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The Single Session Therapy Mindset: Fourteen Principles Gained Through an Analysis of the Literature

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ABSTRACT. Mindset, or the therapist's series of beliefs which influence the actions and decisions taken in the course of their work, is considered fundamental in its impact on the effectiveness and length of a course of therapy. This article gives a definition of "mindset" and analyses its implications for psychotherapy in general and Single Session Therapy (SST) in particular. This is followed by an analysis of the literature surrounding SST, leading to the description of fourteen principles which make up the typical mindset of a single session therapist. The application of the principles is illustrated by a clinical case study.

KEY WORDS: Single session therapy, mindset, epistemology

Introduction: mindset is fundamental

Consider this statement: "[psycho]analysis does not offer any quick fixes. What it can offer is a depth of change and recovery that other, short-term treatments often cannot. Typically, people will see an analyst for several years, though the exact length of an analysis will of course depend on the individual's specific problems and situation" (Institute of Psychoanalysis, n.d.).

What does this tell us about psychoanalysis, people, psychotherapeutic change and change in general?

For example:

- a short-term treatment (whatever this is and whatever "short-term" means) cannot offer "deep" change and recovery (whatever these may be);
- "deep" change typically takes years;
- however, the exact duration depends on the individual's problems and situation (whatever it may be).

Clearly, this is not a criticism of the above statement, which serves its purpose on an informative website (albeit belonging to the Institute of Psychoanalysis of the British Psychoanalytical Society). Neither should the reader see it as a criticism of the psychoanalytical method.

Instead, we would like to pose some questions.

For example: how would a therapist proceed if they believe that "a depth of change and recovery" can only be gained by seeing an analyst "for several years"?

How would the same therapist react if the client returned a few weeks later with a complete remission of symptoms?

And, more generally, how will the therapist's work be influenced by their beliefs?

In this article we will attempt to answer such questions. We will define the concept of

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mindset, explore its place at the heart of Single Session Therapy, identify fourteen principles of mindset drawn from a preliminary analysis of the literature and illustrate a case which can provide a more concrete idea of the issue.

What is mindset?

First and foremost, we should clarify what we mean by "mindset". In English, the definition is "a mental attitude or inclination", where "attitude" is "a feeling or way of thinking that affects a person's behaviour", and "inclination" is "a tendency to a particular aspect, state, character or action"[1].

The mindset of a therapist, then, is the series of beliefs which influence the actions and decisions taken in the course of their work.

Moreover, we believe that these ways of thinking are not always necessarily conscious.

We can also ask ourselves how the mindset of a therapist is formed, in other words how does the therapist come to have his or her particular mindset. Although a detailed answer to this question falls outside the remit of this article, we can assume that it is partly the result of the therapist's personal history, and partly of their professional career. Whether it is the life experience of the individual therapist, or the experiences and studies undertaken in their professional life, jointly these form the ways of thinking and acting in the therapy room that belong to that person. For example, mindset includes epistemological, theoretical, and technical opinions, as well as personal attitudes to relationships with clients.

On the other hand, what do we *not* mean by mindset? It is definitely not operational guidelines which indicate what to do during a session. But we could perhaps say that if the famous alien were to arrive and watch a therapist in action, they could determine the mindset from what the therapist is doing. What they are doing is action (mostly, but not only, verbal), and from these we can determine the therapist's views on various issues: how people work, how change works, what they expect to happen during the session and so on.

Why is it essential to take mindset into account?

We believe that the organised series of ways in which we think and practise acts as a guide to a number of key points of the therapy itself (which is what we aim to demonstrate in the course of this article). For example, depending on their mindset, different therapists will give different answers to basic general questions such as:

- how long should therapy last to be effective?
- what is the minimum and maximum number of sessions, and how should this be decided?

[1] Mindset, Attitude, Inclination https://www.merriam-webster.com/dictionary/

- how is change produced in psychotherapy?
- should the therapist set homework to be done between sessions?
- who should be present in sessions?
- who sets the objective of the therapy?
- what should be addressed in therapy?
- what is the ultimate aim of therapy?

And also highly specific questions, such as:

- is online therapy legitimate?
- should the client be seated on a chair, in an armchair, or lying down?
- should we shake the client's hand?

In fact, all these questions are subjects for discussion and study, if not actual debate, in the writings and gatherings of psychotherapists. Different environments or systems obviously have different ideas of what the correct answers may be, and these lead to different practices: shake the client's hand or not, ask them to sit or lie, offer online therapy or not, what goals to aim for, who defines them, whether to set homework and why, etc.[2]

It therefore appears clear that knowing the mindset of a therapist, or of a particular type of therapist, is key, because it tells us a lot about their way of working. And probably also about their effectiveness and efficiency, in other words their ability to help people and the time needed to do so.

How does mindset affect psychotherapy?

We have previously discussed these considerations (Cannistrà, 2021, pp. 82):

> A mindset creates (and stems from) constructs.
>
> For example, in a psychoanalytic mindset there is the construct of "flight into health."
>
> As Frick (1999, p. 63) explains, "reports to the therapist of rapid improvement and a return to feelings of well-being are viewed with suspicion. Such positive patient reports, sometimes accompanied by early termination, are considered to be 'self-deceptive' […], are 'fraught with inherent dangers' […], are 'not trustworthy' […], and are 'pseudo-successes'."
>
> How can therapy be brief or single session with a mindset based on these kinds of *opinions*?

As Watzlawick et al. (1967) say: "[A] man operates with a set of premises about the phenomena he perceives and [...] his interaction with reality in the widest sense (that is, not only with other human beings) will be determined by these premises" (p. 262).

The question every therapist needs to ask is: what happens when the "reality" we're talking about is the reality of the therapy? What are the "interactions" that come into play in this reality? And, above all, what are the "premises" that determine them?

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[2] Obviously, the issue is more complex than this, and may include *when* to shake or not shake the client's hand, or *when* to ask them to sit or lie; but we assume that the point is sufficiently clear.

In the words of Hoyt (2017, p. 230): “How we look influences what we see, and what we see influences what we do, ‘round and ‘round”.

It therefore goes without saying that we need to understand how we look at “therapy-related things” because this will influence how we see them, how we interpret them, and what they mean to us. And this will influence the action we will consequently take.

We consider it inevitable that the length of a course of therapy is partly determined by the premises with which we approach it.

Prior to Talmon (1990), the general tendency was often (not always, of course) to consider the first session as geared solely to diagnosis, or merely for building the relationship between therapist and client or, in the best-case scenario, for establishing and initiating a strategy.

What might be the outcome of an initial session approached with this kind of mindset? And what might the outcome be if - as discussed elsewhere (Cannistrà & Piccirilli, 2021) - ending after the first session is interpreted as a negation of the “illness”, lack of motivation or an overly serious disturbance?

Our premises - our mindset - determine the actions we carry out in therapy and, to a large extent, the very outcome of the therapy. Others have highlighted the extent to which the therapist’s expectations impact the outcome of the therapy itself (for example, Connor & Callahan, 2015).

And what should we think, therefore, of the therapist’s expectations regarding characteristics attributed to the client, such as “organisation of the Id”, “motivation”, “defence mechanisms employed”, “organisation of the personality”, “diagnosis” etc? Or expectations as to “how long therapy should last”, “how many sessions are needed to establish a therapeutic alliance” or “to consider a resolution of the problem”.

This does not seem very far removed from Rosenthal’s classic experiment, known as the *Pygmalion effect* (Rosenthal & Jacobson, 1992).

Mindset in Single Session Therapy: an initial examination of its constitutive elements

In the last thirty years, interest has grown around Single Session Therapy (SST), a method of (therapeutic) intervention aimed at maximizing the effectiveness of each single (and often unique) session. It all started with the first study by Talmon, Rosenbaum, and Hoyt (Rosenbaum et al., 1992), which led to three findings validated by subsequent research:

> Finding #1: that the most common number of service contacts that clients attend is one, followed by two, followed by three…

> irrespective of diagnosis, complexity or the severity of their problem (Talmon, 1990).
> Finding #2: that the majority (often about 70-80%) of those people who attend only one session was adequate given their current circumstance (Talmon, 1990; Bloom, 2001; Campbell, 2012).
> Finding #3: possibly the hardest finding to accept, is that it seems impossible to accurately predict who will attend only one session and who will attend more, a proposition that has significant clinical and organizational ramifications.
> (Young, 2018, p. 44).

Over the years, various SST methods have been developed (see for example Cannistrà & Piccirilli, 2021), but one thing that seems to us to be common to all is the importance of the mindset underlying them.

For example, Slive and Bobele say that "a crucial element for conducting successful walk-in [single] sessions is the therapist's own beliefs about the effectiveness of brief therapy. Therapists' expectations are communicated overtly and covertly about how rapid and how much change can be expected" (2012, p. 29).

Mindset is so fundamental in SST that Hoyt claims that: "SST can be thought of more as an affirmative and optimistic mindset [...] rather than as a particular method" (2021, p. 31).

The essential question therefore becomes: what are the basic characteristics of the mindset in the therapist who approaches their clients with SST? Or, in other words, what modes of thinking should a therapist adopt to ensure their decisions and actions allow the therapy Single Session?

There are several answers to this question. At our centre we have chosen to extrapolate a response by examining a series of contributions by researchers and practitioners of SST in its various forms, not only clinical and therapeutic (although these make up the overwhelming majority of the sample). This is also the reason why we favour the terms "therapy" and "therapist", which the reader may extend to other nouns such as "counselling" and "practitioner". For the same reasons, we use the alternatives "person", "client" and "patient", while preferring the first two terms, considering the latter excessively medicalised.

Methodology

We reviewed fifty-three contributions on SST, including chapters of books, research and articles. Numerous texts refer to SST, but we limited our search to those which focus explicitly on this approach, excluding those that mention it in passing. Furthermore, we sought to prioritise writers who discuss SST more or less continuously, or who have published major work on the subject (such as systematic reviews or meta-analyses). We are aware that this and the previous criterion exclude many important contributions; our decision was based solely on the need to simplify this work, which is not

intended to be a exhaustive review and may subsequently be extended. Therefore, the non-inclusion of certain contributors/writers does not imply that they have nothing interesting to say; indeed, it may mean that we missed them or did not have time to include them in this article: we may well do so in the future. Moreover, we absolutely do not believe that the elements observed constitute the "true mindset" of SST: since we embrace constructivism and constructionism (von Glasersfeld, 2001; Gergen & McNamee, 1991) and, more generically, pragmatism and pluralism (Bernstein, 2010), the concept of "truth" does not belong to us. What we present here is a version derived from our perspective and our current work, with the sole purpose of giving an interpretation which may be useful in the adoption of a single session mindset.

In our analysis of the literature, we prioritised passages referring explicitly to mindset, in other words direct descriptions of the therapist's approach to therapy, leaving aside situations in which mindset may be derived (interpreted) from other assertions (such as suggestions of what to do during therapy); obviously, the boundaries are not always clear, and we occasionally resorted to abstraction. For example, when Talmon (2014, p. 35) states that "the 'DNA' of good SST" includes "Mobilizing so-called 'client and extra-therapeutic factors' such as the client's underlying strengths, supportive elements in the environment, and chance events of spontaneous healing", we took this as an indication of a mindset in which the belief is that the client has resources, although Talmon does not say this directly, stating, for instance, that "The Single Session therapist believes that the client has resources and that these are part of the therapy". Moreover, when we make this kind of choice, we nevertheless seek to prioritise assertions that were already in accordance with similar views by other writers, while omitting others which would have required inordinate interpretation on our part, at the risk of crudely distorting the author's words.

Above we mentioned that we had referred to descriptions of "how the therapist approaches therapy". This means we sought elements that reference the therapist's view of the characteristics of the client, the therapist, the process of therapy and change. However, we have avoided reference to procedural or operational elements such as methods, practices or guidelines on how to conduct SST, although in certain passages we have used these to add clarity; but we have attempted to minimise this and also to avoid being overly specific. For instance, we avoid giving descriptions or examples of specific techniques.

Among the main sources for our research were three publications edited by Hoyt and colleagues (2014, 2018a, 2021). These allowed us to access a large number of articles and writers directly and explicitly involved in SST. However, we also wanted to include authors whose contributions did not appear in these three works, in order to ensure our research was not overly polarised.

As mentioned previously, during our research we collected both direct and indirect statements, with the aim of identifying their common principles. By doing this, categories were created, in which we placed statements that we believed pointed to common elements of the mindset. We ended up with fourteen categories: the fourteen principles of the Single Session mindset. We are aware that this presentation is a reflection of our viewpoint, which is itself limited, partly by the small amount of material examined. Other writers might differentiate more or fewer categories or disagree partially or wholly with our inclusion of certain elements in certain categories.

The fourteen principles of Single Session mindset

Below we will present the fourteen principles of single session mindset, i.e. the fourteen categories we identified. They are presented in order of the number of mentions they have received, starting with the category that has received the greatest number. However, this order is essentially arbitrary; more extensive research might change the position of one or more categories; moreover, given the process of abstraction we used, we may have omitted some statements. Furthermore, no weighting is given to the statements: some authors may have written several lines highlighting certain elements of mindset and fewer lines on other elements; in such cases we have included both. For this and other reasons, the reader should not assume that a particular principle is more commonly held than others and, above all, should not consider any to be more important or essential (with the possible exception of the first principle): it is likely that the authors quoted (see Table 1) share most of the other principles, but they may not be in agreement on some, or give them different weight.

When choosing names for the categories/principles, we opted for the clearest and most accurate possible, without overly abstract or metaphorical terms. The same goes for our descriptions of the categories.

In order to avoid excessive heaviness in the text, instead of including a bibliography for each principle, we have summarised our sources in Table 1.

