外来森田療法ガイドライン：日英対訳版（2021）

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GUIDELINES FOR PRACTISING OUTPATIENT MORITA THERAPY: PAIRED JAPANESE-ENGLISH TRANSLATION EDITION (2021)

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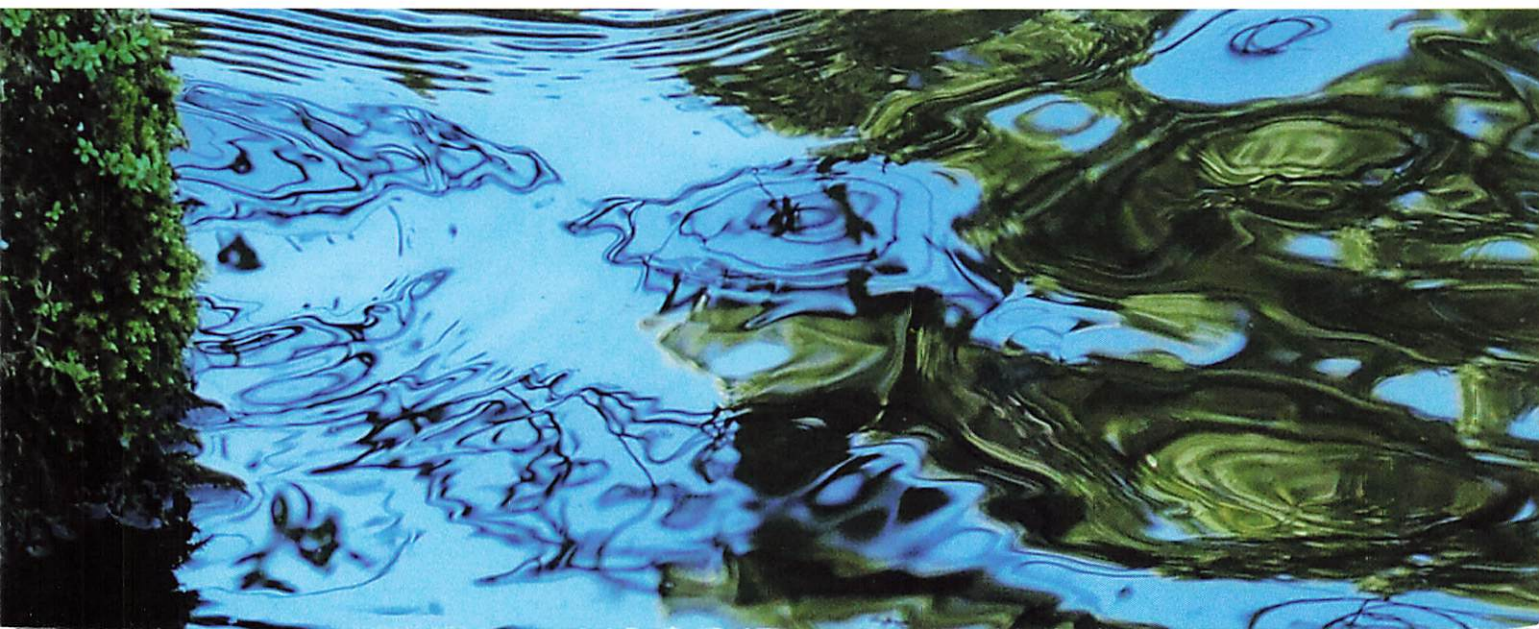
(English Translation & Editing of Paired Japanese-English Translation by Ishu Ishiyama)



外来森田療法ガイドライン：日英対訳版（2021）

日英対訳版（2021）編集者・石山一舟

グラフィックデザイン・MI Consulting, Victoria, Canada

日英対訳版の作成にあたり、対訳を読みやすくするため原著の中の特に長い段落を分割し、英語訳もそれに準じて表記した。なお英語訳は 2010 年に発行されたカナダ式スペル表記の英語版(*Guidelines for Practising Outpatient Morita Therapy*)をそのまま用いた。その序文に述べたように、英訳の際に原文の意味をより明確化するための説明的な加筆によって、英語訳が原文より長くなっている。

この日英対訳版の作成はメンタルヘルス岡本記念財団の助成（2019 年度活動助成）によって可能になった。同財団のご援助に感謝申し上げます。また、この対訳版の編集作業を手伝っていただいた佐々木あゆみ、石山まさみ両氏にも謝意を表したい。（編集者）

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Guidelines for Practising Outpatient Morita Therapy: Paired Japanese-English Translation Edition (2021)

Editor of the current *Paired Japanese-English Translation Edition* (2021): Ishu Ishiyama

Graphic Design: MI Consulting, Victoria, Canada

In preparation of this paired Japanese-English translation edition, extra-long paragraphs in the original Japanese writing were divided into shorter paragraphs for easier reading with corresponding adjustments in the paired English translation section. The English translation used in this document is identical to the 2010 translation version of the *Guidelines for Practising Outpatient Morita Therapy* with Canadian spelling. As stated in its *Preface*, the English version became longer with additional explanatory words for clarification than the original version.

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2010 年発行「外来森田療法のガイドライン（英語版）」の序文より

訳者註および謝辞 ・ 本書はカナダ英語のスペリングを使用している。この英語版においては、明確さと正確さを高める目的で必要に応じて編集上の手を加えた個所がある。森田正馬の下の名前の読みはもともと「まさたけ」であったが、同じ漢字名の読み方の「しょうま」を森田は頻繁に使ったということもあり、この英語版においては一貫して Shoma の表記を使った。なお、英語版作成の準備段階で大変有用な提案をいただいた Dr. Gudrun Dreher と南昌廣氏の二人に謝意を表したい。

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From the Preface for the *Guidelines for Practising Outpatient Morita Therapy (English Edition) Published in 2010*

Translator's Notes and Acknowledgments. Canadian spelling is used. Some editorial changes have been made for this English edition for the purpose of improving clarity and accuracy where needed. Morita's given name (正馬 in Chinese characters) was pronounced "Masatake," while "Shoma" is another way of pronouncing it, and was often used by Morita. "Shoma" is therefore used throughout this English edition. The translator wishes to thank Dr. Gudrun Dreher and Mr. Masahiro Minami for their invaluable editorial suggestions on the draft version of this English Edition.

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I. Process and Purpose of Developing the Current Guidelines

A set of guidelines for practising outpatient Morita therapy has been developed by the Committee on the Standardization of Outpatient Morita Therapy for the Japanese Society for Morita Therapy (*JSMT*). The Committee initially surveyed the honourary members of the Society and its board members as well as the *JSMT*-certified physicians and psychotherapists regarding outpatient Morita therapy (n=102). We obtained data from 56 respondents (return rate: 54.9%). We then analyzed the data and extracted common elements, which we treated as basic components of outpatient Morita therapy. We further explored and revised our categorical organization of the extracted elements, and sought expert feedback from highly recognized senior Morita therapists on our initial draft of the *Guidelines for Practising Outpatient Morita Therapy* (referred to as the *Guidelines* hereunder), in preparation of the final version. Therefore, the content of the *Guidelines* reflects the general consensus among the practitioners of outpatient Morita therapy today.

Our publication offers a set of guidelines for practising outpatient Morita therapy for those who wish to learn and implement this therapy. We have attempted to show the key therapeutic components concretely. These guidelines are not intended to discourage individual practitioners in their attempts to try modified or innovative applications of Morita therapy. There are various ways of engaging in therapeutic interaction, and some of them go beyond the suggested ways of using Moritian explanations and probes in this document.

I.　ガイドライン作成の経緯と目的

このガイドラインは、日本森田療法学会「外来森田療法の標準化に関する委員会」にて作成したものである。同委員会では、日本森田療法学会名誉会員、理事、日本森田療法学会認定医、認定心理療法士　計 102 名に外来森田療法に関するアンケート調査（巻末資料１）を実施し、５６の有効回答（回答率 54.9%）を得た。このアンケート結果を整理し、抽出された共通項を外来森田療法の基本的構成要素とみなし、それを同委員会で検討・修正して草案を作成した。さらに重鎮の森田療法家の意見も踏まえて一部を手直しした末に完成したのが本ガイドラインである。したがって今日、外来森田療法に携わる治療者のコンセンサスに依拠したものだということができる。

このガイドラインは、森田療法を志向する治療者に対して外来森田療法のアウトラインを示し、実践に資することを目的としており、なるべく治療の要点を具体的に提示するよう心がけた。なお、このガイドラインは個々の治療者の創意工夫を妨げるものではなく、ここに例示されている説明や質問のほかにも、様々な治療的対話があり得ることはいうまでもない。

II. Outpatient Morita Therapy

We would like to start by clarifying what we mean by the term "outpatient Morita therapy" in this document. The term is used to differentiate it from "residential Morita therapy," but does not refer to the outpatient practice of this approach only in a medical setting. Various consultative and helping activities in workplaces and educational contexts are also included here. The term "therapists" refers to practitioners who have the professional duty to observe confidentiality (e.g., physicians, clinical psychologists, counsellors, social workers, and other professionals in medical and helping disciplines).

Outpatient Morita therapy includes individual and group therapy approaches. Because the majority of those who responded to the survey were practitioners of individual Morita therapy, the present guidelines offer primarily explanations and examples for the practice of individual Morita therapy. Although there are many outpatient treatment facilities that do not limit the length of the treatment, we have found that most of those with time limits have 10 to 15 sessions set as a maximum number. Approximately 60% of the surveyed outpatient facilities see their patients for the duration of 20 to 30 minutes per session, in a 1 or 2-week interval. Many of these facilities spend 40 to 60 minutes on an intake session. We thus found variations in time frames among the surveyed facilities, ranging from having no specified limits to doing a short-term practice with time-limited interview sessions.

In addition, it might be useful to standardize the interview duration, number of sessions, and interview process in order for us to conduct evidence-based research on the effectiveness of outpatient Morita therapy.

II.　外来森田療法とは

まず、このガイドラインでいう外来森田療法とは何を指すかを明らかにしておくことにする。ここで外来という名称を用いるのは入院森田療法と区別するためであり、必ずしも医療場面に限定するわけではなく、職場や学校での相談業務などもこれに含まれる。また治療者とは、医師、臨床心理士、カウンセラー、ソーシャルワーカーなど、医療・相談業務に携わる専門職（守秘義務を有する者）を意味する。

外来森田療法には個人療法と集団療法があるが、アンケート調査の対象となった施設の大半は個人療法のみを実施していることから、今回のガイドラインは個人療法を想定して記述することにした。治療期限を設定しない施設が多いものの、期限設定を行っている施設ではほとんどが１０～１５回の面接回数と回答している。また１回の面接時間はおよそ６０%の施設が２０～３０分であり、面接間隔は大半が１～２週間であった。ただし初診時には４０分～６０分の面接を実施している施設も少なくない。こうしたことから、外来森田療法には一定の面接時間を定めて比較的短期の期限設定のもとに実施する方法から、一般外来の枠内で特に期限を定めずに行う方法まで幅があるといえる。

なお外来森田療法の効果を実証していくためには、今後，面接時間、回数、プロセスなどを標準化することが課題である。

III. Indications for Morita Therapy and Range of Applications

Morita therapy has been used for treating a kind of neurosis called "Morita *shinkeishitsu*" which Morita classified into three types: (a) obsessive ideational neurosis, (b) ordinary *shinkeishitsu*, and (c) anxiety neurosis. According to the International Classification of Diseases 10th ed. *(ICD-10)*, Morita *shinkeishitsu* corresponds to phobic anxiety disorders, such as agoraphobia and social phobia (e.g., social anxiety disorder, *taijin-kyofu-sho*), panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder as well as some of the somatoform disorders (e.g., hypochondriacal disorder).

More recently, however, Morita therapy has been applied to a wide range of patient conditions other than the ones listed above. Successful applications have been reported by many therapists in the treatment of depressive and dysthimic disorders. Morita therapy has been found useful in treating adjustment disorders, post-trauma stress disorder *(PTSD)*, irritable bowel syndrome, chronic pain, eating disorders, nonorganic insomnia, atopic dermatitis, and oral-dental neurosis, all of which may be regarded as psychosomatic conditions in a broad sense. Morita therapy has also been successfully applied to those with physical ailments, such as cancer patients, to alleviate their anxieties and sufferings.

In addition, some practitioners consider that outpatient Morita therapy is appropriate for: (a) those with intense anxiety about pharmacotherapy, (b) patients who cannot receive residential treatment, or are waiting to be hospitalized for residential Morita therapy, and (c) patients who are willing to try the residential method at their own home. Further, it has been used with clients suffering from low self-esteem, discouragements and difficulties in daily life, challenges in meeting their self-actualization needs and finding meaning in life, problems in the parent-child relationship, adolescent problems, truancy, and various conflicts associated with peer relationships at school and concerns around academic examinations.

