Study of Parental Difficulties in Families With Hikikomori Syndrome Children (Social Withdrawal)

ひきこもり青年の親が抱く困難感に関する研究

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Contents

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Abstract

This study aimed to clarify the features and problems of parents who receive family support for their children with Hikikomori. Both qualitative and quantitative research was conducted and reported in three parts. Study 1 describes a 5 step process in a grounded theory approach of changing the attitudes of parents, and utilizes interviews with 18 parents and 3 counselors: 'Parent's journey to find their own answers to the problems of their withdrawn children'. Study 2-Ⅰ reports the development of an instrument for assessment of the difficulties of parents with children with Hikikomori, and confirms its validity and reliability via data from 176 parents. The scale consists of three sub-scales. Study 2-Ⅱ describes the differences in parental difficulties, among mothers and fathers, using the newly developed scale, via data from 55 couples. Fathers receiving more services had significantly lower difficulties in marital cooperation; although, 60% of the fathers had received any family support, while almost all of the mothers have received some. In conclusion, this thesis highlights the necessity of fathers receiving more support, and makes some suggestions regarding improved clinical practice in family support. (186 words)

Introduction

Hikikomori Syndrome (social withdrawal) has had considerable attentions paid to it in community mental health in Japan. It is defined as a state of almost complete withdrawal from social interaction, limiting the lives of sufferers to at mainly their homes for 6 months or longer[1)]. Hikikomori usually starts by late 20's, and it is estimated that 260,000 families in Japan have a child with Hikikomori[2)].

Hikikomori has become an international concern. Hikikomori still does not have an English translation, but it is called 'acute social withdrawal' or 'primary social withdrawal'. It is considered a problem unique to Japan, although there are some case reports of Hikikomori outside Japan[3)].

Hikikomori is considered to be a culture bound trait unique to Japan and linked to the closed nature of traditional Japanese society and the value placed on the nobility of solitude[4)]. The fourth edition of Diagnostic and Statistical Manual (DSM-IV) has included a cultural formulation and a glossary of culture bound syndromes[5)]. Alarcón et al. [6)] said that diagnostic term: DSM-IV, acknowledges the difficulties of locating these cultural aspects and characteristics in the conventional nosology and realizes the nonpathological nature of some of them, as well as the value of their local explanations. Thus far, although young people with Hikikomori bear similarities to social phobia, personality disorder, anxiety disorder and depression, specialists say there are important differences. Watt[7)] reported that Hikikomori reflects as much on Japanese society as on the individuals concerned.

Providing professional support for families – especially parents - with Hikikomori children is important, because the parent has a central role in consultations with professionals about their child with Hikikomori, and because the parent often faces many difficulties[8)]. The psychological distress of the family members is also reported to be stronger than in the general population[9)]. Family support eases the family's anxiety, and helps the family to see their child with Hikikomori positively[10)].

In addition to supporting the family emotionally, it is also important to strengthen the family function. Some reports point to a possibility that Hikikomori and the family function are related. The family that has a child with Hikikomori tends to have lower adaptability and cohesion[11)]. Moreover, Suwa[12)] suggested that the onset mechanism for Hikikomori is not merely a problem of the withdrawn person themselves alone, but includes the problems of family relationships. Family support prevents the family members from being socially isolated, and being excessively involved in the problems of their child with Hikikomori. By supporting a family member, it is expected that stress at home will be relieved and family relations changed.

Many studies have suggested that increasing family dysfunction causes children to withdraw into their home. Koshiba[13] reported the lack of "Problem Solving" abilities and low "Affective Responsiveness" of families with Hikikomori children. Problematic family functioning, including several patterns of problematic family interactions, has been highlighted as contributing to withdrawing from school among children and adolescents[14]. Such studies highlight several patterns of problematic family interactions that are likely to contribute to the children refusing to go to school. Nihira[15] indicated that family adjustment and functioning were related, not only to the severity of a child's retardation and degree of maladaptive behavior, but also to family demographic characteristics, marital disharmony, family conflict and specific kinds of parental behavior toward their children. This is supported by King & Bernstein[14], who suggested that treatment of youths with anxiety disorders usually involves a multimodal approach which may include family therapy. I concur that targeting difficulties in family dynamics is essential in successfully treating school-refusal. Also, family support in respect of Hikikomori should be designed for the whole family, in order to improve family functioning. Podolski & Nigg[16] have been concerned that—because parents lack support— their stress may increase and lead to greater difficulty with parenting, as well as elevated risk for negative parent-child interactions.

Helping for the family leads to support of their withdrawn child indirectly. Some studies indicate that family support makes a positive impact on withdrawn children. Kurita et al. [17] reported that family support has improved withdrawn children's condition, scope of activity, communication inside the family, and problematic behavior. Twenty percent of children with Hikikomori, whose family received support from mental health professionals, carried out social participation after one year[18].

Consequently, we need evidence to plan, implement, and evaluate the support for families of children with Hikikomori. Kondo[19] emphasized the necessity of examining the actual condition, effectiveness, and limitation of support services for Hikikomori.

To clarify the features and problems of parents who receive family support for their children with Hikikomori, both qualitative and quantitative research was conducted, and is reported here in three parts. First, Study 1 aims to describe the process of changing attitudes of parents with socially withdrawn children and the type of counseling support provided. Next, Study 2-□ reports the development of an instrument for assessing of parents' difficulties with children with Hikikomori. Lastly, Study 2-□ describes parental difficulties, focusing on the difficulties of the fathers in comparison with the difficulties of the mothers.

It is necessary to point out here that the present study did not distinguish clearly between parents whose children have a mental disorder and those whose children do not, due to the

following two reasons. First, among people who have used services for Hikikomori, 35.7% have had a psychiatric disorder diagnosed[1)]. Next, among people who have experienced Hikikomori, 54.5% had also experienced a psychiatric disorder in their lifetime[2)].

Study 1

A qualitative Study of Attitudinal Changes of Parents with Children with Hikikomori Syndrome and Their Relations to the Support They Received

1. Aims

This study aimed to describe the process of changing attitudes of parents with socially withdrawn children and the type of counseling support provided.

2. Methods

2-1. Design

The parents' changing process constitutes an interactive process among family, their child and counselors. A qualitative approach[20], based on the tenets of grounded theory, was considered most appropriate to the study of family changing processes, given the emphasis of grounded theory on interaction and process. Data collection and analysis was conducted based on the constant comparative analysis of Grounded Theory Approach[21].

2-2. Data collection

I conducted semi-structured interviews with parents and their counselors from November 2006 to March 2007, which were audio-taped and later transcribed in full. The participants were directly recruited by the researcher who was carrying out the fieldwork or introduced to the researcher by their counselor. The interviews were conducted in four cities in Japan.

The focus of the interviews and the topics to be pursued in subsequent interviews were identified and suitable follow-on participants were selected after every interview. In accordance with the sampling technique of grounded theory, the selection of participants was based on an emerging core category and a conceptual framework. Saturation, a sense of closure in the core category, was reached after 21 interviews.

2-3. Participants

The participants were 18 parents who had received services for family with Hikikomori children and their 3 counselors. The 18 parents who participated in the interview were: 6 fathers and 12 mothers, age range 45–69 years (mean age: 58.1 years). They had received 0.3–12 years (mean length: 4.4 years) of continuous family support. Four parents were full time workers and five had part time work. The others were retirees or homemakers.

In only one case, both parents of one child were interviewed together. Tables 1 & 2 describe the characteristics of these parents and their withdrawn child. In another case, one mother had two socially withdrawn children. The interviews lasted between14 and 158 minutes (mean duration: 91.2 minutes).

Individual interviews were conducted with eight parents (Table1) and the others were done in focus group interviews (Table 2). Two focus groups in which the parents had received peer support were themselves supported by the Mental Health and Welfare Center and another civilian agency. Individual interviews were conducted with all the counselors (Table 3).

2-4. Data analysis

The transcripts were coded line-by-line using the family's' actual words to analyze and describe the family's changing process. Codes were continually compared in order to identify similarities and differences, and similar codes were integrated. Categories were produced, and characteristics of concepts identified, by repeating the classification and the integration of codes. The interviews were conducted until no new categories were identified. The relationships between the categories were examined by subsuming and abstracting categories, and the conceptual framework was modeled, based on each family's changing process and the support provided.

All interviews and analyses were conducted in Japanese. For the purpose of this report, interview data were translated into English. To ensure accurate translation, translated text was proofread several times by native English speakers.

2-5. Ethical considerations

The Ethical Committee of the University of Tokyo approved the research protocol (No: 1419). All participants were informed orally, as well as in writing, about the study purpose and methods. They were assured that neither they nor their places of work would be identified. They were also informed that participation in the study was voluntary and that they could terminate the interview at any time if they were unhappy with any aspect. Written consent was obtained.

3. Findings

3-1. Core category: Parent's journey to find their own answers to the problems of their withdrawn children.

'Parent's journey to find their own answers to the problems of their withdrawn children' emerged as a core category which represents each family's process of changing their psychological attitude to their child with Hikikomori (Social Withdrawal Syndrome). Five interrelated categories contributed to this: (1) 'having no idea what is going on with the child' (2) 'knowing the child's condition', (3) 'understanding the child's struggles', (4) 'accepting the child as he/she is', and (5) 'finding new values in a parent's life'.

3-2. Family's process of change

Five main stages emerged as part of the process by which families adjust to a socially withdrawn child, with each stage having multiple associated sub-categories. The five main stages were: (1) "Parents have no idea about what is going on with their child ," (2) "parents come to know their child's condition," (3) "parents understand their child's struggles," (4) "parents accept their child as he/she is" and (5) "parents find new value in their life."

Hereafter, I will illustrate parents' attitudes toward their children and the support they received by quoting excerpts from interviews with parents and support providers.

(1)Parents have no idea about what is going on with their child

In the first stage, when parents have no idea what is going on with their child, the family wants their withdrawn child to be involved in society. Parents are eager to do something to control their child, and are ashamed of their child being socially withdrawn. They do not accept their child's condition and feel it is their fault - as parents - that their child is withdrawn. Parents are at a loss as to how to deal with their child, and they are psychologically unstable. One father talked about the first stage:

"I had no idea what was going on with my son at all. He was a bright and cheerful boy. I don't know the reason why he now keeps to himself in his own room."

One mother blamed herself:

"Due to my bad nurturing, my daughter refused to go to school. I'm fully responsible."

At this stage, parents view their child's social withdrawal from a purely negative perspective. They also tended to blame the child and attempted to command and force their values onto the child, against the child's will.

One father said:

"I shout in a thunderous voice everyday ' Go out! Go to work !"

Such psychological attitudes were transformed in the next stage after the family received family support.

(2) Parents come to know their child's condition

In the second stage, parents come to understand their child's condition. The family obtains information and support by seeing a psychiatrist and utilizing counseling services for social withdrawal. Afterwards, however, they entered a psychological stage where they were shocked by acknowledging the reality of social withdrawal. One parent said*:*

"I wished there was an effective drug or magic bullet to cure my child's problem, but I realize that no such thing exists."

After becoming involved with other parents in social withdrawal self-help groups, parents are relieved to discover they are not alone in their situation. They reported feeling less stressed knowing that other families shared similar experiences. One mother said:

"I was relieved to hear there were many parents having the same experience as me at the self-help group."

Furthermore, parents' sense of shame was reduced after learning about the difficult psychological experiences common among young people. In this way, parents were able to share their common distress with other parents, and were able to overcome their shame for their child. One care provider said that parents in this situation could easily say to people around them:

"It's ok, there is no reason to hide our situation," or "Our son is taking a break for a while."

Reducing loneliness and shame in this way led parents to proactively deal with their child's social withdrawal and allowed them to move on to the next stage.

(3) Parents understand their child's struggles

The third stage involves parents coming to understand their child's struggles. Here, parents discover some of their child's positive aspects, though they still do not fully accept their child's negative aspects and still expect their child will become involved in society at large. By expressing their own feelings and struggles in a protected environment, such as a support group or – individually - with a care provider, parents were able to move on to the next stage where they are able to think of their child's feelings. Regarding this stage, one parent commented:

"Although parents and others close to the child have a difficult time, the child himself has an even more difficult time than anyone else. I understood my son's agony; such as he is not able to go

outside the home while he knows he should do so."

Then, through receiving individualized advice from care providers and discussing how to deal with their child, parents became able to objectively think about what they as parents can do for their child. One father confided their decision to devote the rest of their lives to dealing with the problem of social withdrawal, and said:

"I always think seriously about what I can do for my child."

Parents were able to obtain a multifaceted perspective on their child's situation and objectively acknowledge their child's condition and deal with it in cooperation with care providers. Parents became hopeful thattheir child would be capable of integrating into society at their own pace. Parents mentioned:

"Other parents tend to hope their children will have at least some kind of part-time job, but we don't think the children need to work full-time or even part-time for now."

As for parents who were able to obtain a positive view of their children, some mothers said:

"Now I see my child with less strict eyes than before. I am more relaxed. I am seeing my child more positively."

Parents who achieved a positive view of their children were next able to realize that parents themselves need to change. On this point several parents said:

"Although it was the child's problem, it was also largely the parent's problem as well."

Thus, the family who changed psychologically came to adopt the following attitude toward their child: 'not making someone feel pressure'; 'removing a child's uneasiness'; and, 'making a child's feeling of self-denial ease'.

(4) Parents accept their child as he/she is

In the fourth stage, parents are able to accept their child as he/she is. Families able to achieve a positive view of their child were also able to accept the child's limitations. Regarding this, one father remarked:

"There are things the child can do and there are things he cannot do. Keeping in mind what he is incapable of doing, I will encourage him to do what he can do."

Families able to see the child holistically could set aside their expectations (starting school, starting a career and becoming a part of society), and see that it is acceptable to "live off the beaten path." One parent spoke of the relief they felt at being released from following social expectations:

"I was able to relax since I didn't have the same expectations I would have if I was preparing child for the normal world."

Thus the parent was able to accept the life suited for their child. One father said:

"I see that my child thinks it is ok for a person to be socially withdrawn. My son looks like he wants to be inside his home seriously."

Eventually, parents realized their child was leading a life different from their own.

Parents who reached the stage where they were able to accept their child as he/she is exhibited attitudes such as "watching over their child" and "being there for their child with his/her struggles." One caregiver explained that,

"Watching over their child is the most important thing, but I do it without explicitly showing it. Being there for their child with his/her struggles was experiences of sharing and empathizing child's distress."

(5) Parents find new value in their life

The fifth and final stage involved parents finding new value in their lives. Realizing their child has a life separate from their own helped parents create an appropriate psychological distance between themselves and their child. In this way, families were able to achieve a sense of control over the problem of social withdrawal. One father said:

"I can now better control my son's problem compared to before, when nothing made sense."

Then, regardless of whether or not the child breaks free from social withdrawal, parents are able to find meaning in their child's life. One parent said:

"My child may not be fully content, but I hope he has a self-actualized life where he accepts there is nothing else he could have done."

Therefore, families who organize around social withdrawal and find value in their child's life arrive at a position where they are able to help other parents with socially withdrawn children. One father said:

"I want to help other parents, even if just a little. I hope I can encourage others to take heart from what we are doing."

In conclusion, parents who found their own answer to the social withdrawal problem were able to start a new life for themselves**.** These parents were able face their children with a new sense of value and respect. Parents themselves changed so as to find joy in their everyday relationship with their child in spite of social withdrawal. One care provider spoke of a family who reached this point:

"They were able to see their real child and enjoy everyday life together."

3-3. Support received by parents

The support used to help parents in the early stage primarily included the following:

information provision, psychological-medical help and support group work. Information provision helped parents understand mental health factors and how to access various support organizations. Characteristics of psychological-medical help include: assessing if the child has a mental illness, attempting to alleviate symptoms through medical treatment, and providing professional counseling. One father talked about meeting a psychiatrist in the early stage:

"I think psychiatrist is important as one of the supporters, because he can help me in the early stage. He prescribed medicine for my son."

Support group work allows parents to talk about their child's problem, prevents parents from feeling isolated, aids in the feeling of being in same struggle with other parents, provides information about the diversity of social withdrawal, provides opportunities for advice sharing, and helps parents see their experience objectively. One mother said:

"I can communicate freely and engage in mutually support among peers. I can talk about many things that I can't with others. I feel a sense of security in the support group. I need peer support."

When parents were in the subsequent stage, the following forms of support were provided: problem-solving help, spousal counseling, cognitive behavior approach, and empathetic directive therapy.