Table 1. The fourteen principles of the Single Session Mindset and the related references

Principle	References
1. A SINGLE SESSION MAY BE ENOUGH	Rosenbaum et al., 1990; Talmon, 1990; Hoyt et al., 1992; Bloom, 1992; Bobele et al., 2008; Slive et al., 2008; Hoyt, 2009; Miller, 2011; Campbell, 2012; Slive & Bobele, 2012; Paul & van Ommeren, 2013; Hoyt & Talmon, 2014; Keeny & Keeny, 2014; Slive & Bobele, 2014; Talmon & Hoyt, 2014; Rycroft & Young, 2014; Young, Rycroft & Weir, 2014; Barnes et al., 2018; Hoyt et al., 2018b; Hoyt et al., 2018c; Hoyt, 2018; Slive & Bobele, 2018; Söderquist, 2018; Story, 2018; Stweart et al., 2018; Talmon, 2018; Hoyt & Cannistrà, 2019; Dryden, 2019; Cannistrà et al., 2020; Hoyt et al., 2021; Bobele et al., 2021; Hoyt, 2021; Schleider, Dobias et al., 2020; Schleider, Sung et al., 2021
2. THE THERAPIST CAN PLAY AN ACTIVE ROLE	Talmon, 1990; Bloom, 1992; Cummings, 2000; Bobele et al., 2008; Slive et al., 2008; Hoyt, 2009; Miller, 2011; Paul & van Ommeren, 2013; Boyhan, 2014; Hoyt & Talmon, 2014; Keeny & Keeny, 2014; Slive & Bobele, 2014; Talmon, 2014; Talmon & Hoyt, 2014; Rycroft & Young, 2014; Young, Rycroft & Weir, 2014; Hoyt et al., 2018b; Hoyt et al., 2018c; Guthrie, 2018; Rodriguez, 2018; Slive & Bobele, 2018; Soo-Hoo, 2018; Stweart et al., 2018; Young, 2018; Young K., 2018; Hoyt et al., 2021; Hoyt, 2021; McElheran, 2021; O'Hanlon 2021; Schleider, Dobias et al., 2020; Schleider, Sung et al., 2021
3. PEOPLE HAVE RESOURCES THEY CAN USE TO FEEL BETTER	Rosenbaum et al., 1990; Talmon, 1990; Bloom, 1992; Miller, 2011; Campbell, 2012; Feldman & Dreher, 2012; Slive & Bobele, 2012; Hoyt & Talmon, 2014; Slive & Bobele, 2014; Talmon, 2014; Talmon & Hoyt, 2014; Bobele et al., 2018; Hoyt et al., 2018b; Hoyt et al., 2018c; Hoyt, 2018; Guthrie, 2018; Josling et al., 2018; Soo-Hoo, 2018; Story, 2018; Stweart et al., 2018; Talmon, 2018; Young K., 2018; Dryden, 2019; Hoyt & Cannistrà, 2019; Cannistrà et al., 2020; Hoyt et al., 2021; Hoyt, 2021; McElheran, 2021; O'Hanlon, 2021; Schleider, Dobias et al., 2020; Schleider, Sung et al., 2021
4. THE CLIENT IS THE EXPERT IN THEIR OWN LIFE	Hoyt, 2009; Miller, 2011; Feldman & Dreher, 2012; Slive & Bobele, 2012; Slive & Bobele, 2014; Young, Rycroft & Weir, 2014; Barnes et al., 2018; Bobele et al., 2018; Hoyt et al., 2018b; Hoyt et al., 2018c; Hoyt, 2018; Levin et al., 2018; Rodriguez, 2018; Stweart et al., 2018; Söderquist, 2018; Soo-Hoo, 2018; Talmon, 2018; Young K., 2018; McDonald et al., 2021; McElheran, 2021; O'Hanlon, 2021; Rycroft et al., 2021; Schleider, Dobias et al., 2020
5. DIFFERENT METHODS MAY BE USED	Talmon, 1990; Miller, 2011; Paul & van Ommeren, 2013; Hoyt & Talmon, 2014; Slive & Bobele, 2014; Talmon, 2014: Talmon & Hoyt, 2014; Rycroft & Young, 2014; Barnes et al., 2018; Hoyt et al., 2018c; Hoyt, 2018; Josling et al., 2018; Rodriguez, 2018; Söderquist, 2018; Story, 2018; Stweart et al., 2018; Young, 2018; Hoyt et al., 2021; Hoyt, 2021; McElheran 2021; Schleider, Sung et al., 2021
6. FURTHER SESSIONS MAY BE NEEDED	Rosenbaum et al., 1990; Talmon, 1990; Miller, 2011; Hoyt & Talmon, 2014; Hoyt et al., 2018b; Guthrie, 2018; Rodriguez, 2018; Story, 2018; Young, 2018; Hoyt et al., 2021; Bobele et al., 2021; Hoyt, 2021; O'Hanlon et al., 2021; Rycroft et al., 2021
7. SST IS SUITABLE FOR DIFFERENT CONTEXTS AND NEEDS	Rosenbaum et al., 1990; Talmon, 1990; Cummings, 2000; Slive & Bobele, 2012; Paul & van Ommeren, 2013; Boyhan, 2014; Slive & Bobele, 2014; Talmon, 2014; Young, Rycroft & Weir, 2014; Söderquist, 2018; Young, 2018; Dryden, 2019; Hoyt et al., 2021
8. IT'S FINE TO AIM FOR SMALL OR SIMPLE INTERVENTIONS	Rosenbaum et al., 1990; Talmon, 1990; Bloom, 1992; Miller, 2011; Hoyt & Talmon, 2014; Talmon, 2014; Talmon & Hoyt, 2014; Hoyt et al., 2018b; Guthrie, 2018; Söderquist, 2018
9. IT'S FINE TO HAVE LESS PRIOR KNOWLEDGE	Young & Rycroft, 1997; Slive et al., 2008; Bedggood, 2018; Harper-Jacques, 2018; Guthrie, 2018; Levin et al., 2018; Miller et al., 2018; Story, 2018; Hoyt et al., 2021
10. IT'S BEST TO STICK WITH PROCESS AND THE HERE AND NOW	Bloom, 1992; Paul & van Ommeren, 2013; Talmon, 2014; Talmon & Hoyt, 2014; Rodriguez, 2018; Rycroft, 2018
11. RESULTS ARE MAINLY ACHIEVED OUTSIDE THE SESSION	Rosenbaum et al., 1990; Hoyt, 2009; Hoyt & Talmon, 2014; Talmon, 2014; Guthrie, 2018; Josling et al., 2018
12. A STRUCTURE IS NEEDED FOR THE SINGLE SESSION	Talmon, 1990; Bobele et al., 2018; Hoyt et al., 2018a; Dryden, 2019; Hoyt, 2021; Rycroft et al., 2021
13. A CLIENT-THERAPIST RELATIONSHIP CAN BE ESTABLISHED RAPIDLY	Talmon, 1990; Talmon, 2014; Stweart et al., 2018; Talmon, 2018
14. NOTHING IS TAKEN FOR GRANTED	Bloom, 1992; Hoyt & Talmon, 2014

Here are the fourteen principles of the single session mindset.

1. A SINGLE SESSION MAY BE ENOUGH

The therapist believes that a single encounter between them and the client may be sufficient for both parties. This means the therapist accepts the idea that the client may think they do not need further sessions, and that the help given by the therapist in the single session may be all the client needs.

In other words, the therapist approaches the session with the idea that it may be the only meeting between them and the client, not because the session is a "failure", but because, conversely, it has been sufficiently useful.

This also means that the therapist will conduct the session bearing in mind that it must be complete in itself. So they believe it is important to consider the possibility of (co-)creating a session that can achieve a purpose by the end of the time allotted. In other words, the therapist will avoid leaving things hanging or conducting the session in a way that makes another appointment obligatory or essential.

Some authors state other considerations which we believe are linked to this principle.

For example, that change can happen because of the session, and not actually within the session itself. This is a more specific consideration, in which "can" or "could" is vital, and not a necessity, and where perhaps the meaning of the word "change" merits discussion. In general, we believe that all therapists who have this mindset agree that - regardless of how - one session may be all the client needs.

A second consideration is that the therapist does not necessarily believe they can "cure" the person or "solve" the problem. The session may be enough exactly as it occurs, whether it is an instance of listening, problem solving, an opportunity for containment or an encounter with an "expert". This means that the therapist does not go in with the idea of "solving the client's problem", "curing the mental disorder" or "eliminating symptoms", but instead with the idea that the goal they set with the client may be more than sufficient (see 4th Principle).

Paradoxically, this is not the most explicitly stated principle, but this is not unusual: we consider it normal that in any discussion of SST (e.g. a chapter in a book on the subject) there is no need to reiterate the fact that one session may be enough in itself. For this reason we decided to place it before the others.

2. THE THERAPIST CAN PLAY AN ACTIVE ROLE

The therapist believes they can play an active role in conducting the session. This may be done in a number of ways: giving direct feedback, asking the client to do certain things during the session, using various techniques, recommending doing, not doing or changing certain things outside the session, either formally (for example, prescribing a certain technique) or less formally (for example, asking them to slightly change or completely stop certain behaviours); interrupting the client if and when necessary, involving or requesting the more or less direct involvement of other people, being more decisively directive or more indirect and suggestive, etc.

In general, the therapist gives himself or herself permission to conduct the session in the manner they consider most appropriate to help the client. This should absolutely not be confused with the idea of a forcedly directive, imperious or manipulative therapist. As we will see in the 4th Principle, the individual is designated as the expert in their own life and decider of the most appropriate ways to achieve their goal. Instead, this second principle reflects the idea of a therapist who is not limited to listening to the client, letting them vent, asking them to merely describe the past, and generally taking an exploratory and hermeneutic approach. On the contrary, the therapist takes responsibility for thinking and acting in the most appropriate ways in an attempt to help the client in the single session, always in line with the client's requests, needs and individuality, as well as offering the possibility of further sessions where necessary (6th Principle).

Although an active role is a given for many therapists, many single session practitioners highlight this as a fundamental premise which is essential, or at least to be considered, in order to maximise the effectiveness of the therapy.

3. PEOPLE HAVE RESOURCES THEY CAN USE TO FEEL BETTER

Many SST practitioners describe this as a *resource-based* or *strength-oriented* approach. This means that the therapist believes it is useful to assume that the client, like every person, possesses resources which to some extent can be identified during the session and used, partially or wholly, to help achieve their goals.

Such resources may be internal (more directly belonging to the individual in question) or external (more directly belonging to their systems of reference); cognitive, emotional, relational or other types.

They can be identified for example by exploring what the client does, has done or could do to address this or other issues. The therapist approaches the session with the idea of finding and using these resources through the

conversation and the techniques used during and/or after the session.

Many therapists believe that it is these resources that make the difference, and that a large proportion of the therapist's work should be directed to helping the client identify them and use or unlock them. Other therapists consider them as a base on which to work, a starting point or useful in some way.

In this way a view or vocabulary focused on or leading to pathologies is avoided and considered of little use; the therapist seeks to focus on what works or might work, rather than cure something seen as illness or pathology.

4. THE CLIENT IS THE EXPERT IN THEIR OWN LIFE

The therapist believes that the client can identify, recognise and communicate what works for them. This principle encompasses many aspects, including identifying what their problem is and how it works; deciding what the goal is - this may be at the end of a potential course of several sessions, or at the end of a single session - recognising whether a technique, comment, explanation, analogy or other intervention by the therapist may be appropriate for them, whether it is worth putting into practise, etc.

This does not mean the client knows all this *at the time*, i.e. they are immediately and fully aware of it. Rather, the therapist believes that the client should be helped to discover what works for them. It also means that the therapist does not approach the session with the idea of imposing something but, at most, proposing, and always taking the client's opinion into account.

Digging deeper, we could say that the therapist can be considered an *expert in the method* of helping a hypothetical client to achieve their own goal, but at the same time consider the person in front of them as an *expert in their own life*, and as such in what may be appropriate or inappropriate for them.

This means the therapist believes they have to understand the problem from the client's point of view; conduct the session in a manner that ensures it is the client who ultimately decides the goal of the session; in general, making the client the co-constructor of the solution, which will be based on, or at least inspired by, their own resources. For example, a number of therapists ask their clients what they think is the first step to take, or what they need to do to resolve their problem, or work to actively build a plan of action to use outside the session.

Obviously, this also means that the therapist will meet the client halfway in terms of their cultural background and preferences.

5. DIFFERENT METHODS MAY BE USED

Regarding the methods used to increase the likelihood that a single session is sufficient, many therapists explicitly underline that *one size doesn't fit all*, meaning that there is no single method or approach suitable for every person, problem or situation.

Even in view of the fact that every person has their own resources (3rd Principle) and is the expert in their own life (4th Principle), many therapists explicitly state that there is not one single method of conducting SST, and neither is any particular method better than another.

The single session therapist therefore has the expectation that a range of methods can be useful, and considers it necessary to be flexible and pragmatic, in other words to use what works for that individual rather than sticking rigidly to a single model. This is not to say that the single session therapist is necessarily an expert in a wide range of methods or approaches to therapy; in fact, writers tend to describe their own more or less structured methods of conducting SST (see also 12th Principle). Nevertheless, many do so while stating explicitly that they do not believe their method will work for all clients, and this partly coincides with the idea that further sessions may be needed (6th Principle).

By emphasising that SST is not a single structured way of working with a client, several writers explicitly state that, rather than an approach, SST is a form of delivering a service. We could perhaps say that SST is first and foremost a mindset, taking the form of various structured practices which can be used to deliver assistance to individuals.

6. FURTHER SESSIONS MAY BE NEEDED

The therapist knows that one session may not be sufficient and that, consequently, at the end of the session the client may request another appointment, or the therapist himself or herself may acknowledge or suggest that a further session may be needed.

Many single session therapists believe that it is not possible to establish the necessity or desirability of making further appointments before the end of the ongoing session. Therefore, neither the therapist nor the client can know whether other sessions will be needed before the end of the current one - regardless of the number of sessions carried out (whether it is the first, second, third etc). Moreover, the therapist "always leaves the door open" - meaning that they give the client the possibility of further sessions at any time, even if they previously thought the initial session was enough.

