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## ESTABLISHING EMOTIONAL MUTUALITY IN JAPANESE CASES

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### Introduction

The studies of Mahler on the separation-individuation process have shown that a happy stable symbiotic relation between mother and infant and "good enough" maternal availability are the prerequisites of a successful separation-individuation process (Mahler, Pine & Bergman, 1975).

In a country like Japan, where infants had long been cherished as "*kodakara*," treasures bestowed by heaven, motherhood had been a special privilege of women. A happy symbiotic relation between infant and mother was something naturally obtained through maternal preoccupation which was facilitated by the supporting network of women in the family and the community (Benedict, 1946).

The industrialization and urbanization after the Second World War, however, have transformed child rearing into a solitary task. It no longer is something monopolized by women shunning men, the toil and joy of it shared exclusively among women, but it is something that a young mother has to cope with alone. The ongoing liberation of women is furthering the current undermining of the social respect formerly given to motherhood. Therefore young mothers of Japan nowadays are facing the burden of child rearing in a contradictory state, bound up on the one side by the still existing image of traditional motherhood, and deprived on the other side of the physical and emotional resources necessary to comprise a holding environment for her infant.

Because of urbanization, more and more mothers live in tiny apartment houses without any communication with their neighbours. They rely on child rearing books, home doctors and relatives, but even when, for example, a grandmother is available, a young mother will not listen if what she says sounds old-fashioned. There is a deluge of new information flooding into their lonely lives through television, newspapers and magazines. For example, a child rearing magazine stated that mothers should start training children to read at the age of one. The more meticulous, unstable and lonely mothers easily fall prey to such harmful advice and suffer from what we call "*ikuji* (child rearing) neurosis."

Nuclear families have increased dramatically after World War II, but these families, although superficially westernized, in fact remain traditional in that they are child-oriented families, just as they were in olden days (Doi, 1962). Getting married still

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means having children, and there is an expression that "a child is a pledge of affection." The family is based not on man and wife but on the bonds that tie parents and children, and this is typically seen in the sleeping arrangements, for example. More infants sleep in baby beds today, but the beds are usually still placed in the same sleeping room with the parents.

Mothers in Japan still think along traditional lines of thought, that their husband's priority is to go to work every day, and that the longer he works the better (Makita & Okonogi, 1971). A popular television commercial says "A healthy and absent husband is an ideal husband." Thus mothers cannot rely on their husbands to share child rearing with them, and some mothers become more and more isolated. The role of the mother in post-war Japanese nuclear families has been to see to the upbringing and education of children. There is in Japanese an expression that translates roughly as "educational mom," and it seems that Japanese society itself is urging mothers to bring up more and more competent children by themselves. Success in this area brings with it social approval, and most mothers are concerned about their children's academic achievement, regarding the competence of their children as a mark of their own competence.

Reflecting mothers' tendency to regard their children as a part of themselves, they urge their young children to be good in the eyes of others, often at the cost of creating what may be called the false self (Winnicott, 1965). Although Japanese mothers rarely use physical punishment as a means of socializing their children, they control their children with very effective but also harmful ways. They try to tone down their children's aggression not by understanding and neutralizing it but by suppressing it, by threatening abandonment through such words as "Shame on you," "See how people are looking down on you," and "You are not my child to behave in such a naughty way." Vulnerable toddlers and hypersensitive children easily abandon their assertion as individuals in their own right in order to defend themselves from the fear of abandonment.

In addition, the great ecological changes in children's environment have made child rearing more and more difficult: the low birth rate, the increase in traffic casualties and the decreasing numbers of playgrounds necessary for the growing children to foster outdoor play experiences with their peers. Furthermore, because of the keen competition to enter into good private schools, many children are sent to cram schools at an early age.

Such being the case in Japan today, more and more children are becoming emotionally disturbed, their symptoms ranging from psychosomatic complaints such as gastric and duodenal ulcers, to conduct disorders, neurotic symptoms, affective disorders, psychotic episodes and so on. We child psychiatrists thus have a complex problem to cope with. One of the most important tasks is to provide effective support to mothers suffering from the contradictions of modern life. As a partial solution, we urge other members of the family such as fathers and grandparents to participate more in child rearing, and we encourage parents to make friends with other families of the same generation so that they can eventually form a network of support systems to help child rearing.

In cases of more deep-rooted pathology formed through interactional failures in early infancy, a new therapeutic approach was put to practice in an attempt to cultivate emotional availability in the mother and to enable mother and child to establish the emotional mutuality not formed in infancy. I will describe about this next.

Hospital treatment for mother and child couples to establish emotional mutuality not formed in infancy

A Japanese mother is easily led into possessing guilt feeling when her child acquires mental illness. Listening to the mother's self reproach and plea of "Isn't there any chance of undoing my failure in the care of my child in infancy?" I was driven to devise a therapeutic approach which used regression as a vehicle to take the child back to its infancy and which assigned the mother the principal role of interacting therapeutically with the child (Balint, 1968).

