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Social Exclusion and Inclusion of Suicidal Feelings

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Abstract

This paper is a revised version of the report entitled "Living with Suicidal Feelings: COVID-19 and Suicide Care," presented at the Kansai Sociological Association's 73rd Symposium on "Imagining a Future Society Embracing Care: Proposals for a Post-COVID Social Theory."

Section 1 provides an overview of the paper. Section 2 outlines the general state of suicide prevention in Japan. Section 3 examines how suicidal feelings and suicide are excluded from modern society in terms of both social institutions and social interactions, referring to E. Durkheim's discussion of the *culte de la personne*, E. Goffman's discussion of interaction ritual and A. Hochschild's discussion of feeling rule. Section 4 clarifies the ambivalence surrounding suicidal feelings and the double meaning of the utterance "I want to die" based on Durkheim's discussion of the sanctity of the individual in general and eliminating the transgressor. Section 5 draws on interviews with staff of a suicide prevention nonprofit organization (NPO) and discusses how people with suicidal feeling can be included in contemporary society beyond the paradox of the worship of the individual in general. Section 6 presents a perspective on whether not talking about death in general, out of respect and deference, also leads to the exclusion of suicidal feelings.

This study visualizes how and why modern society excludes suicidal feelings and suicide, while at the same time making visible the activities of those who have tried to create a space in society for the expression and acceptance of suicidal feelings. By illustrating the conflict between the exclusion of suicidal feelings provoked by veneration of the individual in general and the acceptance of suicidal feelings provoked by respect for the individual in particular, the paper considers how it is possible to include people with suicidal feelings in society while respecting human life.

Key words: suicidal feeling, suicide, suicide prevention, *culte de la personne,* feeling rule

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1. Introduction

This paper is a revised version of the report entitled "Living with Suicidal Feelings: COVID-19 and Suicide Care," presented at the 73rd Symposium of the Kansai Sociological Association (online Sunday, May 29, 2022), dedicated to "Imagining a Future Society Embracing Care: Proposals for a Post-COVID Social Theory." Based on interviews and participatory fieldwork at a suicide prevention nonprofit organization (NPO), I identified how suicidal feelings are socially excluded or included in contemporary society. In addition, I referred to "emotional capitalism" (Illouz 2007) as a concept for reframing the rationalization and monetization of care.

In light of the above, this study visualizes how and why modern society excludes suicidal feelings and suicide, while at the same time making visible the activities of the NPO has tried to create a space in society for the expression and acceptance of suicidal feelings. By illustrating the conflict between the exclusion of suicidal feelings provoked by veneration of the individual in general and the acceptance of suicidal feelings provoked by respect for the individual in particular, this paper considers how it is possible to include people with suicidal feelings in modern society while respecting human life. This paper will carry an argument mainly referring E. Durkheim's discussions of "*culte de la personne*," and its critical inheritance, E. Goffman's "interaction ritual" and A. R. Hochschild's "emotion management." In the 2010s, Working Group 8 (Society and Emotions) of the International Sociological Association presented new developments in the sociology of emotions. In relation to this movement, it is hoped that this research will provide an opportunity to build a sociological theory and social practice that incorporates human emotions.

The contents of the interviews at a suicide prevention NPO mentioned in this paper have been discussed in detail in another paper by the author (Yamada 2022b), who has also published other related papers (Yamada 2022a, 2023b). The current paper contains statements that partly overlap with the contents of the report. The WHO distinguishes suicide from suicide attempts and suicidal behavior (WHO 2014: 12).[1)] Thinking "I want to die" and actually taking an action to die by suicide are different things. However, here we consider them to be part of one process.

2. General state of suicide prevention in Japan

According to the Japanese government, the total number of suicides in 2020 and 2021 during the COVID-19 pandemic decreased slightly compared to the average number of suicides in the previous five years from 2015 to 2019. While the number of male suicides decreased, the number of female suicides increased. For both genders, the number of suicides among teenagers and people in their twenties increased. The number of suicides among men living with someone decreased among those over 30, regardless of whether they were employed or not. However, suicides among employed women living with someone increased in all age groups from the 20s to the 50s. The number of suicides among

employed women increased above the five-year pre-COVID average in the 50s and younger age groups, regardless of whether they had a cohabitant, with suicide being common in the "administrative" and "other service" occupations. Among unemployed women, the number of suicides by women in their teens and 20s who had a partner increased. In addition, the relationship between the declining rate of active job openings and the rising rate of suicide among unemployed women was pointed out, and the expansion of poverty alleviation measures and safety nets was considered urgent (MHLW 2022: 41–74).

