A study of family functioning in Hikikomori (Social withdrawal)

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Key words：1. Hikikomori (Social withdrawal)　2. Family Assessment Device (FAD)
3. family functioning

Hikikomori (Social withdrawal) has recently been examined as a problem facing Japanese society. Despite the issuance of guidelines by the Japanese government, the creation of parent groups and the availability of support from various government agencies and private organizations, no countermeasure policy has been established. Research on Hikikomori as a problem for the entire family and analysis of functioning in cases of Hikikomori has not been carried out.

Hikikomori is seen in the same home and two or more cases are often seen. Then, it thought whether having related to the family function.

This study is to find the Hikikomori family's characteristic and make available the clue of the method to it.

The present study examines family functioning associated with cases of Hikikomori by assessing 16 families with social withdrawal, 15 families with autism, and 25 control families using the Family Assessment Device (FAD). The seven subcategories of the FAD [Problem Solving (PS), Communication (CM), Roles (RL), Affective Responsiveness (AR), Affective Involvement (AI), Behavior Control (BC) and General Functioning (GF)] were analyzed by a multiple comparison test. Statistical significance was established at $p<0.01$ or $p<0.05$.

Results demonstrated that families with Hikikomori have higher CM, AR and GF scores than families with autism, and higher PS, CM and GF scores than control families. Furthermore, PS scores for fathers with a family member with Hikikomori scored higher than the control fathers. The PS, CM and GF scored for mothers with a family member with Hikikomori were higher than those of the control mothers, and than mothers with a family member with autism. Also, the AR scores for mothers with a family member with Hikikomori were found to be higher than those of the control mothers. No marked differences were observed between the control and autism groups in any of the scores for the families, fathers, or mothers.

While measures and social support are available for autism, the lack of clarification regarding the cause and measurement of Hikikomori appears to have contributed to the observed differences in FAD scores.

Mother feels that the family function is the worst in the family, because there are a lot of items with a significant difference of the FAD score.Therefore, appealing to and mother of the solution of "Hikikomori" obtained the suggestion of effective.

Introduction

The term Hikikomori, which refers to young people who have become socially withdrawn, first appeared in the mass media, and subsequently began to be used widely by the general public around 1990.

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The books "Syakaiteki (social) Hikikomori" by Saito[1], based on his extensive clinical experience, and "Hikikomoru Wakamonotachi (Hikikomori Youth)" by Shiokura[2], based on numerous social interviews, were published in 1998 and 1999, respectively. These books further spread the use of the term Hikikomori throughout Japan.

Hikikomori individuals become withdrawn for various reasons. For example, some individuals first rejected school, then became Hikikomori. Alternatively, some individuals graduated from school but were unable to find employment for various lengths of time, from a few years to more than 10 years. The degree of Hikikomori also varies among individuals, from those who cannot even communicate with their family, to those who are able to go shopping or go to the library, as long as no close relationship with other people is required.

Currently, Hikikomori is one of the social problems with which administrative institutions, private organizations, and parents' groups in Japan are struggling. In 2000, the Ministry of Health, Labour, and Welfare established an investigation committee consisting of specialists. The committee conducted a study based on their definition of Hikikomori, as follows: "the state in which one's opportunities for social participation are reduced by various factors, and one's place outside the home, such as in school or at work, is missed for a long period of time". The findings of this study supported the publication of a pamphlet for the general public about Hikikomori, and a guideline for community mental health activities concerning Hikikomori children in their teens and twenties. Based on these materials, organizations in the administrative divisions and municipalities of Japan have arranged support systems in order to address the current situation.

The research of Hikikomori has just only started. As for current research, there are many case examinations[3-6]. Two or more Hikikomori arrive at the same family, and in some homes there is a person who becomes Hikikomori, and a person who doesnot.

Then, Hikikomori and the family function of the relation staying were investigated.

"Social hikikomori"

Until recently, the term Hikikomori referred to individuals who had difficulty participating in society due to mental disorders, such as schizophrenia. Support for these individuals was the central focus of community mental health care. In the last 10 years, the number of school refusals ("futoukou" children) has increased, and it has been reported that such individuals can not adapt themselves to society even after graduation from school. Therefore, support for such individuals, who do not have "mental disorders" in the narrow sense, but show the "Hikikomori" symptom, has received a great deal of attention as a new problem in community mental health care.

