

## CONCLUSION

Phenomenological elucidation is an attempt not only to describe experiences but also to answer the question, "Why...?" In this study, I tried and succeeded in phenomenologically answering the question: "Why is it possible to become someone else in dreams?" However, while one type of dream, where I become the fictive other, was easily elucidated based on the Husserlian table of intentionalities, another type of dream, where I become the real other, could not be elucidated without revision of this table based on Held's criticism. This may, in turn, suggest that the latter's critical reconstruction of Husserlian theory of intersubjectivity is proven to be a valid development in phenomenological investigation of intentionality. Here is a virtuous circle between empirical, psychological research and theoretical, philosophical investigation in phenomenology.

Methodological significances: I have used examples from my own "dream-diary" website. Such a method of data sampling can be applied not only to dream analysis, but also to any other research, for example, on the experience of "phobia". I expect that using investigators' own reports on their personal websites would mean that everyone, not only "professionals", can participate in phenomenological investigation as both participants and investigators. In this sense, phenomenology is the project of everyone, for everyone, and by everyone.

## REFERENCES

- Bernet, R. (2004). *Conscience et existence: Perspectives phénoménologiques*. Paris, France: P. U. F.
- Cairns, D. (1973). *Guide for translating Husserl*. The Hague, Netherlands: Martinus Nijhoff.
- Held, K. (1972). Das problem der intersubjectivität und die Idee einer phänomenologischen transzendentalphilosophie. In U. Claesges, & K. Held (Eds.), *Perspektiven transzendentalphänomenologischer Forschung* (pp. 3-60). The Hague, Netherlands: Martinus Nijhoff.
- Husserl, E. (1960). *Cartesian meditations: An introduction to phenomenology* (Trans. D. Cairns). The Hague, Netherlands: Martinus Nijhoff.
- Husserl, E. (1966). Zur phänomenologie des inneren zeitbewusstseins: 1893-1917. In R. Böhm (Ed.), *Husserliana X*. The Hague, Netherlands: Martinus Nijhoff.
- Husserl, E. (1980). Phantasie, bildbewusstsein, erinnerung: Zur phänomenologie der anschaulichen vergegenwärtigung. In E. Marbach (Ed.), *Husserliana XXIII*. The Hague, Netherlands: Martinus Nijhoff.
- Langridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow, United Kingdom: Pearson Education.
- Watanabe, T. (2004). Dream diary. Retrieved from <http://fantastiquelabo.cocolog-nifty.com/> (In Japanese).
- Watanabe, T. (2016). *Yume no genshogaku nyumon (Introduction to phenomenology of dreams)*. Tokyo, Japan: Kodansha. (In Japanese).
- Watanabe, T. (2018). Phenomenologically clarifying dreams of becoming someone else: Thematic analysis based on the Husserlian intentionalities. *Japanese Qualitative Psychology*, 17, 66-86. (In Japanese, with English title and summary).
- Zippel, N. (2016). Dreaming consciousness: A contribution from phenomenology. *Rivista Internazionale di Filosofia e Psicologia*, 7(2), 180-201.

## Understanding Your Own Words: Identifying patients with schizophrenia using the program of *Tojisha Kenkyu*

Ikuyoshi Mukaiyachi, Kono Tetsuya, Kodama Chiharu, Hoshino Yoshiko  
Health Sciences University of Hokkaido, Rikkyo University

## SUMMARY

"Tojisha Kenkyu", translated as "self-directed research program", is a "research program" done by the affected parties, not research done on the affected parties. The Program consists of a methodology that naturally developed as patients and their family members continually reworked and revised their use of social skill training and cognitive behavior therapy methods. *Tojisha Kenkyu* is a philosophy of hardships that arises from people who have experienced schizophrenia and other disorders. Thus, it can also be considered an ideological attitude, which highlights issues faced by humanity as a whole, rather than on personal problems. Thus, *Tojisha Kenkyu*, developed as a self-caring method outside the medical setting, now begins to be introduced into the medical clinical world as a radically different method from psychiatry or clinical counseling. This paper introduces and explains what kind of program it is and how people conduct it with concrete descriptions; it also affirms that *Tojisha Kenkyu* would bring about radical changes in the world of psychiatry, counselling, education, and most importantly in relationship between patients and our society.

## INTRODUCTION

The Japanese word "Tojisha" is a legal term that means "insider", "the person (or party) concerned" or "the interested party (or person)", and "Kenkyu" means "study" or "research". "Tojisha Kenkyu" can be translated as "self-directed research program"; it is a "research program" done by the affected parties, not research done on the affected parties. *Tojisha Kenkyu* is a self-help program for people with mental disorders (mainly schizophrenia and personality disorders) and their family members, which was initiated in February 2001, at Urakawa Bethel House and the Department of Psychiatry at Urakawa Red Cross Hospital in Urakawa-cho, Hokkaido which is located north of Japan. It also refers to the initiatives conducted in accordance with the Program's objectives based on hints it receives through its activities. The Program is widely known for its extremely unique efforts to help people deal with psychiatric disorders, not only in the fields of psychiatric treatment and social welfare, but also in the fields of psychology and special education (Tokushu Kyoiku). It conducts its activities throughout Japan.