The United Nations and the World Health Organization (WHO) presented guidelines for suicide prevention at the national level in 1996. On the other hand, Japan's rapid progress in implementing suicide countermeasures began in 2006, when the Basic Act on Suicide Prevention was enacted against the backdrop of the 30,000 Suicides Era (1998–2012). The Basic Act is praised for recognizing that suicide is caused by multiple and complex social factors, rather than view it as an individual problem, and for making society-wide efforts based on mutual cooperation among the state, local governments, medical institutions, enterprises, schools, and private groups, rather than merely implementing mental health measures. According to Takahashi, suicide prevention requires a medical model that diagnoses and treats mental disorders that lead to suicide early (high-risk approach), and a community model that reduces the stigma of suicide through educational activities and connects people who intend to die by suicide with an appropriate support network (Takahashi 2012). Suicide prevention in Japan over the past few years has included many educational activities and trainings in communities, schools, and workplaces to reduce social factors that "inhibit life," such as job loss, bankruptcy, multiple debts, long working hours, bullying, and youth problems (MHLW 2017). By working with local health and welfare departments and unemployment offices, The Ministry of Health, Labour and Welfare aims to promote measures that are more closely linked to communities and occupations and to further reduce the suicide rate (MHLW 2022: 36–40).[2)]

A characteristic feature of suicide prevention during the COVID-19 pandemic is the expansion of counseling services provided by local governments and private groups via telephone and social media (LINE, Twitter, chat). Looking at the FY2020 budget, all prefectures had implemented subsidized projects to strengthen suicide prevention measures. However, of the approximately 1 billion yen to be implemented, 50% was allocated to telephone and social media counseling projects and 20% was allocated to youth projects. The total number of counseling sessions in 2020 at four private groups that received special support from the government[3)] was about 63,000, and counseling requests from young people in their teens and 20s accounted for 75%. Males accounted for about 10% and females for about 90%. However, improving the response rate to counseling and responding to suicides when they occur more frequently, such as late at night and early in the morning, remain challenges for the future, and it is not the case that all counseling requests were answered (MHLW 2021: 43–56).

Thus, in the current suicide prevention measures, suicide has been considered as a social issue while continuing the existing path of medicalizing suicide, and the state, communities, schools, workplaces, NPOs, and the private sector are working together to build networks and develop

infrastructure to prevent suicide.[4) 5)]

3. A society that excludes suicidal feelings

3.1. Overflowing suicidal feelings

When the author talked to a suicide prevention NPO in the Kansai region in the fall of 2021, they said that they could only answer approximately 5% of the calls to their counseling service. They could answer only about 600 of the 10,000 calls they received each month. They faced an overwhelming lack of staff and funding. At another NPO specializing in social media counseling, the high number of counseling requests meant that even an automated response from a bot saying "We are currently experiencing heavy traffic" would take a week to send. Even though they hired people living overseas as consultants to provide 24-hour responses, there were not enough of them. The imbalance is obvious; many people with suicidal feelings wanted someone to listen to them, but the number of people who would accept them was considerably small. It is not only the lack of personnel—the infrastructure for listening to feelings of wanting to die is still developing as a social institution.

According to WHO, suicide prevention has remained a low public policy priority in countries around the world, despite the expected benefits at historically low cost. In the early twentieth century, many countries around the world arrested people who attempted suicide and punished them with imprisonment or fines. Most countries have abolished penalties for suicide in the last 50 years, but some still consider it a crime because of their religious background (WHO 2014: 49–51). In response, WHO has identified suicide prevention as a major global public health and policy challenge and recommends interventions based on scientific and medical evidence (WHO 2014: 11).

Suicide is currently considered a public health phenomenon to be eliminated, not a sin, an immoral act, or a crime. The WHO shows that over 90% of people who die by suicide have indicators of a depressive state or other psychiatric illness, and suicide is considered along a line that extends from disease or pathological illness rather than evil, and is medicalized in this sense. The WHO defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The truth of being "healthy" does not seem to include choosing death or living with suicidal feelings.

According to M.Pinguet (1984=1986), suicide was never a sin in Japan. Committing seppuku was a matter of pride for the samurai, and a double suicide was an act of affirmation of the couple's love for each other. This "willing death" is a well-founded, rational, carefully considered act and even the revelation of a human truth (Pinguet 1984=1986: 400). On the other hand, suicide was first medicalized in Japan around 1900. In 1894, Kure Shūzō, the father of psychiatry in Japan, first wrote a paper on suicide from a psychiatric point of view, following the German example. Around the same time that psychiatry was introduced, a system for isolating and monitoring "psychiatric patients" through home confinement or admission to a psychiatric hospital based on a doctor's diagnosis was established through the enactment of the Psychiatric Hospital Custody Act (1900) and the Psychiatric Hospital Act

(1919). Suicide attempts and suicidal ideation were referred to as "suicidal illness" and segregated as subjects for medical treatment and research (Suzuki 2013; Sadakane 2016).