The problem solving approach helps parents understand the child's psychological condition, provides advice on how to respond to the child, helps parents think through problems with the child, and helps in responding to other specific problems. Spousal counseling is characterized by promoting the husband's involvement, promoting spousal cooperation in dealing with the child, unifying the parents' response to problems, and assessing family relationships. Both family and care providers emphasized that especially spousal counseling is very important among family support. One father told about the effect of receiving family support by both spouses:

"Family support promoted I discussed our problem with my wife so that we could perceive our daughter to the same way. So we could discover new viewpoints about her."

Characteristics of the cognitive therapeutic approach include removing preconceived notions about social withdrawal, thinking positively, noticing changes in the child, and seeing the child from many perspectives. One father talked about the efficacy of the cognitive therapeutic approach:

"I could view my son more fairly. He was certainly not lazy although he has stayed home for years. I gained a new perspective of my son."

The empathetic directive approach includes listening to parents, establishing a trustworthy relationship with support people, accepting parents' feelings, and helping parents express their feelings.

4. Discussion

4-1. Relationship between the parent's process of change and the support received

The purpose of the present study is to describe the process of changing attitudes of parents with a child with Hikikomori and the type of counseling support provided. The results describe 'Parent's journey to find their own answers to the problems of their withdrawal children', which consisted of five main stages of adjustment. At first when the child became withdrawn, parents fell into feelings of gloom and guilt, and their mental condition became unstable. Some studies, as well as the present one, show that parents who face the problems of Hikikomori have psychological disturbance. Amagaya et al.[22] stated that a family whose child has Hikikomori have many difficulties related to "Communication with the child"; "the child's future prospects"; "economic anxiety"; "frustration with the child"; "depressed feeling"; and, "concern with appearances". Parents of a Hikikomori child become depressed because of feelings of anxiety, helplessness, impatience, fatigue, exhaustion and self-condemnation[10].

In the first stage, the parents of a child with other mental problems have similar psychological attitudes. For example when a child is diagnosed with attention-deficit hyperactivity disorder (ADHD), almost all parents cannot accept that their child has a disease, and more than half the parents think that the child aquired ADHD owing to the parents themselves[23]. Likewise, Tanoue[24] reports that the family of a patient with schizophrenia get confused in the first stage. They are shocked by the fact that their family has a psychiatric disorder, and experience affective confusion. Since they cannot understand the patient's behavior, they are at a loss to know what to do. Moreover, sometimes the family exhibit psychosomatic manifestation.

By receiving support, psychological attitudes clearly changed. Families could come to accept and treat positively the fact that their cherished child was suffering from Hikikomori. Finally, they acquired a new perspective on life. This change can be said to be a growing process for the parents. This is a process requiring the parents to accept the child as he/she is, and the child's distinctive lifestyle also including negative aspects, and to find meaning in the child's life with Hikikomori, by discovering new life value in their lives. To support this process, the participants in the present study reported that problem-solving help; spousal counseling; cognitive therapeutic approach; and, empathetic directive therapy are effective. However, there is little support for parents in the subsequently stage.

Support for parents with Hikikomori children has not been sufficiently provided in Japan yet, though the necessity for the support has been recognized in recent years; for example the rate of provision of family support in Saitama Prefecture is only 76.9% [25]. The service consists of

introducing a psychiatrist or offering information on support groups[1].

Although Rodger & Mandich[26] suggest the importance of access to support which suits the family needs, in cases of developmental disease, such support is not offered in the case of Hikikomori. Support needs a specialist in Hikikomori who has sufficiently mastered the techniques of each type of support.

4-2. Clinical Implications

We have little information and knowledge about how to support for the family of a child with Hikikomori, and need evidence to plan, implements, and evaluate it. The present study shows the process of changing attitudes of parents with a Hikikomori child, and the relationship between this process and the type of counseling support provided. These findings can clarify the parents' needs, and contribute to supporting the family effectively.

This study also suggests some problems about family support in Japan. To meet family needs, services need to provide special support for Hikikomori. We have to immediately develop care providers with specialized knowledge and skill in dealing with Hikikomori, and enrich family support such as: problem-solving help; spousal counseling; cognitive behavior approach; and, empathetic directive therapy. If appropriate support to meet each family's needs can be offered, parents will be able to learn various things from the fact that their child has Hikikomori, and acquire new life values in their lives.

4-3. Limitation and significance of the study

We interviewed only parents who already received family support. The process of changing attitudes of parents with a child with Hikikomori, which were found in the present study, is based on the situation of families who have participated in family support positively. So, care must be taken in generalizing to other families.

The present findings must also be generalized to other countries with care, too. Hikikomori is still considered to be unique to Japan and likely to be influenced by political and cultural factors.

To my knowledge, this is the first report of the process by which the psychological attitudes of parents with a child with Hikikomori change by receiving support. We illustrated the process of changing the psychological attitudes of parents and the type of counseling support provided for them with detailed and concrete descriptions.

Study 2:
A Comparison between Fathers and Mothers of Difficulties With Children with Hikikomori Syndrome

Ⅰ. Development of a Scale of Difficulties Experienced by Parents of Children with Hikikomori Syndrome

1. Aims

Study 1 showed parents with a child with Hikikomori having various difficulties and there being eased by family support. We need evidence to plan, implement, and evaluate the support necessary for families of children with Hikikomori. The difficulties for parents of children with Hikikomori are one of the most important indicators for the assessment of family support.

There are some scales which assess the difficulties or burden for families caring for children with schizophrenia or physical disability, but not any scale for parents of children with Hikikomori. This Family Difficulties Scale cannot be applied to children with mental and physical disorders, because it only applies to children with Hikikomori whose daily living and functional activities do not decrease.

This Study 2 - Ⅰ aimed to develop an assessment of the difficulties faced by parents of children with Hikikomori, and to test the psychometric properties (validity and reliability) of this assessment scale.

2. Methods

2-1. Data collection

Participants

Participants who have a child with Hikikomori symdrone were recruited through the support organizations to which they belong. Mental and Welfare Centers from three adjoining prefectures in the Tokai region and four incorporated nonprofit organizations conducting self-help groups for parents with socially withdrawn children participated in this investigation. Parents were asked to complete the questionnaires anonymously and mail them to the supervising the University.

Measures

A family difficulties instrument was developed because, to the investigator’s knowledge, no

known questionnaires exist for assessing family difficulties relative to children with Hikikomori. The procedure for the development of the scale and its analysis are described in Figure 1.
The scale of the families' difficulties was derived from the results of Study 1 and previous research of families with children with Hikikomori. In addition, items were derived from the constructs identified in other family difficulties literature, from studies of families caring for Schizophrenics [27] and families of children with Cerebral Palsy [28].

The initial Family Difficulties Scale for families coping with Hikikomori, which was used in the study, consisted of 42 items describing eight difficulties related to community human resource; information utilization; understanding Hikikomori; relationship with the child; sense of well-being; marital cooperation; mental health expert support; and financial difficulties. Marital cooperation was included, following its importance becoming clean in the research for Study 1. All items were scored on a four-point Likert scale ranging from 1 ('strongly agree') to 4 ('strongly disagree). High scores were indicative of there being difficulties.

The demographic information related to the families and their dependents with Hikikomori, and the data on family difficulties, quality of life, and depression variables were elicited by self reporting questionnaires.

Quality of life was assessed with the short form of the Japanese version[29] of the World Health Organization quality of Life scale (WHO/QOL-26)[30]. WHO/QOL-26 includes four subscales: Physical Domain; Psychological Domain; Social Relationships; and, Environment. All items are scored on a five-point Likert scale. High scores are indicative of high QOL.

Depression was assessed with the Japanese version[31] of the Center for Epidemiologic Studies Depression Scale (CES-D)[32]. All items are scored on a four-point Likert scale. Depression is suspected if the CES-D score is 16 or higher. If the new scale can assess the family difficulties validity, it will have a negative correlation with the WHO/QOL score and a positive correlation with the CES-D score.

Ethical considerations

All participants were informed in writing about the study purpose and methods. They were assured that neither they nor their places of work would be identified. They were also informed that participation in the study was voluntary and that they could terminate at any time if they were unhappy with any aspect. Consent from participants was confirmed by their filling out the questionnaires. A university ethics committee approved the research protocol before starting the study (No:1419).

2-2. Sample

116 of 431 families to whom the questionnaires were distributed responded (response rate = 26.9%). The sample comprised all 176 parents (116 families). 72 parents (40.4%) were fathers and 104 (58.4%) were mothers. The average age was 60.8 years (SD =7.1). Of these178 parents, 124 (69.7%) participated in this study as couples (62 couples). Almost 80% of them have received family support. The average number of type of family services was 2.2 (SD =1.6), for the previous year.

The sample included two families with two withdrawn dependents. The sample concerned a total of 119 dependents: 96 (80.7%) were male and the average age was 30.2 (SD =6.7). Although about 70 percent of the dependents did not have a mental disorder leading to Hikikomori, they had been socially withdrawn for an average of 9.7 years each (SD =5.9). Table 5 describes the condition of dependents with Hikikomori for the month prior to this research. Nearly half (47.2%) of the children were able to go out freely but didn't participate in any social activity. In their attitudes to their families, those with Hikikomori who rejected at least one other member of their family amounted to almost 40%. The study investigated the problematic behavior of those with Hikikomori via a multiple answer questionnaire. Participants were given questions related to 'authoritative attitude in the home'; 'disorderly diet'; 'compulsive behavior'; 'destructive behavior'; 'violence in the home'; 'self-injury', and, disrupted sleep pattern. 61.7% of dependents evidenced at least one problematic behavior; the most common was "disrupted sleep pattern". 40% suffered with this.

2-4. Data analysis

Data analysis was conducted using the Statistical Package for the Social Sciences version 15, and Amos version 7 Significance level was set as $p<0.05$ (two-sided).

Item analysis

Item analysis was conducted by sampling the fathers' and mothers' responses and comparing them with samples from the total of parents' responses..Some items in the initial Family Difficulties Scale, which had significant bias in score distribution, were excluded from later analysis. The criterion of exclusion was (mean-SD) < 1(floor effect) or (mean+SD) >4 (ceiling effect).

Exploratory factor analysis

An exploratory factor analysis of the Family Difficulties Scale items was conducted in order to assess if any items in the scale were measuring aspects of the same underlying dimensions or factors.

To examine the cross-validity of responses from parents, the exploratory analysis was conducted by sampling the fathers' and mothers' responses, and comparing them together with samples from the total.

A least-square method without weighting analysis, with quatimax rotation, was used. A scree plot was used to determine a number of factors, with the criteria having eigenvalues greater than 1. A solution was deemed acceptable based on the following criteria: 1) all items load substantially on only 1 factor; 2) all items have a factor loading of at least 0.40; and 3) the items cluster together in a meaningful fashion. Scale scores were subsequently derived for each subject by computing the mean of the items comprising each factor.

Confirmatory factor analysis

Structural equation modeling (SEM) methods as implemented by AMOS[33] were used to test various models simultaneously. The hypothesized correlated three-factor model of the Family Difficulties Scale was tested to the fit of a one-factor model that assumes that all items load on one single underlying dimension.

Reliability analysis

Internal consistency was assessed using Cronbach alpha. Alpha coefficients were computed for the total scale and then every subscale.

Construct -related validity analysis

To assess validity, Family Difficulties Scale scores were compared with CES-D and QOL, and the variables related to withdrawn children by correlation coefficient.

3. Results

3-1. Item analysis

Score distribution of initial Family Difficulties Scale is reported in Table 6. Seven items had floor effect and five items had ceiling effect. These 12 items were excluded from later analysis.

3-2. Factor analysis

Based on eigenvalue graphing (Figure 2), a three-factor solution was extracted with eigenvalues of 2.8, 3.5 and 5.9, which together explained 41.3% of the variance.

After several refinements, three contractures were established and corresponded to difficulties

in marital cooperation (five item scale), psychological conflict with the dependent (seven item scale), and difficulties in support resource utilization (six item scale). The factor loadings and factor structure are reported in Table 7, and the descriptive statistics of items are reported in Table 8. The fathers' and mothers' samples had almost the same factor structure as the total sample.

The first factor was named 'Difficulties in marital cooperation'. It included, for example, questions such as 'I always share knowledge and information about Hikikomori with my partner', and 'I can discuss Hikikomori freely with my partner.' The second factor was named 'Psychological conflict with the child'. Its questions include, for example: 'I am worried about my child with Hikikomori', and 'I get involved in the problems of my child.' The third factor was named 'Difficulties in support resource utilization'.

The results of confirmative factor analysis (CFA) showed that the expected three-model fit to the data was better than the one-factor model (x^2 (df) = 764.48(3), $p<0.05$) (Table 9). Standardized solutions are shown for the one-factor model and three-factor model in figures 3 and 4, respectively. The correlation among these three factors was low (Table 10).

3-3. Reliability

Cronbach's alpha coefficient of the total scale was 0.88, and for each subscale were 0.88, 0.83, and 0.81 for marital cooperation, psychological conflict, and support resource utilization, respectively.

3-4. Relationship with other variables

Table 11 showed the scores of CES-D, QOL, and the Family Difficulties Scale. Table 12 showed correlation between Family Difficulties, QOL, depression, and child condition. Scale had negative correlation with the WHO/QOL score and positive correlation with the CES-D score. Comparing family difficulties with the childrens' conditions, the Family Difficulties Scale was scored high as parents whose child had much problematic behavior and was very socially withdrawn found their child was more rejective towards their family.

In comparison, between parents whose children have a mental disorder and those whose children do not, there were no significant differences in the Family Difficulties Scale (Table 13).

4. Discussion

4-1. Validity and reliability

Study 2 aimed to develop an assessment of the difficulties faced by parents of children with

Hikikomori, and to test the psychometric properties (validity and reliability) of this assessment scale：The Family Difficulties Scale in Children with Hikikomori. Internal consistency (Cronbach's α coefficient) of both the total score and all the subscales was high and acceptable (>0.800). Both exploratory and confirmatory factor analysis showed an acceptable degree of factor-based validity. A secondary structural model showed that a three-factor model fit best (SEM: GFI = 0.851, AGFI = 0.806, RMSEA = 0.08), although the goodness-of-fit criteria were not sufficient. The total score was significantly and negatively correlated with the WHO/QOL score and positively with the CES-D score. It is suggested that parents who have greater difficulties with their withdrawn child feel lower QOL and more severe depression. Parents, whose total score on the Family Difficulties Scale was higher, recoded their children as having much problematic behavior, being much socially withdrawn and being more rejective of their family. Thus, the criterion-related validity of the Family Difficulties Scale in Children with Hikikomori was supported. Moreover, the cross-validity between father and mother of the scale appears to be good, because both samples showed the same factor structures and acceptable consistency. Consequently, the results indicate that the newly developed Family Difficulties Scale is reliable and valid.

The final Family Difficulties Scale concerned characteristics of difficulties among parents whose children have Hikikomori, in contrast with the initial scale, regarding the following four aspects. Incidentally, three subscales consisting of 18 items were eventually extracted as the Family Difficulties Scale. First, marital cooperation; this was retained after factor analysis. Second, some difficulties in the families of people with schizophrenia and Cerebral Palsy, which were unrelated to those of families with children with Hikikomori, were removed. Third, the final Family Difficulties Scale evaluated difficulties which were not the affect of mental disorder, given that there were no significant differences in the Family Difficulties Scale between parents whose children have a mental disorder and those whose children do not. Fourth, parental responses; this scale is appropriate for measuring parental difficulties, especially among parents, given that because the responses in the present study were all those of mothers and fathers.

The Family Difficulties Scale in Children with Hikikomori consists of three subscales as a result of factor analysis. Marital Cooperation is an especially original concept among the three factors. On the other hand, it has been recognized that families who have children with mental problems had difficulties related to social support and psychiatric distress. For instance, McCubbin HL et al [34] reported four strategies: acquiring social support; seeking community resources; reframing; and, seeking spiritual support , which parents would think of when coping with problematic child behavior. Marital Cooperation was extracted by factor analysis because the content of this scale includes the items which arose from earlier qualitative research into parents'

experiences – study 1. Difficulties in marital cooperation may be particular and notable difficulties in studies of parents with withdrawn children.

4-2. Clinical Implication

Family Difficulties Scale in Children with Hikikomori is the first scale which can quantitatively measure difficulties of families with Hikikomori children, Thus, it is useful both to professionals providing families support and to families with Hikikomori children.

Providing professional support for families with Hikikomori is important, as children with Hikikomori rarely seek help on their own. The families play a central role in obtaining professional help, and families of children with Hikikomori often face many difficulties which support services can assist with. To date, we have difficulties in obtaining information and gaining knowledge with which to properly support families with children who have Hikikomori; and, we need such information and knowledge as evidence with which to plan, implement and evaluate our services. Information about family difficulties is one of the most important outcomes in family support. Family Difficulties Scale in Children with Hikikomori may contribute usefully for care providers to evaluate the effectiveness of their family support.

