Treatment using psychotherapy involving Buddhist concepts in middle-aged women with psychosomatic diseases possible related to mother-child relationships

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Summary

We used psychosomatic theory in the treatment of middle-aged and elderly women referred by the pediatrician in charge of their children.

The children of these 3 women had problems of their own. Their pediatrician found it necessary to treat their mothers from a psychosomatic perspective while he was providing treatment to their children. The child of the first woman had become excessively dependent on her after the onset of an eating disorder. This woman developed a mood disorder. Her child later developed obsessive-compulsive disorder. The child of the second woman had developed school phobia involving hyperventilation. This woman also gradually developed a mood disorder. The third woman had suffered domestic violence for 20 years, beginning immediately after marriage, and had cared for her mentally retarded child for 10 years. Her husband’s parents proposed to her that the couple should divorce, but their view was one-sided and indicated DV and the mentally retarded child were the reason for the family’s “shame” in the eyes of the community. The woman, due to these stressors, developed PMDD.

We provided a form of psychotherapy involving Buddhist concepts to each of these three women. A mental condition that may be referred to as a “spiritual awakening” was attained through this treatment, and it seems to have stimulated recovery from their disturbed mental conditions.


Key words: Psychosomatic disease, Middle-aged women, Mother-child relationships, Buddhist concept, Psychotherapy

Introduction

The maturing of the mother-child relationship is a developmental process that needs to be worked through by mothers and children. If the children are to achieve satisfactory psychological development and the mothers are to evolve through the changing maternal role. Some women develop complaints in the peri-menopausal period for which the causes are unidentified. In 9.0% of women experiencing menopause, the complaints can be attributed to the “empty nest syndrome”, which is to say they have been unable to accept psychologically that their active role as a mother to their child or children has been completed. In 26.7% of cases of peri-menopausal women with complaints whose causes have not been clearly identified, psychological stress due to unsatisfactory human relationships within the family is
found to be responsible. In 32.1% of these cases, their relationship with their children is the source of the stress. The stress related to failed human relationships within the family/society is amplified by a depressive character style (typus melancholicus), a tendency toward introversion, a tendency toward self-sacrifice, domestic martyrdom, or alexithymia, leading to the appearance of various mental and physical symptoms that some have grouped together as unidentified complaint syndrome\(^3\).

In recent years, Western mental health professionals have attracted increasing attention and growing evidence of Asian psychologies suggests that may have been underestimated their potential contributions. Michalon reported that Buddhist psychology has now gained some credence in the West and is starting to exert a growing influence both on various areas of medicine and well-established Western psychotherapies\(^3\). The Buddhist concept of "selflessness" is often perceived by Westerners as a recommendation for the dissolution of their ego and its propelling forces in their competitive societies, instead of an invitation to dispel the artificial compactness of their "I". Furthermore, Zen meditation, or zazen, which is one of the way of practicing Buddhism, has attracted the interest of many psychotherapies\(^4\).

We recently conducted a form of psychotherapy using elements of Buddhist thought, with 3 women of menopausal age referred by a pediatrician treating their children. These three cases will be presented in this paper.

**Cases**

Table 1 shows backgrounds of three cases. It seemed these women had developed problems triggered by treatment and care for the children who had problems of their own, and other factors. Changes in the relationships of these women to or their views about their children were closely related to the courses of their improvement.

**Case 1**

A 48-years-old woman consulted a doctor with complaints of fitful sleeping, shoulder stiffness, and headache. She showed not particular family history and past history. This woman was brought up in a provincial city, in a four-member family composed of her father (a company employee), her mother (a housewife) and an elder brother. At the age of 20, she graduated from a professional school in a large city. Then she returned home and was employed by a company in her locality. When she was thirty, she married a company employee. The next year, she delivered a baby girl. The family household was economically stable. She and her spouse had a good relationship.

