

大会企画シンポジウム2

『臨床の場で大切にしたいこと』

◇日時と演者

日 時: 2010年9月12日(日) 9:00~11:00

基調講演:

- 1) ジャック・キルツエンブラット (アルフレッド病院・精神科医)「精神科医療の臨床現場から」
- 2) 奈須康子 (東京小児療育病院・小児科医, 世界乳幼児精神保健学会)「小児科医療の臨床現場から」

指定討論:

- 1) リオニ・キルツエンブラット (クイーンズランド大学・脳研究所)「神経科学の基礎研究の立場から」
- 2) 田中真介 (京都大学)「発達研究, 療育研究の立場から」

企画・司会: 田中真介 (京都大学)

◇企画の趣旨とシンポジウムの概要

小児科・精神科の医師や教育・療育の専門家は、相手とともにある時間と空間の中で、どのように対象と関係を結び、相手を助けているのだろうか。このシンポジウムでは、①それぞれの臨床場面で展開されている子ども理解・人間理解の方法、②診断と治療・臨床相談活動の中で最も大切にされていること、さらに、③病氣・障害の持つ意味の発見による医療・臨床相談の新展開、これらの観点について話題提供を受けた。

ジャック・キルツエンブラット (Jack Kirszenblat) 氏は、精神科医療の立場から、多種多様な精神疾患をもつ大人の患者たちを対象とした臨床場面での「出会い」、「臨床の場」、「治療的な関係」、「メッセージとしての病い」、「障害の意味」、「老いという祝福」、「回復とは何か」、これらの観点について話題提供した。

奈須康子氏は、小児科医療の立場から、重度の障害のある乳幼児たちを対象とした臨床場面において、①子どもの声なき声を読みとる医療と保育・療育、②家族・地域を支える医療のあり方、これらの観点について話題提供した。

討論では、神経発達研究の専門研究者であるリオニ・キルツエンブラット (Leonie Kirszenblat) 氏を交えて、乳幼児期に重い発達障害を示した事例、また、思春期に精神疾患を示した事例をもとに、＜神経学的・生理学的基礎に基づいた医療＞と＜心理学的な臨床相談活動＞との連携について討議した。さらに、田中真介氏は、病氣や障害への「医学的治療」や、対象を支える受動的な「発達支援」だけでなく、子どもたち・大人たちの未知の力を引き出す能動的な「家庭教育・学校教育・社会教育」を総合的に保障していくことの重要性について、また特にその中でも、豊かな社会的交流活動を意図的・計画的・教育的に組織し、「自己信頼性」を育てる人間教育を展開していくことの大切さについて提起し、討議した。

◇参考文献

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- 2) Tanaka, S. *Development and Education in Childhood. Part 1 —A case study of a profoundly handicapped child*. Kyoto University (1998年) (田中真介『重度心身障害児の発達と療育』京都大学, 1995)。
- 3) Winnicott, D. W. *The Maturation Processes and the Facilitating Environment*. Studies in the Theory of Emotional Development. International Universities Press, Inc. (1965年) (ウィニコット, D. W. (牛島定信訳)『情緒発達の精神分析理論—自我の芽ばえと母なるもの—』岩崎学術出版社)。
- 4) Winnicott, D. W. *Therapeutic Consultations in Child Psychiatry*. The Hogarth Press and the Institute of Psychoanalysis (1971年) (ウィニコット, D. W. (橋本雅雄訳)『子どもの治療相談』岩崎学術出版社)。

◇講師プロフィール

■ Jack Kirszenblat (ジャック・キルツェンブラット)

MB. BS, FRANZCP, Dip. Obs RACOG, Dip. Anaes. RCS (U.K)

Educational and professional qualifications (学歴・職歴):

- 1) Batchelor of Medicine (Honours) Batchelor of Surgery (Honours), Monash University, 1975.
- 2) Diploma of Obstetrics (産婦人科), Royal Australian College of Obstetrics and Gynaecology, 1980.
- 3) Diploma of Anaesthesia (麻酔科), Royal College of Surgeons (United Kingdom), 1981.
- 4) Fellow of the Royal Australian and New Zealand College of Psychiatry, 1994.

