

# Treatment of complicated grief in a bereaved mother who lost her son to suicide

Saeko Takada\*

Supervisory Department, Oyama Memorial Hospital, Nishiwaki City, Japan

## Abstract

**Losing a child to suicide is one of the most painful events and will lead to complicated grief reactions. Bereaved family suffer severe grief reactions that interferes with one's daily functioning. However, there are few case studies on grief or bereavement. The purpose of this paper is to investigate the process of complicated grief treatment (CGT) for a mother who lost her son to suicide. CGT is a manualized evidence-based treatment and it enables client to face the most traumatic aspects of the death and to encourage her to take steps toward the reality. Treating bereaved families is difficult; however, "sense of guilt (ushrometasa, in Japanese)" and "unsolved questions" are keys for understanding these families. There are many limitations for presenting a single case study, however, the client in this study found a reasonable ending to her anguished journey through CGT.**

**Keywords:** Complicated grief, Bereavement, Complicated grief treatment, Suicide-bereaved family.

*Accepted on June 27, 2018*

## Introduction

Losing a child to suicide is one of the most painful events and will lead to complicated grief reactions [1]. Previous studies found that, compared to other parents, those who lost a child (bereaved parents) reported more depressive symptoms, emotional distress, health problems, and hostility [2].

In today's fast-paced society, devoting sufficient time to grieve a death may be difficult. Moreover, in the case of suicide, bereaved families may have more of a sense of isolation than in the case of other deaths. "Unsolved questions" and "sense of guilt" may cause great pain to the bereaved family. Suicide-bereaved family are left behind with tremendous questions, especially the crucial question: why did he/she commit suicide? They often overestimate their own responsibility because they think they could have done something to prevent such a tragic outcome. Those families are incapable of thinking of other reasons or factors that contributed to the suicide, and accuse themselves. When a sudden and unexpected death occurs, it is easy to feel that "time has stopped" since that day. Although time passes, it is as though the mind remains stopped. According to the Japanese proverb, "time is the best healer (hinichi-gusuri, in Japanese)"; this has the same meaning as "time cures all" in Western countries. There are some scars that time will heal; however, it is difficult to heal scars caused by traumatic grief.

The experience of the death of a loved one is universal, and grief is a normal reaction that includes mental, physical, and social reactions to the loss. Even when people suffer serious loss or experience traumatic grief, most can handle the process of grief without professional assistance. Over time, the bereaved come to accept that the deceased person no longer exists, adapt to the loss of their loved one, and once again begin to experience pleasure. This does not mean that the deceased person is forgotten; rather, the bereaved resolve

their sadness and experience "integrated grief," which exists in the background [3]. Sometimes, however, bereaved family suffer severe grief reactions, which are intensely painful and prominent, persist much longer, and cause distress that interferes with emotional, cognitive, and social functioning; this is called complicated grief (CG) and is identified as persistent complex bereavement disorder in the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> edition (DSM-5). Persistent complex bereavement disorder is characterized by strong grief that does not resolve over a year, prolonged sadness, severe yearning, intense feelings of anger or self-blame, and preoccupation with the person who died, mixed with avoidance and longing, feelings of isolation, and difficulty experiencing pleasure over 12 months; these symptoms interfere with daily life [4], such that CG-specific treatment is needed.

It is known that approximately 7 percent of those who are grieving suffer with CG. For bereaved families of suicide, the rate of suffering from CG has been shown to be more than twice as high as that of normal death [5]. Because of prejudice regarding suicide and feelings of shame, bereaved families may have a harder time sharing their grief with others, and thus, have difficulty mourning properly [6]. Survivors of suicide are also more likely than other bereaved individuals to develop symptoms of PTSD (Posttraumatic Stress Disorder) [7].

There are many case studies on grief or bereavement in Japan, primarily based on the narrative approach [8]. The narrative approach allows bereaved families to create reasonable and acceptable thoughts regarding their loved one's death; thus, there is a consensus that this approach is an effective way to treat bereaved families [9]. Sharing one's story and creating a new one is important for bereaved family; however, this process could become too personal, and it is difficult to be generalized. In addition, the narrative approach itself does not focus on CG,

even though CG is the most critical aspect of bereaved families. A CG-specific intervention, complicated grief treatment (CGT) has been implemented for bereaved families in the U.S. CGT is a manualized evidence-based treatment for resolving traumatic grief and facilitating natural mourning, with proven efficacy for treating pathological grief reactions [10]. Unfortunately, few experts assess CG and deliver appropriate CG-specific treatment or intervention with bereaved families in Japan [11,12]. This makes it difficult for bereaved families to recover and leads to prolonged and complicated grief. To address this gap in the literature, this article describes the case of a mother who lost her son to suicide, to explore the effectiveness of CGT in Japanese culture.

