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An Introductory Research on the Applicability of the Foster-Hicks Happiness Leadership Model to the Japanese Health Care Context: Results from a Workshop with Japanese Health Care Leaders

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Abstract
The Foster-Hicks Happiness Leadership Model has been developed as one of the leadership models based on positive psychology and has been used in health care settings in the United States. I held a workshop to introduce the idea of the Foster-Hicks Happiness Leadership Model with Japanese health care leaders who had worked in hospitals for 20 to 41 years in order to gather their opinions about the applicability of the model to the Japanese context.

(1) The elements of ideal leadership presented by the Japanese health care leaders before I introduced the Foster-Hicks Model in the workshop were different from the Foster and Hicks’ ones. The Japanese health care leaders chose the abilities of listening and nurturing as important for leaders in health care settings, while the abilities of stating and directing are designated as important elements in the Foster-Hicks Model. (2) When I introduced the Foster-Hicks Model to Japanese health care leaders in the workshop, they initially asked many questions and offered many opinions regarding it. The Japanese leaders said that it was better to be accountable and to have truth in one’s mind rather than expressing it. However, as the discussion deepened, toward the end the participants said that the model was understandable enough for them and offered some helpful hints for revising it so that it fit into a Japanese context: such as new concepts of internal accountability and external accountability. (3) For leadership training, discussion among the participants using the Foster-Hicks Model was educational and raised awareness of their ideal leadership model which, in fact, had already existed in their mind. Raising awareness of one’s ideal leadership image (which has already existed in one’s mind) would be a more powerful leadership training program than to simply learn a new model as a “good model.”

1. Introduction
In Japan, as well as many other developed countries, health care is one of the most important industries and social functions in the 21st century.
Needs and demands for health care services are expanding due, primarily, to the aging population, and we are going to face a sustainability problem of the health care system because resources are limited. Now we have to examine what the essential purpose of health care services should be and build an efficient, relevant, and higher quality system that can contribute to that purpose. One of the ultimate purposes of health care service is to enhance people’s happiness and quality of life (QOL). Especially in health care services for elderly people, not only curing acute diseases but also keeping and enhancing one’s happiness and QOL is a very important function.

To offer efficient, relevant, and high quality health care, excellent leadership in health organizations is important. In Japan, leadership training have just begun to gain attention and they are becoming popular among health care organizations; however, they have not had an established model yet and need a better one. The Foster-Hicks Happiness Leadership Model is based on positive psychology and has been used and has impacted health care organizations in the United States (Foster and Hicks, 2008). This happiness leadership model was taught in the graduate school of public health at the University of California, Berkeley. The author became interested in investigating the applicability of the model in a Japanese health care setting. If the model could help Japanese health care leaders’ capacity to enhance patients’ happiness and QOL, it would be great news for the Japanese health industry.

In this study, I did a workshop to introduce the idea of the Foster-Hicks Happiness Leadership Model to Japanese health care leaders. The participants and I investigated the differences between the Japanese health care leaders’ model and the Foster-Hicks Model, and discussed the applicability of the model to Japanese health care settings. The Foster-Hicks Model may hold great potential and may contribute to Japanese health care as one of the leadership training models; however we need to examine if the model meets the Japanese health care culture and in turn, may need modification because the Japanese health care culture is different from the American one.

2. The Foster-Hicks Happiness Leadership Model
Rick Foster and Greg Hicks have developed the Happiness Leadership Model, which is a leadership model based on positive psychology. After dozens of interviews with “happy people” they found a mental model that allowed those people to keep positive emotions and happy feelings (Foster and Hicks 1999, 2008). They found that those people tended to make nine
choices intentionally or unintentionally to be happy: intention, accountability, identity, centrality, recasting, option, appreciation, give, and truth (Fig.1). Also, they found from their practices that this positive mental model contributed to good health outcomes and achieved good results even in business (Foster and Hicks 1999, 2008).

