SELF-HELP GROUPS FOR FAMILY SURVIVORS OF SUICIDE IN JAPAN: FOR EMPOWERMENT, NOT GRIEF CARE

Tomofumi Oka[1], Sachiko Tanaka[2], Hidehiko Ake[2], and Shōko Kuwabara[2]
1. Sophia University
2. The National Association of Family Survivors of Suicide

Abstract In Japan, the number of suicide victims has consecutively been greater than 30,000 since 1998. 'The Basic Act on Suicide Prevention' came into effect in 2006, and public subsidies were provided to numerous professional-led support group meetings for family survivors of suicide. Subsequently, some survivors, who were dissatisfied with the professional-led meetings, started to organize their own groups. Family survivors have developed their peer-led meetings differently from those of professionals. Our article aims to describe how their self-help group meetings proceed and to discuss the advantages of these meetings. This research is collaborative between a social work researcher and three leaders of self-help groups. We conducted qualitative interviews with members of the National Association, who were members of self-help groups, and participatory observations on various group meetings. Compared to professional-led support groups, self-help group meetings share common features. (1) Voluntary participation: self-help groups respect the fact that each person who participates in their meetings does so voluntarily. (2) No outsiders and guests: self-help groups are strictly exclusive to those who have lost family members to suicide. (3) Continuity with every life: self-help groups' meeting structure maintains continuity between the group sessions and the everyday lives of the individual participants. (4) Small subgroups: meeting participants are divided into small subgroups for the sharing of their deepest experiences. (5) No medical models: self-help groups do not treat their members as in any way ill, and stress the grieving is very natural. (6) Permanent communities: self-help group members communicate with each other outside of and between meetings. To conclude, self-help group leaders never treat family survivors as 'mentally vulnerable patients', as professionals would do. They trust all group members and accept them as whole people, not as mere meeting attendees. Therefore, their self-help groups are extremely powerful in empowering family survivors of suicide.

Keywords. Self-help groups; Family survivors of suicide; Empowerment

INTRODUCTION

In Japan, the number of suicide victims has exceeded 30,000 in each consecutive year since 1998. In 2006, "The Basic Act on Suicide Prevention" came into effect, and public subsidies

were provided to numerous professionally led support group meetings for the family survivors of suicide (Takeshima et al., 2008). However, following interaction with others, some survivors expressed dissatisfaction with these meetings, and subsequently began to organize their own group meetings instead (Oka, 2010, 2011; Oka, Tanaka & Ake, 2010). In 2008, they went on to establish the National Association of Family Survivors of Suicide, which includes over 1300 family survivors as members. As of July 2011, there are 23 independent self-help groups for family survivors of suicide in Japan. Each group holds a meeting on a monthly or bimonthly basis.

These family survivors have developed their peer-led meetings in a different manner from those operated by professionals, and this has led to a problem with receiving societal sanctions. Borman and Lieberman (1976) stated that self-help groups "must deal with issues of societal sanctions regarding their role and place in offering aid" (p. 415), and also that an important "pathway for legitimization [of self-help groups] . . . was the use of professionals for sanctioning" (p. 416). However, the family survivors' groups have had difficulties in obtaining such sanction, because the ways in which they conduct their meetings are very different from the methods used in those led by professionals. In addition, the leaders of these groups are very critical about grief care that professionals provide.

Our article aims to both describe the careful processes used in these peer-led self-help group meetings and to discuss the advantages of these meetings, so that related professionals and the wider public understand the extent to which family survivors of suicide depend on them. Very little previous research has been conducted on self-help groups for family survivors of suicide in Japan. This is primarily because groups of this type have existed for only a relatively short time—less than five years—and have never been explored before. The few papers on the subject that do exist are misleading, in that the research presented within them was conducted on participants of professionally led support groups who were mistakenly labeled "self-help groups."

METHODS

In September 2008, two leaders of self-help groups for family survivors of suicide approached a social work researcher to request that he use their groups to conduct a social study. It was hoped that the findings would validate the usefulness of the groups, and that this, in turn, would lead to these groups becoming socially sanctioned by related professionals, as well as by bureaucrats of local and national government. At this point, the social work researcher suggested that the self-help group leaders should also have an active role in the study, and this was agreed to. This research was therefore a collaborative effort between the social work researcher and the three self-help group leaders.

The data were collected in several different ways. The social work researcher, as a non-member of any self-help group, conducted conversational interviews with members and leaders of the National Association. The three self-help group leaders collected observational data not only from their own self-help groups, but also from other self-help groups. They have participated in the regular meetings of 16 self-help groups, which is equivalent to approximately 70% of the total number (23) of such groups of family survivors of suicide in Japan. They also held talks and discussions with the leaders and members of all 23 self-help groups, as well as attending many professionally led support group meetings and workshops for facilitators of these groups, at which they observed activities and interactions and collected a large amount of relevant printed materials.