It is also important for families to perceive their own difficulties related to their Hikikomori children. Families can understand their level of difficulty easily and objectively using this Family Difficulties Scale in Children with Hikikomori.

4-3. Limitation and significance of the study

First, in respect of the study's limitation, I would like to note that the sample is small and response rate is low. Second, a majority of the respondents had accessibility to support services and the data collected in this study was obtained from parents who had already received family support. Third, the difficulties of the participants in the present study could be reflected in the quality of the family support which they have received, because the data were collected from parents who belonged to seven organizations providing support for families with Hikikomori children. The instrument needs further testing and evaluation with a larger sample.

It should be noted that there are two sub-scales of Family Difficulties Scale in Children with Hikikomori: Difficulties in support resource utilization, and Difficulties in marital cooperation. They don't have a significant correlation with parents' depression and child condition. We need to use the scale carefully and note that the results of the sub-scales were measured independently.

In the present study, parents whose children have a mental disorder were included, because many people who have used services for Hikikomori have had a psychiatric disorder diagnosed, and

the newly developed scale can therefore easily be utilized in clinical practice. On the other hand, it cannot evaluate difficulties related to mental disorders.

The Family Difficulties Scale in Children with Hikikomori is the first scale which can measure the difficulties of families with Hikikomori children. While King & Bernstein[14] reported that school refusal cases require comprehensive assessment and treatment, and advance have been made in the treatment of school refusal, additional controlled studies evaluating interventions for school refusal are needed. It is expected that the Family Difficulty Scale developed in the present study will assist a number of professionals in such related fields.

Ⅱ. A Comparison the influential factors of Family Difficulties with Children with Hikikomori Syndrome between Fathers and Mothers

1. Aims

In the results of Study1, I noted that the participants emphasized how spousal counseling is an especially important form of family support, and I described the effect of receiving family support by both spouses. Spousal counseling is characterized by promoting the husband's involvement; promoting spousal cooperation in dealing with the child; unifying the parents' responses to problems; and, assessing family relationships. Amagaya[22] state that parents with a child with Hikikomori have difficulty with "poor communication between both partners about the child " and "conflict in family relationships", and they need to have meetings participated in by both spouses. Spousal counseling has a very important role in family support for Hikikomori, and needs to be provided for more parents.

Despite the emphasized importance of spousal counseling, many fathers do not receive family support now in Japan. While mothers had consultation visits in 86.8% of cases, fathers had them in only 37.0% [35]. Social background in Japan can be considered a reason why fathers receive little family support. First, Japanese fathers have not developed familiarity with child-rearing, since their work keeps them very busy. Next, many public and medical institutions for mental health do not provide family support on holidays or at night. Moreover, family relationships including the relation between the child and father have to improve. About 40 percent of the children with Hikikomori avoided their father when they began to withdraw socially[17].

It is necessary to provide family support – especially spousal counseling - not only for the mother but also for the father in Hikikomori cases. Consequently, there is a possibility that the relationship between service use and difficulties may differ between fathers and a mothers. The Study 3 aims to describe family difficulties properties viewed especially in comparisons between fathers and mothers.

2. Methods

Sample

110 parents (55couples) were respondents in the subsequent analysis here, after excluding parents who had missing entries in their questionnaires, also after excluding others who had more than one child with Hikikomori.

Measures

The Family Difficulties Scale in Children with Hikikomori consists of 18 items corresponding to difficulties in marital cooperation (five item scale), psychological conflict with the child (seven item scale), and difficulties in support resource utilization (six item scale). All items are scored on a four-point Likert scale ranging from 1 (‘strongly agree’) to 4 (‘strongly disagree’). High scores are indicative of there being difficulties. Previous analysis demonstrated the validity and reliability of the scale.

The demographic information related to the families and their children with Hikikomori, and the data on family difficulties, quality of life, and depression variables were elicited by self reporting questionnaires.

Quality of life was assessed with the short form of the Japanese version[29] of the World Health Organization quality of Life scale (WHO/QOL-26)[30]. WHO/QOL-26 includes four subscales: Physical Domain, Psychological Domain, Social Relationships, and Environment. All items are scored on a five-point Likert scale. High scores are indicative of high QOL.

Depression was assessed with the Japanese version[31] of the Center for Epidemiologic Studies Depression Scale (CES-D) [32]. All items are scored on a four-point Likert scale. Depression is suspected if CES-D score is 16 or higher. If the new scale can assess the family difficulties validity, it will have a negative correlation with the WHO/QOL score and a positive correlation with the CES-D score.

This analysis compared fathers with mothers in terms of their degrees of family difficulties, QOL, depression, and amount of service use.

Data analysis

A paired t test and McNemar test were used to compare demographic variables; family difficulties; depression; QOL; and, service use. Analyses of covariance (ANCOVA) were employed to assess the impact of difficulties on parental differences regarding service use. Scores in the Family Difficulty Scale were entered as dependent variables, gender was entered as a fixed factor, and the number of services received was entered as covariates, to test the interaction of gender and the number of services received. In ANCOVA, age was adjusted via covariates, because there were significant differences between the ages of the fathers and mothers.

To assess the influential factors of Family Difficulties for families with children with Hikikomori, hierarchical multiple linear regression analyses were carried out in respect of gender. The independent variables were entered into the equation in the following order. At step 1, the mental status of children with Hikikomori such (as the period of suffering and the morbidity of any

mental disorder) were entered simultaneously. At step 2, children's current behavioral conditions (such as the number of problematic behaviors, scope of activity, attitude of family) were entered. At step 3, the parents' number of service uses was entered. All data analyses were conducted using the Statistical Package for the Social Sciences (version 15). Significance level was set as $p<0.05$ (two-sided).

3. Results

Table 14 presents the results of the study into demographic characteristics; service use; QOL; family difficulties, and depression. The average amount of service use received during the past year was significantly lower among fathers than mothers. Significantly few fathers participated in family support than mothers. While 94.5% of mothers received some kind of family support, only 61.9% of fathers received it. Average scores in the psychological domain of WHO/QOL and CES-D were not significantly different between fathers and mothers.

Regarding the Family Difficulties Sale (table 15), the total scores were not significantly different between fathers and mothers. Within three subscales, average scores of the difficulties in support resource utilization were significantly higher among fathers than mothers.

As the result of ANCOVA, gender differences in the relationship between service use and scores in the difficulties subscales were shown separately, with all totals and every subscale score. There was neither significant main effect nor interaction in scores for family difficulties or in psychological conflicts with the children. The difficulties in marital cooperation had a marginal difference of interaction ($F=3.92$, $df=1/109$, $p=0.05$), without significant main effect.. The difficulties in support resource utilization had a significant main effect regarding service use ($F=6.83$, $df=1/109$, $p=0.01$) but no significant interaction.

Table16 presents inter-correlations among the variables entered in the hierarchical multiple linear regression analyses. A high correlation coefficient was found for a number of services which fathers received and a number of services which the mothers received. The number of services which the fathers received was significantly and positively correlated with the scope of activity of their child with Hikikomori, while the number of services which mothers received was significantly and positively correlated with number of problematic behaviors.

Tables 17~20 show the results of hierarchical multiple linear regression analyses including the mental status of children with Hikikomori, the current condition of their behaviors, and the parents' number of services used. The number of services which the fathers received was significantly correlated with the lower total score of the Family Difficulties Scale among fathers (model Ⅲ). On

the other hand, morbidity of mental disorder was significantly and strongly correlated with the total score of the Family Difficulties Scale among mothers (model Ⅲ). For both genders, the number of services which the fathers received was significantly correlated with lesser difficulties in marital cooperation (model Ⅲ). Also for both genders, psychological conflicts with children was significantly and strongly correlated with the number of problematic behaviors; although, it was not significantly correlated with the parents' service use (modelⅢ). The number of services which the mothers received was significantly correlated with lesser difficulty in support resource utilization among both the mothers and the fathers, but only for the mothers was the morbidity of the mental disorder of their child significantly and strongly correlated (model Ⅲ).

4. Discussion

4-1. Comparison: fathers and mothers

The results of Study 2–Ⅱ showed some differences between fathers and mothers. First, the difficulties in marital cooperation had a significant difference only in the interaction between fathers and mothers. It was shown that the relation of the difficulties in marital cooperation and service use by fathers and mothers had a reverse tendency. There were fewer difficulties in marital cooperation for fathers receiving many services, while mothers receiving many services had more difficulties in marital cooperation. There are some reasons for this difference. Family support may not have enough effect on mothers to promote cooperation with fathers. The father who cooperates enough with his wife will use family support himself to reduce problems with his child with Hikikomori. On the other hand, the mother whose husband is not cooperative may need more support.

Second, while almost all mothers have received some kind of family support, only 60% of the fathers had received it. The average number of services received for the past year was significantly lower among fathers than mothers. Podolski & Nigg[16] examined role distress in fathers and mothers coping with children with childhood attention deficit hyperactivity disorder (ADHD), and indicated that mothers have greater role distress and may tend to activate more extensive coping efforts as a result, including seeking support from the community. For fathers, on the other hand, social support and accessing community resources were not significantly associated with role distress. One of the reasons why mothers actively seek support is strong psychological distress. Another reason is that there may be very few opportunities for fathers to receive support with Hikikomori children, because Japanese men in general think that their role is to work, and that housework and child-rearing should be entrusted to women.

Third, in the results of the hierarchical multiple linear regression analyses - for mothers -

whether their children with Hikikomori having any mental disorder or not contributes to their family difficulties. Alternatively, for fathers the number of services received contributes to their difficulties. However, the score of the adjusted R^2 was not high enough.

4-2. Clinical Implications

Findings demonstrate that fathers and mothers differ in need for family support. So, it is important to provide services which suit each need in order to carry out family support for parents of children with Hikikomori effectively.

For fathers, family support systems must first be improved immediately, so that more fathers can participate in it. In the present study, average scores for the difficulties in support resource utilization were significantly higher among fathers than mothers. Fathers have much difficulty in receiving family support, and - compared to mothers - few fathers have actually received family support.

It would also make a positive impact on all family members if fathers actively addressed their child's problems. The number of services which the fathers received was significantly correlated with lesser difficulty in marital cooperation in the present study. In addition, Kerr et al.[36] have noted the value of fathers' reports of child behavior, because only fathers predict the internalizing factor of their child (see: Rating Child Behavior Checklist; 2007).

It is a crucial issue to improve the accessibility to family support for fathers. In this respect, family support can try to offer services not only at daytime, and during the week, but also at a weekends or night-time, and to provide opportunities for fathers to talk about their difficulties with each other freely. Alternatively, supporters can raise awareness of the need to involve fathers in the problems of their children.

For mothers of children with Hikikomori, family support should alleviate their psychological distress. Average scores in the psychological domain of WHO and CES-D were significantly higher among mothers than fathers. Mothers have greater psychiatric distress and need more support. The implication is that – as some studies illustrate - parents' depressive symptoms exacerbate a child's problematic behavior. Elgar et al.[37] examined parental behaviors as mediators in links between depressive symptoms in mothers and fathers and child adjustment problems, and the findings support a hypothesis that the quality of a child's rearing environment is one mechanism that carries risk to children of depressed parents. Interventions for parenting responsibilities could help reduce the risk of some childhood disorders. Marchand & Hock[38] reported that Mothers and fathers who reported more depressive symptoms also reported more avoidance and attacking and avoidance conflict-resolution strategies in the marriage. Mothers and fathers who reported more

conflict-resolution strategies had children who showed more internalizing behaviors.

4-3. Limitation and significance of the study

The present findings must be generalized to all families with Hikikomkori with great care, as noted in Study 2. First, the sample is small and the response rate is low. This may be because many fathers who responded in the present study may have a good marital relationship and are interested in their children with Hikikomori. Second, a majority of the respondents had easy access to support, so that the data collected in this study was carried out only with parents who have already received family support.

This is the first study focused on the differences in difficulties between fathers and mothers whose child has Hikikomori Syndrome. A major strength of this study is using data from couples. We can compare the differences in the difficulties feature between fathers and mothers, without impact on the data of their children's condition.

V. Conclusion

This study concerned a qualitative and quantitative research study regarding parents who received family support with their children who were suffering from Hikikomori Syndrome. Study 1 described the process of changing attitudes of parents with a child with Hikikomori and the relationship between this process and the type of counseling support provided. The results described: 'Parents' journey to find their own answers to the problems of their withdrawn children, which consisted of five main stages of adjustment. It was indicated that spousal counseling was a very important family support measure for parents undergoing this process. Study 2 reported the development of an instrument for the assessment of family difficulties regarding children with Hikikomori - the Family Difficulties Scale in Children with Hikikomori, and confirmed its validity and reliability. The scale consisted of three sub-scales, with difficulties in Marital Cooperation being significant. Study 3 described family difficulties properties, especially viewed from comparisons between fathers and mothers using the Family Difficulties Scale, which was described in Study 2. It may lead to the alleviation of the difficulties in marital cooperation; most significantly it pointed to a need for fathers to receive more services. Indeed, only half of the fathers received family support, while almost all the mothers had received some. The conclusion that is drawn here is that it is a crucial issue in mental health care for improvements to be made in the accessibility of support for fathers. Some other useful and important suggestions in the clinical practice of family support have been given, too.

Overall, this study provides a new perspective on families suffering from Hikikomori Syndrome, and suggests that it is important for professionals not only to support fathers as well as mothers, but also to encourage parents to address their difficulties together.

(9,500 words)

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Table 1　Sociodemographic characteristics of families (individual interview)

family				Withdrawn child					
Relationship to child	Age	Employment	Period of receiving support	Gender	Current age	Genitures	Age of onset of Hikikomori	School refusal	Psychiatric consultation
father	early 60s	retired	5 years	F	29	2nd child	14	yes	yes
mother	early 60s	housewife	15 years	M	35	1st child	18	no	has a history
mother	late 60s	housewife	4 months	M	35	1st child	22	yes	no
father	late 50s	full-time	1 year	F	29	1st child	14	yes	yes
mother	late 50s	part-time							
father	early 60s	retire	12 years	M	35	2nd child	18	yes	yes
mother	late 50s	full time	4 years	M	28	2nd child	18	yes	no
father	early 60s	full time	2 years	M	25	3rd child	20	yes	has a history

Table 2　Sociodemographic characteristics of families (focus group interview)

	family				Withdrawn child					
	Relationship of child	Age	Employment	Period of support receiving	Gender	Current age	Genitures	Age of onset of Hikikomori	School refusal	Psychiatric consultation
Governmental group	mother	late 40s	part-time	9 months	F	22	3rd child	20	yes	no
	mother	early 50s	housewife	10 months	F	28	1st child	13	yes	no
					M	18	3rd child	15	yes	has a history
	mother	late 40s	part-time	2 years and 11 months	M	16	3rd child	13	yes	no
	mother	late 40s	part time	2 years and 6 months	F	17	1st child	16	yes	no
Nongovernmental group	mother	early 60s	housewife	5 years and 5 months	M	31	2nd child	22	no	has a history
	mother	late 60s	housewife	5 years and 5 months	M	39	2nd child	18	yes	has a history
	father	late 50s	full-time	5 years	M	21	1st child	15	yes	no
	father	early 60s	retired	6 years	F	33	1st child	18	no	yes
	mother	late 60s	house-wife	5 years and 5 months	M	38	1st child	30	yes	yes
	mother	late 50s	part-time	5 years and 5 months	F	32	1st child	20	yes	yes

Table 3　Sociodemographic characteristics of care givers

Gender	Age	Career		Work site	Specialization
		mental health	support of Hikikomori		
F	early 50s	3 years	1 years	Non-governmental support organizations	psychology counselor
F	early 50s	3 years	6 years	Non-governmental support organizations	manager
F	early 30s	8 years	1 years	Mental Health and Welfare Center	clinical psychotherapist

Table 4 Sociodemographic characteristics of parents (N=176)

	mean (SD; range)	
Age in years (n=174)	60.8 (7.1; 37-81)	
	n	%
Relationship to child with Hikikomori		
father	72	40.9
mother	104	59.1
Number of children with Hikikokmori		
1	171	96.1
2	7	3.9
Working styles (n=174)		
not working	78	43.8
full-time job	39	21.9
part-time job	57	32.0
Marital status (n=173)		
married/ living together	153	86
married/ separation	9	5.1
divorced	4	2.2
widowed	7	3.9
Participants in family support[a] (n=174)		
medical setting	73	41
home visiting care	34	19.1
ambulant counseling	71	39.9
self-help group	98	55.1
telephone counseling	20	11.2
e-mail counseling	5	2.8
lecture meeting	89	50
Number of services received[a] (n=175)		
0	30	16.8
1	37	20.8
2	35	19.7
3	34	19.1
4	15	8.4
5	22	12.4
6	2	1.1