#### *Method of Approach*

For the purpose of establishing the emotional mutuality not formed in infancy, four girls aged six, eight, ten and eleven were hospitalized with their mothers, one couple at a time. They stayed in a room of the pediatric ward where children under three received pediatric treatment with the mother's around-the-clock attendance. The duration of hospitalization varied from 2 to 5 months, the average being 3 months.

The girls shared in common the characteristic features of limited attachment behaviors in infancy and no assertiveness in the rapprochement phase. They all came from intact families. Their mothers were all free of symptoms, but all showed some kind of personality problems in their Rorschach tests.

At the beginning of the therapy the diagnostic evaluation of the child's problems was explained to the parents in detail. Each mother was told that the child's illness was a consequence of the interaction among constitutional, maturational and ecological factors. Each mother was assured that the appearance of psychiatric symptoms could be converted into an opportunity to undo the past failure through therapeutic regression.

The parents were then given an idea of what would happen in the course of the therapy through vivid illustration of the behavior of a symbiotic infant in blissful unity with the mother, and a conflictual toddler taxing her mother at the peak of rapprochement crises. I depicted each stage of development and suggested the way in which the child should be taken care of, using fables, metaphors, examples and anecdotes so that the mothers would have a clear idea of what they were going to do. I also showed emotional availability and interacted with the mothers with empathy and tenderness, in order to stimulate mothers' emotions and feelings psychobiologically.

#### *The Course of the Therapy*

The therapeutically induced regression in the four cases involved the following four phases in common.

##### *1) The First Phase*

Gradual but unmistakable changes occurred in the child's attitude towards her mother, as she perceived the mother's increased emotional availability. She began to interact with her more actively. Concurrent with this change was a transformation of the symptomatology, which included transient aggravation of symptoms and appearance of persecutory fantasies. The mother took notice of the child's response, became interested in this therapy and began to reflect on her previous interaction with the child.

### 2) *The Second Phase*

The first phase was followed by gradual furthering of the regression which finally appeared as the open expression of the child's feelings and the blooming of infantile behavior. The child became more and more infantile: speaking in a babyish way, driveling, wanting to drink from a bottle or suck mother's breast, to be diapered, or to be hugged, dandled and fondled. These were demanded in an impulsive way, with the child bursting into temper tantrums when the mother hesitated or not responded accordingly. The child resembled a toddler in rapprochement phase.

This was the most trying and critical period for the mother, who needed intensive support of the therapist. I listened with patience and perseverance to the mother's tales of discomfort and distress resulted from the child's expression of anger. The mother was reassured that this discharge of impulses was the very proof that the child began to perceive the mother to be the person whom she could depend on to confide her innermost feelings. These feelings must have tormented her ever since infancy and she must have endured alone because her mother had not been available so far. The validating experience obtained through the mother's patient understanding would help the child become reconciled with her abandonment fear, anger and rage, resulting in relief and a secure feeling. The therapist's keenness in detecting the mother's aggressive feelings and extending warmth, empathy, assurance and validation was indispensable to stabilize the mother and child relationship. If the therapist failed the mother, the mother would fail the child. If the therapist survived and validated the mother's negative feelings, then the mother could do the same to the child, letting her reexperience infantile feelings in the ego-relatedness with the mother.

At this time it was necessary to monitor the child's aggression so that the child would not actually hurt the mother to the point that she felt like rejecting her child. To prevent this the mother was encouraged to mobilize her spontaneity and creativity to neutralize the child's aggression. Sedatives were prescribed to the mother and/or the child at times.

### 3) *The Third Phase*

Having experienced the mother's acceptance and perseverance through the previous phase, the child now showed less aggressiveness and more trust and fondness to the mother, hugging, kissing and sometimes even licking her. The child resembled a symbiotic infant.

### 4) *The Fourth Phase*

The child, now quite satisfied with the affectionate mother, became less and less infantile and more and more independent. She seemed now to progress into a healthy separation-individuation phase.

## *Cases*

### 1) KANA

Shortly after several days of hospitalization for pneumonia, Kana, a six-year-old girl began to have frequent spells of fainting with clinging movements of the arms.

Thorough physical examination failed to reveal any organic cause and because the fainting spells occurred only in front of the mother, the pediatrician suspected a psychologic cause.

Kana was the result of unwanted pregnancy after eight years of the parents' marital life without a child. In fact her mother had lost a boy through stillbirth in the first year of her marriage and had decided never to have a baby again. When she learned of her pregnancy she feared that she might lose her freedom and will have no time for her own. The mother was the youngest of three sisters in a family where the mother dominated, and she had no memory of a warm relationship with her own mother.

