The Influences of Japanese Pre-and Postnatal Care on Education

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Many comparisons have been made about the differences in efficacy between Japanese and U.S. educational systems. Yasuhiro Nemoto writes, “The Japanese education system is admired by many foreign educators, who note that Japanese students do better than their American counterparts in international math and science tests. Disciplined Japanese students obey teachers, rarely commit school violence and have little contact with drugs or alcohol. Some American education analysts insist that the adoption of the Japanese system by the United States would provide American children with a good educational foundation, and reduce school problems such as drug abuse, violence and truancy” (Nemoto, 1999, p.11).

However, according to a series of interviews regarding their personal experiences with the Japanese approach to pregnancy, childbirth and the postpartum experience of Westerners in Japan, in conjunction with Anne Dilenschneider’s research in Developmental Psychology at the Pacifica Graduate Institute in California (2005), lead one to wonder if the differences actually begin much sooner. Indeed, Japanese mother’s dedication to their children is legendary. “In some societies, pregnancy and childbirth confer special status on a woman. In Japan, for example, traditional values place motherhood above all other women’s roles” (Newman & Newman, 2003, p.115).

Yet more than an educational system and mothers’ dedication seems to be involved in these differences. Psychologists and social scientists Harold Stevenson and James Stigler studied hundreds of Japanese, Chinese and American children over a period of nearly ten years. What became clear to them during their study is that schools exist within the cultural context of a society (1992, p.15). Merry White, director of Harvard University’s Program on Japanese and U.S. Education, concurs. She notes that Japanese mothers’ commitment to their children begins with pregnancy (1987, p.13), and this care and attention is only a piece of a far wider societal commitment.

Research has shown that child development begins long before the first day of school.
It begins with conception and the subsequent development of the embryo and fetus in utero. What happens to the mother while she is pregnant happens to her child as well. As Louis Cozolino writes, “There is a distinct possibility that stress is possible even before birth; an unborn child may become stressed as a result of the shared biological environment with its mother. Studies suggest that maternal stress is associated with their children’s lower birthrate, irritability, hyperactivity, and learning disabilities” (2002, p.259, also Thomson, 2004, p.32) and that “the developing brain is vulnerable to damage caused by excess chemical release from neurotransmitters/neuromodulators and neuropeptides/neurohormones in response to chronic or repeated unpredictable stress” (Thomson, 2004, p.10). Long periods of stress are toxic to the brain of the developing embryo and fetus (p.10). Given that “the fluid within the amniotic cavity provides a chemosensory environment that directly transmits the external world of the mother to her embryo and fetus” (p.23) and that, by the third trimester, “long-term learning, sensitization, habituation and selective responses to novelty are all encoded within the fetal brain” (p.15), it seems that if maternal stress impacts a child’s ability to learn and grow, support for a child’s educational future begins with support of the pregnant woman.

**Support starts early**

In Japan, support for the pregnant woman and her child begins as soon as the pregnancy is confirmed. When a mother is ten to twelve weeks pregnant, she reports to her local city hall. At that time, the pregnant woman is given a “Mother & Child Handbook.” Every health visit from pregnancy until the child begins first grade is recorded in this book. This record will include test results, measurements, as well as developmental notes. It also includes a survey section on the home environment, lifestyle and family members, work schedule, health condition and history. The back of the handbook includes support group and emergency information. The “Children’s Charter” is also printed there. The charter, which has been the same since 1951, states the basic rights of children, including the right to be respected.

In addition, potential financial stress is also taken into consideration. The city contributes to the mother and child’s health expenses until first grade through a reimbursement process. While natural childbirth is not directly covered by insurance, it is a national policy to give the mother a lump sum as a “congratulation gift.” The amount differs from city to city. In one city, for example, the amount is about 390,000 yen. Under another private insurance plan for company employees, the “gift” is the equivalent of one month’s salary or 300,000 yen, whichever is the higher amount. This is usually enough to cover the birth expense. This “gift” is provided even if a woman miscarries after the twentieth week of pregnancy, or has a stillbirth. In the event of financial need, the city will provide a monthly stipend for each child, and it will cover the cost of meals
if a child is in daycare, until the child is in first grade. Nationwide, mothers also are
provided with six weeks of paid maternity leave before their due date, and eight weeks of
paid leave after the child’s birth. While the rate of pay during this time period is up to
the employer, 40%-60% is common, and 100% is not unheard-of. (Both leaves are
doubled if the mother is expecting twins.) Mothers are also given the option of one year
of unpaid child-rearing leave. During this time, women do not lose any work status. In
fact, some may even advance with their co-workers, e.g., if the co-workers receive a raise,
the mother’s salary on her return to work often reflects the raised amount.