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<td># 1</td>
<td>48 years old</td>
<td>fitful sleeping, shoulder stiffness, headache</td>
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<td>borderline alexithymia self-degation with other-affirmation nearly normal personality with slight non-cooperative character depressive, neurotic trait borderline alexithymia self-degation with other-affirmation nearly normal personality with slight neurotic and non-cooperative character depressive trait borderline alexithymia typical self-degation with other-affirmation nearly normal personality with slightly nervous and introverted</td>
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<td># 2</td>
<td>44 years old</td>
<td>general fatigue, insomnia, depressed mood</td>
<td>hyperventilation syndrome, truancy</td>
<td>borderline alexithymia self-degation with other-affirmation nearly normal personality with slight neurotic and non-cooperative character depressive trait borderline alexithymia typical self-degation with other-affirmation nearly normal personality with slightly nervous and introverted</td>
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<tr>
<td># 3</td>
<td>41 years old</td>
<td>headache, general fatigue, jittery in the late luteal period</td>
<td>mental retardation, easy infectious predisposition</td>
<td>borderline alexithymia self-degation with other-affirmation nearly normal personality with slight neurotic and non-cooperative character depressive trait borderline alexithymia typical self-degation with other-affirmation nearly normal personality with slightly nervous and introverted</td>
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Two years ago her daughter, then 16 years old, developed an eating disorder. During pediatric management of the eating disorder, the daughter became progressively more psychologically dependent on her mother. She attempted to help her daughter to become more independent by encouraging her to perform various things by herself in the course of her daily activities. The daughter resisted these moves on the part of her mother, and instead became more dependent on her. She thus felt forced to restrict the conduct of her own daily life to the behaviors demanded by her daughter. Her daily activities were completely limited by the daughter all day long. Pediatric treatment of the daughter for her eating disorder proved effective after one year, and her dietary pattern normalized. Around that time, however, it became difficult for the mother to communicate adequately with her daughter. Two months ago, she began to experience fitful sleep, shoulder stiffness and headaches. The daughter had tended to avoid contact with her father. Daughter was still highly dependent on her mother. Daughter became emotionally unstable and began to attack her mother if she felt her will or desires to be thwarted. The pediatrician in charge of the daughter recognized it was necessary to treat the mother simultaneously. Patient was thus referred to our department for treatment with a psychosomatic orientation.

Her personality trait was rated as follows. Cornell Medical Index (CMI) was Fukamachi’s class I (total score 5). Self-rating Questionnaire for Depression (SRQ-D) was 9. The alexithymia scale was 15 (border-line). On egogram, she was rated as type N (with a peak at A). On the YG personality scale, she was rated as type A" (only uncooperativeness was rated as the standard score 4—slightly high).

During her first visit to our department, the mother had evident psychological symptoms, including depressed mood, jittery and anxiety. For these reasons, treatment with an SSRI (paroxetine 20 mg/day) and ethyl loflazepate (2 mg/kg) was begun. When she visited our department two weeks later, she made these statements: “My child shouts, and it always makes me have palpitations” and “Whenever I try to do something, my child gets in my way.” Because she appeared to be low in spirits, feeling helpless, and world weary, etc., we informed her, in her husband’s presence, that the current status of her mental distress seemed to be associated with her relationship with her child. We offered our opinion that she needed sedation, anti-depressant therapy and hospitalization to separate her from her child. She scored 88% on the visual analog scale (VAS) use to evaluate the subjective impact of symptoms. After admission to the hospital, she received sulpiride (100 mg/day, i.m.) and clomipramine (25 mg/day, i.v.) therapy, accompanied by 30 minutes of psychotherapy every day. During psychotherapy, she was told about the Buddhist concept of gaining insight into the thoughts of other people by imagining oneself in similar circumstances (Table 2). This helped the woman understand that the daughter was obstructing the mother’s activities because the daughter loved herself better than she loved any other person. The patient was also advised to accept and affirm reality; i.e., to take the view that one must accept everything as it is. One week after admission, the woman resumed smiling, and her mental and physical symptoms disappeared almost completely. Her VAS score decreased to 26%. She was discharged from the hospital 3 weeks after admission. During the 3-week hospital stay, the woman’s daughter gradually acquired independent activity patterns. For the first 3 days after discharge, she “had difficulty dealing with the daughter”, giving her an impression that the daughter had become more dependent on her.
than before. From the fourth day on, however, the daughter showed an independent behavior pattern. Two months after discharge, her daughter was diagnosed as having obsessive compulsive disorder. The daughter washed her hands for 30 minutes and took bath for 7 hours, and the patient had to attend her often during these periods. The daughter withdrew from school temporarily. She said: "Now I feel refreshed, and can control myself" or "I have learned to stop thinking about my daughter." She was able to think: "The condition of my daughter should be left as it is" and said: "I will accept the present state in a relaxed manner." Two months later, the daughter kept visiting the psychiatric clinic as instructed, and the patient was able to lead daily life without difficulties. She said: "I feel now I am living for providing best treatment to my child."