Besides, the therapist knows that further sessions may be necessary with the same service and with the same therapist, but also with different services and with different therapists; they also know that the client may request a further appointment for the same problem or different ones, or make a new appointment only to realise that there is actually no need. As we saw in the 5th Principle, this is part of the basic flexibility needed by the therapist, who does not consider SST as a challenge or a test, but simply a type of service which, if it turns out to be insufficient, leaves other options open.

Among other things, this implies that the therapist does not approach the session with the idea that they have to make sure that the session is the only one needed, at any cost. They follow the mindset principles and the structure (model, method, approach etc) they consider necessary to maximise the effectiveness of the session, bearing in mind that it may be the only one, but not considering this to be essential.

This principle does not contradict the methods of delivering the service chosen by the therapist or the centre. For example, some walk-in services do not offer the possibility of making further appointments with the same therapist (i.e. ongoing therapy with the same person), but this does not mean they think the single session may not be sufficient.

As previously stated, the fact that this is the 6th Principle does not imply that it is less important than the previous points. Indeed, it is highly likely that all single session therapists believe further sessions may be needed, and that one is not necessarily enough.

7. SINGLE SESSION THERAPY IS SUITABLE FOR DIFFERENT CONTEXTS AND NEEDS

The therapist believes that the idea that a single session may be enough is valid in a wide range of cases. Regardless of who they are faced with and the problems the client brings, the therapist does not approach any initial session thinking that it will definitely be necessary to arrange another, and they usually maintain this approach throughout the session and the course of therapy.

By way of example, this means that the therapist's starting point is the idea that a single session may be enough, regardless of (a) who requests and attends the session, e.g. an individual, a couple, a family or a group; (b) the problem they bring, which may be assessed as "serious" (for example in terms of symptoms) or "urgent"; (c) the culture of the client in question.

Naturally, this assessment may change in the course of the session, but the change is not prior to it; for example, on the basis of

identifying certain diagnoses which are not compatible with SST. The appropriateness of SST depends first and foremost on the goals that the client wishes to achieve with the therapist during the first session, and the possibility of helping the client achieve them.

It should, however, be noted that therapists themselves concur that they should "evaluate situations of risk": a single session therapist may agree or not agree to end the therapy after a single session if, during that session, they ascertain situations of risk, leading to the belief that it is necessary to continue with further sessions.

To summarise - and this will be detailed later - the therapist does not approach the session with methodological limitations or particular diagnostic views that include or exclude the client from SST, or from the possibility that one session may be all the person believes they need. Effectively, as discussed above, it is only at the end of the session that a decision can be made as to whether the session has been sufficient or if others are needed, based above all on the objective agreed with the client.

8. IT IS FINE TO AIM FOR SMALL OR SIMPLE INTERVENTIONS

The therapist believes that when a session is sufficient, this is not due to the use of brilliant techniques, complicated manoeuvres, grand objectives or, in general, efforts to produce major change.

Although the therapist may accept that some changes happen suddenly and obviously, they do not think that the session should necessarily aim to effect this type of change. Instead of undertaking to achieve large or complex changes, they consider it more appropriate to come to the session with the aim of identifying, agreeing and (working towards) achieving small objectives and limited changes. This may also (but not necessarily) involve the setting of simple homework to be done outside the session.

Many authors emphasise the need to not be brilliant and avoid rushing during the session. Approaching a session with the idea that it may be enough, and proceeding with a structure that expresses this idea, does not mean trying to accomplish as much as possible: as stated previously, SST is not seen as a test of skill, so there is no need to seek major results within the session.

Indeed, the single session therapist basically knows that the "outcome of the session" may not coincide with "solving the problem" or "achieving the ultimate goal" of the client. They entertain the possibility that the client may resolve the problem or achieve the objective on their own, with another therapist

or in another context, or in other ways (Principles 5 and 6).

As we saw in Principle 3, therefore, the therapist believes it is useful to establish the aim of the *session* for the client, which will probably be simpler and smaller than a hypothetical goal for the end of a course of therapy designed to be conducted over several sessions. After all, the therapist always knows that if the objective is not achieved by the end of the session, or if it is reached, but is not sufficient for the client, the "worst" thing that can happen is that they realise another session is needed (6th Principle).

9. IT IS FINE TO HAVE LESS PRIOR KNOWLEDGE

Since the therapist does not know which process of change is best for the person they are meeting for the first time, they embark on a session with the idea and the aim of getting to know the person in front of them, the reason why the client has requested help and the details of the situation they are in and the condition they are experiencing. Some authors refer to this principle by saying the therapist starts from a *not-knowing-stance*.

During the session, the therapist avoids conducting or referring to a diagnostic process geared to placing the client in a specific nosographic category. In the words of several writers, the aim is in fact "therapy, not diagnosis": the purpose of the session is to help the person to change, not to decide "what's wrong with them".

This does not mean that the therapist can or should start from a *tabula rasa*: the process of categorisation and recognition is part of being human. Single session therapists instead state that, just as they avoid deciding the aim of SST in advance (1th Principle), they also avoid prior classification of the client in set diagnostic categories.

The underlying idea seems to be that the process of familiarisation should not involve predetermined terminology, such as, for example, certain systems for evaluating and classifying psychological pathologies: instead they concentrate on efforts to explore the person, the problem, the goal and the situation from zero, as well as their resources (4th Principle). This may be done, for instance, by prioritising functional descriptions and investigations into the nature of the problem as described by the client, rather than interpreting what they say and their reference to pre-set psychological theories.

10. IT IS BEST TO STICK WITH PROCESS AND THE HERE AND NOW

As mentioned earlier, the therapist believes that change can happen rapidly and in response

to action on ongoing processes, rather than requiring lengthy periods of investigation and exploration of discursive content relating to the past. Therefore, instead of exploring the meaning, interpreting the content and examining the past, the therapist approaches the session with the idea of focusing the conversation and any intervention on processes and interactions, with an emphasis on the here and now: they are more interested in *what* the person is doing than in seeking a distant *why* they are doing it and, when exploring possible reasons, the therapist is more interested in understanding *present* reasons than going back to (assumed) *past* reasons.

Several writers state explicitly that it is not appropriate to open too many doors or go too deep: working on what the person (or people, in the case of a couple or groups) brings to the session and how they are functioning at the present moment and within their current systems of reference is considered to be the most effective and suitable approach.

The therapist therefore believes that in order to maximise the effectiveness of the single session, interventions on current processes, geared to changing what is actually happening now and in the client's current situation, are preferable to explorative processes based on the past.

11. RESULTS ARE MAINLY ACHIEVED OUTSIDE THE SESSION

The therapist believes that most change happens outside the therapy room. This principle involves the simple idea that a major part of the process of change is more likely to occur in the hours and days following the therapy session than in the hour (or less) spent face to face with the therapist.

This does not imply that the therapist does not think change is possible during the session, or that important changes, or even resolutions, cannot take place during it (see 1th Principle). Nevertheless, the therapist approaches the session with the idea that the client spends far more time in their own life than in therapy, and therefore that the session should in some way trigger change outside itself, even if that change may begin during the time spent with the therapist.

A deeper understanding of the concept of "change" is needed in order to fully clarify this point. However, we can say that in relation to this principle, the therapist conducts part of the session with the view that the person's life is lived *outside* the session, and so it is here that a large part of the process of change will occur. The client could therefore be helped by the assignment of homework, or the drafting of an action plan, or a discussion of what it might be useful to do or think differently once the

session is over and the person is back in their daily life, with the problem they are facing or the goal they wish to achieve.

Nevertheless, the therapist attaches great importance to what happens within the session; it is simply that they do not assume that all the work must be done in the space of a single hour, and believe that in order to maximise the likelihood of the session being single, they need to help the person to somehow translate what happens in the session to their own life.

As mentioned, there may be a number of methods of doing this (5th Principle), and the therapist does not think that inducing such change should be geared to producing major differences (8th Principle).

12. A STRUCTURE IS NEEDED FOR THE SINGLE SESSION

Therapists know that single sessions also happen when they are not planned (*unplanned single sessions*). However, they also know that approaching every session with the idea that it may be the only one, and therefore with a precise (but flexible) structure in mind, increases the likelihood that the session will be the only one needed (*planned single session*). They therefore believe it is necessary to have a single session structure to follow, which is obviously flexible and adaptable, but ensures that the therapist does not attempt to conduct the session in an improvised manner.

13. A CLIENT-THERAPIST RELATIONSHIP CAN BE ESTABLISHED RAPIDLY

The therapist is aware of the importance of the therapist-client relationship for the success of any therapy and believes that this can be created rapidly even within a single session, and in a way which facilitates success. The therapist does not place any theoretical or epistemological limits on the possibility of connecting appropriately in the course of a single session.

14. NOTHING IS TAKEN FOR GRANTED

The therapist believes that although the client may have resources, he or she does not necessarily possess those needed to achieve the goal, or is not necessarily able to recognise, access or use them. Furthermore, although the client is the expert in their own life, the therapist does not overestimate their level of self-awareness or take it for granted that the client sees and thinks the things they see and think. This principle reflects the flexibility with which the therapist approaches the single session and their understanding of the session

as strongly adapted to the needs of the person and their situation.

Mindset in practice: a clinical case

M. presents with a problem she has had for forty-two years: she is fifty, and since the age of eight she has been pulling out her hair. She doesn't do it to excess; there appear to be no bald patches and she does not need to wear hats or other head coverings. Nevertheless she does this constantly and frequently: every day she plays with her hair and pulls out five, ten, fifteen hairs, sometimes more…

First I explore with her how the problem works. I avoid using the term "trichotillomania", since she herself does not use it. Instead, I try to understand the issue from her perspective: I ask her to describe how she does it, when, in which situations… Although this is something that has been with her uninterruptedly all her life, I don't go into the past at all, except to satisfy myself that the problem is not connected to an event she considers important in her current life. For the same reasons, I don't link the problem to any particular symbolic interpretation or family dynamic: I stay always with the here and now, how she feels today.

After this investigation I ask her what goal she would like to achieve by the end of our session: while the aim of therapy is to stop the behaviour, the aim of the session is to find a way, a strategy to start the process.

So we agree to focus on this small objective, and to this end I ask her if there have been situations in the past when she managed to stop pulling out her hair. She answers no: at certain times she might do it more, but she links this closely to poorly-defined periods of stress. I push her a little, seeking to identify possible exceptions of the problem that might be addressed systematically, but we find nothing.

Then, still with the idea of trying to find a strategy before the end of the session which will help her start the process of stopping the behaviour, I ask if there have been other habits she has given up and how this was done. M. tells me that indeed, she used to smoke, and she stopped more or less from one day to the next. I ask her to go into details, and she tells me that after years and years of smoking cigarettes, one day a friend challenged her, saying she was incapable of stopping. "I don't feel the need", she said, "but if you give up, I will too". When the friend agreed, M. found herself having to keep her word. "To start with I didn't know how to do it, but then I realised something: I didn't have to give up smoking, all I had to do was resist one cigarette. And it's easy to not smoke one cigarette!" And from that moment she stopped smoking completely.

I ask her if she could do the same: resist pulling out the first hair. She says yes, but without much conviction. So I ask her whether she was ever tempted to go back to smoking, and how she handled it. M. replies that for a short period she would suck liquorice sweets as an alternative to smoking, and I ask her whether she can do the same now. Again, she agrees, but seems unconvinced. When I ask her if this strategy might work, she agrees, but when I ask if this session will be enough, she says she'd like to book another.

We meet again three weeks later: she hasn't pulled out a single hair. I ask her if she needed the liquorice and she replies that she really doesn't know what happened: she hasn't used the liquorice, and neither has she thought about "resisting pulling out a single hair". Quite simply, she quit overnight.

I ask her if, in forty-two years, she has ever gone three weeks without pulling out her hair, and she answers no: "Not even one week".

She tells me she's happy and thinks she won't need further sessions. I'm slightly concerned that a behaviour that has lasted such a long time might recur unless we work to consolidate the results, but I keep this thought to myself, only saying that my door is open and asking her permission to contact her from time to time for research purposes, to see how she's doing.

We are in touch by email four more times: two months, five months and nine months after the second session, and then almost three years after, when I reach her for an update for this article. M. has still not pulled out a single hair, not even after her father's death, which occurred between our second and third conversations. She sometimes plays with her hair, but she no longer pulls it out.

We consider this to be an emblematic case for several reasons. Firstly because it shows that a single session was sufficient: indeed, the second visit was merely a catch-up, without reinforcement or the suggestion of further strategies. Secondly, it shows how a behaviour that has been ongoing for a very long time (forty-two years) and has never spontaneously been interrupted ("not even a single week") can cease completely and without repercussions after just one session with a therapist: this seems significant to us, partly in view of the belief that, for reasons linked to longstanding unconscious dynamics, deep-rooted cognitive and behavioural patterns or established neurological structures, change is impossible in a single session. Lastly, we wanted to illustrate a case in which even the strategic planning of the therapist (the idea of using liquorice as a substitute) was superfluous: although this does not help us understand what specifically helped

the client, it allows us to hypothesise how a person's own resources were able to make the difference, and we hope this will serve as inspiration for anyone considering a single session mindset.

Conclusions

We hope the fourteen principles discussed above will be helpful to therapists seeking to understand how to help people in a single session.

We have attempted to demonstrate how mindset - i.e. the series of beliefs that influence the therapist's actions - is fundamental in taking therapy in one direction rather than another. In fact, many writers believe that the decision not to adopt a single session model, in spite of the results and benefits the past thirty years of research have brought, is influenced by their own mindset, and, we could say, their epistemology. And even therapists who wish to adopt, or have already adopted, a SST approach can often be hampered by certain elements of their mindset: it is not uncommon to come across a therapist who, even while practising SST, believes it does not work for "personality disorders", or that it is "impossible to resolve certain problems in a single session". We now know that this at the very least contradicts the view of colleagues who prefer to avoid a nosographic interpretation of the person they are treating, or who believe their task is not necessarily to "resolve" anything by the end of the session.