Care reflects mother’s value

“Solicitude and shame, and adequacy and vulnerability, are two dimensions that create
a matrix within which the birth culture of any society or subculture can be located.
Within this framework, pregnancy may be viewed as a time of great rejoicing (Newman
& Newman, 2003, p.124) or extreme shame, of feeling sexually powerful or extremely
vulnerable” (pp.124-125). Solicitude is demonstrated by the increased support and care a
society provides for its pregnant women (pp.123-124). Part of what is needed to support
pregnant women are caring, consistent care relationships. In addition to the support of a
woman’s family, the “caring relationship [between the woman and her health care
providers] provides emotional support to the woman, encouraging her to feel valued as a
client, as a mother, and as an adult in the community” (p.118).

As far as the dimension of adequacy is concerned, one way a society expresses
adequacy vis a vis pregnancy is to honor it as a change into a new social status (Newman
& Newman, 2003, p.124). While the birth culture in the U. S. could be described as one
of “solicitude and vulnerability” (p.125), the birth culture of Japan is significantly different.
The Japanese birth culture seems to be one of solicitude and adequacy. Once a woman
becomes a mother, she is addressed in public (e.g., at the local market) as “Okaasan,” the
respectful term for “Mother.”

The pregnant woman receives her prenatal care from a group of midwives who will
also assist with labor and delivery. When the woman or her husband has a question
outside of the scheduled prenatal appointments, they are encouraged to call the midwives
at any time with their concerns. They are never made to feel inadequate for calling, and
they are never shamed for doing so. These calls are treated as opportunities for learning
and support.

The Japanese medical establishment is not stingy with medical tests, which inform
mother and father and help them prepare psychologically to become parents. An
ultrasound is performed every two to three weeks until the final month of pregnancy. At
that point, an ultrasound is performed on a weekly basis. During the last month, the
woman has two medical appointments each week. One visit is with the midwives, and it
includes a stress test. The other visit is with the doctor; that visit is the one that includes the weekly ultrasound. Fathers, especially, say that seeing the results of the ultrasound makes them feel more involved with the pregnancy process and with the baby itself.

**Knowledge empowers mothers**

According to the experience of several women in both cases of a larger university hospital and a smaller private clinic, a pregnant woman is required to attend three classes during pregnancy. These class sessions are taught by the hospital staff. The classes are attended by the women who have similar due dates, so that the women begin to form a support network among themselves. The first class, at 20 weeks, is a breast massage class. Breast massage is done in order to promote the production of breast milk. The expectant mother is encouraged to massage her breasts in her bath every night. This is very different from a percentage of the attitudes in the U.S. which generally frown on breast massage and bathing during pregnancy.

The second class is focused on breathing and relaxation techniques. No epidural or pain medications provided during labor, because these are viewed as putting the mother’s comfort before the well-being of the child. (These medications are available at many of the larger hospitals and international hospitals and a great deal of Western women take this option). In this class women also learn about the labor process and the different types of breathing that will affect and assist their labor and delivery.

The final mandatory class is conducted by the hospital’s head physician. The doctor provides the mothers with further education about the birth process. The doctor also lets the women know that if a woman has complications or a stillbirth, the pregnancy is still valuable; it was not a waste. In addition, the women are told that the midwives, and not the doctor, will be the primary delivery team. This is because the doctor’s presence can cause stress for mothers in labor. The concern is that the laboring mother might fear that the doctor is present because something is going wrong. The doctor will come in after the birth just to stitch up any episiotomy. Because it takes concentration, this will be the only time the husband will be asked to leave the room.

**Emphasis on moderation aims to reduce stress**

Optional classes are also made available to pregnant women. These include weekly prenatal yoga classes and classes on nutrition. The Japanese view of nutrition during pregnancy differs substantially from views held in the U.S. While sushi is generally forbidden in the States, it is not considered to be an assumed hazard for women in Japan. Pregnant women have even been known to toast to the New Year with Japanese wine as well as continue to drink green tea on a daily basis, which contains caffeine. Moderation is the general rule. There are very few “no’s” in terms of food choices. This is because
“no” creates stress, and creating stress is considered to be the worst thing that can be done to a pregnant woman. The only thing forbidden during pregnancy is smoking; Japanese healthcare providers are very definite about that prohibition.

