Loneliness and Single-Person Households: Issues of Kodoku-Shi and Hikikomori in Japan

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Abstract

Traditionally, Japanese life used to be based on village communities and was a society that highly valued neighborhood relations, but in modern urban life, it is becoming increasingly difficult to establish and maintain close human connections, especially in the city. This creates a situation in which people are likely to become lonely. In other words, people who had hitherto lived in traditional family groupings and communities have increasingly come to spend more time as lone individuals with many actually living alone in the city. Some people living in single-person households in the city tend to feel loneliness, and sometimes this develops into a variety of mental health and psychiatric illnesses based on loneliness. In this chapter, we introduce issues pertaining to single-person households in Japan, especially focusing on kodoku-shi (lonely death) and hikikomori (social withdrawal). Regarding hikikomori, we discuss its psychopathology and propose a stage- and/or condition- oriented therapeutic approach. These issues related to urban single-person households are not merely Japanese or one nation issues but are in fact increasingly global phenomena and as such require breakthrough measures based on worldwide research.

Keywords

Loneliness • Isolation • Kodoku-shi (lonely death) • Hikikomori • Amae • Shame

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Introduction

As modernization and urbanization have progressed, people who had hitherto lived in traditional family groupings and communities have increasingly come to spend more time as lone individuals with many actually living alone. This situation of single-person households tends to induce isolation and/or loneliness and sometimes leads to a variety of mental health and psychiatric issues. Here, we introduce issues pertaining to single-person households in Japan, especially focusing on kodoku-shi (lonely death) and hikikomori (social withdrawal).

The Elderly and Kodoku-Shi (Lonely Death)

In Japan's past, there was a strong custom of adult children living with their elderly parents in extended families, but due to urbanization and the nuclear family, many elderly couples and individuals have come to live alone. Often there is no problem while both partners are healthy, but after the loss of a partner, elderly people tend to fall into a solitary state. In most cases, all is good while activities of daily life (ADL) are intact, but as elderly people living alone develop cognitive decline, dementia and/or physical disability, such single elderly are forced into loneliness with many having their lives fall apart.

The problem of solitary elderly is a serious social issue. Often with almost no social contact with anyone, weeks or sometimes months pass and even in the case of death, nobody notices for a few weeks or even a few months. In Japan, this outcome of a sad lonely death is called "kodoku-shi" (Brasor 2014; Nobel 2010). According to data released by the Tokyo Metropolitan Medical Examiner's Office, the number of deaths at home of people over 65 living alone in the Tokyo metropolitan area (the 23 wards of Tokyo) is increasing every year from 1451 in 2003 to 2869 in 2013 (Japan Cabinet Office 2015). This constitutes a doubling over the last decade.

Furthermore, in an opinion poll conducted by the Japan's Cabinet Office in 2012, the proportion of elderly aged 60 years or over who considered dying alone to be an issue of concern (very concerning + somewhat concerning) was less than 20% overall, while the proportion was over 40% for elderly single-person households (Japan Cabinet Office 2015). Such data strongly suggests that loneliness is becoming a close concern among elderly people especially for single-person households in urban area of Japan.

In addition, kodoku-shi occurs among not only the elderly but also middle-aged people. Japan's Urban Renaissance Agency (URA) reported that the total number of kodoku-shi cases of URA apartments occupants who were discovered more than a week after death was 194 in 2013, and among these cases, 65 people were less than 65 years old (Japan Cabinet Office 2015). Thus connected with such assisted living, it is important to note the social issue of middle-aged and elderly people who had been receiving financial social welfare protection subsequently succumbing to kodoku-shi once such protection has been terminated. Recently, the issue of kodoku-shi in areas afflicted by major disasters such a large earthquakes has also been highlighted (Kako and Ikeda 2009).

In order to avoid social isolation of the elderly and kodoku-shi, further improvement of senior citizens' financial and other welfare services is indispensable (▶ Implementing Community Care in Large Cities and Informal Settlements: An African Perspective by Robertson, L., Paul Szabo, C., in this handbook). In recent years, welfare services have expanded from their core role of providing financial/ human support to offering regular home visits for people living alone and increased community spaces allowing for increased social interactions. Such services remain inadequate and need to be further expanded. This issue now common in Japan, especially in urban areas, is likely to occur in other countries that will face an aging society in the future and as such constitutes an emerging global issue of importance [▶ Urban-Rural Differences in Major Mental Health Conditions by Solmi, F., Dykxhoorn, J., Kirkbride, J., in this handbook). Evidence concerning kodoku-shi is extremely limited, and therefore new and in-depth epidemiological and intervention research is call for moving forward.