**Case 2**

A 44-year-old woman consulted a doctor with complaints of general fatigue, insomnia, and depressed mood. She showed not particular family history and past history. She was brought up in a city in a four-member family composed of her father (a company employee), mother (a housewife) and a younger sister. Since she was a young child, her family members have had a good relationship to each other. Even at present, she has close communication with her parents and sister. Her appetite has been small since she was an elementary school pupil. She was often scolded by the teacher for having not completely taken the school lunch. Also during junior and senior high school periods, she was not able to take food in amounts equal to those ingested by others. It later became unable for her to dine out. She could not tell this fact and her emotion to her parents and she was worried with this problem without help. After having entered university, it became possible to dine out without feeling anything special. The amount of food she took also increased. After completion of the course at the university, she was employed by a company. After she worked as a clerk for 3 years and as a secretary for 2 years, she married the present husband at age 27 under advice of her superior at the company. She retired from the company at the same time. Her husband who was a company employee was 4 years older than her. She delivered a baby girl at age 28 and a baby boy at age 31. Her household has been economically stable. In general, she had a good relationship to her husband. However, he was not able to determine anything by himself, and she desired that he would have a stronger will.

After her son entered a junior high school last April at age 12, he had difficulty doing his homework which was assigned in excessive volumes every day. He developed attacks of hyperventilation. Later, he complained of fatigue and appeared to be spiritless. When his mother (case 2) consulted his teacher, the teacher advised her to
consult a pediatrician because of the possibility of learning disorder (LD). Although his condition improved spontaneously for a while, he stopped going to school after the consecutive public holidays in May. She alone visited the Pediatric Clinic of our university hospital to receive consultation about the truancy of her son. During this visit, she made an appointment for LD test for the son. After returning home, however, she was not able to tell the son about this test for fear of injuring him mentally. She also hesitated to tell it to her husband. The appointment was thus canceled. Her son remained at home all day, sleeping in the daytime and playing with games and the Internet at night. She visited meetings of the Group of Parents Having Truanting Children or the Center for Supporting the Daily Lives of Children. Despite these efforts, her affliction intensified. Around January of this year, she became markedly depressive and began to complain of general fatigue. Around April, she began to shed tears without particular reasons and tended to be inactive in the morning. She had self-punishing feeling about the son such as: “I will regret it in the future if I cannot give any help to him” or “What life will he going to lead from now on?” She was thus mentally placed in a fix and feared that she would become bed-ridden if this condition persisted. She thus came to our clinic.

Her personality trait was rated as follows. CMI was Fukamachi’s class III with high M-R score (total score 28). SRQ-D was 18 (emotional disorder). The alexithymia scale was 14 (border-line). On egogram, she was rated as type N (with AC showing the maximum score 6). On the Yatabe-Gilford (YG) personality scale, she was rated as type A” (nervousness and incooperativeness were rated as the standard score 4—slightly high). The standard score for easy-going, aggressive and extrovert personality was 1-2 (slightly low).

Treatment with SSRI (fluvoxamine 50 mg/day) and alprazolam (0.8 mg/day) was started. At the same time, she was advised to share her mental agony or difficulties with surrounding people and to respect non-attendance of the child to school as his personality or will. That is, she was advised that she should not attempt to change the current state by force but should keep watching the situation and son’s attitude. Furthermore, Buddhist concept-based psychotherapy was performed throughout her treatment. The teaching “Seeing things as they really are”, “There is no such thing as permanence” and “Not same individuality, but same human” were adopted into psychotherapy. She told her agony about the son to her husband completely, while crying loud. She also consulted her parents. Her parents visited her home, to talk with their grandson. She thus came to think that her son had his own style of life. Three months after her first visit to our clinic, the son was able to go outdoors with his elder sister and her friend to watch movies. She found that her son had become mentally stable. Six months later, the time of dialogue between she and her son had increased considerably. Although the son told her that did not want to go to school, she was able to accept the son’s feeling smoothly. Her all symptoms alleviated, allowing her to lead a normal daily life as before. The dose level of SSRI was halved. After treatment of one year, her condition was stable, and all psychotropic agents were discontinued. Two years and ten month after the start of treatment, the son resumed attending school suddenly (4 years and 4 months after he began to truant). It was on the first day of the second term of the second year of senior high school. Since then, the son has been attending school without absence. He is now studying very hard to catch up with other students. She continued to watch that the son did after she began to visit our clinic. She said with a
smile: "I am pleased to know that what I have done to my son was correct." At present, she is only receiving anti-hyperlipidemic agents and is leading a healthy daily life.

