

産後うつ病考

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Review Article

An Invitation to a Spiritual Home How Does Postpartum Depression Appear in the Eyes of Onlookers ?

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Introduction

Postpartum depression (PPD) is an emotional disorder affecting 13.4% of women after childbirth (Japan PPD Study Group, Japan Ministry of Health, Labour and Welfare, 2001). PPD is literally “the birth of tragedy” (*Die Geburt der Tragödie*, Nietzsche, 1827) : a woman in postpartum should be able to enjoy supreme happiness, but to her sorrow, finds misery in seeing a baby beside her. This is a tragedy not only for the PPD sufferer, but also for all members of the family, and above all for the newborn, as the baby’s mental development is known to be heavily impaired for some time after birth by the mother’s distorted patterns of affection, and this experience may result in a female baby developing a negative attitude when she bears children as an adult. PPD creates a generational link between the PPD-affected mother and her child (Sakio, 1995) ; PPD’s seriousness is thus reflected in its effects on both mother and child : the mother’s depression may lead to severely negative behavior (e.g., attempted suicide), and her child may become eventually suffer the same disorder as the mother.

In consideration of PPD’s gravity, the Ministry of Health, Labour and Welfare (MHLW) established a study group (SG) responsible for clarifying the situation of PPD in Japan. This was Japan’s first policy aimed at addressing PPD, and was implemented in 1992. The SG conducted PPD research supported by a fund provided by the MHLW from 1992 to 2003. The SG was composed of more than a dozen psychiatrists and obstetricians (as well as midwives in the latter half of that period ; see Table 1) ; all members worked sincerely and cooperatively. Finally, in 2003, the SG presented reports on key items and proposed a system of benchmarks for policy-making use (a later chapter will further discuss the SG’s activities).

The MHLW initiated the popular movement *Sukoyaka-Oyako 21* (“the 21st century will be a supreme blessing for parents and children”) shortly thereafter. That movement accepted one of the SG’s proposals—that PPD’s public prevalence should be reduced to 5% or less—and set it as a goal.

To date, at least two decades have passed since nation-wide policy and an associated public movement has directly addressed PPD. Accordingly, municipalities in cities, towns, and villages have taken responsibility for policy in this area. The author has maintained an ongoing awareness of the newly emerged *Sukoyaka-Oyako 21* movement and its progress, as he was occasionally appointed to the SG’s membership and to *Sukoyaka-Oyako 21*. He has naturally remained out of direct involvement, particularly following his retirement. To his disappointment, the present situation has never satisfied him. The present story starts at this point.

1. What is a clinical entity?

Advanced medical students learn of diseases declaratively : teachers in various fields present them with

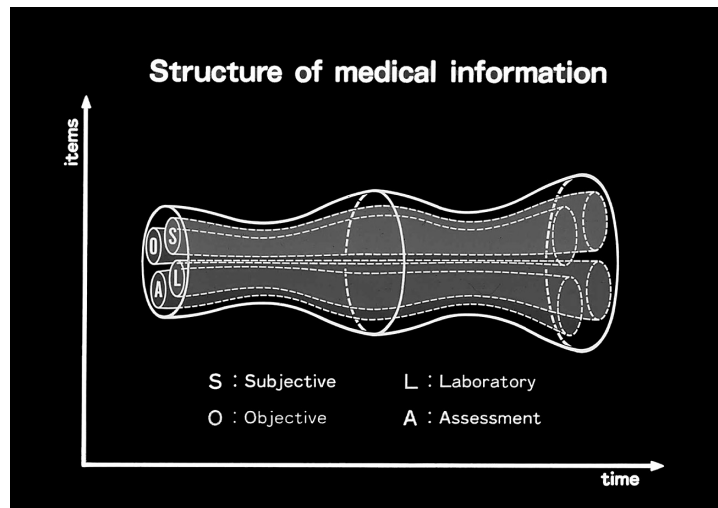


Fig. 1 A model of the informatics. A bundle of each straw of S, O, L and A grew or shrunk as time gone by, which represents any changes of diseases in a clinical entity. Presented at the First World Symposium "Computers In The Care of Mother, Fetus and Newborn, Vienna, March8-12, 1987

signs and symptoms, differential diagnoses, etiology and pathophysiology, methods of treatment, prognoses, and so on, as a cluster of necessary and sufficient conditions for the diseases under consideration. When the relevant conditions are properly satisfied, a disease is regarded as a clinical entity. Cancer, strokes, and heart attacks have long remained three representative causes of death in Japan ; each of these meets the requirements of clinical entity well.