Paper (代表的な論文): Psychiatry in Rehabilitation Medicine, Dissertation for Royal Australian and New Zealand College of Psychiatry.

Current positions (現在の所属):

- 1) Psychiatrist to the Cancer Services, The Alfred Hospital, Melbourne, Australia.
- 2) Senior Consultant, Department of Consultation-liaison Psychiatry, The Alfred Hospital, Melbourne, Australia.
- 3) Examiner for the Royal Australian and New Zealand College of Psychiatry.
- 4) Private Practice, General Adult Psychiatry and Psychotherapy.

■ 奈須康子 (なす やすこ)

鹿児島大学医学部を卒業後、静岡県立こども病院で小児科医として勤務。特にNICU(新生児集中治療室)では東京女子医大母子総合医療センター勤務を含め新生児専門医として従事していたことが、小児科医としての基盤となった。

その後、東京小児療育病院で障害児医療・療育の分野に従事し、1998年6月に宮崎県に派遣される。宮崎生協病院と迫田病院に勤務し、宮崎では初めての発達外来を始める。また北九州市立総合療育センター勤務を経て、宮崎県立こども療育センターにて宮崎県の療育システムの検証・構築に参加した。この間、一般病院では、鹿児島生協病院、奄美中央病院(奄美大島)ほか、第一線の地域型市中病院でも数々の経験をすることができた。大学時代に鹿児島県の保母資格を取得。

宮崎では、障害児者および御家族も支援者も集う手つなぎの学習の場として「みやざき地域療育ネットワーク研究会」を1999年に創設。また2001年1月に発足した「子ども虐待防止みやざきの会」では、幹事として、また2002年4月には同会がNPO法人となり、理事として活動してきた。

現在の専門は、小児科・障害児医療・療育。以上のほか、慶應義塾大学医学部小児科小児精神保健部門でも研修を受けた。赤ちゃん成育ネットワーク研究会世話人、日本乳幼児精神保健学会FOUR WINDS 監事、NPO法人子ども虐待防止みやざきの会理事など。宮崎市では、健康みやざき21プラン策定市民懇話会委員、宮崎市健やか親子21推進協議会委員長などを担当。

【講師からのメッセージ】

子どもは地域や社会の宝物です。障害の有無や環境にかかわらず、子どもが心身ともに健康に幸せに育つための日常をつくるのは私たち地域や社会の大人の義務であり、喜びです。私は医療従事者として子どもとご家族、そして子どもを育てる地域の環境とよく相談しあって一人ひとりの子どもに最も良い道を見つけていけるよう、一翼を担うことができましたら、大変嬉しく思います。

◇報告と討議の概要

■第1報告

A Child and a Gift
—Reflections on the attitude
of a clinician—

Jack Kirszenblat
 (The Alfred Hospital, Australia)

key words: psychiatry, clinical encounter,
 place of therapy, gift

I'd like to say a little about myself first.

I am a psychiatrist. I work with adult patients. I have a small private practice. I also work in a large teaching hospital. My work in the hospital is with patients who have cancer. My job also involves working with, and teaching, doctors who are training in psychiatry.

What do I mean when I say, "I am a psychiatrist"?

I mean that I have studied and trained as a doctor first. My first knowledge is knowledge of the body. I have gained this knowledge by studying the body as "a thing". But to say that I have this knowledge about the body is not the same as saying that I have an understanding of what it means to be human.

To say, "I am a doctor who has trained as a psychiatrist" also means that the *last* thing that I have studied is the mind. It means that my knowledge of the body is considerable but my understanding of the mind is modest. It means that I am slowly groping my way towards an understanding of what it means to be human, to have a human mind. But it also means that I am impeded in my progress towards this understanding by two things: Firstly, by all the knowledge I have accumulated as a doctor and secondly, by my habit of accumulating knowledge about the mind as if it were "a thing" like the body.