The Program consists of a methodology that naturally developed as patients and their family members continually reworked and revised their use of social skill training and cognitive behavior therapy methods. The Program consists of the following five steps:

1. *Separating people from problems*: Holding an impartial view of the problems patients have by shifting from an attitude of "Mr. X, who has repeated outbursts," to an attitude of "Mr. X, who is suffering because he cannot stop his outbursts even though he wants to".

2. *Having patients assign their own names to their illnesses:* Patients assign a name to their illness that is most satisfying to them and best reflects what they believe to be the significance of their symptoms and their suffering. Examples include: "Demon-version of schizophrenia" and "Personality disorder of the allergic-to-people type".

3. *Understanding the patterns, process, and composition of suffering:* The way symptoms manifest and the ways that patients fall into certain behaviors and distressing circumstances always follow a regular and repeated pattern. That pattern and other characteristics are brought out into the open through discussion with peers.

4. *Thinking about specific ways to protect and aid themselves and creating spaces where they can practice these skills:* Thinking about ways to self-handle anticipated hardships and practicing those methods. The main person who can help patients is the patients themselves.

5. *Verifying the results:* Recording the above process and practicing it. Verifying its results and sharing the successful points and the points that need more work with peers leads to implementation of the next research project. Research results are presented publicly to their peers.

The "research" that is referred to in this discussion of the Program, is not being used in the sense of "scientific research". Rather, it refers to the process of self-realization that the people with disabilities and mental health issues engage in. Further, it refers to initiatives that are aimed at allowing them to understand their disorder as a subjective problem and at improving their own quality of life.

Two aspects of the Program are particularly important. The first is that things do not start with a medical diagnosis. Rather, they start from the patient's own problem (Bethel House uses the word "hardship" instead of "problem"). The Bethel House Program of Assessment and Rehabilitation for patients with Mental Disorders and their Families allows patients to assign their own personal names to their illness (sometimes the names are humorous). Thus, the patients themselves decide what their "illness" or "case" is going to be (this does not mean that they ignore the medical diagnosis; it is simply separate from the diagnosis). The disease name provided by medical practitioners is usually a method for medical practitioners to define how they should handle any given patient. Patients are therefore objectified by being placed into this framework, which then leads them to take on a passive attitude. Further, there is intense debate among medical practitioners about whether this type of medical classification system is valid or not. For example, there is heated debate over the diagnostic standards, methods, and distinctions between "normal" and "abnormal" psychologies in the DSM-5.

In contrast, the Program allows patients to assign their own names to their illnesses. This allows patients to take their problem back and make it their own, rather than being at the mercy of a specialist's diagnosis. This then allows them to discover ways that will lead to their own method of understanding and dealing with their problem. The Program is an attempt to let patients have an autonomous perception of what they are and what their problem is. This is different from the "acceptance of a disability," which tends to place patients in a passive position. Instead, it is a thesis for thinking of self-awareness as an assertive starting point. This thesis was obtained from a long-term practice carried

out by Mukaiyachi and his colleagues while Mukaiyachi has been inspired by social skill training (SSK) based on cognitive behavioral therapy, especially by SSK by Kei Maeda who has trained under the direction of Robert Paul Liberman (see Kingdon & Kurkington, 1995; Liberman, 1990-1976; Meda, 2013; Mukaiyachi & Ito, 2007).

The second aspect of the Program is the presence of peers, which is an aspect that the Program considers to be of utmost importance. The theorizing process of the program from the therapeutic experience of Mukaiyachi and his colleagues have been described in his theoretical but readable books beyond twenties volumes (see for example, Mukaiyachi 2009a, 2009b, 2013, 2016; Mukaiyachi & Ito, 2007; Urawaka Bethel no Ie, 2002, 2005). Although the Program's activities are based on the perspectives of specialists, these activities are also aimed at revising how patients understand themselves from their own viewpoints so that they can improve their daily lives. What is particularly important with this effort is the cooperation with other people who have the same problems and difficulties. The Program provides a way for people who share the same "hardships" to support and help each other rather than a way for people who share the same "medically-defined illnesses" to support and help each other. In order for them to know their own disorder, they need to put a certain amount of space between them and their problem, and confront themselves. The perspective that allows them to confront themselves is not provided by a specialist, but rather, it is provided by other people who have the same problems and difficulties. The meaning of the Bethel House slogan "By myself, with others" can be found here. The Program aims at autonomy through mutual support.

The Program has already been mentioned in a large number of books, research papers, and academic treatises, and it is widely known in Japan in the fields of psychiatric care, counseling, and special needs education. Visitors from throughout Japan and abroad visit Urakawa every day. The Program is not only being implemented in facilities and medical institutions throughout Japan, it is also being increasingly applied as a program for those with developmental disabilities, pathological dependence problems, and dementia. A Center for Tojisha Kenkyu has been established at the Research Center for Advanced Science and Technology at the University of Tokyo in 2015.