## **Description of the Treatment**

CGT involves approximately 16 weekly sessions following a combination of both loss-focused and restoration-focused components in 4 phases. Phase 1 involves a review of the client's history and grief experience, psychoeducation on normal and complicated grief, introduction and encouragement to complete a grief monitoring diary, setting personal goals, and a joint session with a significant other. Phase 2 comprises gradual exposure to what the client is avoiding, utilizing imaginal revisiting, which involves retelling the story of the time when the client learned of the death, or situational revisiting to confront traumatic reminders. Imaginary revisiting is conducted to re-think and re-understand the meaning of the death of a loved one. Although telling the story of losing someone is painful, it is useful for thinking about difficult experiences. Imaginary revisiting permits acceptance of the reality of the death of a loved one by telling the story repeatedly. Finally, Phase 4 involves reviewing memories (not only positive but also negative ones, to integrate a whole memory of the loved one), imaginal conversation with the deceased, and preparing for the termination of the program.

## **Case Representation**

The current clinical case reports the treatment procedure of Ms. X, a 55-year-old Japanese widow. Ms. X lost her husband due to an accident 8 years ago. About four years ago, her 26-year-old son who had suffered from depression after quitting his job committed suicide through carbon monoxide poisoning in his car. The day before his death, he called Ms. X, but she was busy at the time and told him to hang up. They lived separately, and Ms. X started to worry about him several days later because she could not contact him. Two days after his death, the police found his body in his car. Since then, Ms. X suffered with severe sleeping difficulties, depressed mood, and irritation and anger toward her son or other families who seemed "happy." Ms. X had a daughter who avoided her because she was always irritated or crying. Ms. X did not want to lay her son's ashes to rest and kept them for 4 years in her house; she had also avoided entering his room since he died. In addition, Ms. X tried to avoid social contact with others, because her neighbor told her "If you seriously wanted to cure his depression, you should have taken him to the hospital." In this way, Ms. X felt strongly that she was being accused of being responsible for her son's death.

Ms. X said that her life was dominated by her son's death; she

continuously thought about why he chose to commit suicide and why he did not say that he needed some help to her on the phone so that she could do something to prevent his death. Moreover, she continuously questioned whether she was a good mother. Ms. X's birth family was not supportive of her and she suffered with postpartum depression after her son's birth; as a result, she thought that she had not been a sufficiently responsive mother to her son. She seemed to be searching for reasons that he chose to commit suicide.

With respect to ethical considerations, written informed consent to publish the case report as a web-based paper was obtained and modifications were made (without affecting the meaning) to the case descriptions to protect personal information.

## **Assessment**

For psychological evaluation, the Impact of Event Scale (IES-R), Beck Depression Inventory-II (BDI-II), and Inventory of Complicated Grief (ICG) were used. The IES-R does not provide a diagnosis; however, it is used most widely for screening for PTSD by measuring subjective distress caused by traumatic events; scores above 24 are considered to indicate partial or full PTSD [13,14]. Ms. X's initial score was 47. The BDI-II [15] is a self-rating questionnaire for depression symptoms with 21 items based on the DSM-IV diagnostic criteria. A Japanese version of the BDI has been translated and published [16]. The BDI-II has a two-factor structure that reflects the physical and emotional aspects as well as cognitive aspects of depressive symptoms. Ms. X's initial score was 23. The ICG is broadly used for measuring grief [17]. A total score of 26 or higher is generally considered to indicate a high risk of suffering with CG [18] and a Japanese version of the ICG has been created [19]. Ms. X's initial score was 33. The psychological evaluations and CGT sessions were conducted by the author, a female clinical psychologist with a certificate in CGT.