FINDINGS

In contrast with professionally led support groups, self-help group meetings led by family survivors of suicide share common features. We hypothesize that these characteristics have been developed through active interactions between members of these groups. We have classified the shared features as follows: (1) voluntary participation, (2) no outsiders and guests, (3) continuity with everyday life, (4) small subgroups, (5) no medical (recovery) models, and (6) permanent communities.

Voluntary participation

Self-help groups respect the fact that each person who participates in their meetings does so voluntarily. For example, the group leaders do not strongly encourage family survivors to attend any meetings. Therefore, even if the leaders notice somebody hovering near the door of the meeting room, they do not speak to them; they wait for that person to speak first of their own accord. People may also join self-help group meetings without revealing their real names and addresses. If given postal addresses by meeting attendees, the group leaders carefully avoid sending out “pushy” invitations to future meetings; they send only the necessary information regarding these meetings instead. They know from their own personal experience that, sometimes, family survivors want to be left alone and that it is crucial that the decision made to join a meeting is a voluntary one.

Conversely, many professionally led support groups strongly encourage family survivors to attend the meetings they hold. Some of these groups are also keen to obtain genuine names and postal addresses from first-time attendees, so that they can subsequently use this information to invite them to forthcoming meetings. Furthermore, members of staff are trained to encourage participants leaving after one meeting not to miss the next one. This

"pressurizing" attitude irritates some family survivors.

No outsiders and guests

Japanese self-help groups for family survivors are strictly exclusive to those who have lost family members to suicide: no outsiders or "guests" are permitted to join their meetings. Any and all attendees are allowed, and are also expected to contribute to the meetings by undertaking various tasks, such as preparing and cleaning the meeting room, serving tea, and offering refreshments.

However, in professionally led support groups, family survivors are invited as "guests," rather than as active participants in the meeting. They are welcomed by the professionals and volunteers, who serve them with tea, refreshments and, sometimes, "gorgeous" lunch boxes. Even if the family survivors try to help the staff, their offers are clearly and politely declined with "kind" words or phrases, such as "Oh, no, no, please sit down and relax."

Continuity with everyday life

Monthly self-help group meetings tend to last for several hours, for example, from around noon to late evening, and are divided into a series of varied subsections. Typically, they start with group members chatting very informally with each other on arrival in the meeting room, while group leaders speak to newcomers before the official meeting start time. The participants therefore feel that they have been made welcome. At the proper start time, the formal part of the meeting begins, and each person briefly introduces themselves to everyone else. If there is sufficient space, the attendees are then divided into small groups, and in each group, the members share very deep experiences and feelings (see below for further discussion). After this sharing session, the small groups break up, the meeting reverts to a whole group situation once more, and the participants chat freely with each other again. During this period of chatting, tea and refreshments are served. The leaders refer to this relaxing period of informal talking as "cooling down," and stress that it is important for attendees to have this time, because it helps them to "cool it" and to slip back into the routine thoughts, feelings, and behaviors of their everyday life. After the formal meeting has ended, available attendees are invited to another meeting in a public place, such as a coffee shop, a restaurant, or a bar. Outsiders are permitted to join this informal meeting; for example, journalists who want to report on the group may talk with the members at this time. This meeting structure maintains continuity between the group sessions and the everyday lives of the individual participants. This continuity not only allows members to gradually prepare to reveal and share their deepest feelings in the small-group session, but also to revert to the behavior of their usual lives during the large relaxing "cooling down" session and the

subsequent, more public, talks.

Some members complained that professionally led support group meetings have no such structures. If anyone arrives before the meeting start time, they must wait alone, either outside or inside the meeting room, as if they are in the waiting room of a clinic. At the end of the meeting, they must vacate the premises soon afterwards, as the availability of the professional staff is often limited, as is that of the meeting room, which is often in a busy, public building used by the mental health service. As a result, some attendees had to suddenly stop crying when the facilitator announced that the meeting was at an end, and subsequently, had to leave the room alone while still wiping the tears from their eyes. In other groups, the participants are always given a feedback sheet, and are required to fill in a form to evaluate the group session, which implies that the service provided by the group ends at that moment. There is thus no bridge between the end of the participants' therapeutic sessions and the return to their everyday lives.

Small subgroups

As stated above, participants are divided into small subgroups for the sharing of their deepest experiences. These divisions are normally made according to the relationships of the individual participants to the deceased family member. Parents, children and spouses are usually kept apart, as, for example, a woman could hardly express her anger at, and grudge against, her deceased son's wife, who was unable to save her husband, in the presence of another woman whose husband had died by suicide. It is thought that the proper number of participants for these small subgroups should be less than from six to eight, and, as it is considered that the facilitation of such groups requires no special training or knowledge, it is rarely difficult to find volunteers to undertake this task.