Notes: [a]=over the past year

Table 5 Sociodemographic characteristics of children

	mean (SD; range)	
Age[a] (n=118)	30.24 (6.75; 14-49)	
Age since Hikikomori started[a] (n=115)	20.42（5.77；10-37)	
Period of Hikikomori[a] (n=114)	9.78 (5.97; 0-32)	
Age since family visited support organization at first[a] (n=113)	21.92（7.39；8-45)	
	n	%
Gender		
male	96	80.7
female	23	19.3
Geniture		
first child	52	43.7
(no sibiling)	(9)	(7.6)
second child	56	47.1
third child	10	8.4
fourth child	1	0.8
Prevalence of mental disorder (n=115)	31	26.1
fulfilling guideline of Hikikomori (n=111)	55	46.2
Experience of school refusal (n=116)	65	54.6
Problematic behaviors (N=117)		
disrupted sleep patterns	47	39.5
self-injury	1	0.9
violence in the home	5	4.3
destructive behavior	15	12.6
compulsive behavior	15	12.6
disorderly diet	28	23.5
authoritative attitude in the home	15	12.6
Number of problematic behaviors（n=117)		
0	44	37
1	37	31.1
2	23	19.3
3	9	7.6
4	2	1.7
5	2	1.7
Scope of activity for the past month（n=111)		
participating in social activities	3	2.5
going out freely, excluding social activities	49	41.2
going out with reservations	30	25.2
being freely limited in home	22	18.5
keeping in one's room	7	5.9
Attitude to family for the past month（n=111)		
not rejecting family members	66	55.5
rejecting some of the family members	30	25.2
rejecting all of the family members	15	12.6

Notes: [a]=years

Table 6 Means and deviations of the initial Family Difficulties Scale 42 items

	Parents (N=176)				Fathers (n=72)				Mothers (n=104)			
	mean	SD	mean-SD	mean+SD	mean	SD	mean-SD	mean+SD	mean	SD	mean-SD	mean+SD
1 I have friends who I can consult about Hikikomori.	2.38	1.12	1.26	3.50	2.04	0.99	1.05	3.04	2.61	1.15	1.46	3.77
2 I am supported by other families whose children suffer from Hikikomori.	2.15	1.09	1.06	3.24	1.95	1.04	**0.91**	2.99	2.28	1.12	1.16	3.40
3 I have someone who I can talk to freely concerning my ideas and feelings about Hikikomori.	2.63	1.14	1.49	3.77	2.23	1.13	1.10	3.36	2.90	1.09	1.82	3.99
4 I feel lonely because I don't have anyone I can talk to freely about Hikikomori.	2.91	1.00	1.91	3.91	2.84	1.10	1.74	3.94	2.97	0.94	2.04	3.91
5 I know the support resource which I will be able to use in the future.	2.39	1.03	1.36	3.43	2.11	1.00	1.11	3.12	2.57	1.02	1.55	3.58
6 I know the support resource for Hikikomori which I can use now.	2.68	1.00	1.69	3.68	2.44	1.04	1.40	3.47	2.84	0.93	1.90	3.77
7 I know the future progress of my child's condition.	2.07	0.86	1.21	2.94	1.85	0.82	1.03	2.66	2.22	0.87	1.35	3.10
8 I I have heard the experiences of people who recovered from Hikikomori.	2.95	1.13	1.83	**4.08**	2.68	1.15	1.53	3.84	3.17	1.06	2.10	**4.23**
9 I have heard the condition of families whose children recovered from Hikikomori.	3.16	0.95	2.21	**4.11**	2.99	1.07	1.92	**4.05**	3.29	0.85	2.44	**4.14**
10 I have heard the experiences of families whose children recovered from Hikikomori.	2.71	1.12	1.58	3.83	2.55	1.13	1.42	3.68	2.82	1.12	1.70	3.94
11 I don't know what information is useful.	2.50	0.98	1.52	3.48	2.59	1.05	1.54	3.63	2.44	0.94	1.50	3.37
12 I need financial support for the daily life of child with Hikikomori.	2.08	1.02	1.06	3.11	2.15	1.10	1.05	3.26	2.04	0.98	1.06	3.01
13 I need financial support for the future life of my child with Hikikomori.	1.70	0.87	**0.83**	2.58	1.76	0.90	**0.86**	2.67	1.66	0.86	**0.80**	2.52
14 I need financial support to be able to use the sevices for children with Hikikomori.	1.89	0.93	**0.96**	2.82	1.89	0.96	**0.93**	2.85	1.89	0.93	**0.96**	2.82
15 I need financial support to prepare my child with Hikikomori to hold a job or attend school.	1.83	0.89	**0.94**	2.71	1.81	0.96	**0.85**	2.77	1.83	0.85	**0.99**	2.68
16 I understand the anguish of children with Hikikomori.	3.31	0.73	2.58	**4.04**	3.14	0.84	2.30	3.98	3.42	0.62	2.80	**4.04**
17 I respect the need to be patient with children suffering from Hikikomori.	3.27	0.72	2.55	**4.00**	3.22	0.80	2.42	**4.03**	3.31	0.67	2.64	3.99
18 I am earger for my child with Hikikomori to attend school or hold a job.	1.79	0.91	0.88	2.70	1.68	0.86	**0.82**	2.55	1.87	0.94	**0.93**	2.81
19 I compare children with Hikikomori to others of the same age without it.	2.14	0.92	1.22	3.05	1.93	0.92	1.02	2.85	2.30	0.89	1.42	3.19
20 I talk to my child with Hikikomori about hobbies and news.	2.57	1.04	1.52	3.61	2.33	1.05	1.28	3.37	2.75	1.01	1.75	3.76
21 I have a joke with my child with Hikikomori.	2.36	1.07	1.29	3.43	2.07	1.01	1.06	3.08	2.56	1.08	1.48	3.64
22 I often have a quarrel with my child with Hikikomori.	3.13	0.86	2.27	3.98	3.21	0.84	2.37	**4.05**	3.06	0.87	2.19	3.92
23 I always talk down to my child with Hikikomori	3.15	0.83	2.33	3.98	3.20	0.82	2.38	**4.02**	3.13	0.83	2.30	3.96
24 I get involved in the problems of my child with Hikikomori.	2.68	0.93	1.76	3.61	2.80	0.97	1.84	3.77	2.58	0.89	1.69	3.48
25 I don't know how to communicate with my child with Hikikomori.	2.32	0.87	1.46	3.19	2.20	0.83	1.37	3.03	2.41	0.89	1.52	3.30
26 I feel anger and frustration with my child with Hikikomori.	2.38	0.83	1.55	3.21	2.34	0.85	1.49	3.19	2.41	0.82	1.59	3.24
27 I am worried about my child with Hikikomori.	2.41	0.91	1.50	3.31	2.48	0.98	1.50	3.46	2.37	0.86	1.50	3.23
28 I caused my child to suffer from Hikikomori.	2.42	0.78	1.63	3.20	2.39	0.84	1.55	3.24	2.41	0.72	1.69	3.13
29 Care for my child with Hikikomori drains me physically and emotionally.	2.49	0.81	1.67	3.30	2.58	0.76	1.82	3.34	2.42	0.85	1.57	3.27
30 I worry that my status within the local community will be affected by my child.	2.34	0.88	1.46	3.22	2.33	0.96	1.37	3.29	2.33	0.84	1.50	3.17
31 I feel anxious and rushed about the future of my family.	1.83	0.77	1.06	2.60	1.86	0.80	1.05	2.66	1.81	0.76	1.05	2.57
32 I always share knowledge and information about Hikikomori with my partner.	2.76	0.92	1.84	3.68	2.96	0.76	2.20	3.73	2.64	0.99	1.66	3.63
33 I can discuss Hikikomori freely with my partner.	2.86	0.95	1.91	3.81	3.16	0.79	2.37	3.95	2.68	0.99	1.69	3.67
34 I handle the problems of Hikikomori differently to my partner.	2.56	0.81	1.75	3.36	2.46	0.72	1.74	3.18	2.61	0.85	1.76	3.47
35 I and my partner support each other emotionally.	2.70	0.92	1.77	3.62	2.82	0.82	1.99	3.64	2.64	0.98	1.66	3.61
36 I participate in lecture meetings and consultations about social withdrawal together with my partner.	2.40	1.10	1.30	3.51	2.54	1.08	1.47	3.62	2.34	1.11	1.22	3.45
37 I deal with Hikikomori in collaboration with my partner.	2.78	0.92	1.86	3.69	2.96	0.78	2.18	3.73	2.69	0.97	1.73	3.66
38 I have specialists who I can consult about Hikikomori.	2.57	1.10	1.48	3.67	2.30	1.00	1.30	3.31	2.74	1.13	1.61	3.86
39 My child with Hikikomori was examined by a psychiatrist.	2.28	1.09	1.18	3.37	2.19	1.03	1.16	3.21	2.31	1.13	1.18	3.45
40 I have heard from specialists about the mental problems related to Hikikomori.	2.75	1.08	1.67	3.83	2.43	1.14	1.29	3.57	2.96	0.99	1.97	3.94
41 I have heard from specialists about communication with children with Hikikomori.	3.04	0.95	2.09	3.99	2.85	1.03	1.83	3.88	3.16	0.89	2.27	**4.04**
42 I have heard from specialists about children with Hikikomori preparing to hold jobs or attend schools.	2.72	1.01	1.71	3.72	2.64	1.03	1.61	3.67	2.77	1.00	1.77	3.78

Table 7 Factor structure for Family Difficulties Scale in Children with Hikikomori

Factors	Factor scale name	parents N=176 (α=0.858)	father n=72 (α=0.727)	mother n=104 (α=0.860)
		Factor loadings		
1	Difficulties in marital cooperation	(α=0.888)	(α=0.808)	(α=0.795)
	32 I always share knowledge and information about Hikikomori with my partner.	0.913	0.876	0.952
	33 I can discuss Hikikomori freely with my partner.	0.881	0.850	0.862
	37 I deal with Hikikomori in cooperation with my partner.	0.817	0.777	0.879
	35 I and my partner support each other emotionally.	0.742	0.539	0.806
	36 I participate in lecture meetings and consultation about social withdrawal together with my partner.	0.566	0.573	0.550
2	Psychological conflict with the child	(α=0.831)	(α=0.762)	(α=0.899)
	27 I am worried about my child with Hikikomori.	0.810	0.810	0.803
	24 I get involved in the problems of my child with Hikikomori.	0.654	0.654	0.692
	26 I feel anger and frustration with my child with Hikikomori.	0.647	0.647	0.769
	29 Care for my child with Hikikomori drains me physically and emotionally.	0.609	0.609	0.601
	30 I worry that my status within the local community will be affected by my child.	0.601	0.601	0.587
	25 I don't know how to communicate with my child with Hikikomori.	0.600	0.600	0.548
	31 I feel anxious and rushed about the future of my family.	0.540	0.540	0.580
3	Difficulties in support resource utilization	(α=0.813)	(α=0.825)	(α=0.825)
	5 I know the support resource which I will be able to use in the future.	0.814	0.901	0.797
	6 I know the support resource for Hikikomori which I can use now.	0.807	0.766	0.889
	7 I know the future progress of my child's condition.	0.676	0.753	0.639
	3 I have someone who I can talk to freely concerning my ideas and feelings about Hikikomori.	0.603	0.558	0.413
	38 I have specialists who I can consult about Hikikomori.	0.538	0.634	0.447
	10 I have heard the experiences of families whose child recovered from Hikikomori.	0.471	0.522	0.388

Notes: α= Cronbach's alpha coefficient

Table 8 Descriptive statistics of the final Family Difficulties Scale 18 items

Factors	Items	parents (N=176)				father (n=72)				mother (n=104)			
		Strongly Disagree	Disagree	Agree	Strongly Agree	Stromgly Disagree	Disagree	Agree	Strongly Agree	Stromgly Disagree	Disagree	Agree	Strongly Agree
		n (%)				n (%)				n (%)			
MC	32 I always share knowledge and information about Hikikomori with my partner.	20 (11.4)	41 (23.3)	77 (43.8)	38 (21.6)	2 (2.8)	16 (22.5)	36 (50.7)	17 (13.9)	17 (16.5)	24 (23.3)	41 (39.8)	21 (20.4)
	33 I can discuss Hikikomori freely with my partner.	17 (9.7)	42 (23.9)	66 (37.5)	51 (29.0)	1 (1.4)	14 (19.7)	29 (40.8)	27 (38.0)	15 (14.6)	27 (26.2)	37 (35.9)	24 (23.3)
	37 I deal with Hikikomori in cooperation with my partner.	20 (11.4)	36 (20.5)	82 (46.6)	38 (21.6)	3 (4.2)	13 (18.3)	39 (54.9)	16 (22.5)	15 (14.6)	23 (22.3)	43 (41.7)	22 (21.4)
	35 I and my partner support each other emotionally.	22 (12.5)	43 (24.4)	77 (43.8)	34 (19.3)	5 (7.0)	16 (22.5)	37 (52.1)	13 (18.3)	16 (15.5)	26 (25.2)	40 (38.8)	21 (20.4)
	36 I participate in lecture meetings and consultation about social withdrawal together with my partner.	48 (27.3)	45 (25.6)	45 (25.6)	38 (21.6)	15 (21.1)	18 (25.4)	21 (29.6)	17 (23.9)	31 (30.1)	27 (26.2)	24 (23.3)	21 (20.4)
PC	27 I am worried about my child with Hikikomori.	28 (15.9)	68 (38.6)	58 (32.9)	22 (12.5)	13 (18.3)	20 (28.2)	27(38.0)	11 (15.5)	15 (14.6)	46 (44.7)	31 (30.1)	11 (10.7)
	24 I get involved in the problems of my child with Hikikomori.	16 (9.1)	63 (35.8)	56 (31.8)	41 (23.3)	6 (8.5)	22 (31.0)	21 (29.6)	22 (31.0)	10 (9.7)	41 (39.8)	34 (33.0)	18 (17.5)
	26 I feel anger and frustration with my child with Hikikomori.	23 (13.1)	78 (44.3)	59 (33.5)	16 (9.1)	11 (15.5)	29 (40.8)	25 (35.2)	6 (8.5)	12 (11.7)	47 (45.6)	34 (33.0)	10 (9.7)
	29 Care for my child with Hikikomori drains me physically and emotionally.	17 (9.7)	73 (41.5)	68 (38.6)	18 (10.2)	5 (7.0)	24 (33.8)	36 (50.7)	6 (8.5)	12 (11.7)	48 (46.6)	31 (30.1)	12 (11.7)
	30 I worry that my status within the local community will be affected by my child.	28 (15.9)	77 (43.8)	52 (29.5)	19 (10.8)	14 (19.7)	26 (36.6)	22 (30.9)	9 (12.7)	14 (13.6)	51 (49.5)	28 (27.2)	10 (9.7)
	25 I don't know how to communicate with my child with Hikikomori.	29 (16.5)	76 (43.2)	54 (30.7)	17 (9.7)	12 (16.9)	37 (52.1)	16 (22.5)	6 (8.5)	17 (16.5)	38 (36.9)	37 (35.9)	11 (10.7)
	31 I feel anxious and rushed about the future of my family.	63 (35.8)	83 (47.2)	24 (13.6)	6 (3.4)	25 (35.2)	32 (45.1)	11 (15.5)	3 (4.2)	38 (36.9)	49 (47.6)	13 (12.6)	3 (2.9)
SR	5 I know the support resource which I will be able to use in the future.	46 (26.1)	39 (22.2)	65 (36.9)	26 (14.8)	26 (36.6)	14 (19.7)	26 (36.6)	5 (7.0)	20 (19.4)	24 (23.3)	39 (37.9)	20 (19.4)
	6 I know the support resource for Hikikomori which I can use now.	30 (17.0)	34 (19.3)	76 (43.2)	36 (20.5)	19 (26.8)	12 (16.9)	31 (43.7)	9 (12.7)	11 (10.7)	21 (20.4)	45 (43.7)	26 (25.2)
	7 I know the future progress of my child's condition.	49 (27.8)	74 (42.0)	43 (24.4)	10 (5.7)	27 (38.0)	27 (38.0)	15 (21.1)	2 (2.8)	22 (21.4)	45 (43.7)	28 (27.2)	8 (7.8)
	3 I have someone who I can talk to freely concerning my ideas and feelings about Hikikomori.	42 (23.9)	33 (18.8)	51 (28.9)	50 (28.4)	25 (35.2)	17 (23.9)	17 (23.9)	12 (16.9)	17 (16.5)	15 (14.6)	33 (32.0)	38 (36.9)
	38 I have specialists who I can consult about Hikikomori.	39 (22.29	43 (24.4)	51 (29.0)	43 (24.4)	18 (25.4)	21 (29.6)	23 (32.3)	9 (12.7)	21 (20.4)	19 (18.4)	30 (29.1)	33 (32.0)
	10 I have heard the experiences of families whose child recovered from Hikikomori.	35 (19.9)	38 (21.6)	48 (27.3)	55 (31.3)	18 (25.4)	12 (16.9)	25 (35.2)	16 (22.5)	17 (16.5)	24 (23.3)	23 (22.3)	39 (37.9)