Hikikomori

In Japan, one of the most highlighted issues of loneliness faced by many younger people is the problem of hikikomori (social withdrawal), which was originally reported in Japan. The word "hikikomori" has been listed in the Oxford Dictionary since 2010 as "(*in Japan*) *the abnormal avoidance of social contact*, *typically by adolescent males/a person who avoids social contact [Origins] Japanese*, *literally 'staying indoors*, *(social) withdrawal*'." In the guideline of hikikomori (Japanese Ministry of Health, Labour and Welfare), hikikomori has been defined as a social withdrawal condition (or, persons) staying almost all time and every day in their own home and preventing school/job participation for 6 months and more, and schizophrenia is not included in this condition (Saito 2010). Hikikomori negatively impacts

not only the affected individual's mental health but also population-level education and workforce stability and as such is an urgent issue in the administration of Health, Welfare and Labor (Kato et al. 2011, 2016). We have recently developed a new hikikomori diagnosis based on the above diagnosis standards in Japan (Saito 2010) as well as suggestions from Teo and Gaw (2010). We have proposed that the following four criteria should be included and observed for 6 months or more: (1) the person stays at home almost all day, almost every day; (2) the person avoids nearly all social situations such as school, work, etc.; (3) the person avoids direct social interaction with family or acquaintances; and (4) the above hinders the individual's social life. Individuals who fulfil all four of these criteria will be defined as "hikikomori." People with severe hikikomori cannot leave their homes at all, while majority of people with hikikomori can occasionally go out for shopping and the like.

Hikikomori Persons Who Live Alone

In Japan, many persons of hikikomori live with their families, but a portion of such individuals live alone. Our recent survey has shown that the majority of persons with hikikomori live with their families; however, a small number live alone (11%) (Teo et al. 2015a). The following case vignette is a typical case of a hikikomori sufferer who lives alone:

> Mr H is a single man in his early thirties living alone in an apartment in a big city. Raised in a regional city by working parents and with a sister 5 years his senior. As his father lived in other cities for his work, he saw him only about once every 2–3 months and as such did not have much of a relationship with his father. During early childhood and schooling, H experienced no major difficulties and despite being quiet he had a few good friends. H had always for some reason dreamed of living in a large cosmopolitan city. An average student academically, he was accepted to the economics faculty of a metropolitan university, and started to live alone. Unfortunately, he could not make many friends, and his university life was rather lonely. H had hoped to become a civil servant but failed the examination and instead found employment at a middle-size trading company. After a year of training, H was assigned to the sales division but found the work difficult and came to be constantly reprimanded by his supervisors and by his 4th year was often absent, felt depressed and finally took leave from his position at his 5th year.
>
> While on leave, he did not return to the family home but spent his days alone in his apartment on his computer. Finally coming to the conclusion by himself that 'I'm not made out for sales' and 'This company is not for me', he resigned his position. Afterwards, H lived on his savings but running out of money started to work short-term manual labor jobs thinking 'this is not the type of work I'm meant to be doing'. This also did not last. Once again feeling fatigued and depressed, he visited a nearby psychiatric clinic where social welfare protection was recommended for him. He applied and began to receive payments. After this, H does not look for reemployment but spends most of the day on the Internet and playing online games. For food, everyday he buys convenience store 'lunch boxes' or pre-prepared meals from supermarkets. H has no friends nearby, has lost contact with his old friends and basically has no friendships.

> With this situation having continued for 5 years, his parents urge him to return home, which he does not do, but rather continues to live in this solitary manner. At a complete loss for what to do, his parents seek advice at the Hikikomori Support Center. . .

As shown in this case, some hikikomori persons living without families are supported by the welfare system in addition to parental support and dependence. In Japan, even when unemployed, it is possible to obtain full economical support to live alone, if certain conditions are satisfied (such as poverty and mental/physical illnesses) by a governmental social welfare system called “seikatsu-hogo” and “shogai-nenkin.” Against this backdrop, unemployed single-person households are increasing not only amongst the elderly but also among younger and middle-aged people. In many cases, young people start living alone when entering university or finding employment, but even if they drop out of school or quit their jobs and become unemployed, many continue to receive financial assistance from their parents and/or the social welfare system enabling them to remain shut in alone.