### DIFFICULTIES PATIENTS WITH SCHIZOPHRENIA FACE, IDENTIFIED BY TOJISHA KENYU

Tojisha Kenkyu is a methodology for self-guided (psychological) intervention. It was created as a "concept" through trial and error as Mukaiyachi and his colleagues improved and refined the program to ensure that people with schizophrenia could find it easier to deal with the difficulties of life that stem from a variety of daily events. Figure 1 shows Kiyoshi Hayasaka (currently serving as the Representative and Director of Bethel) packaging Hidaka konbu with other participants in the project, which was initiated in 1983. He did not continue with this project for a very long, since he faced a troubled time and was in and out of hospitals due to unexplained confusion and agitation. Episodes like this demonstrated the problems these patients faced. Tojisha Kenkyu was started to identify the problems these actions were intended to resolve,

such as the “explosions” of emotion and inappropriate behaviors and words. Patients with schizophrenia often find it a “struggle” to remove themselves from painful and pressurized circumstances. Once this is understood, it becomes possible to search for ways to deal with this situation, in a constructive, moderate, and reasonable way (see Kawamura and Mukaiyachi, 2008, for examples; see also an ethnography of Bethel House by Nakamura (2017)). This allows the patients to battle their isolation together as a joint effort (about the theoretical basis for this, see Ishihara, 2013; Kono, 2013; Mukaiyachi, 2008, 2009a, 2009b; Urakawa Bethel no Ie, 2002, 2005). It must be noted that what lies beneath this “struggle” is the longing to find a way that will lead to self-expression and a search for a way of life that will allow them to survive.



Figure 1. Working together packaging konbu.

Tojisha Kenkyu provides a venue for participants to carefully comprehend the structure and composition of life-related difficulties. Thus, it is important that each individual recognizes that there is sometimes a gap between the needs identified through another person's words and actions and their actual needs. For example, being physiologically hungry can sometimes be linked to suicidal ideations or provide an opportunity for auditory hallucinations of negative messages. In addition, the program identified that a perception gap between the “reality” of patients based on their five senses and the reality that the people around them experience, often underlies difficulties in communication.

This is the puzzling phenomenon that occurs when, for example, the patient perceives another person's smiling face as an expression of anger or when they interpret someone's greeting of “good morning” as “get away from me!” One participant reported seeing horns growing out of the heads of people passing by on the street and that the length of the horns changed according to this person's mood or physical condition. Figure 1 shows a scene of participants packaging *konbu*. At Bethel House, to ensure that people with this type of “perception gap” can relax and do their work, it is essential that they can exchange information on a daily basis with others about how their reality looks and feels. Recently, there has been increased interest in the cognitive dysfunctions displayed by people with schizophrenia, but the issue of a perception gap

is an “unseen difficulty in daily life,” which patients and their family members rarely mention when receiving treatment or talking with counselors.

Many patients and family members have both lost hope for the future and any will to live, while at the same time earnestly searching for both. Richard Warner (2000) stated that physical restraint, control, and the associated emptiness weigh heavily upon the lives of patients whether they live in communities or are hospitalized due to acute symptoms, so that many patients face lives of boredom that are devoid of purpose. The “existential emptiness” that all humans experience is more serious for those with schizophrenia, due to the unique difficulties they face in life, which in turn worsens their superficial symptoms, thus, creating a vicious cycle, as can be seen in Figure 2, which shows the “Hardship Pyramid”. Once the patient recovers from symptoms (i.e., psychological and physical symptoms, or superficial distress), which can manifest in many forms of “distress,” they then face everyday hardships, such as money, job, personal relations, and other types of hardships. Even after these hardships are resolved, there can be yet another deeper level that cannot be avoided, i.e., “intrinsic anguish,” which is related to “the meaning of life”. The structure of the process of recovery emphasized by the Program addresses these hardships. Naturally, recovery from psychological disorders leads to a return to normal daily life, employment, and participation in society, all of which may improve the person's quality of life. At the same time, this also shifts focus from “distress” to “hardships,” and finally to the four inevitable sources of “anguish” faced by all people, i.e., birth, aging, sickness, and death.

The Hardship Pyramid.

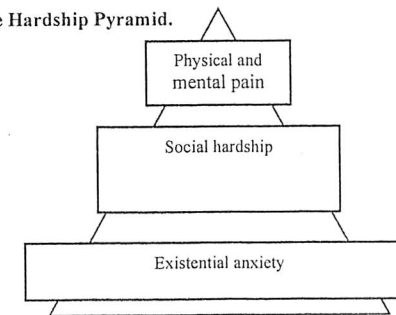


Figure 2. The Hardship Pyramid. Recovery is the process by which “pain” descends through “hardship” and then “distress”.

Tojisha Kenkyu is a philosophy of hardships that arises from people who have experienced schizophrenia and other disorders. Thus, it can also be considered an ideological attitude, which highlights issues faced by humanity as a whole, rather than on personal problems.

### THE POTENTIAL OF TOJISHA KENKYU

Mukaiyachi once asked a patient with schizophrenia, Hitomi Suzuki (resident of Osaka), who is involved in creative artistic projects to show what her participation in the Program means to her. Her reply was as follows: "It is a way for me to understand my own words." People who are afraid of their own world and who have refused to discuss it can then break away from their isolation and loneliness and begin to talk about their world. This world then is one in which there is more hope than fear." Illustration 1 shown here was drawn by Bethel member Hiroto Osaki. He has lived every day of his life with these "companions." These small "companions" float in the air. He told us that we could "take them home" with us (see Mukaiyachi, 2008).