More in-depth analysis of the literature, or even analysis simply carried out by a different observer, could undoubtedly provide another reading of the principles underlying the mentality of therapists who use SST in their own practice. However, we hope we have made a meaningful contribution for those wishing to adopt this effective way of helping people.

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The Effect of Depression Label on Verbal Communication

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ABSTRACT. This study examines the effect of the diagnosis of depression (depression label) on verbal communication. We set a situation in which the subject listened to another person's problem for seven minutes, who they met for the first time. The subjects were 20 women (M=21.4, SD=1.7), and the independent variables were the presence (labeled group) or absence of a "depression label" (unlabeled group), which conveyed if the person was a depression patient. The dependent variable was the subjects' verbal index (Sando, 2016). The data were analyzed using a 2×5 chi-square test. No significant difference was found in Sando's (2016) classification (χ^2 (4) = 4.134, n.s.). Therefore, we classify and reanalyze the utterances including those in the "Other" category, as defined by Sando (2016). Results showed that the "labeled group" was less used to "Compliment" than the "unlabeled group" (χ^2 (3) = 12.887, p<.05). These findings indicate the risk that depressed person with depression label are rejected more by others than depressed person without depression label in non-continuous relationship, such as first meeting. We further discuss the effects of the depression label and related issues.

KEY WORDS : depression, label, diagnosis, verbal communication

Introduction

According to a report by the National Institute of Mental Health (NIMH, 2017), an estimated 17.3 million people, or 7.1% of all adults in the U.S., have experienced at least one episode of major depression. The number of depressed patients and patients diagnosed with depression tends to only increase (Ministry of Health, Labor and Welfare, 2017). Depression affects patients as well as the people around them; it becomes more serious in interpersonal relationships (Sugiyama, 2002 ; Joiner et al., 1992 ; 1993).

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Research on the interaction between a depressed person and others

Research related to the interaction between depressed people and others has been previously conducted, such as assessing subjective psychological distress and depression in a depressed person's spouse, family members, children, roommates, and others (Benazon, 1998; Coyne et al., 1987; Coyne, Burchill & Stiles, 1990; Howes et al., 1985; Joiner, 1994; Joiner, Alfano & Metalsky, 1992; Katz, Beach & Joiner, 1998; Sato, 2006; Takeshima & Matsumi, 2013), studies on verbal communication between depressed people and others (Benazon, 1998 ; Coyne et al., 1987 ; Coyne, Burchill & Stiles, 1990 ; Howes et al., 1985 ; Joiner, 1994 ;

Joiner & Metalsky, 1995 ; Joiner, Alfano & Metalsky, 1992 ; Katz, Beach & Joiner, 1998 ; Sato, 2006 ; Takeshima & Matsumi, 2013), studies on verbal and non-verbal communication between others and depressed people (Sando, 2016 ; Kamoshida et al., 2021) can be broadly classified.

Coyne et al. (1987) indicated that about 40% of people who had depressed spouses had psychological distress that required psychotherapeutic intervention. Howes et al. (1985) indicated that people who spent three months with a depressed roommate showed higher depression scores than the control group. Takeshima and Matsumi (2013) examined the interactions between students and their peers. A previous study suggested that depression suppresses the anger and aggressive behavior of others. Hence, to elucidate such negative effects from the perspective of communication, interactions between others and people in depression have been examined. Recent studies on communication between depressed persons diagnosed with depression and others who interact with them (Sando, 2016 ; Kamoshida et al., 2021) have also been previously conducted.

Research on the interaction between a person who has been diagnosed with depression (depression label) and others

In a study on the interaction with accordance to the diagnosis of depression (depression label), Sando (2016) conducted a questionnaire experiment using the assumption method on the influence of depression label on the verbal responses of others in lasting relationships. Sando's (2016) hypothetical method was to set up a situation in which the subject talked about a problem of a depressed friend. The participants' advice was divided into six categories. Specifically, "Criticism" which expresses negative emotions such as blame and anger, "Coping" which suggests overcoming mechanisms with little evidence, "Optimism" is simply a positive counteracting statement, "Involvement" which tells the depressed person that subject will be involved in solving the problem, "Mix" and "Others". The subjects who interacted with depressed friends with a depression label, were on a higher rejection cognition but stated "Involvement" and suppressed "Optimism," contrasting their behavior towards the unlabeled. Haley (1963) describes illness (symptoms) as a paradoxical communication. Specifically, a person with symptoms blames the illness for their behavior, even though it is the subject who is responsible for their behavior. In other words, the presence of a disease (symptom) label makes it impossible to blame the behavior that is controlled by symptoms. Sando (2016) also mentions that when a friend has a depression label, others are constrained to make supportive self-involvement statements rather than direct negative statements to the depressed person.

Kamoshida et al. (2021) experimented to examine the effects of depression label on the verbal and non-verbal behaviors of others. It sets a situation in which the depressed person was listened to by a subject who they met for the first time in a non-continuous relationship. This experiment focused on the direction in which the

subject was trying to develop a conversation in response to the content of the consultation. In addition, the utterances were categorized based on brief therapy, such as "Reframing," "Do something different" and "Do more." The results show that subjects who listened to people with depression label used the answer "Do more", such as conveyed rest more, compared to subjects who listened to unlabeled people. Besides, this experiment focused on the Japanese ending of the word "Ne" (Watanabe & Wakashima, 1998), which is used relatively unintentionally among linguistic aspects to encourage more involvement in the conversation. The number of participants who listened to a depressed person was lower than those for a person who was not depressed. There was no difference in non-verbal communication, such as silent time, gaze time, or number of smiles. Sando (2016) examines the effect of depression label in lasting relationship. however, there are many situations in which people were exposed to a depression label in non-continuous relationships, such as first meeting. Therefore, we presume that the depression label may have affected communication during the first meeting. However, although Kamoshida et al. (2021) conducted an experiment assuming the effect of depression label on the relationship at the first meeting, they analyzed the results from different variables than Sando (2016) did. Hence, we cannot compare Sando (2016) and Kamoshida et al. (2021).

Here, we report the response statements of the subjects in Kamoshida et al. (2021), which overcomes these limitations. The experiment of Kamoshida et al. (2021) set a situation in which a depressed person met the subject for the first time and listened to their worries about their study. The effect of the presence or absence of a depression label on the participant's response statements (Sando, 2016) was examined.

Sando (2016) mentioned that when the subject talked to a depressed person with a label, the subject was constrained to make supportive self-involving statements, instead of direct negative comments. Therefore, we hypothesize that we can obtain the same results as Sando (2016), even in the first meeting. Specifically, the others who talked to depressed persons with depression label (Labeled group) will make supportive statements classified as "Involvement" statements and will make fewer "Optimism" statements than those who talked to the unlabeled depressed persons (Unlabeled group).

Hypothesis: The labeled group has significantly more "Involvement" statements and significantly fewer "Optimism" statements than the unlabeled group.

Method

Survey period

June 2019 - December 2019

Subjects

We analyzed 20 females, (M = 21.4 years, SD = 1.7), excluding the 2 those who responded "I don't believe the depression label" in the operation check sheet.

An application was distributed among university students. The subjects were recruited from university classes and snowball sampling

was conducted. Subjects were recruited on the condition that they were of the same sex as the consultant. The subjects were asked to participate in the experiment after being informed that they might be required to talk to a highly depressed person for seven minutes, their privacy would be protected, and they were being recorded on a videotape. 10 subjects were randomly assigned to each group (Labeled group: M = 21.5 years, SD = 1.7; Unlabeled group: M = 21.3 years, SD = 1.6).

Procedure

Depression label

In the labeled group, we said, "The person who is going to talk is a sophomore female student attending graduate school, who has been diagnosed with depression. However, based on her current physical condition, we have determined that she will be able to cooperate with the survey. Please be assured that the experiment is safe and secure. We have told her to tell us as much as she can about what is troubling her. There are no restrictions on communication; please feel free to respond."

The unlabeled group said, "The person who is going to talk is an ordinally sophomore female student attending graduate school. We have told her to talk about her current problems to the extent that she can. There are no restrictions on communication; please feel free to respond".

Contents of consultation

We prepared the content of the consultation on depressive communication with three graduate students engaged in psychology. We prepared "a consultation about being physically and mentally exhausted and not being able to finish the paper in time for the deadline" referring to studies describing the characteristics of depressed people (Beck, 1967; Joiner & Metalsky, 1995; Holmes, Hagan & Joiner, 2013; AI-Mosaiwi & Johnstone, 2018). The woman who was prepared as an experimental collaborator was trained to provide a depressive response to the consultation. In the depressive response, the depressed person asked others for reassurance repeatedly, represented by "reassurance-seeking," and used "but" to cancel out the opinions of the subject to express "negative evaluation seeking," in which the depressed person rejects others' affirmation while seeking reassurance. They also unified to use the self-attributive denial (Beck, 1967) for negative events such as "I am bad" and linguistic features such as "I am" and "absolutely" (AI-Mosaiwi & Johnstone, 2018). In addition, about three hours of training were conducted (conducted in March and June 2019) to lower the gaze, nod or respond less, and speak slowly (Holmes, Hagan & Joiner, 2013) as non-verbal behaviors. Based on the above, a consultation was conducted.

Experimental procedure

The experiment was conducted in a behavioral laboratory with one-way mirrors at a university. The experimenter was presented in an observation room across a one-way mirror. The subject sat in a chair in the behavioral laboratory, and the experiment was recorded on a videotape.

We set up a situation in which the subject listened to a problem from a person who they met for the first time, for seven minutes. The

duration of seven minutes was set in consideration that the effect of depression label could be examined and that it would not be a burden to the subjects. All experiments were conducted in a behavioral laboratory. All subjects were asked to explain the study, fill out a consent form, complete the Japanese version of the Zung Self-Reported Depression Scale (SDS) (Zung, 1965), a depression screening instrument to control the degree of depression of the subjects, exclude highly depressed subjects from the analysis, and the Multiple Mood Scale, Short Version (MMSS) (Terasaki, Koga, & Kishimoto, 1991). Next, the label was given, and the subject was asked to "place the chair on the wall where he/she wanted it and decide where to sit. At the end of seven min, the experimenter moved back to the laboratory, stopped the video recording, and terminated communication. The subjects were asked to move to another room, and then they were asked to complete the short version of the MMSS again. Finally, as a debriefing, an explanation of the experiment and a operation check were conducted. In the operation check, the participants were evaluated for the credibility of their perception of the actual consultation. Subsequently, the experiment was terminated.

Ethical considerations

The Tohoku University Graduate School of Education's Ethics Committee granted ethical approval for this study (ID: 19-2-005).

Scales

(1 Zung Self-Reported Depression Scale (SDS) (Zung, 1965)

The SDS (Zung, 1965) was used as a screening scale for depression before the experiment, and as in Coyne (1976), it was decided not to conduct the experiment on subjects with high depression who scored more than 55 points.

(2)Multiple Mood Scale, Short Version (MMSS) (Terasaki et al., 1991)

In this study, participants were asked to rate their current mood state using a four-point scale of "not at all (1 point)," to "clearly (4 points)" in relation to eight factors related to emotional states: "Anxious," Hostile, "Polite," and "Loving". It was used to examine the effects on mood before and after the experiment (i.e., before and after teaching and communication). This was not used in the analysis because it did not correspond to the purpose of this study.

(3)Operation check sheet

We asked the participants to indicate whether they believed the labels they were taught and whether they were aware that they were in a real consultation situation and were not acting.

Procedures for analyzing speech content

Data for linguistic analysis

The data analysis was conducted for seven minutes after the speaker began to talk about her problems.

Coding and analysis of verbal communication

First, we created a protocol for the seven minutes of conversation data to be analyzed. Next, the data dividing into unit of speech based on Ito's (1991) definition of sentence. When the same person speaks continuously, a silence of one second or more is considered a break. The kappa coefficient was calculated between the two raters for the classification of speech units,

and the agreement was high, k=0.874. Next, the response utterances of the subjects were classified based on the utterance categories of Sando (2016). The response utterances were categorized into six categories : ①Blame, ② Coping, ③ Optimism, ④ Involvement, ⑤ Mix, ⑥Other (Table1).

Next, we selected one of the conversational data, calculated the kappa coefficient between the raters, two graduate students who were licensed clinical psychologists and specialized in communication, and found a low agreement rate of k=0.579; therefore, the raters discussed and recorded the data. When the kappa coefficient was calculated using the same procedure, the agreement rate was as high as k=0.838; therefore, the grading was performed by one experimenter. The following are some examples of utterances that caused disagreement among the raters (Table2).

Table 1. Utterances categories (Sando, 2016, p. 59, Table3-1)

Blame	Subject expresses negative emotions, such as blame, anger, and so on, in response to the depressed person's negative comments. Or they are making negative evaluations. Ex) "You're overreacting", "Then, you should die"
Coping	A sudden offer of a coping strategy that has little evidence or is optimistic. Ex) "You shouldn't die", "You should make up with friend"
Optimism	A statement that simply counteracts a depressed person's negative statement with a positive one. Ex) "You can make it up", "That's not true, you'll be fine"
Involvement	In response to the depressed person's negative comments, Subjects states that subject will be involved in solving the problem. Ex) "I'll talk to you about it if it's okey with you" "Let's figure out a way to make up together"
Mix	One that contains more than one (2 or more) of the above categories. Ex) "Don't think about dying. Don't worry, we'll make up." "That's not true, Mr. A wants to make up with you too"
Other	Anything that did not categorise of the above categories Ex) "Why did you fight?", "Oh my god"

To remove as many communicative characteristics of each subject as possible, out of the total number of utterances (N=1301), the ones excluding exclamations such as “um,” “ah,” and “yes” and those corresponding to fact-checking (N=707) were used for the analysis (N=295). In addition, since none of the utterances in this study corresponded to “Blame” (N=0), they were not used in the analysis.

IBM SPSS Statistics 27 was used for statistical analysis.