As the status of such individuals distinctly differs from that of conventional Hikikomori caused by mental disorders in the narrow sense, the new term Hikikomori was coined. This Hikikomori phenomenon, which is unique to modern Japan, was not observed in Japan before the economic growth that occurred following the Second World War, and has not been observed in other developed nations. In his book, Saito defined Hikikomori individuals as "becoming problematic by their late 20s, continuously withdrawing from any social activities by staying at home for periods longer than 6 months, with no underlying mental disorder as the primary cause"[7].

However, this is only a description of the state of Hikikomori, and was not proposed as a clinical diagnosis. Among individuals who are classified as having Hikikomori, a wide variety of symptoms and conditions can be seen. Thus, the discussion of whether an individual has "syakaiteki Hikikomori", does not have much relevance. It is important to remember the following points when managing this condition in the real world: (1) various individuals develop the condition of Hikikomori as a method of responding to stress, (2) a state of Hikikomori is prolonged regardless of whether or not the individual has a mental disorder in the narrow sense, and (3) support for individuals with Hikikomori is often started without full knowledge of the detailed condition or psychology of the individual, which is unique to Hikikomori.

Research Purpose

With the aim of obtaining data useful for determining the course of future support for individuals with Hikikomori, the present study survey, used a family function assessment scale, and revealed the functional characteristics of families with "Hikikomori"

youth by comparing them to those of other families.

Research Methods

A survey using the Japanese version of the self-administered Family Assessment Device (FAD) was conducted; a questionnaire survey about family, which was developed and confirmed to be reliable and valid by Saeki et al[8].

1. Family Assessment Device (FAD)

The original FAD is a self-administered questionnaire, which was developed as a screening test for evaluating the degree of family health based on a family model theory called the "McMaster Model of Family Functioning (MMFF)", developed by a group of family researchers at Brown University in the United States.

The MMFF is a family model theory proposed by Epstein et al. in 1978[9]. According to the initial research in the "Silent Majority Study"[10], family functions are more closely related to mutual and systematic characteristics of a family system rather than the mental characteristics of individual family members. Based on this observation, in the MMFF, the whole family system consists of 6 functional dimensions: (1) Problem Solving, (2) Communication, (3) Roles, (4) Affective Responsiveness, (5) Affective Involvement, and (6) Behavior Control.

The FAD is a self-administered family function assessment scale, which consists of 60 questions in 7 dimensions, including "General Functions" in addition to the 6 functional dimensions of the MMFF. Subjects are required to respond to the questions by selecting one of 4 choices: "1. true", "2. generally true", "3. not generally true", and "4. mostly not true". Researchers converted the responses into numerical data on a score sheet. The calculated scores represent the evaluation of the subject regarding family functions in her/his family. By definition, higher scores indicate poorer perceptions of family functioning. In terms of the 7 dimensions, "Problem solving" indicates the ability of a family to solve problems, which threaten the existence of the family and maintenance of the family structure. "Communication" indicates verbal information exchange among family members. "Roles" indicates whether roles and responsibilities are shared among family members and if family functions are properly conducted. "Affective responsiveness" indicates whether it is possible to express affective emotions at the appropriate levels of quality and quantity during various situations. "Affective involvement" indicates the degree to which concerns and values are expressed regarding activities and interests of other family members. "Behavior control" indicates the behavioral patterns of families in certain situations. The final dimension, "General functions", evaluates other extensive functions.

2. Subjects

Subjects consisted of 54 individuals from 21 families (including 5 families represented only by members who attended a meeting), who attended meetings at 1 of 3 organizations for parents with Hikikomori children, and who agreed to participate in this study.

In the first control group, subjects were 43 individuals from 17 families (including 1 family represented by only the meeting participant), who attended meetings at 1 of 3 organizations for parents with children with autism, and who agreed to participate in this study.

In the second control group, subjects were 34 individuals from 10 families of university students that had no family members with "Hikikomori" or any other mental disorders, and 54 individuals in 15 families who attended child-rearing seminars, and agreed to participate in this study.

The definition of Hikikomori in the present study included a period of Hikikomori lasting for more than 6 months, and other family members recognized the person's behavior as Hikikomori and attended parents' meetings hoping to solve their problems.

Children with autism were diagnosed as being autistic by special medical institutions.

There is a common feature that both "Hikikomori" and people with autism cannot express themselves well. It is socially perceived to some degree as disease of the autism. However, big difference from which Hikikomori has not action method established it. Then, autism was assumed to be one of the contrast groups and method has not established.