In contrast, professional-led support groups often hold only large meetings, for all participants, without any breakdown into smaller groups at any time. This is probably because of the limited availability of trained facilitators; it is believed that high-level skills are required to facilitate such meetings. However, the family survivors sometimes find it difficult to share their experiences with those whose relationships are different, as described above, so for them a whole-group situation is not ideal. In addition, it is often too hard for many survivors, especially those who have lost their loved one only recently, to listen to the stories of others for any length of time without having the opportunity to share their own experience.

No medical (recovery) models

Professionals and volunteers generally use a medical, or recovery, model, through which they

stress the importance of survivor recovery from the grief they are suffering. However, use of a model of this type could lead to several problems.

First, the medical model often makes survivors feel worse. For example, the leaflets produced by the support groups often not only include a long list of mental, physical and behavioral problems, but also state that family survivors are likely to suffer from these difficulties. Furthermore, these problems are described in exactly the same way as one would explain a chronic disease. A typical example of this is "anniversary reaction"; many support groups suggest that family survivors are likely to have severe grief reactions on the anniversary of the death of their loved one. Leaders and members of self-help groups are upset and offended by being labeled as mentally vulnerable. Furthermore, they claim that such a long list of problems forces survivors to feel worse, almost as if it is predicting that they will definitely face these difficulties at some stage in the future. Self-help groups, on the contrary, do not treat their members as in any way ill, and stress that grieving is very natural. Any theories in which survivors have to recover from their grief are rejected; instead, it is suggested, through sayings like "Our recovery is impossible," and "Grief is part of our body," that survivors choose to lead a life with their grief.

The second problem with using the medical model is that it means that support groups ignore the social and economic aspects of survivors' problems. The members of staff accept nothing but what they are trained to accept, that is, psychological or psychiatric problems grasped in the theoretical framework of grief care. Conversely, self-help groups are well prepared to accept and address any problems that members are undergoing in their lives, including monetary problems and social discrimination.

Finally, support groups are quite wary of troublemakers. In workshops catering for professionals and volunteers as facilitators of support groups for family survivors of suicide, there is much discussion around how to deal with people who may cause trouble by disturbing the meetings and causing distress or harm to other members. This attitude might be inevitable if support group professionals and volunteers do indeed consider family survivors to be people with severe mental illness. Conversely, leaders of self-help groups do not believe that they need any strategies to cope with such problems, because they claim never to have faced troublemakers like those described. The absence of such people might be related to the emphasis self-help groups place on voluntary membership.

Permanent communities

Leaders of self-help groups are frequently ready to listen to and give group members telephone advice whenever their members need help, indeed many leaders have described episodes in which they have spent hours late at night talking on the phone. Leaders and

members exchange emails and messages through blogs and online bulletin boards around the clock. People also meet freely, and go to dinner, shopping and karaoke together. Family survivors of suicide in Japan tend to isolate themselves, but they feel that they can enjoy social activities with other self-help group members without any fear of being misunderstood. For example, on seeing a man singing in a karaoke bar, a group leader remarked to one of the authors of the present study, "He can enjoy karaoke with us, because we all know he has lost his only child. We all know even if he looks as if he is singing merrily [he still has a great grief]." Another leader added, "We are a community and a big family."

In contrast, the support of professionally led support groups is usually limited to that which is offered during the group sessions. Attendees are discouraged from both exchanging personal details and from communicating with each other outside of the meetings, in the same way that addicts are deterred from associating with each other outside of their therapy sessions. Professionals and volunteers are usually unavailable outside of the meetings, and the attendees are asked to use other resources if they need help in the meantime.

CONCLUSIONS

Self-help group leaders never treat family survivors as "mentally vulnerable patients," which is in direct contrast with professionally led support groups. The latter groups also apply the treatment methods and concepts ordinarily used for patients with mental illness to the facilitation of group meetings. Self-help groups trust all group members and respect their voluntary participation. They accept the group members as whole people, not as mere meeting attendees or as unilateral recipients of their help. All of the differences between peer-led self-help groups and professionally led support groups discussed above are linked to the difference between the existence and the lack of empowerment perspective. In other words, peer-led self-help groups are extremely powerful in empowering family survivors of suicide.

The self-help groups say publically that they do not appreciate current government policy, because it attaches too much importance to psychological or psychiatric care for family survivors, much of which can be provided by these groups. However, they do admit that some family survivors will need professional help if they suffer from mental illness. To this end, the National Association of Family Survivors of Suicide has appealed that the central government assign more social workers, not psychiatrists, psychologists, or grief-care specialists, to support family survivors of suicide; these people may have many social and financial problems that they may find difficult to solve without the help of social workers. Social workers should never follow the example of psychiatrists or psychologists in trying to provide grief care. Rather, they would more usefully be employed in working with self-help support groups to help empower family survivors of suicide.

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Address for correspondence

Correspondence concerning this paper should be addressed to Tomofumi Oka, PhD, Professor of Social Work, Department of Social Services, Sophia University, Kioi-cho, Chiyoada-ku, Tokyo, 102-8554, Japan. Email: t-oka@sophia.ac.jp