MC=Difficulties in marital cooperation, PC=Psychological conflict with the child, SR=Difficulties in support resource utilization

Table 9 Results of confirmatory factor analyses of Family Difficulties Scale in Children with Hikikomori (N=176)

Model	x2	df	GFI	AGFI	CFI	RMSEA	AIC
Model 1 (1factor)	1040.54	135	0.528	0.402	0.327	0.198	1112.5
Model 2 (3factors)	276.05	132	0.851	0.806	0.893	0.080	354.0

Notes: GFI = Goodness-of-Fit Index; AGFI = Adjusted Goodness-of-Fit Index;

CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation;

AIC = Akaike's Information Criterion

Table 10 Correlation among three factors (N=176)

	Marital cooperation	Psychological conflict	Support resource utilization	Total Score
Marital cooperation	1.000	0.045	0.191*	0.587**
Psychological conflict		1.000	0.305**	0.671**
Support resource utilization			1.000	0.761**
Total score				1.000

*p<0.05, **p<0.01

Table 11 Means and deviations of Family Difficulties Scale, WHO/QOL-26, and CES-D (N=176)

	mean (SD; range)
Family Difficulties Scale in Children with Hikikomori	
Total score (18items)	44.9 (8.5; 22-67)
Difficulties in marital cooperations (5items)	13.4 (3.9; 5-20)
Psychological conflict with the child (7items)	16.4 (4.1; 7-26)
Difficulties in support resource utilization (6items)	15.0 (4.4; 6-24)
WHO/QOL-26 average	
Total score	3.1 (0.5; 1.8-4.7)
Physical Domain	3.4 (0.7; 1.7-8.2)
Psychological Domain	3.1 (0.6; 1.5-4.5)
Social relationships	3.0 (0.5; 1.0-4.0)
Environment	3.1 (0.5; 1.2-4.2)
CES-D	16.0 (9.9; 0-54)

Table 12　Corrrelation between Family Difficulties, QOL, depression, and child condition (N=176)

Family Difficulties Scale in Children with Hikikomori	Total score	DM[a]	PC[a]	SR[a]
	r	r	r	r
Child condition				
Number of problematic behaviors	0.165 *	0.004	0.227 **	0.095
Scope of activity[b](N=164)	0.223 **	0.113	0.234 **	0.101
Attitude to family[c](N=163)	0.172 *	0.109	0.234 **	0.014
WHO/QOL-26 Total	-0.550 **	-0.328 **	-0.499 **	-0.281 **
Physical Domain	-0.391 **	-0.268 **	-0.322 **	-0.200 **
Psychological Domain	-0.530 **	-0.261 **	-0.506 **	-0.295 **
Social relationships	-0.449 **	-0.243 **	-0.399 **	-0.259 **
Environment	-0.527 **	-0.347 **	-0.496 **	-0.224 **
CES-D	0.309 **	0.136	0.386 **	0.101

r=Pearson's product-moment correlation coefficient

[a] MC=Difficulties in marital cooperation, PC=Psychological conflict with the child, SR=Difficulties in support resource utilization

[b] 0= participating in social activities,1=going out freely excluding social activities, 2=going out with reservations, 3= being freely limited in home, 4=keeping in one's room

[c] 1=not rejecting the family members, 2= rejecting some of the family members, 3= rejecting all of the family members

*p<0.05, **p<0.01

Table 13 Comparison between parents whose children have a mental disorder and those whose children do not

Morbidity of mental disorder	yes	no		
	mean (SD)	mean (SD)	t-value	p
Family Difficulties Scale in Children with Hikikomori	n=37	n=107		
Total score (18items)	46.7 (9.5)	43.6 (7.8)	1.904	0.080
Difficulties in marital cooperation (5items)	13.7 (3.9)	12.8 (3.7)	1.260	0.845
Psychological conflict with the child (7items)	17.4 (4.7)	16.2 (3.8)	1.576	0.170
Difficulties in support resource utilization (6items)	15.4 (4.7)	14.5 (4.3)	1.031	0.398
WHO/QOL-26 average	n=36	n=105		
Total score	3.2 (0.5)	3.1 (0.5)	1.456	0.148
Physical Domain	3.4 (0.6)	3.3 (0.7)	1.003	0.317
Psychological Domain	3.2 (0.6)	3.0 (0.5)	1.125	0.263
Social relationships	3.2 (0.5)	3.0 (0.5)	2.225*	0.028
Environment	3.2 (0.5)	3.1 (0.5)	1.201	0.232
	n=37	n=107		
CES-D	17.4 (9.8)	12.7 (9.1)	-2.547*	0.010

*p<0.05

Table 14 Comparison between fathers and mothers of demographic characteristics, service use, QOL, and depression（N=110)

	fathers (n=55)		mothers (n=55)		t-value[d]	p
	mean (SD; range)		mean (SD; range)			
Age in years	63.5 (7.1; 43-81)		59.4 (6.4; 43-76)		10.119**	<0.01
Number of services received[a]	1.6 (1.6; 0-5)		2.6 (1.5; 0-6)		-4.219**	<0.01
	n	%	n	%	χ^2value[c]	p
Working styles						
not working	14	37.8	23	62.2		
full-time job	18	48.6	5	13.5	11.67**	<0.01
part-time job	5	13.5	9	24.3		
Particpates in family support[a]						
no	21	38.1	3	5.5	**	<0.01
yes	34	61.9	52	94.5		
medical setting						
no	40	72.7	27	49.0	**	<0.01
yes	15	27.3	28	51.0		
home visiting care						
no	46	83.6	43	78.2		0.62
yes	9	16.4	12	21.8		
ambulant counseling						
no	38	69.1	28	50.9	*	0.02
yes	17	30.9	27	49.1		
self-help group						
no	32	58.2	15	27.3	**	<0.01
yes	23	41.8	40	72.7		
telephone counseling						
no	52	94.5	49	89.1		0.45
yes	3	5.5	6	10.9		
e-mail counseling						
no	54	98.2	53	96.4		1.00
yes	1	1.8	2	3.6		
lecture meeting						
no	33	60.0	25	45.5		0.05
yes	22	40.0	30	54.5		
	mean (SD; range)		mean (SD; range)		t-value[d]	p
WHO/QOL-26 average						
total	3.3 (0.4; 2.5-4.7)		3.2 (0.5; 1.8-4.2)		1.393	0.17
Physical Domain	3.6 (0.8; 2.4-8.2)		3.4 (0.6; 1.7-4.7)		1.421	0.16
Psychological Domain	3.2 (0.5; 1.8-4.1)		3.1 (0.6; 1.5-4.5)		1.579	0.12
Social relationships	3.1 (0.4; 2.0-4.0)		3.2 (0.4;1.6-4.0)		-0.603	0.54
Environment	3.2 (0.4; 2.3-4.1)		3.1 (0.5; 1.2-4.1)		1.354	0.18
CES-D	14.3 (8.7; 3-41)		16.3(9.0; 8-40)		-1.129	0.26
	n	%	n	%	χ^2value[c]	p
Depression state[b]						
yes	19	34.5	26	47.3		0.24
no	36	65.5	29	52.7		

Notes; a= for the past year, b=Cut-off- points of CES-D is 16, c=by McNemar test, d= by paired t test
*p<0.05, **p<0.01

Table 15　Comparison of Family Difficulties Scale scores between mothers and fathers (N=110)

	fathers (n=55)	mothers (n=55)	t-value	p
	mean (SD; range)	mean (SD; range)		
Total score (18items)	44.9 (7.6; 27-63)	45.7 (9.5; 22-67)	- 0.547	0.58
Difficulties in marital cooperation (5 items)	14.6 (3.3; 7-20)	13.8 (3.8; 5-20)	1.716	0.09
Psychological conflict with the child (7 items)	16.7 (3.9; 7-26)	16.2 (4.6;7-26)	0.682	0.49
Difficulties in support resource utilization (6 items)	13.5 (4.5; 6-24)	25.6 (4.1; 6-23)	- 2.887**	<0.01

*p<0.05, **p<0.01

Table 16 Correlations between child-related factors and parents service use (N=110)

	1	2	3	4	5	6	7
1. Period of Hikikomori (years)	-	0.05	0.06	0.27 *	-0.12	0.17	-0.13
2. Morbidity of mental disorder (yes=1, no=0)		-	-0.16	0.15	-0.23 †	-0.12	0.10
3. Number of problematic behaviors[a]			-	0.12	0.06	0.19	0.30 *
4. Scope of activity for the past month[b]				-	-0.20	0.32 *	0.18
5. Attitude to family for the past month[c]					-	0.05	0.02
6. Number of services received (father)[d]						-	0.36 **
7. Number of services received (mother)[d]							-

a: select from disrupted sleep patterns, self-injury, violence in the home, destructive behavior, compulsive behavior, disorderly diet, and authoritative attitude in the home

b: 0= participating in social activities,1=going out freely excluding social activities, 2=going out with reservations, 3= being freely limited in home, 4=keeping in one's room

c: 1=not rejecting the family members, 2= rejecting some of the family members, 3= rejecting all of the family members

d: over the past year

† <0.1, *p <0.05, **p <0.01

Table 17 Comparison the influential factors of Family Difficulties Scale (total score) between fathers and mothers

	fathers (n=55)						mothers (n=55)					
	Ⅰ		Ⅱ		Ⅲ		Ⅰ		Ⅱ		Ⅲ	
	β	p	β	p	β	p	β	p	β	p	β	p
Period of Hikikomori (years)	-0.27 *	0.04	-0.33 *	0.02	-0.32 *	0.02	-0.25 †	0.06	-0.31 *	0.02	-0.32 *	0.02
Morbidity of mental disorder (yes=1, no=0)	0.18	0.17	0.18	0.21	0.14	0.30	0.30 *	0.02	0.32 *	0.02	0.32 *	0.03
Number of problematic behaviors[a]			0.17	0.21	0.26 †	0.06			0.30 *	0.02	0.34 *	0.01
Scope of activity for the past month[b]			0.11	0.44	0.24 †	0.08			0.09	0.47	0.15	0.30
Attitude to family for the past month[c]			-0.11	0.42	-0.08	0.52			-0.1	0.44	-0.09	0.50
Number of services received (father)[d]					-0.32 *	0.03					-0.10	0.48
Number of services received (mother)[d]					-0.17	0.23					-0.10	0.50
R^2	0.10		0.16		0.30		0.13		0.26		0.28	
ajusted R^2	0.06		0.07		0.19		0.10		0.17		0.17	

β= standardized regression coefficients

a: select from disrupted sleep patterns, self-injury, violence in the home, destructive behavior, compulsive behavior, disorderly diet, and authoritative attitude in the home

b: 0= participating in social activities,1=going out freely excluding social activities, 2=going out with reservations, 3= being freely limited in home, 4=keeping in one's room

c: 1=not rejecting the family members, 2= rejecting some of the family members, 3= rejecting all of the family members

d: over the past year

† <0.1, *p <0.05, **p <0.01

Table 18 Comparison the influential factors of Family Difficulties Scale (Difficulties in marital cooperation) between fathers and mothers

	fathers (n=55)						mothers (n=55)					
	Ⅰ		Ⅱ		Ⅲ		Ⅰ		Ⅱ		Ⅲ	
	β	p	β	p	β	p	β	p	β	p	β	p
Period of Hikikomori (years)	-0.16	0.24	-0.13	0.37	-0.06	0.64	-0.34 *	0.01	-0.36 *	0.01	-0.29 *	0.04
Morbidity of mental disorder (yes=1, no=0)	0.18	0.19	0.15	0.29	0.07	0.61	0.22 †	0.09	0.23	0.10	0.14	0.31
Number of problematic behaviors[a]			-0.08	0.56	-0.08	0.57			0.14	0.30	0.11	0.41
Scope of activity for the past month[b]			-0.12	0.42	-0.01	0.90			0.00	0.99	0.08	0.58
Attitude to family for the past month[c]			-0.08	0.58	-0.06	0.67			-0.08	0.54	-0.06	0.62
Number of services received (father)[d]					-0.36 *	0.02					-0.33 *	0.03
Number of services received (mother)[d]					0.09	0.57					0.16	0.29
R^2	0.54		0.08		0.17		0.15		0.17		0.25	
ajusted R^2	0.01		0.01		0.04		0.11		0.08		0.14	

β= standardized regression coefficients

a: select from disrupted sleep patterns, self-injury, violence in the home, destructive behavior, compulsive behavior, disorderly diet, and authoritative attitude in the home

b: 0= participating in social activities,1=going out freely excluding social activities, 2=going out with reservations, 3= being freely limited in home, 4=keeping in one's room

c: 1=not rejecting the family members, 2= rejecting some of the family members, 3= rejecting all of the family members

d: over the past year

† <0.1, *p <0.05, **p <0.01

Table 19 Comparison the influential factors of Family Difficulties Scale (Psychological conflict with the child) between fathers and mothers

	fathers (n=55)						mothers (n=55)					
	Ⅰ		Ⅱ		Ⅲ		Ⅰ		Ⅱ		Ⅲ	
	β	p	β	p	β	p	β	p	β	p	β	p
Period of Hikikomori (years)	-0.09	0.50	-0.2	0.13	-0.2	0.15	-0.08	0.54	-0.16	0.23	-0.17	0.22
Morbidity of mental disorder (yes=1, no=0)	0.09	0.49	0.10	0.45	0.10	0.48	0.26 *	0.06	0.27 *	0.05	0.28 *	0.05
Number of problematic behaviors[a]			0.36 **	0.00	0.38 *	0.01			0.33 *	0.01	0.33 *	0.02
Scope of activity for the past month[b]			0.22	0.10	0.24	0.10			0.13	0.33	0.11	0.43
Attitude to family for the past month[c]			-0.15	0.24	-0.15	0.26			-0.16	0.23	-0.16	0.23
Number of services received (father)[d]					-0.03	0.83					0.06	0.67
Number of services received (mother)[d]					-0.02	0.85					-0.02	0.89
R^2	0.01		0.25		0.25		0.07		0.23		0.24	
ajusted R^2	0.02		0.17		0.13		0.03		0.15		0.12	

β= standardized regression coefficients

a: select from disrupted sleep patterns, self-injury, violence in the home, destructive behavior, compulsive behavior, disorderly diet, and authoritative attitude in the home

b: 0= participating in social activities,1=going out freely excluding social activities, 2=going out with reservations, 3= being freely limited in home, 4=keeping in one's room

c: 1=not rejecting the family members, 2= rejecting some of the family members, 3= rejecting all of the family members

d: over the past year

† <0.1, *p <0.05, **p <0.01

Table 20 Comparison the influential factors of Family Difficulties (Difficulties in support resource utilization) Scale between fathers and mothers

	fathers (n=55)						mothers (n=55)					
	Ⅰ		Ⅱ		Ⅲ		Ⅰ		Ⅱ		Ⅲ	
	β	p	β	p	β	p	β	p	β	p	β	p
Period of Hikikomori (years)	-0.26 †	0.05	-0.29 †	0.05	-0.31 *	0.02	-0.17	0.21	-0.21	0.15	-0.03 †	0.07
Morbidity of mental disorder (yes=1, no=0)	0.10	0.46	0.10	0.50	0.10	0.47	0.18	0.20	0.21	0.15	0.26 †	0.08
Number of problematic behaviors[a]			0.04	0.76	0.17	0.21			0.19	0.19	0.31 *	0.04
Scope of activity for the past month[b]			0.08	0.58	0.22	0.12			0.06	0.65	0.13	0.39
Attitude to family for the past month[c]			0.00	0.98	0.03	0.79			0.02	0.85	0.04	0.76
Number of services received (father)[d]					-0.24	0.10					-0.01	0.92
Number of services received (mother)[d]					-0.33 *	0.02					-0.34 *	0.03
R^2	0.07		0.08		0.28		0.05		0.10		0.20	
ajusted R^2	0.03		-0.01		0.16		0.01		0.01		0.07	