At least one person has the family of the age of the young people as three crowds' common features.

3. Survey method

The agreement of meeting representatives was obtained in advance. Researchers attended meetings and were introduced by representatives of the meetings before addressing participants. The researchers explained the purpose of the study, ensured that participation in the study is entirely voluntary, and explained that the data and results would be processed so that privacy would be protected. Participants who agreed to cooperate with the study were asked to contact the researcher at the end of the meeting, provide written consent, were given survey questionnaires for each family member along with a return envelope, and were requested to return the envelope with all documents when completed. Since responses were returned by mail, without documents for agreement or cancellation of agreement, subjects who returned the responses were considered to have agreed, while those who did not return the responses were considered to have cancelled their agreement.

4. Survey period

The survey was conducted from February to August 2003.

5. Analytical method

FAD subscales were compared among family members. The FAD scores for fathers, mothers, siblings, and the whole family were compared among families with Hikikomori children (Hikikomori group), families with autistic children (control group 1), and families with university students and seminar participants (control group 2).

Research Results

1. Structure of subjects

According to the supplementary survey questionnaire results, 21 individuals with Hikikomori were identified among the subjects. Of these individuals, 3 subjects did not fill out the questionnaire; the gender and age data of the remaining 18 subjects are shown in Table 1. Hikikomori subjects consisted of 11 males and 7 females. It was observed that one family had 2 Hikikomori individuals. The mean age of the Hikikomori individuals was 25.28 years, with a range from 11 to 38 years.

The numbers and mean ages of the Hikikomori group, control group 1 (autism), control group 2, the parents of each group, young family members (selves, siblings), and grandparents are shown in Table 2.

Table 1. "Hikikomori" subjects

		Male (n)	Female (n)	Total (n)
Age (years)	10-19	3	2	5
	20-24	0	3	3
	25-29	2	2	4
	Over 30	6	0	6
	Subtotal	11	7	18
Length of "Hikikomori" period	Between 6 months and 1 year	0	2	2
	Between 1 and 3 years	3	4	7
	Between 3 and 5 years	0	1	1
	Between 5 and 10 years	5	0	5
	More than 10 years	2	0	2
	Not known	1	0	1
	Subtotal	11	7	18

Table 2. Age of family members

		"Hikikomori"		Control 1 (autism)		Control 2	
		n	mean age	n	mean age	n	mean age
Fathers		17	59.7	14	43.3	20	52.8
Mothers		19	56.4	16	40.2	24	50.3
Young family members	Selves	6	26.4	—	—	41	20.7
	Siblings	5	22.3	8	16.8		
Grandparents		6	76.8	2	62	3	76.3
Total		53		40		88	

2. Comparison of FAD scores among the "Hikikomori", "autism", and "control" groups.

The comparison of FAD scores among the 3 groups is shown in Table 3. Significant differences with a level of significance at p=0.01 were observed for the "Problem Solving", "Communication", "Affective Responsiveness", and "General Functions" dimensions. In a multiple comparison of "Problem Solving" scores, the "Hikikomori" group showed scores significantly higher than those of the "autism" and "control" groups with significance levels of p=0.05 and p=0.01, respectively. For "Affective Responsiveness", the score of the "Hikikomori" group was significantly higher than the "autism" group (p=0.01).

The comparison of FAD scores for fathers among the 3 groups is shown in Table 4. Scores for 4 of the 6 dimensions, excluding "Roles" and "Affective Involvement", showed significant differences with a level of significance at p=0.01. In a multiple comparison of "Problem Solving" scores, the

“Hikikomori” group showed scores significantly higher than those of the “autism” and “control” groups with significance levels of p=0.05 and p=0.01, respectively. For “Communication”, the score of the “Hikikomori” group was significantly higher than that of the “control” group (p=0.05). For the “Communication”, “Behavior Control”, and “General Functions” dimensions, the scores of the “Hikikomori” group were significantly higher than those of the “control” group only (p=0.05), while for “Affective Responsiveness”, the score of the “Hikikomori” group was significantly higher than for the “autism” and “control” groups (p=0.05).