**Fig.1** The Nine choices to be happy (by Foster and Hicks)

1) Intention: state your intention
2) Accountability: avoid victimhood, sense of determination, discipline, non-defensiveness
3) Identity
4) Centrality: work from your central passion that gives you your identity
5) Recasting: recast from victimhood
6) Option: have options/help people have options
7) Appreciation: thanks/praise
8) Give: give first before being given to
9) Truth: tell the truth

Foster and Hicks have emphasized that this mental model is useful as a leadership model, and have continued to apply it to the health sector. Foster and Hicks say that “happiness leaders”, who act based on these nine choices, will cultivate positive and happy attitudes among their staff and create a positive and happy culture in their organizations. This attitude will, in turn, empower patients and their families and will enhance their QOL and natural healing capacity (Fig.2).

**Fig.2** Mechanism of how happiness leadership contributes to patient outcomes in health care

Made by the author
3. Research Objectives and Questions
The objectives of the research were 1) to investigate the differences between Japanese health care leaders’ model and the Foster-Hicks Model, and 2) to explore the applicability of the model to the Japanese health care context. The Foster-Hicks Model may hold great potential and may contribute to Japanese health care as one of the leadership training models; however, different cultures often need different leadership models. We need to check if the Foster-Hicks Model, which was developed in the American culture, works in the Japanese culture. Health care is an especially culture-dependent industry; we need to examine this carefully to see if the American leadership model will work in Japan.

My research questions were:
(1) Is the Foster-Hicks Happiness Leadership Model applicable to the Japanese health care settings?
(2) How can we use the Foster-Hicks Happiness Leadership Model for leadership training in Japanese health care settings?

In order to answer these questions fully, we should try applying the model in Japanese health organizations for several years and measure how much health care outcomes are improved from multiple perspectives using various health performance indicators. In this study, as preparatory work for a future thorough study, the author tried to get overall pictures answering the research questions. For this purpose, I held workshops with 11 Japanese health care leaders to ask (1) What are the elements of ideal leaders in the Japanese health care context? I asked this in order to explore the differences between the Japanese elements and the Foster-Hicks elements, and (2) What were the Japanese health care leaders’ opinions of the Foster-Hicks Leadership Model?

4. Method
I held a workshop to introduce and discuss the Foster-Hicks Happiness Leadership Model with Japanese health care leaders. Through the workshop with them, I gathered information on (1) the commonalities and differences between the ideal leadership image in Japanese health care settings and that of the Foster-Hicks Model, (2) Japanese health care leaders’ opinions about the model in order to explore if and how the model could work in the Japanese health care context. In addition to the workshop, I gave the Japanese health care leaders questions addressing the “order of importance among the elements of the Foster-Hicks Model,” I gave the same survey to American students who took a “Happiness Course” (course number PH290.05) with Mr. Foster and Mr. Hicks at the
graduate school of the University of California, Berkeley as a control group. I did this in order to get an idea of the different tendencies regarding leadership in Japan and the United States.

4-1. The Title of Workshop
I held a workshop titled “Application of the Foster-Hicks Happiness Leadership Model to Japanese Health Care Leaders”.

4-2. Date and Technologies
I facilitated two workshops with Japanese health care leaders connecting two cities by Skype. The Japanese leaders participated in the workshop from a computer room at Kumamoto University in Kumamoto, Japan; and I facilitated this workshop from Berkeley, California in the United States. The first workshop was from 6:30pm-8:15pm on November 5th, 2010 (Japan time) with seven participants and the second one was from 8:45pm-10:30pm on the same day with four participants. The contents of the workshop were the same.

4-3. Demography of Participants
I had eleven participants in the two workshops in total; 10 were female and one was male. The age of the participants ranged from 37 to 61 years old, and the average of age was 50.2 years old. Regarding the professional background of participants, 8 of the 11 were nurses who had had 20–41 years of experience in hospital nursing and had experienced working as a leader. Three of the 8 nurses were still working as hospital nurses, two university hospital, one private hospital, at the time of the workshop; the other 5 had quit working as nurses. Three from the five were community nurses, two were professors of nursing, and one was a doctoral graduate student. One of the eleven was a pharmacologist who worked as a vice-president and safety manager of a psychiatric hospital with more than 30 years of experience, one was a health information manager in a university hospital with more than 20 years of experience, the last one was a vice-president of a school of nursing/physiotherapy/occupational therapy with 10 years of experience.