β= standardized regression coefficients

a: select from disrupted sleep patterns, self-injury, violence in the home, destructive behavior, compulsive behavior, disorderly diet, and authoritative attitude in the home

b: 0= participating in social activities,1=going out freely excluding social activities, 2=going out with reservations, 3= being freely limited in home, 4=keeping in one's room

c: 1=not rejecting the family members, 2= rejecting some of the family members, 3= rejecting all of the family members

d: over the past year

† <0.1, *p <0.05, **p <0.01

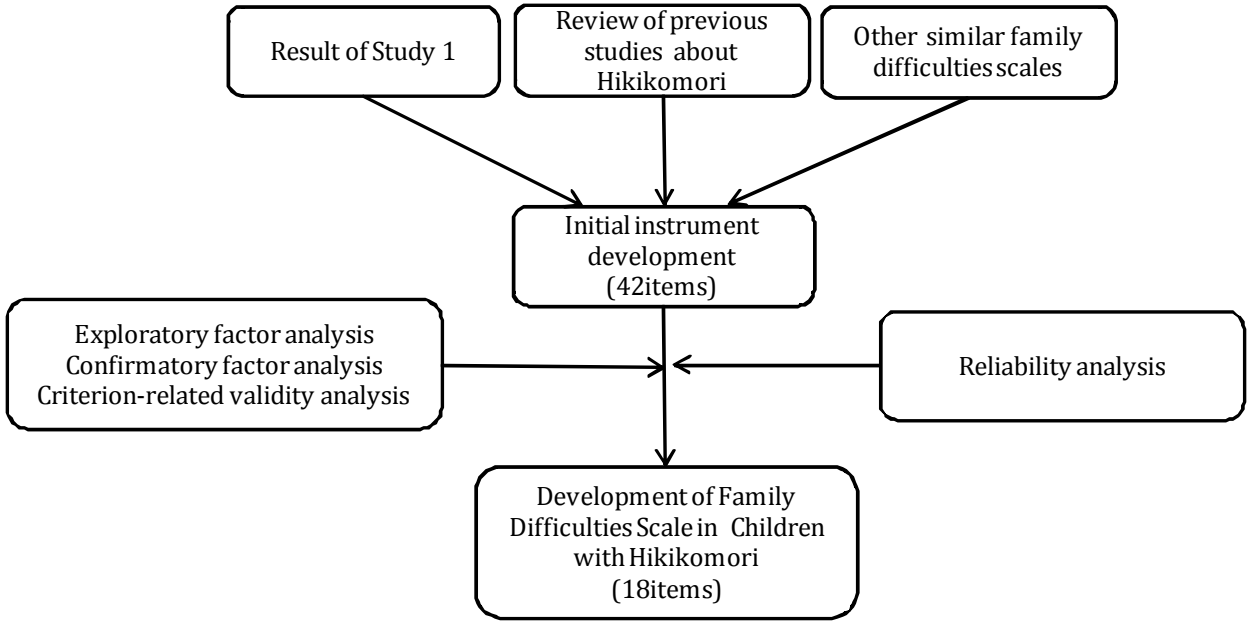


Figure 1 Procedure of scale development

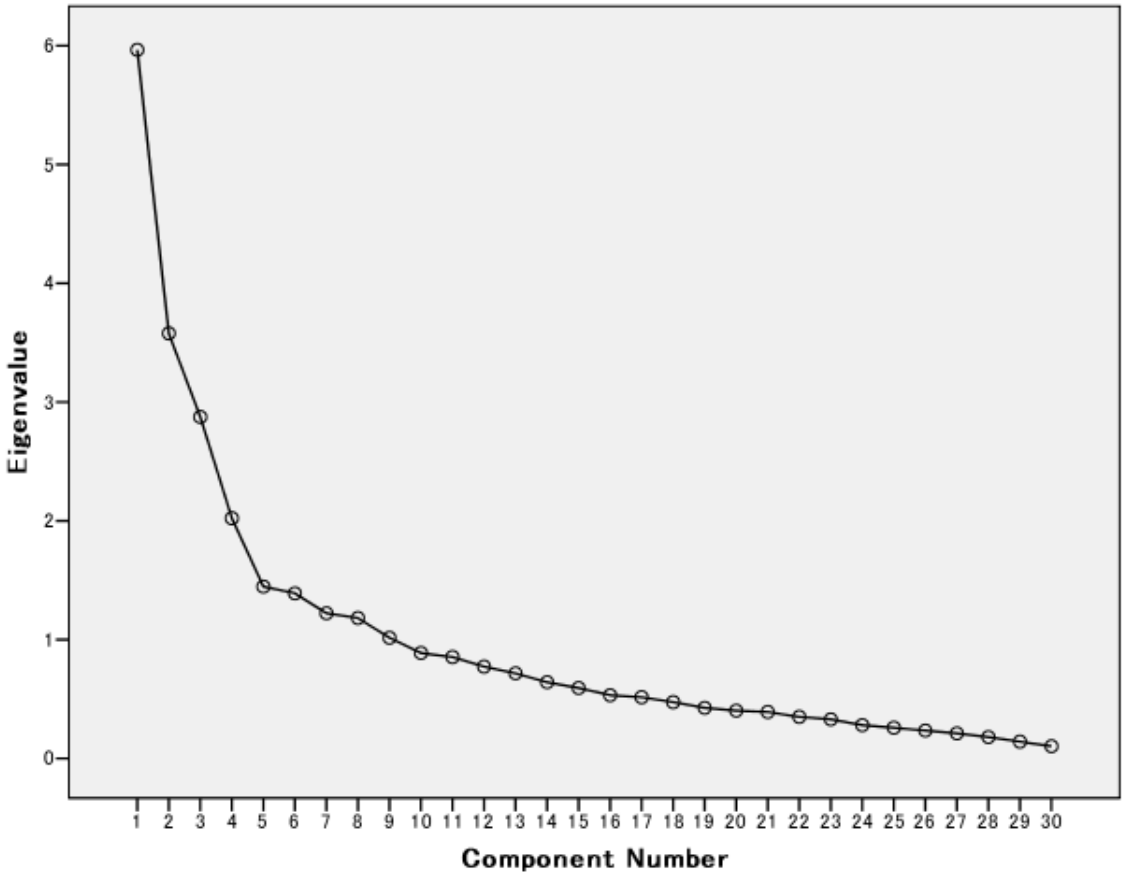
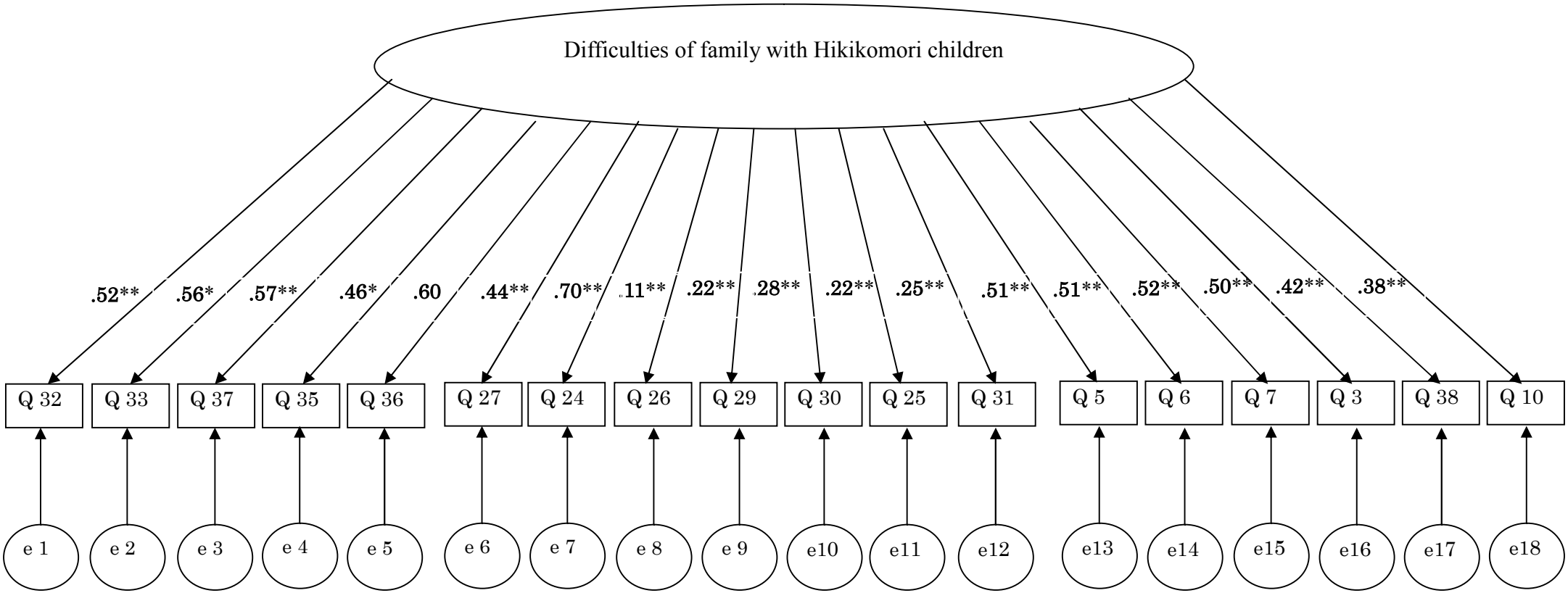
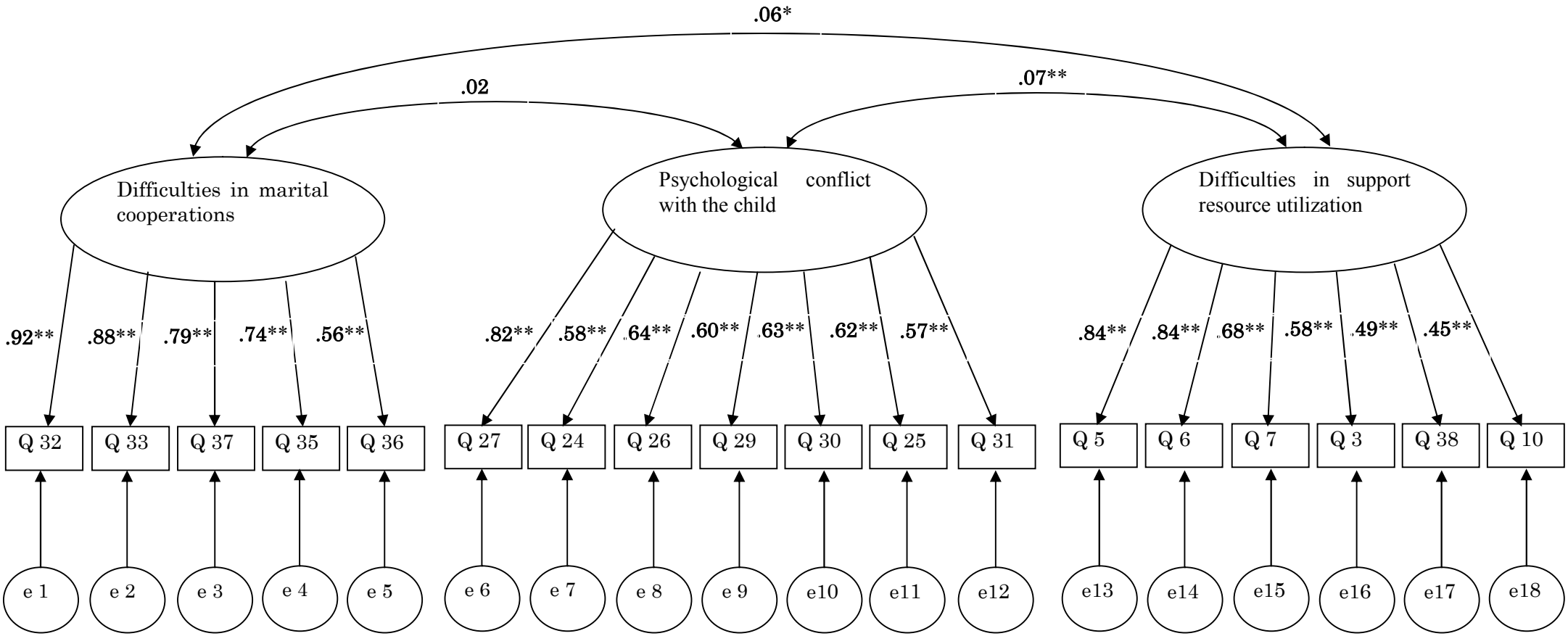


Figure 2 Scree plot and eigenvalue graphong (N=176)



*p<0.05, **p<0.01

Figure 3 Standardized solutions of one factor model (N=176)



*p<0.05, **p<0.01

Figure 4 Standardized solutions of three factor model (N=176)

Appendices

「ひきこもり青年を抱える家族の困難感尺度」

現在のひきこもり青年の親のとしてのあなたの状況についてお尋ねします。各々のことがらについて、A～D のうち一つだけを選択し、アルファベットを○でかこんでください。

		全く当てはまらない	どちらかというと当てはまらない	どちらかというと当てはまる	よく当てはまる
1	ひきこもりに関する知識や情報を夫婦で常に共有している	A	B	C	D
2	ひきこもりについて夫婦間で自由に話し合うことができる	A	B	C	D
3	ひきこもりについて夫婦で協力して取り組んでいる	A	B	C	D
4	夫婦で精神的に支えあっている	A	B	C	D
5	ひきこもりに関する講演会や相談などには夫婦一緒に参加している	A	B	C	D
6	自分の気持ちのやり場がない	A	B	C	D
7	ひきこもり青年に巻き込まれる	A	B	C	D
8	ひきもり青年に対して欲求不満や憤りを感じる	A	B	C	D
9	ひきこもり青年の世話で心身ともに疲れる	A	B	C	D
10	子どもがひきこもっていることは世間体が悪く、気苦労を感じる	A	B	C	D
11	ひきこもり青年と普段どのように関わったら良いかわからない	A	B	C	D
12	家族の将来設計が立てられない不安や焦りがある	A	B	C	D
13	現在利用できるひきこもり青年を支援するサービスについて知っている	A	B	C	D
14	ひきこもりの状態の今後の見通しについて知っている	A	B	C	D
15	ひきこもりについての自分の考えや気持ちを自由に話せる人がいる	A	B	C	D
16	ひきこもりについて相談できる専門家がいる	A	B	C	D
17	ひきこもりからの回復を果たした家族の体験談を聞いたことがある	A	B	C	D
18	将来利用できるひきこもり青年を支援するサービスについて知っている	A	B	C	D

✎A=4 点, B=3 点, C=2 点, D=1 点
✎6,7,8,9,19,11,12 は反転

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The Family Difficulties Scale in Children with Hikikomori

There are 18 questions of your situation according to Hlkikomori now.
Chose one answer of following 'A' ～ 'D' and put a ring around the alphabet.

