Self-Help Groups, Self-Help Supporters, and Social Work: A Theoretical Discussion with Some Case Illustrations of Family Survivors of Suicide in Japan

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The purpose of this article is to offer theoretical guidelines to social workers in Japan who have contact with self-help groups, though not necessarily providing such groups with their support or help. The theoretical framework focuses on two points: first, the conceptual differences between peer-led self-help groups and professional-led support groups; second, the characteristics of a new type of professional known as "self-help supporters." This paper then discusses the differences between self-help supporters and traditional professionals. We hope that the insights provided by our research will help Japanese social workers to extend their practice so as to take the work of self-help supporters into account. While many professionals working with self-help groups in Japan are "therapists" (for example, doctors, nurses, and psychotherapists) and focus on individual sufferings or ailments, a social worker concentrates on groups and organizations, social issues, and the social and environmental problems faced by the groups. Social workers could greatly contribute to the development of self-help groups if they act as self-help supporters.

In Japan, many scholars have not yet arrived at a clear consensus on the definition of self-help groups and support groups, and the confusion has been further aggravated by recent changes in the college-level curriculum for certified social workers in Japan (Ministry of Health, Labour and Welfare, 2008). Under the new curriculum, social workers are apparently expected to help a self-help group that is assumed to have evolved out of their social work. We are concerned that social workers who are trained under this new curriculum might want to help self-help groups in a way different from what is expected of them. This is another reason that we decided to introduce a "self-help supporter" model for Japanese social workers.

To illustrate and explore these issues, we have used two kinds of materials. The first source of information has been taken from Oka's three-year fieldwork and participatory action research with Japanese self-help groups for family survivors of suicide (Oka, 2010b, 2011; Oka, Tanaka, Ake, & Kuwabara, 2011). Because some leaders and members of the self-help groups have used professional-led support groups for family survivors, we used, to describe these support groups, not only the literature on support groups but also the experience of the members of these groups. Additionally, Oka had reviewed the literature discussing issues of grief, which was relevant to self-help groups for family survivors of suicide. We chose self-help groups for family survivors of suicide for two main reasons. First, we thought that nowhere in Japan is the difference between peer-led self-help groups and professional-led support groups more controversial and disputed in terms of social policy than in the field of support for family survivors of suicide. Shimizu (2010), Jishi-Izoku-Kea-Dantai-Zenkoku-Netto (2009), and the Ministry of Health, Labour and Welfare (2011) have partially discussed these issues. Second, because such groups have been organized recently in Japan, little social research has been conducted on them and Japanese social workers know almost nothing about them. We also introduce some interesting theoretical discussion on issues concerning the grief-work approach because Japanese self-help groups do not appreciate this approach (Oka, Tanaka, & Ake, 2010) and theoretical discussions in English refuting this approach are not yet widely known in Japan. While we use the self-help groups for family survivors of suicides as our primary case study, we believe that our comments are applicable to many other self-help groups too.

We also use more theoretical material, mainly provided by Borkman's long and detailed studies on self-help groups and her involvement in global discussions and collaborations supporting self-help groups. As the editor of the *International Journal of Self-Help and Self-Care*, the only international journal dedicated to studies on self-help groups, Borkman is one of the few scholars qualified to discuss issues from this international perspective.[1]

1. Self-Help Groups and Support Groups

We have emphasized that it is crucial, especially for human service

professionals who want to work with peer-led self-help groups or professional-led support groups, to understand the differences between these two groups (Oka, 2010a; Oka & Borkman, 2000; Oka & Takahata, 2000).[2] The most important distinction between self-help groups and support groups lie in their ownership, that is, whether they are directed by peers or professionals (White & Madara, 2002). In self-help groups, only peer members possess decision-making powers about their group, on issues such as how to hold the meetings, what "meaning frameworks" are to be adopted, what organization structures organizations are required, and in an extreme case, whether their groups could be dissolved. On the other hand, support groups are supervised and sponsored by professionals, who are primarily responsible for what happens in these groups.

Some authors (for example, Hurvitz, 1977; Lieberman, 1990) discuss the above differences mainly from a psychological perspective, considering a self-help group as a form of peer-led group psychotherapy. In contrast, we would like to explain the social aspects of these differences. From the social perspective, these discrepancies can naturally vary according to the social context, time, and issues concerning the people. For example, while placing support groups in between self-help groups and psychotherapy groups, Kurtz (1997) observes, "self-help groups typically admit anyone who qualifies for membership; therapy groups do not. Professional psychotherapists charge fees for their services in the group; self-help groups rarely charge a fee" (p. 6). However, in Japan, these differences are not evident amongst those supporting the family survivors of suicide, as professional-led groups in Japan are maintained by public mental health service organizations or well-subsidized private organizations, and hence, any family survivor can utilize their services for free. In short, the differences between self-help groups and support groups may be difficult to generalize.

We analyzed the differences between the two types of groups particularly in the context of their support for family survivors of suicide in Japan, because understanding them would help us to comprehend why a fierce dispute has arisen between family survivor leaders and some bereavement professionals. According to Oka's fieldwork, the differences can be classified under the following three categories: philosophy, community, and advocacy.