## **Case Conceptualization**

It was clear that the death of her son precipitated the onset of CG and depression. However, she seemed to have been suffering with a depressed mood since she was young, because of her relationship with her mother. Moreover, she suffered from postpartum depression and felt that she was not a good mother. Psychological evaluation revealed that she had clear avoidance symptoms and cognitive distortions. The treatment plan was to reduce Ms. X's severe grief to natural grief through CGT, since CGT helps in understanding the fact of a loved one's death, reducing negative distorted thinking regarding the death of loved one and increasing self-value as a mother.

## **Course of Treatment**

Ms. X received 18 one-hour sessions of individual CGT for 5 months. Her therapy was conducted by the author.

### **Phase 1**

When she came to the clinic, she looked unhappy and angry. During the session, she criticized her son often, saying how foolish he was to commit suicide, and showed regret about not being supportive of him. Her therapist listened to what

she said, stated repeatedly that she had suffered pain through his death, and delivered psychoeducation about normal versus complicated grief. When setting personal goals, Ms. X. smiled a bit for the first time and chose 3 goals: 1. Lay her son's ashes to rest, 2. Become able to talk naturally with her daughter, 3. Begin hiking again (she used to like hiking, but stopped after her son's death), 4. Cook some dishes that she really liked (she used to like to cook, but had not enjoyed it since her son died.). Since Ms. X was no longer close to her daughter, her therapist asked her daughter to come to the clinic prior to the joint session, with Ms. X's permission? During the joint session, they shared how they were affected by the death in the family. The therapist told them that each family member's level or way of expressing sadness is different, which can lead to misunderstandings or breakdowns within bereaved families. At the end of the session, Ms. X's daughter invited Ms. X for dinner that day and they agreed to text each other 2-3 times per week and have dinner together once a month.

## Phase 2

The therapist introduced Ms. X to imaginal revisiting and asked her to talk about details from the time when she learned of her son's death. During her first imaginal revisiting, she said, "On \*\* (the date), I picked up the phone and it was the police. I had been worried about him since he disappeared and I realized that I had lost him forever when I picked up the phone. It was my fault, 100% my fault. Then, I drove to see him. Sorry, I can't remember what happened next. I attended his funeral, then his boss said that I should not have left him alone. Maybe it was my fault because I did not love him when he was a baby. Maybe he committed suicide for revenge. Because I could not understand him." She was obviously confused and overwhelmed. In addition, she had the dysfunctional thought that her son felt abandoned in his moment of death and that he would have accused Ms. X. The therapist asked her what she felt at that time and praised her when she finished talking about it.

After completing several imaginary revisiting sessions, Ms. X said, "Maybe my son could not think clearly when he decided to die because he suffered with depression. When I delivered my son, I could not think clearly, either." Therefore, the therapist asked her about the symptoms of depression. Ms. X answered, "A person who suffers with depression cannot sleep well, cannot think flexibly, has depressed mood, does not have perspective, and cannot make rational decisions." The therapist said, "If your son suffered with depression, he might not have been able to make rational decisions, as you said." Then Ms. X quietly said, "He committed suicide because he could not make rational decisions due to depression."

In addition, Ms. X practiced situational revisiting by following these steps: "Go to the door of his room," "Open the door of his room," "Open the door and look around his room through the doorway," "Enter his room for 1 minute," "Be in his room for 3 minutes," and "Be in his room for 5 minutes." Through this gradual exposure, Ms. X was able to stay in his room as long as she wished and started cleaning up his room. Although the therapist did not talk about laying the ashes to

rest, Ms. X started working on it spontaneously and laid her son's ashes in the tomb 4 years after his death. At the end of Session 7, she said she still blamed herself about 70% because she thought she could have said something to him before he died. The therapist introduced imaginal conversation to her at the next session. Ms. X could say anything she wanted to her son, and was asked to reply as if she were her son (To prevent confusion, " " refers to what Ms. X said, and < > refers to what her son said in this imaginal conversation).