In another scenario where the partner accompanies the woman in the delivery room, when she arrives at the hospital in labor, she is issued and dressed in a floral pregnancy robe. She and her husband are then escorted to a comfortable, restful room that is furnished much like a hotel suite. The midwives use an intercom to alert the couple that they will be coming into the room. The couple can also use the same intercom to communicate their needs to the staff. If she chooses to do so, the woman is encouraged to walk about the facility during this time to assist the labor process. Unlike the protocol in U.S. hospitals, in Japan the laboring mother, and her husband, are fed meals throughout this time. The midwives massage the mother, and show her husband how to do this as well. Labor is allowed to progress at its own pace. There is no sense of rushing the process, because the prevailing belief is that babies are born on their own schedule. When a woman’s amniotic sac breaks, the midwives have her walk with her husband to the delivery room. There she puts on new slippers, and her husband dons a jacket. Whereas in many western hospitals the husband may be by the woman’s feet in order to watch the baby coming out, during this final phase, the husband will stay by the woman’s head, holding her hand.

**Midwives supervise birthing process**

Midwives encourage the laboring mother to take several deep breaths and then hold her breath. This process is repeated as necessary. Because the woman delivers her baby while sitting up, there is no need to push. As the baby crowns, the midwife calls the doctor. However, in order not to stress the mother, the doctor remains at a distance—in one case, almost 15 feet away. Again, the doctor is not part of the delivery process; he or she only provides any necessary stitching.

When the baby is born, she is placed briefly on her mother’s abdomen, and then she is taken for a few minutes to be checked and weighed. During this time, the midwives help the mother take off the pregnancy robe and put on a “mother’s robe.” (Fresh “mother’s robes” and underwear will then be provided twice each day for the length of her hospital stay). Then the staff leaves the new family together for exactly two hours. After that, the parents are sent to bed, and the nurses attend to the baby during the first night.

Traditionally, in the delivery room, the parents are given a portion of their baby’s umbilical cord in a cedar box as a keepsake. Perhaps a strange concept to Westerners, as one explained, “It represents the attachment on the inside, [and] now it’s up to [the parents] to build a new attachment on the outside. They hand it to the father to sort of send home the “you’re on” signal since that part was somewhat all Mommy up to then.”
The following day, the new mother begins to attend a series of classes with her “cohort” – the mothers who gave birth on the same day. The classes are on topics such as bathing, diapering, and clothing her baby. The baby may be with her all day, if she desires, but during the second night the baby again sleeps in the nursery. By the third and fourth nights, the mother may co-sleep with her baby. However, there is no pressure to do so. On the fifth night, the nurses insist that the mother co-sleep with her infant because, as one Westerner was told by a midwife, “‘daytime and nighttime babies are different.’”

On the second day, the babies are put on a breastfeeding schedule. The “cohort” goes together to feed their babies at set times, every three hours. At the appointed time, each mother weighs her baby, nurses, and then weighs the baby again. Based on the baby’s weight, the nurses supplement the baby’s feeding until the mother’s milk comes in. The midwives emphasize that the new mothers do not have to keep to a schedule at home; the schedule at the hospital simply allows the staff to organize the care of all the mothers and babies. At home, the midwives say, the mother is to adapt with her baby.

Research has shown that attachment and bonding are crucial to a child’s ability to grow and learn. “Early bonding failures lead to lower levels of serotonin, resulting in greater risk of depression, irritability, and decreased positive reinforcement from interpersonal interactions” (Cozolino, 2002, p.282). All facets of the baby’s development-cognitive as well as physical, social, and emotional-require the support of family and other caregivers in the family’s wider community context (Newman & Newman, 2003, p.173). “While older brains need some sort of context for learning--a reason, such as a reward, to pay attention to one stimulus over another--baby brains soak up everything coming through their senses” (Shreeve, 2005, p.10). In an optimal situation, “the mother’s nervous system is actively shaping the infant’s resiliency to adapt to novelty and stress. Through an ongoing experience-dependent interaction between the mother and her infant, the baby will gradually gain abilities to form attachments with significant others which will shape the growth of auto and interactive affective regulations and the coping strategies necessary for successful interactions within the world of the maturing child ”(Thomson, 2004, p.49). Without this type of physical support and interaction from her parents, an infant can easily be overwhelmed.

The parents communicate with baby through touch

The parents are clearly the baby’s primary support team. As D.W.Winnicott writes, “What then is communicated when a mother adapts to her baby’s needs? I now refer to the concept of holding. There is a valuable economy in the use, even exploitation, of the term holding in description of the setting in which major communications take place at the beginning of a baby’s experience of living. If I adopt this line, exploiting the concept
of holding, then we have two things: the mother holding the baby, and the baby being held and rapidly going through a series of developmental phases which are of extreme importance for the establishment of the baby as a person. *The mother does not need to know what is going on in the baby.* But the baby’s development cannot take place except in relation to the human reliability of the holding and handling” (1987, p.96-97 italics as in original).

