

Hikikomori: clinical and psychopathological issues

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Abstract

Hikikomori is the Japanese term used to define a condition of social withdrawal, typically involving adolescents or young adults, who refuse to attend school/work, seclude themselves in their own room, and interrupt personal relationships, communicating only via the Internet. Although the phenomenon shows a clear correlation with Japanese culture and structure of society and is prevalent in Asia, lately extra-Asian scientific literature has begun focusing on individuating hikikomori-like cases worldwide, following the hypothesis that hikikomori may be a global, cross-national issue. Aim of this paper is to analyse the scientific literature currently available about hikikomori, providing a coherent discussion on the characteristic features, the clinical aspects and the related psychopathologic issues.

KEY WORDS: hikikomori, social withdrawal, adolescents, psychopathology.

Introduction

Hikikomori (引き籠もり) is a Japanese term, which literally means "being confined, pulled inward". *Hikikomori* is commonly translated as "social withdrawal" in Western cultures, and it has been included in the Oxford Dictionary of English in 2010, defined

as "the abnormal avoidance of social contact, typically by adolescent males" (1). The word is interchangeably used to indicate both the disorder and the affected subject (2).

Similar phenomena have been described in Japan since the late 1970s: in 1978 Kasahara reported cases of 'withdrawal neurosis' or *taikyaku shinkeishou* (3), while in the early 1980s, Lock described several cases of "school refusal syndrome", as she labelled them, related to what appeared to be a form of resistance to social pressure and expectations (2, 4). It was only a decade later that the term *hikikomori* gained worldwide popularity, mostly thanks to Saito (5), the Japanese psychiatrist who identified the clinical situation as youths who seclude themselves in their own home, for at least six months, with a prevalent onset by the latter half of the third decade of life, and no other psychiatric disorders to explain the primary symptom of withdrawal. In 2003, the Japanese Ministry of Health, Labour and Welfare established a more accurate list of diagnostic criteria for *hikikomori* (6) including: 1) home-centred lifestyle; 2) refusal to attend school or work; 3) symptoms persistence for at least six months; 4) exclusion of schizophrenia, mental retardation or other mental disorders; 5) lack of personal relationships (e.g. friendships) (7).

Although the phenomenon shows a clear correlation with Japanese culture and structure of society, and researchers have proposed to consider it a new psychiatric disorder (2) *hikikomori* has not been included among culture-bound syndromes in DSM-5. On the other hand, *Taijin kyōfushō*, Japanese for interpersonal fear disorder, was already entombed in the DSM-IV-TR appendix and has made its appearance as a cultural syndrome in DSM-5. It is characterized by anxiety about and avoidance of interpersonal situations due to the thought, feeling, or conviction that one's appearance and actions in social interactions are inadequate or offensive to others. In addition to performance anxiety, *Taijin kyōfushō* includes two culture-related forms: a "sensitive type," with extreme social sensitivity and anxiety about interpersonal interactions, and an "offensive type," in which the major concern is offending others (8).

The prevalence of *hikikomori* is difficult to assess (Tab.1). In Japan, more than one million cases have been estimated by experts, but there is no population-based study to confirm these data (9). In 2003, the Japanese Ministry of Health, Labour and Welfare declared that over 14000 consultations regard-

ing *hikikomori* took place in mental health and welfare centres in a one-year period (6). This is probably an underestimation of the actual size of the issue, because *hikikomori* subjects and/or their parents often do not ask for help, and the study did not consider clinics and hospitals, but only mental health and welfare centres (7). In 2002, a group of Okinawan researchers reported 14 cases among 1646 families; grossing up the data to the entire nation, cases number might rise to 410,000 (10). In 2008, Kiyota et al. summarized 3 population-based studies involving 12 cities and 3951 subjects, highlighting that a percentage comprised between 0.9% and 3.8% of the sample had an *hikikomori* history in anamnesis (11).