III. 治療の対象

森田療法の元来の対象は森田神経質と呼ばれるような神経症であり、森田はそれを強迫観念症、普通神経質、発作性神経症に三分類した。今日の国際疾病分類第 10 版（ICD-10）では広場恐怖や社会恐怖（社会不安障害、対人恐怖症）などの恐怖症性不安障害、パニック障害や全般性不安障害など他の不安障害、強迫性障害、心気障害など一部の身体表現性障害に相当する。

しかし最近では、上記の他にも多様な病態に森田療法が適用されている。なかでもうつ病や気分変調症は、多くの治療者が森田療法を用いて効果を挙げている。そのほか、適応障害や外傷後ストレス障害（PTSD）、過敏性腸症候群、慢性疼痛、摂食障害、非器質性不眠、アトピー性皮膚炎、歯科口腔領域の神経症など広義の心身症的病態、癌などの身体疾患を有する患者の不安や苦悩などにも森田療法が広く応用されている。

こうした診断以外に、薬物療法に不安の強い患者、入院が困難であったり、入院の準備過程にある患者、家庭で実行する意欲のある患者などを外来森田療法の条件と考える治療者もいる。さらに、自尊心が脅かされ、挫折して日常生活が困難になった人、自己実現ができずに悩んでいる人、生きるための苦しみを抱えている人、親子関係や思春期の問題を抱えている人、不登校、学校の対人関係や受験などに葛藤を有する人などが挙げられる。

Although there are many possible ways of applying Morita therapy to clients with a wide range of problems and emotional conditions, practitioners must consider the following client characteristics in assessing the suitability of outpatient Morita therapy: (a) having relatively healthy ego functions and a sufficient intellectual ability to comprehend and follow the treatment, (b) capacity for self-reflection, (c) ability to recognize and verbalize the nature of their difficulties and sufferings, (d) ability to make a practical assessment of current situations and problems in life, and (e) ability to comprehend the nature of Morita therapy from reading reference materials. Like most other therapies, Morita therapy is particularly suitable for clients who have a relatively high level of adjustment prior to the start of their treatment. This approach is also considered appropriate for clients who show *shinkeishitsu*-type personal traits accompanied by perfectionistic and competitive tendencies, high self-expectations, high need for self-control, and strong self-actualizing desires with corresponding fears.

Individuals with these qualities tend to show the Moritian mechanism of *seishin kogo sayo* (i.e., symptomatic self-aggravation with selective and heightened sensation of discomfort and *shiso no mujun* or so-called "ideational contradictions" (i.e., self-generated inner conflicts over the disparities between reality and unrealistic expectations), as discussed in a later section. A good prognosis of treating clients successfully with Morita therapy is affirmed whenever one or more of these traits in combination with self-defeating and symptom-aggravating processes are present. Of course, the prerequisite for any successful Morita therapy is that the clients show a reasonably high level of help-seeking motivation. See *Appendix 2* for the basic diagnostic criteria for *shinkeishitsu* developed by the Japanese Society for Morita Therapy.

これらの対象には広く森田療法を適用できる可能性があるが、治療の適否を判断するには下記の条件も併せて考慮すべきである。それは、先ず比較的健康な自我機能とある程度の知的理解力が必要だということである。ある程度自己を内省できること、自分の悩みを自覚し語ることができること、生活を吟味できること、本を読んで森田療法の概略が理解できること、などである。また病前の適応レベルが高い患者ほど治療効果を期待しやすいことは、森田療法も他の精神療法と同様である。次に、完全主義、勝気、「かくあるべし」が明瞭で、克己の姿勢、生の欲望が強いなど、神経質傾向を有しているかどうかである。

こうした性格傾向の人では「精神交互作用」や「思想の矛盾」などのとらわれの機制が認められやすく、それだけに森田療法が奏効する可能性も高いといえる。最後に、当然のことながら、ある程度の治療意欲は精神療法を開始する上で必須の条件となる（巻末資料２として日本森田療法学会が作成した森田神経質診断基準案を収録したので参照されたい)。

IV. Entry Phase of Therapy

The entry phase prior to the start of treatment is aimed at motivating clients to be engaged in their treatment. The therapist explains to his/her clients the psychological mechanism that creates a vicious cycle of symptom aggravation, and discusses the goal of the treatment. This is typically done in the initial interview session or over the first two sessions.

1. Promoting an Understanding of the Symptoms

An outpatient treatment interview typically starts with a probe to inquire about how clients experience their symptoms in concrete terms. The therapist fosters the understanding in his/her clients that anxieties and fears are at the base of their neurotic symptoms and reflect their innate desires to stay alive and to live well (the so-called "desire for life"). The client's desire and fear may be considered to form two sides of the same coin. For example, one's fear of others' negative evaluation, commonly found among socially phobic individuals, reflects the other side, that is one's desire to be positively regarded and appreciated by others. Similarly, the concern of hypochondriacal persons that they may be suffering from serious ailments is paired with the desire for good health. Behind the fear among those with obsessive disorders that they may have been contaminated by filth is their desire to live in a hygienic and safe environment. The fear among clients with panic disorder that they may die of a panic attack coexists with their earnest desire to live and not die.

Both these fears and anxieties and the corresponding desires reflect the bilateral aspect of natural human psychology, which may be regarded as a fact of human nature. Nevertheless, clients with neurotic characteristics consider that fears and anxieties are abnormal and unnatural, and therefore attempt to control and eliminate these affective reactions. Such controlling attempts lead to the exacerbation of the symptoms, and many clients become further preoccupied with the very thing that they try to eliminate. Some end up living in isolation to avoid experiencing the fear of being evaluated negatively by others, or they almost live like bed-ridden patients in order to avoid contracting illness despite the fact that they truly wish to live well and in good health.

IV. 治療導入

治療の導入に当たっては、患者を治療へ動機づけるとともに、症状を悪循環的に増強させるような心理機制を明らかにして、治療の目標を設定することが課題になる。通常は初回もしくは２回目までの面接において実施される。

１．症状の理解

患者の症状を具体的に尋ねることが、面接の出発点になる。その際、神経症症状の根源にある不安や恐れは、よりよく生きたいという人間本来の欲望（生の欲望）と表裏の関係にあることに理解を導くのである。例えば社会恐怖の人たちが抱く「他人から悪く思われるのではないか」という不安の裏には「人からよく思われたい、認められたい」という欲望があり、心気障害の人の「深刻な病気に罹っているのではないか」という懸念の裏には「健康でありたい」という欲望が存在する。強迫性障害の人が呈する「不潔なものに汚染されたのではないか」という恐れの裏には、「清潔に、安全に生きていきたい」という欲望があり、またパニック障害の人が有する「このまま死んでしまうのではないか」という不安の裏には、端的に「死にたくない、生きたい」という欲望が存在するのである。

こうした不安や恐れとその裏にある欲望は、どちらも自然な人間心理の両面の事実に他ならない。にもかかわらず、神経症の人々は、これらの不安や恐れを異常なもの、あってはならないものと考え、それらを排除しようと努める結果、かえって不安や恐れが増して、症状にとらわれていくのである。そして「他人から悪く思われる」恐れを避けるために孤立した生活を送ったり、あるいは病気に罹る可能性から逃れようとして、半ば「病人のような生活」に陥ったりするというように、かえって望んでいた生活とは反対の結果を招いてしまうのである。

There are two main ways of fostering the clients' understanding of the above points. One is a direct method of providing explanations and illustrative diagrams, while a more indirect way is to use probing techniques to help clients recognize the core emotions and desires underlying their symptoms; *see Note 1*. When they complain of multiple symptoms, the therapist may prepare a list of symptomatic items and help them recognize what might be the healthy desires associated with each symptom.

Further, to help his/her clients understand the above points, the therapist may discuss their key personality traits, such as (a) having strong desires for life, and (b) making dogmatic demands on themselves with ideas of "how I should be" and "how I should not be." He/she may point out how the self-defeating nature of such traits and the clients' self-demands are contributing to an impasse. The therapist may employ comments and observations such as the following:

- You get stuck with your excessive attempts to be perfect.
- You value your relationships with others so much that you end up feeling tied up with obligations.
- You tend to seek to feel safe and secure at all cost, which has caused you various difficulties in daily living.

As expressed in the above examples, the therapist may assist his/her clients to understand that their anguish and hardships result from their tenacious pursuits and self-demanding attempts.

Clients' self-evaluations are often based on a deficit model with an assumption that they are lacking something important and are therefore not worthy persons the way they are. The therapist needs to facilitate the clients' self-understanding and self-acceptance and increase their motivation for therapy by indicating that their problems are caused not by lacking something but by having too much of something. Pointing out the excessive nature of their mental and behavioural attempts is important in increasing the clients' recognition of their own perfectionism and self-preoccupied lifestyle. It is thus recommended that the therapist indicate to clients that their therapy will focus on making changes and improvements in these tormenting areas.

こうした点に患者の理解を導くには、図などを用いて治療者が患者に説明を行うといった直接的方法と、問いを重ねることで、患者自らが症状の根本にある感情や、その裏にある欲望に気づいていくよう促す間接的方法がある（註１）。　また患者が複数の症状を有している場合には、症状リストを作成し、順次上記のような不安と欲望の両面を明らかにしていく作業が必要になる。

さらに、上記の理解の上に、患者の性格、すなわち生の欲望が過大で、「かくあるべき」「かくあってはならない」という心の構えが強いことにも言及し、そのような性格ゆえに「生き方が行き詰っている」現実を指摘してもよい。　その際には、「あまりに完全にしようして行き詰まっているのですね」「人との関係を大切にしすぎて、むしろそれに縛られているのですね」
「安全を求めすぎて、苦しくなっているのですね」など、むしろ「多すぎる」「過剰である」という理解を示すのである。

患者はしばしば「自分には何か欠けている、だめな人間だ」という“欠損モデル”に依拠して自己評価している。それを「足りないのではなく、多過ぎるのだ」と指摘することは、自己の状態を理解し、受け入れ、治療への動機付けを強めることに結果する。このような“過剰である”ことの指摘は、患者の完全主義的・自己中心的な生き方に気づきと修正をもたらす上でも重要である。そしてこのように指摘した上で「あなたを苦しめている所を改善していこう」といった治療への提案を行うことが望ましい。

2. Pointing out the Self-Defeating Mechanism of *Toraware*

The mechanism of *toraware* (mental preoccupation) is a central concept in Morita therapy which explains how a neurotic vicious cycle is developed. There are two types of the *toraware* mechanism: (a) *seishin kogo sayo* (i.e., cyclical self-aggravation effect, or the effect of psychologically mediated symptom aggravation in a self-reinforcing loop with the use of selective attention and anticipatory ideations), and (b) *shiso no mujun* or ideational contradiction (i.e., unrealistic thinking causing a disparity and a contradiction between reality and ideality or expected reality); see *Section V* for more details.

The therapist may point out in simple and clear terms to clients at the beginning of the therapy how they have aggravated their symptoms by their very attempts to avoid or manipulate them. (Morita called such self-manipulative attempts to resist spontaneous affective experiences *hakarai*.) For example, an obsessive client may be confronted by the fact that his/her effort to deny a certain spontaneous thought results in further intensifying the thought. The therapist may explain this concept with illustrative diagrams, or probe to help his/her clients realize how they are contributing to the development and maintenance of a vicious cycle.

Indicating to clients how mental preoccupations (i.e., *toraware*) precipitate and maintain a vicious cycle of symptom aggravation helps them understand that the problem lies in how they are relating to their experiences of anxiety and fears. This is done in order not to reinforce their belief that they have a defective or weak personality and are hopelessly "no good." Thus, clients are guided to consider that their neurotic problems are not caused by their defective or weak personality but by their self-preoccupations. This helps clients become more hopeful about finding solutions to their problems by reversing the vicious cycle of symptom aggravation and unproductive lifestyles, and enhances their motivation for active engagement in the therapy.

２．とらわれ（悪循環）の機制を示す

とらわれの機制とは、神経症発症のメカニズムとして、森田療法理論の基本に位置づけられるものである。とらわれの機制には大別して「精神交互作用」と「思想の矛盾」があるが、詳しくはⅤにおいて説明する。

治療導入時には、患者がこれまで症状から逃れようとしたり、症状をやりくりしようとしてきた努力（はからい）が、かえって症状を増強させている事態を簡潔に指摘すればよい。たとえば強迫観念を有する患者に、考えを打ち消そうとすればするほど、いっそうその考えが増強する事実を示すのである。ここでも図示して直接説明する方法と、問答形式により本人にそれと気づかせる方法がありうる。

とらわれ（悪循環）を明確にすることは、「自分の性格に弱さがあるから」「自分がだめだから」と悩み、無力感にさいなまれている患者に、不安や恐怖への関わり合い方が問題であることを伝えることになる．つまり問題は「弱さ」や「だめだから」でなく、とらわれゆえであり、悪循環を打破すれば問題は解決できるのだ、という希望を与えるものである．それが治療の動機付けにもなるのである。

3. Explaining the Attitude of *Arugamama* and Setting Therapeutic Goals

After clarifying how a state of mental preoccupation (*toraware*) is caused by the clients' excessive attempts to control their undesirable symptoms, the therapist may point out that they need to cultivate new ways of dealing with the symptoms and alleviating self-preoccupations. The new attitude required here is that of *arugamama* or being "as-is" (i.e., being authentic and natural and intuitively accepting the experience of self and the present situation as they are without intellectually manipulating or being judgmental about the present authentic experience).