Clinical practice is mainly concerned with the diagnosis and treatment of a patient with particular symptoms in the presence of a doctor, or with medically checking a patient with no symptoms in order to prevent disease.

Diagnostic procedures generally assess items that are predicable in the following categories : subjective complaints (S), objective findings (O), and laboratory examinations (L) (items the former two categories are commonly examined in physical exams). The author includes assessment (A) in this series, as selection of the most suitable mode of assessment could only be achieved through consideration of some possible pathophysiology ; however, modes of consideration may have varied either within or between instances of patient assessment. It was therefore reasonable to include A in the list of variables. This assessment scheme is termed "SOLA" (Fig. 1.) The space in SOLA expands or diminishes over time like a buoyancy chamber, presenting a complete view of the temporal course of particular disorders before and after any medical intervention. Almost all physical disorders may be satisfactorily modeled using the SOLA scheme. In sum, diagnosis initially proceeds in order through the categories in the SOLA scheme ; assessment then drives subsequent decisions about which treatment will be most appropriate. Treatments would then be appropriate in light of the patient's particular pathophysiology. The disease's etiology is importantly involved in proposing a theoretical background explaining the condition's causality.

This clinical process allows for a broad conception of a clinical entity. A clinical entity should be a mature specimen that ensures a satisfactory outcome for both patients and physicians.

2. What is a mental disorder?

In a sense, mental breakdown impedes the normal analytical techniques used in physical disorders, which

may involve SOLA in conjunction with various methods of physical and laboratory-based examinations used for managing clinical entities.

In contrast, the mind cannot be seen, heard or touched, and is only available through the physician's understanding. In this context, the patient's attitude and behavior help the physician to perceive the patient's mind through his or her understanding, requiring a process like tuning a radio to a particular frequency. This indispensable process allows people to apprehend, gauge, and understand one another.

Put another way, we have few effective tools to examine mentality, since the physical senses present in the human body are unhelpful for this task. Nonetheless, human ability is not limited to those senses but includes inspiration and cognitive capacity as additional "senses." Each of these may seem inconsiderable compared with the physical senses ; nonetheless, these extra senses are structured by the brain's ability to integrate sensory input. It is less evident that these "senses" correspond with any terminal receptors ; one might therefore sardonically remark that these senses appear to be "brain-generated." Nonetheless, these senses have proven trustworthy in their role as evaluators of mentality.

Psychotic disorders are currently taxonomically described in the ICS-10 (World Health Organization, 1990) and the DSM-V (American Psychiatric Association, 2013). A modern etiological point of view agrees well with the disease profiles present in these resources, and they facilitate treatment of disorders adequately in practice. Nonetheless, a bystander's apprehension of mental disorder might not consider it to be composed of neatly categorized clinical entities, particularly if the bystander were aware of the highly varied characteristics of psychotic disorders' etiology (more so than among any of the physical disorders), and further, if that bystander had long been aware of a particular instance of mental breakdown. This point of view would appear in contrast with that of modern medicine, which aims to intervene with discretely occurring physical problems. Around the middle of the nineteenth century, shortly after the appearance of modern medicine, psychotic disorders were individually documented as schizophrenia, depression, and so on. It was considered characteristic of these illnesses that their patients very often made no subjective complaints. Additionally, indistinct etiology would likely lead one to confine the disease to the syndrome, or similar. This appeared to present no problem : the situation was deemed acceptable so long as a patient was able to return to his or her kin following proper evaluation and treatment.

This context was highly suggestive that mental disorder ought to be categorized differently than physical disorders ; in fact, this is illustrated by the differences in spectrum of the clinical entities of mental and physical disorder : the former covers a wider range of sensory inputs, considering it incorporates inspiration and cognitive capacity, as discussed above, as well as the physical senses. It may seem strange, but mental disorders were considered properly located in the broader category of disease as a matter of course. The problem was that mental disorder had been left undisturbed since its origin. This circumstance may have been unavoidable while mental disorder was seen as less real than physical disorder, and partly explains suffering individuals' historical mistreatment and abandonment as weak members of society.