1.1 Philosophy: "Liberating meaning perspectives"

Mature self-help groups have developed their own frameworks in which problems are identified, conceptualized, and solved in ways different from those used by professionals. The frameworks of self-help groups have attracted the attention of many scholars. For example, Antze (1979) called the framework "ideology" and stated:

> Each self-help group claims a certain wisdom concerning the problems it treats. Each has a specialized system of *teachings* that members venerate as the secret of recovery . . . . I have chosen to call such teachings "ideologies." . . . This term includes not only the group's explicit beliefs but also its rituals, rules of behavior, slogans, and even favorite expressions. (p. 273)

This term was also used by Suler (1984) and Kurtz and Chambon (1987). However, after the 1990s, few articles used this term, probably because it is likely that "people misinterpret the term 'mutual help ideology' to mean that mutual help [self-help] groups are cult-like or somehow more ideological than are professionals or other groups" (Kennedy & Humphreys, 1994, p. 182). As an alternative to "ideology," Kennedy and Humphreys (1994) suggested a term "worldview" meaning "assumptive world," but this term has rarely been used so far. In these authors' discussion, both terms—"ideology" and "worldview"—are closely related to a psychological phenomenon. However, scholars in this field have not paid much attention to social conditions, especially the oppressive conditions that the members of these self-help groups live in.

On the other hand, the concept of "a liberating meaning perspective" as suggested by Borkman (1999) includes social factors. She states:

> People with stigmatized conditions need a liberating meaning perspective that can free them of self-hate, a negative self-identity, and assumptions that they are inadequate. They need to redefine their humanity. Moreover, they need a constructive way of dealing with their problem. (p. 115)

The term "liberating meaning perspective" is more useful than other terms to illustrate the extent of the differences between self-help groups for family survivors of suicide and support groups led by bereavement professionals.

This is because this concept is more socially oriented and self-help groups refuse to consider themselves "psychotherapy" groups. In the subsequent section, we will illustrate the liberating meaning perspectives of family survivors of suicide in Japan and their social backgrounds, including the counseling services provided for them.

Professional service and the grief-work approach

First, let us describe the social context in which self-help groups operate. Japan has had a high suicide rate for a long time (McCurry, 2006; Yamamura et al., 2006), and consequently, there are about three million family survivors in the country (Chen et al., 2009). The government decided to adopt national suicide prevention measures through postvention, supporting and treating family survivors of suicide (Yamashita et al., 2005). As a result, many professional-led support groups for family survivors of suicide were started in many places (Khan et al., 2008).[3]

The following are important facts about professionals who work with family survivors of suicide: First, Japanese professionals rarely question the effectiveness of the grief-work approach in supporting bereaved families. According to Breen (2010-2011), "research has demonstrated that grief interventions for those with 'normal' grief tend to be minimally, if at all, effective" (see also, Currier, Neimeyer, & Berman, 2008; Jordan & Neimeyer, 2003); however, Japanese bereavement professionals seem to have rarely discussed the results of such studies. Under such circumstances, family survivors, despite finding professional-led support groups ineffective in their own experience, would not find it easy to publicly criticize such groups.

Second, Japanese bereavement professionals basically use the grief-work approach and the stage theory of grief in practice (Jishi-Izoku-Kea-Dantai-Zenkoku-Netto, 2006, 2007, 2008). The summary provided by Breen (2010-2011) after reviewing the literature on the practice of grief counseling agrees with the Japanese situation. She states:

> Despite [the counselors'] acknowledgment that the stages are not progressive or necessary, the counselors believed that grief is time bound and clients could become "stuck" within particular stages, and many prioritized facilitating "closure" of the relationship between the

> client and the deceased. . . . These understandings of grief align with the grief work hypothesis, which is the notion that healthy grief necessitates the expression of the pain of grief in order to complete the grief process. . . . The grief work hypothesis . . . was fundamental to several theorists' constructions of grief as a finite and stage-based response to bereavement. Despite the emergence of an empirical and theoretical critique of the grief work hypothesis . . . , it continues to shape the understandings of grief presented in university curricula and post-university training across multiple disciplines. (p. 286)

According to Bonanno and Kaltman (1999), "Several highly critical reviews [of the grief-work perspective] have appeared in the late 1980s" (p. 771), and criticisms or skepticism of the stage theory of grief have been expressed in English papers (Holland & Neimeyer, 2010; O'Rourke, 2010). Various statements pertaining to the stage theory of grief are interpreted as "myths" supported by little scientific data (Holman, Perisho, Edwards, & Mlakar, 2010; Konigsberg, 2011). However, this theory has rarely been challenged in Japan.

Consequently, many professional-led support groups in Japan seem to operate with the stage model of grief, and the participant survivors feel encouraged to move to the next stage and finally achieve a state of resolution. For these professionals, "'chronic grief' or failure to recover is identified as a major type of 'pathological' mourning" (Wortman & Silver, 1989, p. 352). Hence, "unrealistic assumptions [on grief] held by health-care professionals and the social network may also unnecessarily exacerbate feelings of distress among those who encounter loss, and lead to a self-perception that their own responses are inappropriate and abnormal under the circumstances" (Wortman & Silver, 1989, p. 355). Because some professionals in Japan need to obtain data on how effectively their service works, they ask the participants of their support groups to evaluate the progress of their "recovery" whenever the support group meeting ends. This kind of self-examination, which takes place according to the scales set by the professionals, may lead to a more negative self-image of the survivors, because whenever the participants examine their state of mind, they find that their recovery is yet to be realized and therefore consider themselves imperfect and insufficient.