First, *arugamama* means that clients leave their symptoms and experience of anxiety as they are without *hakarai* (i.e., manipulative, controlling, or resisting attempts). Clients may be advised not to fight the symptoms but to learn to accept them. Such an advice poses a completely different stance from what clients are used to so far. Second, the Morita therapist emphasizes that clients need to express their desire for life in the forms of concrete, practical, and constructive actions in their daily living. The message here is that clients are to leave the present mental state as it is without manipulation or resistance and do what needs to be done here and now. The ultimate goal of therapy is to live life fully.

Thus, it may be noted that the aim of Morita therapy goes beyond dismantling the clients' preoccupations with their symptoms and that clients need to be helped to develop a constructive way of living free of excessive preoccupations. The therapist is cautioned not to allow his/her clients become too preoccupied with the idea that they *must* be in *arugamama*, which could inadvertently block or reverse the therapeutic progress.

At the last stage of his life, Shoma Morita came to the realization that we cannot help but fear death, that is, we have no choice but to accept the fear as it is. He also realized that we cannot abandon desires within us so long as we live, and that we need to acknowledge and actualize our desire for life constructively. The therapist may consider these points in order to offer appropriate therapeutic advice to his/her clients.

３．「あるがまま」の態度を説明し、治療目標を定める

症状に対するはからいが、とらわれをもたらすことを明らかにしたなら、次にはとらわれから脱するため、症状に対してこれまでとは異なる態度が求められることを伝える。それがすなわち「あるがまま」の態度である。

「あるがまま」とは、第１に、症状や不安をやりくりしようとせず、そのままにしておく姿勢を意味する。「症状と闘わないこと」「それとつきあってみること」など、いままでの患者のやり方とは全く違った対処の仕方を助言するのである。第２には、症状や不安の裏にある生の欲望を、実生活において建設的な行動の形で発揮していくという、より積極的な意味があることも伝えるのである。言い換えるなら、心の状態はそのままに、なすべき生活、行動をなすということである。最終的には、自己をよりよく生かしていくということが治療の目標に定められる。

このように森田療法では、症状へのとらわれを打破するだけに留まらず、とらわれのない生き方を実現するまでが射程に入れられていることを、治療者は銘記すべきである。なおこの際、「あるがままでなければならない」ということにとらわれて、治療が停滞・逆行することのないよう注意を払う必要がある。

ちなみに森田正馬が最晩年に到達した人間性の事実への自覚、「死は恐れざるを得ない」（恐怖はそのまま引き受けざるを得ない）「欲望はあきらめられない」（生の欲望の自覚と発揮の重要性）を念頭に入れておくと適切な助言がしやすいだろう.

4. Additional Points

Some therapists discuss Shoma Morita's life with their clients, or give examples of past treatment cases for the purpose of illustrating the above points and increase their clients' understanding of Moritian ideas and explanations, while others disclose their own experience and process of overcoming their neurotic sufferings. Many therapists ask their clients to read books on Morita therapy or give them relevant handouts. These are effective ways of fostering clients' understanding of the therapy between sessions. Finally, there are cases in which clients specifically ask for Morita therapy as a treatment of choice. In other cases, Morita therapy is incorporated into a general treatment approach without announcing to clients that it is based on Morita therapy. The therapist may use discretion and flexibility in introducing this approach effectively depending on the therapeutic context and client factors.

４． その他

治療者によっては森田の人生を語り伝えたり、過去の症例を紹介して上記の説明を補強することがある。また自ら神経症を克服した体験を有する指導者は、自己の体験を開示することもある。また森田療法関係の図書を読むよう指示したり、森田療法を紹介するプリントを手渡す治療者も多い。それは次の面接までに、森田療法の理解をいっそう図るための効果的な方法である。なお、森田療法を実施する際、患者自らがそれを希望し、治療者と患者との合意によって森田療法を開始する場合もあれば、あえて森田療法とは明言せず治療に導入する場合もあるが、それは治療環境や患者の条件によって、柔軟に考えて差し支えない。

V. Basic Therapeutic Components

The following five therapeutic components of outpatient Morita therapy practice were identified in our survey data which offered the basis for establishing the current *Guidelines*: (a) increasing client awareness and acceptance of emotions, (b) recognizing and mobilizing the client's desire for life, (c) clarifying the vicious cycle, (d) giving instructions for constructive action taking, and (e) facilitating client re-evaluation of their behavioural patterns and lifestyles. These components are discussed in the following sections.

1. Increasing Client Awareness and Acceptance of Emotions

When clients are able to accept their affective experiences as they are without further resisting or combative attempts, the therapist may consider that the conclusion of therapy is nearing. As mentioned earlier, there exist fears and anxieties at the base of various neurotic symptoms. Clients, however, tend to react with hypersensitivity to affective discomfort such as anxiety, and make futile efforts to eliminate it or engage in the avoidance of anxiety-provoking tasks and situations so as not to face such discomfort and other emotions. The affective experiences that clients try to avoid, in addition to fears and anxieties, vary from client to client. For example, socially phobic persons may be confronted with the feelings of embarrassment and timidity, while clients with an obsessive disorder may have feelings of irritation or anger. In order for these clients to accept their affective experiences, they must first recognize such experiences. The therapist may foster the clients' awareness of their affective experiences in given situations with the repeated use of questions such as: "How were you feeling inside then?" and "What affective condition were you in at that time?"

V. 治療の基本的構成要素

アンケート結果から導かれた外来森田療法の基本的構成要素は、「感情の自覚と受容を促す」「生の欲望の発見と賦活」「悪循環の明確化」「行動指導」「生活の見直し」の５つであった。以下、各要素について解説する。

1. 感情の自覚と受容を促す

患者が自己の感情をあるがままに受け入れることができるようになったなら、治療は終結に近づいたといってよい。先にも述べたように多様な神経症症状の根底には不安や恐れの感情が存在する。しかも、患者はこうした不安や恐れのような不快な感情に過敏に反応し、それらを除去するために努め、あるいは必要な行動も回避することによってこうした感情に直面しないように腐心しているのである。不安や恐怖の他にも、患者によって様々な感情が体験されている。社会恐怖の人々の抱く羞恥や怯えの感情、あるいは強迫性障害にしばしば見られる苛立ちや怒りの感情などである。これらの患者が、自己の感情を受容するには、まずそうした感情に気づかなくてはならない。そこで治療者は「そのときどのように感じていたのですか？」「どんな気持ちだったのですか？」といった質問を繰り返すことによって、感情の自覚を促すことが重要である。

Further, the therapist may advise clients to look at the ups and downs in their affective states. According to the *DSM-IV*'s diagnostic criteria for panic disorder, a panic attack is expected to reach its peak within 10 minutes from its onset. That is, the intensity of anxiety subsides after reaching its peak. Clients receive the following core instruction about the nature of emotion (one of the "laws of emotion" that Morita discussed), which is presented repeatedly throughout therapy: "If an emotion is left as it is without your tampering, it will eventually and naturally dissipate and disappear." When clients come to realize experientially that this is indeed true, they begin to be able to let emotional reactions be as they are without fighting them. The therapist needs to offer concrete and contextualized advice to clients in this regard, such as: "Be patient," "Observe the flow of emotions without retreating from them," and "Just experience emotion as they come and go." When clients follow such advice, they experience the above-described nature of emotions first hand. The therapist needs to be reminded that many clients do have difficulty persevering with certain types of emotional discomfort.

Metaphors and similes are often used for explaining to clients how emotions flow and fluctuate over time. The following is an example of the use of a metaphor: "Emotions are weather conditions. Anxiety is a brief rain." The therapist is cautioned here to remember that his/her clients' pain and discomfort, which accompany their anxiety, may be quite intense. In order to help them face such a painful emotion, it is essential that the therapist works with his/her clients empathically. They gradually learn that intense emotions are not to be avoided but to be regarded as natural and unavoidable human experiences. This approach corresponds to the normalizing technique as discussed by Aizawa.

To add, mood fluctuations may have longer intervals among mood disordered clients with depressive feelings than among those with anxiety neurosis. In dealing with mood disordered clients, the therapist may choose a more appropriate weather-related metaphor such as "depression is a rainy season" to infer that it takes a longer time to allow for changes in their affective states. See *Note 2* for further suggestions about how to deal with client emotions in mood disorder cases.

さらに患者には、自己の感情の流れをしっかりと見つめるよう助言していく。パニック発作を例に挙げれば、DSM-IV の基準には１０分以内に頂点に達するということが明記されている。頂点を過ぎれば、徐々に不安は鎮まっていくのである。このように「感情はこれをそのままに放任すれば、時を経るに従って自然に消失する」という「感情の法則」を徹底して指導する。こうした事実に患者が体験的に気づくことができれば、はからわずにそのままにおくこともできるようになっていくのである。このとき、治療者が患者に「待つこと」、「その感情の流れをしっかりと観察すること」、「それを体験すること」などを具体的場面に沿って助言することが重要である．それが「感情の法則」をそのまま実感できることにつながるのである．悩んでいる人は一般に「待てない人たち」であることを治療者は知っておくことも大切であろう。

ところで感情が時間と共に流転することを患者に伝えるには、しばしば比喩が役に立つ。「感情は天気。不安は一時の雨模様」といった比喩である。ただし、患者の不安に伴う苦痛や不快は相当の程度だということは理解しておかなくてはならない。患者が、そのような苦痛を伴う感情を抱えることができるためには、治療者が共感を持って接することが欠かせない。患者が味わっている感情は、程度が甚だしいにしても、本来私たちにとって自然な、それゆえ避けることのできない感情なのだということを、折に触れて伝えていくのである。藍澤のいう普遍化という技法がそれに相当する。

なお、気分障害の際の抑うつ感は、変化流転するには神経症性の不安より、かなり長時間を要する。この場合には天気の比喩を用いるにしても、「うつは梅雨の季節」といった長期間を暗示する表現が必要になるだろう（気分障害の際の感情の扱い方については、註２を参照のこと)。

2. Recognizing and Mobilizing the Client's Desire for Life

It is considered one of the most fundamental components of Morita therapy that the therapist directs the attention of his/her clients to the healthy desires that underlie their fears and anxieties so as to help them discover, nurture, and act on such desires. A focus on their desire for life may thus mobilize the clients to take desirable action in the presence of their anxiety rather than waiting for the anxiety to subside with no action. In residential Morita therapy, direct and physical experiences such as bed-resting serve to mobilize the inpatients' desire for life, whereas clients in outpatient Morita therapy come to recognize their desire for life mainly through therapeutic dialogues.

During the introductory phase of treatment, the therapist focusses on helping clients recognize their healthy desires underneath the symptom complaints (e.g., a desire for positive evaluation by others which lies underneath social phobia). However, clients need to learn to identify a wide range of healthy desires inherent to their daily living as well as those accompanying the symptoms in order to further the therapeutic change process. Human desires for life exist limitlessly, ranging from basic day-to-day desires such as "wanting to eat when hungry or to drink when thirsty," "wanting to take a shower to feel fresh after sweating" to more spiritual or existential desires such as "wanting to pursue a unique life" and "wanting to achieve a high quality of life." Certain desires are easily fulfilled by quick action such as eating to appease hunger, while other desires may take years before they become fulfilled, such as reaching personal goals or embodying certain internal values in life.

However, in Morita therapy, there is no hierarchy placed on clients' desires; no judgment is made on which desires and values should be considered higher and better. Rather, all desires ranging from "the desire for food" to "the desire for a meaningful life" are treated equally as valid natural human desires. By recognizing these diverse desires, clients are guided to take corresponding constructive action to lead a fulfilling life. They need to be cognizant of what is important to them and what they desire, as reflected in Morita's statement: "After all, we must come to an understanding of what we are pursuing when we engage in quiet self-reflection" (Morita, 1934/1975).