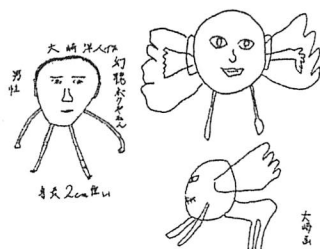


Illustration 1

The activities of Tojisha Kenkyu provide a venue for people who live in such a world to express themselves, thereby, creating opportunities for them to regain pride. An event that symbolizes this function is the Hallucination & Delusion Contest, which has been held for the last 25 years. The Hallucination & Delusion Contest is an event at which those with psychological disorders present awards to their peers for the most impressive and moving hallucinations and delusions that they have experienced over the previous year (see Figure 3). This contest held in the city hall of Urakawa gathers a couple of thousands audience, including patients, their families, psychotherapists, counsellors, social workers, school teachers, from all over the world every year so that it is difficult to make a reservation of hotel during the days before and after the contest day. The photograph included here shows a scene in which participants dressed as "Mr. Auditory Hallucination" are congratulating the group that won the Grand Prix for their depiction of their experiences being controlled by "Mr. Auditory Hallucination". Awarding a prize to a person who has the most extraordinary hallucination in front of a large audience has the implication that a hallucination and delusion could be regarded as a kind of work or performance like those of art to be shown to the public because they are the expression of one's own personality and the process of interacting with the world. Hallucinations and delusions have been dignosed as mere symptoms by medical doctors and therapists; they have simply rejected and neglected their hallucination and delusion as false beliefs. This attitude also means for Tojisha the rejection and neglect of their personality. Showing one's hallucination and delusion in front of the audience means

that his/her hallucinations and delusions become something to be shown to other people. Even the audience admires them. Now hallucinations and delusions come to be a kind of self-expression through which the other people understand the way how the Tojisha faces his/her world, at the same time by which the Tojisha becomes able to separate oneself from the problems.

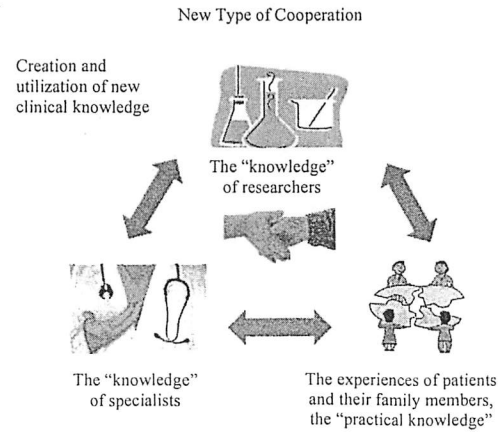


Figure 3. The Hallucination and Delusion Contest.

In Urakawa, hallucinations and delusions are not simply thought of as symptoms of an illness that must be cured; but rather, as an important part of the human experience and a significant event. Since hallucinations and delusions are a kind of method or way to cope with the problems that the Tojisha faces, even though the Tojisha seems to be possessed by them (Mukaiyachi, 2008, 2009a). In a unique episode, a woman with schizophrenia insisted that unhappiness in the world was her personal responsibility, and continuously engaged in acts of self-punishment, such as hitting herself in the face. Thus, she was in and out of hospitals, before being taken care of by Bethel members. The members tried several ways of dealing with this woman, but she continued hitting herself in the face. Finally, they tried tickling her under her arms to make her laugh. Once she started laughing, to everyone's amazement she immediately stopped her acts of self-punishment: Holding an impartial view of the problems patients have by shifting from an attitude of "Mr. X, who has repeated outbursts," to an attitude of "Mr. X, who is suffering because he cannot stop his outbursts even though he wants to". Her laughing can be interpreted as a sign of opening herself to the other. In other words, she comes to be able to put some distance from her acts of self-punishment. This is the process of self-objectification as a step of "separating oneself from problems" as we see above. Lauging, parody, humor, and joking as well are indispensably important factors in the process of Tojisha Kenkyu. Actually, a reader easily sees that the books of Mukaiyachi are full of humors and funny paradox.

The fact that the members of the Program were able to get her to stop her acts of self-punishment in a matter of minutes where specialists had failed over a period of 10 years is a testament to the success of Tojisha Kenkyu.

The Program holds a national meeting of Tojisha Kenkyu practitioners nearly every year. At the meeting, the results of research on the experiences of these people are presented. This includes research on the following: personality alternations, like “Mr. Auditory Hallucination” who always says disparaging things; stopping unidentified electrical waves emitting from the neighbor’s house; and the mechanism of endlessly flowing drinking water, which consist of singing and dancing. The method of conducting this research and the manner in which it is presented is completely up to the researcher/presenter. Researching and sharing their experiences, which they had previously only encountered in examination rooms and discussed with their peers, with the publicly, allow the researchers to grasp the significance and potential of these psychological disorders.



Over 600 examples of research have been presented over the past 15 years. The concept of Tojisha Kenkyu has spread through a variety of fields. The fields of brain science and phenomenological psychiatric medical care, which have been engaged in a continuous conflict of belief, have begun to form links through the medium of this Program. This phenomenon was mentioned in a course on the Program (representative: Shinichiro Kumagaya), which was delivered at the Research Center for Advanced Science and Technology, The University of Tokyo, in 2015. Academic research on themes that are common to patients, their families, citizens, researchers, and clinicians in a variety of fields has also been initiated. Thus, Tojisha Kenkyu is facilitating a new co-productive potential in the world of psychiatric care.

