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Validating a Colombian Spanish Translation of the Ikigai-9: A Measure of a Life Worth Living

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Abstract. *Rationale***:** The Japanese concept of ikigai relates to living a life worth living and with meaning, and through a growing body of work, has predicted benefit in areas of both physical and mental health. In response to the growing interest of ikigai, globally, and a need to establish community-based means of supporting health provision, locally, this manuscript documents the translation of the internationally-used Ikigai-9 (Imai et al., 2012) into Colombian Spanish and its validation within a Colombian context. *Methods***:** Three hundred and ninety-eight adults (M_{age} = 43.51 years, 67.6% female) originating from Colombia completed a Colombian Spanish translation of the Ikigai-9. *Results***:** A confirmatory factor analysis tested our data on previously defined single- and three-factor models, wherein the three-factor model evidenced a significantly better fit. In line with existing work, our proposed subscales comprised: [1] *Optimistic and Positive Emotions Toward Life*, [2] *Active and Positive Attitudes Toward the Future,* and [3] *Recognition of the Meaning of Existence*. Inter-correlations confirmed strong positive correlations between the subscales, which reinforces the idea that these factors are closely related and together contribute to the overall concept of ikigai. *Conclusion***:** This study supports the validity of the three-factor model of the Ikigai-9-Col in a Colombian sample, and so provides a quick and efficient means of indexing ikigai within this population. Future work should look for opportunities to establish interventions to improve ikigai as a means of supporting physical and mental wellbeing outside of clinical settings.

Keywords: Ikigai, Purpose in Life, Psychometric Analysis, Colombia.

Introduction

The term *ikigai* is formed through the conjunction of the Japanese words *iki*, meaning "living", and *gai*, relating to "the value of" or "worth", which together describe the concept of leading a life that is worth living and meaningful (Ikeda et al., 2024; Kemp, 2022). Ikigai is perhaps best showcased through the work of Japanese psychiatrist, Mieko Kamiya, who some describe as the "Mother of Ikigai" (Kemp, 2022). Kamiya documents her lived experiences of working with patients with leprosy, wherein some evidenced deep resilience and were able to maintain hope and meaning in their lives despite facing significant barriers and challenges (Kamiya, 1961). Prior to presenting our methods, this manuscript first reviews the development of a psychometric tool to index ikigai, before discussing the broad relationships between ikigai and physical/mental health and the specific need for such tools within a Colombian context.

Amplified through amplification in Western media (e.g., Gaines, 2020; Perry, 2024) and international organizations seeking to expand public knowledge of ikigai, such as Nicholas Kemp's *Ikigai Tribe*, there has been growth in interest for both understanding the benefits of ikigai as well as finding an empirical means of indexing it. Early studies simply asked participants questions such as "*Do you have Ikigai in your life?*" with response options ranging from categorical 'yes'/'no' answers to Likert scale options anchored from 'definitely yes' to 'definitely no.' This relied on participants having extant knowledge of ikigai, which either created biases in those willing to respond (e.g., self-selection bias) or ceiling/floor effects in those with limited knowledge of the phenomena. However, a more psychometrically-informed index was proposed via the Ikigai-9 (Imai et al., 2012), a 9-item measure of ikigai across the three dimensions of [1] '*Optimistic and Positive Emotions Regarding Life*, [2] '*Active and Positive Attitudes Toward One's Future,'* and [3] '*Recognition of the Meaning of One's Existence.'* So successful was this tool that it was subsequently translated and validated in English (Fido et al., 2019), French (Vandroux & Auzoult, 2022), Turkish (Belice et al., 2022), and German (Ajek et al., 2024), with the English version also validated within an Indian cohort (Mahadevaswamy & Fido, 2026). Of note, however, whilst most replications support the original three-factor solution, the data presented within Fido et al. (2019) and Belice et al. (2022) supported a single-factor solution, suggesting the need for further exploration and replication to understand this measurement nuance.