2．生の欲望を発見し賦活する

患者の不安や恐怖、あるいは症状の裏にある健康な欲望を照らし出し、発見させ、発展させるよう水路づけることは、森田療法の根幹だといっても過言ではない。そのような生の欲望は不安を伴う行動に患者が踏み込む原動力に他ならない。入院森田療法では、臥褥のような直接的、身体的体験が生の欲望を賦活するのだが、外来治療においては、治療者との対話の中から患者が自らの欲望を自覚することが主な手立てになる。

ところで治療導入期には、患者の症状を手がかりに、その裏にある欲望（例：対人恐怖の裏にある、よく思われたいという欲望）に言及することが課題であった。けれども治療を本格的に展開する時期には、症状に関連した欲望ばかりでなく、患者の日々の生活に内在する健康な欲望を幅広く見出していくことが鍵になる。実際、生の欲望といっても、その裾野は広い。「お腹が空いたら、ご飯を食べたい」「渇いたら、水を飲みたい」「汗をかいたら、入浴してさっぱりしたい」といった生活の基本的な欲望から、「自分らしく生きたい」「価値ある生活をしたい」というような、より精神的、実存的な欲望まで、限りがないのである。また空腹のようにそのつどの行動（食事）によって充足し得るものから、人生の目標や価値のように、長い年月の中ではじめて充足可能な欲望もある。

けれども森田療法では、「人生の価値」といった特定の主題を優位におくことはせず、「ご飯を食べたい」から「有意義な人生を送りたい」まであらゆる「～たい」を等しく人間の自然な欲望として承認するのである。そしてそれらの欲望を建設的な行動に発揮し生活を充実させることを目指すのである。「結局われわれは、静かに自分を見つめる時に、自分は果たして、何を求めつつあるかということを知らなければならない」（森田, 1934/ 1975）。

The therapist may look for an appropriate moment for asking his/her clients direct questions such as "How would you want to be?" and "What kind of life will you pursue when you overcome your current difficulties?" These questions can activate the clients' self-reflective process even when they cannot come up with ready answers. Inquiring into the details of their daily living and discussing their personal interests often lead them to recognize and articulate their own desires. For example, having a discussion on their work activities may lead clients to express their commitment to pursuing certain personal goals such as obtaining a qualification to enhance their career. While talking about his/her hobbies, a client might move on to discuss his/her desire to go to certain musicians' concerts. Even when clients say that they have nothing they are interested in doing, their basic desires associated with day-to-day living remain active, such as a desire to eat when hungry and a preference for something delicious to poor-tasting food.

Through the process of verbalizing and articulating their desires, clients can turn their vague wishes and desires into concrete ones with clear images. In this process, the therapist is required to refrain from critiquing and making hasty value judgments on clients' verbalized desires. Instead, the therapist must maintain a respectful stance toward the expressed desires and regard such desires as natural and common, and to recognize and reflect empathically his/her clients' desire for life as a natural expression of their healthy mental activities. This way of dealing with clients in therapy mobilizes and expands their desire for life, which is considered a very important component of the therapeutic process in outpatient Morita therapy.

治療者は機を見て「どうなりたいのですか」「治ったらどのような生活を求めているのでしょうか」といった直接の質問を患者に投げかけるとよい。直ちに答えが得られなくとも、そのような質問が患者の自問自答を促す契機になることがある。また、患者の生活の実際を詳しく聞き、何に関心を寄せているのかを話題にすることが、患者の欲望の発見に繋がることも多い。たとえば仕事についての対話から、何らかの資格を取得して仕事に生かしたいといった具体的な目標が見出される場合もあるし、趣味について話題にするうち、特定のミュージシャンのコンサートに行きたいという希望が語られることもあるだろう。たとえ「やりたいことは別にない」という患者であっても、生活の基本的な欲望は失われておらず、空腹時には「ご飯を食べたい」し、まずいものより「うまいものを食べたい」のである。

いずれにしても、患者が自らの欲望を言葉にすることによって、漠然とした願いから具体的な形、イメージが手繰り寄せられていくのである。それと同時に治療者は、患者によって語られる希求に対して、性急な価値判断や批評を加えず、自然な欲望として承認（普遍化）する姿勢が求められる。治療者が、患者の自然な心の動き（生の欲望）に気づき、共感的に反応し、それを照り返していくことである．そのような治療者の関わりが、患者の生の欲望を賦活することになるからである。ここは治療上重要なポイントである。

3. Clarifying the Vicious Cycle

Morita therapy focusses on the self-defeating mechanism of *toraware* (i.e., mental preoccupation) which contributes to the exacerbation of the clients' neurotic symptoms. This vicious cycle of *toraware* has two main components: (a) the attention-mediated sensory aggravation effect (*seishin kogo sayo*, or a mechanism of symptomatic exacerbation through a mutually escalating interaction between attention and sensation), and (b) ideational contradictions (*shiso no mujun*, or unrealistic thinking causing a disparity between reality and ideality or expected reality). As mentioned earlier, the therapist is required to point out how clients are engaged in a vicious cycle of *toraware* at the beginning phase of the treatment. Furthermore, clients need to be reminded routinely throughout therapy that the self-defeating mechanism of *toraware* plays a critical role in various problematic situations in their daily living.

We will look at *seishin kogo sayo* or the mechanism of attention-mediated symptomatic sensory aggravation, using an example of a panic attack. When clients with a *shinkeishitsu* personality type accidentally notice that they are experiencing heart palpitations, they become very anxious about this temporary condition and continuously fix their attention on the palpitations. As a result, they become hypersensitive to their physical condition, which heightens their anxiety, narrowly fixates their attention to the heart, and thus exacerbates the experience of the palpitations. *Seishin kogo sayo* is therefore a process of attention and sensation to be caught in a self-reinforcing interactive loop of mutual escalation. Various types of hypochondriacal anxiety in addition to panic attacks inherently have this attention-sensation mechanism of self-aggravation.

３．悪循環を明確にする

森田療法では、神経症症状の発展機制として、とらわれ（悪循環）に着目する。とらわれの機制には大別して「精神交互作用」と「思想の矛盾」がある。治療導入の際にも、患者のとらわれの様相について治療者が簡潔に指摘することが求められたが、導入の後にも、患者の体験に即して悪循環の機制を繰り返し明らかにすることが重要である。

先ず精神交互作用について、パニック発作を例に挙げて説明しよう。偶然の機会に心悸亢進が起こると、ことに神経質傾向にある人はそれに強い不安を覚えて心臓部に注意を集中する。その結果益々感覚は鋭敏になり、いよいよ不安がつのって心臓部へ意識が狭窄し、一層の心悸亢進をもたらす。精神交互作用とはこのように注意と感覚が悪循環的に作用して症状が発展する機制である。パニック発作に限らず、種々の心気的不安には、精神交互作用が介在している。

The second component of the mechanism of *toraware* is called *shiso no mujun* or "ideational contradictions." *Shinkeishitsu* persons have a strong tendency to try to control certain affects such as fears and anxieties. Their attempts to control such affective reactions intellectually and willfully are accompanied by self-imposed beliefs about "How I should be" and "How I should not be." Such beliefs and controlling attempts result in an inner conflict about their inability to fill the gap between reality and ideality. Erythrophobic clients, for example, blame themselves for getting embarrassed and turning red in front of others in situations where most people can honestly admit such affective reactions as normal and human. However, erythrophobics consider that these reactions are inappropriate, and make conscious efforts to feel self-confident and not to feel shy or embarrassed. Contrary to such self-controlling efforts, they end up becoming more preoccupied with their feelings of embarrassment and redness of the face. It has been pointed out that the tendency to get entrapped in *shiso no mujun* (ideational contradictions) is a psychological characteristic of a particular personality type closely associated with obsessive needs for control. An obsessive type, compared to the other types of *shinkeishitsu* neurosis, tends to involve the client ego function more actively than the mechanism of attention-mediated sensory aggravation. The symptoms of social phobia as well as many obsessive thoughts can be explained with the notion of psychological entrapment in ideational contradictions.

An effective way of addressing the above mechanism of self-entrapment in a vicious cycle is to explore the clients' covert processes during the times when they were actually experiencing their symptoms. The therapist may ask questions such as: "Where was your attention focussed?" and "What were you thinking of at that moment?" In this way, clients are helped to recognize that they were fixing their attention narrowly on certain bodily parts and affective reactions, and that they were making unrealistic self-demands as well as futile attempts to convert the present reality (i.e., the fact of their actual experience here and now) into the self-imposed version of a preferable or ideal experience.

とらわれの機制の第２は思想の矛盾と呼ばれる。一般に神経質性格の人々は不安や恐怖などの感情を「かくあるべき」「かくあってはならない」という知性でもって解決しようとする構えが強く、そこに不可能を可能にしようとする葛藤が生じるのである。例えば赤面恐怖の患者は、何かの折りに人前で恥ずかしく感じ顔が赤らむといった当たり前の感情や生理的反応を「ふがいない」「もっと堂々としていなければならない」と考え、恥ずかしがらないように努める結果、かえって自己の羞恥や赤面にとらわれるのである。思想の矛盾は、より性格特異的なメカニズムであり、強迫的なコントロール欲求にも関連が深いことが指摘されている。精神交互作用より、自我が能動的に関与しているともいえる。対人恐怖症状の他、多くの強迫観念の発生についても思想の矛盾から説明することができる。

さて、上記のような悪循環機制を明確にするには、症状出現時の患者の体験に焦点を当てることが有効である。「そのとき注意はどこに向かっていましたか？」「どんなことを考えていましたか？」といった質問を向けることによって、自己や自己身体の部分に注意がとらわれ、また「かくあるべし」の考えが自己を強制していたことに自覚を促すのである。

It is also effective to engage clients in a simulated experience during an interview. For example, clients with a fear of writing with hand tremors in front of others may be invited to write their names before the therapist. In many cases, their hands do not tremble in front of the therapist nearly as much as in front of other people in real life situations. Clients learn from such a simulated activity that they unintentionally escalate their fear of hand tremors in real life situations by focussing too much on their self-defeating thoughts while with others. They may be saying to themselves, for example, "I am ashamed of my hand tremors" and "I must try not to allow my hand to shake when I am writing."

Another common explanation shared with clients in outpatient Morita therapy is that *hakarai* (willful control or manipulative management of self and situations to suit one's own needs) and *toraware* (preoccupations) form the basis of a vicious cycle. *Hakarai* refers to an attempt to manage and change anxiety and other affective symptoms intentionally. Attentional focus in the case of *seishin kogo sayo* (attention-mediated sensory aggravation) and *shiso no mujun* (unrealistic thinking causing ideational contradictions) are both covert processes. On the other hand, manipulative management or *hakarai* has both covert and behavioural dimensions, and the behavioural manifestation of *hakarai* itself can become a form of a symptom. For example, erythrophobics try to mask their red face by consuming alcohol before being with others, or agoraphobics demand that they be accompanied by their family members whenever they need to go outside, in order to reduce their own anxiety. Similarly, phobic clients may simply avoid entering a feared situation, while other people, who also find the same situation to be anxiety-provoking, may face it and proceed.

Such attempts to control the affective symptoms as in the above examples end up reinforcing the symptoms and complicating the problematic situation for the clients. Attempts for *hakarai* (i.e., manipulative management) are reflected not only in their verbalizations but also their attitudes expressed during treatment sessions. Similarly, the therapist may recognize signs of *hakarai* in those agoraphobic clients who bring another person with them to interview sessions in order to reduce anxiety. By sharing his/her observations with the clients and discussing the consequences of such manipulative attempts and avoidant maneuvers for reducing anxiety, the therapist can engage the clients in a therapeutically meaningful examination of their unconstructive coping strategies.

また時には、治療者の面前でシュミレーションを行うことも効果的である。たとえば人前での書字困難を苦にするふるえ恐怖の患者には、治療者の前で氏名などを書いてもらう。大抵治療者の面前では、ふだんの人前状況よりふるえが目立たないものである。そこから、人前で生じる「ふるえたらみっともない」「ふるえないように努めよう」といった意識が、かえってふるえを助長するというパラドックスを今そこで明らかにすることができるのである。

ところで「はからい」と「とらわれ」が悪循環をなす、といった説明もよくなされる。その場合の「はからい」とは、不安などの感情や症状を意図的にやりくりしようとする行為を意味するが、精神交互作用における注意や、思想の矛盾の際の思考（思想）のように内的なプロセスだけでなく、実際の行動の形で出現し、それ自体が症状の一部をなすことがある。たとえば赤面恐怖の患者が、赤面をごまかすために人前に出るときにあらかじめ飲酒したり、広場恐怖の患者が外出の際、必ず家族を同伴して不安を軽減させたり、あるいは恐怖症の人が一般に恐れている状況を回避するといった行動である。

これらの「はからい」は、症状を固定化し、事態を益々複雑にする結果になる。こうした「はからい」行為は、患者の陳述から明らかにされるだけでなく、面接時の患者の態度、同伴者の有無などによっても確かめられることである。そこで、治療者がそれを直接指摘したり、「はからい」行為の結果、どのような事態が招来されているかを患者と共に吟味していくことが大切な治療のプロセスになる。

4. Giving Instructions for Constructive Action Taking

By elucidating the above-described vicious cycle to clients, the therapist proceeds to help them translate their desire for life into constructive action. Although most clients tend to consider taking such action only after the symptoms have subsided, the therapist encourages them to take practical action within their present capacity while experiencing anxiety and other symptoms.

It is a therapeutic principle of Morita therapy that the therapist does not dictate to his/her clients as to which action they need to take, but instead helps them identify by themselves or in a collaborative dialogue with their therapist what concrete behavioural tasks need to be undertaken. At times, clients set one or more action goals to strive for before the next interview session. The selected action does not have to be limited only to the action or activities in the symptom-related problematic areas. Clients need to engage in various types of action to fulfill their desires for leading a productive and meaningful life. One of the instructional points here is to help clients develop small, practical, and achievable behavioural goals rather than setting highly demanding and unrealistic ones. While clients tend to be hesitant and feel hampered by their own perfectionism to take their first step in action toward big and challenging goals, they are more likely to engage in action with small steps, which makes it easier for them to engage in the next small steps. Such a series of small steps consequently nurtures an action-based living attitude in clients.