Additionally, in cultural contexts, this grief-work approach, "in which the ultimate goal is the severing of the attachment bond to the deceased" (Bonanno & Kaltman, 1999, p. 760), might be hard for the bereaved to accept (Yamazoe, 2011). Culture greatly influences type of relationship with the deceased (Rosenblatt, 2008). The grief-work approach reveals "the culture-bound nature of prevailing North American practices, which view grief as an isolated individual experience and emphasize detachment from the dead as a way to promote recovery" (Shapiro, 1996, p. 313). According to Shapiro (1996):

> Many of the mental health field's assumptions about bereavement . . . are riddled with an unexamined combination of cultural and professional assumptions that support the cultural and professional status quo. These widely held assumptions include: belief that . . . bereavement has a specified endpoint; and that an ongoing relationship with images of the deceases is pathological. (p. 314)

Scholars believe that many concepts used in grief counseling are so scientific that they are generalizable across cultures; however, these concepts are culture-bound in reality. Repeating what Stroebe et al. (1992) said, we believe that Japanese readers must remember that:

> Principles of grief counseling and therapy follow the view that, in the course of time, bereaved persons need to break their ties with the deceased, give up their attachments, form a new identity of which the departed person has no part, and reinvest in other relationships. (pp. 1206-1207)

A Japanese family survivor of suicide said in a public discussion meeting, "We feel extremely reluctant to accept an idea of getting through 'grief work' to a new identity at last" (Jishi-Izoku-Kea-Dantai-Netto, 2010, p. 62). This remark explains the cultural differences.

As pointed out by Klass (2001, p. 751), "continuing bonds with the dead remain an enduring part of Japanese culture," in contrast with other cultures in which detachment from the dead is emphasized. The Japanese believe that the "spirits of the dead interact with the living" (Klass & Goss, 1999, p. 550). Moreover, Klass offered a historical and religious perspective on this issue, which most Japanese scholars had probably never thought of. He states, "Throughout Western history, bonds to the ancestral dead

representing family, clan, or tribal membership have been periodically suppressed in favor of bonds to God that more directly support the power of the standing order" (Klass, 2001, p. 759). Further, in Christian history, "there is a continual tension between heaven as a human place, which continuing bonds with those we loved on earth, and heaven as a non-human place, where the triviality of human relationships are replaced by the bond or union with God alone" (Klass, 1999, p. 169). This is one of the reasons that in Western countries, "for much of the 20th century continuing bonds had been regarded an indicator of pathology in grief" (Klass, 2006, p. 844).

The above discussion explains why many Japanese family survivors of suicide decided to organize self-help groups by themselves after being disappointed by professional-led support groups. The former groups have developed their liberating meaning perspectives, which are discussed below.

"Living with grief"

The fact that Japanese professional-led support groups are often found in mental health centers or mental hospitals shows that professionals consider the problems faced by family survivors of suicide within the theoretical frameworks of mental health. According to members of self-help groups, this is one of the reasons survivors are not attracted to support groups. Some survivors even distrust mental health professionals, as the latter had already failed to prevent the suicide of their loved ones, who were victims of mental illness, and after such misfortunes, the survivors had sad memories of the hospital and consequently found it difficult to approach mental hospitals. Additionally, family survivors do not like to be treated as mental patients. However, professionals following the grief-work approach are apt to consider survivors who are extremely grief-stricken as being in the process of recovery and treat such survivors as if they require guidance and protection.

In contrast, the self-help groups of family survivors of suicide reject this "pathologization of grief" (Granek, 2010) and consider living with grief normal. The self-help groups for family survivors of suicide stress the importance of "living with grief" rather than trying to recover from grief as patients who need professional care. Once the family survivors accepted this

liberating meaning perspective, they are ready to overcome the negative self-perception that has been imposed by professionals who consider the former's continuing grief pathological. They no longer consider themselves powerless. The inner strength they feel while rejecting the given goal of recovery is probably what Bonanno (2004) calls "resilience":

> The term *recovery* connotes a trajectory in which normal functioning temporarily gives way to threshold or subthreshold psychopathology (for example, symptoms of depression or posttraumatic stress disorder [PTSD]), usually for a period of at least several months, and then gradually returns to pre-event levels. Full recovery may be relatively rapid or may take as long as one or two years. By contrast, *resilience* reflects the ability to maintain a stable equilibrium. . . . Resilience to loss and trauma . . . pertains to the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning. A further distinction is that resilience is more than the simple absence of psychopathology. . . . Resilient individuals . . . may experience transient perturbations in normal functioning (for example, several weeks of sporadic preoccupation or restless sleep) but generally exhibit a stable trajectory of healthy functioning across time, as well as the capacity for generative experiences and positive emotions. (pp. 20-21)

According to Oka's interviews with leaders of self-help groups for family survivors of suicide, members of such groups in the meeting consider any kind of stories that the bereaved participants recount normal and "OK," and not "crazy" or a symptom of mental illness. For example, a mother expressed her strong anger at her deceased son's wife, revealing that she had made a straw doll to curse her. A couple described their loved child's rotten and damaged corpse in detail. A pair of parents confessed that they were so sad that they had eaten their daughter's ashes little by little. These stories might frighten those who have never had similar experiences and make them believe that these participants may need professional care or

counseling. However, the self-help group members listen to such stories and accept them as normal reactions to overwhelming grief.