This “holding and handling,” of course, very literally engage the sense of touch. “The skin is the largest sensory organ and the earliest to develop in utero. A variety of evidence from animal and human research suggests that touch plays a central role in development” (Newman & Newman, 2003, p.139).

Japanese postnatal courses and traditions encourage the use of touch. Parents are encouraged to hold their baby often, and they are told to pick up the child whenever she cries, as it is impossible to spoil a baby. There’s no attitude that a baby should “cry it out” alone. And, interestingly, there’s no original Japanese word for “colic,” rather, a borrowed form of the word from American English is used, although not recognized in mainstream Japan. Babies are held close, and are far more likely to be carried during short trips rather than kept at a distance in strollers, and mothers tend to take their babies with them to run errands or attend social functions, as opposed to leaving them with babysitters.

The emphasis on touch is also seen in Japanese bathing practices. The infant is only bathed in a “baby tub” for the first month of her life. During that time, her mother is encouraged to hold the baby close to her breast, skin to skin, after bathing, whether she is breastfeeding or not, because “it is thought that the baby wants to be close.” After the first month, the baby will be included in the family tub. There, she will bathe with a family member such as her father and her siblings every evening until she reaches puberty. In addition, mothers are encouraged to take baby massage classes. These classes are primarily are focused on touching and the bonding between mother and child. However, there is a practical side as well: the Japanese successfully use massage rather than medication to ease constipation in babies. Also, most parents in Japan co-sleep with their children in a family bed. This continues until each child needs her own desk; this is usually about the time the child begins to attend elementary school.

In an optimal situation, parents do not raise their children alone. Each family is a part of a wider society, and supported as such. “The effective use of a social support network ensures that adults will not be isolated as parents, and that others will be available to help the parents identify and interpret childrearing problems” (Newman & Newman, 2003, p.173). Additionally, “interventions that engage the mother and support her emotional involvement in the parenting process can have a beneficial impact on the emotional development of the child” (p.168).
Mothers form early network

During her five to seven day stay in the hospital, much longer than the one to three day stay in many Western nations, the new mother has her meals with other new mothers in the hospital dining room. The mothers have assigned seating at the tables so that they will mingle and get to know each other. The resulting informal conversations provide additional education and reassuring “tidbits” for the newest mothers. On their final night of their stay, a celebration is held for the “cohort” who gave birth on the same day.

After they leave the hospital, the members of the same cohort will be called in to the hospital together every two weeks for routine baby check-ups. The city’s health center will also call the mothers in for vaccinations and monthly check ups during the early years.

At the two-week visit, the hospital provides breastfeeding consultation and advice. Breastfeeding mothers are advised to avoid excess salt and processed food. It is also recommended that they refrain from fried food because it blocks milk production. Rice is promoted as a healthful food due to its high water content. For the first weeks postpartum, many mothers also come in biweekly for breast massage by a lactation consultant. This massage encourages the mother’s milk production. According to one mother’s experience, the lactation consultant’s attitude is very comforting; she “talks to [the mother] like a hairdresser.” As part of the process, she tastes the mother’s milk to see if it is good and sweet.

The city sends a midwife to the family’s house when the baby is one month old. At that time, she measures and weighs the child. She checks in to see how the mother and family are doing. The midwife provides contacts to agencies that might be helpful. She also gives the mother a list of the other new mothers in the neighborhood, so that they can have the opportunity to meet. These reassuring visits are repeated several times during the first six months of the child’s life. During these early months, continuing classes are also available to the mother and child. These include instruction on introducing solid foods, weekly cooking classes, and weekly massage classes. Each of these classes is another opportunity to be with other new mothers in a supportive environment.

The experiences reflected by the interviews for this study of Western women in Japan highlight significant differences between the Japanese and American approaches to pregnancy, childbirth, and the postpartum experience. When considered in the light of international research on child development, these experiences confirm Merry White’s observation: “In Japan the care of children is not just a domestic concern. Indeed, the entire nation is mobilized behind children and education. This national obsession may well be responsible for children Western parents and educators would be proud of, children whose lives and future prospects meet our standards of approval. In short, the
Japanese national engagement in child development is something we should envy” (White, 1987, p.11).

Bibliography