It may be noted that the therapist is required to some extent to guide clients when they are making choices of action. The following suggestions and advice may be useful to clients: (a) "Let moods and feelings be, and do what needs to be done," (b) "Distinguish moods and feelings from action," and (c) "Recognize what you can do and cannot do, and refrain from doing impossible things (e.g., manipulating or resisting spontaneous moods). Instead, proceed to the action that is needed in your daily life." Clients are thus encouraged to tackle, and not to run away from, the necessary tasks and issues in daily living despite their inner suffering and discomfort. Some Morita therapists instruct clients to act like a healthy person and lead a constructive life with patience and hard work. For example, clients who are students are required to go to school and study as their daily tasks in spite of their sufferings. Similarly, working adults need to go to work and get their jobs done, and full-time homemakers need to get their work done at home.

４．建設的な行動を指導する

以上のような悪循環を明確にした上で、治療者は患者の生の欲望を建設的な行動に結び付けるよう促していく。患者は大抵、症状が改善した後に、これらの行動を手がけようと考えているが、治療者は、不安や症状を抱えたまま、今できることから実行していくよう指導していくのである。

森田療法においては、治療者が患者に行動を指示するのではなく、患者自らが、あるいは患者と治療者が相談して具体的な行動課題を見出すことが原則である。次の面接までに、一つないしいくつかの実践課題を患者自身が設定するというやり方もなされている。行動の内容については、症状に関連したものに絞る必要はない（ここにおいて認知行動療法との相違が明白である)。生活を充実させるには、生の欲望にしたがって、広く多様な行動に踏み出していくことである。また大きな目標よりも、今日実行可能な小さな目標を立てることも指導のポイントである。大きな目標は完全欲が妨げになってなかなか着手できないものだが、小さな目標、ささやかな行動が次の行動の呼び水になり、結果として活動的な生活態度が醸成されることも多いのである。

ただし、ある程度は行動の選択について治療者の助言が必要になる。よく森田療法では「気分は気分として、なすべきことをなす」よう指導される。または「“気分”と“行動”を分けること」、「できないこととできることを自覚し、できないこと（気分を操作すること）をやめて、できること（日常の行動）に取り組むように」などと伝える．このようにして患者にとって必要な仕事や生活上の事柄に、苦しくても逃げずに取り組むよう促していくである。「健康人のふりをして忍苦努力して生活すること」を強調する治療者もいる。学生なら登校し勉強に当たること、社会人であれば自分の仕事に着手すること、そして主婦であれば家事に携わることなどがそれに相当するだろう。

Behavioural guidance aims at cultivating a purpose-oriented and action-based lifestyle in clients. For example, clients with panic disorder are encouraged to go out to buy necessary clothes as one of the tasks. However, it is quite common that they judge their own therapeutic progress based on the presence or absence of panic attacks or anxious feelings while outing for fulfilling a task. Such clients are encouraged to judge their effectiveness based on the achievement of their original purpose of outing. For example, they may assess how productive they were in finding the kinds of clothes they were hoping to buy and whether or not they found reasonably priced and good quality items suitable for their purchase. Through such real-life training, clients learn to break out of a symptom-focussed and mood-oriented lifestyle and begin to lead a more purpose-oriented and action-based way of living.

Clients who have withdrawn from social life for some time might say that they cannot find things that need to be done, and feel confused because they do not know what they should be doing. The therapist, in such a situation, may direct their attention to basic daily activities such as changing clothes, face washing, teeth brushing, and having meals regularly. At times, clients may be asked to observe their way of living closely and find concrete and practical tasks requiring their action. For example, when they feel not at ease with their current living condition (e.g., an untidy room with scattered items on the floor), they can find a task at hand and proceed to a cleaning activity. As they begin to pay closer attention to their living environment, they begin to notice more tasks to be done and are guided from one action to another.

It is also helpful to focus on what clients would enjoy doing and to encourage them to act on it, which will release them from self-obliging thinking about "what I should be doing." Some clients prevent themselves from taking necessary action as the result of immersing themselves in self-blaming or self-inhibitive thinking, such as "I should not be playful and have fun because I am not employed." As long as action is not anti-social, doing something entertaining may be considered much better than doing nothing at all in life. Some Morita therapists strongly promote the use of specific activities and tasks, including making humourous speeches and walking, as part of the therapy.

そして行動に際しては、目的本位の姿勢を指導する。たとえばパニック障害の患者が洋服を買いに行くとする。患者はたいがい、外出中に症状が出たか、不安を感じたか否かを判断の基準にするものである。このような「症状本位」「気分本位」のあり方から脱し、本来の目的が果たされたか否か、この場合であれば目的の洋服を手に入れることができたか、しかもなるべく安価でよい品を購入できたかどうかを評価の基準にするよう指導するということである。

ところで社会生活から撤退しているような患者は、「なすべき行動がない、何をしていいか分からない」と困惑する場合がある。このようなケースには、衣服を着替える、洗顔・歯磨きを行う、きちんと食事を取るといった生活の基本的な事柄から実行するよう助言する必要もある。ふだんの生活をよく観察し、たとえば部屋が散らかっていて見苦しい、など「感じの悪い」ところを見つけることが、行動を起こす出発点になる。また、「なすべき」ことにとらわれず、「～したい」と感じることを、実行するよう奨励することも大切である。

患者によっては、「仕事もしていないのに、遊んでいてはいけない」などの自責的考えや規範意識から、やりたいことも手控えている場合がある。しかし、たとえ娯楽的な事柄であっても（反社会的なものでない限り）、実行に移すことは何もしないよりはるかによいのである。なお、ユーモアスピーチやウォーキングなど特定の行動課題を積極的に奨励する治療者も見られる。

It is also a characteristic of Moritian instructions that clients are encouraged to maintain continuous engagement in action. That is, clients are prompted to indentify the next action to be taken and swiftly move from one task to another upon completion. Thus, their focus of attention gradually and naturally shifts from their covert symptoms to the external events and activities; this helps to expand the clients' awareness field as the result of developing a more extraverted lifestyle. Morita often quoted the following saying: "Adjust the exterior (e.g., lifestyle and action), and the interior (e.g., covert conditions and emotion) will adjust itself naturally."

Certain types of neurosis require even more concrete behavioural guidance. Clients with social phobia or *taijin-kyofu-sho*, for example, often benefit from the instruction that they try to be good listeners rather than to be good speakers. Clients with strong obsessive-compulsive behaviours may be asked to move from one activity to another with a time limit placed on each activity.

When encouraging clients to take action, it is also important that the therapist shows interest in what actions his/her clients have taken and what they have achieved. The therapist may ask for the details of the clients' actions, and validate their efforts in recognition of their successful attempts. Empathic and affirmative comments may be effectively offered, such as "You have done a great job" and "It is a big progress." Many clients have a limited number of positive experiences of praise and recognition by others. Such positive words of recognition by the therapist further reinforce the clients' newly acquired action pattern. As such, therapeutic progress may be indicated when the range of discussion topics during outpatient sessions begins to expand to include various life situations and personal experiences beyond the complaints of symptoms.

さらに行動に当たっては、次のこと、次のことと手早く動くよう助言していくことも森田療法の特徴的な指導である。このように活動的で外向的な生活を実践していくことから、おのずと注意は自己の症状から外界の事物へと転換し、意識が開かれていくことになるのである。森田は「外相（生活の形、行動）を整えれば、内相（心の内面、感情）おのずから熟す」という言葉をよく引用してもいた。

神経症のタイプによっては、さらに具体的な行動指導が必要になる場合がある。たとえば社会恐怖（対人恐怖症）の患者には、話し上手より聞き上手を心がけることを、また強迫行為の顕著な患者には、時間を目安に次の行動に移るよう指導するなどのことである。

治療者は行動を促すと共に、患者が実行した事柄には関心を寄せて詳細を尋ね、「やりましたね」「大きな進歩です」などと共感をもって肯定することが重要である。患者はほめられたこと、認められたことの経験が少ない人たちであるだけに、こうした関わりは、患者のさらなる行動を勢いづけていくものである。このような対応を重ねることによって、面接の話題が症状のことから患者の生活の広がりに自然に移っていくようであれば、それは治療の進展を意味するものである。

5. Facilitating Clients' Re-Evaluation of Their Behavioural Patterns and Lifestyles

Clients' habitual dogmatic thinking often surfaces as they try to expand their behavioural repertoire. Clients with social phobia, for example, become attached to the idea that they should be relaxed and speak smoothly prior to giving a speech. Clients whose social life has begun to expand may apply their dogmatic expectations about "how one should be (or should not be)" not only to themselves but to others and become irritated with other people's imperfections.

The therapist raises his/her clients' awareness of their own self-defeating patterns, and offers instructions and encouragements for engaging in constructive action and changing their current dogmatic lifestyle to a more realistic and action-based one. This is done to enable the clients to respond more productively and swiftly to the demands of daily tasks and situations. Their *shinkeishitsu* trait, characterized by high self-standards and strong self-actualizing desires (i.e., the desire for life), is converted to a more functional and positive quality.

Regarding the former example, clients may be assisted to admit the fact that they get tense in front of others, and then to proceed to practical preparation for the purpose of giving a good speech by improving its content (e.g., making their presentation easy to understand for the audience). For the latter example of interpersonal communication, clients may realize that people have different thoughts and feelings about the same thing and clients are therefore required to make active efforts to communicate with others and also to look for something in common to facilitate mutual understanding.

５．行動や生活のパターンを見直す

患者が行動を拡げようとするとき、元来の「かくあるべし」の姿勢もまた明るみに上ってくることが多い。例えば社会恐怖の患者が人前でのスピーチに臨む際に、「緊張せず、なめらかに話さなくてはならない」といったことに拘泥するように、である。また、他者との関わり合いが増えるにしたがって、他者に対しても「かくあるべし」を求め、思うようにならない他者の態度に苛立つこともしばしば見受けられる。

このようなパターンを具体的に指摘し、「かくあるべし」から脱して「かくある事実にしたがって臨機応変に対処する」よう助言していくことは、最終的には神経質の性格陶冶に帰着する。

先の例であれば、人前で緊張するという事実を受け入れ、その上で伝えたいことが伝わるよう予めしっかり準備し、わかりやすく伝えるような工夫を凝らすといった具体的対処が大切なのである。

These instructive suggestions and encouragements need to be made in consideration of specific client needs and life circumstances. Further, examining each client's neurotic pattern leads to an evaluation of his/her habituated lifestyles and ways of living. For example, many clients with neurotic problems exhibit a rather obsessive lifestyle, commonly characterized by their excessive perfectionism, "all-or-nothing" type thinking, which seriously limits the scope of their activities, and their tendency to avoid unpredictable situations and activities, even prior to the development of full symptomatology. As another self-defeating pattern, clients may suffer from their inability to say "No" to various requests and demands for fear of upsetting others and being criticized; they thus get overwhelmed and immobilized by the excessive amount of tasks they have accepted. There are also individuals who become preoccupied with their attempts to please others and be likable, and who fail to recognize what they really wish to do. As a main therapeutic task in the latter half of treatment, the therapist is required to assist clients to recognize and appreciate their genuine self and to pursue the kind of life they truly wish for themselves.

As treatment progresses, the therapist begins to notice more clearly his/her clients' *shiso no mujun* (ideational contradictions), such as the disparity between how they believe they should be (i.e., the ideal self) and how they really are (i.e., the actual self as experienced at present). Some clients experience much discomfort and unacceptable affective responses and end up fighting such covert conditions. Thus, therapeutic progress may be hampered and the treatment may enter an impasse. When these difficulties are encountered, the therapist may point out to his/her clients their dogmatic and dichotomous thinking with observations, such as: "Reality does not necessarily conform to your expectations," "Things may not be perfect in reality as you would hope," and "Are you not trying to judge black-or-white prematurely?" It is also important that the therapist find an appropriate moment to share with clients his/her experience of a similar difficulty. The therapist and his/her clients thus need to work collaboratively to explore the present issues and jointly look for practical solutions. When clients are making little progress, the therapist may let them know that this challenging moment can be an important opportunity to learn new things. Through this collaborative process, the therapist and his/her clients may closely examine the unnatural aspects of their ways of living and dealing with emotional issues, which can deepen the clients' self-awareness and facilitate therapeutic progress.