Liberty, equality, and philanthropy were the principles of the French Revolution. It may seem excessive to refer to that event in the present context ; however, the Revolution was an indication of the coming spread of democracy and of modern society founded on human rights. Further, the author would presume to suggest that people in distress should be cared for and treated regardless of whether they are aware of their own circumstances : regarding those who are not aware, their disease should be considered as affecting all of society, rather than the individual alone. In this sense, mental disorders may be considered a *morbis communitas*—a social disease.



Fig. 2 An eternal burden of a human race. Humans are born to meet each mother, who is a guidepost for a trail tomorrow, where the human society awaits. The central dogma, ever kept running, is only one that God blessed. To live be a burden for all God's creatures encouraged either positively or negatively all along, and amplified by the society? Living in a remote and lonely island, the PPD suffered wouldn't be aware of her nuisance, so much so that the PPD must be a social "Morbus". Drawn by Miss Fukunaga, M., 1988.

3. Is PPD a disease?

It is said that onlookers can read a game far better than the players themselves ; however, an onlooker would probably struggle to answer if he or she were asked if PPD is a disease. Indeed, this is the case for many physicians, excepting specialized psychiatrists. Of course, if it were generally believed that PPD was a disastrous condition, patients would quickly receive ample assistance. Nonetheless, given the above discussion proposed that mental disorders should be considered to affect society, rather than only the individual, PPD should naturally be considered a mental disorder. Further, as mentioned above, mental disorders should be categorized differently than physical disorders ; PPD therefore should be considered similarly.

Remarkably, PPD has long remained unaddressed, without being recognized by either the suffering mother herself nor those around her, even though if by chance it had been recognized, the community may have abandoned the sufferer as weak (Fig.2).

Following Emil Kraepelin's first description of clinical depression in the late nineteenth century, numerous psychiatrists have seemed to consider depression an emotional disorder. PPD was included in this categorization. It was considered natural that the *morbus* of PPD would occupy a certain region in the spectrum of psychopathology, ranging from severe to slight, and to sometimes approach the "maternity blues" (MB), although this condition is self-limiting and involves temporary emotional instability appearing a few days after childbirth and was therefore quite separate from PPD. Nonetheless, MB significantly predicts PPD appearing at 2-3 weeks postpartum (73% correlation, $P < 0.05$; Yoshida, 1995).

Pregnancy, childbirth, and child rearing are central life events for women ; these may cause mental disturbance leading to distress if sufficient support is not available from the mother's husband, mother, or others. Such life events generally present the highest risk for PPD.

The author would suggest, though fearing to attract a charge of ignorance from among psychiatrists, that

all the happiness of marriage, conception, childbirth and child rearing are present in *The Woman's Life* (de Maupassant, 1883). A series of problems with negative mood commences with pregnancy-related depression, which has 31% incidence in the first trimester as measured with the Self-rating Depression Scale by Zung, W.W.K (SDS), a self-report instrument (Kitamura, 1996), and moves on to MB, which has 25% incidence (Okano, 1991), and 37% incidence among Japanese people residing in London (Yoshida, 1994). (Ref. 1-8)

MB was measured using Stein's self-rating scale (1980) of Japanese version. Rates of incidence varied between populations of Japanese postpartum women (Japanese women living in London : 50% ; Japanese women living in Japan : 25%). The former figure is greater than in Japan, but less than in the general European population (approximately 50~80% incidence). This difference suggests that Japanese women retain more capacity after childbirth than was observed, and that intercultural stress created by mothers' social environment strongly affects sufferers in addition to limited social support resources (e.g., the absence of the mothers' mother or husband). These issues contributed to a PPD rate of 13.4% (Japan PPD Study Group, Japan Ministry of Health, Labour and Welfare, 2001)

Given PPD's considerable and enduring prevalence, one might expect that it would be regarded as a disease. Additionally, we should recall that it seemed justified above to consider PPD to belong to a different category than physical disorders ; finally, we should recall that PPD is a social *morbus*. These considerations make it appropriate to consider PPD a gender-related disorder or a family- and environment-dependent disorder.