In examining this clear medicalization and closure of suicidal feelings and suicide, it is important to note that modern society has kept death out of sight. In the midst of a linear flow of time, which considers progress and development to be right, death simply means the end. Public assistance and social security systems have been developed to guarantee the right to "the minimum standard of living". However, these are social systems to prevent citizens from dying through monetary payments and the provision of medical and social services in kind, not a commitment to suicide itself. Public social insurance in Japan provides for "risks" that everyone alive may encounter, such as sickness, aging, long-term care, loss of employment, and industrial accidents. Everyone pays insurance premiums in advance; if a risk materializes, insurance benefit or compensation is paid out of the premiums. If the various pensions and allowances of the social security system and the provision of medical care and social assistance are not sufficient, even if they are used to the maximum, there is the livelihood security system, financed by various taxes, as the last safety net. In this case, the vector is directed toward living. This social system that prevents people from living below the poverty line "from the cradle to the grave" has been indifferent toward people who seek to take themselves to the grave. The social expansion of welfare and care has had the effect of making death invisible in modern society. As is well known, making people live without letting them die and controlling the population by providing the bare minimum to avoid misfortune rather than pursuing happiness are intended to increase national power and create economic growth (Yamada 2023a).

3.2. Scripts and ad-libs concerning suicidal feelings

With the social systems, politics, and cultural circumstances as a backdrop, the reality is that people cannot say "I want to die" in everyday, face-to-face conversations. Biases against and negative evaluations of suicide and those who die by suicide are difficult to eradicate; when someone says "I want to die," they are silenced, or subtly reprimanded by being told "Don't say that," or encouraged to "live forward," or lectured that "some people cannot live even though they want to". One bereaved family member I met during my fieldwork said when she lost a close relative to suicide and also wanted to die, she decided that "this person might accept me" and opened up to a friend. However, the friend was at a loss for words. While the atmosphere at the time felt strange, and she felt unable to bear being there any longer. Her already painful emotional state was further hurt, and she became depressed and fell into a critical state.

The WHO rejects the myth that "suicides happen suddenly without warning," noting that "many suicides are preceded by warning signs, whether verbal or behavioral. Some suicides do occur without warning, but it is important to understand what the warning signs are and to look out for them" (WHO 2014: 29). However, it is not uncommon for the suicide news to be received with shock and a sense of "they would never do that". This is partly because the person is unable or unwilling to express their feelings of wanting to die, which means that those around them have not heard or wanted to hear, or

have no idea, and have not tried to notice subtle signs.

Even if we look back later and think of something like a precursor to suicide and think, "Maybe that's what it was," it's hard to see it in advance. For people who focus their awareness on suicide prevention every day, let alone "ordinary people" who do not, it is difficult to tell if the person we are talking to is having suicidal feelings. We do not look at and predict the words and actions of others with such a gaze. When we have a casual face-to-face conversation with someone and wonder, "What kind of person is this? "What are they thinking?" and "What were they doing yesterday?", we rarely anticipate answers such as "A person who wants to die," "I simulate the kind of death I want to choose every day," or "Yesterday I went to buy the tools and materials necessary to put it into practice.

As evidenced by the friend of the bereaved mentioned above who was at a loss for words and fell silent, expressing a desire to die is not part of the script of everyday conversation. Such utterances and behaviors are carefully excluded in advance as things that will disrupt the order of the "gathering" (Goffman 1963). This is well known by people who have suicidal feelings. They may remain silent out of fear of ruining a gathering by expressing their suicidal feelings, fear of being labeled "abnormal" or "mentally ill" and ostracized, or a sense of resignation that "I won't be understood anyway". They may refrain from expressing their suicidal feelings out of hesitation, compassion, or regret for placing the burden of an improvised response on the other person. They may become extremely mentally and physically exhausted, find it difficult to even stand up, feel more pessimistic, and stop caring about anything in the world, which in turn prevents them from saying anything. In any case, the social barrier preventing them from saying "I want to die" is high.

In terms of feeling rules, emotion management and interaction ritual, the above points can be considered as follows. According to A. R. Hochschild, the "rules of feeling" that determine what kinds of emotions a person should feel, how deeply, and for how long, are identified based on the social setting, and people perform "emotional work" based on them, such as "surface acting" and "deep layer acting". "Appropriately managed emotions" are an "offering" to others and the social setting (Hochschild 1983: 82 =2000: 94). Emotion management is an expression of respect for the other person, as well as a kind of ritual act to present oneself as a desirable presence. Hochschild's emotion management theory has been influenced by Goffman's discussion about "interaction ritual".