The existence of rapid and valid means of measuring ikigai has allowed us to curate a persuasive narrative of the importance of this phenomena, with data suggesting positive relationships between ikigai and both physical health (Okuzono et al., 2022; Tsuzishita, 2022) and mental well-being (Fido et al., 2020; Seko et al., 2022; Yamamoto-Mitani et al., 2002), as well as negative relationships with depression (Fido et al., 2020; Wilkes et al., 2022), the use of maladaptive emotion regulation strategies

(Mahadevaswamy & Fido, 2026), and risk of both cardiovascular vascular- (Miyazaki et al., 2022; Seko et al., 2022) and pneumonia-associated mortality (Sumiyama et al., 2022). Moreover, those with heightened ikigai report a better quality of life (Hajek et al., 2024; Stickley et al., 2025; Zilioli et al., 2015) as well as faster recovery time following surgery (Smith & Zautra, 2004).

This is pertinent to the context of Colombia, which has, for decades, been the site of major internal conflict and violence (Instituto Nacional de Salud, 2017). This has not only disrupted key physical infrastructure, workforces, and funding for social services, but in turn, has directly contributed to high rates of physical illness and mortality (World Health Organization, 2026), as well as post-traumatic stress disorder, depression, anxiety, and suicidal behaviour (Instituto Nacional de Salud, 2017). As a result, a review of health services within Colombia has called for the need for supplementary community approaches (Alarcón Garavito et al., 2023). Given the strong ties between ikigai and physical/mental health, validating an index of ikigai within the Colombian Spanish language has potential to not only assess baseline levels of ikigai within Colombia, but can help facilitate the development of community-based interventions and efficacy assessment thereof.

Taken together, this study aimed to extend the applicability of the Ikigai-9 by translating it into Colombian Spanish, and validating it within a Colombian sample, whilst testing whether the single- or three-factor model of ikigai fits better within this population. We hope that this study will assist in the generation of a tool for use in future publications, which would facilitate a better understanding of the antecedents and consequences of experiencing ikigai in the context of health-related outcomes and/or well-being in individuals derived from Colombia.

METHODS

Participants

Three hundred and ninety-eight participants (M_{age} = 43.51 years, SD = 23.49 years, $range_{age}$ = 75 years; 67.6% female), all originating from Colombia, consented to take part in the research. Of these, *n* = 198 formed a 'younger' cohort (M_{age} = 20.44 years, SD = 3.12 years, $range_{age}$ = 23 years; 83.8% female, 100% from urban areas), and *n* = 200 formed an 'older' cohort (M_{age} = 66.36 years, SD = 6.08 years, $range_{age}$ = 34 years; 51.5% female, 89.0% from urban areas). The younger cohort were opportunistically sampled from the Universidad del Sinú, and the older cohort were opportunistically sampled through an advertisement campaign within the local region. To participate in the research, participants had to be inhabitants of Córdoba (a Department of the Republic of Colombia located to the north of this country in the Colombian Caribbean Region), over 18

years if age, and be fluent in Colombian Spanish. No other explicit exclusion criteria was made.

Measures

The original Ikigai-9 (Imai et al., 2012), and its English translation (Ikigai-9-UK; Fido et al., 2020) consists of nine items rated on a five-point scale (1 = *Does not apply to me*, 5 = *Applies to me a lot*). Here, the Ikigai-9-Col was translated from English to Colombian Spanish by a professional bilingual English-Spanish translator, before being back-translated by a second bilingual translator from Colombian Spanish to English, with translation discrepancies resolved by discussion where appropriate. The final Ikigai-9-Col can be found in Table 1, and the reliability statistics in Table 3.

Table 1. Colombian version of the Ikigai-9 (Ikigai-9-Col)

1. A menudo siento que soy feliz.
2. Me gustaría aprender algo nuevo o empezar algo.
3. Siento que contribuyo a alguien o a la sociedad.
4. Tengo espacio en mi mente.
5. Me interesan muchas cosas.
6. Creo que algo o alguien necesita mi existencia.
7. Mi vida es mentalmente rica y plena.
8. Me gustaría desarrollarme.
9. Creo que puedo influir en alguien.