I must confess that I feel a little uneasy talking to you today because my teaching work, and my clinical work, is something that I try to keep alive in the moment and I cannot easily transfer it to a lecture. I have also found that literature and film provides a very useful means of reflecting upon important life experiences and the challenges of clinical work.

The hero and the fool

Earlier this year I saw two films by the great director Akira Kurosawa—*Scandal* and *The Hidden Fortress*. In both these films Kurosawa presents two very opposite human types. One human type is a stupid, clumsy buffoon. This type is driven by the base human desires—greed, gluttony, lust and fear. The other type is the hero. He is handsome, clever and courageous. In these two Kurosawa films these two types are brought together by fate. In both films the task faced by the hero is to rescue a young woman.

In Kurosawa's *Scandal* the hero is an artist and he becomes innocently involved with a singer. As a result of this involvement the singer's public reputation is put at risk. The singer's private life comes under scrutiny from a scandal mongering, sensationalist popular press. The hero artist sets out to rescue this woman's reputation.

But in order to do this he needs the assistance of a lawyer. The lawyer turns out to be a mendacious, not very bright alcoholic. But finally, despite all his errors, it is the stupid, oafish lawyer who helps the hero in saving the singer's reputation.

In Kurosawa's film *The Hidden Fortress* the hero is a famous general who has been entrusted with the responsibility of protecting a princess while she escapes her pursuers through dangerous country. If the princess falls into the hands of her enemies she

will be executed. However brave and fearless the hero general is, he relies, this time not on one, but on two, greedy, self-serving peasants. He needs them to not only find a way through the cordon of enemy soldiers, but also to help carry the gold that will be needed to restore the princess to a position of power. As in the earlier film, it is the working together of these two types—the stern hero and the clownish simpleton—that brings success to the task.

These two types—the hero and the fool—are traditional figures in the world's art and literature. But nowhere are they so beautifully, so lovingly and so sensitively depicted as in Kurosawa's films. And as one looks at these types, one of course, sees oneself. Who has not imagined themselves on a heroic quest? Who does not aspire to glory? Who does not wish to stand upon the world's stage and be admired for bravery, for skill, for intelligence and for cunning? And who has not berated themselves for their stupidity, their yielding to base desire, their all too human weakness and lack of courage. Kurosawa shows us that these two human types cannot fulfill their quest without each other. They cannot carry what is precious to them without each other's help. Kurosawa is saying many things in these films. But I feel strongly that what he is most concerned with is to depict the struggle between our hopes and our limitations. And to suggest that, in order to express as fully as possible the potential of our precious lives we must, of necessity, accept this uneasy alliance between two fundamental and contrasting aspects of our humanity.

In each of these Kurosawa films, the hero and his less than heroic assistant or assistants engage in a task. In *Scandal*, the task seems to be saving a young woman's reputation. In *The Hidden Fortress* the task seems to be about saving the life of a royal prin-

cess. But each film also presents the audience with a task—the task of seeking the truth. This is the real task. It is the truth that is precious. And the truth that the audience discovers is, after all, not so surprising. The audience discovers *this* truth—things are not always what they at first seem to be.

The truth is that the artist who appears to be, at first glimpse, a cool, handsome heroic type is in reality a naïve hot head. The truth is that the singer is a somewhat histrionic woman who does not realize that fame and success come at a cost. The truth is that the lawyer is a man who is addicted to alcohol and has betrayed the trust of his wife and daughter, and has shamed himself in the eyes of his profession. The truth is that the journalists have a job to do and sometimes they do it with honour and sometimes they don't. The truth is that we live in an imperfect society. The truth is that each of us is imperfect, and yet that each of us has our own unique value and that, if we harness all our unique potential, our courage and our hopes, our childishness and our desires, we can carry our precious treasure through the journey of our lives and also make a contribution to the good of our society.