また後者の例では、「他人は自分とはまた違った感じ方、考え方をする」という事実を認め、相手との積極的なコミュニケーションを図り、折り合える点を探す努力を続けることが必要になる。こうした助言は、患者の生活の様々な側面において、きめ細やかになされなくてはならない。そして、個々の行動に現れる神経症的パターンを見直すことは、結局のところ患者の元来のライフスタイル、生き方を問い直すという課題に立ち至る。たとえば神経症の患者には、症状が顕在化する以前から過度の完全主義や「全か無か」といった強迫的スタイルのために、関与する領域が狭小化していたり、予測の難しい状況や行動を回避するといったスタイルが見られることが少なくない。また批判を恐れるために、依頼されたことを一切断ることができず、結果として仕事を抱え込んで身動き取れなくなるといったパターンもしばしば見出される。あるいは「人によく思われたい」一心から、相手の期待に合わせて振舞うことにのみ目を奪われ、自分は本当に何がしたいのかを忘却している人もいる。こうした患者の生き方を取り上げ、もっとありのままの自分を認め、その人らしい生き方が実現できるよう援助することが、治療後半の課題になるのである。

治療が展開するにつれて、思想の矛盾、あるいは「かくあるべし」（理想の自己）と「かくある事実」（現実の自己）との葛藤が顕在化してくる場合もある．具体的には不快な感情をどうしても受け入れられない、それと戦ってしまう、あるいは治療が行き詰まる、などという形を取る．それに対しては「思い通りにならないこともある」「完全には行かない」「白黒つけようとしすぎていないか」などと患者の全か無かの思考を指摘し、それを共有し、その修正を一緒に考えることも重要である．治療が行き詰まったときには「ピンチはチャンス」と伝え、そこで患者と共に不自然な生き方を見直していくという作業が、患者の自覚を深め、治療プロセスを進めていくのである。

6. Progression of Treatment

The following five fundamental components of outpatient Morita therapy have been described as above: (a) increasing clients' awareness and acceptance of emotions, (b) recognizing and mobilizing the desire for life in clients, (c) clarifying the vicious cycle, (d) offering instructions for constructive action taking, and (e) facilitating clients' re-evaluation of their behavioural patterns and lifestyles. There are variations in sequencing these therapeutic components depending on client pathology, treatment structure, and each therapist's approach. Regardless of such variations, however, it is recommended that the therapist pay close attention to the therapeutic change process and remain flexible about the focus of each interview session in terms of themes and treatment components of Morita therapy.

６．治療の流れについて

以上のように「感情の自覚と受容を促す」「生の欲望を見出し賦活する」「悪循環を明確にする」「建設的行動を指導する」「行動や生活のパターンを見直す」という外来森田療法の５つの基本的な構成要素を抽出した。これらの要素をどのような流れで実施するかについては、対象の病理や治療構造、治療者の特性によって様々なバリエーションがあり得る。いずれにしても治療者は、患者の治療的変化のプロセスに注意を払い、どの課題に重点を置いて面接するかを柔軟に考慮することが大切である。

VI. Regarding Therapeutic Techniques

Key techniques in outpatient Morita therapy are discussed in the following section.

1. Interview Techniques

(1) The Attitude of Active Listening and Empathy

The starting point in any psychotherapy is listening to client complaints with an open and non-judgmental mind. Empathic and non-judgmental attitudes powerfully communicate therapist support to clients. Because outpatient therapy does not have the same kind of structural support as residential treatment, forming an empathic relationship with each client plays a critical role in offering steady support for clients who must cope with their challenging symptoms while trying to improve their behavioural patterns. It has been discussed earlier that the therapist needs not only to reflect client verbalizations but also to convey a normalizing message to clients that their difficulties and struggles involve natural emotions and desires commonly shared among human beings. In conveying such empathic understanding and support, the therapist may use the first person plural "we" rather than the second person pronoun "you" when referring to clients. Occasional and appropriate therapist self-disclosures may deepen the empathy-based therapist-client relationship. However, it must be clearly noted that self-disclosures should be used strictly for the purpose of helping clients and not for fulfilling the therapist's own self-validation needs in such a therapeutic relationship.

VI. 治療技法をめぐって

ここで、特に外来森田療法において意識しておくべき技法について解説することにしたい。

１．面接技法

1) 傾聴・共感の姿勢

患者の訴えに虚心に耳を傾けることは、あらゆる精神療法の原点である。そして治療者が素直な共感を伝えることは、患者にとって強力な支えとなる。外来治療では入院のような治療の場の支えが少ないだけに、患者が困難を抱えながら行動を立て直していくには治療者・患者間の共感的雰囲気が一層重要なものとなる。森田療法の治療者が共感を伝える具体的な方法として、単に患者の語る言葉を繰り返して映し出すだけでなく、普遍化、すなわち患者の体験が、人間にとって自然な感情であり欲望なのだというメッセージを伝える作業が重要であることは既に述べた。そのような共感を伝えるには、患者の体験を２人称ではなく、１人称複数形、すなわち「私たちは・・・」「我々は・・・」といった表現で語りなおすことが有用である。また時には治療者の自己開示が、患者と治療者の共感を深める手立てともなり得る。ただし自己開示はあくまで患者のためのものであり、治療者の自己確証に患者を利用することは、厳として慎むべきである。

(2) Therapeutic Dialogue

Morita therapists utilize various dialogical techniques to facilitate client understanding, including metaphors and common Japanese proverbs. In addition to the example of a weather metaphor discussed earlier, therapists who work with clients with obsessive ideations may use (a) the metaphor of a flowing river to refer to the natural fluidity of affective moods, or (b) the metaphor of clouds floating in the sky. To point out how *shinkeishitsu* clients' attempts to control anxiety and other symptoms end up aggravating such symptoms even further, Morita used the following instructive metaphor: "By trying to stop one wave with another wave, you end up producing thousands of waves." For clients who are constantly checking the presence or absence of the symptoms, Morita used impactful similes, such as the following one: "What you are doing is like trying to plant a cutting and grow it but checking to see its condition by pulling it out of the soil."

The use of metaphors and similes such as above effectively generates visual images in clients. Obsessive clients tend to have an intellectualizing tendency, and therapist attempts to use logical persuasion often result in creating an endless and futile ground for further explanations and discussions. It might be more effective in working with such clients if the therapist used metaphors and similes instead of intellectual explanations, in order to facilitate an intuitive understanding by clients. Another visual approach, not identical to the use of metaphors and similes, is the use of schematic drawings to illustrate how clients are dealing with their difficulties.

Another technique employs brief summative phrases and expressions to reflect clients' experiences and problematic patterns. The therapist may quote Morita's words for this purpose, or create "summary headings" to refer to various aspects of client problems and therapeutic experiences. Summary headings are developed jointly as collaborative efforts between the therapist and his/her clients. Another technique used in outpatient Morita therapy is a reframing or reinterpretation method. Whenever clients complain of anxiety, the therapist reframes it as a reflection of their healthy desire for life.

2) 治療的対話

患者の理解を促すために、種々の対話技法が活用されている。なかでも森田療法の治療者がよく用いるのが、比喩やことわざである。先に紹介した天気の喩えの他にも、気分を川の流れに喩えて自然に流転していくことを暗示したり、強迫観念を空に浮かぶ雲に喩えることはしばしばなされている。また森田は「一波をもって一波を消さんとす、千波万波こもごもおこる」という比喩によって、不安や症状をやりくりしようとする態度がかえってこれらを増強する結果になることを示し、日々症状の有無を確認している患者には「挿し木をさして、毎日それがついたかどうか、引き抜いて確かめているようなものだ」と喝破したのだった。

これらの比喩はいずれも視覚的イメージを強く喚起する働きがある。強迫傾向を有する患者は往々にして知性化の傾向が強く、理屈で説得しようとすれば言葉にとらわれて藪の中に入り込むことが少なくない。このような患者には、理屈のかわりに比喩を活用して、直観的な理解を促す方法が効を奏するのである。比喩とは異なるが、患者のあり方を図示する方法も、視覚的イメージを利用したアプローチである。

患者の体験を端的な言葉に置き換えるという方法もよく用いられる。そのために、森田の言葉を引用することもあるし、また治療者が患者の体験に「見出し」をつけて共有するといったやり方もある。また、患者が不安を訴えるたびに、それを不安の裏にある欲望に読み替えていくという一種のリフレーミング（再解釈）も提唱されている。

The therapist uses various confrontational techniques to point out specifically how clients are neglecting action taking as the result of their symptom preoccupations. For clients with heightened anticipatory anxiety, a paradoxical technique may be effective; the therapist describes an exaggerated scenario that shows the clients in the worst anticipated condition with escalated symptoms. In this process, the clients come to see the absurdity and unrealistic nature of their own neurotic anticipation. The therapist needs to be able to assess when it is therapeutically appropriate to introduce such a paradoxical technique for a desirable outcome.

(3) Fumon Technique (Selective No-Response Technique or Strategic Inattention)

Generally, the basic stance of the Morita therapist is that of *fumon* or strategic inattention to clients' complaints of their symptoms. It means that the therapist does not dwell on the minute symptomatic details of the client complaints or try to extricate the personal meanings or causes of such symptoms in an analytic way. In residential Morita therapy, *fumon* starts from the very beginning of the first phase (i.e., bed-resting period), and inpatients are instructed to simply be the way they are and let their symptoms come and go without interferences. Regular therapist visits during the bed-resting period are kept brief and mainly used for observing the patient condition, without probing into their symptoms.

In contrast, outpatient Morita therapy starts with a therapist-client dialogue on the latter's symptomatic complaints as discussed earlier. The outpatient therapist is not required to adhere rigidly to the *fumon* approach. The initial phase of outpatient treatment cannot exist without a discussion of the client's symptoms. However, as the treatment progresses toward the latter half, there will be a natural progression in a therapeutic dialogue between the therapist and the client to focus less on the symptoms and more on the latter's daily activities and ways of living. The therapist is required to facilitate a natural and gradual process of shifting the client's concerns and interests more toward the practical aspects of living thus moving the symptomatic complaints away from the central stage of the dialogue.

そのほか、症状にかまけておろそかになっていることをピンポイントで指摘する直面化の方法、あるいはとらわれの強固な患者に対して、あえて恐れている結果を誇張して示すことで、患者の懸念が非現実的であることを明らかにするような逆説的接近も、時機を捉えれば効果的である。

3) 不問技法について

一般に森田療法の治療者は、症状不問の姿勢が基本だといわれる。症状不問とは、症状の訴えを細かく取り上げず、また症状の意味を追求しない姿勢を意味する。入院療法では、第１期の臥褥期から症状不問の対応がなされる。患者には「症状は起こるがままにおく」ことが求められ、治療者の回診も短時間の状態観察が主眼で、症状の詳細を尋ねることはしない。

しかしながら外来治療においては、見てきたように症状をめぐる対話が出発点であり、症状を扱うことなしには初期の治療は成立しないため、症状不問に治療者が拘泥する必要はない。ただし、治療の後半に行くにしたがい、徐々に面接の話題は症状から行動や患者の生活のあり方に移行していくことが自然な流れである。このように症状からの脱中心化、脱焦点化を自然なプロセスとして促していくことを治療者は念頭に置くべきである。

2. Diary Guidance

Diary guidance is an effective means of promoting therapeutic progress in outpatient Morita therapy. Clients have opportunities to reflect on their experiences through the task of writing and to deepen their self-awareness by reading their diaries. At the same time, the therapist can learn about the clients' daily activities. Furthermore, the client-therapist relationship becomes solidified as the result of having both face-to-face dialogues in interview sessions and dialogues through therapist comments on his/her clients' diaries.

In the standard Moritian approach to diary guidance, clients are instructed to write an approximately one-page-long entry into their diary books every evening without spending more than 30 minutes on it each time. The content of each diary entry covers clients' daily activities, and they are asked not to write about their anxiety and other symptoms or dwell on their subjective complaints. However, clients are invited to write freely, and the therapist remains more lenient about the diary content at the beginning of the diary guidance. It is more likely that the clients will continue with their diary keeping when they know that they have freedom in this regard. On the other hand, those who list daily events and activities mechanically like a business diary are encouraged to include comments on what they have thought and felt during the activities, which will facilitate a therapeutic dialogue in the interview sessions.

Some therapists read the submitted diaries quickly during interviews and offer their comments, while others use two alternately submitted diary books. In the latter case, clients use the second book while the therapist reads the entries in the first one between two sessions and returns it with therapist comments in the next session. The therapist may choose any method in this respect to suit client needs and therapist preferences.

Diary entries by clients are typically made on one page, leaving some blank space (e.g., a 5-centimeter blank column on the right side of the page) to allow for therapist comments written in red to be entered in this space. The therapist may underline some parts of each submitted diary entry to require client attention and reflection. The content of therapist comments varies. For example, a comment may focus on how clients were immobilized by their own preoccupations, or it may convey therapist empathy for clients and words of support for clients to take constructive action in spite of their symptoms.