According to Goffman, the modern person's "sacred self" is emerged as each person continually performing "avoidance ritual", "presentational ritual" and "demeanor" (Goffman 1967). If a person's domain is invaded, their sanctity is harmed and threatened and loses its luster. Thus, people conspire to exclude people who do not perform the rituals and strive to maintain their sanctity and the order of the social environment. Thus, those who cannot successfully perform rituals and facework have been sent to hospitals as "mentally challenged" or stigmatized as "maladjusted" and segregated from society. Because they are seen as those who do not respect the gathering and are incapable of "facework", others also abandon their facework efforts (Goffman 1967, Yamada 2007: 73). In model contexts that treat individuals' personalities and faces as sacred, suicidal feelings that might damage these aspects are concealed and rendered invisible. They are excluded as "misfitting feelings" (Hochschild 1983: 63–66

=2000: 72–75) that do not conform to the "rules of situational propriety" (Goffman 1963: 24 =1980: 27) of modern society. Goffman's concept of interaction ritual was influenced by Durkheim's discussion of moral individualism and the sociology of religion. The mechanism for the elimination of suicide from this point of view will be discussed in detail in Chapter 4.[6)]

3.3. "Unspecified" motive for suicide among young people

According to the Japanese government, in 2020, during the COVID-19 pandemic, the leading cause of death for all age groups from 10 to 39 years (regardless of gender) in Japan was suicide. Suicide was the leading cause of death for 29% of people aged 10–14 years, surpassing the previous year's leading cause, malignant neoplasm. In the five-year age groups between 15 and 29, suicide accounted for at least 50% of all deaths, significantly overshadowing deaths from unintentional injury or malignant neoplasm (MHLW 2022: 11–12). In this way, suicides among young people increased significantly during the COVID-19 pandemic. However, the most common motive or reason for their suicide is "unspecified," which accounts for nearly half of elementary school students. According to the National Police Agency, 47% and 42% of elementary school boys and girls, respectively, and 43% and 29% of junior high school boys and girls, respectively, processed the reason for suicide as "unspecified" (MHLW 2022: 82). Even among senior high school, college, and advanced vocational school students, 20–30% of suicides occurred because of an "unspecified" motive, and the proportion is higher among boys and men. In addition, the most common motives among elementary and junior high school students were "problems at home" (problems in their relationship with their parents, being scolded) and "problems at school" (problems with their school friends, poor academic performance). More than 30% of suicides among senior high school boys and girls were attributed to "school problems" (worries about future career, poor academic performance) and "health problems" (depression, psychiatric illness), respectively (MHLW 2022: 83, 90).

A significant proportion of "unspecified" motives can be explained by the underdeveloped ability of young people to verbalize complex emotions. However, children often do not say anything out of the consideration that they do not want to worry adults or out of the thought that "I must not make my parents sad". A survey conducted in December 2021 among 4,519 students from the fifth year of elementary school to the third year of junior high school throughout Japan and their guardians showed that children with more severe depressive states tend not to seek help (NCCHD 2022).[7)] Conversely, adults tend to think that children may not have suicidal feelings because they see them as full of potential and hope for the future. The manifestation of suicidal feelings in a child is tantamount to a rejection of the existence of adults, their ways of raising children, and the society they have built on their foundations; it is not easy to accepted.[8)]

A suicide prevention nonprofit organization interviewed by the author noted that requests for lectures and teacher training in school settings have increased since the COVID-19 pandemic. Since the suicide rate among children is increasing without any clarity on the reasons or motives, it is difficult to find concrete methods of resolution, and the school environment suffers. From another point of view,

this clearly shows that society does not have a script to interpret suicide and suicidal feelings in children sufficiently, or the vocabulary to restore and stabilize the order of interactions that has collapsed.

According to Gerth and Mills, "motive" becomes an issue when there is "a situation involving unforeseen intentions and actions with a wide range of options"; this is "often called a crisis" (Gerth & Mills 1953=2005: 130). When we perform routines and habitual actions, there is no examination of why we do so. Even when there is an examination, the answer is often "because it is natural" or "because everyone does it. Motives are the "convincing justification" when something happens that society does not take for granted (Gerth & Mills 1953=2005: 131). They are language generated by a post-mortem construction given to the act by the people around it (Doi 1984: 209).

The "causes and motives for suicide" listed in the National Police Agency's statistics are determined by looking at (1) writings left by the deceased, (2) posts on suicide websites and social media platforms, and (3) the deceased's words and actions while alive as part of police investigations into suspicious deaths (Yamada 2021). The causes and motives can list up to three of several categories, such as "health problems" and "economic or lifestyle problems." Since each category is broken down into 10 or more subcategories (e.g., "health problems" includes worries about illness, the body, depression, schizophrenia, drug abuse, etc.), there is a wide range of combinations and realities. Among adults, health, family, economic, lifestyle and employment problems are common every year. While these "motive" in suicide statistics is reported in the media and influences public opinions and social policies, it should be noted that "unspecified", which is not omitted in the media, is actually second in number only to the leading cause—health problems. "Unknown" is selected when the police, despite their investigations, are completely unable to identify a cause or motive, and accounts for about a quarter of the total.

Thus, we can recognize that a considerable number of suicides by adolescents and adults defy any kind of post-mortem construction by others. Even if it were possible to categorize them, the actual person is no longer in this world, and there is no way to ask them the truth to verify this classification. The motives for suicide that appear in statistics and are reported are nothing more than a construction by the police and the society that supports them.