The typical *hikikomori* patient is male (4:1 male-to-female ratio), mostly the young adult eldest son of a family with a good socioeconomic background (12-14). Age of onset of the syndrome varies in different studies, ranging from 20 to 27 years old, but prodromal symptoms often show up in adolescence (5, 6, 12). Several cultural, social, familiar and educational Japanese features are considered as predisposing factors to social withdrawal. Historically, Japan is a democracy in which society is presented as cohesive and protective for each citizen, and it is based on two major criteria: inclusion and mainstreaming, which predominate over individuality expression. Saito Tamaki, one of the most prominent *hikikomori* experts, justifies the development of this phenomenon as a way to contrast the effects of rigid social structures on individual characteristics (13). The economical and political modernization process that begun in Japan after World War II has not involved the conservative values transmitted by traditional Japanese families, which are committed in overprotecting their offspring. Therefore, in a modern society that needs reflexive actions and greater individual resilience by its young exponents, Japanese families still have a tendency to over-indulge their offspring (10, 14-16). *Hikikomori* subjects usually belong to middle and upper class families (5, 10, 15), and do not have apparent conflicts at home (16, 17). Kondo et al. in their research on 88 *hikikomori* cases, found out that 60% of the sample lived with both parents, 18% only with the mother, 3% only with the father, and 16% in a three-generation household (12). Moreover, in their cross-sectional study, Umeda et al. highlighted two important correlations: the frequency of the *hikikomori* phenomenon is higher in families with little socioeconomic disadvantages, and the mother of the subject has often a positive psychiatric anamnesis for panic disorders (17). It has been hypothesized that highly educated parents may have higher expectations toward their children, and this could lead them to interpersonal conflicts and failure feelings (18, 19). Furthermore, parents with higher income can indulge their young children jobless at home (20), strengthening the dependence feeling known as *amae* (20, 21). *Amae*, commonly translated as "indulgent dependency", is a traditional Japanese concept primarily described by the psychiatrist and psychoanalyst Takeo

Doi, who roots it in the mother-child bond. The subsequent social bonds, such as teacher-student and supervisor-subordinate, may be patterned after the primary mother-child experience. This dependent behaviour may be among the causes of why Japanese youths are more economically and emotionally dependent on their parents (22, 23). Parental psychiatric history, instead, and mainly mother anxiety and panic disorders, has been associated to *hikikomori* in a number of studies (24-27), and is considered as a reinforce to children's anxiety and avoidant coping strategy (21, 25-29).

Japanese society emphasizes school curricula, considering them as one of the fundamental criteria for individual abilities evaluation (25). Moreover, Japanese schools are extremely selective, and final exams are so difficult that students are often forced to attend expensive private evening schools (*juku*) in order to better prepare for them. Many *hikikomori* subjects present at a first stage a "school refusal syndrome" (*tokokyohi*), characterized by a gradual withdrawal from school (15). The Japanese Education Ministry describes *tokokyohi* as "a phenomenon in which students do not go or can not go to school, in spite of the desire to go; this is due to psychological, emotional, social or environmental reasons" (25). Among the main causes of school withdrawal, bullying (*ljime*) has to be mentioned (25). *Ijime* is in most cases a form of psychological intimidation perpetrated by classmates or other peers to mentally weaker, or just "different", victims; name calling, teasing, and even extreme forms of social isolation are commonly acted (26). Another potential predisposing factor to *hikikomori* is the so-called "student apathy", in which children and adolescents withdraw from academic activities and society (27). Kasahara has identified peculiar characteristics of this disorder: subjects are apathetic and avoid competitions for the fear of losing; they can show obsessive-compulsive traits; they withdraw from academic environment; they may present identity conflict (28). Uchida has evidenced as a high number of Japanese university students, especially 4th-year males, leave school, repeat or take off academic year because of an apathetic situation (29, 30).

Aim of this paper is to analyse the scientific literature currently available about *hikikomori*, providing a coherent discussion on the characteristic features, the clinical aspects and the related psychopathologic issues.

Materials and Methods

We searched Pubmed (<http://www.ncbi.nlm.nih.gov/pubmed>) and Scopus (www.scopus.com), using the keyword *hikikomori*, in order to identify published papers written in English, Italian or Spanish focusing on the matter.

The search was conducted on July 4th, 2014 and yielded a total of 54 results. We excluded 14 articles from total records, for being reviews, written in Japanese or French, or both. By reading titles and

Table 1 - Diffusion of the hikikomori phenomenon.