Procedure

The protocol of this research, as well as the informed consent form and the instrument, were evaluated and approved by the Health Research Ethics Committee of the SINU University. This study considered the ethical aspects of research with human beings considered in Resolution # 008430 of 1993 of the Ministry of Health and Social Protection of Colombia and the deontological normative framework of the psychologist contemplated in Law 1090 of 2006 updated to June 2016 and Law 1164 of 2007 - Chapter VI, which includes professional secrecy, the right to refuse to participate or withdraw, informed consent and return of results.

For test administration, a booklet was administered individually that included documents addressed to participants (such as an information sheet and consent form), as well as demographic questions (e.g., age, sex, and whether participants lived in rural or urban areas) and the Ikigai-9-Col. On average, the study was completed in about 10 minutes, and all participants gave written informed consent. During administration, the investigators assisted participants individually as required.

Statistical Analysis

JASP 0.19.1 software was used to analyze our data. First, a confirmatory factor analysis (CFA) was conducted to assess construct validity across previously defined single- (Belice et al., 2022; Fido et al., 2020) and three-factor (Hajek et al., 2024; Imai et al., 2012; Mahadevaswamy & Fido, 2026; Vandroux & Auzoult-Chagnault, 2023) models. Items were treated as ordinal and the diagonally weighted least squares (DWLS) estimation method was used. Model fit was assessed via the root mean square error of approximation (RMSEA < 0.06), the standardized root means square residual (SRMR < 0.08), and the comparative fit index (CFI ≥ 0.95) in order to minimize Type I and Type II errors (Hu & Bentler, 1999). Second, reliability was estimated using Cronbach's alpha (α) and McDonald's omega (ω), which aimed for values over 0.7, with inter-factor correlations computed via Pearson's correlations. Third, *t*-tests were computed to identify differences in ikigai across age (younger vs. older cohorts) and rural living (rural vs. urban) for the whole sample and sex (females vs. males) for both our younger and older cohorts, individually. Of note, owing to recruitment methods, we do not have a representation of young responders from rural areas, hence the choice of *t*-tests over ANOVAs within this analysis.

RESULTS

Construct Validity and Reliability

The CFA results indicated that although the one-factor model utilized in English (Fido et al., 2020) and Turkish (Belice et al., 2022) samples was not suitable in our Colombian sample: $\chi^2(27) = 254.13$, $p < .001$, CFI = 0.71, TLI = 0.62, RMSEA = 0.15 [90% CI 0.13; 0.16], SRMR = 0.09, the three-factor model, which was originally conceptualized within Japanese (Imai et al., 2012), and later validated within French (Vandroux & Auzoult-Chagnault, 2023) and German (Hajek et al., 2024) samples, provided a better, yet not perfect, explanation: $\chi^2(24) = 127.30$, $p < .001$, CFI = 0.87, TLI = 0.80, RMSEA = 0.10 [90% CI 0.09; 0.12], SRMR = 0.08.

Mirroring previous three-factor validations, factor 1, '*Optimistic and Positive Emotions Regarding Life*, comprised items 1, 4, and 7, factor 2, '*Active and Positive Attitudes Toward One's Future*, comprised items 2, 5, and 8, and factor 3, '*Recognition of the Meaning of One's Existence*', comprised items 3, 6, and 9. Figure 1 and Table 2 show the standardized factor loadings of the Ikigai-9-Col items across the three subscales, with all items > .53, as well as strong and positive Pearson's correlations between subscales in Table 2 (all $p < .001$).