Table 2. Example of Utterances that was discussed

L8-61	But no one can do everything perfectly, so if you can't plan it out, don't be upset.
L8-62	One time, I guess, in my own way.
L8-63	If you can do one of them, I don't think anyone can do it perfectly right away.
L8-64	Let's just start with what we can do first.
L8-65	I think it can be a feeling.

Data analysis

IBM SPSS Statistics 27 was used for statistical analysis. First, we confirmed the participants’ depressive state bias. A t-test was conducted. The independent variables were the label and unlabeled groups. The dependent variable was the SDS score. Next, a 2×5 chi-square test (test of differences in proportions) was conducted. The independent variables were the label and unlabeled groups. The dependent variable was the subject's statements classified according to the categories of Sando (2016).

Results

Confirmatory analysis of bias in SDS scores

A t-test was conducted. The results showed no significant bias (t(1, 18)=0.842, $n.s.$). Hence, the following subjects were used for analysis in this study.

Classification of response statements to depressive person.

A 2×5 chi-square test (test of differences in proportions) was conducted (Table3). The results showed no significant bias ($\chi^2(4)=4.134$, *n.s.*). Mixes ($N=4$) like coping with optimism, and so on, were combined with others.

Table 3. 2×5 chi-square test

	Labeled ($N=264$)	Unlabeled ($N=330$)	Total ($N=594$)
Coping	46(17.4%)	68(20.6%)	114
Optimism	4(1.5%)	3(0.9%)	7
Involvement	82(31.1%)	87(26.4%)	169
Mix	3(1.1%)	1(0.3%)	4
Other	129(48.9%)	171(51.8%)	300

Labeled=the group with depression label
Unlabeled=the group without depression label

Microscopic classification of "other" (Sando, 2016) responses.

The contents of the "Other" responses ($N=295$) obtained in this study were classified using the KJ method (Kawakita, 1967). To eliminate arbitrariness, two graduate students who were licensed clinical psychologists and specialized in communication classified all the conversation data, and we tried to make the basis of the classification as clear as possible. As a result, three categories were obtained: "Empathy", "Compliment", "Self-disclosure", and "Mix".Table4 shows the characteristics of each category as the basis for the extracted classification.

Next, we conducted a 2×4 chi-square test (test of differences in proportions). The independent variables were the label and unlabeled group. The dependent variable was the utterances of "Other" statements classified by the KJ method (Table4).

Table 4. Utterances categories of "Others"

Empathy	Something that is emotionally close to you. Ex) "Well, it's hard when there are 30 people, isn't it?" "It's difficult "It makes you feel incredibly anxious when you don't have something concrete to settle on"
Compliment	Something that praises or shows affirmation. Ex) "I think it's great" "It occurred to me that it's also very kind of you to feel sorry for it."
Self disclosure	Anything that discloses events from the subject's own past. Ex) "I'm an economics major." "There was a time when I was having a lot of trouble with my club activities, and at that time..."
Mix	One that contains more than one (2 or more) of the above categories. Ex) "I think it's hard to read books, isn't it? I have a graduation thesis to write, too."

The results showed a significant bias ($\chi^2(3)=12.887$, $p<.05$), and the labeled group used "Compliment" fewer times than the unlabeled group ($p<.01$) (Table5).

Table 5. 2×4 chi-square test

	Labeled ($N=129$)	Unlabeled ($N=171$)	Total ($N=300$)
Empathy	26(20.2%)	21(12.3%)	47
Compliment**	23(17.8%)	55(32.2%)	78
Self disclosure	76(58.9%)	94(55.0%)	170
Mix	4(3.1%)	1(0.6%)	5

*$p<.05$, **$p<.01$, ***$p<.001$
Labeled=the group with depression label
Unlabeled=the group without depression label

Discussion

The purpose of this study was to examine the effect of the presence or absence of depression label on first meeting others on the subject's response utterances (Sando, 2016).

There was no difference in response utterances (Sando, 2016), between the labeled and unlabeled group. Therefore, this hypothesis

is not supported.

The reasons why the hypothesis was not supported, unlike Sando (2016), were that the relationship in this study was the first meeting, and the study used face-to-face communication. In contrast to the questionnaire survey, it is assumed to involve more subtle communication than that defined by Sando (2016). Face-to-face communication may have occurred while observing others and developing the topic through interaction. Therefore, it can be said that the content of the utterances in this study was relatively more categorized as "Other," and it was expected to be examined microscopically. In addition, Sando (2016) examined communication in lasting relationships, but this study did not examine in non-continuous relationships. Therefore, no significant in non-continuous relationship.

In this study, many utterances were categorized as "Other". Thus, we reanalyzed the content of the responses classified as "Other" in Sando(2016). We reclassified the data using the KJ method (Kawakita, 1967). It was classified into four categories: "Empathy," "Compliment," "Self-disclosure," and "Mix". The results showed that the ratio of the four categories was examined with and without depression label, and the labeled group showed fewer "Compliment" statements.

This contrasts with the results of Sando (2016). In Sando (2016), when there was depression label on others in lasting relationship, the response was supportive speech included in "Involvement" statements. However, in this study, depression label others in a non-continuous relationship, and the response refrained from compliment. Therefore, this was avoided.

Two aspects of this result can be suggested.

First, the subjects did not convey compliment statements because they did not have a positive impression of others with depression label, which is a direct inference. For example, Yoshioka and Misawa (2012), who examined causal attributions of mental illness on social distance, showed that evaluating depression as dangerous increased social distancing. In communication, Howes and Hokanson (1979) and Gotlib and Robinson (1982) have shown that others use silence and direct negative expressions toward the depressed persons they meet for the first time without depression label. Thus, it can be seen that depression and depressive disorders are, in general, relatively easy to be evaluated negatively.

On the other hand, Haley (1963) states that others cannot reject the behavior of a person with a disease (symptom). Sando (2016) found that people with depression label were not communicate rejection even though they had rejection perceptions. Therefore, the results of Sando (2016) can be interpreted in the same way as those of Haley (1963). However, in this study, the results showed that the participants were able to show avoidance. In other words, the restraint of others, which is the inability to reject the actions of those with depression label, seems to be demonstrated only when the relationship continues. Thus, it is possible that in the present study, the others were able to show avoidance despite the accompanying depression label.

Second, subjects might have been fearful of maintaining the relationship or worsening the symptoms when they conveyed compliments to a person with depression label. Namiki et al. (2015) found that managers felt “unsure of how to treat” and “confused about how to treat” those who returned to work after depression. It is possible that the situation of “not knowing how to treat them” was reproduced in this study, and that the respondents' compliments were suppressed because they considered “what to say to them.

Additionally, the effect of the suppression of compliments on the interpersonal system was considered. Brown and Levinson (1978) and Takiura (2008) explain politeness theory, which is a basic stance in interpersonal relationships and a means of communicating the distance between the other person and oneself. In politeness theory, speech strategies are used to minimize face-threatening acts (FTA), which indicate the desire for dialogue between two people. Among these, negative politeness strategies (NPS) and positive politeness strategies (PPS) have been proposed. PPS is used when the speaker evaluates others as having a relatively high desire for proximity and when the speaker attempts to approach others. Meanwhile, NPS is used when others adjust to engage in social distancing. In particular, compliments are classified as PPS and are used when the speaker evaluates the interaction of others as having a desire for proximity in the relationship or when the other's FTA is estimated to be relatively small. It is said to be characterized by the empathy of the expression, which is to shorten the distance with the other person and to directly touch the matter with the other person, and it is also said to be politeness of “sympathy” or “solidarity.” Therefore, it can be assumed that in the unlabeled group, subjects were told that they were listening to an “ordinary graduate student,” had a relatively smaller FTA than the labeled group, even though the content of their consultations was similar, and that they were evaluated to be at a lower risk of becoming distant. In other words, depression label may have caused the subjects to evaluate the content of the others as lacking proximity needs, and to suppress verbal expressions such as “Compliment”. Kamoshida et al. (2021) found that when depression label was not attached, the ending particle “Ne,” which encourages conversation, varied depending on the attitude of the others, but when depression label was attached, there was no variation in the way the subjects interacted with the ending particle “Ne,” even if the attitude of the others changed. Therefore, based on the results of Kamoshida et al. (2021), depression label in a first-meeting relationship may cause a sense of social distance between the subjects and others.

Finally, we discuss the impact of this study’s results on others with depression in actual clinical situations. We believe that the suppression of compliments in others’ interactions with depression label will reduce the sense of acceptance of patients with depression. Sugiyama (2002) defined “perceived-being-accepted” as the perception and emotion that one feels about the existence of others who support one, and that one is valued and supported by

others with a certain level of understanding, warmth, and approval. He proposed a model in which depressed people have low perceived acceptance towards themselves, leading to depression mediated by negative mood tendencies and negative self-evaluation. In addition, depressed people and patients are said to be in a complicated state of mind. Specifically, they feel abandoned by others, they cannot be together comfortably (Roberts et al., 1996), and they cannot be satisfied by others' satisfaction (Joiner et al., 1992; 1993). Therefore, it can be inferred that depression label suppress direct compliments to patients with depression from others, which may lead to a decrease in the depressed person's sense of acceptance and positive self-evaluation. As a model of interpersonal communication between a depressed person and others, there is the "cycle of depression" (Joiner & Schmit, 1998), in which the depressed person confirms excessive affection for significant others, only to be rejected by significant others and maintain depression (Joiner & Schmit, 1998). In addition, the interaction model of depression (Coyne, 1976), in which the depressed persons' depression is maintained when significant others become verbally supportive but nonverbally rejective. In addition to these models, this study's findings indicate the risk that persons with depression label are more likely to be rejected by others than depressed persons without depression label in a non-continuous relationship. Thus, we can speculate that in this kind of relationship, subjects may reinforce the depression of the depressed person through criticism. However, how this affects a depressed person is still unclear. Therefore, it is necessary to examine the effects of not using "Compliment" as a way of interacting with a depressed person in non-continuous relationship, such as the first meeting.

One of the challenges of this study is that it used a between-subject design. Thus, the communication style of each participant was not controlled. In the future, it will be necessary to examine the effect of label after controlling for the communication styles of the subjects through a within-subject design.

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Development of the Risk Assessment Scale for Ijiri: A Study on Reliability and Validity -

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ABSTRACT. Ijiri is one of the collective games using communication among peers, and is an act that annoys the target without any intention to hurt the actor's side. Because Ijiri is an in-group play, it has norms that constrain the target to respond compliantly, and the risk that the acdtor will continue to attack the target unintentionally. The purpose of this study was to develop a tool to measure ijiri risk and to examine its reliability and validity. Ijiri risk was measured from the following two parts: part A) invasiveness to the target, and Part B) cognitions related to action supression of the target. A web-based questionnaire survey was administered to 913 participants (327 males, 583 females, and 3 others; mean age = 29.25 years). As a result of exploratory factor analysis, two factors were extracted for Part A and four factors for Part B. The results of the confirmatory factor analysis showed that the goodness-of-fit indices for the Part A and Part B factor structure models were adequate. The results of the reliability analysis showed that the alpha coefficients for each factor were sufficient, confirming their reliability. The following two hypotheses were examined for criterion-related validity: 1)The higher the Part A - Invasiveness scale, the higher the scores for the stress cognitive scores and the stress response scores, 2)The higher the score on Part B - Action suppression scale, the higher compliant reactive behavior scores. The results of the correlation analysis supported the two hypotheses and demonstrated the validity of this scale.

KEY WORDS: ijiri, assessment tool, reliability, validity

Introduction

As social beings, it is always an important concern for us to position ourselves in a group and to build coexisting relationships with others. As social trends that respect diversity take shape, we are expected to live in harmony with others who differ in diverse aspects such as values, characteristics, and culture at work and at school. In this context, communication strategies to avoid the occurrence of conflicts are becoming increasingly important. Ijiri is one such example.

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1. What is Ijiri?

Ijiri is one of the collective games using communication among peers, and is an act that annoys the target without any intention to hurt the actor's side (Sakamoto, 2021). For example, it is communication that targets one person in a group of friends and plays at making that person a laughingstock, a collaborative effort to create humor in the group (Honda, 2011; Doi, 2008; Mochizuki, 2017). Humor is a whole series of processes: 1) the social context that presupposes the occurrence of humor, 2) the occurrence and perception of incompatibility between an event and its context, 3) the emotional response to the incompatibility, and 4) the vocal and behavioral expression of laughter (Martin, 2007). There are

three main types of humorous behavior: 1) "Joke," which is a complete story with a preamble and a punchline, 2) "Accidental," which is an unintentional misstatement or misuse of language, and 3) "humor that occurs naturally in conversation" (Martin, 2007). Ijiri is included in "humor that occurs naturally in conversation.

There are various types of humor that naturally occur in conversation, among which ijiri is considered to be one of the "teasing" types (Long & Graesser, 1988; Sakamoto, 2017). Teasing is an act that simultaneously contains of two messages: provocative and playful (Maki, 2008). Provocativeness is a message intended to annoy the target and elicit further responses, and often takes an aggressive form (Maki, 2008). In addition, playfulness is a message intended to imply that the behavior may not be a true provocation or aggression, and is expressed through nonverbal messages such as smiles and gestures (Maki, 2008). Sakamoto (2017) qualitatively analyzed the message structure of ijiri and showed that teasing, like teasing, contains messages of provocation and playfulness, making ijiri one form of teasing.

So what are the conditions that distinguish ijiri from teasing? It can be said that there is a difference in the communication mode in which they are used. Communication mode is a labeling for communication that indicates what each act is done as (Bateson, 1972). Communication modes include "play," "non-play," "fantasy," "sacrament", and "metaphor" . Teasing is used in more modes compared to ijiri (Keltner et al, 1998; Terrion & Ashforth, 2002). For example, teasing can be used as an expression of "intimacy" by inverting the meaning of the two conflicting messages (Terrion & Ashforth, 2002). This is based on the mode of "play" because it is used to indicate a meaning that is inverted from what the provocative act literally means. Second, teasing is also used to convey blame or frustration and to induce behavior modification while avoiding offending the target (Keltner et al, 1998). Rather than inverting the sense of blame or frustration that the provocative message represents, the playful message is used to reduce its severity while maintaining the same direction. Thus, it is based on the "non-play" mode. In fact, it has been demonstrated that the reactive behavior of receivers differs between teasing for intimacy in the "play" mode and teasing for influence in the "non-play" mode. (Keltner et al, 1998). In other words, the differences in communication modes indicate that teasing is perceived as having an entirely different meaning. Thus, teasing is used in multiple modes, such as "play" and "non-play.