Woman of the Dunes

When I was a medical student I thought that when I became a doctor all I would need to do would be to apply my knowledge—the knowledge about the body of which I spoke to you earlier—to cure patients of their diseases and to show them the path to good health and the way to take responsibility for their health. I thought that there was already sufficient knowledge available to do this and that there was no need to enquire any further—no need for me to bother myself with research of any sort. Of course I can now see that this was a very arrogant and shortsighted perspective. This

was the perspective of the insect collector in *Woman of the Dunes*, the film that some of you will, I hope, enjoy this afternoon. The insect collector knows everything about the insects and when he finds one, he kills it and adds it to his collection. When he finds a woman at the bottom of the sand quarry he also looks down upon her as if she was an unusual specimen.

A scientific attitude IS important. I want to stress this. And by scientific I mean an attitude of observation and enquiry in relation to what the patient brings and ALSO what the clinician brings. And a capacity that the clinician has, and this is very important, of being able to wait rather than immediately act on, or react to, what the patient brings to the clinician. I will have some more to say about this later when I tell you the story of a patient who brings a gift for the clinician.

A baby and three doctors

One of the most difficult things for a clinician to do in his or her work is to remain honest to the attitude that *not everything can be known*, and to wait for what can be known to slowly *emerge*.

I wish to illustrate this idea by quoting from the first paragraph of a monograph written by Professor Shinsuke Tanaka about a small girl who was born with a chromosomal mutation and who did not live to see her second birthday. Here is what Professor Tanaka writes: "A mother has already entered a delivery room in Kyoto General Hospital. It is 1300 hours. Three doctors and a midwife are near the mother. Her husband and several nurses are standing beside her bed, anxious for her. The baby was suspected of congenital abnormalities when it was in her uterus. At 1400 hours the baby's head begins to appear. However, the whole head doesn't come out. At 1401 its whole body appears."

When a patient appears in your office you do not see the person *inside the patient* immediately. The person only emerges later—and only if you are able to allow it to emerge and assist it to emerge. The three doctors represent, I would suggest, three important characteristics of the clinician—her knowledge, her experience and her skills. The midwife represents the clinician's *capacity* to reach forward and assist at that moment when the person INSIDE reaches out towards a fuller realization of himself or herself. The husband and the nurses who wait anxiously represent the clinician's anxiety about the uncertainty of this moment. They also represent the clinician's fear that the patient will not be able to cope with SEEING WHAT IS THERE—the person within.

No matter how anxious or distressed the patient (represented here by the mother) this does not mean that the doctors have to cut into the mother and open her up to deliver the baby. In most situations the baby will, with the right assistance, emerge—with pain, with fluid, with shit certainly—but it will emerge. This is the challenge for the clinician. To assist the person who is INSIDE the patient to emerge from within the patient.

What did I mean when I referred to "cutting into" the patient?

Clinical encounter and the place of therapy

Clinicians, and certainly doctors, are often driven by a powerful imperative, the imperative of "doing". Doing is antithetical to the position of "remaining in a state of NOT knowing," a state of being prepared to wait in order to gain some small measure of understanding. It is this need to "do" that makes it difficult for clinicians to adopt the attitude of a researcher who is prepared to wait, to explore a little, to wait some more, to explore some more and so on.

Admittedly there may be enormous pressure placed on clinicians by patients to do something. It is tempting for a clinician to respond to this pressure because it does a great deal for the clinician's self-esteem to be regarded as "one who knows everything." Here the clinician can become Kurosawa's heroic general who thrives on exercising power over others, or the talented artist who paints landscapes while sitting on a distant mountain top but who avoids the close up moral and emotional complexity of what it is to be human.

Our first task is to try to understand the patient in THEIR world rather than look down upon them from some high point. But at the same time the clinician has the task of bringing TO the patient's world the clinician's understanding and the clinician's perspective. How to manage these two tasks in order to assist the patient to allow what is creative and lively to emerge within them is the challenge for the clinician.

The clinician, like the three doctors and the midwife in the Kyoto Central Hospital room, has to wait to see what is emerging and how it is emerging before rushing in with his or her clinical instruments. And in this process the clinician, like the collector in *Woman of the Dunes*—the film that is being screened this afternoon—may make a surprising discovery. The clinician may discover that he or she will also emerge as a changed person from this encounter.