"Our grief is also ours"

In professional-led groups, the professionals often offer their clients explanations of what is happening to their mind and how they can overcome or recover from such grief. They elucidate on the nature of grief, possible psychological and physical symptoms related to it, and psychological theories such as the stage model for recovery. Hence, professionals tend to show that they know more about grief than the survivors do. Bereavement professionals treat grief as oncologists treat cancer, trying to remove grief from the survivors' mind as doctors eradicate a disease from patients' bodies.

On the contrary, self-help group members claim that their grief is something belonging to them alone, not for others to deal with; that they know their grief more than someone else who has never experienced it does; and that nobody else is more eligible to talk about their grief than they are as survivors. They neither want nor allow professionals to treat their grief as if it were an illness. They publicly declare, "Our grief is as much ours as our bodies are." Leaders of self-help groups like to quote a fact about an ancient Japanese verb, *kanashimu*, which means both "love" and "grieve," to show that love and grief cannot be separated in traditional Japanese sentiments. Survivors grieve because they love, not because they suffer from a disease (Oka, 2011). We can also call the above claims "experiential knowledge," as Borkman (1976) states:

> Experiential knowledge is truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others. . . . the term "experiential knowledge" denotes a high degree of conviction that the insights learned from direct participation in a situation are truth, because the individual has faith in the validity and authority of the knowledge obtained by being a part of a phenomenon. (pp. 446-447)

1.2 Community

Another large difference between self-help groups and support groups is that whereas support groups basically work as a temporary group session, self-help groups function as a continuing community where people can also interact outside meetings. Such communities in which family survivors can freely talk are crucial because these survivors are often very isolated in their original community (Feigelman, Gorman, & Jordan, 2009; Jordan & McIntosh, 2011). Cerel, Jordan and Duberstein (2008) point out that a family member's suicide can distort communication between the family and members of their surrounding social networks in three ways: the family being blamed for the suicide, maintaining secrecy about the cause of the suicide, and isolating themselves. We will show that a self-help group works as a community for family survivors by providing human social networks that are always available as support and by keeping continuity between meetings as members carry out their everyday activities together.

Round-the-clock support and friendship

In "a schematic, ideal-type contrast between the professional and the aprofessional modes of human services," professional service is provided within limited time, while in self-help groups as an aprofessional system, time is not a constraint (Gartner & Riessman, 1977, pp. 110-111). As an example, professional-led support groups offer help during the allotted two- or three-hour group session held monthly or bimonthly. Obviously, professionals and volunteers do not reveal their private telephone numbers to group participants, and they prefer not to talk to survivors outside the group sessions. According to Jordan and Neimeyer (2003), "it is possible that the dosage (how many sessions) and timing (when they were delivered) of treatment were simply too 'weak' to produce measurable effect" (pp. 773-774).

Self-help group leaders often point out, "They [support group staff] help only for some hours once in one or two months. How can it be helpful?" Some leaders say that they share their private phone numbers with other members, and that they are ready to help any survivor in a crisis, round the

clock. Not only leaders but also each member provides help. Whereas professional-led support groups generally discourage participants from exchanging their personal email addresses or phone numbers, self-help groups work as a place where people make friends—as seen in the following extract from Feigelman and Feigelman (2011), who studied suicide survivor groups:

> Again and again we heard that new friendships with other survivors were extremely important for these survivors in helping them to feel better. Many survivors found their social networks shrinking after their suicide losses, as some close family members and friends said hurtful things about their lost loved one or suggested accusative roles for their parts in the demises of their loved ones. In other cases, significant others' failures to acknowledge the loss and avoidance actions left survivors with hurt feelings. Others bereaved by suicide or other sudden death losses almost always knew what to say to show compassion and to act supportively to a survivor. (p. 182)

The participants of a self-help group meeting are expected to support each other before and after as well as outside the meeting, thereby facilitating mutual aid.

Continuity between group sessions and everyday life

Support groups follow meeting formats different from those followed by self-help groups, owing to the restricted time frame. In a support group, professionals and volunteers work within a tight schedule; hence, they start and end meetings on time. A leader told us that she had to wait alone in silence for the meeting to start; again, in a meeting, a participant was still narrating her story in tears, when much to her embarrassment, she was suddenly asked to stop as one of the staff members announced, "Sorry for interrupting you, but our meeting has to be closing, now." A support group meeting is usually held in a busy building meant for mental health service or other public utilities, so any meeting has to end on time. After the meeting, the support group staff resume their own business and the participants are left alone. As participants are often discouraged from talking to each other

outside the meeting, their discomfort worsens.