The comparison of FAD scores for mothers among the 3 groups is shown in Table 5. Similar to the findings among fathers, for 4 categories, excluding “Roles” and “Affective Involvement”, significant differences were observed with a level of significance at p=0.01. In a multiple comparison of scores for “Problem Solving”, “Communication”, and “General Functions” dimensions, scores of the “Hikikomori” group were significantly higher than those of the “autism” and “control” groups with a significance level

Comparison of FAD scores amang the “Hikikomori”, “autism”, and “control” groups

Table 3. The whole family

	“Hikikomori”		“autism”		“control”		Kruskal-Wallis test		Multiple comparison		
	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	χ^2 value	p value	“hikikomori”・“autism”	“hikikomori”・“control”	“autism”・“control”
PS	16	2.50 (2.23, 2.84)	15	2.08 (1.84, 2.25)	25	2.06 (1.83, 2.25)	11.98	0.0025	<0.05	<0.01	NS
CM	16	2.40 (2.24, 2.48)	15	1.96 (1.78, 2.06)	25	1.98 (1.89, 2.28)	12.82	0.0016	<0.01	<0.01	NS
RL	16	2.08 (1.93, 2.22)	15	2.09 (1.78, 2.25)	25	1.98 (1.85, 2.14)	1.45	0.4840			
AR	16	2.42 (2.25, 2.71)	15	2.00 (1.59, 2.17)	25	2.20 (1.96, 2.36)	10.56	0.0051	<0.01	NS	NS
AI	16	2.37 (2.18, 2.45)	15	2.29 (2.07, 2.50)	25	2.18 (1.98, 2.31)	3.42	0.1811			
BC	16	2.23 (2.18, 2.45)	15	2.17 (1.72, 2.39)	25	1.96 (1.78, 2.28)	5.13	0.0770			
GF	16	2.24 (2.13, 2.49)	15	1.78 (1.59, 2.00)	25	1.79 (1.68, 2.02)	13.78	0.0010	<0.01	<0.01	NS

Table 4. Fathers

	“Hikikomori”		“autism”		“control”		Kruskal-Wallis test		Multiple comparison		
	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	χ^2 value	p value	“hikikomori”・“autism”	“hikikomori”・“control”	“autism”・“control”
PS	17	2.50 (2.17, 2.28)	14	2.00 (1.67, 2.17)	20	2.00 (1.59, 2.25)	12.36	0.0021	<0.05	<0.01	NS
CM	17	2.33 (2.11, 2.56)	14	2.06 (1.78, 2.33)	20	2.00 (1.84, 2.17)	7.06	0.0294	NS	<0.05	NS
RL	17	2.09 (2.09, 2.27)	14	2.04 (1.91, 2.18)	20	1.96 (1.64, 2.14)	3.09	0.2134			
AR	17	2.33 (2.33, 2.67)	14	2.00 (1.83, 2.17)	20	2.00 (1.75, 2.33)	10.89	0.0043	<0.05	<0.05	NS
AI	17	2.43 (2.14, 2.71)	14	2.14 (2.00, 2.43)	20	2.14 (2.00, 2.50)	3.88	0.1438			
BC	17	2.22 (2.11, 2.44)	14	2.11 (1.78, 2.22)	20	1.89 (1.62, 2.22)	8.94	0.0114	NS	<0.05	NS
GF	17	2.17 (1.92, 2.58)	14	1.83 (1.67, 2.00)	20	1.83 (1.58, 1.96)	8.65	0.0132	NS	<0.05	NS

Table 5. Mothers

	“Hikikomori”		“autism”		“control”		Kruskal-Wallis test		Multiple comparison		
	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	χ^2 value	p value	“hikikomori”・“autism”	“hikikomori”・“control”	“autism”・“control”
PS	19	2.67 (2.17, 3.17)	16	2.00 (1.83, 2.17)	24	2.00 (1.67, 2.25)	14.97	0.0006	<0.01	<0.01	NS
CM	19	2.56 (2.11, 2.89)	16	1.89 (1.56, 2.11)	24	1.95 (1.57, 2.22)	15.15	0.0005	<0.01	<0.01	NS
RL	19	2.09 (1.19, 2.54)	16	2.05 (1.78, 2.36)	24	2.00 (1.62, 2.18)	2.21	0.3306			
AR	19	2.50 (2.33, 2.83)	16	1.67 (1.42, 2.09)	24	2.09 (1.75, 2.42)	13.17	0.0014	<0.01	<0.05	NS
AI	19	2.43 (2.00, 2.86)	16	2.29 (1.86, 2.43)	24	2.14 (1.86, 2.43)	3.41	0.1820			
BC	19	2.33 (2.11, 2.67)	16	2.00 (1.78, 2.25)	24	2.06 (1.44, 2.33)	8.78	0.0124	NS	<0.05	NS
GF	19	2.42 (2.17, 2.83)	16	1.75 (1.33, 2.00)	24	1.58 (1.25, 2.13)	16.27	0.0003	<0.01	<0.01	