I want to make use of an example to illustrate the way a clinician might try to approach the clinical encounter.

In order to become psychiatrists doctors have to undergo special training and pass examinations. In Australia one of these examinations involves placing the doctor in a simulated clinical situation. In one example of this type of examination an actor is trained to play the role of a patient who

presents a psychiatrist with a problem.

In the example I am using, the task for the examinee was to deal with a situation that has arisen in the treatment of a long-term psychotherapy patient. The patient was a young music teacher who had low self-esteem and was a compulsive caregiver. As the examination begins the doctor notices that the patient is carrying a gift and during the consultation the patient offers this gift to the doctor.

An Indian doctor

I want to tell you what I observed about the doctors who I examined.

Some doctors did not accept the gift. Some doctors did accept the gift. But the best doctor was the one who completely surprised me. She was an Indian woman who spoke softly and hesitantly. She seemed unsure of herself. But at the end of the consultation she neither took the gift nor returned the gift. She simply left the gift in the room.

This doctor demonstrated a real grasp of what the place of therapy (and by extension the therapeutic relationship) is all about. The place of therapy is a place where things can be returned to time and time again; it is a place where things are safe; it is a place where things DON'T have to be understood immediately; it is a place where the patient's true self can slowly emerge. It is a place where the failures of the past (the failures of the patient and the patient's social environment) can be seen *and emotionally experienced* for what they are, in the here and now. It is a place where *the pain of those feelings* that are connected to those failures CAN be borne—and in so doing the patient may discover that there *are other ways to live*.

Why do I think that the Indian doctor made the therapeutically correct decision when she left the gift in the room?

I think this because she made it clear that

she didn't *have* to understand the significance of the gift immediately. In doing this she conveyed the message to the patient that the doctor was prepared to wait for the emergence of something that would make the significance of the gift clearer. She also affirmed that the place of therapy is a safe place and a place where things could be returned to later. She also made it clear that she appreciated that EVERYTHING that the patient brings into the space of therapy is potentially a communication about the patient's internal reality—the patient's inner life.

The doctor or therapist's role is to firstly offer a safe space to play and secondly to assist the patient to play with what it brings to this space or with what emerges in this space.

If the therapist takes the gift out of the space, the therapist is virtually saying to the patient "I will take what you offer for my personal gratification." This message carries the implication that the patient is only allowed to exist if the patient offers him or herself to be made use of by the therapist. You'll remember that the patient in this examination was a compulsive gift giver with low self-esteem. This patient, in their inner world, may believe with complete conviction that his or her existence DOES depend on being used in this way—that there simply is NO other way to live—in fact no other way to survive at all.

This is where the enormous pressure on the therapist comes from—this belief of the patient that despite their suffering there is no other way to live. And the therapist has to risk being hated by the patient for refusing the gift. But if the therapist is prepared to take this risk and be hated—in fantasy, destroyed by the patient—then the patient may discover something. The patient may discover that the therapist has survived the

patient's hatred and destruction. In discovering this, the patient may discover that they do not need to subordinate their needs to the therapist. And therefore—and most importantly—the patient may discover that they themselves can survive even when therapist does not accept the gift. From this discovery the patient may realize that they can choose to live differently.

Discovery of Rights

When the therapist fails to fit in with the patient's expectations—in the above example, the expectation that the patient's only right to exist is obtained through caring for the needs of others—then the patient discovers that they have the right to BE without DOING for others.

I am very aware, as I say these words that I am talking to an audience that includes many people whose work involves caring for others. I simply want to make this point: that those in whom a self-identity is closely tied to giving care to others or healing others (like all of us here) may be trying to unconsciously repair themselves in their treatment of the patient. In other words the therapist may be seeking to make himself special to the other (the patient) in order to repair rejections or disappointments in his earlier relationships (the parents). This may be one understandable element of what influences someone to become a therapist. But it can give rise to complications.