4. The task force

The Japanese Government has begun to implement policies aimed at managing Japanese society's advancing age and declining birth rate. These initiatives have been termed "silver plans" or "angel plans." The MHLW has created a task force responsible for drafting principle policy for these plans. In 1992, the MHLW's advisory committee (The Committee on Maternal and Child Health in the Future, Chaired by Professor Kobayashi of Tokyo University) announced its final report. This addressed such difficult topics as fetal therapy and an ordinance requiring the support of mental disorder in mothers and their children. The author was a member of the committee ; he was therefore partly responsible for addressing these items, and on that account was requested to organize and manage the newly established task force regarding addressing mothers and their children's mental disorder. PPD thus surfaced for the first time as a policy priority among all health and welfare policy in Japan.

As mentioned above, the SG was established in 1992. After over a decade of activity, it decided to close itself down as having carried out its mandate. It is the author's obligation that all the SG's members should be presented here in full, to praise them publicly for their unrecognized efforts, with an apology for enumerating them only by name (Table 1.)

5. The evidence

The SG reported its results annually to the MHLW. The following examples indicate the overall character of this series of research enterprises.

In the early stages of research, PPD's principle features were reconfirmed in order to firmly characterize it among the SG's members ; that is, the SG implemented an ad-hoc standardization to fix the field of inquiry. PPD was then selected as a leading target of investigation alongside related problems such as negative mood during pregnancy and MB following childbirth. The Japanese versions of the Blues Scale (Stein, 1980) and the Edinburgh PPD scale (EPDS by Cox, 1987), which are both self-administered

Table 1 The members of PPD-SG

The members of the “mind” sect:

Kyushu Univ.	Prof. Yoshida, K., Dr. Yamashita, H.	Psychiatrist
Mie Univ.	Prof. Okano, S.	Psychiatrist
National Center of Neurology and Psychiatry and Kumamoto Univ.	Head Researcher and Prof. Kitamura, T.	Psychiatrist
National Children's Hospital	Late Dr. Sakio, E.	Psychiatrist
Tokai Univ.	Prof. Kobayashi, R.	Psychiatrist

The members of the “body” sect:

Kyushu Univ. and Hosp.	Prof. Nakano, H., Dr. Maeda, H. Dr. Sato, S.	Obstetrician-Gynecologist
	Head Ns. Yamashita, .H.	Midwife
Okayama Univ.	Prof. Kudo, N.	Obstetrician-Gynecologist
Ryukyu Univ.	Prof. Kanazawa, K.	Obstetrician-Gynecologist
Kitazato Univ.	Late Prof. Nishijima, M.	Obstetrician-Gynecologist
Fukushima Prefectural Univ.	Prof. Hoshi, K.	Obstetrician-Gynecologist
Miyazaki Univ.	Prof. Samejima, H.	Obstetrician-Gynecologist
Kobe Univ. Hosp. and Aomori Univ. of Health and Welfare	Head Ns. and President Shindo, S.	Midwife
Tohoku Univ.	Prof. Okamura, K.	Obstetrician-Gynecologist
Saitama Med. School	Prof. Kinoshita, K.	Obstetrician-Gynecologist
Mie Univ.	Prof. Toyoda, N.	Obstetrician-Gynecologist
Osaka Shoin Women's Univ.	Prof. Takeuchi, T.	Pediatrician
Tokyo Women's Medical College	Prof. Nishida, H.	Pediatrician
Saga Medical School	Assoc. Prof. Taniguchi, H.	Midwife
Health Center of Fukuoka	Dr. Suzumiya, H.	Doctor of Public Health
Juntendo Univ.	Prof. Takeda, S.	Obstetrician-Gynecologist
Yamaguchi Univ.	President and Prof. Kato, H.	Obstetrician-Gynecologist

instruments, were used as screening measures. Other scales allowing more detailed examination were introduced in subsequent research ; cohorts were established using distributed observation sites in Japan and in London. The first striking research trial involved training co-medical staff, mainly midwives, who were considered the most appropriate population to perform institutional screening and administer care due to their proximity to PPD cases. The SG member Kitamura was outstandingly well suited as an instructor, and enthusiastically led participant training across multiple cohorts.