In the fall of 2020, I asked the representative of the suicide prevention NPO about their views on suicide among children during the COVID-19 pandemic. While they suggested that a major cause was the fact that society as a whole was seriously shaken by the COVID-19 pandemic, when children were establishing their identities and were unstable due to Sturm und Drang, and adults had no way of knowing their children's feelings, they also admitted that no one really had a definitive answer.

Durkheim (1897=2019: 514) found that the suicide rate of a society remained constant even though its members changed every year, and that a "collective passion" had a kind of unique power that transcended the individual. The large fluctuation in suicide rates among children and women during the COVID-19 pandemic is evidence that society was seriously shaken. In this regard, it is necessary to continue empirical sociological research on suicide from the perspective of integration and cohesion beyond individual motives, in line with Durkheim, and to focus on what is chosen as a "justified" motive that everyone agrees with. This will reveal the social norms of life and death that bind modern

people. Currently, at least, the fall of society into a state of anomie due to the COVID-19 pandemic has significantly affected the youth and women. However, we do not have a vocabulary to order this and have not yet found new words for it.

4. Double meaning of suicidal feelings

4.1. Ambivalence surrounding suicidal feelings

Gorer (1965) called the way in which death has become unmentionable in the process of modernization and cannot be revealed to people the "pornography of death". However, suicide and suicidal feelings also exist quietly but certainly in places that do not attract attention. The innumerable suicidal feelings of young people are flooding medical institutions and telephone and social media counseling services. In recent years, death has come to be discussed in the open, based on the topic, as reflected by *shūkatsu* (end-of-life preparations), terminal care, and death with dignity, for example, and it has pronouncedly commercialized in *shūkatsu*. Nevertheless, this is not the case for suicide and suicidal feelings. For example, in parallel with steady education activities aimed at overcoming biases, taboos, and stigma around suicide, such as community gatekeeper training, counseling services are being expanded to prepare several places to accept suicidal feelings and place them in support networks through various channels. Conversely, the WHO has placed reporting restrictions on suicide to protect the dignity of the person who died by suicide and avoid unexpectedly stimulating people currently in a difficult situation and causing imitation or copycat suicides (WHO 2017). The media strategy of actively broadcasting news about people who overcame their desire to die or the tales of people who continue to live despite wanting to die has been adopted with the Papageno effect in mind.

Judging from the above, society is ambivalent about suicide. Suicide and suicidal feelings seem to be visible, but they are not. People seem to be encouraged at one moment to reveal their feelings, and then they are restricted. For example, no one answers the phone when people try to call after being given the number. Suicidal people seem to be respected, but are targets for elimination. Dead bodies are immediately covered with blue tarps, and everyone around them either tries to keep them out of sight or peers in out of curiosity. Removing death from view is also a sign of respect for the dead and the people around them. Where does this ambivalence about suicide and suicidal feelings come from?

4.2. Double meaning surrounding suicidal feelings

In Japan today, the desire to die has been medicalized in the form of "suicidal ideation" and is eligible for medical treatment under health insurance.[9)] Many cases are considered symptoms of a psychiatric disorder, such as depression or schizophrenia, and suicidality is an important indicator in diagnosing these illnesses (DSM-5). When suicidal ideation is so strong that it cannot be controlled by hospital visits or medication, it is treated by hospitalization. The existence of people who wish to die is accepted and affirmed "as is," but the actual desire to die is considered a "disorder" that requires medical treatment. If it reaches a severe level, the person is isolated from society as an inpatient.

According to Durkheim (1897=2019: 567), suicide is criticized because it harms the moral spirit of respect for the individual that forms the foundation of modern society. In the supposedly more secular modern society, what people continue to believe jointly is "reverence for personality and individual dignity" (*culte de la personne, de la dignité individuelle;* Durkheim 1893: 396=1996: 384). However, regardless of how much we observe a person, all that lies within is secular, and the divinity that dwells in the personality is never an intrinsic part of the individual.

What is selected as sacred can be considered so if the collective power overlaps with it through "coincidental circumstances," even if it is meaningless and profane. Durkheim said, in the modern era, the concept of sanctity resides in the individual (Durkheim 1924=1985: 55). A sacred object is a forbidden existence that inspires awe, alienates, and keeps people at a distance, while at the same time being an existence to be loved and sought after, and an object of attachment and desire. Suicide invites disgust, if only because it violates this sacred quality (Durkheim 1897=2019: 567).

According to Durkheim, reverence and respect for humanity and individual dignity originate in society as "a great moral force." But today, the dignity of the individual is considered self-evident and inherent. Even if we are aware that suicide and murder are daily occurrences and that mass slaughter occurs in war, this does not shake the common belief in worship for the individual. When people respect humanity and human life and emphasize the sanctity and dignity of the individual, they are strongly bound by the collective consciousness.