For example the patient may feel a pressure to comply with the therapist in ways that ultimately falsify the experience of the relationship and implicitly discourage the patient from feeling they have the right to be themselves. This can lead to a repetition of the patient's own early traumas. It is even possible, in the example of gift giving, that the patient has unconsciously been testing the therapist to see if they will simply con-

firm the patient's belief that they have no right to be anything more than an object for the therapist's use. It is even possible that the therapist has to risk hating the patient for not being compliant rather than loving the patient for complying with the therapists' needs. The patient may be seeking the right to say, in the words of the American songwriter and musician Kurt Cobain, "I would rather be hated for whom I am, than loved for who I am not."

You'll notice that I have used the word "rights" here. What do "rights" have to do with our patients? One way to consider this question is to conceptualise some of our patients, such as in the example I have just given, of living in an inner world that does not give them any rights other than to behave in certain ways. To behave differently would, in the patient's inner world, amount to risking the annihilation of their identity.

Because I am very interested in this question of "rights" I was delighted to discover, at the back of the monograph of Professor Tanaka's from which I have already quoted, the United Nations Declaration on the Right to Development. The first part of the first article of this declaration states the following: "The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in ...".

It is my view that this is the sort of struggle that we are engaged in when our patients come to us. Because we find that our patients live in inner worlds that are often characterised by tyranny and the absence of a belief that they can live differently. It is also the sort of struggle that we ourselves as clinicians MUST engage in throughout our professional careers. Rights—even and perhaps especially the right to development—are never won without hardship and pain. And to submit ourselves to continue to learn

from others, and to endure the pain of accepting that we don't, and never will, know everything is necessary if we are to retain the right to professional and personal development.

A boy and the father

I wish to end by saying something about the maturation of a clinician.

I want to tell you about something that happened when I was a young doctor working in a suburban general practice. I was about 28 years old. I had seen a boy—he was about 11 years old. This boy was brought by his parents to be examined because he was suffering from headaches. I looked into his eyes with an ophthalmoscope, an instrument for looking at the back of the eyeball. I noticed some unusual changes that made me worried and I sent him and his parents to a large children's hospital for further investigations. He was subsequently diagnosed with a malignant brain tumour.

Sometime after these events I left the practice to pursue some further medical studies overseas and I returned a few years later. During this time the boy's condition had greatly deteriorated. One day I paid a visit to the boy at his home to check on his condition because he had developed a respiratory infection. The boy had, over the time I had been away, gradually lost control of his body. He was unable to speak or to comprehend. In short, he was now completely dependent on his parents for care. His father had given up his own work to care for his son. The father had bought a special bed for the boy that could be used to alter the boy's position while he lay on it so that he could be cared for more easily. The bed had been placed in the middle of the family's main room and the boy lay on the bed. He was now unrecognisable from the boy I had first met in my office. He was swollen with fat

and fluid because of the medications he was on. He had a tube in his nose so that he could be fed. His face was like a moon. He moved and made noises in a fitful way.

I watched the father fussing over his son. I was overcome by a terrible sense of hopelessness. It seemed to me that any treatment of this boy was quite futile and I felt that I had no power to alter anything in a way that might improve matters. As I watched the father I felt myself recoiling from the scene unfolding before me. In fact I felt a strong urge within me to escape as fast as possible so as to rid myself of my feelings of powerlessness and futility.

When I look back now, I realize that, at that time, I simply could not comprehend why this father was tending to this boy whose condition mocked my powers to cure or to release us all from suffering. I was too immature to understand the nature of this father's love. Now I understand that this father's love accepted the boy that he *saw at that moment*. This father did not recoil from what he saw. This father saw his son, distorted by suffering, but unmistakably his son.

Now when I look back to that moment of wanting to run away I wonder if the child that I wanted to run away from was actually the child within me that felt helpless to change what could not be changed. In other words, the child that I saw on the bed was like a mirror. But what I saw in the mirror, a childlike part of me, was something I couldn't accept at that time. I had wanted to see a heroic general. But instead, I saw a child.