In contrast, self-help groups are not bound by time constraints. As a result, the gatherings of a self-help group tend to last a longer time. To explain the difference between such meetings and professional-led ones, we describe a meeting conducted by the self-help group, as follows: Key members arrive an hour or more prior to the time set for the meeting to open, in order to welcome participants and newcomers and start conversing with them so as to become familiar with them. The meeting begins, and each of the participants introduces his- or herself to the whole group briefly. Then, they are divided into small groups according to their relations with the lost ones, for instance, a parent group, child group, and spouse group. The most intensive experience-sharing takes place in these small and homogeneous groups, the homogeneity of which is rarely realized in professional-led support or therapy groups, and the lack of this homogeneity can explain why the latter group's service is ineffective (Jordan & Neimeyer, 2003). Thereafter, all participants come together again for an informal chat over tea and refreshments. The leaders call this process "cooling down" because it helps the participants to compose themselves and divert their attention towards socialization. After the formal meeting ends, the participants are invited to an informal gathering in a coffee shop or a Japanese-style bar, where they enjoy talking freely in an open space for hours. Sometimes, after eating or drinking, they go to a karaoke bar to sing merrily together until midnight. While comparing her self-help group and a support group, a family survivor of suicide said,

> If anybody but a family survivor said to me, "You are cheerful," I would be offended. Even if I looked so, I would say, "What? How come you can understand me?" However, if a family survivor said to me, "You are always cheerful," I would say, "Yes, yes," because they know I am in my grief. So, I can laugh. Even if we laugh loudly, we will accept it. In our self-help group, we laugh. . . . [On the other hand,] when I joined a support group to share my experience, I found nobody laughing. It's like a funeral. I felt very suffocated. The staff treated me as if it's a funeral. [The staff were] very quiet and wore black. Nobody talked. I am not always sad. Family survivors do not always weep. It depends on days. [So, that support group] made me feel that I had to show my tears to them. I was aware that I was reluctantly

playing the part of "family survivors in grief." (Jishi-Izoku-Kea-Dantai-Zenkoku-Netto, 2009, p. 69)

Because a self-help group is not a therapy group but a community, the members can laugh.

1.3 Advocacy and empowerment

A third important difference between self-help groups and support groups is that the professionals who sponsor support groups rarely help survivors to cope with concerns beyond their psychological or intrapersonal problems. They show an interest in only issues that they are professionally adept to deal with. However, survivors have to face various financial, social, and legal issues, too (Tanaka, 2009). Self-help groups provide constant support to such survivors, tackling any problem that they might have. Further, considering survivors to be merely in a socially disadvantageous situation and not vulnerable or powerless, self-help groups make efforts and take actions to safeguard the social rights of the survivors.

Combating social stigma

In Japan, suicide has sometimes been viewed as "a moral act" (Young, 2002). However, according to Leenaars et al. (2002), "there is still strong stigma toward suicide in Japan. When suicide unfortunately happens, Japanese people behave as if nothing took place. . . . Survivors themselves feel that suicide is a shame for the family, wish to be left alone, and do not seek help from outsiders" (p. 195). Under such circumstances, since June 2010, the National Association of Family Survivors of Suicide has been waging a campaign against the social stigma and discrimination suffered by these survivors, even taking social action to enact anti-discrimination legislation for them and creating public awareness about their social problems (Zenkoku-Jishi-Izoku-Renrakukai, 2011).

The webpage of the aforementioned national self-help organization describes various bitter experiences of family survivors of suicide, caused by social stigma. First, survivors are apt to have financial problems. For

example, the owner of an apartment house in which a woman died by suicide demanded compensation from her family for the damage caused to the reputation of the house. The owner claimed that few people would want to rent a room in a house where people died by suicide. The amount demanded included the cost of rebuilding the apartment house, compensation for the loss of rent, and a fee for "purifying the place" by a Shinto ritual (see also, Buerk, 2011; Hiratate, 2010; Ryall, 2010). Second, these survivors are often tormented by priests on whom they have to depend in funerals, because the priests consider suicide a religious sin and some even predict that the souls of the victims would go to hell. In an extreme case, a person who died by suicide was given an unconventional name meaning "suicide" (it is customary for priests to give Japanese people Buddhist names after their death). Third, family survivors have to undergo various hardships while explaining the circumstances in which they found the corpse of their loved one; they are often the first persons who come to know of the suicide and have to repeat what they had seen to the police, and all this could be extremely traumatic. In some cases, the police even censure the survivors for having touched the corpse, as had occurred in a particular case where the son, making a last attempt to save his father, had tried to release the corpse of his father, who had hanged himself. Clearly, survivors are generally looked down upon and humiliated not only by the police but also by the victims' teachers, employers, etc., who are strongly prejudiced against the family survivors.

Hence, in their campaign for anti-discrimination, leaders of self-help groups usually state that the victim had undergone *jishi* [self-death] and not *jisatsu* [self-murder], which is the term commonly used to refer to suicide in Japan. Using a word with less negative connotations is expected to not only bring some solace to the family survivors but also teach people to be sympathetic to the survivors. Thus, these leaders want people to consider suicide as "normal death" and to refrain from discriminating against the deceased.

Helping family survivors resolve legal issues

Family survivors often have to seek legal help. For example, in the

example we previously mentioned, the parents filed a case against the real-estate owner who had claimed that their child's suicide devalued the property and had demanded compensation. Others sued the school for failing to control bullying among children, because they claimed that this bullying had forced their child to die by suicide. A woman filed a suit against her husband's company for having overworked him, which had driven him to die by suicide (see Kawanishi, 2008). However, family survivors find it very hard to take legal action, partly because in many cases, they are already under financial pressure, and therefore, bearing the cost of a lawsuit is difficult. Further, taking legal action to resolve such issues is relatively rare and difficult in Japan. Finding a trustworthy lawyer is also problematic if the survivors happen to live in small cities. Since lawyers in small cities and towns treat big companies and schools as important customers, few dare to help isolated small families who want to bring suit against them. Professional-led support groups are not helpful in dealing with such social and legal issues because the concerned professionals think that their role is restricted to "psychotherapy" rather than providing legal or other non-therapeutic aid.