Japan	<i>Watts J (1999):</i> lifetime prevalence over 1% among adults	
	<i>Ministry of Health, Labour & Welfare (2003):</i> 14.000 consultations regarding hikikomori per year	
	<i>Furlong A (2008):</i> 410.000 hikikomori cases estimated in the whole nation	
	<i>Kiyota A, et al. (2008):</i> 0.9% - 3.8% of the sample had an hikikomori history in anamnesis	
	<i>Koyama A, et al. (2010):</i> 232.000 estimated ongoing hikikomori cases	
	<i>Japanese Cabinet Office (2010):</i> 236.000 estimated ongoing hikikomori cases	
Rest of the world	Asia	No prevalence studies are available for Asian countries other than Japan. A variable number of hikikomori cases have been described in China, Korea, India, Bangladesh, Oman and Iran.
	Other western countries	No prevalence studies are available. A variable number of hikikomori cases have been described in Australia, USA, United Kingdom, France, Italy and Spain.

abstracts, one further paper was excluded for being unrelated to the topic. The full texts of the remaining 39 papers have been analysed to perform a qualitative synthesis, reported in this overview. In addition, we have searched Google Scholar and PsychInfo to identify any other study missed by the previous analysis. One relevant study has been evidenced using the same keywords (Fig.1).

Results

The vast majority of scientific literature focusing on hikikomori has Asiatic, and more specifically Japanese, provenance. In 2010 the World Mental Health Initiatives (WMH-J), promoted by the World Health Organization, conducted a national survey in Japan selecting 4134 respondents, aged 20-49 years old, from voter registration lists in different areas of the country. Results showed that 1.2% of the sample had experienced hikikomori, estimating more or less 232.000 ongoing cases (31). In the same year, Japanese Cabinet Office study reported an estimated number of 236.000 hikikomoris, confirming it as a real Japanese problem (32).

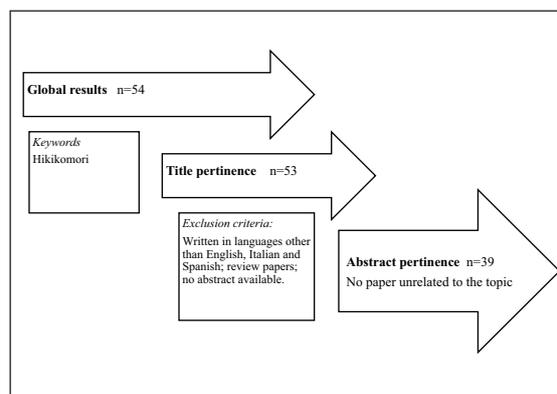


Figure 1 - Articles selection.

Tateno et al. investigated the public perception of hikikomori administering a questionnaire to a total number of 1038 medical doctors (in particular psychiatrists and paediatricians), nurses, psychologists, students and other professionals. All the interviewees disagreed with the statement “hikikomori is NOT a disorder”, even if there were differences in the perception of the problem; 30% of the psychiatrists de-

scribed presented *hikikomori* cases as schizophrenia, applying ICD-10 criteria, while 50% of paediatricians as neurotic or stressed-related disorders (33). Moreover, Kondo et al. stated that, in some cases, a *hikikomori* diagnosis may conceal other psychiatric diagnoses, such as schizophrenia (3 cases according to their database), Asperger's syndrome (6 cases), personality disorders (4 cases), social phobia (4 cases) and adjustment disorders (2 cases) (12).