In such situations, human relationships are diluted, as is contact with family members, friends, and colleagues resulting in a solitary condition. When this situation lasts more than 6 months, the individual may be included within the definition of hikikomori. Such individuals sometimes go out to shop at convenience stores and supermarkets and occasionally go out for fun, but they usually stay at home and spend most of their time watching TV and surfing the Internet. The existence of such lone hikikomori has been facilitated by the development of information technology (IT). With the development of Internet, most shopping can be done via the net (and “net shopping” coupled with advanced delivery networks is especially advanced in Japan), making it possible to live without going out. Furthermore, even when withdrawn from society and shut in at home, it has become possible to enjoy various types of entertainment such as online games in complete isolation. Indeed, a universal world can be achieved by living alone.

Psychopathological Understandings of Hikikomori Living with and Without Families

While hikikomori persons who live alone share some commonality with hikikomori persons living with family members, there are also important differences. Both types of hikikomori sufferers often have a present/past history of psychiatric comorbidity such as avoidant personality disorder, major depressive disorder, paranoid personality disorder, post-traumatic stress disorder, social anxiety disorder, dysthymic disorder, obsessive–compulsive personality disorder, and specific phobia (Teo et al. 2015b). Although there is yet to a comprehensive epidemiological survey, from the viewpoint of the authors’ clinical experience, narcissistic personality disorder seems to be especially prevalent among hikikomori persons who live alone. Many of those who are suffering in families often have problems at an earlier stage of separation and independence from their parents. On the other hand, hikikomori persons who live alone tend to have achieved separation to some extent,

but there is a tendency toward insufficient independence. In addition, hikikomori people who live alone often experience strong discord with their families, refuse to live with their families, and many have the desire to run away from their families. Interestingly, such hikikomori youth are often found to live in relative close proximity to their parents, suggesting the existence of internal conflict between independence and dependence. Such behaviors may be considered the result of Japanese "*amae*" culture. Japanese "*amae*"-related dependent behaviors were originally described by the late Takeo Doi, a psychiatrist and psychoanalyst (Doi 1973). To a great extent, dependent behaviors related to "amae" are conducted with the belief that the parent will forgive all. Doi believed that Western societies tend to consider such dependence in children to be something that should be overcome or corrected, while in Japan "*amae*" remains an acceptable mode of behavior even in adult life (Doi 1973). Doi discussed "sullenness" or a sullen withdrawal as one transformation of "*amae*"; thus the behaviors of hikikomori may be seen to be close relation to the classic behavior of "*amae*." Hikikomori persons living with families are suggested to be indirectly induced by "*amae*" to the extent that parents accept their child staying at home for prolonged periods of time (Kato et al. 2012), while hikikomori persons living alone also have some similar tendencies because majority of such people do not live a great distance from their families.

Internationalization of Hikikomori Phenomenon

Recent studies have strongly suggested that cases of hikikomori exist not only in Japan but also many other countries. Our previous case vignette survey among psychiatrists in Australia, Bangladesh, India, Iran, Japan, Korea, Taiwan, Thailand, and the United States has suggested that hikikomori cases are observed in all countries especially in urban areas (Kato et al. 2012). In addition, hikikomori-like cases have been reported in France, Hong Kong, Oman, South Korea, and Spain (Furuhashi et al. 2012; Garcia-Campayo et al. 2007; Lee et al. 2001, 2013; Malagon-Amor et al. 2015; Sakamoto et al. 2005; Teo and Kato 2015; Wong et al. 2015). However, with the exception of Japan, this phenomenon has long been ignored. To our knowledge, alternative terms for hikikomori do not exist in Western countries, while hikikomori-like phenomena have recently been termed "운둔형외토리; 隠遁型" in Korea and "宅男/宅女" in China. We have conducted the first international clinical survey focusing on hikikomori using the above evaluation tool for hikikomori and revealed that persons with hikikomori exist in the United States, South Korea, and India (Teo et al. 2015a).