With these preparations in place, all necessary activities were performed : a survey, a monitored intervention, and refinement of the understanding of the disorder's character under various circumstances.

Results collected until the year 2000 measuring the incidence of depression and anxiety during pregnancy in Japan varied between scales. Zung's scale gave a figure of 15%, the State-Trait Anxiety Inventory (STAI), gave 25%, Stein's scale estimated MB incidence at 25%, and Cox's scale estimated PPD at 15%. Remarkably, as described before, MB incidence among English women was estimated at 50~80%, and that of Japanese women residing in London was estimated at 37% (Yoshida), suggesting racial differences as well as the psychosocial strain of living in a foreign country. Co-medical staff were rewarded with evidence of the effects of their training in structured interviews. Trained staff showed individual variations in reliability within a moderate range, and their excellent performance yielded diagnoses as accurate as those of specialized psychologists. This was promising evidence supporting the creation of a “grass-roots movement” in Japan, where either midwives or health care nurses could be responsible for caring for PPD.

In the subsequent stage of research, the SG expanded the cohorts previously recruited to reinforce the research effort. Additionally, the SG established a new grass-roots movement whose leadership naturally included active midwives and public health nurses, that aimed to establish a Japanese mental health

support system for PPD sufferers. The movement launched successfully in several provinces in northern Japan and north Kyushu ; this indicated to the SG that maintaining a grass-roots movement would be practical. The psychiatrist researchers moved between cohorts to assist with their activities, to gather further evidence of psychopathological PPD and its related disorders, and generally to extend the SG's activities to the whole of Japan. Additionally, the "body" team examined various conditions and complications of pregnancy and labor in each cohort in order to confirm patterns suggested by patients' records. One SG study measured maternal affection in a control group as well as normal infertility and in-vitro fertilization and egg transfer (IVF-ET) groups in an Okinawa cohort using the Hanazawa scale (1992) (Kanazawa, 1996). Maternal affection in the control group gradually increased during pregnancy and jumped upwards after childbirth, as if awakened by the sight of the crying child ; in contrast, participants in the IVF-ET group gave their highest scores before childbirth and gave lower scores thereafter. These findings are likely to importantly illuminate the development or decline of maternal affection.

In the final stage of its research activities, the SG invited several mental and physiological neonatologists to help extend data collection to PDD's consequences on children, particularly regarding anxiety in child rearing and child abuse. By the second year of this research, the SG had confirmed the importance of policy supporting the childcare of babies born to PPD mothers, with the intention of preventing further generations of PPD. The SG recommended that the MHLW organize a new task force to investigate the effects on babies born to PPD mothers before announcing its closure.

6. The goal remains far away.

Similarly to European countries, psychiatry in Japan elucidated PPD and its related problems over some time. Policy making has proceeded methodically, however, did not commence until 1992—about a decade later than in the U.K.

Louis Victor Marcé, a French psychiatrist, first raised awareness of the risk of mental disorder around childbirth in 1858. In 1980, the Marcé Society was founded in the U.K., and expanded to international activity thereafter. Considering this timeframe, Japan took timely, rather than late, action in making PPD policy. Public sentiment regarding PPD's significance has nonetheless remained lukewarm, despite the tremendous efforts of some passionate people.

By the early 90s, Japan had completed a medical service system incorporating standard triage practices (i.e., urgency levels 1-3), and adequate regionalization had been established even for pregnancy and labor. Sadly, this system's development was swayed from its initiation by misgivings that it might inadvertently cause the relative negligence of normal pregnancies. The author, who was earnestly engaged in creating the new system regarding maternal transport and in-utero transport of high-risk cases, noticed that concern for normal pregnancies increased the prioritization of care efficiency. Mental health in pregnancy and labor were thus deliberately introduced into the system to partly redefine what was considered normal.

The Japan Association of Obstetricians and Gynecologists (JAOG) has recently advocated importance of women's mental health around gestation. Professor Yoshida, who was once a member of the SG, has advised JAOG to systematize itself. This would be beneficial ; however, development is apparently slow.