Thus far, we have discussed the differences between professional-led support groups and peer-led self-help groups. As many professionals do not make any distinction between these two kinds of groups, they have probably established or facilitated support groups under the name of "supporting self-help groups." Our next question is how professionals should change their ways of supporting self-help groups if they are aware of the differences between support groups and self-help groups. To consider this, we will discuss a new type of professional—"self-help supporters"—in the following section.

2. Self-Help Supporters and Traditional Professionals

As a second pillar of the discussion, we explain a relatively new term "self-help supporter," which refers to a professional, official, or anyone who is not a peer of the members of a self-help group but who respects the autonomy and integrity of the group and works as the members wish. The literature on self-help groups demonstrates that some professionals respect a

self-help group's capacity to make their own decisions and assist the group if and when requested to do so by the group (Borkman, 1999; Farquharson, 1995; Wilson, 1995). However, in general, scholars have not agreed upon a term or name for such people.

Borkman learned about self-help supporters through her first research, in the 1970s, on a self-help group for people who stutter. A speech therapist helped initiate the group. His private speech therapy clients became the first group members. He obtained space for them in a university building, helped them advertise to gain more members, and suggested speaking activities that they could share with the public. When the group was on a solid foundation, the therapist withdrew, stopped attending their meetings, and only gave suggestions when the group requested advice. A second self-help supporter that Borkman met was the director of a self-help clearinghouse or resource center in the northeast US in the 1980s. Borkman asked her how she happened to get involved in developing and directing the resource center. The director, a social worker, replied that she had been running a therapy group for women on welfare to help them become employed and financially independent. Over time, the women in her group became depressed and discouraged, and showed an increasing number of symptoms of mental problems. Meanwhile, the social worker became aware of a nearby self-help group for women on welfare. She saw them become empowered by taking part-time jobs and classes, gaining skills and experience, and becoming more hopeful and confident with each other's encouragement. This prompted the director to quit her job as a therapist and work through the self-help clearinghouse as an ally assisting self-help members and their groups.

Borkman (2006) referred to such professionals as "sympathetic professionals" who respect and learn from the experiential knowledge of self-helpers; are allied with self-help groups as partners, not dominators; and assist, not control, self-help and mutual aid efforts. In contrast, traditional professionals have "an exclusively professional point of view which rejects, or sees only a minimal role for any alternative forms of helping or social support" (Farquharson, 1995, p. 82), and consequently, frequently attempt to control, lead, or otherwise interfere in the natural operations of the group "for their own good." Between these two extremes are professionals who value some aspects of the autonomous functioning of self-help groups.

Under such circumstances, the term “self-help supporter” is gaining currency as a much-needed concept to denote professionals, officials, and other outsiders, as described above, who respect the self-help and mutual aid approach, recognize and explain its value to the participants and society, and are willing and able to assist and support self-help groups on their own terms. In the following sections, we will illustrate five features of self-help supporters: respect for self-help groups, familiarity with the diversity of self-help groups, understanding a self-help group as a normative community, responsive orientation and social education, and controlling the “two-hat issue.”

2.1 Respect for self-help groups

We will illustrate with a thought experiment how a self-help supporter would approach and regard a self-help group. Assume that a self-help group is like a group of Ph.D. physicists who are meeting to improve their communication skills for some reasons. Because physicists are accomplished and intelligent people, you, as the human service professional, would not treat them as helpless or powerless, nor presume to know what they need, nor assume you know how they want to meet together in their group, nor rush in and try to take over the group. A self-help supporter will accept the members as individuals with their strengths and limitations, believe that they have their own problem-solving capacities and the ability to develop and change themselves and their society, accept them as members of communities with cultural values and problem-solving approaches, recognize that their experiential knowledge is different from professional knowledge, and respect their autonomy and integrity.

The above attitudes, beliefs, and values are the ideal way in which leaders and members of self-help groups want to be approached by social workers and other health professionals. Wilson (1995) found that many leaders and members of various self-help groups wanted to be treated with respect as intelligent people who knew a great deal about the issues from their personal experiences and were able to choose the kind of help they required, the person from whom they would like to get help, and the methods they would like to apply to resolve or cope with the issue.

Thus, self-help supporters respect people and their groups and

organizations. They look at the strengths of the self-helpers, not their weaknesses. Their attitude is congruent with the strengths perspective (Saleebey, 2008), a well-known social work perspective.

2.2 Familiarity with the diversity among self-help groups

In Japan, professionals who support self-help groups are generally therapists for the same problem that the groups address. For example, almost all professionals who support alcoholics' self-help groups, whether by referring their clients to the groups or by giving a speech to the group, are therapists for alcoholics. Those who support stutterers' self-help groups are speech therapists, and those who support parent groups for ill children are medical professionals. This could lead to the following complication: traditional professionals tend to give suggestions by referring to their experience in professional-led therapy groups. This professional perspective can subtly influence the viewpoint of self-help groups, thereby damaging or destroying the distinctiveness of the experiential self-help perspective.