Hikikomori was first identified in Japan, and it was previously regarded as a culture-bound syndrome unique to Japan (Kato et al. 2012). The Japanese tend to socially interact in a manner that prioritizes indirect communication, and this is because of a unique sense of values involving concepts such as the above-introduced "*amae*" and "shame." Our series of international surveys have shown that hikikomori exist in countries with different cultural and social backgrounds (Kato et al. 2016, 2012; Teo et al. 2015a, b). Why did hikikomori manifest as an

international mental illness? Even now, compared to Western societies, young people in Asian societies, including South Korea, Japan, and Taiwan, tend to be more economically dependent on their parents, and this phenomenon seems to be one of the expressed forms of “*amae*” (Kato et al. 2012). Even though the concept of “*amae*” was originally considered to be uniquely Japanese, contemporary views suggest that “*amae*” is actually more universal in nature (Niiya et al. 2006). Thus, there is an interesting parallel to the hikikomori phenomenon that has been thought of as unique to Japan but, as our preliminary results show, is perceived by psychiatrists as occurring in a variety of other countries. “Shame” is another factor to consider in our understanding of the psychopathological mechanisms of hikikomori (Kitayama 1998). There has been a general tendency within Japanese society to have a strong sense of shame in front of others, which might compound attitudes that allow for hikikomori in Japanese society. However, this shame consciousness might not be something uniquely limited to Japanese society. In the famed American musical “*Beauty and the Beast*,” the selfish prince is magically turned into a beast by a witch. Believing that he cannot venture outside in his ugliness, and with a deep shame consciousness, he withdraws in his castle. This exactly equates to some hikikomori youth in Japan today. Many hikikomori sufferers harbor an ideal (narcissistic) self-image – “I should be an executive,” or “I should become a great person,” and when they are faced with the fact that this ideal self-image has not been actualized in the community, it is the Japanese “shame society” of “I’m not worth to go out (in public), I’m ashamed,” and the belief that going out in public will lead to a miserable and shameful experience that has led many young hikikomori sufferers to cut ties with society at large. What they fear is that in society, they will be treated as “ugly people”; in other words, what they fear most is a denial of their very own narcissistic self-image.

Stage- and Condition-Oriented Therapeutic Approaches for Hikikomori

Therapeutic interventions for hikikomori are difficult to achieve, and this is particularly so for hikikomori persons living alone when compared to those living with their families. Hikikomori persons living with family members are occasionally introduced to some kinds of support services when their family seeks help even without their own help-seeking behaviors. However, in the case of hikikomori persons living alone, there is a tendency not to seek these support services which would potentially free the individual from their socially withdrawn situation. In such situations, it is often only when for economic reasons, solitary life becomes difficult leading to a breakdown in life that help is sought. This is also the case in the situation of a mental crisis.

As shown in Fig. 1, we herein propose that individuals with hikikomori can be classified into the following five stages based on living with families [A category] and living alone [B category]: (*1A*) *rarely leaves own room and rejects cohabitating family*, (*2A*) *rarely leaves own home but with some communication with cohabitating*