Concluding —to find myself—

Now, if I were to find myself in such a situation I hope that I would understand better what was expected of me. I would understand that the father was not expecting me to be a heroic general or a talented artist or

even a doctor who can restore his son to the boy he once was. I was only expected to do what I could do, in the circumstances and within the limits of my skills and knowledge; to offer encouragement to the father who was the real hero in this sad story; and to marvel, as a child might, at the wonder of the love that one human being can have for another.

This is what psychotherapy is mainly about. It is not about being clever or heroic. It is about being able to accept what our patient's bring to us, and yet returning it to them in a way that makes them know that they exist and that they are real. This is the gift that is seen and appreciated but is neither taken nor refused.

Thank you for listening to me.

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■第2報告

小児科医療の臨床現場から

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キーワード：新生児医療、非言語コミュニケーション、関係性、中核自己、育ちの環境

このたびは、歴史ある応用心理学会にお声かけいただき本当にありがとうございます。また、乳幼児精神保健の分野をご紹介させていただけます機会を与えられましたこと、心より感謝申し上げます。

私は、新生児医療をベースとして、乳幼児精神保健、障害児医療および療育の仕事をしています。医療を通して、子どもたちの変化・成長を機軸として、家族になっていくことを支援させていただいているのですが、実は、子どもと家族に生きる力がついていくことに感謝し、支えられ、私自身が幸せにさせていただいている関係です。

どんなに重い障害のある方も、障害のない方も、人間は、胎児期から、五感を超越した無様式感覚で、快か不快かを感じる力を持っています。赤ちゃんたちのさまざまなサインは、そのサインを受け止めた私たちを幸せにします。乳幼児期のお子さんの存在と育ちを大切に思うことは、すなわち、子ども一人ひとりのプライドを大切にし、人権を尊重することでもあるでしょう。

赤ちゃんのサインを受け取った母は、受け取ったよというサインを赤ちゃんに返します。快の感覚で発信されたサインが、こだまのように快のサインを引き出し、母から返信された快のサインによって、赤ちゃんの安心や喜びや高揚が得られ、次のさらに発達した具体的なサインへとつながります。

新生児医療のフォローアップの現場をはじめ、子どもたちの育ちを支援する発達外来に多い主訴に、例えば「ことばの遅れ」があります。話し言葉の遅い子は、幸せな時間と大切な人たちとのつながりを目にみえないリュックにつめて生まれてきたのだと思います。家族をはじめとした育ちの場で、じっくりゆっくり深く繊細に、コミュニケーションする真髄が育ち、豊かな人格形成の礎をつくることができるからです。非言語コミュニケーションのサインには、話し言葉の表面上のことばの意味理解よりも、もっ

と多くの大切な真実に近い複雑な情報が含まれ、子どもたちはそれを伝える能力を持っています。子どもたちの「問題行動」は、環境との不協和音によって引き起こされますが、「問題行動」とは、子どもたちからの大事なSOSが含まれる、メッセージ性の高い重要な現象といえるでしょう。

人間の脳は、大切な人との関係性によって獲得した中核自己を中心に、家族や地域社会の関係性の中で発達します。子どもの育ちに影響するすべての要素がタイミングよくつながりあうことで、包み込まれるような暖かで安心できる育ちの環境(holding environment)が整えられていきます。この環境づくりが小児医療を担う者の大切な役割です。

実際の臨床現場には、重症心身障害(運動発達も精神発達も重度の遅れがある)の方、なかには呼吸器を使用したり胃ろうからの栄養を必要とする医療依存度の高い超重症児さんもいらっしゃいますし、運動発達は問題なくみえる方でも、感じ方や学び方の違い、ものごとのとらえ方の違いなどによって、自閉症スペクトラムなどの発達障害の特性を持ち、困り感をお持ちの方もいらっしゃいます。

療育医の臨床現場は、出会ったその瞬間から支援が始まっています。診断は支援の一部であり、診断の告知は、家族形成や育ちの環境づくりを通じて、暖かくその効果を発揮できる必要があります。そのために、人格の成り立ちと、心の安全基地、さらに、関係性の発達の視点でその子の育ちの環境をとらえることを最も大切にしています。