In a 2002 population-based study, Kim found that 1.27% of the adult sample selected in a rural municipality reported a current *hikikomori* status, while 2.50% reported to have experienced it in the past. The small geographic area considered represents a clear limitation of the study (34). In the same year, Suwa and Suzuki highlighted that 12 out of 14 *hikikomoris* who consulted public health centres presented psychiatric disorders characteristics such as social phobia, obsessive-compulsive disorder, delusional disorder, pervasive developmental disorder, somatization disorder, depression, attention deficit/hyperactivity disorder and borderline disorder. It has however to be considered that often *hikikomori* subjects do not refer to mental health centres, while *hikikomori* with psychiatric comorbidities refer to them more frequently, giving a possible overestimation. In addition, it is not taken into account which disease occurs as first, if *hikikomori* precedes or follows another psychiatric disorder (22). Koyama et al. conducted a face-to-face household survey on 4134 community residents. This study has been the first study about lifetime prevalence, demographic correlates and psychiatric comorbidities in a general Japan population. All the interviewed subjects (n=1660) have been asked whether they have any children currently experiencing *hikikomori* and/or if they had ever personally experienced it. Results showed that only 0.5% had a *hikikomori* child, but 1.2% of the sample had a history of *hikikomori*, and among them, 54.4% presented also the occurrence of a psychiatric disorder lifetime (mood, anxiety, impulse control and substance use/abuse) (31). *Hikikomori* lifetime prevalence was about 1% among 20-49 years old subjects, and males were more affected than females, as highlighted by Takahata in his 2003 study (35).

Lately, extra-Asian scientific literature has begun focusing on individuating *hikikomori*-like cases worldwide, following the hypothesis that *hikikomori* may be a global, cross-national issue, as pointed out by Kato et al. (23). A number of *hikikomoris* have been described in United States (36), Oman (37), Australia, Bangladesh, Iran, Korea (27), China and, more recently, Spain (38) and Italy (39).

It is however important to underline that *hikikomori*-like cases outside Japan have to be correlated with each country's culture. For example, in Korea *hikikomori* is seen as a maladaptation form, in which withdrawal from society in a state of seclusion for at least three months (40) is associated to mental diseases, mostly depression, anxiety, PTSD, social defiant disorder and internet addiction (41). Similarly, in the US,

the correlation among *hikikomori* and other mental illnesses is tight enough, and sometimes *hikikomori* behaviour is considered as a coping strategy to prevent nervous breakdown or anxiety-related disorder (42-44). In 2008, the Australian organization ARAFMI (Association of Relatives And Friends of the Mentally Ill), defined social withdrawal as "the apparent reluctance to participate in "normal" interpersonal contacts of day to day life and retreat into one's own comfort zone" (45); it appears be caused by loss of energy and motivation to take part in social activities, loss of self-esteem and not being able to stay in contact with others than close family. In Hong Kong (46) young people unable to perform in school or work are discriminated by society, and turn to social withdrawal as a coping strategy. In Oman, *hikikomori* is connected to religious conceptions and interpreted as the consequence of demoniac possession (37): spirit possession may be a way of communication displayed by oppressed individuals incapable of communicating with others in other forms (47, 48).

Teo et al., in their cross-national case series, interviewed subjects from four culturally different countries: Japan, India, Korea and United States. They identified 36 *hikikomoris*, described as subjects with high levels of loneliness and moderate functional impairment. Among them, 28 (78%) asked for a pharmacologic and psychotherapeutic help. In some cases, an overlap with heavy Internet use, the predominant way of social communication, could be identified (44).

Korean researchers described a number of Internet addiction cases among young people (49-52), one of the highest prevalence in the world. This phenomenon is strictly connected to suicide risk (53, 54) and *hikikomori* propension, but while Internet addiction and suicide are seen by Korean psychiatrists as primary issues to be treated with active therapeutic strategies, *hikikomori* treatment is mostly based on passive interventions, excluding forced hospitalization. In their study, Lee et al. applied a home visitation program to social withdrawal issues, evaluating psychopathology and treatment. They enrolled 65 young subjects referred by community mental health centres and psychiatric clinics around Seoul and Kyongki-Do province. Among them, 41 subjects presented social withdrawal symptoms; results showed that their Depression Inventory, Trait Anxiety Inventory, Social Anxiety Scale, and Internet Addiction Scale scores were significantly higher than those of baseline controls (49). In Hong Kong, a study by Hong-ye Chan & Tit-wing Lo aimed at investigating correlation between hidden youths life quality and the duration and level of their social withdrawal. The sample consisted of 588 subjects, and results showed that a "hidden" situation was among preferred youths lifestyles, and it was not seen as an undermined factor for life quality (55).

Teo described a case report about an American suspected social withdrawal case. Different scales, clinical interviews and psychometric tools were administered to the subject, and the diagnosis was *hikikomori*

in comorbidity with bipolar disorder. Social withdrawal occurred in fact only during depressive episodes. The patient declined pharmacotherapy, preferring cognitive behavioural therapy: after 25 sessions his social isolation went under remission (36).