If suicidal feelings are mentioned in this situation, people under the common belief of "reverence for humanity and individual dignity" will interpret it as a dangerous statement that will destroy the collective consciousness, even if it is a cry for help from the actual person to those around them. When people listen to the suicidal feelings with respect for the individual in front of them, they are also strongly bound by deference to the individual as a universal moral force simultaneously. Therefore, operations surrounding suicidal feelings are inevitably in constant ambivalence. They accept the existence of the person describing such feelings without rejecting them, but they treat the suicidal feelings themselves as though they had better not exist. It will eventually lead to despair and resignation for those who have suicidal feelings, that no one will affirm their thoughts or talk about it (Yamada 2022a, Yamada 2022b). In the next section, we will further discuss the dilemma posed by this ambiguity and its resolution based on fieldwork and interviews in a suicide prevention NPO in Osaka, Japan in 2020.

5. Living with suicidal feelings

5.1. Constructing and sharing motives for suicide

Fieldwork and interview surveys at the suicide prevention NPO by the author revealed that suicide prevention activities involve the dilemma between the universal reverence for human beings in general and the reverence and respect for individual human beings. More specifically, the counselors of the NPO experience a tension between complying with the generalized norm that humanity and human life

are more important than anything else, while at the same time respecting the person in front of them (on the phone) and not denying their suicidal feelings. In general, the individual's suicidal feelings are denied in front of the slogan "human life first". However, the telephone counselors of the suicide prevention NPO I interviewed conducted their activities with the idea that "it would be great if people became aware that everyone gets into situations where they want to die".

Behind this is the clear awareness that people who want to die cannot tell those around them about their suicidal feelings, let alone the difficult situation they find themselves in, and they also suffer from not being fully accepted even if they do tell others. This awareness is widely shared among counselors, as similar statements are made directly by suicide attempters. In addition, in the bereavement support groups that took place between counseling sessions, many survivors reported feeling a strong sense of guilt for not recognizing their loved one's suicidal feelings and for not providing appropriate support. They suffer additional blows by thinking, "Was what the deceased did such a terrible thing?" every time they read or hear an announcement that reporting on suicides on media has a negative effect on society.

When someone's suicidal feelings manifest themselves in the form of a death by suicide that shocks the people around them, those feelings stay with them for a long time afterward. "Why did he die alone?" "When I saw her before, she asked me about a trip she was going to take in the winter. "We promised that we would always be together." "He would never do such a thing. He is not that kind of person. He would not die without talking to me." "She seemed strange lately. But I did not think it would turn out this way. If only I had listened to her then." In these comments by the bereaved in my interview surveys, we see sadness and the dilemma and suffering of wanting to respect the thoughts and actions of the deceased, but ultimately not being able to accept them. The motives for suicide are constructed posthumously by those around the deceased; however, this is also the work of reestablishing ties that had been partially severed between the deceased and the bereaved in the face of the extensive wavering of the image of the deceased that had been formed during their lifetime (Yamada 2019: 106–10).

The survivors restore the disrupted order of everyday life by thinking about the meaning of the deceased person's death and life, and their relationship to the deceased person, revising and restating it over and over again. However, the suicidal feelings of the deceased are not easy to digest for the survivors. The work of mourning that arises in response to suicide is accompanied by difficulties that can be considered physically repulsive. This inability to digest can lead to new suicidal feelings or depression, or can be a turning point in the lives of those around them. In the fieldwork, I have seen and heard examples of people exhausted by filing workers' compensation claims or lawsuits while healing from the grief of losing a close relative or spouse and ending up seeing psychiatric specialists themselves, or where they were unable to cope with the situation or to eat and drink due to excessive shock and lost 10 kilograms or more in a short period of time, while being unable to work, do housework, or manage their child-rearing responsibilities. In the case of a person has lost a friend in high school, they have scoured the literature of psychiatry and psychology to understand the meaning of their friends' death and life to a degree that could convince them, and then advanced to a related undergraduate faculty and

began working in a position to support counseling.

After the suicide is completed, the immeasurable feelings of suicide are divided among those left behind as a parting gift that cannot be left unopened. The survivors carry, interpret, and nurture them in their own way to rebuild a life without the deceased. It may be slightly different from the suicidal feelings of the deceased, but that should be as such.[10)]

5.2. Shivering in the face of suicidal feelings

When an operator at a suicide prevention helpline asks, "Do you feel like you want to die?", many people begin to talk about their situation as if they are relieved to be able to express themselves. This is because they feel safe: "I can talk about suicide here." The accumulation of such experiences made the counselors certain that "having suicidal feelings is not a 'bad' thing" and that "people can go on living while having suicidal feelings". Accepting such feelings, however, is not easy. Even if a counselor eliminates his or her biases and taboos, and is willing and trained to listen with an open mind, he or she cannot remain calm inwardly when confronted with someone who sincerely tells them that he or she wants to die. This is because they are directly confronted with a situation that shakes the order of modern society—"reverence for individual in general"—to its foundations.