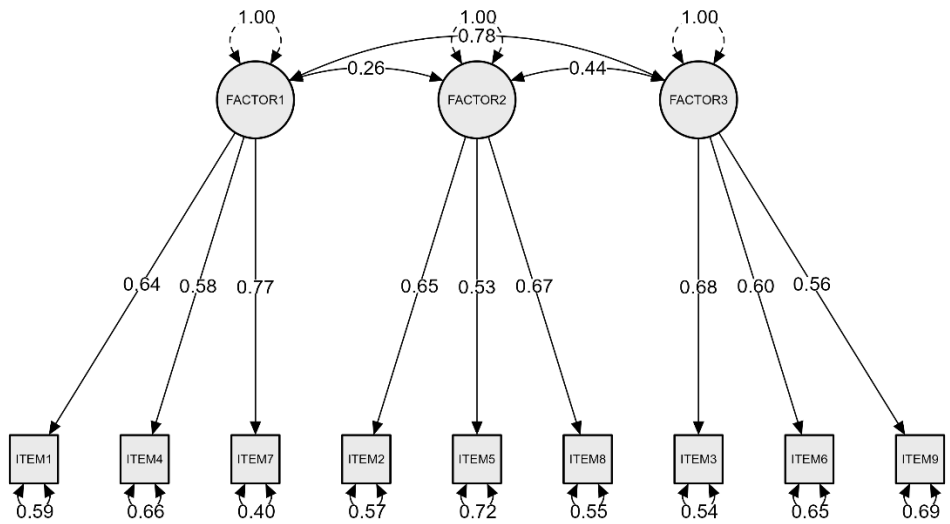

Figure 1. Factor loadings of the Ikigai-9-Col across a three-factor solution.

Table 2. Standardized factor loadings of the Ikigai-9-Col and pairwise correlations (Pearson's r) between subscales (SE in parentheses).

	Subscale 1: Optimistic and Positive Emotions Regarding Life	**Subscale 2: Active and Positive Attitudes Toward One's Future**	**Subscale 3: Recognition of the Meaning of One's Existence**
Item 1	.64 (.06)		
Item 4	.58 (.05)		
Item 7	.77 (.05)		
Item 2		.65 (.07)	
Item 5		.53 (.05)	
Item 8		.67 (.06)	
Item 3			.68 (.05)
Item 6			.60 (.05)
Item 9			.56 (.04)
Subscale 1	1		
Subscale 2	.213***	1	
Subscale 3	.530***	.306***	1

Note. *** $p < .001$

Reliability statistics as well as distribution data for the total Ikigai-9-Col as well as the individual subscales are displayed in Table 3. Although the total scores met our pre-defined benchmark for reliability (> 0.7), the reliability of the subscales largely fell just short (.640 - .715) of this idea. Moreover, data across all dimensions were negatively skewed, reflecting typically higher reports of ikigai within our sample.

Table 3. Indices of reliability and distribution for the Ikigai-9-Col and each subscale.

	Total Ikigai-9-Col	**Subscale 1: Optimistic and Positive Emotions Regarding Life**	**Subscale 2: Active and Positive Attitudes Toward One's Future**	**Subscale 3: Recognition of the Meaning of One's Existence**
Cronbach's alpha (α)	.752	.692	.645	.643
McDonald's omega (ω)	.784	.715	.658	.640
z-skew	-5.05	-5.39	-11.55	-6.94
z-kurtosis	0.51	0.75	8.80	2.78

Between Group Differences

When comparing our younger and older cohorts, younger individuals scored significantly lower on *Optimistic and Positive Emotions Regarding Life*, $t(396) = -7.45$, $p < .001$, $d = -.746$, and *Recognition of the Meaning of One's Existence*, $t(396) = -2.70$, $p = .007$, $d = -.270$, but significantly higher on *Active and Positive Attitudes Toward One's Future*, $t(396) = 9.01$, $p < .001$, $d = -.904$. Such variation between subscales likely contributed to the non-significant differences between age groups on the total Ikigai-9-Col, $t\ (396) = -.0.73$, $p = .465$, $d = -0.073$.

For our younger cohort, specifically, we did not find any statistically significant differences between male ($n = 32$, $M_{age} = 20.75$ years, SD = 4.14) and female participants ($n = 166$, $M_{age} = 20.38$ years, SD = 2.90) for either the total Ikigai-9-Col, $t(196) = 0.64$, $p = .521$, $d = 0.124$, or subscales 1, $t(196) = 0.88$, $p = .378$, $d = 0.171$, 2, $t(196) = 0.15$, $p = .878$, $d = 0.032$, or 3, $t(196) = 0.17$, $p = .867$, $d = 0.032$.