このような人と人との間でくりひろげられる奥深いやりとりに魅せられて研究を深め、その成果を日々の臨床に楽しく活かしていこうとする学会があります。世界乳幼児精神保健学会(WAIMH)と「FOUR WINDS」日本乳幼児精神保健学会です。これらの学会のことをご紹介させていただきながら、関係性の発達の大切さについてお伝えします。

世界乳幼児精神保健学会(WAIMH)について

すべての赤ちゃんの健やかな心の発達を願っている学会です。乳幼児期の体験は人間の生涯に重要な影響を与えます。乳幼児と両親、そして家族が求めるものに暖かく応える社会づくりを目指す世界中の医療・保健・福祉の専門家たちが集まっています。

1970年代の欧米では、社会精神医学・地域精神

医学が誕生し、地域のホームドクターを中心に、保健師たちが家庭訪問を行うようになりました。保健師たちは、対象となったアルコール依存の方や精神疾患の方の家庭には、おのずと、放っておかれる赤ちゃんたちが存在することに気づき、さらに能面のような表情で育つ過程を目の当たりにします。そのような状況に対応するために、パラメディカル仲間たちが家庭に入り、ダイナミックな家庭精神医学が実践されるようになり、プログラムに位置づけられていきました。理論的背景には、1950年代より発展したボウルビィ (Bowlby) によるアタッチメント理論があり、メアリー・エインスワースが加わった母子関係の研究によって体系づけられた、心の安全基地 (secure base) の概念があります。

また、タビストック・クリニックのクライン (Klein) による、内的世界を掘り下げた研究から、時代を越えて年代を越えて、人間の心には1~2歳のレベルの怒りや恨みや傷が、10歳になっても20歳になっても50歳になっても沸き起こるという認識が生まれてきました。ウィニコットの教科書などから学ぶことのできる、乳幼児の心は現在の自分とつながっているという対象関係論の認識も加わって、多方面から乳幼児期の心の発達についての貴重な発見と取り組みがなされてきました。

1972年には、シカゴの精神医学講座のセルマ・フライバーグ (Fraiberg) というソーシャルワーカー兼精神科教授が、赤ちゃんの養育プログラムを正式に作り、「Psychiatry for infants (赤ちゃんのための精神医学)」という言葉を使ったことが、乳幼児精神医学の基になっていると考えています。

日本では、1996年タンペレで開催されたWAIMHに日本から初めて参加した仲間たちによって、1997年に第一回日本乳幼児精神保健研修研究会が開催されました。

その後、全国各地域で学術集会を開催し、2008年にはアジアで初めてのWAIMH世界大会を日本で開催することができました。2~3か月に一回のペースで半日ほどのセミナーも開催しています。2010年のセミナーでは、アンナ・フロイトの遺産である、ロバートソン (Robertson) フィルムに学びました。

「FOUR WINDS」乳幼児精神保健学会について

日本の乳幼児精神保健学会です。赤ちゃんおよび

赤ちゃんの世界から学ぶことを大切にして、次の五つを学会の柱として活動してきました。1) 赤ちゃん和家人を主体とする、2) 領域を越えた連携、3) 関係性の世代間伝達、4) ライフサイクルにおける発達、5) 神経科学と臨床の統合。

□これまでの全国学術集会での主な講演

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人は、診断や判断の対象ではなく、愛される対象ではないでしょうか。楽しみあい、ともに安心して生きていける暖かい関係の中で幸せを感じ、ともに育ちあえる豊かな環境づくりが世界中で行えることを願っています。私たち一人ひとりが持っているやさしさをおしみなく表現しあえる世の中にしていきましょう。

短い討論時間でしたが、素敵な感性をお持ちのジャック先生とお嬢様、田中先生、そして皆様と、響きあえるコミュニケーションの場となりましたこと、心より感謝申し上げます。

(なす やすこ)