive. Rather, it should be understood as an effort to create work environments in which meaning, autonomy, supportive relationships, and opportunities for contribution can be experienced on a daily basis. In this sense, workplace suicide prevention extends beyond individual coping skills and becomes closely connected to job design, organizational culture, and meaningful work. Such an approach is consistent with a strengths-based model of suicide prevention because it emphasizes the cultivation of factors that promote living rather than solely the reduction of risk factors.

Table 3. Positive Psychological Interventions in Workplace Settings

Approach	Description	Outcomes	Key References
Strengths-Based Training	Identifying and applying individual strengths at work	Increased work engagement and job satisfaction	Seligman et al. (2009) [16]
Meaning / Purpose-Oriented Interventions	Enhancing sense of purpose in work	Increased work meaningfulness and well-being	Steger et al. (2012) [46]
Psychological Capital (PsyCap) Training	Development of hope, efficacy, resilience, and optimism	Improved performance and organizational commitment; limited evidence for direct suicide-related outcomes	Luthans et al. (2004) [29]
Psychological Safety Interventions	Enhancing trust and openness in teams	Improved communication, reduced interpersonal stress, and enhanced team functioning	Edmondson (1999) [47]; Frazier et al. (2017) [30]
Job Crafting Interventions	Redesigning tasks and relationships proactively	Increased engagement and perceived job control	Oprea et al. (2019) [32]; Knight et al. (2017) [33]
Gratitude Interventions	Promoting recognition and appreciation in the workplace	Improved interpersonal relationships and positive affect	McCullough, Emmons, & Tsang (2002) [48]
Organizational-Level Interventions	Changes in job design and work environment	Reduced job strain and improved employee well-being	Semmer (2006) [49]

4. Community-based suicide prevention grounded in positive psychology

Community-based suicide prevention is particularly important for older adults, who are less likely to be reached through schools and workplaces. Beyond mental health problems, social isolation, loss of social roles, and diminished meaning in life are important contributors to suicide risk in later life^{34, 35}.

From a positive psychological perspective, community suicide prevention focuses not only on reducing risk factors but also on fostering social connectedness, meaningful roles, purpose, and participation in community life. Community well-being is therefore understood as emerging from relationships, shared activities, and opportunities for contribution rather than from individual psychological functioning alone.

As shown in Table 4, community-based approaches include strengthening social capital, promoting meaning in life (ikigai), supporting social participation among older adults, building community resilience, and universal mental health promotion. These interventions aim to cultivate psychosocial resources associated with healthy and meaningful living^{36–39}.

Community resilience provides an example of a resource-based approach in which information sharing, social support, and collective meaning-making contribute to psychological recovery and community well-being³⁸. Community-level health promotion programs have also reported reductions in suicide rates following resident-participatory activities³⁹, suggesting that community interventions may contribute to suicide prevention at the population level.

From this perspective, community suicide prevention should not be limited to identifying high-risk individuals. Rather, it should seek to create conditions in which meaning, belonging, social participation, and mutual support can emerge naturally through everyday community life. This perspective also extends to support for suicide-loss survivors. Through meaning reconstruction, peer support, and opportunities for posttraumatic growth, support for survivors may contribute not only to individual recovery but also to the strengthening of psychosocial resources within communities⁴⁰. From this perspective, suicide prevention becomes embedded within the ordinary activities of communities rather than being treated solely as a specialized response to crisis.

Table 4. Positive Psychological Approaches in Community Settings

Approach	Description	Outcomes	Key References
Social Capital Enhancement	Strengthening trust and social networks	Improved mental health, reduced depressive symptoms, and associations with population-level suicide outcomes	Kawachi & Berkman (2001) [34]; Hamano et al. (2010) [35]
Ikigai / Meaning / Purpose	Promoting purpose in life and meaningful involvement	Improved well-being, meaning in life, and reduced all-cause mortality	Alimujiang et al. (2019) [36]
Social Participation (Older Adults)	Encouraging community involvement and roles	Reduced depressive symptoms and enhanced life satisfaction	Glass et al. [50]
Role Restoration	Re-establishing meaningful social roles	Improved psychological well-being and social integration	Nordenmark (2004) [51]
Community Resilience	Building collective coping and recovery capacity	Improved psychological recovery and community-level adaptation	Norris et al. (2008) [38]; Jewett et al. (2021) [37]
Universal Mental Health Promotion	Population-wide well-being initiatives	Improved well-being indicators at the community level	Purtle et al. (2020) [52]
Community-Based Suicide Prevention	Multi-component community interventions	Reductions in suicide rates at the community level (ecological evidence)	Motohashi et al. (2004) [39]