Nonetheless, it may be considered ironic that the U.K. has remained a paradigmatic case of materialism since the Industrial Revolution began there in the mid-eighteenth century. Had materialism raged in the U.K. thereafter, the revival of spiritualism might constitute a paradigm shift away from materialism and the restoration of human mentality. In any case, the U.K. received strong motivation to promote perinatal mental health. That is, the movement toward perinatal mental health in Japan was "contents oriented"

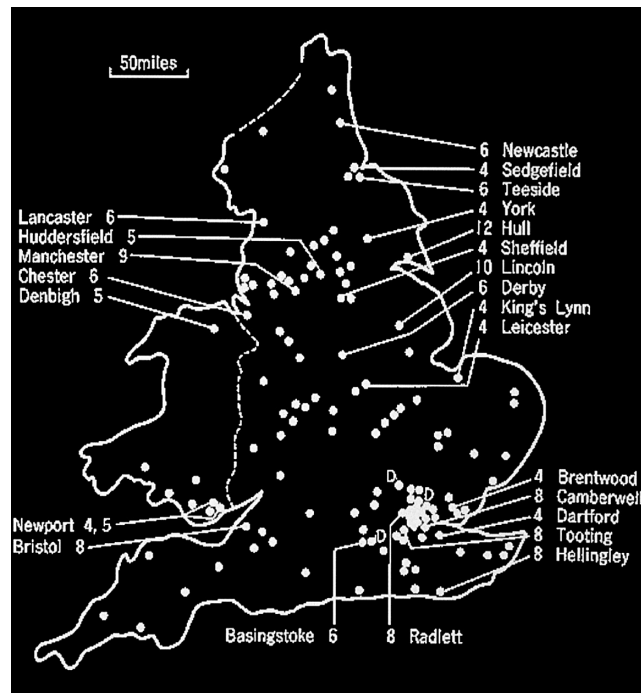


Fig. 3 Mother-Baby Units in England & Wales 1985–1986 (Aston et al. 1987). (By the courtesy of Prof. Yoshida, K.)

rather than “frame oriented”.

Following the establishment of the Marcé Society in 1980, the U.K. developed and established numerous service units with impressive rapidity. (Fig. 3)

7. Should the current Japanese paradigm shift towards that of the U.K.?

Regarding racial consciousness, people in modern Japan have generally been giving themselves up to the pleasure of materialistic life.

The Japanese government has certainly initiated policy supporting an aging society in association with the mega-trend of reduced childbearing : the angel plans were designed to address the mother and her child’s mental health in new ways. This was promising ; however, development in this direction sadly remains incomplete. The notion of changing outcomes was very positive ; however, the plans’ motivation has not been powerful enough to bring progress or create public acceptance for the plans. Support for the plans has been mixed overall : no particular parties are responsible for the lack of progress ; the prevailing mood has simply been one of expectant economic uncertainty, connected with gradually rising materialistic opportunism. Indeed, the former government advocated a return to the mind and a movement away from material things, and ended in failure.

Rapid progress towards any significant health care service policy such as took place in the U.K. would require widespread public acceptance of an idea ; that is, a paradigm shift. The author does not mean to suggest the wholesale replacement of materialism with spiritualism—merely the further expansion of the latter in society. A “slow” society and a “slow” way of living are more necessary than ever. Naturally, no motivation promoting the idea of a paradigm shift is present ; however, if the global economic system were to become either temporarily or permanently unstable, promotion of positive mood and happiness in life might become more valued.

Regarding either preparation for an aged society or the mother and child’s mental health, a positive aim

might only succeed if it were favored with good timing. The time is currently appropriate to address each of these concerns.

8. A bridge over troubled water

Where would we find the starting point, if we sought the ideal moral upbringing for proper care of mental health? Regarding mental health particularly between the mother and her child, relevant topics would include PPD, MB, anxiety in pregnancy, and nursing care for disabled babies. PPD would no doubt be representative among these.

PPD, which appears to be a modest problem but in fact causes new mothers to suffer cruelly, should never be stigmatized, as this inflicts concealed harm on new mothers who ought to be able to enjoy the presence of their child. PPD has become widely known following Marcé's publication on the disease. The Marcé Society pioneered much PPD research, the results of which have guided policy and led to the rapid introduction of standardized care resembling the U. K. model overall. Japan began to address PPD a decade later ; however, this was not simply lateness : it was the consequence of the slow penetration of required outcomes, possibly due to public and government indifference as PPD is not primarily a fiscal concern.