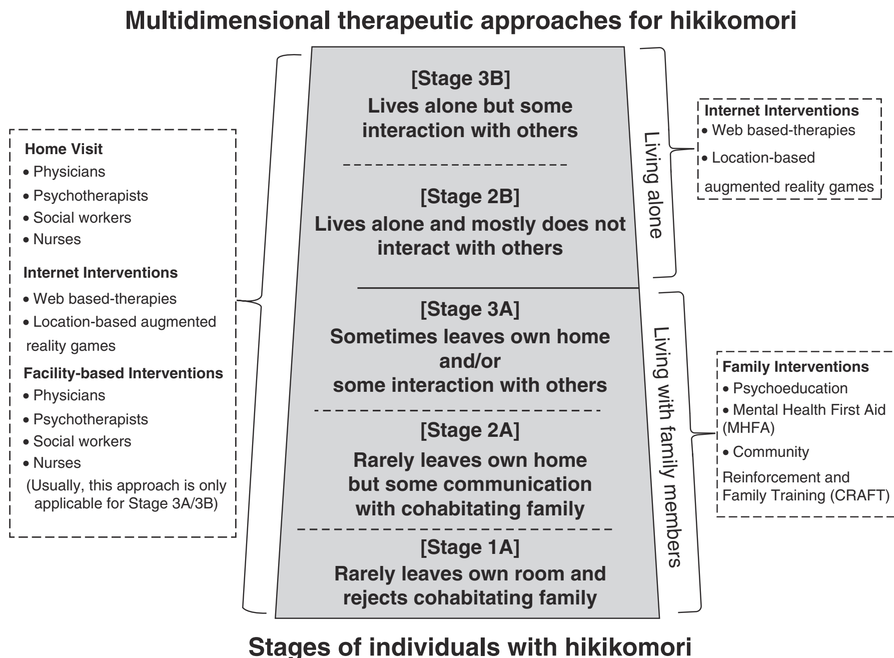

Fig. 1 Multidimensional therapeutic approaches for hikikomori
Individuals with hikikomori can be classified into the following five stages based on living with families (A category) and living alone (B category): (*1A*) *rarely leaves own room and rejects cohabitating family*; (*2A*) *rarely leaves own home but some communication with cohabitating family*; (*3A*) *sometimes leaves own home and/or some interaction with others*; (*2B*) *lives alone and mostly does not interact with others*; *and* (*3B*) *lives alone but some interaction with others*
Family interventions and direct interventions with the person themselves are both important. Initially, it is unlikely that the persons themselves would seek treatment, and therefore family interventions are crucial in case of living with family members. It is important for families to acquire the appropriate knowledge and techniques for dealing with hikikomori individuals. The Australian-developed Mental Health First Aid (MHFA) may be useful for educating the actual skills to contact the individuals appropriately. Furthermore, home visits by physicians, nurses, and psychologists also play an important role.
For individuals who live alone, a different intervention method may be necessary than for those living with their families. Early intervention methods utilizing technologies such the Internet and *Pokémon Go* may be particularly important in guiding such individuals to outside support organizations. Once in contact with support organizations, such as medical facilities (psychiatric hospitals/clinics), psychotherapy rooms, mental health support centers, and hikikomori support centers, various types of psycho-bio-social interventions can be applicable in the same way as other psychiatric disorders. In any case, a combination of various approaches is called for.

family, (*3A*) *sometimes leaves own home and/or some interaction with others*, (*2B*) *lives alone and mostly does not interact with others*, *and* (*3B*) *lives alone but with some interaction with others*.

Interventions with the hikikomori persons themselves and family interventions are both important. Initially, it is unlikely that the persons themselves would seek

treatment, and therefore family interventions are crucial in case of living with family members. In clinical practice dealing with hikikomori, the first consultation is often made by family members (especially parents). However due to a lack of knowledge (about mental illness in general and hikikomori in particular) and prejudices against such mental conditions, in many cases, family members cannot respond directly to individuals with these ailments, are unable to intervene at all, and waste many years without seeking help. As a result, we are now facing the new issue of longer-term hikikomori of ever increasing age. Thus, it is important for families to acquire the appropriate knowledge and techniques for dealing with hikikomori individuals. Mental Health First Aid (MHFA) may be useful for educating actual skills for family members in how they may interact with hikikomori sufferers appropriately. MHFA was originally developed as a 12-hour educational course that teaches participants (mainly laypeople) how to identify, understand, and respond to signs of mental illnesses, which gives participants the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or experiencing a crisis (Kitchener and Jorm 2002, 2006). The five steps of the MHFA (third version) are as follows: step (1), approach the person, assess, and assist with any crisis; step (2), listen nonjudgmentally; step (3), give support and information; step (4), encourage the person to get appropriate professional help; and step (5), encourage other support (Kitchener et al. 2013). We have been promoting usage of the MHFA in Japan (Hashimoto et al. 2016; Kato et al. 2010; Suzuki et al. 2014) and are now in the process of developing an educational support model that enables families (especially parents) of persons with hikikomori to obtain specific skills and knowledge in dealing with hikikomori based on MHFA. Community Reinforcement and Family Training (CRAFT), a disorder-specific and partner-assisted intervention, that was originally developed for family members of individuals with substance use disorders (Meyers et al. 1998, 2002) has also been highlighted as another powerful interventional candidate for family members dealing with hikikomori individuals (Sakai and Nonaka 2013). Furthermore, home visits by physicians, nurses, psychologists, and social workers also play an important role.