According to the director of the NPO I interviewed, the attitude of the person receiving the call is examined when the call comes from a person who actually expresses a desire to die. He told me, "when I am confronted with a person who says he wants to die, I question by myself how I will live and how I have lived". In this regard, Nishihara, the founder of the Tokyo Suicide Prevention Center, said that shortly after she started the center, she responded to people's claims of wanting to die by convincing them that they "must not die. She had an "intrusive," "arrogant" feeling that she had to help the people who called her, even if she has to trace the call. However, she realized that the reason she ended up begging a person who reported having suicidal feelings not to die was that she could not handle the responsibility of being the last person the caller spoke to in the living world when the caller was not ready to face death, and she then stopped "interfering" (Nishihara 2003: 35–40).

According to the director above mentioned, when people feel that they do not belong anywhere or lose sight of the meaning of life, they want to die or disappear. An anonymous caller tries to confirm the meaning or value of living in society by asking the counselor or oneself, "Why are you living?" while remaining on the borderline between living and dying. Telling such a person that you do not want them to die does not answer the question. Everyone is afraid to hear someone say they want to die. However, when they get past that and listen carefully to the suicidal feelings, some people change their minds in favor of living (Yamada 2022b). Nishihara (2003: 39) wrote that when she was confronted with a caller who was determined to die by suicide, she said, "I respect your intentions," and the person abandoned the thought of dying by suicide because his suicidal feelings were accepted by another person for the first time. The director said, "People have a domain that others cannot enter. He is active every day while thinking that he does not want anyone to die by suicide. However, when asked, he said that he and his comrades cannot change whether a person lives or dies, nor can they change that person's life and

thoughts, because they all belong to that person. All he can do is turn to their suicidal feelings with an open mind and listen carefully to the words that no one else wanted to hear, and thus send the person the message that he does not want them to die and that they are important.

Counselors of the NPO tremble in tense situations, sometimes do not know what to say in response, and wonder if their answers were helpful. When they later learn from police investigations that they were unable to prevent a suicide, for example, they have a feeling that cannot be expressed in words. This heaviness, which no one can bear alone, is carried by all through the counselors, who talk about it and share it with each other. In some cases, they prefer to share these stories with their colleagues in order to maintain a calm and attentive listening attitude, rather than answer the phone. Although they don't share the full story with each other because of confidentiality, the counselors accept the suicidal feelings of anonymous callers on the phone, and what makes this possible is the mutual support among them (Yamada 2022b; Yamada 2023b).

5.3. Living with suicidal feelings

At the NPO, counselors do not condemn suicide for religious reasons or consider it the result of possession by demons or Satan. They do not view it as criminal or immoral. They do not interpret it as an act committed while lacking normal judgment or orientation due to psychiatric illness. They do not evaluate the suicide victim's mental state using terms such as "diminished capacity" or "temporary insanity." People with suicidal feelings are not treated as deviant, and suicidal feelings remain free from social norms that consider it aberration and exclude it from society in the activities of this NPO. Counselors listen to those living with suicidal feelings, speaking as friend, neither rejecting nor validating. Sometimes they tremble or partially share with their colleagues as they listen.

Underlying this are the counselors' histories of wanting to die or experiences of losing close family members to suicide. One counselor who lost her husband to suicide said, "If he knew the place to accept the suicidal feelings like this on that day at that time, he might still be alive. She has also had the experience of being saved by telephone counseling when she was contemplating suicide. This means that the counselors are living with the suicidal feelings of their past selves, the close relatives who died by suicide, and the person on the phone in the present moment. This is a coexistence paradoxically made possible by empathy based on the awareness that "we cannot fully understand each other" (Yamada 2022b). From the 1970s to the present, this NPO has provided suicide counseling. Volunteer telephone counselors have been giving unpaid advice late at night, but their existence and activities have received little attention, just as suicide and suicidal feelings have been made invisible.

It is certainly important not to neglect the social environments that cause people to want to die. Empirical evidence of the causes or factors that suppress suicide will lead to social policies that reduce suicide. However, people who seem to be blessed financially and in interpersonal relationships, and who seem to have no areas for improvement, may suddenly put an end to themselves without saying anything. This may seem "sudden" to those around them, but it may not be to the person themselves, and they may simply not have expressed their suicidal feelings.

If this is the case, sociological studies of suicide need to examine the social norms surrounding suicidal feelings and what is included and excluded by the common consciousness that recognizes humanity, human life, and health as having the highest value. It is especially important to update social norms by adding "it is okay to disclose suicidal feelings" to the rules of feelings and behaviors, and in the form that disclosing suicidal feelings does not violate the sanctity of individual and "face" and social settings. These may not be supported in a contemporary society increasingly focused on "health" and "well-being" (Yamada 2023a). The idea of equating subjective happiness with moral "goodness"pervades contemporary society (Cabanas & Illouz 2018). Nevertheless, there are many people in society who live in circumstances that do not allow them to be positive. It is clear from the fact that during the COVID-19 pandemic, a large number of anonymous suicidal calls were made.