On the other hand, ijiri is a communication behavior used only in the "play" mode. Ijiri is a collaborative process for creating enjoyable communication within a group, and is used as a communication strategy for avoiding in-group conflict for recent youth with a friendship style that prioritizes conflict avoidance (Okada, 2007a; Doi, 2008; Mukai, 2010). Thus, in situations where ijiri takes place, there is a peer pressure to invert the meaning of the provocation into an expression of intimacy based on the mode of "play". In fact, the

rejection or aversion to ijiri as "non-play" is a violation of peer pressure and a trigger for in-group exclusion (Moriguchi, 2007; Doi, 2008; Mukai, 2010; Nakano, 2018; Koiwa, Komatsu, & Wakashima, 2020). Even when the actor has malicious intent and truly intends to harm the target, the actor skillfully manipulates the way the message is presented to "disguise" the mode of communication as if it were a "play. " (Kimura, 2017). Disguise is a situation in which a participant in one situation manipulates the communication mode perceived by other participants and acquires a different definition of the situation themselves (Goffman, 1974). In other words, ijiri is designed and executed based on the mode of "play" regardless of the intention of the actor.

The characteristics of ijiri can be summarized in the following three points: 1) it is performed as a play within a group, 2) the provocative behavior elicits reactive behavior by making the receiver feel troubled, and 3) it is designed to be received as a meaning that inverts the meaning originally indicated by the provocative behavior. This is also defined in this study in order to focus on the subjective experience of being target of ijiri. Based on the above three characteristics, this study defined the experience of being target of ijiri as comform to the following three conditions: 1) you perceived it as social playing within a peer group, 2) you perceived that the actor had no malicious intent to hurt you, and 3) you were troubled by the ijiri to varying degrees.

2. Ijiri's positive and negative functions

Ijiri is used on a daily basis among contemporary Japanese youth and has a variety of effects on individuals and groups. Prior studies have shown the positive and negative functions of ijiri. First, one of the positive functions of ijiri is in-group conflict avoidance functions (Okada, 2007; Doi, 2008; Mukai, 2010). In Japan, since the 1980s, a social trend has been formed to respect diversity rather than uniformity, and people are expected to accept and coexist with others who differ from them in various aspects such as personality, characteristics, and cultural backgrounds (Doi, 2008). Since differences with others can trigger conflicts within a group, it is said that modern adolescents connect with others through superficial and enjoyrable interactions, and by focusing on these interactions, they divert attention from the differences between themselves and others and avoid the manifestation of conflicts (Okada, 2007; Doi, 2008; Mukai, 2010). As we have seen, ijiri is a form of in-group play that creates enjoyable interactions and helps to avoid in-group conflict (Doi, 2008). As a result, smooth symbiotic relationships with others are established through ijiri, and ultimately participants in ijiri enjoy a sense of self-affirmation and group belonging (Mukai, 2010). Thus, ijiri is an important aspect of the interpersonal foundation for Japanese youth.

On the other hand, the negative function of ijiri has also been shown. First, even if there is no intention to hurt the actorside and a message of playfulness is shown, ijiri may function as a provocation or attack and hurt target(Doi, 2008;

Mukai, 2010; Honda, 2011; Sakamoto, 2017). In humorous behaviors such as ijiri and teasing, where two contradictory messages, provocative and playful, are presented simultaneously, there is always an "ambiguity" in the message (Maki, 2008). The "ambiguity" is the characteristic that when conflicting messages, such as provocativeness and playfulness, are presented simultaneously, the message can be interpreted in multiple ways, either provocatively or playfully (Shapiro et al, 1991). That is, there is always a possibility that ijiri will be interpreted as provocative or aggressive behavior by the receiver, regardless of the actor's intentions or the way the message is presented (Bateson, 1972; Shapiro et al, 1991; Martin, 2007; Maki, 2008). In fact, there have been several reported cases where ijiri has harmed target and caused serious consequences. For example, Nakano (2018), who investigated workplace ijiri, presents a case in which a subordinate felt so much emotional distress from his boss's ijiri that he had suicidal ideation. Also in Japan, a second-year high school boy committed suicide in Yamaguchi Prefecture in 2016, suffering from repeated ijiri (Kadowaki, 2019). Since ijiri is performed as a "play" within a group, it does not appear to be a problem from a third-party perspective. However, ijiri that functions as a provocation or aggression and cause mental distress to target is a serious problem and urgently needs to be addressed.

Second, because ijiri is a "play" within the group, it has the function of bind target to behave according to the mode of "play". This makes it difficult for target to reject ijiri or to openly express their displeasure or anger (Moriguchi, 2007; Mukai, 2010). Bind is a function of language that does not uniquely determine the response of the receiver of a message, but limits the range of choice (Hasegawa, 1991). In fact, Moriguchi (2007) shows that target may be hurt by ijiri but continue to react compliantly without expressing it. Communication is mutually bind, the reactive behavior of the target influences the next actor's choice of action, and the exchange between actor and target unfolds as a single system (National Foundation of Brief Therapy, 2016). In other words, the target's compliant response based on the mode of "play" may induce further ijiri by the actor, and there is a risk of escalating ijiri. In addition, target's compliant reactive behavior is one of the factors that may cause some third parties to belittle the seriousness of the problem. Assessment is necessary because the suppression of open expressive behavior by the target increases the risk of ijiri.

3. Necessity to develop assessment tools

Ijiri is a communication behavior that carries significant risk, and it is important to assess its risk factors. However, target's mental distress and cognitions related to action suppression are internal and unobservable by others. Therefore, it is considered necessary to develop a self-administered questionnaire as a tool to measure these factors. Tools for assessing risk factors for ijiri have not yet been developed. The purpose of this study was to develop and examine the reliability and validity of a scale

measuring two aspects of ijiri's target: 1) mental distress and 2) cognitions related to action suppression.

In order to measure two risk factors related to ijiri in this study, the scale consists of the following two parts: 1) Part A Invasiveness Scale, which measures mental distress for target, and 2) Part B Action suppression scale, which measures cognition related to behavioral inhibition for target. The mental distress target measured in Part A can be caused by any humorous behavior that includes messages of provocativeness and playfulness. Thus, the Part A scale is not limited to ijiri, but is positioned as a scale that can measure psychological distress for all humorous behaviors such as teasing and sarcasm. On the other hand, the cognition related to the behavioral inhibition of target, which is measured in Part B, only occurs when target is bound to the mode of "play," which is unique to ijiri. Therefore, the Part B scale is positioned as a scale that can be used only for the phenomenon of ijiri.

The mental invasion of target caused by ijiri is considered to be related to the concept of stress. Mental invasiveness is the impairment or burden on the mind caused by some other person's intervention (Kikuchi, 2004; Okuyama et al., 2016). Stress also refers to a series of processes in which internal equilibrium is disrupted by a stressor from the external environment, leading to a stress response (Selye, 1936; Niina et al., 1990). In other words, there is conceptual agreement between the concepts of mental invasion and stress in that internal equilibrium is disrupted by external factors. From the above, it is predicted that the invasiveness of target by ijiri, stress perception and stress response to ijiri be positively correlated. In addition, the cognition related to behavioral inhibition of target is considered to be related to the reactive behavior to ijiri. In the playful situation of ijiri, the target is requested to accept the ijiri, respond back in an amusing manner, and play a role in enlivening the situation (Doi, 2008). In light of this, it is expected that cognitions related to behavioral inhibition of target will be positively correlated with compliant reactive behavior toward ijiri. Based on the above, the two hypotheses in this study are as follows

1. The higher the Part A - Invasiveness scale, the higher the scores for the stress cognitive scores and the stress response scores.

2. The higher the score on Part B - Action suppression scale, the higher compliant reactive behavior scores.

Method

Survey period

The survey was conducted in August 2020.

Participants

Table1 Basic characteristics of participants and ijiri episodes (1/3)

	N	%
Age		
≦20s	67	7.34
21~25	131	14.35
26~30	273	29.90
31~35	442	48.41
Sex		
Male	327	35.82
Female	583	63.86
Others	3	0.33
Relationship with the actor		
Younger generation / subordinate	12	1.31
Same grade students / colleague	714	78.20
Seniors / Supervisors	167	18.29
Family	7	0.77
Others	13	1.42
Topics of Ijiri (multiple responses: *N*=1940)		
Physical characteristics	478	52.35
Favorite thing	86	9.42
Name	139	15.22
Age	19	2.08
Past happening	208	22.78
Love Experience	133	14.57
Failures	212	23.22
Quirks	190	20.81
Fashion	97	10.62
Occasional action	315	34.50
None of the subject	30	3.29
Others	33	3.61
Ways of Ijiri (multiple responses: *N*=2025)		
Directly mentioned	640	70.10
Indirectly mentioned	149	16.32
Spread around	241	26.40
Given a nickname	304	33.30
Blamed	66	7.23
Exaggerated imitation	221	24.21
Ignored	64	7.01
Reacted in an unusual way that would not normally be taken in that situation	26	2.85
Apathetic reaction	37	4.05
Praised like a joke	113	12.38
Be pranked	39	4.27
Unreasonable request	114	12.49
Others	11	1.20

We included 913 participants (327 males, 583 females, and 3 others). Participants ages ranged from 18 to 35 years (mean age = 29.25 years, SD = 4.72 years). The characteristics of the Participants and the episodes are shown in Table 1, Table2, and Table3.

Procedure

We conducted a questionnaire survey using a crowdsourcing service. An explanation of the

Table2 Basic characteristics of participants and ijiri episodes (2/3)

	N	%
Ijiri episode start period		
Before entering elementary school	17	1.86
1st to 3rd grade elementary school	133	14.57
4th to 6thrd grade elementary school	219	23.99
Junior high school students	258	28.26
High school students	112	12.27
Universities, Graduate Schools, Vocational Schools	77	8.43
After employment	97	10.62
The Situation of Ijiri (multiple responses: *N*=1079)		
Situation where only actor and target are present	219	23.99
Surrounded by acquaintances	763	83.57
Surrounded by strangers	97	10.62
Reactions of surrounding people (multiple responses: *N*=1167)		
Pretending not to see something	225	24.64
Watching enjoyably from the sidelines	469	51.37
Further encouraged Ijiri	111	12.16
Tried to stop Ijiri	33	3.61
Pay no attention	237	25.96
No bystanders	81	8.87
Others	11	1.20
Emotions toward Ijiri (multiple responses: *N*=2185)		
Anger	280	30.67
Aversion	328	35.93
Fear	90	9.86
Sadness	272	29.79
Joy	31	3.40
Surprise	60	6.57
Confusion	291	31.87
Proudness	6	0.66
Embarrassment	457	50.05
Guilt	20	2.19
Enjoyment	168	18.40
Boredom	148	16.21
Other	34	3.72
Have Chara or not		
Have no Chara	672	73.60
Have Chara	241	26.40

study and informed consent were provided on the first webpage of the questionnaire. The page was designed such that respondents could only proceed to the response page after checking the "I agree to participate in the survey" box.

Ethical consideration

The survey was anonymous. The following information was provided on the questionnaire cover page to ensure informed consent and consideration of invasiveness: "Responses are voluntary and can be refused or interrupted. The refusal or interruption of responses will not cause any disadvantage to the survey cooperator.

Table3 Basic characteristics of participants and ijiri episodes (3/3)

	M	*SD*
Degree of friendship	3.61	0.55
Amount of conversation	3.07	1.18
Frequency of revenge	2.19	0.87
Number of actors	2.76	1.03
Degree of attention of bystanders	2.75	1.42
Frequency of Ijiri	2.22	0.982

Responses will be processed statistically and individuals will not be identified. Survey results will not be used for any purpose other than research purposes. A clinical psychologist will be available if the respondent wishes to consult with someone as a result of the survey." In addition, we stated at the top of each screen of the questionnaire that participants could immediately stop answering if they felt sick or wished to end the survey to prevent participants from experiencing psychological pain. This study was approved by the ethics review committee of the Graduate School of Education, Tohoku University (Approval ID: 20-1-010).

The questionnaire

The content of the questionnaire for this study is presented below.

1. Cover page

The participants answered four items: gender, age, occupation, and grade.

2. Instructional manipulation check

This item checked for the minimization of participants' efforts (e.g., skipping instructional text) when conducting an online survey. One item was rated on a two-point scale. After providing a definition of the "experience of being a target of ijiri," it stated, "This question is to ensure that you did not skip over the questionnaire. Please ignore this question and proceed to the next question without checking the box." Checking the box would close the survey. The survey was designed to be terminated when a skipped reading was identified.

3. Items to check the agreement between recalled episodes of the experience of being a target of ijiri and the definition.

This item examined whether the subject could recall an episode based on the definition of the experience of being a target of ijiri. Three items were rated on a four-point scale. The survey was designed to end if the respondents answered "1 - Not at all," indicating that they were not able to recall episodes based on the definition.

4. Items related to the recalled episodes of ijiri

These items examined the participants' recalled episodes of the experience of being a target of ijiri. This scale was intended to have the participants recall the episode in detail before answering the questions. Therefore, it was not used in the analysis of this study. Respondents were asked to answer 17 questions: 1) the time of the episode, 2) the place of involvement with the actor, 3) the actor's position, 4) the degree of closeness with the actor, 5) the amount of normal conversation with the actor, 6) whether the position was ever reversed, 7) the topic of ijiri, 8) how the ijiri was

conducted, 9) the number of actors, 10) the context, 11) the degree of attention paid by the audience, 12) the reactions of the audience, 13) the degree of patterning of the ijiri, 14) the emotional reactions to the ijiri, 15) the chara in the group, 16) the course of the ijiri episode, and 17) other characteristics of the ijiri episode. The concept of "Chara" in 15) is not an integrated self-image like "identity," but rather a way of viewing the self-image as a collection of fragments of one's personality (Doi, 2009). Chara is an important concept in this study because it defines the role of ijiri. (Ogiue, 2008).