In contrast, self-help supporters know a lot about self-help groups and the differences between self-help and professional approaches. They know about the variations in self-help groups in relation to different diseases, addictions, and family and social issues. For example, they know that alcoholics can easily go out for meetings once a week, whereas caregivers find it difficult to leave home to attend a meeting even once a month, because of their responsibilities. While many groups for patients with rare diseases would like to work with medical specialists because they want to keep themselves abreast of the latest updates about the disease, few groups for people with physical disabilities might welcome the involvement of rehabilitation professionals. Self-help supporters know that generalizing about self-help groups is difficult. They recognize the uniqueness of each group, and they respect self-help groups for developing their own rules and original ways of operating that are appropriate for their members.

2.3 Understanding a self-help group as a community

Self-help supporters recognize and understand that most self-help groups are more like communities than like therapy groups. In particular,

most non-medical self-help groups can be more accurately and usefully thought of as normative communities that follow the principles of self-help/mutual aid (Riessman, 1997), instead of being viewed as alternative treatment services or compared with professional therapy groups. A normative community is one with specific values and a philosophy, like a church, citizen action group, service organization, or political party (Rappaport, 1994). The normative aspect refers to values, preferences, and liberal perspectives developed by the members to understand and cope with a common issue. Membership in a self-help group is like belonging to a labor union, voluntary association, or church rather than a therapy group, and is not like receiving professional treatment. From the normative community perspective, one would look for or study changes in identity, perspectives, personal experiences, friendship networks, and social support (for example, Humphreys & Rappaport, 1994; Rappaport, 1994). "The members are not clients getting services and therefore somehow different from the rest of us; rather they are people living lives. Professional treatment is not necessarily the appropriate comparison group if one wants to understand such experiences" (Rappaport, 1994, p. 123). Julian Rappaport, a well-known community psychologist, and his graduate students studied GROW, a self-help group for people with mental illness, over a period of years. Rappaport was struck by how members told different narratives or stories about themselves, unlike mental patients treated by psychiatrists, nurses, and other mental health professionals. GROW members did not see themselves as patients, sick, or dependent on medication to control their behavior (even though they used psychiatric medication); instead, they referred themselves as "a 'caring and sharing' community of givers as well as receivers, with hope, and with a sense of their own capacity for positive change" (Rappaport, 1994, p. 122).

When one looks at the family survivors of suicide as a normative community, it is easy to understand why their gatherings continue throughout the day into the evening. Being with friends and companions who truly grieve and suffer in similar ways and who empathize with their situation in a way that no outsider could, these family survivors learn to develop their own perspective so as to accept their grief.

2.4 Responsive orientation and social education

Unell (1989) found a "responsive orientation" in practice policies of local self-help centers in Europe, according to which, "help is given to those who come forward to seek it" (p. 138). Instead of the traditional social worker, who is likely to rush into a self-help group to correct, improve, or take over its functioning in the name of efficiency and efficacy, self-help supporters communicate to the group that they are available to help the group should they be asked for help. They respect the independence and self-reliance of self-help groups and wait for the group to decide if it requires help. This decision is not guided by the professionals.

This does not mean that self-help supporters continue waiting for somebody to come to their office. Instead, they work for the people as a social educator or advocate "a way of living with a self-help group," through which various problems or sufferings can be resolved or ameliorated. Self-help supporters make the "vast wasteland" green, planting several trees of "self-help groups" and increasing awareness among people who have yet to know that a self-help group can offer them a new way of living and add a new perspective and meaning of life. For example, in Japan, many family survivors of suicide had led bitter and isolated lives for a long time, without knowing the great possibility and potential of a self-help group, while in the United States, those with the same experience had already joined self-help groups (Feigelman & Feigelman, 2009).

Self-help supporters are aware that ignored suffering certainly exists in society, but they do not know what is ignored or who is suffering. They strive to make the way of living with self-help groups known to everybody. The best way of doing so is not by becoming a speaker or a lecturer, but offering members of self-help groups an opportunity to speak to the populace about how their groups change and enrich their lives. Unfortunately, in Japan, self-help groups are rarely given such chances outside their own meetings or conferences with related professionals. Self-help supporters should change society so that self-help groups can interact more effectively with the public.

2.5 Controlling the two-hat issue

Finally, we consider a problem that we name the "two-hat issue." A two-hatter is a professional who also has personal experience with the focal issue of the group, for example, the nurse who attends cancer patients and also has breast cancer, the speech therapist who stutters, and the suicide-related grief counselor who is a family survivor of suicide.

Some two-hatters, as professionals, lead their support groups and call them self-help groups, because they happen to have the same experiences personally as the group members share. In order to be a good leader of a self-help group, such professionals need to have strong self-control so that when they are in self-help groups, they are able to take off their "professional hat" and put on an experientialist "self-helper's hat." However, this usage of two hats is not easy for everyone, and we call this difficulty the "two-hat issue."

In reality, many people who have two hats often wear both simultaneously and pretend to understand the problem from both angles: that of a professional as well as of a self-helper. Consequently, some with the two-hat issue become a dominant leader, who does not listen to members, and the members often believe in the leader's superiority because the latter claims that he or she has not only experiential but also professional knowledge. Even if the two-hatters do not dominate their group, their group sometimes comes to be their (supplementary) means of livelihood, and they begin to collect a large fee from meeting participants for their own sake or receive it as a lecturer or a trainer.

