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The World Psychiatric Association (WPA)

The WPA is an association of national psychiatric societies aimed to increase knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies are presently 140, spanning 120 different countries and representing more than 200,000 psychiatrists.

The WPA organizes the World Congress of Psychiatry every three years. It also organizes international and regional congresses and meetings, and thematic conferences. It has 72 scientific sections, aimed to disseminate information and promote collaborative work in specific domains of psychiatry. It has produced several educational programmes and series of books. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996).

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against women⁶. In addition, violence related to both the war and family conflicts contributes independently to children's psychopathology. This includes PTSD, depression symptoms as well as internalizing and externalizing behavior problems⁴.

A key question refers to the mechanisms behind this "cycle of violence" in the aftermath of war. How are the exposure to violent conflict and increased rates of child maltreatment interlinked? So far, studies have focused mainly on intergenerational effects, i.e. parental trauma and psychopathology as potential mediators. Evidence suggests that exposure to organized violence and psychopathology associated with these experiences might act as a catalyst for domestic violence and child maltreatment. In particular, PTSD symptoms, such as irritability and outbursts of anger, as well as elevated rates of alcohol consumption in parents, may contribute to higher levels of child abuse. In line with this hypothesis, studies in post-war Sri Lanka and Uganda have shown that, next to parents' own experiences of child abuse, children's reports of maltreatment were associated with the parents' exposure to war and their PTSD symptom severity as well as with male guardian's alcohol consumption⁷.

Research, so far, has neglected a further pathway by which war trauma could translate into increased levels of family violence. It might be the child's own war exposure and related psychopathology that increase the risk of experiencing violence at home. Children who grow up in the midst of war are at greater risk of developing challenging behavior problems associated with their traumatization, e.g. irritability, outbursts of anger, internalizing and externalizing symptoms. Their mental health problems are typically accompanied by functional impairments that compromise their ability to perform well at school, carry out household duties, and engage in social relationships. All of these difficulties could make war-traumatized children more challenging to manage for their parents, who, in turn, may apply more violent and coercive parenting strategies. Consistent with this hypothesis, a recent study with Tamil families in post-war Sri Lanka found that children's exposure to mass trauma and child psychopathology were the main predictors of children's self-reported victimization in their families, even after controlling for parental trauma and parental mental health⁵.

The notion that stressors from different ecological contexts interact with each other is supported by earlier longitudinal data on maltreated children, which showed that children's externalizing behavior uniquely predicted later exposure to community violence⁸. These findings have important implications for future research with war-affected children and their

families. Instead of focusing on mental health problems as a mere outcome of war trauma in children, they should be considered as a potential risk factor for the experience of further adversities at a different ecological level, i.e. the family.

Applying a risk and protection perspective to the study of child mental health in a post-war context requires considering potentially protective factors that, again, may be found at various ecological levels. The family in particular may not only act as a stressor, in the case of family violence, but also foster children's resilience through care and warmth. There is some evidence that this is also valid in war-torn populations. Sris-kandarajah et al⁹ showed that, in a context of multiple trauma caused by war and natural disaster, parental care moderates the relation between children's trauma severity and their internalizing behavior problems. Children who reported their parents to be highly caring did not show a significant increase in internalizing problems related to exposure to mass trauma. Likewise, data from families in post-war Uganda revealed that the effect of war trauma on children's psychopathology was partially mediated by lower child-perceived care from female guardians¹⁰.

We can conclude that children and families living in or fleeing war regions have a high probability of suffering from mental health problems. This is because they are confronted with an accumulation of risk factors at different socio-ecological levels. Parenting practices seem to play a crucial role for children's psychological wellbeing in a war context, both as a risk and a protective factor. Consequently, adequate health care programs for war-traumatized communities require both individual and family level approaches. The latter would assess and address potential problems between parents as well as in parent-child relationships. This might halt a potential vicious circle of war trauma, psychopathology and dysfunctional family dynamics, including the maltreatment of women and children.

Claudia Catani

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Hikikomori: experience in Japan and international relevance

The appearance of people in Japan, especially young men, who stopped going to school or the workplace and spent most of the time withdrawn into their homes for months or years,

came to be seen as an increasing social phenomenon called *Shakaiteki hikikomori* (social withdrawal) by the late 1990s¹.