5. Operational check

This item investigated the degree to which participants could recall specific details about the episode of the experience of being a target of ijiri, rated on a 4-point scale. The survey was designed to end when participants answered "1 - Not applicable at all," thus confirming that they were unable to accurately recall the event.

6. Items for evaluating the recalled episodes

These two items determined the degrees of enjoyment and distress of the recalled episode, respectively, rated on a 4-point scale. This scale was intended to have the participants recall the episode in detail before answering the questions. Therefore, it was not used in the analysis of this study.

7. Risk Assessment Scale for Ijiri Part A - Invasiveness scale

Based on previous research, these 16 items were developed to measure the participants' recalled invasiveness regarding the experience of being a target of ijiri, rated on a 5-point scale. The procedure for creating the items was as follows. The extant literature addressing ijiri and involving distressed targets was reviewed and 20 items were created by the author (Doi, 2008; Moriguchi, 2007; Doi, 2009; Mukai, 2010; Kimura, 2017; Nakano, 2018; Sakamoto, 2018). During item development, items related to violations of identity and to negative emotions were created. The items were then reviewed by 6 graduate students majoring in psychology, including the author, and 1 researcher in clinical psychology, and 16 items were thus adopted.

8. Risk Assessment Scale for Ijiri Part B - Action suppression scale

Based on previous research, we created 31 items to measure the cognitions related to the behavioral inhibition of the target, rated on a 5-point scale. The procedure for creating the items was as follows. Among the previous studies on ijiri, the author reviewed those describing cases in which the target elected to respond compliantly while experiencing invasive ijiri, and thus formulated 35 items (Moriguchi, 2007; Doi, 2008; Ogiue, 2008; Mukai, 2010; Nakano, 2018). At the time of item development, we created items related to perceptions of: 1) in-group roles, 2) risks of rejecting ijiri, 3) benefits of accepting ijiri, and 4) the inability to control the situation when being targeted by ijiri. The items were then reviewed by 6 graduate students majoring in psychology, including the author, and 1 researcher in clinical psychology, and the 31 items were thus adopted.

9. "Impact", "Disturbance", and "Threat" factors of the cognitive rating scale of stress.

Table 4. Results of Exploratory Factor Analysis of the Part A - Invasiveness Scale
(Factor Patterns after Maximum Likelihood Method and Promax Rotation)

		I	II
Ⅰ. Negative Emotional Response（α＝.963）			
1.	I hate ijiri.	.984	-.121
6.	Ijiri is annoying.	.900	-.026
5.	Being subjected to ijiri makes me irritated.	.849	-.007
2.	Being subjected to ijiri makes me angry.	.845	.003
8.	That Ijiri is making me uncomfortable.	.756	.176
7.	Ijiri makes it challenging for me.	.695	.267
12.	Ijiri is a burden to me.	.684	.243
3.	Ijiri makes me sad.	.667	.248
10.	Ijiri hurts my feelings.	.656	.315
4.	Ijiri makes me feel embarrassed.	.464	.157
Ⅱ. Identity Violation（α＝.932）			
13.	Ijiri disrupts my self-perception.	-.049	.903
9.	Ijiri threatens my identity.	-.018	.879
11.	Ijiri affects my identity.	.044	.820
15.	Ijiri negatibely affects my personality.	.108	.803
14.	Ijiri is the least of my concerns.	.275	.589

inter-factor correlation	I	II
I	—	.827
II		—

Deleted items

16. Ijiri shocks me.

These 15 items measured impact, disturbance, and threat among cognitive rating scales of stress created by Okayasu (1992), rated on a 4-point scale. The participants responded to the cognitive assessment of stress in the recalled experience of being a target of ijiri.

10. Comprehensive Stress Response Inventory

Asai et al. (2013) developed a scale to measure stress reactions. It comprises two subscales: the general stress response scale and the disaster-specific stress response scale. The disaster-specific stress response scale measures PTSD-like stress responses and includes 15 items rated on a 4-point scale.

11. Response to jokes in specific situations scale

An item created by Hayama & Sakurai (2010) was used to measure response behavior to jokes. Respondents were asked to describe how they responded to the recalled experience of being a target of ijiri.

Analytical method

In this study, in examining the factor structure, an exploratory factor analysis was

Table 5. Confirmatory Factor Analysis results for the Part A - Invasiveness Scale

	Model 1	Model 2
χ^2	1125.140***	127.728***
df	89	58
CFI	0.933	0.995
RMSEA	0.113	0.036
90% CI	0.107-0.119	0.028-0.045
SRMR	0.035	0.013
BIC	32018.091	31231.997

Note: CFI, comparative fit; RMSEA, root mean square error of approximation; SRMR, standardized root mean square residual; and BIC, Bayesian information criterion; ***p<.001

conducted on the created scale to confirm the factor structure, and then a confirmatory factor analysis was conducted to examine the validity of the factor structure model. In confirmatory factor analysis, following some previous studies (Mitsutake et al., 2011; Asai et al., 2013; Ode, 2020), the goodness of fit of the model is modified with reference to the modification index to the extent theoretically comprehensible. Specifically, covariance is added between errors for items of the same factor. Modification of the model based on the modification index is stated to be available in Kano (2002) to the extent that it is theoretically comprehensible.

Results

Factor structure of the Risk Assessment Scale for Ijiri

We examined the factor structure of the risk assessment scale for ijiri created in this study.

1. Factor structure of the Risk Assessment Scale for Ijiri: Part A - Invasiveness scale

First, we examined the factor structure of the Part A - Invasiveness scale. Exploratory factor analysis with the maximum likelihood method and Promax rotation was conducted for 16 items, for which ceiling and floor effects were not identified. From the scree plot, it was determined that a two-factor structure was appropriate. When items were extracted based on factor loadings of .35, one item was excluded, and 15 items were extracted for 2 factors (Table 1). The first factor examined items related to negative emotional reactions to ijiri, such as “1. I hate Ijiri,” “6. Ijiri is a pain,” and “5. I get irritated when I am subjected to Ijiri.” Therefore, we named the first factor,

“Negative Emotional Response.” The second factor investigated items related to the influence and violation of selfhood and identity by ijiri, such as “13. Ijiri destabilizes the way I perceive myself,” “9. Ijiri undermines my identity,” and “11. Ijiri affects my identity.” Therefore, we named the second factor “Identity Violation.” The inter-factor correlation was r=.827

Table 6 Results of Exploratory Factor Analysis of the Part B - Action Suppression Scale
(Factor Patterns after Maximum Likelihood Method and Promax Rotation)

	I	II	III	IV
Ⅰ. Risk Aversion（α＝.921）				
24. Depending on my reaction, it would be awkward to be there.	.888	.023	.127	-.184
23. Depending on my reaction, the mood of the place would be bad.	.830	.060	-.122	.131
25. Depending on my response, some problems may occur.	.818	.065	.189	-.243
29. Depending on my reaction, my relationship with the actor will suffer.	.797	.019	.133	-.141
19. Depending on my reaction, the place would be boring.	.768	.002	-.171	.264
15. Depending on my reaction, people will think I'm an wet blanket.	.737	-.028	-.109	.244
3. Depending on my reaction, there may be a conflict.	.568	-.124	.070	-.036
16. I have to escape ijiri in the right way.	.546	-.022	-.015	.339
22. Ijiri is initiated dependeing on the mood of the person you are talking to.	.482	-.141	.259	-.069
7. Depending on my reaction to ijiri, I would be subjected to more ijiri.	.461	-.009	.164	.094
Ⅱ. Gaining Profit（α＝.915）				
30. By accepting ijiri, I can enjoy myself.	-.041	.910	-.121	-.057
21. There are positive effects of receiving ijiri.	.083	.896	-.184	-.073
13. I am attached to ijiri.	-.040	.883	-.190	-.101
8. By accepting ijiri, I made more friends.	.017	.856	-.071	-.067
4. By accepting ijiri, I have a sense of belongingness.	.008	.635	.104	.087
26. Accepting ijiri has helped me have a good relationship with my peers.	.134	.633	.094	.042
20. I accept ijiri because I am the Chara in receiving ijiri.	.053	.561	.220	-.007
28. It is my role in the group to accept ijiri.	-.041	.511	.309	.108
5. Ihave no choice but to accept ijiri.	-.154	.448	.245	.264
1. I am used to accepting ijiri.	-.277	.448	.161	.218
Ⅲ. Sense of Helplessness（α＝.742）				
27. I gave up on resisting ijiri.	.159	-.108	.662	-.001
9. Ijiri is inevitable.	.060	.268	.504	.011
14. I can not make ijiri stop.	.304	-.038	.452	-.102
31. Rejecting ijiri is bothersome.	.266	.021	.393	.056
Ⅳ. Prioritizing Role-playing（α＝.861）				
2. I must create a pleasant atmosphere through my reaction to Ijiri.	-.026	.039	-.050	.812
6. I have to liven the atmosphere with my reaction to ijiri.	.058	.014	-.041	.741
10. Preserving the atmosphere is more important than my feelings toward ijiri.	.092	.124	.142	.550
12. The audience were anticipating my reaction to ijiri.	.253	.216	.035	.376

inter-factor correlation	I	II	III	IV
I	—	.326	.605	.608
II		—	.406	.691
III			—	.508
IV				—

Deleted items

11. Depending on my reaction to ijiri, the atmosphere would be interrupted.
17. Accepting ijiri gives me a sense of satisfaction.
18. The process of initiating ijiri is beyond my control.

(p<.001).

In addition, confirmatory factor analysis was conducted to confirm the goodness of fit for the factor model (2 factors, 15 items) of the Part A - Invasiveness Scale. Results indicated that the goodness of fit for the Part A - Invasiveness Scale was inadequate (*GFI*=.868, *CFI*=.933, *RMSEA*=.113, *SRMR*=.035). To improve the goodness of fit, the model was modified by adding covariance between the errors of the items of the same factor, with reference to the modification index. Results revealed that the

Table 7 Results of Confirmatory Factor Analysis of the Part B - Action Suppression Scale

	Model 1	Model 2
χ^2	2398.259***	1197.958***
df	344	289
CFI	0.871	0.943
RMSEA	0.081	0.059
90% CI	0.078-0.084	0.055-0.062
SRMR	0.077	0.065
BIC	68242.971	67417.590

Note: CFI, comparative fit; RMSEA, root mean square error of approximation; SRMR, standardized root mean square residual; and BIC, Bayesian information criterion; ***$p<.001$

goodness of fit of the modified model was adequate (*GFI*=.982, *CFI*=.995, *RMSEA*=.036, *SRMR*=.013) (Table2). Thus, the 15 items of the two factors were designated as the Risk Assessment Scale for Ijiri: Part A - Invasiveness Scale. The mean scores for each factor were 3.429 (*SD*=.1.135) for Negative Emotional Response and 2.986 (*SD*=1.167) for Identity Violation.

2. Factor structure of the Risk Assessment Scale for Ijiri: Part B - Action Suppression Scale

Next, we examined the factor structure of the Part B - Action Suppression Scale. Examination of the ceiling and floor effects revealed a floor effect in the item, “17. I find that taking ijiri gives me a sense of satisfaction.” Exploratory factor analysis with a maximum likelihood method and Promax rotation was conducted for the 30 items for which ceiling and floor effects were not identified. From the scree plot, it was determined that a four-factor structure was appropriate. When items were extracted based on factor loadings of .35, 2 items were excluded, and 28 items were extracted for 4 factors (Table 3). The first factor included items exploring the risk of being disadvantaged depending on one's reaction to ijiri, such as, “24. Depending on my reaction to Ijiri, I would have difficulty being there,” “23. Depending on my reaction to Ijiri, I could spoil the atmosphere,” and “25. Depending on my reaction to the Ijiri, it could interfere with everything else.” Therefore, we named the first factor “Risk Aversion.” The second factor included items related to benefits gained from Ijiri, such as, “30. By taking Ijiri, I am able to have a good time,” “21. There are positive effects of receiving Ijiri,” and “13. I have an attachment to Ijiri.” Therefore, we named the second factor “Gaining Profit.” The third factor

included items related to being unable to control the situation when being targeted by ijiri, such as “27. I gave up refusing Ijiri,” “9. Being subjected to Ijiri is inevitable,” and “14. I can't

Table 8 Correlation coefficient between Part A - Invasiveness Scale and other scales

	Impactivity	Disturbability	Threativeness	Anxiety / Nervousness	Grumpiness / Anger	Autonomic Neurosis	Special Stress Response to Disaster
Negative Emotional Response	.521****	.788****	.696****	.594****	.638****	.379****	.542****
Identity Violation	.661****	.749****	.763****	.645****	.592****	.479****	.597****

**** $p<.001$

make Ijiri stop." Therefore, we named the third factor "Sense of Helplessness." The fourth factor included items related to prioritizing the group over personal emotional reactions, such as, "2. I have to create a pleasant atmosphere with my reaction to Ijiri," "6. I have to liven things up with my reaction to Ijiri," and "The atmosphere was more important than my feelings towards Ijiri." Therefore, the fourth factor was named "Prioritizing Role-playing." The inter-factor correlation between Factor 1 and Factor 2 was r=.326 (p<.001). The inter-factor correlation between Factor 1 and Factor 3 was r=.605 (p<.001). The inter-factor correlation between Factor 1 and Factor 4 was r=.608 (p<.001). The inter-factor correlation between Factor 2 and Factor 3 was r=.406 (p<.001). The inter-factor correlation between Factor 2 and Factor 4 was r=.691 (p<.001). The inter-factor correlation between Factor 3 and Factor 4 was r=.508 (p<.001).