4-4. Contents of Workshop
I did the workshop using material that I made to introduce the core ideas of the Foster-Hicks Happiness Leadership Model. Foster and Hicks presented nine choices in order to be a happiness leader as I showed in section 2 above; however I set eight elements by combining 3) identity and
4) centrality on the agreement because I thought they were inevitably combined. In order to keep consistency between my workshop contents and the original Foster-Hicks Model, I received Mr. Hicks’ advice on what the important elements of the Foster-Hicks Happiness Model for “a leadership training” were and I developed the workshop program according to his advice; then I showed the workshop plan to Mr. Foster and Mr. Hicks, and received Mr. Foster’s advice and finalized the plan.

A summary of the workshop process is given below. The workshop was held in Japanese and consisted of three parts. First, before I introduced the Foster-Hicks Model to the participants, I asked them what the elements of ideal leaders were in the Japanese health care system (Part A). Second, I explained the Foster-Hicks Model to the participants using the materials that I made, then we had a group discussion and interviews with the participants to take their questions and offer opinions regarding the Foster-Hicks Model (Part B). The third part was a survey with some questions asking their opinions on the model (Part C). For Part C, I asked the participants to answer the survey individually after the workshop.

Part A: Elements of Ideal Leaders in the Japanese Health Care System
Step 1: Participants thought of examples of ideal leaders they had met in their organization or work circumstances, or thought of their past experiences if they succeeded as leaders.
Step 2: Participants wrote down the elements of a good leader.
Step 3: I analyzed the result using the “KJ method”. The “KJ method” is a methodology to group and to categorize many opinions gathered by open questions.

Part B: Group discussion and interviews: Japanese health leaders’ opinions and attitudes on the Foster-Hicks model
Step 1: I explained the Foster-Hicks Leadership Model to the participants.
Step 2: Participants wrote down their initial questions and comments on the Foster-Hicks Leadership Model.
Step 3: Group discussion on the Foster-Hicks Leadership Model using question and comments they wrote in step 2.

Part C1: Survey on the order of importance among the elements of a happiness leader
This was a survey on the order of importance among the elements of the Foster-Hicks Leadership Model. The participants gave numbers to each of the elements to show which elements they thought the most important.

Part C2: Survey on frequency of using the elements of the Foster-Hicks Leadership Model in their clinical experiences
This was a survey on how often the Japanese leaders consciously use each
of elements that were shown in the Foster-Hicks Leadership Model.

4-5. A Survey of public health graduate students in the United States
I conducted the C1 survey on public health graduate students in the United States who took a lecture on happiness leadership by Mr. Foster and Mr. Hicks at the University of California - Berkeley as a control group in order to see the difference of opinions between American people and the Japanese people.

5. The Results of the Workshop
5-1. Elements of ideal leaders in the Japanese health care system (Part A)
120 items, as elements of ideal health care leaders, were presented to the participants and I categorized them into groups using the KJ method. Fig. 3 shows the group names and the number of items that belong to each group. Underlined words are shared with the Foster-Hicks Model.

5-2. Group discussion and interviews: Japanese health care leaders’ opinions and attitudes on the Foster-Hicks Model (Part B)
I asked the participants to raise questions and offer opinions on the Foster-Hicks Model after I introduced it including the choices of Fig 1.
Accountability, truth, and identity/centrality were the top three elements that the Japanese health care leaders raised questions to. In this section, I present the questions and comments by the participants to those three elements.

(1) Accountability

Questions and opinions for “accountability” were as follows:

“Accountability seems to involve inconsistent and irrelevant concepts. I cannot understand how “avoid victimhood” and “non-defensive” are relevant to “sense of determination” and “discipline”.

“Why should we account and state? In order to avoid victimhood, just having a positive mind is enough and accountability or reasoning are not necessarily needed. Or, just recognizing the reason in one’s own mind without stating is enough.”

“To account or to have accountability is important, but self-reflection about what happened is more essential than the process of stating and accounting. Sometimes, leaders should reflect the things that have happened to them without saying anything to the staff members. To be a good leader, patience in order to avoid victimhood without giving any excuses will be a virtue, as we have a proverb regarding the Samurai mind ‘Bushi wa Kiwanedo Takayoji’9. ‘Patience’ is the most important value of leader.”