Of course, two-hatters could be very helpful leaders or members in a self-help group. However, to do so, they have to be adept at wearing both hats appropriately according to time and circumstances.

3. Conclusions: The role of social workers

We would like to summarize what Japanese social workers can do for self-help groups after learning about the differences between self-help groups and support groups, and becoming aware of the new orientation: the existence of self-help supporters. We emphasize two things: learning from self-help groups and playing the role of a non-therapeutic mediator.

3.1 Learning from self-help groups

Because social workers are always ready to help people, it is prudent that they first think of the means by which they can help the groups assuming that they *need* help. However, they should also consider what they might learn from these self-help groups.

Let us take Oka's experience with family survivors of suicide. One day, three years ago, two leaders of self-help groups visited Oka at his university office. They decided to meet him after reading his book on self-help groups, and they believed he could help them. They told him how badly suicide-related bereavement professionals had treated family survivors of suicide and talked about their bitter experiences in professional-led support groups. They also explained how harmful the practice of the stage theory of grief had been and asked him if he could support their claims. Oka was very surprised because he had learned "the stage theory of grief" as a classic and "indubitable" theory, although he had little knowledge about grief therapy. He replied, "Sorry, I cannot help you, because I am a social worker, neither a psychologist nor a psychiatrist. Invalidating such a psychological theory is out of my expertise." Subsequently, using the Internet, he looked for the names of psychologists who might be able to work with these survivors and emailed the latter a list of names. However, their repeated requests moved him. He thought he could study their ideology or worldview, which opposed a classic psychological theory; this topic would fall within his expertise. The first section of this article shows that the survivors' claims were correct: the use of the stage theory of grief in practice could hurt their feelings and pride. As our first section showed, the survivors' claims were well supported by academic articles in English, many of which probably have never been translated into Japanese.

What lessons can we learn from this story? One of them is that self-help groups can provide us with new knowledge that they have obtained from their painful experiences and which we may hardly accept without destroying our preconceived ideas. Therefore, we say, "Learn from them, first." Self-help groups are one of our best teachers for improving our practice.

3.2 Non-therapeutic mediator

Several authors have discussed supporting roles that human service professionals can play for self-help groups. Even if we refer to the literature focusing on the roles of social workers, the list of such works, including Iwata (1994) in Japanese and Adams (1990) in English, is long. Owing to the limited scope of this study, let us take one role that we consider the most important and which is forgotten most often: the role of a non-therapeutic mediator.

Our readers know the definition of social work by the International Federation of Social Workers (2005):

> The social work profession promotes social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Note that this definition does not contain words such as "therapy" or "counseling." If we take a case of family survivors of suicide who are already involved with self-help groups, the help provided by social workers is well appreciated partly because social workers do not intrude into their sentiments. What they need is not psychological, but social support. For example, one such survivor wanted to make her self-help group known to other isolated family survivors in the community and asked help from a social worker of a community council of social work. The social worker, understanding how important the group was for the other family survivors, put an advertisement in a newsletter. He then contacted those who were in charge of the newsletter in nearby municipalities to encourage them to include another advertisement of the group in their publications. He also negotiated with the local government so that the group could have a meeting in a public building (Oka & Singū; in press). It was crucial to make the group known through a public newsletter and have meetings in public facilities, because this could relieve people's apprehensions: the use of the mass media and public facilities proved that the group had no links with cult-like organizations or fraud companies.

Social workers are well trained and very knowledgeable about the social, health, and welfare services in their community. Further, they usually have first-hand knowledge of how to access such services, what their requirements are, and how to facilitate receiving services. Moreover, social workers understand government bureaucracy and the ways various professionals, NGOs or nonprofit foundations, philanthropic, community and neighborhood associations, as well as local political bodies operate. These knowledge sets and skills are exactly what many self-help groups lack but need in order to obtain social, health, and other services that they do not have access to. Social workers may act as mediators to assist self-help groups to obtain the services and resources they need from government bureaucracies and philanthropic, community, and neighborhood associations. Social workers can also mediate between informally organized self-help groups and bureaucratic and professionally organized services, by serving as "interpreters" that explain to each side the other's point of view and ways of operating. As mediators, social workers can play an important role in facilitating the empowerment of self-helpers and their groups by making their knowledge, resources, and skills available to the groups.

Generally, the problems and life conditions that self-help groups are dealing with are neither easily solved nor ameliorated by therapies or direct interventions. Consequently, people cannot but live with the problems and life conditions for a long time. In order to live under such circumstances in their society, they need social support and help. We need to be aware that social work is the profession most suitable to provide such help in Japan.

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Notes

[1] Owing to the collaboration between the Japanese and American authors, this article was originally written in English and later translated into Japanese, while part of it was condensed to fit within the word limit prescribed by the journal. The original English version is available from http://pweb.sophia.ac.jp/oka/papers/2011/socialwork/

[2] Some authors assign somewhat confusing names such as "professional-led self-help groups" (Stang & Mittelmark, 2010) and "peer-led support groups" (Stevinson, Lydon, & Amir, 2010). Throughout the present paper, we refer to self-help groups as "peer-led," and support groups as "professional-led."

[3] Some support groups in Japan are led by volunteers. Because these volunteer-led support groups and professional-led ones operate under the same guidelines (Ōtsuka et al., 2009), we consider those led by volunteers as a part of professional-led support groups.