Once in the past, the author requested the MHLW via Kyushu University Hospital to approve active mental health care of mothers and their children at the Hospital as "highly advanced medical treatment" (a category of care under the health care system established in Japan in 1984). The application was submitted in the late 1990s ; the reaction was cold : neither the Hospital's staff nor any government officers seriously considered it. This outcome was to be expected, as this category is commonly granted to potentially highly lucrative treatments, and non-profitable maternal mental healthcare would therefore attract little attention at all levels of administration. Nonetheless, the author remained active in this enterprise.

It is useful to consider what social environment might lead to public prioritization of mental welfare. The reader may be acquainted with the flower of *samurai* virtue, which simultaneously manifests the opposites of sternness and broad-mindedness. That Japanese virtue of mind once governed Japan, and remains available for the retrieval of the Japanese people, facilitating the Japanese mind's recollection of the true value of spiritualism. Reformed educational practices, and particularly involving "active education," may be beneficial in this regard ; however, the author can offer little guidance on this topic.

Returning to the original subject, the uncertainty initially stemmed from a deeper problem : if any strategy might subtly change Japan's public and social mood—as subtle as the changing color in a woman's shawl. Society should aim to dye education with the color of philanthropy.

9. "Mazu-kai-ori-hajime-yo"

An old Chinese saying goes, "a journey of one thousand miles begins with a single step." Whoever would attempt to be a pioneer would certainly attend to the symbolic meaning and significance of "an active education." Indeed, the term represents a vague idea, although it is meaningful. The pioneer would, after much thought, ultimately realize that it refers to the significance of a conceptual framework that permits freedom to its user.

Nonetheless, the author advocates a framework and subject matter that aim to achieve innovative medical education.

The established program should naturally aim to create enthusiasm for mental health and minimizing social distress ; it should therefore target associations of medicine and learning—that is, medical schools and their students—as these will be the most accessible targets and the easiest to begin working with. Ultimately, such an organization would need to consider establishing an independent "psychiatric school";

however, this would occur in the distant future. Introduction of a “new educational pathway” (NP) would maximize the program’s practicality ; indeed, Harvard Medical School’s New Integrated Curriculum, which represented a major reform in MD programs, was implemented decades ago. That program was allowed to run for a designated period, after which its results were evaluated and the program was revised as necessary, before a further period of monitored use. Similar programs might employ trial periods of arbitrary length.

Given such a program would need to help educate specialized medical doctors, basic and advanced course content should include psychology and psychiatry, respectively. Preferably, students would complete their clinical training in general patient wards, as this will improve their understanding of patients’ emotions. For instance, students might come to understand a patient’s reaction to news that he or she was nearing death from reflecting on changes in their own emotional state.

A NP of this type would centrally aim to train highly skilled physicians to treat patients’ mental and physical state, as well as aiming to train highly specialized psychiatrists able to broaden existing social services to match social needs resulting from PPD and its consequences, which currently receive little public consideration. Such a movement (for it would need to be a movement) would ideally become active nation-wide, and issue in a paradigm shift of some extent.

10. “More haste, less speed.”

The NP would also need to establish adequate student recruitment methods. Simply put, it might be reasonable to propose setting introductory psychology as the subject of an entrance examination ; however, one can readily imagine that the proposer would be bombarded with criticism and a roar of protest. Nonetheless, this reaction would itself be illuminating.

The modern Japanese mentality seems still bound by the Meiji Restoration, which was deeply engraved into the public mind as an emblem of modernization. Further, defeat in the last World War established human rights in Japanese society. Japan likely took quite a different historical route : the French Revolution and Industrial Revolution took place around the same time (i.e., the late 18th century). It was another century before these innovations would arrive in Japan. The noble spirit of modernization has remained active since then, sadly leaning in favor of materialistic welfare. Indeed, the Japanese government has long argued vigorously that the future of the country will be prosperous Japan travels down the road of a technologically advanced and industrialized nation. This idea remains coherent ; however, it remains unclear why the Japanese public continues to support its pursuit. Such a public attitude would be significant if it were to precipitate an event as momentous as the Industrial Revolution in Japan ; however, even this outcome carries the concern that such a one-sided proliferation of material wellbeing would lead to an unbalanced society, unless industrialized developed countries were to collapse altogether.