The participants in the initial stage of our group discussion made the questions and comments above; however, after the discussion went deeper, we received the opinions below:

“What would be the proper Japanese word for translation of ‘Accountability’? We usually use the Japanese word ‘setsumei-sekinin’ or sometimes use the word ‘setsumei kanousei’ for ‘accountability’, but probably ‘setsumei nouryoku’ would be an appropriate word to present the essence of accountability by Foster and Hicks.”

“Probably, introducing new concepts of ‘internal accountability (accountability in one’s own mind)’ and ‘external accountability (accountability to state to others)’ would be helpful to understand the essence of “accountability” in the Foster and Hicks model in the Japanese context. Because external accountability is not always important in Japanese organizations, but internal accountability will be always helpful to be a good leader”

At the end of discussion, most of the participants agreed that “internal accountability” is fundamentally important and that “external accountability” is becoming more important today in Japan because it is
affected by western culture.

(2) Centrality and Identity:
Questions and opinions for “centrality and identity” were as follows:

“Central passion that gives a person one’s identity is not essential for leaders.”

“It would be better to work from one’s central passion, but it is more important and essential for leaders to respond to the expected role in the context than following one’s own passion. In order to respond to and play the expected role, a leader doesn’t need to have a central passion which emerged from his or her own heart. Passion of the leader should not come from the leader’s own mind but should be formed by other’s expectations.”

While we had the opinions above, some other participants said centrality and identity were very important. The participants did not reach an agreement on this element after the group discussion.

(3) Truth:
Questions and opinions for “truth” were as follows:

“Telling truth is basically important, but it is not always good as we work as leaders. To tell the truth sometimes hurt one’s feelings. To care about one’s feeling is more important than telling the truth if it hurts him or her. In communication with staff, a leader should not tell or cannot point out the staff’s weakness directly too much. A leader should nurture their staff without hurting him or her. In communication with patients and families, informed consent is important, but in some cases, they don’t want to know the truth. I feel truth is multi-dimensional. Different people have different truths. So, a leader needs to make a decision ‘which aspect of the truth’ he or she should tell according to the person they communicate with.”

“The top leader should tell the truth but the middle leader should not always tell the truth in order to act as a buffer in the organization.”

“As a leader, finding and recognizing a truth is important; however telling the truth is not necessarily important.”

“In clinical settings, we use the word “fact” but never use the word “truth” because truth differs depending on one’s perspective. Truth is more subjective than fact; truth has some psychological aspect. Leaders should tell facts but should not adhere to telling the truth too much in health care settings.

“Truth is important in communications regarding a psychological
reality. Facts are important in communicating about a physical reality.”

“Knowing what is the truth is for myself is important; then it will give a foundation for other elements of the Foster-Hicks Leadership Model.”

As the discussion went deeper, the participants also pointed out that health care professionals had a tendency to put an emphasis on telling facts but patients and families often wanted to know “truth” rather than “fact” and that professional’s telling the truth helped patients and families feel relief from their mental and spiritual suffering. Also, the participants found that some communication skills with which we tell “my truth” while keeping openness to “your truth” or “other’s truth” would be helpful in clinical settings (for example, “I message”) and that such kind of communication skill will contribute to team building and organizational development as well.

5-3. Order of importance among the elements of the Foster-Hicks Model

Fig 3 indicates the aggregated points that show the order of importance among the elements of the Foster-Hicks Model (Fig1). These were answered by Japanese health care leaders and by University of California, Berkeley public health students.

Intention was the most important for both groups. Accountability was the second most important for the Japanese health care leaders and was the third most important for the United States graduate students. Truth was the second most important for the students; but it ranked 5th for the Japanese leaders. Options were the 3rd most important for Japanese leaders; but it ranked 6th for the students.

5-4. Frequency of Japanese leaders using the Foster-Hicks leadership elements in their daily work

In this question, I asked the participants which elements of the Foster-Hicks Model the Japanese health care leader consciously used. The Japanese health care leaders were using “appreciation”, “accountability”,

![Fig.4 Order of importance among the elements of the Foster-Hicks Model](chart.png)

The numbers on the graph represent the aggregate points of the element/total points, percentage (Calculation: The most important is valued at 8 points, the least important is valued at 1 point)
and “intention” for their daily work. This is a little different from the order of importance answered in C1. Appreciation was used as the element that the Japanese leaders used the most often; however, it was 6th in the order of importance.