I observed the couple in the pediatric unit and noted a robot-like girl with a harsh aggressive mother. The mother knew me and somehow had trust in me and confided to me that the spells began to appear right after her return from the short hospitalization, when Kana grumbled for the first time in her life that her Mom was too strict as compared with other mothers. I suspected that the symptom must have been an expression of her fear of abandonment which must have arisen from the guilty feeling of having directed outward aggression towards her mother. The mother was shocked to hear that the superb manners of her child might be a sign of a character disturbance, but was willing to undergo the hospital treatment I proposed in order to establish a good emotional bond which Kana seemed to have failed to develop in infancy.

The mother followed my instruction to attend Kana at the bedside warmly, and the sensitive child responded by deliberately throwing a toy to the floor on the first day. The next day she threw another toy more violently, and the third day she shouted at the mother saying, "You fool!" At this the mother rushed to me breathlessly and was totally astonished at the child's misbehavior. I assured the mother that this might be the beginning of the loosening of the child's harsh superego and that it would be followed by increasing expression of her hitherto repressed primitive impulses.

Kana then began to express her needs to be hugged and caressed as well as becoming more and more demanding and aggressive. The mother began to understand Kana's need and began to respond with all her heart. Kana now began to use baby talk and jargon, drooling like a toddler and indulging in a pacifier. Once when her mother rejected her wish to put on diapers she threw herself on the floor in a temper tantrum which lasted nearly an hour.

This was a truly trying period for the mother who had hitherto been dominating the child. I kept providing firm emotional support for her, intervening right on the spot whenever my help was needed. Gradually Kana began to show more affectionate behavior towards her mother, and on the second month of hospitalization she was observed contentedly on her mother's back, the two of them looking like a pair of koala bears.

At the end of the second month Kana began to show attachment towards other adult also, and was found actively playing with other small patients. By the middle of the third month she was a gay and happy girl spending more and more time away from her mother. The follow-up sessions after her discharge revealed a continuing good mutual relationship between the mother and the child.

## 2) YAE

Yae, an eleven-year-old preadolescent girl entered the hospital in an acute

psychotic state. This started one day when she was scolded at school for a trivial mistake. Two months before this, she had her first episode of the same kind, and underwent a thorough medical examination in another hospital which failed to reveal any organic cause.

Yae, the first child of a nuclear family of four, had been a quiet, tense and hypersensitive girl since infancy, always lonely and was bad at school. During infancy and childhood she never showed delight when her mother approached her. In stead she responded with repulsion and repugnance. At the time of admission to my department, Yae showed outbursts of archaic fears, whining incoherently all day and night. Onset of a psychotic process was suspected, and she was given haloperidol. The confusional state gradually subsided in one week.

At this time I considered that Yae would profit from hospital treatment with her mother for establishment of a stable bond with a mother figure.

It was characteristic of Yae that she became tense and uneasy when her mother came to attend her. She avoided her mother by going out of the room to chat with other patients, nurses and others in an unnaturally elated, and somewhat manic mood. Her mother was clearly disappointed at this, felt helpless and sought my help. I perceived that she was more fragile than she looked, and I decided to intervene a little to make Yae approach her mother, acting as a go-between for the parent and child. I noted that an exclusively close relation with the mother seemed to be too delicate an issue for Yae, who was hypersensitive and shy in a way. Ten days after the mother first came to stay, Yae got into her mother's bed with her mother sleeping in Yae's bed. Asked what it was like sleeping in her mother's bed the next morning, she answered in a tender voice, "mmmm. . . it was cozy and warm there and mum's blanket smelt good." The next week she was found sleeping with her mother in one bed, putting her arms around the mother's neck like an infant.

Although she tried to do her best for her child, Yae's mother never fully acquired a genuine quality in her maternal preoccupation, for she was always eager to confide her marital conflicts in which she accused her husband of mistreating her. The mother's Rorschach test revealed a weak basic trust and archaic aggression. My listening to her helped to partially alleviate and neutralize her aggression but did not lead to a fundamental resolution of the conflicts. I functioned as a buffer for her aggression and released Yae from becoming her mother's target. Yae eventually got rid of her symptoms, became fond of her mother, continued school in spite of her low achievement, became tomboyish and more care-free and was never found to be psychotic again in the five-year follow-up. Because of unstable elements in Yae's mother, I continued inviting her to my office for monthly follow-ups, in which she eventually revealed to me her distant relationship with her own mother. Thus I continued to act as a buffering agent for the mother and consequently for Yae. Yae visited my office and the pediatric ward whenever she felt her mother to be transiently unavailable, and in this way the treatment milieu continued to play its role as a holding environment for Yae.