We are currently working on “re-exporting” the practical knowledge gained from the Program to psychiatric care settings. Tojisha Kenkyu is basically a program of self-caring carried out in a group home, care center, and private meetings, so that the re-exporting of Tojisha Kenkyu would radically change the method and way of psychiatric, medical caring. Further, we are also implementing it with in-hospital patients who are considered “difficult to treat” and were referred to us by four psychiatric hospitals, where we have been kindly allowed to work. The results of our

efforts in this area have demonstrated improvements in symptoms, which were seen in all the cases with whom we worked. The results we have obtained at NHO Hamamaki Hospital in Iwate Prefecture were notable to such an extent that the practical results obtained at this hospital are now referred to as the “Hamamaki Principle”. Hamamaki principles are the guidelines to introduce the method of Tojisha Kenkyu into a mental hospital. A number of psychiatrists and medical doctors try to adopt Tojisha Kenkyu in their medical caring. Thus, Tojisha Kenkyu, developed as a self-caring method outside the medical setting, now begins to be introduced into the medical clinical world.

Principles for the Program in Clinical Settings (The Hamamaki Principles)	
Principle	Clinical attitude
1. Non-judgmental/Non-evaluative	Staff members do not tell patients of their assessments, such as whether what they are saying is a delusion, whether there is a problem, etc., and they are not dismissive or negative.
2. Separating the person and the problem/ Externalization	It is important to always have an empathetic and positive attitude that is never critical of the person even if it is critical of the problem.
3. Active interest	An active interest is shown in order to understand vague or unique words used by patients and thereby understand the world they live in. Questions and conversation are used to understand these words.
4. Triangular conversation	Repeatedly use an exploratory conversation style that places experiences and events (theme, question, issue) in front of the conversation participants in all situations.
5. Visualization of hardships	Visualizing and converting into data the contents of conversations, creating visuals such as charts and graphs together with the patient at the computer, drawing pictures/graphs/flowcharts on whiteboards, and sometimes including act-outs in conversations.
6. Create encounters	Use the Program to create encounters for the purpose of sharing the results of research projects, try to link up with community networks.

Based on this principle, new practices have come into use in psychiatric care settings. The next section will show some examples of Tojisha Kenkyu.

DESCRIPTIONS OF HOW THE PROGRAM WAS USED BY TWO PARTICIPANTS WITH SCIZOPHRENIA

The first patient is Chiharu Kojima (Keizoji Clinic Day Care Service “Fabula”) from Gunma Prefecture, who gave a research presentation on “Communicating with Mr. Auditory Hallucination (building a relationship between people and hallucinations)”.



## Chiharu Kojima's Tojisha Kenkyu

### Introduction

I (Chiharu Kojima) go to the Keizoji Clinic's "Fabula" Day Care Service. When I first started going there, in 2016, I was a member of the Operating Committee for the lecture meeting entitled "Keizoji Clinic with Bethel" and I performed in plays about auditory hallucinations and delusions. I then spoke about my experiences with Mr. Auditory Hallucination at the Osaka venue of Tojisha Kenkyu 13th National Exchange Meeting in 2016. I then gave a demonstration of the Program at the 2016 Peer Step Tochigi Lecture Meeting in Bethel. Currently, I continue to visit universities and vocational schools with staff members where I talk about auditory hallucinations. Here, I would like to describe the steps I have taken to understand my steadily increasing auditory hallucinations.

### Description of my hardships

The name I used for my own illness is "Everyone is equal: The ability to communicate with Kind Mr. Auditory Hallucination". When I was in third grade of elementary school I was bullied. At the time, the people who bullied me picked up an omelet that had fallen on the floor, placed it on my school lunch plate and said "Eat it!" They told me I was disgusting and mimicked wiping germs away. I even wrote out my will at that time. I continued to be bullied when I went to middle school, and developed a fear that I would be bullied if I went to school. This led to me isolating myself at home. Once I got to high school, I found I couldn't get used to life at a new school. When I was in first year of high school my maternal grandfather died. On the day after the funeral when I went to pay my respects I thought I could hear a voice behind my head saying "Die! Die!" and "You should just die!" I was so scared when I heard this voice that I did not know who to tell and just suffered it by myself.

Five years ago, when I was going to what is now known as the Keizoji Clinic, I was diagnosed with schizophrenia. I then understood that the voice that I could hear behind my head was Mr. Auditory Hallucination. The relationship I started with Mr. Auditory Hallucination when my grandfather died has now continued for over 20 years! For the first 15 years or so after I first started hearing Mr. Auditory Hallucination. I would pull at my hair and hit myself. This was because I thought that the sound of the voice saying "Die!" was coming from inside my own head. As I continued in my introspection, I was able to enjoy talking to the doctors and staff at the clinic, as well as my peers in the Day Care program about Mr. Auditory Hallucination.

### Objective

Recently, Mr. Auditory Hallucination who used to say "Die!" has become kinder and gentler. Thus, I began this research to inform others in Japan about the potential for this to happen to them as well. Further, I would like to communicate more with increasing numbers of Mr. Auditory Hallucinations.