It seems there should remain ample scope to encourage the Japanese public to recall a more spiritual life, which was once normal in this country. It seems there is still time to begin the return home, with the honors of the missionary.

The proposed subject (i.e., introductory psychology) for examination for admittance to the new medical educational program may thus constitute a substantial option in minimal preparation for negative outcomes following the continued negligence of PPD, this manuscript’s central concern.

Closing remarks

PPD was this document’s central motif. It is present but little considered in society ; even serving physicians rarely consider it as it’s prevalence is somewhat low and it is difficult to detect. If the public is

aware of this social *morbus*' reality, public reaction has been particularly slow, although most people are concerned for their health currently.

Naturally, the author has no information on the Japanese historical mental composition, particularly regarding the prevalence of social charity, which might have caused a social *morbus* like PPD to attract considerably more consideration. In this regard, the author anticipated a possible wholesale shift in public attitudes, such as to give rise to spiritual turmoil, due to the public's ongoing engagement with materialistic concerns. Nonetheless, a revolution of homecoming should remain a possibility as long as one's mental health suffers the effects of neglect. Sound mental health balances with the individual's physical wellbeing. For its own sake, and as a protective factor in a society biased towards materialism, the wellbeing of the human mind should be carefully balanced in consideration.

References

Annual Research Papers of the Japan Ministry of Health, Labor and Welfare on the mental health of the mother and child :

- 1 http://www.niph.go.jp/wadai/mhlw/ssh_1992.html
- 2 http://www.niph.go.jp/wadai/mhlw/ssh_1993.html
- 3 http://www.niph.go.jp/wadai/mhlw/ssh_1994.html
- 4 http://www.niph.go.jp/wadai/mhlw/ssh_1995.html
- 5 http://www.niph.go.jp/wadai/mhlw/ssh_1996.html
- 6 http://www.niph.go.jp/wadai/mhlw/ssh_1997.html
- 7 http://www.niph.go.jp/wadai/mhlw/ssh_1998.html
- 8 http://www.niph.go.jp/wadai/mhlw/ssh_1999.html

(和文抄録)

産後うつ病考

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中 野 仁 雄

産後うつ病 (postpartum depression) は女性の精神疾患である。産後 2~3 週から半年にかけて発症し、その頻度はわが国でおよそ 15% のリスクにのぼる。その影響は、罹患者のみならず、家庭や社会にも及ぶ。罹患者の自殺は最も忌むべきとして知られるが、並んで深刻な問題は罹患者の女兒が母子愛着行動の歪みを介して心理的な傷を負い、成長して自ら出産するに至った折、母親を再現することにある。

厚労省は母子の精神保健を政策課題に取り上げ、1992 年に研究班を設置、2003 年まで課題解決に取り組んだ。その中で、産後うつ病はもとより、妊娠中の不安、マタニティー・ブルーズなどの実像を明らかにしていった。頻度や精神病理の検証はもとより、公衆衛生の実現策としてコメディカル関与が有効なことをも示した。産科・精神科の医師、並びにコメディカルが共同して、地域に展開し、あるいは施設においてすべての妊産褥婦を対象に、メンタルヘルスの支援介入を行うなかで産後うつ病ならびに関連する問題の発掘と対応を行う実効性が示された。

その後、行政はもとより諸方面で上記の答申に基づく事業展開が図られてきた。しかし、その達成度たるや満足いくものではない。英国の場合と比べるとその違いは明らかである。

つまるところ、この問題の認知度を高め、政治・行政の、いやそれ以上に社会と国民の受容性を確かなものにするを前提としなければならない。迂遠なことながら、その端緒として医学教育を標的に取り上げ、その改善工夫のなかから、物質主義一辺倒の気配すら感じられる現状の営みのなかに精神主義の存在とその価値を再認識する運動を展開することが肝要である。いわばパラダイム・シフトとなる運動の効果は広くわが国民のマインドをより常識に満ちたスロー・ライフへと誘うものではないであろうか。