２．日記療法

日記療法は、外来森田療法においても治療を促進する有力な手段である。患者は言葉として記すという作業を通して自己の体験を見直し、書いた日記を読み返すことによって一層自己のあり方に気づくことができる。また治療者は日記によって患者の日々の生活の概要を知ることができる。さらに、日記は面接と並行して治療的対話を促すと共に、治療者患者関係を築く大切な媒体となるのである。

標準的な日記療法では、毎夜、ノート１頁ほどの日記を、３０分程度の時間内に書き上げるよう指示する。内容は１日の行動を中心に記載し、不安や症状、愚痴ばかりを書かないよう指導する。ただし日記療法の開始当初は、もう少し自由に書きたいことを書いてよいことを保証したほうが、日記が継続しやすい。また、さながら業務日誌のように行動のみを事務的に記す患者には、行動に伴い何を考え何を感じたかも記入するよう促したほうが治療的対話に結びつきやすい。

日記を面接時に手早く読んでその場で質問やコメントをする治療者もいるし、また２冊の日記に交互に記載してもらい、１冊を預かって次回の面接までにコメントを付して返却するという治療者もいる。患者の特徴や治療者側の諸条件によって、用いやすい方法を採用して差し支えない。

コメントを記入する場合は、ノートの１側に 5cm 幅程度の余白を残すように指示し、患者の記述の中で重視すべき部分に赤線を引いて、余白に赤字で書き込むのである。コメントの内容は、患者のとらわれを指摘したり、建設的行動に支持や共感を寄せたりと様々である。

In conducting diary guidance in Morita therapy, the therapist may consider the following key points:

(1) Convey to clients who tend to focus on complaining about various symptoms that anxieties and desires are two inseparable sides of the same coin. Thus normalize anxiety experiences, and remind clients that their attempts to eliminate anxiety result in intensifying it.

(2) Encourage clients to proceed to necessary action while learning to co-exist with anxiety and other symptoms. (Example: "Because you want a good job, you also feel anxious about failing to do so. Let your anxiety be, and take a first concrete step in action to finish the task at hand.")

(3) Help clients appreciate their attempts and efforts to engage in action, and encourage them to value the learning experience that they have gained in the process. (Example: "This is a valuable experience of realizing that feelings and moods change over time instead of staying the same.")

(4) Articulate clients' neurotic stance and maladaptive action (e.g., all-or-nothing-type thinking, mood-governed attitudes, and the tendency to reject the experience of discomfort), and ask them to identify the tasks they should attend to. (Example: "Do not judge yourself on the basis of the presence or absence of the symptoms. Let's appreciate the fact that you have achieved a behavioural goal in spite of your emotional difficulty.")

Through such interventions, clients learn to take necessary action with anxiety and to accept themselves for who they are. To add, the therapist may opt not to write any comments in the particular areas of the client diary that have only a list of subjective complains. This approach may be considered a form of *fumon* or a selective no-response technique.

その際のポイントは、症状の訴えに対して、

1) 不安と健康な欲求が表裏一体であることを伝えながら（自然な感情として普遍化）、不安を排除しようとする構えが逆に不安を強めている事実を指摘する，
2) 不安や症状と付き合いつつ必要な行動に踏み込むよう促していく（例：「きちんとやりたいとおもうからこその不安。そのまま、目の前のことに手を出してみよう」），
3) 行動に踏み込もうとする姿勢を評価し、そこで得られた経験を深めていく（例：「大切な経験。気分とはこのように時間と共に変化するものです」），
4) 神経症的な構えや不適応的な行動（全か無かの思考、気分本位な態度、不快なものは排除しようとする姿勢など）を指摘し、本来必要な関わりは何かを問いかける（例：「症状の有無だけで一日をはからない。辛いながらも目的を果たせたことに目を向けよう」），

などである。

こうした介入を通して、患者が不安と付き合いつつ必要な行動が取れるように援助すると共に、患者がありのままの自分を受け止められるよう支えていくのである。なお症状ばかりを記載している箇所にはあえてコメントを付さないということも、不問技法ということができる。

3. On the Use of Pharmacotherapy

Contrary to the misunderstanding that Morita therapy does not involve medication, most physicians who practise Morita therapy in Japan today combine pharmacotherapy and Morita therapy for suitable clients. Compared to Morita's days, there are many effective drugs for treating neurotic symptoms, as well as many clients who seek Morita therapy and are already on medication at other medical institutions. Therefore, the practice of Morita therapy does not preclude concurrent pharmacotherapy.

However, it must be noted that the endless prescription of drugs for the ultimate purpose of eliminating anxiety and other symptoms is considered counter-therapeutic. The therapist needs to explain to his/her clients that medication is only used secondarily to assist their efforts to rectify their problematic lifestyles, and that the primary agent of therapeutic recovery is the client himself/herself; see *Note 3*. Clients need to be assured that the therapist will address any concerns and questions about the prescribed medication. At the same time, when they show excessive and neurotic concerns about medication (e.g., a demand that there should be absolutely no danger associated with medication, and a need to eliminate any potential of danger from their life experiences), the therapist may treat such concerns as themes for psychotherapeutic work.

３．薬物療法の併用をめぐって

森田療法は薬物を用いない療法だとの誤解があるが、今日では一部の例外を除き、森田療法に携わる医師は症例によって薬物療法の併用を行っている。森田の時代とは異なり、今日では神経症症状にある程度の効果を有する薬物が数多く存在すること、また森田療法を希望して受診する患者の多くが既に他の医療機関で投薬を受けていること、などの実情があるからである。したがって、外来森田療法の実施は薬物療法を排除するものではない。

ただし、不安や症状を除去するという目論見で、際限のない増量や処方変更を行うことは決して治療的ではない。患者に対しては、薬物が「患者の生活を立て直す補助手段である」ことを明確にし、回復の原動力は患者自身の取り組みにあることを伝えるべきである（註３）。また投薬中は、薬に対する不安や疑問をきちんと面接で取り上げることを保証した上で、患者の懸念に潜む神経症的態度、たとえば「万が一の危険をすべて排除しようとする姿勢」などについては、精神療法のテーマとして扱うことが望ましい。

VII. Termination and Evaluation of Treatment

In the practice of time-limited outpatient Morita therapy, the therapist needs to incorporate a termination component before the last session in order to summarize and conclude the treatment. In the concluding session, the therapist and his/her clients need to engage in reflections on their therapeutic work and the clients' recovery process.

The following aspects of therapeutic improvements must be considered comprehensively in the evaluation of the treatment effectiveness of Morita therapy.

1. Reduced Symptoms and Accompanying Psychological Distress

The fundamental aim of Morita therapy is to shift the focus of the client's efforts from reducing the symptoms to dealing with the tasks and situations in his/her daily living. This does not mean that the therapist turns a blind eye to the changes in his/her clients' symptomatic complaints over the course of the treatment. Rather, when clients have shifted their attention and efforts to more realistic and practical aspects of living, their aggravated symptoms and psychological distress will subside naturally. Morita therapy is no exception in that reduced symptoms and pain are considered necessary elements of therapeutic improvement.

2. Changes in Client Lifestyles and Behavioural Patterns

In addition to reduced symptoms, constructive changes in the clients' lifestyles and behavioural patterns must be considered in the assessment of the effectiveness of Morita therapy. The therapist and his/her clients need to explore together the various dimensions of change in their collaborative assessment of the therapeutic improvements. Examples of assessment questions are as follows:

(a) Is the client's desire for life actively put into practical action in his/her daily living?
(b) Are the client's attention and interest directed toward the environment and external situations?
(c) Is the client attending to the necessary tasks at hand and does he/she immerse himself/herself in daily activities to lead a practical and constructive life?
(d) Has the client established an attitude of readiness for taking practical and purposeful action without being governed by his/her moods and symptoms?
(e) Has the client's lifestyle reached a satisfactory level of adaptation?

VII. 治療の終結と評価

期限を設定して外来森田療法を実施する場合には、最終面接までに、まとめの作業を行って締めくくりをつける。まとめの面接においては、治療過程を振り返り、患者の変化について評価を行い、それを患者と共有すべきである。

ところで森田療法の治療効果を評価するには以下の点を総合的に考慮すべきである。

1. 症状とそれに伴う苦痛の軽快

森田療法では患者が症状を除去せんとする努力をやめ、本来の生活に取り組んでいくことが根本である。とはいえそれは症状の変化を治療上、度外視するということではない。むしろそのような患者の方向転換が果たされたとき、結果として症状と苦痛はおのずと軽快に向かうのである。症状とそれに伴う苦痛が軽減していることが回復の必要条件であることは、森田療法でも例外ではない。

2. 生活・行動の変化

しかし、森田療法の効果を判断するには、症状の軽快に加えて、患者の生活･行動が建設的な方向に変化していることが重要である。生の欲望が現実に発揮され、注意や関心が外界に広がっているかどうか、生活に没入し、やるべきことがなされているかどうか、行動に際しては目的本位の態度が身についているかどうか、そして生活が充実し適応レベルが向上しているかどうかを患者と共に判定するのである。

3. Self-Acceptance and Insight

In addition to the positive changes discussed above, we may consider that clients have made satisfactory therapeutic progress when they can readily recognize their authentic self and accept themselves in the *arugamama* or as-is state. Emancipation from their neurosis has been achieved in a true sense when clients can be genuine and natural in their ways of living and being, rather than being caught in the gap between reality and ideality or between how they are and how they think they should be.

Therapy terminates upon the clients' recognition of their actual improvements in the areas discussed above. Clients are also invited to articulate what the remaining areas for further improvements are. In the practice of outpatient Morita therapy which is not time limited, it is common that the interval between interview sessions gradually becomes longer based on the therapist's and/or the clients' decision, and that the treatment eventually reaches its point of natural termination. It is recommended even in such cases of eventual termination that the therapist and the client engage in an interim review of the latter's progress using the above assessment criteria at an appropriate point during the treatment. Further, it is desirable that the amount of medication has been reduced before the treatment comes to an end in case of pharmacotherapy combined with outpatient Morita therapy, but stopping medication is not a requirement that has to be fulfilled before the termination of the therapy. When clients require continued medication after the termination of Morita therapy, their conditions and progress may be monitored by attending physicians in the outpatient department of a medical clinic or a hospital.

３．自己の受容と洞察

さらに患者が自分自身のあり方を自覚し、あるがままの自己を受け入れられるようになったのであれば、改善の十分条件を満たしたといえる。かくあるべき自己と現実の自己との落差に拘泥するのではなく、自然体で自分らしく生きることができるようになったとき、本当の意味で神経症からの脱却がなされたといえるのである。このような変化については、患者の自己評価が判断の根拠になる。

以上の点について、実際にどのような進歩があり、また残された課題は何かを明確にして治療を終結するのである。なお期限設定を行わない場合は、患者もしくは治療者の判断で面接間隔が徐々に延長し、やがて自然に終了することも少なくない。そのような場合においても、一定の面接回数を過ぎた時点で治療経過をいったん振り返り、上記の点を念頭に評価を行うことが望ましい。また、薬物療法を併用している場合、治療終結までに減量がなされていることが望ましいが、必ずしも休薬がなされていなければならないということではない。投薬をもう少し続ける必要があるなら、外来森田療法終了後、一般外来でしばらくの間フォローすればよいのである。

Notes

Note 1. A Probing Approach to Explicating the Condition of *Toraware* to Clients

1. "What do you wish to change?" [Probing clients about their chief complaints (i.e., symptoms)]
2. "How do you want to be after a successful therapy?" "What condition would you wish to be in at the end of our treatment?" [Exploring clients' desire for life]
3. "Desires and anxieties reflect two sides of how the mind works. They are like the two sides of the same coin which are inseparable. Would you agree? [Indicating the bilateral nature of how the mind works]
4. "Believing that everything will go well if it were not for these symptoms, you have devoted all your efforts to eliminating the symptoms as your first priority. Is this true?" [Indicating clients' *hakarai* (i.e., manipulative attempts)]
5. "The more you try to eliminate the symptoms, the worse they seem to get. Isn't this the case for you?" [Exploring how the vicious cycle is set in motion via the client's manipulative attempts and preoccupations with the symptoms]

Note 2. Dealing with Clients with Mood Disorders

Since it is appropriate to regard depression, despair, and an irritable mood accompanied by anxiety as symptoms of an emotional disorder rather than as normal mood fluctuations, it is advised that the therapist does not rush depressed clients to engage in action with instructions such as: "Let your mood be, and proceed to the necessary action." In the early phase of mood disorder treatment, the basic approach needs to be that of encouraging clients to take sufficient rest instead of encouraging action. It may be important that the therapist helps clients focus on exploring the nature of their irritability during this phase. The therapist may advise them not to rush to get things done but to rest and wait for a while, and may offer a reframed and seemingly paradoxical idea that resting is the job that needs to be done right now.