5. Positive psychological interventions for individuals at elevated suicide risk

The preceding sections have focused primarily on universal and community-based approaches. However, positive psychological interventions have also been applied to individuals at elevated suicide risk, including people with major depressive disorder accompanied by suicidal ideation, individuals with a history of suicide attempts, military veterans, and populations exceeding clinical screening thresholds. A recent systematic review identified 19 intervention studies published between 2012 and 2022 and concluded that positive psychology components may provide benefits when integrated into suicide prevention programs⁴¹.

One notable finding concerns the central role of meaning. Meaning-based interventions were among the most frequently used approaches in high-risk populations⁴¹. Several studies have operationalized this approach through the identification of reasons for living and the reconstruction of meaning during suicidal crises^{42,43}. This finding is consistent with the broader literature reviewed in the present paper. Across schools, workplaces, and communities, meaning has repeatedly emerged as a factor that promotes living. The intervention literature suggests that this role may extend beyond universal prevention and remain relevant even among individuals experiencing elevated levels of suicide risk.

A second noteworthy finding concerns savoring. Although savoring has rarely been emphasized in the universal interventions reviewed in the preceding sections, it appeared relatively frequently in interventions targeting high-risk populations⁴¹. Savoring involves intentionally attending to, appreciating, and emotionally engaging with positive experiences in everyday life. For individuals experiencing severe distress, hopelessness, or meaninglessness, identifying reasons for living may be psychologically demanding. By contrast, engaging with positive everyday experiences, such as music, pets, or close relationships, may be more immediately accessible. From this

perspective, savoring may represent an experiential pathway through which positive emotions contribute to the reconstruction of meaning and reasons for living. This finding suggests that positive psychological techniques may need to be adapted according to the severity and characteristics of the target population.

A third implication concerns outcome evaluation. Most positive psychology intervention studies have relied on self-report measures of well-being, depression, or suicidal ideation. However, some studies included in the systematic review used epidemiological indicators⁴¹. For example, a study of high-risk military personnel reported a lower hazard ratio for suicide attempts during follow-up⁴⁴. Although such evaluations are more feasible in high-risk populations than in universal prevention settings, they demonstrate that positive psychological approaches can be assessed using clinically meaningful suicide-related outcomes. Future research may benefit from incorporating similar epidemiological indicators.

Taken together, the emerging literature suggests that positive psychological interventions may have relevance not only for universal prevention but also for indicated prevention among high-risk populations. While the evidence base remains limited and heterogeneous, the findings support the view that psychological resources such as meaning, positive experience, and reasons for living may complement conventional risk-focused approaches to suicide prevention.

6. Summary and future directions

The present review argues that positive psychological approaches provide one practical framework for implementing the national policy goal of strengthening factors that promote living.

Across schools, workplaces, communities, and individuals at elevated suicide risk, the approaches reviewed here suggest that positive psychological resources may be relevant across universal, selective, and indicated levels of prevention. They share a common emphasis on

cultivating psychological and social resources, including meaning, hope, belonging, social participation, and opportunities for contribution. From a positive psychological perspective, suicide prevention is understood not only as the management of risk but also as the promotion of conditions that support meaningful and fulfilling lives.

A common implication across the domains reviewed is that suicide prevention may be more effectively embedded within existing educational, occupational, and community systems rather than implemented as a separate set of specialized activities. Positive psychological approaches may therefore complement existing suicide prevention policies while reducing stigma and strengthening primary prevention.

Several limitations should be acknowledged. Most positive psychological interventions have not been evaluated using suicide deaths or suicide attempts as primary outcomes, and the evidence remains heterogeneous across populations and intervention types. Nevertheless, emerging studies have begun to employ epidemiological indicators such as relative risks and hazard ratios in high-risk populations, suggesting a promising direction for future research. Further investigation is needed to clarify how resources such as meaning, savoring, hope, and social connectedness influence suicide-related outcomes and how universal, selective, and indicated interventions can be integrated within a coherent public health framework.

Overall, positive psychological approaches should be viewed not as alternatives to established medical and crisis-response interventions but as complementary strategies that strengthen factors supporting life and well-being across the lifespan.

Additional remarks:

The authors have no reportable conflicts of interest.

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