The seeds of a new society are already germinating. It is a society that neither rejects nor excludes suicidal feelings, that does not suspend thought by leaving it to the specialized systems of medicine and law, that does not shy away from suicidal feelings and recognizes them for what they are.

6. Conclusion

Taking the ambivalence surrounding suicide as a starting point, this paper discussed the mechanism by which respect for human beings inescapably excludes suicide from the perspective of the sociological history of the sanctity of individual, self and emotion, such as *culte de la personne*, interaction ritual, and feeling rules. The abhorrence of suicide inevitably derived from the worship of the individual, discussed by Durkheim in *Le Suicide,* continues to this day. This survey showed that even in this situation, NPO volunteers try to live with people who feel suicidal. If prejudices and taboos are broken down, will the day come when life with suicidal feelings will be considered normal? In closing, I would like to say a few words about the silence that surrounds suicide and suicidal feelings.

To tell the truth, this paper does not mention the inner truth of suicidal feelings. It has built its arguments by looking only at society's reactions to such feelings. We have, of course, interviewed counsellors about their telephone counselling sessions and bereaved families about the circumstances in which their loved one died, taking into account personal information and privacy. These are not discussed here, however.

We chose to remain silent out of respect and reverence for the lives of others. The silence came as a result of the effort to listen calmly their words without any prejudice against suicidal feelings and suicide, despite being overwhelmed. It may be possible to recombine and organize the content of the interviews to say, "These people chose death for themselves because of their difficult circumstances and motivations", for display in a showcase. However, this seemed to be the same as sorting cases by "motive" assuming that we understand inner of deceased. Furthermore, even though it would remove the stigma and taboo surrounding suicidal feelings and suicide, it is not necessary to reveal all of the circumstances that led up to the suicide.

People in charge of the practicalities, such as transporting bodies when a suicide occurs, go about

their work quietly, with an attitude of not interfering and gently leaving things they do not understand without understanding. This attitude is not based on prejudice or taboo, or on a cold disregard of suicides. It is out of respect and consideration for the life of the person who is the victim of suicide. But might this attitude of gently leaving people alone and not interfering (what Goffman might call an "avoidance ritual") ultimately lead to pretending not to see or silently excluding suicidal feelings and suicides? Key to further thinking about living with suicidal feelings is how we view expressions of respect through silence.

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Notes

1) Suicide is the act of deliberately killing oneself. A suicide attempt refers to non-fatal suicidal behavior and intentional self-poisoning and self-harming acts. Suicidal behavior refers to thinking about, planning, or attempting suicide (WHO 2014: 12).
2) Japan's suicide rate is highest among the G7 countries. The Third Fundamental Principles for Suicide Countermeasures aims at reducing the suicide rate by 30% when compared to 2015 by 2026 and bringing it closer to the rates prevalent in other developed countries (MHLW 2022: 37).
3) Four groups: NPO Corporation Suicide Prevention Support Center Life Link, Tokyo Mental Health Square, Corporation BOND Project, and Child Line Support Center.
4) Japan's suicide response is a tug-of-war between the psychiatric approach, which focuses on depression prevention, and the social work and social policy approach. (Takahashi 2012; Moriyama 2021).
5) Religious groups and facilities have conventionally played a key role in suicide counseling (Nara Prefecture 2012), but this paper does not discuss this topic.
6) For the theoretical succession from Durkheim's moral individualism to Goffman's discussion on interaction ritual and Hochschild's keyconcept of emotion management, see the author's work (Yamada 2007: 58–119).
7) In the survey, the participants read a vignette of "Tarō," a boy who displayed a depressive state, and were asked whether they would ask others around them for help if they were Tarō in each setting, based on the severity of symptoms. The results showed that children tended to keep depression to themselves, especially if it was severe.
8) Nishihara Yukiko recalled the first day she began activities at the suicide prevention center in 1978 and wrote that when a child called, sobbing and saying, "I just want to die already," she was convinced that the ones afraid of the words "suicide" and "want to die" are adults and our society (Nishihara 2003: 32–3).
9) Among the symptoms mentioned in the diagnostic manual for depressive disorder in DSM-5, the

American Psychiatric Association's diagnostic standard is "recurrent thoughts of death (not merely fear of death), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide." If at least five of the nine listed symptoms, including "depressed mood" and "loss of interest or pleasure," are present for two weeks, depression is suspected (APA 2014).

10) Another paper by the author (Yamada 2019) discusses in detail how the bereaved family forms an interpretation of suicide when trapped among the administrative, legal, and medical examinations and appraisals of death by the Labor Standards Bureau, courts, and psychiatrists in cases of suicide suspected to be the result of the strain from long working hours or harassment.

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