In addition, confirmatory factor analysis was conducted to confirm the goodness of fit for the factor model (4 factors, 28 items) of the Part B - Action Suppression Scale. Results indicated that the goodness of fit of the Part B - Action Suppression Scale was inadequate (*GFI*=.817, *CFI*=.871, *RMSEA*=.081, *SRMR*=.077). To improve the goodness of fit, the model was modified by adding covariance between the errors of items of the same factor, with reference to the modification index. Results revealed that the goodness of fit of the modified model was adequate (*GFI*=.913, *CFI*=.943, *RMSEA*=.059, *SRMR*=.065) (Table 4). Thus, the 28 items of the four factors were designated as the Risk Assessment Scale for Ijiri: Part B - Action Suppression Scale. The mean scores for each factor was 3.128 (*SD*=.924) for Risk Aversion, 2.530 (*SD*=.892) for Gaining Profit, 3.002 (*SD*=.876) for Sense of Helplessness, and 2.856 (*SD*=1.029) for Prioritizing Role-playing.

Reliability and Validity of the Risk Assessment Scale for Ijiri

The reliability and validity of the risk assessment scale for ijiri developed in this study was examined.

1. Reliability and validity of the Risk Assessment Scale for Ijiri: Part A - Invasiveness Scale

First, to examine the internal consistency of the Part A - Invasiveness Scale, the Cronbach's alpha coefficients of the two factors were calculated. "Negative Emotional Response," and "Identity Violation," scored alpha values of α=.963 and α=.932, respectively, indicating sufficient reliability.

Next, to examine the criterion-related validity of the Part A - Invasiveness scale, we calculated the correlation coefficients between the scores of the subfactors of the scale, and the

Table 9 Correlation coefficient betweeen Part B - Action Suppression Scale and Compliant Response

	Compliant Response
Risk Aversion	.456****
Gaining Profit	.410****
Sense of Helplessness	.390****
Prioritizing Role-playing	.565****

**** $p<.001$

three subfactors of the Cognitive Assessment of Stress Scale and the four subfactors of the Comprehensive Stress Inventory scores (Table 5). Negative Emotional Response was significantly positively correlated with Impact (r=.521, p<.001), Disturbance (r=.788, p<.001), Threat (r=.696, p<.001), Anxiety/Nervousness (r=.594, p<.001), Grumpiness/Anger (r=.638, p<.001), Autonomic neurosis (r=.379, p<.001), and disaster-specific response to stress (r=.542, p<.001). Identity Violation was also significantly positively correlated with Impact (r=.661, p<.001), Disturbance (r=.749, p<.001), Threat (r=.763, p<.001), Anxiety/Nervousness (r=.645, p<.001), Grumpiness/Anger (r=.592, p<.001), Autonomic neurosis (r=.479, p<.001), and disaster-specific response to stress (r=.597, p<.001). Thus, hypothesis 1 was supported and the criterion-related validity of the Part A - Invasiveness Scale was confirmed.

2. Reliability and validity of the Risk Assessment Scale for Ijiri: Part B - Action Suppression Scale

First, to examine the internal consistency of the Part B - Action Suppression Scale, Cronbach's alpha coefficients for the four factors were calculated. Results were as follows: "Risk Aversion," α=.921; "Gaining Profit," α=.915; "Sense of Helplessness," α=.742; and "Prioritizing Role-playing," α=.861, indicating sufficient reliability.

Next, to examine the criterion-related validity of the Part B - Action Suppression Scale, we calculated the correlation coefficients between the scores of the subfactors of scale and the "compliant response" score of the Response to Joke Scale (Table 6). Risk Aversion had a significant positive correlation with compliant response (r=.456, p<.001). Gaining Profit was significantly positively correlated with compliant response (r=.410, p<.001). Sense of Helplessness showed a significant positive correlation with compliant response (r=.390, p<.001). Prioritizing Role-playing was significantly positively correlated with compliant response (r=.565, p<.001). Thus, hypothesis 2 was supported, and the criterion-related validity of the Part B - Action Suppression Scale was confirmed.

Discussion

This study aimed to create a tool to measure the risk of ijiri. We developed a Risk Assessment Scale for Ijiri, comprising two subscales; namely, Part A - Invasiveness Scale

and Part B - Action Suppression Scale. We examined its reliability and validity, as well as the cut-off value, which is an index for extracting those who exhibit stress reactions to ijiri. In the following, we will discuss 1) the factor structure and reliability/validity of the Part A - Invasiveness Scale, 2) the factor structure and reliability/validity of the Part B - Action Suppression Scale, and 3) the cutoff value of Part A regarding the expression of stress response.

Factor structure and reliability/validity of the Part A - Invasiveness Scale

For the Part A - Invasiveness Scale, a two-factor structure of negative emotional response and identity violation was adopted as a result of exploratory and confirmatory factor analysis, and the model fit was confirmed. The inter-factor correlation was r=.827, indicating a strong positive correlation. That is, it was shown that the invasiveness caused by ijiri comprises two aspects: the violation of the target's identity, and a negative emotional reaction. This result supports previous studies (Doi, 2008; Doi, 2009; Mukai, 2010; Kimura, 2017; Nakano, 2018; Sakamoto, 2018) indicating that targeted individuals feel uncomfortable with ijiri which stifles authentic behavior or disrupts their identity. The results are consistent with extant research (Moriguchi, 2007; Doi, 2008; Doi, 2009; Honda, 2011; Kimura, 2017; Nakano, 2018; Sakamoto, 2018) contending that ijiri causes not only primary negative emotions, such as anger, disgust, and sadness, but also secondary negative emotions, such as embarrassment and discomfort. Goffman (1967) argues that we should choose topics and wording that do not infringe on face to facilitate smooth communication with others. Face is a positive social value, or self-image, that a person desires, similar to the concept of identity (Goffman, 1967; Spencer-Oatey, 2004). Positive emotions are generated when face is retained, and negative emotions are generated when face is violated (Goffman, 1967). Thus, it is presumed that the second factor, Identity Violation, measures the degree of identity and face violation, and the first factor, Negative Emotional Response, measures the degree of negative emotions associated with identity and face violation. In measuring the invasiveness of communication with others, it is useful to measure two aspects: identity violation, and the correlated negative emotions.

In addition, reliability analysis showed that Cronbach's alpha coefficient was sufficient, confirming the reliability of the Part A - Invasiveness Scale. Both Negative Emotional Response and Identity Violation showed significant positive correlations with the cognitive rating scale of stress and the Comprehensive Stress Response Inventory. The criterion-related validity was thus demonstrated, indicating that the negative emotions and identity violation caused by ijiri account for interpersonal stress. In addition, this study showed that the Part A - Invasiveness Scale was positively correlated not only with the general stress response scale, but also with the disaster-specific stress response scale, which measures PTSD-like reactions. Thus, there are two routes through which ijiri can function as an

interpersonal stressor. The first route involves the continued exposure to ijiri, which triggers general stress responses such as anxiety/tension, anger, and autonomic symptoms. This route assumes a vicious cycle in communication, whereby ijiri is constantly repeated. This creates an unbalanced relationship between the actor and the target, and this relationship induces further ijiri. Watzlawick, Bavelas and Jackson (1967) classified communication patterns into two categories: symmetry and complementary. They noted that when one of the patterns escalates, a pathological relationship is established. Symmetry is a communication pattern in which both parties behave similarly, such as mutual responding, or being humble when someone is humble. Conversely, a complementary communication pattern involves both parties behaving differently, such as one individual asserts, and the other perseveres. Ijiri is thought to form a complementary communication pattern. If there is an escalation of complementary communication patterns due to the repetition of ijiri, then the relationship itself is considered to be an ongoing interpersonal stressor. However, if the target retaliates, or a symmetrical communication pattern is established, or there is a complementary communication pattern in which the target gains an advantage, then ijiri may not be a stressor. This is because it prevents escalation into a complementary communication pattern in which the target is placed in disadvantaged position, even if ijiri is repeated. The relationship between the escalation of communication patterns and the invasiveness of ijiri must be examined further. The second route is that ijiri rapidly functions as a major stressor, and the experience of being a target of ijiri becomes a traumatic experience, triggering a PTSD-like stress response. This route is considered to be ijiri, which is a strong invasion of the target. Brown and Levinson (1987) proposed the politeness theory and termed the act of face violation a Face Threatening Act (FTA). The degree of violation of face is estimated by the sum of 1) the social distance between the speaker and the listener, 2) the relative power difference between the speaker and the listener, and 3) the absolute ranking of the rudeness of an action in a given culture. Therefore, in ijiri, if the social distance between the actor and target is far, the power differential is large, and the degree of rudeness of the ijiri is high, then it is considered as an FTA to the target and becomes a significant stressor. It is necessary to further investigate the characteristics of ijiri in Japanese culture, and to subsequently examine the hypothesis of invasiveness based on politeness theory.

Factor structure and reliability/validity of the Part B - Action Suppression Scale

Regarding the Part B - Action Suppression Scale, the results of exploratory factor analysis and confirmatory factor analysis showed that the four-factor structure of Risk Aversion, Gaining Profit, Sense of Helplessness, and Prioritizing Role-playing was adopted, and the model fit was confirmed. Ogiue (2008) suggests that most people understand the risk that resisting bullying will induce further bullying and ijiri, which is supported by Risk Aversion in this study.

Moreover, in perceiving such risks, the target prioritizes their expected behavior in the situation over their own emotions, and resorts to chara-based behavior (Doi, 2008; Ogiue, 2008; Doi, 2009; Nakano, 2018). This is supported by Prioritizing Role-playing in this study. However, by acquiring the role of the actor/ target, contemporary adolescents have positioned themselves in the group and thus acquired a sense of self-esteem. Therefore, they are unable to break the cyclical communication of ijiri (Moriguchi, 2007; Mukai, 2010), which is supported by Gaining Profit in this study. In addition, targets experienced helplessness due to the unwillingness to expand the size of the group in which ijiri occurred and the repeated experience of being subjected to ijiri, even after taking measures to escape the position (Kimura, 2017; Nakano, 2018). The third factor, Sense of Helplessness, supported these previous studies. The four constructs related to behavioral inhibition of the target, which were assumed from previous studies, were extracted in this study, and the content validity of Part B was confirmed. Hence, ijiri participants proposedly accept ijiri and avoid the position of being a target of ijiri by repeated self-presentation.

In addition, reliability analysis showed that Cronbach's alpha coefficient was sufficient, confirming the reliability of the Part B - Action Suppression Scale. In addition, Risk Aversion, Gaining Profit, Sense of Helplessness, and Prioritizing Role-playing were all positively correlated with “compliant response” scores on the response to jokes scale, indicating criterion-related validity. This indicates that 1) perceiving the risks of ijiri and attempting to avoid them, 2) perceiving the benefits of ijiri, 3) feeling helpless against ijiri, and 4) perceiving one's role in the group and prioritizing it are related to the compliant response to ijiri. Risk Aversion is presumably related to the perception of punishment when individuals are not compliant with ijiri, and Gaining Profit is associated with the perception of reward when complying with ijiri. The compliant response of the target is thus enhanced when people perceive that they are avoiding risks and reaping benefits by complying with ijiri. The sense of helplessness is assumed to be a cognition formed by the target’s experience of being unable to control being subjected to ijiri. Ogiue (2008) states that ijiri is a communication based on chara, which may be formed altruistically, and can forcibly determine the target’s position and role in the group. In addition, Kimura (2017) contends that situational changes, such as unwanted changes in the stage or the appearance of an unexpected audience may render the target unable to escape the situation. This is because the audience continues to seek a performance that enhances the situation by subjecting the target to ijiri, although the ijiri exceeds the scope of the target's voluntary self-presentation. Thus, the target unwillingly continues to assume the role of the target of ijiri, thereby increasing Sense of Helplessness and choosing a compliant response. Next, Prioritizing Role-playing is considered to be a cognition regarding in-group roles in the target. Contemporary adolescents tend to repeat smooth and pleasant interactions with others, stay constantly connected, and

endeavor to build herd friendships (Okada, 1995; Okada, 1999; Okada, 2007a; Okada, 2007b; Doi, 2008). To maintain herd friendships, individuals must take the hint, maintain the norm within a group of friends as a herd, and act accordingly (Doi, 2008). In this context, the target perceives his own in-group role and chooses a compliant response to maintain friendships. The target thus prioritizes in-group role-playing over his own hurtful experiences and emotional reactions. This attempt to meet external expectations and demands, even by suppressing internal desires, is called over adaptation (Ishizu, 2006). Future studies should examine the relationship between the Part B - Action Suppression Scale and the tendency to over-adapt. In addition, further research should examine what factors promote each factor of the Part B - Action Suppression Scale, which encourage the compliant response behavior of the target.

Conclusion

In this study, we developed a scale to measure the risk of ijiri from two aspects: 1) invasiveness to the target and 2) cognitive factors related to the suppression of expression, and its reliability and validity were confirmed. This scale enables us to measure the subjective sense of invasiveness of target and cognitive factors related to the suppression of expression, which are difficult to measure and observe objectively. This scale can be employed in schools and workplaces where ijiri is a problem to enable the early detection of pathological ijiri and implement preventive and intervention measures. A challenge in clinical implementation would be regarding the age of the study subjects. The present study was conducted on adolescent persons aged between 18 to 35 years. Since ijiri is a characteristic communicative behavior among contemporary adolescents, there is a certain validity to the research subjects of this study. However, given that ijiri has become a problem among school-age children, it is necessary to modify the scale to suit the target population for clinical implementation. Regarding ijiri in the workplace, this scale can be used as is.

The scale developed in this study provides a basis for the quantitative examination of risk-related factors in ijiri. This study is academically significant in that it forms the basis for further empirical examination of the sociological concept of ijiri. Thus far, there has been only anecdotal discussion and no empirical research on the factors that cause ijiri to function pathologically. Future studies should examine the relationship of this scale with the content of ijiri, factors of the relationship between the actor and the target, factors of the communication pattern between the actor and the target, and the risk-related factors of ijiri.

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