Table 6. Siblings

	“Hikikomori”		“autism”		“control”		Kruskal-Wallis test		Multiple comparison		
	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	χ^2 value	p value	“hikikomori”・“autism”	“hikikomori”・“control”	“autism”・“control”
PS	4	2.84 (2.63, 3.09)	5	2.50 (2.17, 2.50)	23	2.33 (1.92, 2.58)	7.23	0.0270	NS	<0.05	NS
CM	4	2.33 (2.17, 2.72)	5	2.06 (2.00, 2.22)	23	2.08 (1.78, 2.41)	2.36	0.3072			
RL	4	2.44 (2.07, 2.64)	5	2.27 (1.82, 2.28)	23	2.09 (1.73, 2.32)	2.19	0.3353			
AR	4	2.59 (1.92, 2.71)	5	2.33 (2.17, 2.42)	23	2.33 (1.67, 2.67)	1.13	0.5681			
AI	4	2.42 (2.10, 2.75)	5	2.29 (2.00, 2.29)	23	2.14 (1.86, 2.39)	1.67	0.4346			
BC	4	2.12 (1.67, 2.62)	5	2.44 (2.22, 2.45)	23	2.11 (1.95, 2.39)	1.32	0.5158			
GF	4	2.21 (2.00, 2.46)	5	1.92 (1.84, 1.92)	23	1.92 (1.36, 2.29)	2.08	0.3537			

Table 7. Selves

	"Hikikomori"		"autism"		"control"		Mann-Whitney test	
	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	sample number	mean (25th%, 75th%)	χ^2value	p value
PS	6	2.84 (2.63, 3.09)	0		23	2.33 (1.92, 2.58)	3.26	0.0011
CM	6	2.33 (2.17, 2.72)	0		23	2.08 (1.78, 2.41)	2.29	0.0220
RL	6	2.44 (2.07, 2.64)	0		23	2.09 (1.73, 2.32)	2.24	0.0220
AR	6	2.59 (1.92, 2.71)	0		23	2.33 (1.67, 2.67)	1.65	0.0995
AI	6	2.42 (2.10, 2.75)	0		23	2.14 (1.86, 2.39)	1.65	0.0992
BC	6	2.12 (1.67, 2.62)	0		23	2.11 (1.95, 2.39)	2.00	0.0460
GF	6	2.21 (2.00, 2.46)	0		23	1.92 (1.36, 2.29)	2.61	0.0090

of p=0.01. For "Affective Responsiveness", the score of the "Hikikomori" group was significantly higher than those of the "autism" and "control" groups with significance levels of p=0.01 and p=0.05, respectively. For "Behavior Control", the score of the "Hikikomori" group was significantly higher than that of the "control" group only (p=0.05).

The SAS statistical software package, version. 8.2, was used for all statistical analyses. Mann-Whitney U and Kruskal-Wallis tests were used to estimate the statistical significance of differences observed between groups.

The comparison of FAD scores for siblings among the 3 groups is shown in Table 6. The only significant difference was observed for "Problem Solving" scores (p=0.01). A multiple comparison indicated that the "Hikikomori" group had a significantly higher score than the "control" group.

The comparison of FAD scores for Hikikomori individuals, autistic individuals, and individual controls, only the "Hikikomori" and "control" groups as the sample size of the "autistic" group was 0. The results are shown in Table 7. The scores of the "Hikikomori" group were significantly higher for "Problem Solving" and "General Functions" (p=0.01), and for "Communication", "Roles", and "Behavior Control" (p=0.05).

Discussion

The present research revealed that in comparison to families with children with autism and families in the control group, a significantly higher number of family members with Hikikomori children, including those who are Hikikomori themselves, considered that there were problems in family functioning. In particular, "Problem Solving" scores for both the whole family and each family member were significantly higher. Conversely, only Hikikomori individuals considered that there was a problem in "Roles". For siblings, the only category that showed a significant difference in comparison to the control group was "Problem Solving".