**Fig. 5: Frequency of Japanese leaders using the Foster-Hicks leadership elements in their daily work**

(Calculation: Always: 3 points, Often: 2 points, Sometimes: 1 point, Never: 0 points)

6. Discussion
In Part A of the workshop, 120 items were presented as elements of ideal leaders in the Japanese health care context. The most emphasized elements were related to an ability to listen and that of nurturing and parenting. The emphasized elements of Japanese leadership seem different from the ones in the Foster-Hicks Model.

While the Foster-Hicks Model put “Intention: state your intention” as the first element of a good leader, the Japanese leaders chose the ability to listen as the most important. The same opinions were observed in Part B as well; the participants said that “stating” was not always essential in Japan. Also, nurturing and parenting were chosen as important elements by the Japanese health care leaders, the Foster-Hicks Model emphasizes directing.

In Part B of the workshop, when I introduced the Foster-Hicks Model to the Japanese health care leaders in the workshop, they initially asked many questions about it and even objected to parts of it.

First, the participants raised questions on the importance of telling and stating in the Foster-Hicks Model. For the elements of accountability and truth, some participants claimed that being accountable and knowing truth in one’s mind is more essential for a leader than telling and stating it to others. The participants said patience, and not telling everything, was sometimes an important virtue for a leader. They also said that telling the truth sometimes hurts others especially when the news is bad and that a leader should take into account the entire context before deciding to tell or not. These opinions seemed to reflect the Japanese culture of harmony. Keeping harmony is an important value in Japanese society; in order to maintain harmony, Japanese tend to avoid saying negative things to others. Patience not to tell such negative things sometimes is an important value. It was interesting that the participants created new words “internal
accountability” and “external accountability” in the process of our discussion. The concept would be helpful when Japanese people introduce and apply Foster-Hicks Model to the Japanese society. Regarding “truth” also, the participants said that the finding and recognizing of truth was important, but telling it was not always essential. This discussion about “truth” comes from the same understanding of “internal accountability” and “external accountability”.

Regarding “centrality and identity”, the participants made the point that central passion was not always essential for a good leader in Japan. Some participants said that it would be more important to play the role that was expected in the organization and to meet expectations than to act on his or her personal passion. This might have been a reflection of the difference between the Japanese culture and the United States culture. Probably stating one’s opinion clearly and acting on one’s belief is an important value in the United States’ culture of individualism, while keeping harmony and acting properly in context is a virtue in the Japanese collective culture. Another interpretation of this opinion might be possible; those who said that centrality and identity are not important were people who had quit working as a clinical nurses and had become professors. In other words, they might have quit their job as clinical nurses because they were not able to find their passion for it. On the other hand, those who emphasized the importance of centrality and identity were clinical nurses who were actively working as leaders and were attempting to reform their organizations.

Thus, in Part B of the workshop, many questions were asked and many opinions were offered regarding the Foster-Hicks Model. However, this does not mean that the Foster-Hicks Model was not understood and accepted by the Japanese leaders. As the discussion went on, the Japanese participants started to grasp the essence of the model and gave some helpful hints and offered revisions so that the model could be applied in Japan: for example, the internal accountability and external accountability discussion stated above.

More than that, through the workshop, the Foster-Hicks Model worked as a great catalysis for the participants to deepen their own image of ideal leadership. At the end of the discussion, most of the participants said they didn’t feel that is was strange and didn’t make them uncomfortable once they understood the essence and intention of it. The model might need some revision in order for it to be accepted as a good leadership model for Japanese people; however other than that, I found a greater possibility for it to be used as a model to stimulate Japanese health care leaders and help
them deepen and cultivate their own thoughts and ideas.