For individuals who live alone, a different intervention method may be necessary than for those living with their families. Early intervention methods utilizing technologies of the Internet and mobile tools may be particularly important in guiding such individuals to outside support organizations. Very recently, the appearance of "*Pokémon Go*" – the location-based augmented reality game, which connects the Internet society with real road maps, has brought us to a new phase. Some people with hikikomori who have not gone out for years are leaving their homes in search of *Pokémons* (Kato et al. 2017). To our amazement, a single male patient who previously was barely able to go out who live alone has begun to venture out daily with the emergence of *Pokémon Go*. His main destination is public parks filled with other people in search of *Pokémons*, though they do not converse with each other. No matter what the reason, for a hikikomori suffer who rarely goes out, any "adventure" outside is important as the first step in the treatment. Notwithstanding obvious limitations, we can perhaps expect much from this as an evolutionary therapeutic tool enhancing motivation toward the outside. Such new location-based augmented

reality games that can connect the Internet society with real roadmaps, offer a tempting new approach to treating hikikomori. It is important to utilize such technology to successfully attract people with hikikomori from their isolated room to places where they may be treated. Looking to the future with the aim of a fundamental breakthrough combating the hikikomori condition, we need to develop an online intervention system using e-learning materials that allows easy usage for persons with hikikomori themselves and also their family members. Once in contact with support organizations, such as medical facilities (psychiatric hospitals/clinics), psychotherapy rooms, and/or mental health support centers, and hikikomori support centers, various types of psycho-bio-social interventions can be applicable in the same way as other psychiatric disorders. In any case, a combination of various approaches is called for.

Psychotherapeutic Approaches Against Hikikomori

In an international hikikomori survey, we previously asked persons with hikikomori in Japan, India, South Korea, and the United States whether they themselves want to have treatment such as psychotherapy and/or pharmacotherapy with direct methods or indirect online methods (Teo et al. 2015a). This international survey revealed for the first time that most hikikomori persons would like to undergo some form of treatment to resolve their hikikomori status (Teo et al. 2015a). Most desired psychotherapy (counseling) rather than pharmacological therapy. Significantly more persons desired direct psychotherapy and pharmacological therapy than online treatment using webcams and the like. The most popular form of treatment was direct (face-to-face) personal psychotherapy by a mental health professional. With regard to comparisons between different countries, American hikikomori persons had a more pronounced tendency than Japanese counterparts to not desire treatment from their primary care physician.

Our international research has supported the finding that the majority of hikikomori sufferers feel a strong sense of loneliness and have functional disabilities. The fact that most people with hikikomori desire therapeutic interventions also deserves attention. At the time the survey was initiated, we expected that because most people with hikikomori do not go outside, they would be likely to actively search out nondirect forms of treatment over the Internet; however, in contrast to this hypothesis, most respondents desired direct treatment. We believe that the results of this survey will be beneficial in considering treatment strategies for people with hikikomori. Based on our clinical observations (no survey exists to our knowledge), we suppose that most persons are extremely isolated from venues of social interaction in an attempt to be freed from annoying human relationships; however, at the same time, they desire direct interpersonal interaction at a preconscious and/or unconscious level especially as their shut-in durations are prolonged. Psychotherapy is useful in handling these ambivalent sentiments, and the reason why most persons with hikikomori desire direct psychotherapy may lay within this internal motivation.

Psychotherapy has long been one of the main approaches for the treatment of hikikomori in Japan (Kano and Kondo 2000; Kitayama et al. 2001; Nakamura and Shioji 1997), and various psychotherapeutic methods, including the psychoanalytical approach, the group psychotherapy approach, and the house call approach, have been practiced (Kano and Kondo 2000). In terms of psychoanalysis, it has been pointed out that psychopathologies such as schizoid and narcissistic personalities underlie the hikikomori phenomenon (Kano and Kondo 2000). Among various types of psychotherapy, psychoanalytic psychotherapy conducted over a long duration plays a significant role in treating these personality pathologies. Ambivalent sentiments such as “I want to engage with this person” and “I want to let him/her in peace” emerge among analysts engaged in psychoanalytic treatment, particularly non-face-to-face psychoanalysis employing couches. Winnicott D.W. proposed such a treatment approach involving an ambivalent paradoxical attitude and venue, where a patient can be “alone but not alone,” that can cultivate a patient’s ability “to be alone” (Winnicott 1958). Another important point that psychoanalysis alerts us to is the fact that even individuals living out their lives in perfectly healthy ways have some degree of hikikomori-like qualities (such feelings as “want to be alone” and/or “let me alone”). This understanding helps us to develop a sense of empathy with hikikomori and to build a unified treatment approach. Fairbairn W.D. proposes the “exciting object” and the “rejecting object” as the two main elements of personality (Fairbairn 1952). Hikikomori may be an extreme manifestation of the rejecting object (Kato et al. 2015). Dynamic group psychotherapy based on psychoanalytic theories is effective in allowing people with hikikomori to observe each other and achieve mutual understanding by sharing experiences with the above pathologies in groups (Kubo et al. 2017). Additionally, in many cases, people with hikikomori have not been examined at medical institutions, and in such cases, in-home counseling is effective; recent research has suggested the usefulness of house calls among hikikomori in South Korea (Lee et al. 2013).