While parents in the "Hikikomori" group considered that there was a significant problem in "Affective Responsiveness" compared to parents in the other 2 groups, Hikikomori members indicated no significant difference. Regarding "Affective Involvement", no family members in the "Hikikomori" group considered it problematic enough to show a significant difference in comparison to the other 2 groups.

In contrast, no significant differences were observed among the "autism" and "control" groups in multiple comparisons. This may be attributed to the fact that autism has been recognized as a disorder, some treatments and coping methods have been established, and support systems have been organized.

In the last 10 years, Hikikomori has been perceived not as a disorder, but rather as a social problem. Thus, no methods for managing "Hikikomori" have been established, and the support system, which includes various methods, is not effective. As many families hide Hikikomori children from other people, it appears that such families are themselves "Hikikomori" from society as a whole.

The young person of Hikikomori feels that there is a problem in his family. So they throw feelings at their mother who is near to themselves, and snarl. As a result, the mother feels my family has problems. But, the father cannot feel the family members' feelings.

Based on his experience as a psychological therapist, Yuuichi Hattori[11] described Hikikomori as follows: "the most common symptom of Hikikomori is the distrust of other human beings", and "the family environment is one of emotional neglect, Hikikomori persons are individuals who could not express them-

selves freely in a period of growth, and Hikikomori is a disorder caused by not being able to affectionately depend on their parents since childhood".

Professor Akihito Kurokawa[12] at Kogakkan University, who had been managing juvenile delinquents and school refusals long before the problem of Hikikomori arose, stated that "the phenomena of school refusal and Hikikomori correlate to the mother-child relationship in childhood".

It is difficult to judge this issue based only on the FAD results obtained in the present study. However, when considering the different perceptions of "Affective Responsiveness" between parents and Hikikomori children according to the theories of Hattori[11] and Kurokawa[12], these results may indicate that parents have finally become aware of the "Affective Responsiveness" that Hikikomori children had already relinquished. The fact that only Hikikomori children were aware of the problem in "Roles" may indicate that they expected their mothers to not only play an instrumental role, but to also be the one to receive their emotions.

Conclusion

In the present research, a comparison between "Hikikomori", "autism", and "control" groups was performed using the Japanese version of the self-administered FAD questionnaire, which is a questionnaire survey about family functions. The results indicated no significant differences between the "autism" and "control" groups; however, significant differences were observed in several categories in the "Hikikomori" group. In particular, the findings indicated the importance of focusing on the lack of "Problem Solving" abilities and low "Affective Responsiveness" among families with Hikikomori children. For "Roles", which only Hikikomori children considered to be a problem, the findings indicate that conducting further research, including interviews with individuals who have recovered from Hikikomori about their experiences, may provide insight into how to solve this problem.

References

1. Saito, T.: Shakaiteki Hikikomori. PHP Research Institute, Kyoto, 1998
2. Shiokura, Y.: Hikikomoru Wakamonotachi. Co.Village Center, Tokyo, 1999
3. Morishita, H.: "Futoukoji" ga 0shietekuretamono. Graphsha, Tokyo, 2000
4. Kuramoto, N. and Kawakami, M.: Hikikomori no Rikai to Enjo. Kondo, N. and Hasegawa, T. (eds.): Hobunsya, Tokyo, 1999
5. Kanou, R. and Kondo, N.: Seinen no Hikikomori. Iwasaki Gakujutu Shuppansya, Tokyo, 2000
6. Kondo, N.: Hikikomori case no kazokuengo. Kongo Shuppan, Tokyo, 2001
7. Saito, T.: Shakaiteki Hikikomori. p.28, PHP Research Institute, Kyoto, 1998
8. Saeki, T., Asukai, N. and Miyake, Y. et al.: Reliability and validity of Japanese versionof Family Assessment Device (FAD). Journal of Psychiatry department diagnosis study, 8: 19-31, 1997
9. Epstein, N.B., Bishop, D.S. and Levin, S.: The MacMaster Model of Family Functioning. Journal of Marriage and Family Counselling, 4: 19-37, 1978
10. Westley, W. and Epstein, N.B.: The Silent Majprity. Jossey-Bass: San Francisco. 1999
11. Hattori, Y.: Hikikomori and Family trauma 14, NHK Publish, Tokyo, 2005
12. Kurokawa, A.: Futoukou counseling. Tokishobo, Osaka, 1997