At the beginning, Ms. X looked awkward, but she stated, "Why did you choose to die? If I could touch you, I would spank you. But I cannot touch you anymore. I feel so sad and lonely. Maybe I was hurting you since you were small." The therapist asked Ms. X to reply as her son. Then she said, < Mom, I don't know what to say...I wanted to talk with you more and more, but I know you cared about me.> The therapist asked Ms. X to reply. "So...then, why did you do it?" However, her imagination stopped at this moment and she started to cry. So, the therapist asked Ms. X to remember the conversation about depression and review the symptoms of depression. Ms. X said, "Maybe my son could not think about anything because his mental state was so bad." The therapist asked her to reply as her son. < It's hard to tell...I'm not sure about my behavior at the time, but I think I did it impulsively. I could not think rationally about anything.> Then, Ms. X said, "I understand" for the first time. "I understand how you felt. I know it. I know it. But, I should have told you to go see a doctor. I am so sorry." Then, she replied < If you asked me to go see a doctor, I wouldn't have gone. So, it was my fault. It is not your fault, mom. I want you to understand that.> "Are you sure that it was not my fault?" said Ms. X. < No.> Then Ms. X replied, "I have felt sorry for you because I could not speak a lot when you were small. I suffered with depression. I wish we could have had more conversation." < Yeah, I wish we could have had more conversation, too.> "I'm so sorry. I felt like I was not a good mother." < No, please don't say that. I know you were busy.> "I'm so sorry." By the end of the imaginal conversation, Ms. X took on her son's role spontaneously and conducted an imaginal conversation. After this session, she reported her rate of self-blame had decreased to 50% and she felt less angry with him. Her score on the IES-R had decreased to 30, BDI-II was 18, and ICG became 23. Around this time, the therapist asked her to bring pictures of her son to engage in memory work, which involved talking about both positive and negative memories of her son. She said that she missed eating dinner with him the most, but that she didn't like that he was not as tall as she had expected.

## Phase 3

During further imaginal revisiting, Ms. X told the story of her son's death. She cried a lot while talking, but soothed herself afterward. Then, Ms. X described that she realized that "both of us were lacking conversation, but it was not his fault or my fault. Also, I am able to think that my son had no clue how to handle his life." Her process of accepting her son's death seemed to be complete. However, she showed resistance to ending therapy and several psychosomatic symptoms, and sometimes came late or cancelled sessions. The therapist accepted her feelings and

pointed out that Ms. X was not losing therapy, but just finishing the procedure. In addition, the therapist reviewed what Ms. X had done during the sessions and oriented her to think about her life goals. Moreover, the therapist and Ms. X talked about future times when Ms. X would miss her son, such as the anniversary of his death, his birthday, and Christmas or New Year's Eve. During this phase of treatment, Ms. X joined a local hiking club and started making Japanese cuisine that she used to like. Before the last session, her score on the IES-R was decreased to 19, BDI-II was 6, and ICG was 13. During the last session, she said, "I feel like it has been a long time." When the therapist asked her how she had changed through the program, she answered, "My life was filled with sadness and anger, but now I think I am separated from my sadness. I miss my son, feel sad and lonely, and of course I have pain. But, I think it is natural as you said at the beginning of this program" and she quietly smiled. During a follow-up session after 3 months, she reported that some of her son's friends came to her house during Obon (an annual event to welcome ancestors' spirits around the 15th of August) to share in her son's memory, and that she had a good time with them.

## **Discussion**

### ***Implications for clinical practice with bereaved family***

For the presented case, Ms. X's current emotional distress was linked to her son's suicide and she talked openly from the beginning of therapy. However, other clients may hide their traumatic loss or fail to realize that their current suffering is related to the death of a loved one. When the client hides grief, it is difficult to focus on the episode of loss. Moreover, the relationship between emotional or physical symptoms and grief is denied, which is essential for using specific therapeutic techniques and developing knowledge about traumatic grief and loss. As a previous study indicated, bereaved families thought that "just being close" or "just staying with me" were most helpful [19]. Thus, as a therapist, it is important to wait until the client is ready to talk about her/his experience of loss. Once grief and emotional or physical symptoms are related to each other consciously, a therapist can bring up the relationship between one's current symptoms and past experience, as part of bereavement and trauma-focused therapy. However, death, and especially suicide, is a delicate matter and is sometimes difficult to bring up. Thus, it seems preferable to listen supportively to what a client says and receive and accept his/her grief. To cope with a traumatic loss, the therapist must provide a secure foundation. Only when a secure foundation is provided, is it possible to face the death and take steps toward the reality of being without the loved one. It is painful to face losses. Therefore, clients need to be encouraged to face them. If a client has traumatic grief, he/she needs more courage to remember compared to a person with normal grief. Therefore, whether conducting CGT or other forms of psychotherapy, if therapists set an environment for talking openly and sharing pain, clients will have the courage to remember.