Case 3

A 41-year-old woman consulted a doctor with complaints of headache, general fatigue, and jittery in the late luteal period. She showed not particular family history. She has experienced postpartum depression at 31 y.o. She was brought up in a six-member family composed of parents (operating a restaurant), an elder brother and paternal grandparents. After graduation from senior high school, she helped her parents in operating the restaurant. She married a boy friend at age 20. She delivered the first son at age 22 and the second son at age 31. Immediately after marriage, her husband began to exercise domestic violence (DV). For the subsequent 20 year-period, she had lived with fear of DV. Her husband occasionally used violence even at his workshop and changed his job 5 times during the 20-year period. The current employer is very sympathetic to the husband, and he has been working here for 8 years.

Immediately after she delivered the second son at age 31, she developed postpartum depression. She was not able to nurse the child adequately for 4 months. About 6 months after birth, the child began to show signs of mental retardation. Around age 1, he repeated fever and diarrhea. Cold often advanced into pneumonia. She spent most time caring for this child during the 9-year period. Her husband used hard violence on her occasionally, but she endured it and cared for the second son. The 9-year-old eldest son helped her caring for the second son. Her parents refused to keep company with her family on the grounds that having a violent spouse and a mentally retarded child is a shame. They refused economical support to her and her family. At age 3, the second son began to become excited, cry or speak loudly occasionally. He was mentally unstable and she had to keep watching him all day long. The husband avoided to see his wife having difficulty with caring for the second son. In those days, she often developed headache, general fatigue and jittery before menstruation. The condition of the second son, however, stabilized after he reached the age 10. After the second son caused less trouble to her, she came to be concerned about the future of her life with the husband. One year before, the violence of the husband had intensified, and he had begun to think that he was sick himself. In those days, the eldest son, which had never caused trouble before, withdrew from university at his own discretion and began to prepare for receiving an entrance examination to another university. These events made her uneasy, and her affliction was intensified when she was told that the communication between the second son and his teacher at the school for disabled children had been lost. The school proposed her to transfer the second child to another school (a school for normal children). Three months before her first visit to our clinic, she had begun to live separately from her husband. Her eldest son passed the entrance examination to another university, but the issue on the second son had not been resolved. Her premenstruation symptoms aggravated after she began to live separately from her husband. She was advised by the pediatrician in charge of her second son to visit our clinic. Her VAS score showed 77%.

Her personality trait was rated as follows. CMI was Fukamachi's class II (same scores for C, I, J and M-R; with a total score being 12). SRQ-D was 22. The alexithymia scale was 14 (border-line). On egogram, she was rated as type N (with AC showing the maximum score 7 and a CP score of 0). On the YG personality scale, she was rated as
Buddhist psychotherapy for middle-aged women

Discussion

Patients with peri-menopausal unidentified complaint syndrome (including mental disorders) are often exposed to various mental stress associated with complex social environments. These patients are often in environments where no support from surrounding people is available, and they often make no attempt to tell their agony to surrounding people. Nowadays, factors which often cause mental stress to middle-aged women are one’s own health, relationship to partner, and care for parents. The percentage of middle-aged women exposed to mental stress associated with children has recently been increasing. The percentage in the 1997-2000 survey was 4.7 times as high as that in the 1994-1996 survey. During the same period, the percentage of women exposed to mental stress associated with relationship to husband rose 2.9-fold. These changes probably indicate that the aging and less-child trend of the Japanese society in recent years has gradually been reflected into the psychosomatic disease profiles of middle-aged women.

All of the three women presented in this paper had sick children. The pediatrician in charge of these children noted the necessity of checking these women for psychosomatic abnormalities while he was providing treatment to their children. In the first case, the only child developed eating disorder and became excessively dependent on the mother. This mother developed mood disorder and received treatment as an inpatient. Fortunately, her spouse understood the necessity of repairing the mother-child relationship and treatment of sickness, and familial cooperation was obtained. The psychotherapy for this woman adopted Buddhism views “Others love themselves most” and “Seeing things as they really are” as the score. This therapy altered the woman psychologically to an extent which could be viewed as “enlightenment”. This probably served as an accelerator for her healing. In the second case, the onset of hyperventilation syndrome and truancy in the child triggered the onset of mood disorder in the mother. We advised her to tell the difficult situation about the child to her spouse, spouse’s parents and her own parents. She thus shared the pain with other people. She was able to accept the child’s truancy as reality and the view that everything in the world is variable in nature. The mother accepted the child’s
frequent absence from school as a personality of the child. As the mother adopted an attitude of leaving the child's mind to follow its own course, her symptoms alleviated rapidly. The scope of the child's activity gradually expanded as the mother assumed such an attitude. Suddenly, the child's truancy disappeared. The direct factor for disappearance of truancy in this case remains unidentified, but it seems highly likely that resumption of mental and physical health by the mother after treatment stimulate the child to show better mental development. When the Buddhist views "Seeing things as they really are", "There is no such thing as permanence" and "Not same individuality, but same human" were adopted into psychotherapy, they allowed smooth acceptance of the child's thoughts and their truanting tendency by their mothers. These two women seem to have undergone a king of "enlightenment and self-fulfillment" or "coming to bay", although the extent may vary from case to case. Thus, Buddhist concept-based psychotherapy was successful®. When dealing with this kind of disease seen in individuals under quite restrictive environments, approaches of psychosomatic medicine, adopting Buddhist views, seem to be indicated®.