註

註１．問いによってとらわれを浮き彫りにするアプローチ

「何を治したいのですか？」

患者の主訴（症状）を尋ねる。

「どのように治りたいのですか？」または「治ってどのようになりたいのですか？」

患者の生の欲望を探る。

「欲望と不安は心の両面であり、切っても切り離せないものですね」

治療者は両面観を提示する。

「症状さえなければ物事がうまくゆく。だからまず症状をなくすことに努力を傾けてきたのではありませんか？」

患者の「はからい」を明らかにする。

「症状をなくそうとすればするほど、ますます症状がつのってしまいませんでしたか？」

「はからい」と「とらわれ」の悪循環について尋ねる。

註２．気分障害の患者の感情の扱い方

うつ病の患者に対しては、性急に「気分は気分として、なすべきことをなす」よう促してはならない。うつ病の際に見られる抑うつ感、絶望感,不安焦燥感などは正常な気分変動と異なり、病気の症状と考えたほうがよいからである。特に病初期には、行動を促すより先ずは十分な休息を取ることが基本になる。ここで患者の「焦り」を積極的に取り上げることも重要であろう．つまり「焦らないこと」「待つこと」あるいは逆説的に「休むこと仕事」などと伝えることも必要な場合がある。

As clients begin to recover from their debilitating moods, they may be encouraged to get back to the tasks that they were previously engaged in and within their comfort zone, with the therapist advising something like: "Start with an easy action that you can readily deal with when you want to do something rather than remain idle." Thus, the therapist helps his/her clients not to resist the emotional condition in any given moment, but to adjust their behavioural output flexibly according to their affective state. During the latter part of the recovery phase, clients may follow one of the typical Moritian instructions, such as: "Let your moods and feelings be, and work on your action." However, the therapist must not forget to encourage his/her clients to shorten their behavioural engagement before they get too tired to continue. When it comes to their social reintegration, clients may be advised not to try to catch up with the lost time and the lost opportunities for action by placing undue pressure on themselves for rushed action. Instead, the therapist needs to emphasize that what counts is the clients' cumulative efforts over time at their own pace. Rushing to increase their behavioural output is likely to increase the possibility of a relapse.

However, it is not therapeutically effective to encourage dysthymic clients (i.e., chronic and mild depression) to rest whenever they feel like. Instead, the therapist needs to guide clients to learn experientially that their moods shift spontaneously while engaged in action.

Note 3. Explanations about Combining Morita Therapy and Pharmacotherapy

The therapist may opt to address candidly the benefits and shortcomings of psychotherapy, including Morita therapy, and those of pharmacotherapy at the very beginning of treatment. One of the benefits of pharmacotherapy is its simplicity and quick effects with minimum efforts required of the clients. On the other hand, in addition to having side effects as one of its shortcomings, there are certain drugs which develop drug tolerance and/or chemical dependency in clients, and stopping or reducing the medication becomes rather difficult. Another shortcoming is that the symptoms tend to resurface after stopping the medication. Therapists who combine psychotherapy and anti-anxiety medication or anti-depressants need to have sufficient knowledge and clinical experience regarding the symptoms of withdrawal and have preventative strategies for minimizing potential withdrawal effects.

In a combined approach with pharmacotherapy and Morita therapy, it is often effective to discuss how the use of medication contributes to the client's therapeutic progress. The therapist may explain that the medication plays only an auxiliary role in that the vicious cycle of symptom aggravation is mitigated by using such medication.

回復期には、回復状態に応じて無理なく行動を再開することも大切であるが、当初は「おっくう感が比較的軽いときに、手のつけやすいことから行動してみる」よう助言し、その時々の状態に逆らわず、臨機応変に行動を切り替えることを重視するのである。回復の後期には、「気分は気分として行動を整える」という通常の森田療法的指導で差し支えないが、疲労感が強ければ早めに行動を切り上げることも併せて指導すべきである。そして社会復帰に際しては、「今までの休んだ分を取り戻そうとしないこと」「徐々に積み上げる感じで」などと助言することも大切である．ここで焦って何とかしようとすると、それが再発の危険を高めるからである。ただし気分変調症（慢性・軽症のうつ状態）の患者に対しては、休息を強調し過ぎることは治療的ではなく、「行動によって気分が変わり得る」ことを患者が体験的に自覚できるよう指導することが要点になる。

註３．薬物療法併用の際の説明

治療の開始時には、森田療法を含む精神療法一般と薬物療法の長所と短所を率直に話題に取り上げてみてもよい。薬物療法の長所は、簡便で効果の発現が早く、かつ患者側の努力が最小限ですむということに尽きるが、一方、短所として副作用のほかに耐性や依存を生じやすく、なかなか減薬・中止できない種類の薬物があること、また中止すると再発しやすいことなどの問題点がある。実際、精神療法と抗不安薬・抗うつ薬を併用する場合は、薬物の減薬・中止の際の離脱症状の予防と対策について十分な知識と経験を身に付けておくことが望ましい。

また薬物療法を森田療法に併用する際、その作用機序として精神交互作用の悪循環を薬物が軽減することで症状も改善してゆくと説明することは、薬物をあくまで補助的な手段として認識するうえで、しばしば有効である。

Appendix 1:

Original Questionnaire Survey on Outpatient Morita Therapy

Developed by the Japanese Society for Morita Therapy's (JSMT's)
Committee on the Standardization of Outpatient Morita Therapy

Respondent's Name: _____

1. Which category do you apply when you practise outpatient Morita therapy?
   ( ) Health insurance covered treatment
   ( ) Fee-for-service treatment (paid by self)
2. What is the normal length of an interview session in your practice of outpatient Morita therapy? How long is a typical interval between two sessions?
3. Do you practise time-limited outpatient Morita therapy? If so, how many sessions do you typically cover?
4. What are the targeted client types for your outpatient Morita therapy? Please list the criteria or characteristics you use for client selection.
5. Please indicate what you consider to be the essential elements of outpatient Morita therapy.
6. What explanations do you offer when you introduce outpatient Morita therapy to clients? Please indicate the key points you typically cover.
7. Please describe the general treatment process in your practice of outpatient Morita therapy.
8. Please explain concretely what techniques you intentionally use in your practice of outpatient Morita therapy.
9. Do you combine pharmacotherapy with outpatient Morita therapy?
   ( ) almost always ( ) sometimes ( ) no
10. Do you use diary guidance in your practice of outpatient Morita therapy?
    ( ) yes ( ) no
    If you do, do you comment on the submitted diaries in writing?
    ( ) yes ( ) no
11. What are the criteria you use for assessing treatment effectiveness?
12. On what basis do you decide to terminate the therapy?

巻末資料1

外来森田療法に関するアンケート調査

日本森田療法学会外来森田療法の標準化に関する委員会

ご氏名 _____

1．　外来森田療法を実施する際、診療区分は次のどちらですか。

保険診療　　自費診療

2．　外来森田療法の診察時間、実施間隔は通常どれくらいですか。

3．　外来森田療法に期限を設定していますか。その場合、何回ぐらいのセッションを基本とされていますか。

4．　通常、どのような対象に外来森田療法を実施していますか。その際の適応基準もご記入ください。

5．　外来森田療法に必須と考えられる要素をご記入ください。

6．　外来森田療法の導入には、どのような説明をされていますか。要点をご記入ください。

7．　先生が実施されている外来森田療法のおよその流れをご記入ください。

8．　外来森田療法で意識的に用いている技法があれば、具体的にご説明ください。

9．　外来森田療法に薬物療法を併用していますか。

ほとんど常に併用　　時に併用　　併用しない

10．　日記療法を実施していますか。

実施する　　実施しない

実施する場合、コメントを記入しますか。

記入する　　記入しない

11．　治療効果はどのような基準で判定しますか。

12．　治療終結はどのような基準で判断しますか。

Appendix 2:

Proposed Standard Diagnostic Criteria for *Morita Shinkeishitsu*

Developed by the Japanese Society for Morita Therapy's (JSMT's)
Committee on the Standard Diagnostic Criteria for Morita Shinkeishitsu

I. Clinical Symptoms

To be considered *Morita shinkeishitsu*, the client must meet the Symptom Criteria A and B, and three of the five items in Criterion C.

A. The client considers the symptoms (or difficulties) to be unusual and unnatural, and suffers from anguish, pain, and ego-dystonic feelings.

B. The client is anxious about being unable to adapt to the environment (i.e., adaptation anxiety) because of his/her current condition (e.g., personality, symptoms, and difficulties).

C. Three of the following items must be present in terms of symptom characteristics, recognition of the symptoms, and the client's way of dealing with the symptoms:

1. *Anticipatory anxiety*: The client continuously feels anxious about the onset of the symptoms.

2. *Defensive oversimplification (selective focus and suffering over the main complaint)*: The client has a clear focus on particular symptoms or difficulties.

3. *Self-specialization*. The client considers that his/her suffering is special and unusual.

4. *Symptom-overcoming attitude*: The client displays an attitude of wanting to reduce and eliminate the problematic symptoms.

5. *Problem acknowledgment*. The client is able to understand and acknowledge that his/her problematic symptoms are located on the continuum of affective experiences in daily life.

巻末資料２

森田神経質診断基準案

日本森田療法学会「森田神経質の診断基準委員会」作成

I. 症状上の臨床的特徴

森田神経質の症状レベルとしてA,Bの基準を満たすと共に、Cの５つの基準のうち、３項目を満たすこと

A. 症状（悩み）に対して異和感を持ち、苦悩、苦痛、病感を伴う（自我異質性）

B. 自己の今の状態（性格、症状、悩み）をもって環境に適応し得ないという不安がある（適応不安）

C. 症状内容の特徴、症状への認知、関わり合いかたなどの項目のうち、３項目以上を満たすこと

1. いつも症状（悩み）が起こるのではないかという持続的不安を持つ（予期不安）
2. 症状（悩み）の焦点が明らかである（主に１つのことについて悩んでいる、防衛単純化）
3. 自分の症状（悩み）は特別、特殊であると考える（自己の悩みの特別視）
4. 症状（悩み）を取り除きたいという強い意欲を持つ（症状克己の姿勢）
5. 症状の内容が、通常の生活感情から連続的で、了解可能である（了解可能性）

II. Presence of the Symptom Formation Mechanism of *Toraware*

The client must meet both Criteria A and B (two types of the mechanism of *toraware*) as follows:

A. A vicious cycle of symptom aggravation effects (*seishin kogo sayo*) is present. That is, attention and sensation (i.e., affective symptoms) interact with each other in a mutually aggravating way, which results in reinforcing the client's selective focus on discomfort and thus further intensifies the symptomatic sensations in a self-defeating loop.

B. There are ideational contradictions (*shiso no mujun*) reflecting the client's unrealistic thinking and forceful attempts to conform his/her genuine experience to expectations. The following two criteria must be met.

   1. The client tries to eliminate the symptoms, with a belief that he/she can do desirable things. Or, the client wishes to be completely free from the experience of fear and anxiety.

   2. The client experiences a gap between "How I want to be" and "How I think I am now."

II. 症状形成（とらわれ）の機制

ここではA,Bの両者の基準を満たすことが必要である

A. 精神交互作用が認められること：注意と感覚（あるいは症状）の相互賦活による感覚（あるいは症状）の鮮明化と注意の固着、注意の狭窄という悪循環過程の把握

B. 思想の矛盾が認められること：1) 2) の基準を満たすことが必要である

1. 症状除去の姿勢：この症状さえなかったら、自分は望むことができると考えること、あるいは不安、恐怖のまったくない状態を望んでいる
2. 「こうありたい自分」と「患者自身が考えている現在のこうある自分」とのギャップに対する葛藤

III. Personality Traits

The client needs to have at least one trait from Group A (a total of 5 traits associated with introversion and fragility) and one trait from Group B (a total of 5 traits associated with obsessive and self-empowering characteristics).

A. Introversion and Fragility

1. *Introversion* (tendencies to be over-introspective about one's own existence and to feel inferior to others)
2. *Worrisomeness* (a tendency to be concerned about minute details and become unable to move beyond anxious preoccupations)
3. *Interpersonal fragility and hypersensitivity* (tendencies to feel easily hurt by others' subtle comments and to be vigilant of others' verbalizations and behaviours)
4. *Hypochondriasis* (a tendency to be hypersensitive to one's own physical conditions and sensations)
5. *Passivity* (tendencies to take a passive role in social interaction, to be reactive to situations rather than active or proactive, and to have difficulties dealing with new situations)

B. Obsessive and Self-empowering Characteristics

1. *Desire for perfection* (tendencies to pursue perfection obsessively and to feel unfinished if perfection is not achieved as expected)
2. *Desire for superiority* (tendencies to feel competitive, to pursue a sense of superiority, and to avoid feeling defeated and inferior to others)
3. *Desire for self-esteem* (tendencies to feel proud of oneself, to have high self-esteem, and to wish to be well regarded by others)
4. *Desire for health* (tendencies to wish to be always healthy both physically and mentally, and to wish to be entirely anxiety-free)
5. *Desire for control* (strong tendencies to wish to be in control of oneself and to control the others around oneself)

III. 性格特徴

A. 内向性、弱力性の５項目、 およびB. 強迫性、強力性の５項目のうち、それぞれ１項目以上の基準を満たすことが必要である

A. 内向性、弱力性

1. 内向性（自分の存在全体について、過度に内省し、劣等感を持つ）
2. 心配症（細部にこだわり、なかなかそこから抜け出せない）
3. 対人的傷つきやすさ、過敏性（些細な人の言動に傷つく、人の言動が気になる）
4. 心気性（自分の身体や感覚に対して過敏となりやすい傾向）
5. 受動的（イニシアティブを取れない、消極的、新しいことが苦手）

B. 強迫性、強力性

1. 完全欲（強迫的に完全にしないと気が済まない）
2. 優越欲求（負けず嫌い）
3. 自尊欲求（プライドが高い、自尊心が強い、人にちやほやされたい）
4. 健康欲求（常に心身とも健康でありたい、全く不安のない状態を望む）
5. 支配欲求（自分や周囲を自分の思いどおりにしたいという欲求が強い）