		Strongly Disagree	Disagree	Agree	Strongly Agree
1	**I always share knowledge and information about Hikikomori with my partner.**	A	B	C	D
2	**I can discuss Hikikomori freely with my partner.**	A	B	C	D
3	**I deal with Hikikomori in cooperation with my partner.**	A	B	C	D
4	**I and my partner support each other emotionally.**	A	B	C	D
5	**I participate in lecture meetings and consultation about social withdrawal together with my partner.**	A	B	C	D
6	**I am worried about my child with Hikikomori.**	A	B	C	D
7	**I get involved in the problems of my child with Hikikomori.**	A	B	C	D
8	**I feel anger and frustration with my child with Hikikomori.**	A	B	C	D
9	**Care for my child with Hikikomori drains me physically and emotionally.**	A	B	C	D
10	**I worry that my status within the local community will be affected by my child.**	A	B	C	D
11	**I don't know how to communicate with my child with Hikikomori.**	A	B	C	D
12	**I feel anxious and rushed about the future of my family.**	A	B	C	D
13	**I know the support resource which I will be able to use in the future.**	A	B	C	D
14	**I know the support resource for Hikikomori which I can use now.**	A	B	C	D
15	**I know the future progress of my child's condition.**	A	B	C	D
16	**I have someone who I can talk to freely concerning my ideas and feelings about Hikikomori.**	A	B	C	D
17	**I have specialists who I can consult about Hikikomoril.**	A	B	C	D
18	**I have heard the experiences of families whose child recovered from Hikikomori.**	A	B	C	D

✎A=4, B=3, C=2, D=1

✎Reversing items: 6,7,8,9,19,11,12

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平成 18 年　月　日

＿＿＿＿＿＿様

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船越　明子

「ひきこもり青年を抱える家族の援助ニーズに関する研究」
インタビューおよびアンケート調査
－ご協力のお願い－

私たちは、地域の方が、充実した精神保健サービスを受けることができますよう、地域精神保健サービスに関する研究に取り組んでおります。この度、ひきこもり状態にある青年のご家族からご家族の困難やひきこもりに対する地域の援助サービスなどについてのお話をうかがうことになりました。つきましては，お忙しいところ大変恐縮ではございますが、貴施設にてひきこもりに対する援助サービスをご利用されているご家族へのインタビューおよびアンケート調査に関しまして、ご理解・ご協力を頂けますようお願いいたします。

記

Ⅰ．調査の概要

(1) **背景：**近年、青年のひきこもり現象が社会の注目を集めています。2003 年に厚生労働省が作成したガイドラインによると、ひきこもりは、地域精神保健サービスの対象とされており、保健所、児童相談所、精神保健福祉センターなどでの援助活動の充実が期待されています。ひきこもりへの援助活動は、引きこもっている当事者の青年が当初から相談に訪れることはまれであるため、第一の支援対象はご家族であり、ご家族との連携が非常に重要です。しかし、ご家族がどのような援助を必要としているかは明らかにされていません。

(2) **目的：**本調査の目的は、ひきこもり青年を抱える家族の援助ニーズを明らかにすることです。それによって、ご家族のニーズに合った効果的な地域精神保健サービスの提供に対する示唆を得ることができると考えています。また、ご家族のニーズをより正確に、より様々な角度から捉えるために、インタビューとアンケートの二つの調査手法を用います。

(3) **対象：**ひきこもり状態にある青年のご家族

(4)調査期間：

インタビュー調査 平成 18 年 10 月～同年 12 月
アンケート調査　平成 19 年 1 月～同年 3 月

(5)調査内容:

インタビュー調査
ご家族の抱える困難やひきこもりに対する地域の援助サービスへのニーズ（ご要望）についてのお話を個人またはグループでのインタビュー調査を実施します。インタビュー内容は録音され、逐語録を作成した上で、質的調査の手法（グラウンデッド・セオリー法）を用い分析いたします。

アンケート調査
ご家族の心理面や支援のニーズについてのアンケート調査を実施致します。調査内容は、統計的手法を用いて分析いたします。

調査結果については、調査・分析終了後、報告書を送付させて頂きます。

Ⅱ．貴施設の担当者にご協力いただく内容

対象者への調査依頼に関して、一部ご協力をお願いいたします。ご協力いただく内容、調査の日程および手順の詳細は、それぞれの対象施設とご相談の上、個別に決定いたします。

Ⅲ．倫理的配慮および個人情報の取り扱い

対象者の方へは本調査についてご説明し、任意でのご協力をお願いいたします。また、プライバシーには最大限の配慮を行います。本調査で得た情報は、本研究以外の目的に用いることはありません。なお、本調査は、対象者への倫理的配慮および個人情報の取り扱いに関して、東京大学医学部倫理委員会による承認を受けております。(詳細については別紙『－倫理的配慮および個人情報の取り扱い－』をご参照下さい。)

－お問い合わせ先－
「ひきこもり青年を抱える家族の援助ニーズに関する研究」

＜調査担当者連絡先＞
調査担当者：船越　明子
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住所：〒113-0033　文京区本郷 7-3-1
東京大学大学院医学系研究科
健康科学・看護学専攻　精神看護学分野

「ひきこもり青年を抱える家族の援助ニーズに関する研究」

－倫理的配慮および個人情報の取り扱い－

対象者の方へは本調査についてご説明し、任意でのご協力をお願いいたします。また、プライバシーには最大限の配慮を行います。本調査で得た情報は、本研究以外の目的に用いることはありません。なお、本調査は、対象者への倫理的配慮および個人情報の取り扱いに関して、東京大学医学部倫理委員会による承認を受けております。

1)情報の取り扱いに対する配慮

- 質的分析のためにインタビュー内容を録音する場合には、逐語録作成時に、個人を特定できる恐れのある固有名詞は、記号に変換するなど匿名化の処理を行う。音声データは、研究終了後に消去する。
- 質問紙調査は匿名で行い、調査票には個人を特定する情報を記載しない。
- 電子データの漏洩および部外者の閲覧を最大限に制限する。電子ファイルには全てパスワードを設定し、暗号化されたデータ記憶媒体に保存する。パスワードは、東京大学医学部倫理審査で承認を受けた研究者のみが取り扱う。電子データは調査終了後に消去する。
- 調査に関わる全ての書類は、研究者によって厳重に管理され、研究終了後に裁断処分する。
- 調査結果の報告や発表に際して、名前や個人を識別する情報は一切使用しない。
- 調査で得られた情報は本研究の目的以外には使用しない。

2)個人情報の使用に関する本人からの同意の取得

- 研究の主旨、データの扱い、調査への参加が自由意志であること、調査結果の公表について書面にて説明した上で、研究協力への同意が得られた場合のみ、調査を実施する。
- インタビュー対象者に対しては、調査実施時に、書面にあわせて口頭による説明も行い、調査協力にあたっては同意書を取得する。
- 質問紙調査対象者に対しては調査票に情報の取り扱いおよび倫理上の配慮を記載し、質問紙への回答をもって研究への協力の同意が得られたとみなす。

あなたの声をお聞かせください

「ひきこもり青年を抱える家族の援助ニーズに関する研究」インタビュー調査
―ご協力のお願い―

私たちは、地域の方が、充実した精神保健サービスを受けることができますよう、地域精神保健サービスに関する研究に取り組んでおります。このたび、ひきこもり状態にある青年のご家族から、ご家族の困難やひきこもりに対する地域の援助サービスなどについてのお話をうかがうことになりました。

つきましては, お忙しいところ大変恐縮ではございますが、インタビュー調査に関しまして、ご理解・ご協力を頂けますようお願いいたします。

調査の概要

(1) 背景：2003 年に厚生労働省が作成したガイドラインによると、ひきこもりは、地域精神保健サービスの対象とされており、保健所、児童相談所、精神保健福祉センターなどでの援助活動の充実が期待されています。ひきこもりへの援助活動は、ひきこもっている当事者の青年が当初から相談に訪れることはまれであるため、第一の支援対象はご家族であり、ご家族との連携が非常に重要です。しかし、ご家族がどのような援助を必要としているか明らかにされていません。

(2) 目的：本調査の目的は、ひきこもり青年を抱える家族の援助ニーズを明らかにすることです。それによって、ご家族のニーズに合った効果的な地域精神保健サービスの提供に対する示唆を得ることができると考えています。

(3) 対象：ひきこもり状態にある青年のご家族

調査内容

(1) 日時・場所：ご希望される日時および場所（プライバシーが保たれる場所）

(2) ご協力頂く内容： 1 時間程度の個人（またはグループ）インタビューにご協力頂きます。インタビューの内容は、「ご家族の抱える困難やひきこもりに対する地域の援助サービスへのご要望などについて」です。インタビュー内容は録音され、逐語録を作成した上で、質的調査の手法（グラウンデッド・セオリー法）を用いて分析されます。

(3) 面接者：看護師（保健師）の資格を有し、かつ精神保健領域の臨床経験をもつ者であり、インタビューにご協力くださる方の心理面に十分配慮しながらインタビューを行います。

成果の活用について

調査にご協力くださった方には、後日調査報告書を送付致します。また、ひきもり青年を抱えるご家族のニーズに合った効果的な地域精神保健サービスの提供に対する学術的知見を提供するため、調査結果をもとに、学位論文執筆、専門誌への投稿および学会発表などを行います。

倫理的配慮および個人情報の取り扱い

①本調査は、対象者への倫理的配慮および個人情報の取り扱いに関して、東京大学医学部倫理委員会による承認を受けております。

②参加にあたっては、プライバシーには十分配慮致します。インタビュー内容が施設の職員など他人に知られることはありません。また、ご参加にあたってのご意見が一部の個人と特定されることは絶対ありません。

③インタビュー調査へのご参加は、自由意志によるものです。調査を受けることに同意した後でも、自由に取りやめることができます。答えたくない質問については、お答え頂かなくても構いません。ご負担を感じられた場合は、いつでもインタビューを終了することが可能です。

④データの漏洩および部外者の閲覧を防ぐため、調査に関わる全ての書類・音声データ・電子ファイルは厳重に管理され、研究終了後、裁断処分されます。

⑤調査で得られた情報は、本研究以外の目的に用いることは一切ありません。

－お問い合わせ先－

「ひきこもり青年を抱える家族の援助ニーズに関する研究」

＜調査担当者連絡先＞

調査担当者：船越　明子

E-mail:akkokuma-tky@umin.ac.jp

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＜研究事務局＞

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東京大学大学院医学系研究科

健康科学・看護学専攻　精神看護学分野

平成１８年　月　日

＿＿＿＿＿＿＿＿＿＿＿＿＿＿様

東京大学大学院医学系研究科
健康科学・看護学精神看護学分野
船越　明子

「ひきこもり青年を抱える家族の援助ニーズに関する研究」インタビュー調査
―ご協力のお願い―

私たちは、地域の方が、充実した精神保健サービスを受けることができますよう、地域精神保健サービスに関する研究に取り組んでおります。このたび、ひきこもり状態にある青年のご家族へのケア提供者から、ひきこもり青年を抱えるご家族への支援などについてのお話をうかがうことになりました。

つきましては, お忙しいところ大変恐縮ではございますが、インタビュー調査に関しまして、ご理解・ご協力を頂けますようお願いいたします。

記

Ⅰ．調査の概要

(1) 背景：近年、青年のひきこもり現象が社会の注目を集めています。2003 年に厚生労働省が作成したガイドラインによると、ひきこもりは、地域精神保健サービスの対象とされており、保健所、児童相談所、精神保健福祉センターなどでの援助活動の充実が期待されています。ひきこもりへの援助活動は、ひきこもっている当事者の青年が当初から相談に訪れることはまれであるため、第一の支援対象はご家族であり、ご家族との連携が非常に重要です。しかし、ご家族がどのような援助を必要としているか明らかにされていません。

(2) 目的：本調査の目的は、ひきこもり青年を抱える家族の援助ニーズを明らかにすることです。それによって、ご家族のニーズに合った効果的な地域精神保健サービスの提供に対する示唆を得ることができると考えています。

(3) 対象：ひきこもり状態にある青年のご家族へのケア提供者

(4) 方法：ひきこもり青年を抱えるご家族への支援などについてインタビュー調査を実施します。インタビュー内容は録音され、逐語録を作成した上で、質的調査の手法（グラウンデッド・セオリー法）を用いて分析いたします。

Ⅱ．調査内容

(1) 日時・場所：ご希望される日時および場所（プライバシーが保たれる場所）

(2) ご協力頂く内容：１時間程度の個人またはグループインタビューにご協力頂きます。インタビューの内容は、「ひきこもり青年を抱えるご家族への支援などについて」です。

Ⅲ．インタビューデータの取り扱いついて

①参加にあたっては、プライバシーには十分配慮致します。インタビュー内容が施設の職員など他人に知られることはありません。また、ご参加にあたってのご意見が一部の個人と特定できることは絶対ありません。データを質的調査の手法（グラウンデッド・セオリー法）を取り入れ分析するため、インタビューの内容を録音し、逐語録を作成することをご了承ください。

②インタビュー調査へのご参加は、自由意志によるものです。調査を受けることに同意した後でも、自由に取りやめることができます。また、質問の内容によっては、心理的に負担を感じる可能性が考えられます。答えたくない質問については、お答え頂かなくても構いません。ご負担を感じられた場合は、いつでもインタビューを終了することが可能です。

③音声データは、インタビュー終了後、すみやかに電子ファイル化し、消去いたします。電子ファイルには全てパスワードを設定し、暗号化されたデータ記憶媒体に保存します。パスワードは、東京大学医学部倫理委員会で承認を受けた研究者のみが取り扱い、部外者は一切取り扱いません。以上の処理によって、電子データの漏洩および部外者の閲覧を最大限に制限します。逐語録作成時に、個人を特定できる恐れのある固有名詞は、記号に変換するなど匿名化の処理を行います。調査に関わる全ての書類は、研究者によって厳重に管理され、研究終了後に裁断処分します。

④調査結果につきましては、研究者の論文執筆および専門誌投稿、学会発表を行う予定です。学術論文で、インタビューのデータをそのまま論文中に掲載することが望ましい場合には状況から個人が特定されないよう一部改変するなどの配慮をする予定です。

⑤調査で得られた情報は、本研究以外の目的に用いることは一切ありません。

Ⅳ. その他

①ご希望の方には、後日調査報告書を送付致します。

②本調査研究は、東京大学医学部倫理委員会で承認を受けたものです。

以上の内容をご理解の上、調査にご協力頂ける場合は、別紙「同意書」にご署名いただきたく存じます。なお、ご不明な点等ありましたら、いつでも下の連絡先までご連絡下さい。

－お問い合わせ先－

「ひきこもり青年を抱える家族の援助ニーズに関する研究」

＜調査担当者連絡先＞

調査担当者：船越　明子

E-mail:akkokuma-tky@umin.ac.jp

TEL：050-3002-3875（月～金 9:30-16:00）

＜研究事務局＞

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東京大学大学院医学系研究科

健康科学・看護学専攻　精神看護学分野

同　意　書

私は下記の調査協力を行うにあたり、調査者担当者から別紙説明書記載の事項について説明を受け、これを十分理解しましたので、調査に協力することに同意いたします。

（説明事項）

１．調査内容：ひきこもり青年を抱えるご家族への支援ついての個人またはグループでのインタビューをプライバシーが保たれた静かな場所で実施される。インタビューの内容は録音され、分析のため逐語録が作成される。

２．調査への参加は自由意志であり、同意した後でも、自由に取りやめることが可能である。

３．インタビューデータの取り扱いおよび調査結果の公表について：

１）音声データは、インタビュー終了後、すみやかに電子ファイル化し、消去される。
２）電子ファイルには全てパスワードを設定し、暗号化されたデータ記憶媒体に保存される。
３）パスワードおよび調査データは東京大学医学部倫理審査で承認を受けた研究者のみが取り扱う。
４）逐語録作成時に、個人を特定できる恐れのある固有名詞は、記号に変換するなど匿名化の処理を行う。
５）調査に関わる全ての書類は、研究者によって厳重に管理され、研究終了後に裁断処分される。
６）学術論文において、インタビューデータの一部を論文中に掲載することが望ましい場合には、状況から個人が特定されないよう一部改変するなどの配慮がされる。
７）調査で得られた情報は、本研究以外の目的には使用しない。

記

研究課題名：　ひきこもり青年を抱える家族の援助ニーズに関する研究

研究代表者：東京大学大学院医学系研究科健康科学・看護学専攻　精神看護学分野
船越　明子

平成　　年　　月　　日

研究協力者氏名＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

アンケートにお答え下さい

「ひきこもり青年を抱える家族の援助ニーズに関する研究」アンケート調査
―ご協力のお願い―

私たちは、地域の方が、充実した精神保健サービスを受けることができますよう、地域精神保健サービスに関する研究に取り組んでおります。この度、精神保健福祉センターまたは民間の自助組織であるひきこもりに関する親の会にご協力いただき、ひきこもり状態にある青年のご両親からご家族の心理面や親としての役割についてのアンケート調査を実施することになりました。つきましては，お忙しいところ大変恐縮ではございますが、アンケート調査にご協力を頂けますようお願いいたします。

調査の概要

(4) **背景：**2003 年に厚生労働省が作成したガイドラインによると、ひきこもりは、地域精神保健サービスの対象とされており、保健所、児童相談所、精神保健福祉センターなどでの援助活動の充実が期待されています。ひきこもりへの援助活動は、ひきこもっている当事者の青年が当初から相談に訪れることはまれであるため、第一の支援対象はご家族であり、ご家族との連携が非常に重要です。しかし、ご家族がどのような援助を必要としているか明らかにされていません。

(5) **目的：**本調査の目的は、ひきこもり青年を抱える家族の援助ニーズを明らかにすることです。それによって、ご家族のニーズに合った効果的な地域精神保健サービスの提供に対する示唆を得ることができると考えています。

(6) **対象：**ひきこもり状態にある青年のご両親

ご協力いただく内容

☆アンケート用紙が**二部**同封されております。

☆**お父さん、お母さんがそれぞれ一部ずつ**ご記入ください。

☆ご回答いただいたアンケート用紙は、同封いたしました返信用封筒に入れ、直接調査担当者宛にご返送ください。

☆もし、お父さん、お母さんのどちらか一方しかご回答いただけなかった場合は、一部のみご返送ください。

☆アンケート用紙は、<u>平成１９年３月 31 日までに</u>ご返送いただきますようお願いいたします。

成果の活用について

調査にご協力くださった方には、後日調査報告書を送付致します。（ご希望の方は送付先を別紙にご記入ください。）また、ひきもり青年を抱えるご家族のニーズに合った効果的な地域精神保健サービスの提供に対する学術的知見を提供するため、調査結果をもとに、学位論文執筆、専門誌への投稿および学会発表などを行います。