### ***The process of accepting the death of a loved one by suicide***

Losing a significant other means losing an attachment

figure. Previous research showed that when people lose an attachment figure, they have difficulty asking for help under traumatic circumstances, which can cause mental distress [20]. The person left behind can suffer with painful emotions and become preoccupied with dysfunctional and/or intrusive thoughts related to the death. As a previous study indicated, "naturalness" and "expectedness" of death are related to lower grief [21]. Moreover, those who are bereaved due to suicide not only experience sadness or sorrow, but also stigma, shame, and guilt, so that they try to avoid social interaction [22-24]. Among them, parent(s) who lose a child to suicide have tremendous pain and overwhelming guilt [25].

Previous studies were completed in Western countries; however, it is assumed that the effect of suicide is the same for bereaved families in Japan. In the case presented, Ms. X could not share her feelings and avoided communicating with others because of shame and guilt regarding her son's death; she thought that not only her son, but also she would be stigmatized. In addition, she had been wondering why her son decided to commit suicide. Bereaved families must face this "unsolved question" regarding the death of family members. Treating bereaved families is difficult; however, "unsolved questions" and "sense of guilt" are keys for understanding these families. If bereaved family can find a "reasonable conclusion," their concerns will be diminished. For example, Ms. X concluded that "my son had no clue how to handle his life," which was not her fault, through an imaginal conversation with her son.

### ***Issues for conducting CGT***

As mentioned previously, many individuals suffer after a death. The rate of suicide in Japan is significant and many families suffer emotional distress. For these families, treatment options include medication, client-centered therapy, interpersonal therapy (IPT), writing therapy, and CGT [26]. From a meta-analysis study, interventions targeting CG were more effective than supportive counseling, IPT, or wait-list [27].

This case report demonstrates an implementation of CGT with a Japanese woman. Through this program, she faced her loss and successfully reduced her traumatic and depressive symptoms after 18 sessions. In particular, psychoeducation about complicated grief and imaginal conversation played a crucial role in her improvement. Ms. X showed signs of recovery, such as becoming aware of her feelings about the deceased, being able to recall the deceased, returning to daily life, experiencing enjoyment again, and building relationships with others through CGT. Even though the reason for the suicide was still unknown, the client found a reasonable ending to her anguished journey. However, there are some issues that should be discussed. First, in this program, the therapist decided not to focus on the relationship between Ms. X and her son when he was a child and Ms. X's experience of postpartum depression. In the CGT manual, the contents of each session are outlined and not flexible. Ms. X might have wanted to talk about her experience of postpartum depression, other stories regarding her

son, or even her husband's death, which might have caused her to show resistance to finishing the program in the 3rd phase. Therefore, therapists should pay attention to important topics not discussed or treated in the program. Even though CGT is a manualized treatment technique, therapists who work with bereaved families should be careful about being too focused on one aspect; this does not mean modifying CGT, but rather enhancing the understanding of the client.

## Conclusion

Another limitation of this study is generalizability, since this is a single case study. The interpretations made by the therapist could be biased. In addition, scores on the IES-R and BDI-II should be compared with those of other clients who experienced traumatic loss, to confirm the effectiveness of CGT. However, the recovery of Ms. X was shown through the change in assessment scores. Although there are many disadvantages of a single case study, it enables examination of changes in a client through treatment within a real-life context. Future studies are needed to accumulate these case studies and confirm the best treatment for CG to improve public mental health.