In Japan, Morita therapy has been applied for the therapy of neurosis or some psychosomatic disease including climacteric disorder. Unlike cognitive-behavior therapy, Morita therapy is not aimed at removing symptoms. This therapy can be characterized by resolving the problem while the patient continues to show the symptoms. The theoretical basis and therapeutic principles of Morita therapy are taken from Zen Buddhism, such as the development of the ego in the "space" between subject and object, the unity of body and soul, the distinction of inner and outer nature, and the principles of emptiness and nothingness®. The teaching and practices of the Zen Buddhism are understood as encouraging important areas of both psychological and spiritual development.

The third case developed PMDD, which seemed to be associated with DV (beginning immediately after marriage lasting for 20 years), care for the mentally retarded child for 10 years and the one-side proposal of divorce by the parents for a reason of "shame". Although she was released from daily DV by living separately from the husband, she had many unresolved problems, including inability to discontinue receiving financial aid from the husband, inability to receive mental and economic supports from parents, and anxiety about the future of the child. However, learning the Buddhist view "There is no such thing as permanence" allowed her to accept the unfavorable environments around her. Several studies have demonstrated an association between PMDD and stressful life events® and particularly day-to-day stress™, and socio-cultural factors®. The consistent relationship between life stressors and PMDD has prompted the suggestion that symptoms may develop as "a learned, legitimate, feminine way of expressing frustration"® and, in particular, expressing frustration with the conflict between women's productive and reproductive social roles®.

Women at peri-menopausal ages are now likely to develop unidentified complaint syndrome triggered by exposure to stress associated with spouse, parents (due to the need of their care in daily living) and relationship to children. Children are often the most important for mothers, and not a few women lay primary emphasis on children during their daily living. It should be noted that loss of a good relationship to children or excessive relationship to children can disturb these women mentally and physically, sometimes necessitating treatment with approaches of psychosomatic medicine. When dealing with these
women, diverse clinical measures will be needed, including temporarily shifting the woman’s concern from the child, administering Buddhist concept-based psychotherapy and arranging environments for familial cooperation in the care for the child.

References
母子関係が発症の要因と考えられた中高年女性症例への
仏教思想を心理療法に盛り込んだ心身医学的対応

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概要  子供の主治医の小児科医より診療依頼を受け、心身医学的治療を行った中高年女性を経験した。
3名の患者の子供は全員が疾患を有していたため、小児科医師が子供の治療経過の中で母親の心身医
療の受診の必要性を認めた。1例目は、子供が摂食障害の発症により母親への依存行動が出現し、気
分障害となった。子どもはその後強迫性障害を発症したが、薬物療法に加え、現状を“ありのまま”に
受け入れることと、子供の立場や考え方を“わが身に引き当てて”子供の目線で母親（自分）の行動を
客観的に観察することにより、行動の歪みを認知でき、子供に対して自然な接し方ができるようになった。
2例目は、子供が過換気症候群を契機に不登校となった。家族の誰にも自分の苦しみを表現できない
うちに、気分障害を発症し、周囲に苦しみを分け与えたこと、子供の不登校を“ありのまま”に受け
入れ、世の中のすべては“諸行無常”であるという仏教的概念を心理療法の中心として薬物療法に加え
て実施したところ、徐々に考え方が楽になり、6カ月後には不登校には変化がないものの、自覚的には健
康感が回復した。3例目は、配偶者との結婚直後から20年間に及び、DV、精神発達遅滞の子供の10
年間に亘る介護、「世間体が悪い」との理由による両親からの一方的な絶縁の申し出などにより月経前不
快症候群（PMDD）を発症した。本例も薬物療法を行いながら“諸行無常”という仏教的概念を中心と
した心理療法を行ったところ、月経3周期目には自覚的な精神、身体症状が著明に改善した。
治療として、いずれも仏教の思想、概念、教義を加味した心理療法を行い、それぞれが「さとり」に
近い心理状況を得たことが治療効果を促進したと思われた。