### *Results*

The whole picture of the mother and child relationship showed radical change in all four cases. They acquired emotional mutuality which was gratifying to both, facilitating

the growth of the child's personality and the mother's maternal capacity. The children who had been withdrawn, tense, timid and vulnerable turned into sociable, flexible and adaptive children. They all were free from their symptoms, which never recurred, and the development of severe psychotic processes seemed to have been avoided. The children continued to show the favorable outcome in the follow-ups of two to five years, including resiliency to new life stresses. All mothers regained self-confidence and became attractive as a person, having done their best for the children.

*Regression, Interactional Circles and Transmission of Affect*

It was noted that the following two factors arising from the vicissitudes of symptom development in the child provided an optimal timing and situation for the renewal of a good mother and child relation through therapeutic regression.

First, the very fact that the child became symptomatic indicated that regressive forces were already at work within the child (Loewald, 1982). Second, the onset of symptoms in the child worked as an eyeopener for the mother who had been unaware of her child's vulnerability. It naturally gave her a shock, making her feel guilty and leading her to reflect on herself. Out of her need to be relieved of her helplessness she turned to the therapist, willing to make up for the earlier interactional failure.

Establishment of good mutuality between the mother and the therapist induced remedial interaction of the mother and her child. The therapist, when she won the mother's heart could become an object for the mother to rely on and identify and then the therapist could act as a model of an affectionate trustful mother which the mother introjected. How the mother interacted with her child depended on her relationship with the therapist. When the mother felt that the therapist was emotionally available, perseverant and trustworthy, then the mother was able to interact in the same way with the child. If the relationship was spurious, the mother was likely to assimilate the therapist's response to what may be called the false self (Winnicott, 1965).

Once the mother's maternal preoccupation with the child switched on the mechanism of rewarding interactional circles between the mother and child, the mother became more and more involved, acquiring self-confidence and autonomy through her child's positive feedback. Then the therapist could sit back and enjoy the unfolding of the unique reciprocity of the mother and child dyad, letting Nature do most of the work in her creative way (Stern, Barnett & Spieker, 1983). It was considered feasible to assign the mother a therapeutic role, since the mother had a psychobiological bond with her child, could interact with her on an around-the-clock basis and had many more years of mother and child relationship ahead.

Each child reexperienced infantile feelings in her mother's embrace. Those feelings of conflict that had been isolated and had caused symptoms now became understood and validated by the mother's empathy. They became integrated in the child's personality, which allowed the personality organization to resume progression.

The treatment milieu and staff functioned as a holding environment and a support system for the mother and child dyad. Infants and toddlers receiving pediatric treatment acted as good stimulants. Other mothers helped and supported the mother at the time of distress.

The hospital treatment of the mother-child couples yielded valuable data. However, it proved in the long run to be pecuniary too expensive and psychologically stressful for the family members who remained at home. Therefore, the approach was shifted to an outpatient treatment basis. So long as the establishment of a therapeutic alliance between the therapist and the mother was trustful, weekly interview with the couple sufficed to keep the therapeutic process going. In this way, more than 60 dyads have been helped, in which the children's problems included obsession, anorexia nervosa and pre-psychotic states.

### Conclusion

The results with the four cases treated by hospitalization indicated that the interactional failures of infancy which led to a psychopathological state can be reversed therapeutically with this specific approach of therapeutic regression at the time of the onset of symptoms. The emergence of reciprocity between the mother and child effected the personality of the child and the maternal capability of the mother through mutual stimulation. This approach, based on the recent infant research findings of mother-child interactional mechanism, also utilized the Japanese affinity for intimacy and regression. It proved effective in the management of psychopathologies rooted in early mother and child interactional failures.

### References

- Balint, M. (1968). *The Basic fault : Therapeutic aspects of regression*. New York : Grune and Stratton.
- Benedict, R. (1946). *The chrysanthemum and the sword : Patterns of Japanese culture*. New York : Meridian Books.
- Doi, T. (1962). Amae : A key concept for understanding Japanese personality structure. *Psychologia*, 5 ; 1-7.
- Loewald, H. W. (1982). Regression ; Some general considerations. In P. Giovacchini, and Boyer B. (Eds.) *Technical factors in the treatment of the severely disturbed patients*. New York : Aronson.
- Mahler, M. S., Pine, E., and Bergman, A. (1975). *The psychological birth of the human infant*. New York : Basic Books.
- Makita, K. and Okonogi, K. (1971). Parental attitude and family dynamics on children's problems in Japan. In J. G. Howells, (Eds.) *Modern perspectives in international child psychiatry*. New York : Brunner Mazel.
- Stern, D. N., Barnett, R. K., & Spieker, S. (1983). Early transmission of affect : Some research Issues. In J. D. Call, E. Galenson, & R. L. Tyson, (Eds.) *Frontiers of infant psychiatry*. New York : Basic Books.
- Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. London : The Hogarth Press.