### Methods

1. I participated in self-help activities, such as the Keizoji Clinic Fabula Schizophrenics Anonymous (SA) and Tojisha Kenkyu. SA is a group of anonymous sufferers of schizophrenia and other disorders that was started in the United States. It conducts

meetings using the recovery steps that are based on the 12-step program of Alcoholics Anonymous. It was introduced in Urakawa in 2001 and has now spread throughout the country.

2. I conducted interviews with staff members, kept a Mr. Auditory Hallucination notebook (I made notes every time the hallucinations increased), and held consultations with other members of the Mr. Auditory Hallucination Conversation Notebook group and other peers.

### Contents

#### 1. *Be Brave: Consult with Peers*

Since the time when I first started hearing Mr. Auditory Hallucination's voice, it continued endlessly for 15 years saying things like "Die! Die!" and "You should just die!" During that period, my only way of dealing with it was to pull at my hair and hit myself in the head. That was because I thought the voice that was attacking me was coming from inside my own head.

The turning point came 6 years ago when I went to a consultation program at Day Care Fabula. A member said to me, "Why not ask Mr. Auditory Hallucination what his name is?" I thought, "How do I do that?" I decided to ask him his name when I was in the bath at home. The member who made the suggestion advised me to "ask him kindly and politely."

#### 2. *Meeting with Mr. Auditory Hallucination*

Much to my surprise, when I asked "Mr. Auditory Hallucination, would you please tell me your name?" I actually got an answer! Mr. Auditory Hallucination said his name was "Haruki." That was how I met the first Mr. Auditory Hallucination.

The Mr. Auditory Hallucinations kept increasing until now there are over 400 of them. Now, I do not just ask them their names, I also ask their birthdays, ages, and blood types. Among them are non-Japanese people as well; for example, Americans, Chinese, Koreans, and English. There are those that get along with each other, those that are couples, those that are married, and those that are both married and have children. Until recently, I could only hear their voices in my left ear, but now I hear them in both ears so I can talk with them more now.

### List of Mr. and Ms. Auditory Hallucinations

Name	Age	Gender	Other Info
Haruki	15	Male	
Yuki	16	Female	
...	...	...	...

### 3. Changes in Mr. Auditory Hallucination

Most people see Mr. Auditory Hallucinations as scary, but mine are kind and gentle. I once asked why they became kinder. The reply was that the world of auditory hallucinations is isolated and lonely, so when I asked for their names and started talking with them, they became kinder to me. Next, I asked Mr. Auditory Hallucination why he keeps multiplying. He said that he wants other people who are troubled by auditory hallucinations to ask them their names. They want to be spoken to, which led me to tell people all over the country that auditory hallucinations are not scary; they are kind.

I am now getting along well with Mr. Auditory Hallucination. I discuss my problems with him and communicate with him. Mr. Auditory Hallucination became kinder and started to listen to my troubles once I asked him his name. But, when I talk to Mr. Auditory Hallucination, sometimes he multiplies. Even now, every time he multiplies, I report it to my peers and staff members. This makes him happy.

### Findings

What I learned through this research was that I was good at communicating with Mr. Auditory Hallucination and that Mr. Auditory Hallucination would talk about my opinions. The most important thing I learned was that auditory hallucinations are not scary, they are kind and gentle. My Mr. Auditory Hallucination wants me to tell more and more people all over the country who have their own auditory hallucinations that auditory hallucinations are kind and gentle. Mr. Auditory Hallucination asked me to tell everyone that the world of auditory hallucinations is isolated and lonely and that is the reason they say things like "Die! Die!"

I would like to continue talking about Mr. Auditory Hallucination to people all over the country who are troubled by their own auditory hallucinations. For me, Mr. Auditory Hallucination has become a vital part of my counselor and I. If a doctor asks whether I would like them to invent a medicine to take Mr. Auditory Hallucination away. However, I would not want that since Mr. Auditory Hallucination has become kind and I can communicate with him now. Further, I want to tell more and more people everywhere who are troubled by their own auditory hallucinations about my experiences and how auditory hallucinations are not scary by kind. Although the multiplication of Mr. Auditory Hallucination keeps multiplying can sometimes cause problems, I communicate and get along with them all.

Although I wish that Mr. Auditory Hallucination were not only my own, but rather could be shared with people everywhere, it seems that he likes it here with me. I would like people everywhere to know that they can communicate and have friendly conversations with Mr. Auditory Hallucination. I want to spread the word by giving presentations anywhere there are people who are troubled.

Next, we have the research presentation delivered by Yoshiko Hoshino, who is from Niigata.