倫理的配慮および個人情報の取り扱い

①本調査は、対象者への倫理的配慮および個人情報の取り扱いに関して、東京大学医学部倫理委員会による承認を受けております。

②参加にあたっては、プライバシーには十分配慮致します。アンケートへの回答が施設の職員に知られることはありません。また、調査内容は統計的手法を用いて分析されるため、ご参加にあたってのご意見が一部の個人と特定できることは絶対ありません。

③アンケート調査へのご参加は、自由意志によるものです。また、いつでも調査へのご協力を取りやめることも可能です。また、全項目へのご回答を原則としてお願いしておりますが、ご回答にあたって、心理的な負担等を感じる質問項目については、お答えいただかなくてもかまいません。

④アンケート用紙は、研究者によって厳重に管理され、研究終了後に裁断処分します。

⑤調査で得られた情報は、研究以外の目的に用いることは一切ありません。

ーお問い合わせ先ー
「ひきこもり青年を抱える家族の援助ニーズに関する研究」
＜調査担当者連絡先＞
調査担当者：船越　明子
E-mail:akkokuma-tky@umin.ac.jp
TEL：050-3002-3875（月～金 9:30-16:00）
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「ひきこもり青年を抱える家族の援助ニーズに関する研究」
―お父さんへのアンケート調査―

アンケート用紙は８ページあり、所要時間は２０分程度です。

ご協力のほどよろしくお願いいたします。

☆お一人あたり２冊子以上アンケート用紙が送付された方
→すでに他のアンケート用紙にご回答いただいている場合は、下の□に✔を入れていただき、<u>無回答のまま</u>調査担当者まで<u>ご返送ください。</u>
□他のアンケート用紙に回答したので、このアンケートは無回答で返送します。

＜調査担当者連絡先＞　船越　明子
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東京大学大学院医学系研究科健康科学・看護学専攻　精神看護学分野

Ⅰ．ひきこもり当事者について

ひきこもり当事者について下の 1)～13)の質問にお答えください。
ご回答にあたっては、ご夫婦で相談してご記入いただいて構いません。

1)年齢：（　　）歳

2)性別：　1．男　　2．女

3)きょうだいの有無：　1．あり　　2．なし

4)何番目の子どもですか？：第（　　）子

5)ひきこもり状態が始まった年齢:（　　）歳

6)ひきこもり当事者の世話を主に行っているのは誰ですか？
1．父親　　2．母親　　3．兄弟　　4．祖父　5．祖母　6．その他（　　）

7)自宅にひきこもっており、学校や仕事に行かない、または就いていない状態が６ヶ月以上続いていますか。
1.はい　　・　　2.いいえ

8)ひきこもりの原因となる明らかな精神障害があると医療機関で診断されましたか？

1.はい　　2.いいえ

9)現在、不登校である、または過去に不登校を経験したことがありますか？

1.はい　　2.いいえ

10)**ご家族が、初めて**ひきこもりについて相談機関を利用された時、ひきこもり**当事者の年齢**はおいくつでしたか？また、初めて利用された相談機関はどこでしたか？

（　　）歳　　相談機関（　　）

11)**ここ一ヶ月**のひきこもり当事者の生活について、当てはまるもの**全て**の数字に○をつけてください。

1．日中寝て、夜間起きている
2．自分の身体を傷つける
3．同居している家族へ暴力をふるう
4．物を投げたり、壊したりする
5．特定の行為（手を洗う、物事の確認など）を繰り返し行う
6．適当な食事内容・回数・量の食事ができず、食生活が乱れている。
7．非行行為がある（　　）※具体的な非行行為をお書きください
8．　家族に対して命令的・支配的である

12)**ここ一ヶ月**のひきこもり当事者の活動の程度について、当てはまるものを**ひとつ**選び、その数字に丸をつけてください。

1．社会的活動以外は自由に外出できる
2．条件付で外出可能（具体的な条件は何ですか：　　）
3．外出はできないが家庭内では自由に活動できる
4．自室で閉じこもっている

13)**ここ一ヶ月**の家族に対するひきこもり当事者の態度について、当てはまるものを**ひとつ**選び、その数字に丸をつけてください。

1．家族全員を拒否する
2．家族の一部を拒否する（具体的な拒否対象は誰ですか：　　）
3．家族を拒否することはない

Ⅱ．お父さんについて

お父さんご自身について、1)～9)の質問にお答えください。

1)年齢：（　　）歳

2)現在の就業形態：

1．就業なし　　2．フルタイム勤務　　3．パート（アルバイト）勤務

3)夫婦関係：

1．夫婦同居　　2．夫婦別居(単身赴任など)　　3．離婚　　4．.死別

4)ここ一年以内に、ひきこもっている子どものために、お父さんご自身が利用したことがある援助サービスの数字に〇をつけ、その援助サービスの具体的な提供機関（援助者）として、当てはまるもの全てに〇をつけてください。

※民間機関またはその他に回答された場合は、利用された機関を（　　）に具体的にご記入下さい。民間機関とは、ＮＧＯ、ＮＰＯ、ボランティア団体、寮、カウンセリングルームなどが当てはまります。

1．医療機関：精神科　・　心療内科　・　小児科　・　その他（　　）

2．家庭訪問：医師　・　保健師　・　看護師・　精神保健福祉士　・　児童相談員
教師　・　訪問サポート士　・　民間機関の担当者（　　）
当事者の家族　・　その他（　　）

3．通所相談：保健所/保健センター　・　精神保健福祉センター　・　児童相談所
医療機関　・　民間機関(　　)・　その他(　　)

4．家族の集い：保健所/保健センター　・　精神保健福祉センター　・　児童相談所
医療機関　・　民間機関(　　)　・その他(　　)

5．電話相談：保健所/保健センター　・　精神保健福祉センター　・　児童相談所
医療機関　・　民間機関(　　)　・　その他(　　)

6．メール相談：保健所/保健センター・精神保健福祉センター・児童相談所
医療機関・民間機関(　　)・その他(　　)

7．講演会：保健所/保健センター　・　精神保健福祉センター　・　児童相談所
医療機関　・　民間機関(　　)　・　その他(　　)

6．<u>現在</u>のひきこもり青年の親のとしてのあなたの状況についてお尋ねします。
各々のことがらについて、<u>A～D のうち一つだけ</u>を選択し、アルファベットを○でかこんでください。

全く当てはまらない　＝A　どちらかというと当てはまらない　=B　どちらかというと当てはまる　=C　よく当てはまる=D

		全く当てはまらない	どちらかというと当てはまらない	どちらかというと当てはまる	よく当てはまる
1	ひきこもりについて相談できる友人がいる	A	B	C	D
2	ひきこもり青年をもつ他の家庭からの支えがある	A	B	C	D
3	ひきこもりについての自分の考えや気持ちを自由に話せる人がいる	A	B	C	D
4	ひきこもりについて気軽に話せる人がおらず、孤独感を感じる	A	B	C	D
5	将来利用できるひきこもり青年を支援するサービスについて知っている	A	B	C	D
6	現在利用できるひきこもり青年を支援するサービスについて知っている	A	B	C	D
7	ひきこもりの状態の今後の見通しについて知っている	A	B	C	D
8	ひきこもりからの回復を果たした当事者の体験談を聞いたことがある	A	B	C	D
9	ひきこもりをもつ他の家族の状況について聞いたことがある	A	B	C	D
10	ひきこもりからの回復を果たした家族の体験談を聞いたことがある	A	B	C	D
11	自分に役立つ情報が何か分からない	A	B	C	D
12	ひきこもり青年の現在の生活のため、経済面での援助が必要である	A	B	C	D
13	ひきこもり青年の将来の生活のため、経済面での援助が必要である	A	B	C	D
14	ひきこもり青年を支援するサービスを利用するにあたって、経済面での援助が必要である	A	B	C	D
15	ひきこもり青年が就労・就学に向けた準備をするために経済面での援助が必要である	A	B	C	D
16	ひきこもり青年のつらさが理解できる	A	B	C	D
17	ひきこもり青年の生活のペースを尊重しようと思う	A	B	C	D
18	早く就労または就学してほしいと思う	A	B	C	D
19	同年齢の他の子どもと比べてしまう	A	B	C	D
20	ひきこもり青年と趣味やニュースなどの話を日常的にする	A	B	C	D
21	ひきこもり青年と冗談をかわすことがある	A	B	C	D

		全く当てはまらない	どちらかというと当てはまらない	どちらかというと当てはまる	よく当てはまる
22	ひきこもり青年と親子でよく喧嘩をする	A	B	C	D
23	ひきこもり青年に対してよく命令口調で話す	A	B	C	D
24	ひきこもり青年に巻き込まれる	A	B	C	D
25	ひきこもり青年と普段どのように関わったら良いかわからない	A	B	C	D
26	ひきもり青年に対して欲求不満や憤りを感じる	A	B	C	D
27	自分の気持ちのやり場がない	A	B	C	D
28	子どもがひきこもったのは自分のせいだと思う	A	B	C	D
29	ひきこもり青年の世話で心身ともに疲れる	A	B	C	D
30	子どもがひきこもっていることは世間体が悪く、気苦労を感じる	A	B	C	D
31	家族の将来設計が立てられない不安や焦りがある	A	B	C	D
32	ひきこもりに関する知識や情報を夫婦で常に共有している	A	B	C	D
33	ひきこもりについて夫婦間で自由に話し合うことができる	A	B	C	D
34	ひきこもり青年への対応が夫婦で異なっている	A	B	C	D
35	夫婦で精神的に支えあっている	A	B	C	D
36	ひきこもりに関する講演会や相談などには夫婦一緒に参加している	A	B	C	D
37	ひきこもりについて夫婦で協力して取り組んでいる	A	B	C	D
38	ひきこもりについて相談できる専門家がいる	A	B	C	D
39	ひきこもり青年の精神面について医師による判断を得ている	A	B	C	D
40	ひきこもりに関連ある発達障害や精神疾患について専門家の話を聞いたことがある	A	B	C	D
41	ひきこもり青年への関わりについて専門家の話を聞いたことがある。	A	B	C	D
42	ひきこもり青年の就労・就学について専門家の話を聞いたことがある。	A	B	C	D

7．<u>ここ2週間</u>のあなたの生活についてお聞きします。下の質問について、「どのくらいの頻度で経験したか、どのように感じたか、どのくらい満足したか」を選択し、〇でかこんでください。

全くない 全く悪い 全く不満	=A	少しだけ 悪い 不満	=B	多少は ふつう どちらでもない	=C	かなり 良い 満足	=D	非常に 非常に良い 非常に満足	=E

		1	2	3	4	5
1	あなたの生活の質をどのように評価しますか	全く悪い	悪い	ふつう	良い	非常に良い
2	自分の健康状態に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
3	体の不快感のせいで、しなければならないことがどのくらい制限されていますか	全くない	少しだけ	多少は	かなり	非常に
4	毎日の生活の中で治療（医療）がどのくらい必要ですか	全くない	少しだけ	多少は	かなり	非常に
5	毎日の生活をどのくらい楽しく過ごせていますか？	全くない	少しだけ	多少は	かなり	非常に
6	自分の生活をどのくらい意味あるものと感じていますか	全くない	少しだけ	多少は	かなり	非常に
7	物事にどのくらい集中することができますか	全くない	少しだけ	多少は	かなり	非常に
8	毎日の生活はどのくらい安全ですか	全くない	少しだけ	多少は	かなり	非常に
9	あなたの生活環境はどのくらい健康的ですか？	全くない	少しだけ	多少は	かなり	非常に
10	毎日の生活を送るための活力はありますか	全くない	少しだけ	多少は	かなり	非常に
11	自分の容姿（外見）を受け入れることはできますか	全くない	少しだけ	多少は	かなり	非常に
12	必要なものが買えるだけのお金をもっていますか？	全くない	少しだけ	多少は	かなり	非常に
13	毎日の生活に必要な静寂をどのくらい得ることができますか	全くない	少しだけ	多少は	かなり	非常に
14	余暇を楽しむ機会はどのくらいありますか	全くない	少しだけ	多少は	かなり	非常に
15	家の周囲を出回ることがよくありますか	全くない	少しだけ	多少は	かなり	非常に
16	睡眠は満足のいくものですか	全く不満	不満	どちらでもない	満足	非常に満足
17	毎日の生活をやり遂げる能力に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
18	自分の仕事をする能力に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
19	自分自身に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
20	人間関係に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
21	性生活に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
22	友人たちの支えに満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
23	家と家の周りの環境に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
24	医療施設や福祉サービスの利用しやすさに満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
25	周辺の交通の便に満足していますか	全く不満	不満	どちらでもない	満足	非常に満足
26	気分がすぐれなかったり、絶望、不安、落ち込みといった嫌な気分をどのくらい頻繁に感じますか	全くない	少しだけ	多少は	かなり	非常に

８．<u>この１週間</u>のあなたのからだや心の状態についてお聞きいたします。

20 のうち、各々のことがらについて、この 1 週間で、<u>A～D のうち一つだけ</u>を選択し、アルファベットを○でかこんでください。

全くないまたは一日続かない =A　週のうち 1～2 日=B　週のうち 3～4 日=C　週のうち 5 日以上=D

		全くないまたは一日続かない	週のうち 1～2 日	週のうち 3～4 日	週のうち 5 日以上
1	普段は何でもないことがわずらわしい	A	B	C	D
2	食べたくない、食欲が落ちた	A	B	C	D
3	家族や友達から励ましてもらっても､気分が晴れない	A	B	C	D
4	他の人と同じ程度には、能力があると思う	A	B	C	D
5	物事に集中できない	A	B	C	D
6	憂うつだ	A	B	C	D
7	何をするのも面倒だ	A	B	C	D
8	これから先のことについて積極的に考えることができる	A	B	C	D
9	過去のことについてくよくよ考える	A	B	C	D
10	何か恐ろしい気持ちがする	A	B	C	D
11	なかなか眠れない	A	B	C	D
12	生活について不満なく過ごせる	A	B	C	D
13	普段より口数が少ない、口が重い	A	B	C	D
14	一人ぼっちで寂しい	A	B	C	D
15	皆がよそよそしいと思う	A	B	C	D
16	毎日が楽しい	A	B	C	D
17	急に泣き出すことがある	A	B	C	D
18	悲しいと感じる	A	B	C	D
19	皆が自分を嫌っていると感じる	A	B	C	D
20	仕事が手につかない	A	B	C	D

９．あなたのご家庭の<u>今の</u>様子についてお尋ねします。

下の２０の文章は家族関係や家庭状況を表しています。あなたは、自分のご家庭はどんなふうだとお考えですか。A～E に示す頻度の中で、最も当てはまると思われるアルファベットを<u>一つだけ</u>○でかこんでください。

ほとんどない =A	まれに =B	時々 =C	しばしば =D	ほとんどいつも =E

		ほとんどない	まれに	時々	しばしば	ほとんどいつも
1	家族の誰もが、お互いに強い結びつきを感じている	A	B	C	D	E
2	家族のまとまりが、とても大切である	A	B	C	D	E
3	家族は、一緒に自由な時間を過ごすのが好きである	A	B	C	D	E
4	私たちは、家族で何かをするのが好きである	A	B	C	D	E
5	家族は、お互いに助け合う	A	B	C	D	E
6	私たちは、家族で一緒にすることをすぐに思いつける	A	B	C	D	E
7	家族で何かをするとき、全員が集まる	A	B	C	D	E
8	相談のある者は、家族の誰かに話を聞いてもらう	A	B	C	D	E
9	家族は、他人よりもお互いに親しみを感じている	A	B	C	D	E
10	何かをするとき、子どもの意見が取り入れられる	A	B	C	D	E
11	家族の中で子どもが決定権をもっている	A	B	C	D	E
12	子どもは、しつけについて意見が言える	A	B	C	D	E
13	家族のなかで、さまざまな者がリーダーになる	A	B	C	D	E
14	子どもの問題について、親子で話し合う	A	B	C	D	E
15	家族のなかで、リーダーが誰か特に決めにくい	A	B	C	D	E
16	家族の仕事の分担は特に決まっていない	A	B	C	D	E
17	家族はその場に応じて、仕事を分担する	A	B	C	D	E
18	家族の決まりは、その時々で変化する	A	B	C	D	E
19	私の家族は何かをするとき、その仕方を色々と工夫する	A	B	C	D	E
20	私たちは、お互いの友達を受け入れる	A	B	C	D	E

これでこのアンケートは終わりです。

返信用封筒にて、<u>平成 19 年 3 月 31 日まで</u>に調査担当者へご返送ください。

ご協力ありがとうございました。