Such clinical experience resulting from the practice of Japanese psychotherapists should be widely introduced overseas, and at the same time, we should attempt to build evidence of the effectiveness of psychotherapy.

Future Perspectives

The main causes of the internationalization of hikikomori may be urbanization, globalization, and in particular the international spread of nondirect communication due to the popularization of the Internet (Kato et al. 2011, 2015). We have recently been proposing a concept of “boundless syndromes” in modern society (Kato and Kanba 2016). A more interconnected world due to globalization and the growing importance of “(Inter)net society” may be major contributing factors behind the hikikomori phenomenon. An interconnected world is resulting in a boundless society and building a boundless psychological world in modern persons, which may form a variety of novel psychopathological conditions including hikikomori. Behind the increase of people with hikikomori, there may be an interconnection with

societies that are increasingly boundless. Ironically, this very interconnectedness may spur an increase in the number of people who need to drastically “disconnect” (withdraw) from society. As information technology continues to evolve the social issues brought about regarding single-person households will be of increasing importance. We should consider an interconnected world producing novel psychopathology in the twenty-first century.

Hikikomori, Kodoku-Shi, and Suicide as Urban Loneliness-Related Phenomena

As modernization and urbanization have progressed, people who had hitherto lived in traditional family groupings and communities have increasingly come to spend more time as lone individuals with many actually living alone in the city. Traditionally, Japanese life used to be based on village communities and was a society that highly valued neighborhood relations, but in the modern urban life, it is becoming increasingly difficult to establish and maintain close human connections. This creates a situation in which people are likely to become lonely. As shown in this chapter, this situation of single-person households in the city tends to induce isolation and/or loneliness and sometimes leads to a variety of mental health and psychiatric issues based on loneliness. In other words, we should not overlook the fact that as individuals in single-person households in the city experiencing loneliness, they also develop associated mental health issues, including hikikomori, kodoku-shi, and also suicide. One of the major background factors of suicide is loneliness (▶ Violence and Mental Health in Megacities by Ziebold, C., Jaen-Varas, D., Mari, J., in this handbook), and, interestingly, an American expatriate living in Japan remarked that hikikomori seems to be an alternative suicidal behavior. Even though no epidemiological data exists, there have been many case reports of hikikomori persons who committed suicide. Further studies between hikikomori and suicide should be conducted. Hikikomori was first reported in Japan, and recently Japan’s Cabinet Office reported that the number of sufferers presently is in excess of 500,000 (age 15–39). This number does not take into account a much larger population when including middle- and senior-aged hikikomori people (Jozuka 2016). Although there has yet to be any epidemiological research, we have seen an increase in visits of hikikomori sufferers aged over 40 years old and their parents at our hikikomori advice facilities; thus it has been predicted that the aging of such individuals will continue to develop into a serious social issue in the not-too-distant future. Especially in urban areas where we see little to no community bonds, it is more and more likely that lone hikikomori suffers will one day also become victims of kodoku-shi.

Conclusion

As shown above, the hikikomori-like phenomenon is not limited to Japan but also exists in many other countries; thus we have warned that hikikomori and kodoku-shi may not simply be Japanese cultural/social phenomena but actually indicators of a pandemic of psychological problems that a continually globalizing society will have to face in the near future (Kato et al. 2011). The presented topics related to single-person households in the city are not merely Japanese or one nation issues but are in fact increasingly global phenomena and as such require breakthrough measures based on worldwide research. Precisely as we are living in such a lonely era, especially for people who live alone in cities, many of us are beginning to seek human connectivity in new ways as the emergence and popularity of Facebook and Instagram exemplify. Meanwhile for those who are not satisfied by the emotional connection brought about by such SNS, a new kind of deep loneliness is being experienced. While a fundamental breakthrough to these loneliness-related situations is yet to be thought of, perhaps it is by utilizing such global networks that we may achieve one.

Conflict of Interests

In this review paper, all the authors report no financial relationships with commercial interests.

Cross-References

- ▶ Implementing Community Care in Large Cities and Informal Settlements: An African Perspective
- ▶ Urban-Rural Differences in Major Mental Health Conditions
- ▶ Violence and Mental Health in Megacities

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