A community-based survey published in 2010 reported that

the prevalence of hikikomori was approximately 1.2% of the Japanese population², and in 2016 a Japanese cabinet report estimated people with hikikomori to be about 541,000 within the age range of 15-39 years.

Early epidemiological studies were limited by not being based on strict diagnostic standards. In 2010, Japan's Ministry of Health, Labour and Welfare announced a guideline for hikikomori which included a definition ("a situation where a person without psychosis is withdrawn into his/her home for more than six months and does not participate in society such as attending school and/or work")³. More recently, in order not only to diagnose but also to assess the severity of the condition, we proposed even more precise diagnostic criteria based on the levels of physical isolation at home, avoidance of social interactions, and functional impairment or distress, as well as a sustained duration of six months or more⁴.

The Japanese sociocultural background has been traditionally permeated by "*amae*" (accepting overdependent behaviors) and shame, which may underlie the culture-bound syndrome called *Taijin Kyofusho* (a severe form of social phobia) as well as hikikomori^{5,6}. Parent-child relationships in Japan have long been considered less oedipal than in Western societies and marked by an absent father and an extremely prolonged and close bond to the mother, which may result in difficulty to become independent⁷. Especially in hikikomori, the development of basic interpersonal skills during the early stages of life seems to be insufficient, which can induce vulnerability to stress in later school/workplace environments and lead to escape from social situations⁷.

On the other hand, hikikomori-like cases have recently been reported in other countries of varying sociocultural and economic backgrounds such as Hong Kong, Oman and Spain, and our studies based on structured interviews have revealed the existence of hikikomori in India, South Korea and the US⁴. Thus, hikikomori has now crossed the limits of a culture-bound phenomenon to become an increasingly prevalent international condition. A major contributing factor may be the evolution of communication from direct to increasingly indirect and physically isolating⁸. This is especially the case for social interactions which hitherto required face-to-face contacts in a mutual physical space but can now occur, at least partially, in a virtual world.

Through our recent study using the Structured Clinical Interview for DSM-IV Axis I Disorders, we have found that hikikomori may be comorbid with various psychiatric disorders, including avoidant personality, social anxiety disorder and major depression⁹. In addition, autistic spectrum disorders and latent or prodromal states of schizophrenia may have some overlapping symptomatology with hikikomori. Thus, hikikomori is now understood to have links to several mental illnesses, and we hypothesize that some common psychopathological mechanisms may exist in the act of "shutting-in" regardless of psychiatric diagnosis.

Currently, there are more than fifty government-funded community support centers for hikikomori located throughout the prefectures of Japan, providing services such as telephone consultations for family members, the creation of "meeting spaces" for affected people, and job placement support. In addition, various private institutions provide treatment for hikikomori sufferers. However, there is yet to be a unified evidence-based method for these public/private interventions. A 4-step intervention is recommended by the government guideline for hikikomori, including family support and first contact with the individual and his/her evaluation; individual support; training through an intermediate-transient group situation (such as group therapy); and social participation trial³.

We have recently established a hikikomori clinical research unit in a university hospital to develop evidence-based therapeutic approaches in collaboration with public/private hikikomori support centers. As a first step, we are trying to establish an evidence-based educational program for parents of individuals with hikikomori, because in the majority of cases the first consultation is made by them. Due to prejudice and lack of knowledge, in many cases family members cannot respond directly to individuals with this problem, are unable to intervene at all, and tend to turn a blind eye for many years without seeking help. Thus, we believe that education of parents to deal with hikikomori sufferers is essential for early intervention.

Within decades, following further advances in Internet society, more and more people may come to live a hikikomori-like existence, which may or may not be seen as a pathological condition at that time. Hikikomori is still a hidden epidemic in many countries and, to grasp its worldwide relevance, diagnostic criteria should be included in ICD-11 and future DSM systems. In addition, evidence-based evaluation tools such as structured diagnostic interviews, screening instruments and online systems should be developed for international and population-level epidemiological surveys. Such tools will also help to evaluate risk factors and effectiveness of interventions.

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