For our older cohort, specifically, though we did not find any statistically significant differences between male ($n = 97$, $M_{age} = 66.95$ years, SD = 5.34) and female participants ($n = 103$, $M_{age} = 65.80$ years, SD = 6.68) for either the total Ikigai-9-Col, $t(198) = -0.47$, $p = .642$, $d = 0.066$, or subscales 1, $t(198) = 1.16$, $p = .249$, $d = 0.164$ and 3, $t(198) = 0.44$, $p = .664$, $d = 0.062$, females (M = 12.09, SD = 2.30) did, on average, score

higher than males (M = 11.23, SD = 2.79) on Active and Positive Attitudes Toward One's Future, $t(198) = -2.28$, $p = .018$, $d = 0.337$.

Finally, when comparing our participants who lived in rural (n = 178), relative to urban areas (n = 120), although there were no significant group differences in regard to the total Ikigai-9-Col, $t(396) = -0.45$, $p = .651$, $d = 0.046$, or subscale 3, $t(396) = 1.75$, $p = .080$, $d = 0.177$, individuals from rural areas (M = 12.34, SD = 2.31 vs. M = 10.96, SD = 2.23) scored higher on Optimistic and Positive Emotions Regarding Life, $t(396) = 6.02$, $p < .001$, $d = 0.607$, and individuals from urban areas (M = 13.46, SD = 1.26 vs. M = 11.50, SD = 2.65) scored higher on Active and Positive Attitudes Toward One's Future, $t(396) = -9.67$, $p < .001$, $d = 0.975$.

DISCUSSION

The factorial distribution of the Colombian Spanish translation of the Ikigai-9 mirrors that of the original Japanese version (Imai et al., 2012), wherein the three factors identified comprise [1] '*Optimistic and Positive Emotions Regarding Life*, [2] '*Active and Positive Attitudes Toward One's Future'*, and [3] '*Recognition of the Meaning of One's Existence*'. Despite this, we note that our data did not provide a fully optimal fit, with moderate levels in the CFI and TLI indicators, specifically, which could refer to difficulties in the correspondence of the data with a neutral and independent structure (Brown, 2015; Schumacker & Lomax, 2016). However, we did reach adequate levels in the RMSEA and SRMR parameters, which is interpreted as a low standard error of approximation between the proposed model with the evaluated population, as well as an adequate agreement between the expected covariances and those estimated by the model (Hair et al., 2014) and strong, positive correlations between factors without showing conceptual overlap (i.e., they do not exceed .70). Adequate test item correlations are also identified (Brown, 2015), which contributes as an indicator of good overall reliability of the instrument (Hair et al., 2014). Taken together, we can have confidence in the utility of the Ikigai-9-Col within our Colombian cohort, which has the potential to facilitate future health- and well-being-focused research within this population.

We do however note the tendency for our participants to report overall high levels of ikigai, which was statistically skewed, suggesting that further validations within this population would benefit from a broader and more diverse sampling strategy. Though this might reflect a true description of this population, we should also consider the need for both qualitative works to help us validate their understanding of the items, as well as quantitative work and replications reducing the likelihood of our data reflecting social desirability and a bias of attribution of this psychological characteristic at high levels by the respondents. This could be resolved by including a Likert scale with a wider rating range (Tabachnick & Fidell, 2019) and a greater neutralization of the wording of the items in the translated version (Bäckström & Björklund, 2013).