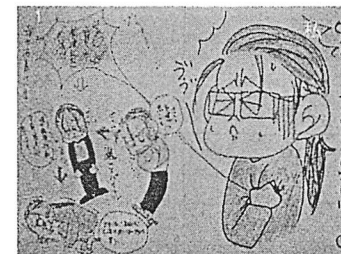
## Yoshiko Hoshino's Tojisha Kenkyu

### Introduction

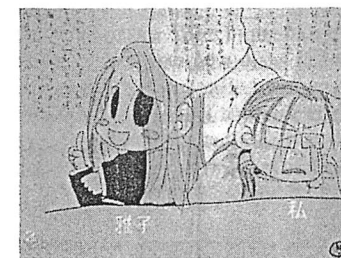
Hello, my name is Yoshiko Hoshino. I have schizophrenia and I am an outpatient at Sasaei Yorozu Clinic. Today, I would like to report on my research entitled, "Raising a child and getting along with Ms. Auditory Hallucination." I currently have one child and live with my parents. Around the time I was 6 years old I realized that I had an auditory hallucination called "Masako". When I was 30 years old, she was joined by "The Black Man (also known as Black)" and "The Bearded Old Man," which made three of them. When I got pregnant, I was very troubled over my relationship with my mother, but the good auditory hallucination Ms. Masako helped me raise my child. However, things were bad when Black showed up, since I could not disobey his orders to kick my child. This led to my repeatedly being hospitalized so that I could be separated from my child.

### What happened

I drew pictures (I am good at drawing) of events that happened to me. The person on the right (Illustration 1) is me. I was very troubled over my relationship with my mother, but I was particularly hurt by her comment that I was raising my child in the wrong way. The color of her face made me think that maybe she was in a bad mood and I began to tremble. As this continued I gradually fell into depression and became sedentary. This got my mother even angrier, and we got stuck in a vicious cycle of anger and depression.



It was Masako, my auditory hallucination from the time I was 6 years old (Illustration 2), who came to my side to help me. When I told Masako that my mother was irritable and got angry at me, and that I thought I couldn't stand it any longer, Masako cheered me up by saying, "Yoshiko, this happens all the time ... your mother is just tired ... don't worry about it ... don't worry about it..." I'm glad that Masako is always positive. As I continued living with my irritable and quick-to-anger mother, my son, and Masako, my auditory hallucination, one day, the "Bearded Old Man" appeared, and then the Black Man, who made me suffer even more, also showed up. It was then that I reached the worst of my suffering. They were like my family, but in fact it was a terrible time (Illustration 3).



The Black Man was the most troublesome since he stood behind me and ordered me to kick my son (Illustration 4). Masako tried to stop him by screaming "Stop!" However, since the Black Man was stronger, there was nothing I could do but kick my son. Naturally, I was hospitalized as a result many times. I was prescribed many different types of medication. Although it was difficult for me to take my medicine, I did take them.

A turning point came when I participated in Tojisha Kenkyu meeting, which was held in Niigata. It was recommended to me by the visiting nurse staff. When they asked if there was a "specialist in auditory hallucinations" in the room, I responded and that is when I made the impromptu decision to participate in the Program's work on dealing with auditory hallucinations. I began discussing my relationship with my "family," including Ms. Auditory Hallucination, and asked for ideas from everyone. The instructor asked everyone to give a round of applause in thanks to the "Black Man" who came with me to the venue. I was shocked when they clapped because the Black Man, who was always angry, laughed for the first time. That is how I started with the Program.



Interview with the "Black Man"

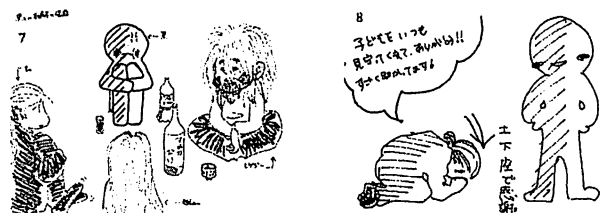
One attempt I made was to interview the Black Man (Illustration 6). When I did this, the Black Man, who was always angry, said in a depressed whisper, "I don't want to go away" and "I'm lonely." When I went for an examination at a hospital, the psychiatrist there said that the Black Man who encouraged me to abuse my child was the source of all evil and that he should go away. However, the Black Man had said that he did not want to go away.



Discovery: I wanted to depend on my mother's kindness

When I thought, "OK, so the Black Man is just lonely...", I made a miraculous discovery about my own feelings. I realized that I had just wanted to depend on my mother's kindness. Once I made this realization, I felt like a great load had been lifted and I was more relaxed. I thought that maybe the Black Man had pushed me to do what I wanted my mother to do for me when I was a lonely little child. Once I had this thought, I felt an overwhelming affection for the Black Man.

Then, I had a meeting with the Black Man, the Bearded Old Man, and Masako (Illustration 7). I was able to reconcile with the Black Man. I was thankful that he was an important member of my family who protected my child. When I said this, the Black Man laughed as if he were embarrassed (Illustration 8).



Reasons why I am glad I participated in the Program

Before participating in the Program, I was deeply troubled by my relationship with the Black Man. I was at a loss as to how to raise my child. However, what I learned through my research was that the auditory hallucination also wanted a parent, affection, and was angry at the fact that disappearing was the same as a person dying. In that sense, my auditory hallucination was no different from any other person. This was something that even I could understand, and so I realized that both people and auditory hallucinations are presences who both have a life.

Another reason I am glad I participated in the Program is that I was able to gain a good understanding of what was happening to me. Once I was able to listen to and pay attention to my auditory hallucination, our relationship improved. Further, my relationship with my mother also improved, which allowed the entire family to become closer.