Through this process, I found that the discussion process of the key issues in the Foster-Hicks Model was useful for the participants to increase their leadership awareness. I realized that a discussion was a more effective way of leadership education than simply learning some particular leadership model. The initial intent of my workshop was to find out if the Foster-Hicks Model could be applicable to the Japanese health care system. Actually, many questions were asked and many opinions regarding the differences between the Japanese leadership and the Foster-Hicks Model were presented in the workshop. However, I saw that the participants’ thoughts and ideas deepened from the process of exchanging their experiences as leaders and the examination of the Foster-Hicks Model, independent of their opinion and attitude toward the model itself.

7. Conclusion
The Foster-Hicks Happiness Leadership Model, which is based on positive psychology, has been gaining popularity as a leadership model for health care leaders in the United States. In this paper I reported the results and findings from a workshop I held which introduced the Foster-Hicks Happiness Leadership Model to Japanese health care leaders in order to ascertain the applicability of the model to a Japanese health care setting.

The elements of ideal leadership that the Japanese health care leaders presented before they got to know the Foster-Hicks Model were different from the ones stated by Foster and Hicks. In Japan, leaders should “listen” rather than “state”, and that the role of leaders should not be to “direct and lead” but to “nurture and encourage their growth”.

When I introduced the Foster-Hicks Model to the Japanese health care leaders in the workshop, they initially asked many questions and presented many opinions regarding it. They raised the most questions about accountability, truth, and centrality/identity. They understood the importance of accountability and truth; however they claimed that leaders would not necessarily state it. To be accountable and to have the truth in one’s mind is more essential for leaders rather than actually expressing it. This might reflect the Japanese culture of keeping harmony with others; it is more appropriate to avoid talking about negative things with others than stating one’s own passion. Japanese culture is more collective, while the United States culture values individualism.

However, as the discussion deepened, the participants started to say that the model was understandable enough for them and that they didn’t feel strange or uncomfortable with it once they understood the essence of the
model. Some revision of the wording might be necessary if we want to use the model in leadership trainings in a Japanese health care setting; however I found more potentiality in using the model as a catalyst for Japanese trainees in order to raise awareness about their own ideal leadership style; ideal leadership styles that have been cultivated from their clinical experience and which already exist in their minds. Gaining awareness about their own ideal leadership style will be more powerful in bringing about a strong leader than acquiring a new model from others. A discussion process using a model as reference will be a richer educational experience for Japanese health care leaders.

1 Iryo-maneijiment Gakkai 2011, Kango no Kagakusha Kango Jissen no Kagaku Hensyubu 2014
2 In this paper, health care leaders indicate health care workers and professionals who take leadership roles in their workplace such as chief nurses, chief physicians, chief public health nurses, chief administrative staff in hospitals and clinics, and so on.
3 Positive psychology is a movement that emerged at around 2000 in the field of psychology. In the movement, psychologists tried to focus not on the negative aspects of, or problems with, the human mind but positive aspects of it. Seligman and Csikszentmihalyi, and so on gave a foundation for this psychology. (Shimai 2006, Seligman 2011)
4 The definition of happiness is diverse among people and among scholars. Foster and Hicks did not define “happiness” academically when they started their interviews as they were not academic professionals but practitioners (Foster and Hicks 1999)
5 Revised from Foster and Hicks 1999, 2008, and the lecture materials by Foster and Hicks at the graduate school of public health at the University of California, Berkeley (Course number:PH290 2010) . In the workshop, I integrated 3) Identity and 4) Centrality as a set of choices based on the advice and consent of Foster and Hicks.
6 Foster and Hicks explained this mechanism in their class at the University of California, Berkeley in 2010.
7 The author made this figure based on Foster and Hicks’ explanation of the mechanism above.
8 The KJ method was developed by Professor Jiro Kawakita, a Japanese scholar. This method can be used for brain storming types of meetings and can be used to categorize the opinions presented. In this research, I used a modified KJ method; usually the KJ method should be done by a group, but I categorized the items by myself.
9 This proverb literally means “Samurai are people who conspicuously use a toothpick even when they do not have anything to eat,” in other words, Samurais should have pride and not show their sufferings and negative aspects to others. The participants stated that a leader should have such Samurai spirit and be patient.
“I message” is one of the conflict resolution/prevention communication skill. Using a sentence starting with I instead of you, we can avoid accusing someone directly and can communicate softly. For example, saying “I was scared that you did not follow the manual” instead of “you are terrible nurse that you did not follow the manual”.

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