Upon reporting our descriptive statistics, we identified an opportunity to further interrogate the manifestation of ikigai across 'younger' (M_{age} = 20.44 years) and 'older' (M_{age} = 66.36 years) cohorts, which revealed statistically significant differences across all dimensions. Specifically, whilst the older cohort scored higher on the '*Optimistic and Positive Emotions Regarding Life*' and '*Active and Positive Attitudes Toward One's Future*' subscales, they scored lower on the '*Recognition of the Meaning of One's Existence*' subscale. These differences were compensated on the results of the total scale, where no differences were evident between cohorts. This finding may be due to differences explained by aspects such as the young population prioritising autonomy in contrast to the older population prioritising emotional stability and close relationships (Lacey et al., 2022) and would greatly benefit from further qualitative interrogation.

When exploring overlapping sex differences, our data yielded largely non-significant effects across both total and sub-scale comparisons. However, women in the older, but not younger cohort, did achieve higher scores in the '*Active and Positive Attitudes Toward One's Future*' factor. This finding might be explained as being a priority for older women with high levels of social connection and significant interpersonal relationships (Martela & Steger, 2016), gratitude and life satisfaction (Kashdan et al., 2020), and the perception of caring for others (García et al., 2021). In essence, these are aspects that could contribute to a greater level of ikigai in this population.

Limitations

We encourage readers to view the findings of this manuscript in light of the following limitations. First, although we report on a large sample, it was obtained at convenience, which limits the generalisability of the results to other Colombian or Spanish-speaking populations. Indeed, currently uncaptured differences in the reporting of ikigai could arise as a result of cultural biases and environmental experiences (Diener et al., 2028; Ryff, 2022). Second, this is cross-sectional data, wherein we haven't been able to report on test-retest reliability, which would allow us to evaluate the stability of the measure over time. To our knowledge, no existing literature to date has provided such data, across any population. Third, within this specific data, we did not capture any additional contextual data or covariate information, which could have played an unknown weight on some of the participants' responses. For example, the recurrence of long-term illness has been shown to impact both the immediate quality of life as well as cognitive and emotional outlook (Colombo et al., 2017); facets previously associated with ikigai. Finally, unlike Mahadevaswamy and Fido (2026), our analyses did not capture measurement invariance (i.e., configural, metric, scalar, and strict); a process which aims to identify whether the structure of the instrument varies according to sociodemographic profiles and, thus,

whether differences reported are due to biases inherent to the instrument (Bauer et al., 2020; Byrne, 2016).

Implications

Beyond the psychometric findings, our data has a series of implications. First, in the context of recent calls for supplementary community approaches to physical and mental health within Colombia (Alarcón Garavito et al., 2023), the Ikigai-9-Col creates opportunities for the integration of ikigai within community-based health initiatives, aligning well with both preventative and strengths-based models of health. Second, given the structural inequalities and regional disparities that shape access to resources and opportunities within Colombia (Instituto Nacional de Salud, 2017), ikigai provides an avenue through which meaning-based public health frameworks could be strengthened within this region. In practice, this might include creating opportunities for members of the public to reflect upon and acknowledge the purpose created through their social connectedness, employment, and small moments of joy (Mogi, 2017). Third, the Ikigai-9-Col establishes a baseline through which bespoke interventions can be developed and tested within this population, which may confer unique means by which individuals can recognise and experience meaning in their life, and ultimately, benefit their physical and mental health.

Conclusion

Taken together, this manuscript reports on the Colombian Spanish translation of the Ikigai-9, which, in our Colombian sample was deemed to have acceptable goodness-of-fit indicators that assume a three-factor solution aligning with the original Japanese conceptualization of the Ikigai-9 (Imai et al., 2012). We encourage further translations and validations of the Ikigai-9 to enhance its utility to index ikigai within the general population and support the use of it within clinical, forensic, and general populations as a means of identifying potential interventions to enhance ikigai across the globe.

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Availability of Data and Material
N/A

Conflict of Interest
The authors declare that they have no conflicts of interest.

Author's Contributions

SV, AGA, GR, and JMQ led on study design, ethics applications, and data collection. DF analysed the data and drafted the initial manuscript. DF and SV refined the manuscript.

Ethical Approval and Informed Consent

Ethics was granted by the Health Research Ethics Committee of the SINU University. Participants gave informed consent prior to data collection.

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