## References

- Bailley SE, Kral MJ, Dunham K. Survivors of suicide do grieve differently: Empirical support for a common sense proposition. *Suicide and life-threatening behaviour*, 1999;29: 256-271.
- Beck AT, Steer RA, Brown GK. *Manual for the beck depression inventory*. The psychological corporation, 1996.
- Cvinar JG. Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in psychiatric care*, 2005;41:14-21.
- Jordan JR. Is suicide bereavement different? A reassessment of the literature. *Suicide and life-threatening behavior*, 2001;31: 91-102.
- Knieper AJ. The suicide survivor's grief and recovery. *Suicide and life-threatening behavior*, 1999;29: 353-364.
- Kojima M, Furukawa TA, Takahashi H, et al. Cross-cultural validation of the beck depression inventory-II in Japan. *Psychiatry Research*. 2002;110(3): 291-299.
- Mitchell AM, Kim Y, Prigerson HG, et al. Complicated Grief in Survivors of Suicide. *Crisis*, 2004;25: 12-18.
- Middleton W, Raphael B, Burnett P, et al. A longitudinal study comparing bereavement phenomena in recently bereaved spouses, adult children and parents. *Australian psychiatry*, 1998;32(2): 235-241.
- Miwa K. Supporting the bereaved families of suicide victims-The current status and related issues concerning victim support social work, 2010;51: 41-51.
- Miyata I, Asajima Y, Kubota Y, et al. A case in which we practiced a grief care for a family in bereaved state due to suicide. *The Japanese Society of General Hospital Psychiatry*, 2013; 25(4): 391-397.
- Leenaars AA. Shneidman on Suicide. *Suicidology Online*, 2010;1:5-18.
- Nakajima S, Ito M, Ishimaru K, et al. Prevalence and risk factors for prolonged grief disorder in adults who lost significant others. Research-aid paper of the Yasuda life welfare foundation, 2009;45: 119-126.
- Prigerson HG, Shear MK, Jacobs SC, et al. Consensus criteria for traumatic grief: A preliminary empirical test. *British journal of psychiatry*, 1999;174: 67-73.
- Prigerson HG, Maciejewski PK, Reynolds CF, et al. Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry research*, 1995;59: 65-79.
- Prigerson HG, Horowitz MJ, Jacobs SC, et al. Prolonged grief disorder: Psychometric validation of criteria proposed for DSM-V and ICD-11, 2009.
- Rash CJ, Coffey SF, Baschnagel JS, et al. Psychometric properties of the IES-R in traumatized substance dependent individuals with and without PTSD. *Addictive behaviours*, 2008;33(8): 1039-1047.
- Simon NM, Shear MK, Fagiolini A, et al. The impact of concurrent naturalistic pharmacotherapy on psychotherapy of complicated grief. *Psychiatry Research*, 2008;159(2): 31-36.
- Shear K, Frank E, Houck PR, et al. Treatment of complicated grief: A randomized controlled trial. *JAMA*, 2008;293: 2601-2608.
- Shear MK, Simon N, Wall M, et al. Complicated grief and related bereavement issues for DSM-5. *Depression and anxiety*, 2011;28: 103-117.
- Shear MK, Wang Y, Skritskaya N, et al. Treatment of complicated grief in elderly persons, a randomized clinical trial. *JAMA Psychiatry*, 2014; 71: 1287-1295.
- Shirai A. What kind of role does exposure play in grief focused psychotherapy? *Japanese Journal of Traumatic Stress*, 2016;14(2): 136-140.
- Ueda T, Fujita G, Yanagita T, et al. Risk factors for mental health problems and complicated grief in bereaved families of motor vehicle accident victims. *The Japanese journal of psychology*, 2017; 87(6): 569-578.
- Yoshino J. The cure of suicide-bereaved family and Narrative approach-The record of dialogue effort to reunion, 2014.
- Weiss DS, Marmar CR. The impact of event scale- revised. *Assessing psychological trauma and PTSD: A handbook for practitioners*. New York: Guilford Press, 1997;pp. 399-411.
- Wetherell JL. Complicated grief therapy as a new treatment approach. *Dialogues in clinical neuroscience*, 2012;14(2): 159-166.
- Wittouck C, Van Autreve S, De Jaegere E, et al. The prevention and treatment of complicated grief: a meta-analysis. *Clinical Psychology Review*, 2011;31: 69-78.

**Citation:** Takada S. Treatment of Complicated Grief in a Bereaved Mother Who Lost Her Son to Suicide. *J Public Health Policy Plann.* 2018;2(2):84-89.

27. Zisook S, Chentsova-Dutton Y, Shuchter SR. PTSD following bereavement. *Annals of clinical psychiatry*, 1998;10(4): 157-63.

**\*Correspondence to:**

Saeko Takada,  
Supervisory Department,  
Oyama Memorial Hospital,  
Nishiwaki City, Japan,  
Tel: 81-90-5883-2220  
E-mail: cocosae@yahoo.co.jp