### CONCLUSION: THE WORLD OF PEOPLE WITH SCHIZOPHRENIA THAT HAS BEEN OPENED BY THE PROGRAM

For 40 years Mukaiyachi have been in psychiatric settings and continually putting into practice the most advanced techniques. However, when we look back on our experiences, we find that since the fields of psychiatry and related fields of medicine and welfare place a great deal of importance on scientific bases; the knowledge utilized in those fields is biased toward psychobiology and brain science. In Japan in particular there is an overdependence on pharmacological therapies, which we think has led to



physicians in these fields losing sight of their position as medical specialists, who need to pay attention to circumstances that maximize human suffering.

I believe that we need to reconsider the words of Bin Kimura, a famous Japanese psychiatrist: "Patients become ill because they are alive, because they need to live. Illness is one of the highest forms of expressing the fact that we are alive. Patients live throughout their lives, go through their daily lives, and live their lives. From the time we first experience difficulties in life and attempt to live in spite of them, we begin to have a sense of futility. When a patient feels distress in his relationships with others, when he experiences anguish over his relationship with himself, and even when he ends his relationship with the world around him prematurely, he is attempting to live as fully as he can while at the same time accepting the futility of this act. This is a patient's way of living." Paying attention to "living people" is not idealistic, nor is it a form of escapist romanticism that both therapists and supporters fall into. Rather, the research of the two individuals included here suggested that paying attention to living people may be a clue to an important entryway into an extremely realistic type of therapy and support. I think that within their research one can find an important hint that suggests a way to confront the criticism from the psychiatric world that our efforts "do not lead to a treatment".

In that sense, the experience of the Program has been what we have learned. It is important to pay attention to and respect the world in which people with schizophrenia and mental disorders live, learn from it, and cooperate with those who live in that world. We also look forward to opportunities to promote discussion and conversation about the experiences of the Program with people around the world who face the same realities.

## REFERENCES

- Ishihara, K. (Ed.). (2013). *Tojisha Kenkyu no Kenkyu* (Studies on *Tojisha Kenkyu*). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Ishihara, K. (2013). *Tojisha Kenkyu to wa nanika* (What is *Tojisha Kenkyu*?). In K. Ishihara (Ed.), *Tojisha kenkyu no kenkyu* (pp. 11-72). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Kawamura, T., & Mukaiyachi, I. (2008). *Taiin-shien Bethel shiki* (Supporting being out of hospital, in *Bethel way*). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Kida, G. (1970). *Genshougaku* (Phenomenology). Tokyo, Japan: Iwanami-Shoten. (in Japanese).
- Kimura, B. (1995). *Seimei no katachi / katachi no seimei* (The Form of life / Life f the form). Tokyo, Japan: Seidosha. (in Japanese).
- Kingdon, D. G., & Turkington, D. (1995). *Cognitive-behavioral therapy of schizophrenia*. Hove, United Kingdom: Psychology Press.
- Kono, T. (2013). *Tojisha Kenkyu no yuisei* (The priority of *Tojisha Kenkyu*). In K. Ishihara (Ed.), *Tojisha kenkyu no kenkyu* (pp. 73-111). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Liberman, R.P. (1990/1976). *Personal effectiveness: Guiding people to assert themselves and improve their social skills* (Trans. N. Anzai). Tokyo, Japan: Sozo Shuppan.
- Meda, K. (2013). *Kiso kara manabu SSK* (Learning SSK from the beginning). Tokyo, Japan: Seiwa Shoten Publisher. (in Japanese).
- Mukaiyachi, I. (2008). *Bethel na hitobito* (People of Bethel) (Vols. 1-4). Sapporo, Japan: Ichibaku-Shuppan-Sha. (in Japanese)
- Mukaiyachi, I. (2009a). *Togoshicchoshu wo motsu hito no tame no enjo-ron* (A theory for supporting the persons with schizophrenia). Tokyo, Japan: Kongo-Shuppan. (in Japanese)
- Mukaiyachi, I. (2009b). *Giho Izen* (Before Skills). Tokyo: Igaku-Shoin. (in Japanese).

- Mukaiyachi, I. (2013). *Tojisha Kenkyu*. In M. Fukuda, & M. Itokawa (Eds.), *Togoshicchoshu* (*Schizophrenia*) (pp. 250-265). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Mukaiyachi, I. (2016). *Tojisha Kenkyu to Seishin-Igaku no korekara* (*Tojisha Kenkyu and Psychiatry in the future*). In K. Ishihara, T. Kono, & I. Mukaiyachi (Eds.), *Seishin-Igaku to Tojisha* (pp.180-205). Tokyo, Japan: University of Tokyo Press. (in Japanese).
- Mukaiyachi, I., & Ito, E. (Eds.). (2007). *Ninchi Kodo Ryoho, Bethel-shiki* (*Cognitive Behavioral Therapy in Bethel way*). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Nakamura, K. (2017). *A disability of the soul: An ethnography of schizophrenia and mental illness in contemporary Japan*. Ithaca, NY: Cornell University Press.
- Urakawa Bethel no Ie. (2002). *Bethel no ie no 'hi'-enjo-ron* (*Bethel no ie's theory of non-supporting*). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Urakawa Bethel no Ie. (2005). *Bethel no ie no 'Tojisha Kenkyu'* (*Bethel no ie's Tojisha Kenkyu*). Tokyo, Japan: Igaku-Shoin. (in Japanese).
- Warner, R. (2000). *The environment of schizophrenia: Innovations in practice, policy and communications*. London, United Kingdom: Routledge.