In Europe, Spanish researchers begun to report *hikikomori* cases in the first decade of 2000s. A paper by Garcia-Campayo et al. (38) described what is considered to be the first case of *hikikomori* in Spain: an 18-year-old patient presented all the typical characteristic features of social withdrawal, but had no psychiatric history or symptoms, according to anamnesis and administered scales (SCAN, IPDE), with the exception of paranoid traits and introversion assessed with MMPI. According to the authors, young *hikikomoris* appeared as introverted-paranoid subjects, with permissive parents and a high standard of living. Garcia-Campayo strictly linked *hikikomori* syndrome to the rapid economic growth and the generational technological gap between parents and children, especially in very family-oriented cultures. Another Spanish research group (56) presented a second case of severe social withdrawal in a 19-year-old male, with the progressive onset of significant negative symptoms (e.g., deficient initiative, apathy). The diagnosis was simple schizophrenia, according to the criteria of DSM-IV-TR, as the researches argued that *hikikomori* should not be considered a “new disease”, but a transnosologic syndrome limited to developed countries and characterized by the contemporary manifestation of different psychiatric disorders. In 2013, Ovejero et al. reported the case of a 25-year-old man with prolonged social withdrawal lasting for 4 years, and suggested that *hikikomori* behaviours may be based on the individual characteristics of the patient, more than on culture (57).

In UK, hidden youth phenomena and *hikikomori*-like cases were associated to the so-called NEETs (“Not in Education, Employment or Training”), due to economic and working recession (58).

In Italy, the first *hikikomori*-like case was described in 2013 by De Michele et al. The patient was a 28-year-old man living in complete isolation since 10 years and communicating only via the Internet. A number of psychiatric diagnoses had been proposed for him over time, including Obsessive-Compulsive Disorder and Schizoid Personality Disorder, but according to the authors, *hikikomori* may better describe the symptomatological situation of the patient (39).

Discussion

As previously mentioned, the majority of *hikikomori* adolescents are males; females constitute a minor fraction of the reported cases, and usually their period of social isolation is limited. These data could allow the hypothesis that *hikikomori* phenomenon may be considered as the male counterpart of anorexia nervosa, a kind of “social anorexia”: in both cases, in fact, the negation of the body is a central element (59). The reasons why a young Japanese male, el-

dest son or only child of a wealthy family, is the prototype *hikikomori* patient are rooted in the structure of Japanese society. Traditionally, in fact, the first son or the only child is invested with the highest responsibilities; moreover, the strong pressure to perform at one’s best in the hypercompetitive environment of Japanese educational system, the common episodes of school bullying (*ijime*) and a reduced ability to cope with the “dishonour” of low academic results or failings may sum up and lead towards social withdrawal (60).

The low rate of suicidality among *hikikomoris*, which seems to have a far less incidence than in general teenage population, needs to be emphasized. As Tamaki Saito reported in a 2008 interview: “...often hikikomoris tell me that they want to die, but they do not commit suicide because their narcissism prevents them from acting it. [...] For this reason, the percentage of suicides among hikikomoris is low” (61). The young man wounded in his pride and overwhelmed with shame decides to seclude himself being excluded from society; however, he does not choose to die, but rather rejects everything that has caused him suffering (62). *Hikikomoris* are described as apathetic, bored and nihilistic; they are disillusioned and estranged from school, society and social contexts, lack motivation to engage with the world and when they are asked about their own feelings, thoughts, desires, passions, ambitions or interests, their answer is ambiguously “I don’t know” (14, 62).

The growing number of *hikikomori* cases recently highlighted outside Japan, however, imposes us to move the psychopathological focus from specific cultural aspects to a broader view of the phenomenon. *Hikikomori* may be interpreted as linked to the so-called “Modern-type Depression”, a disorder common to youths born after the 1970s in rich and technologized countries, in which the collectivism has been replaced by individualism and there is a lack of desire to participate in social life (63). Social withdrawal conditions may also be interpreted as a mirror of young people’s increasing marginalization in labour market, in which they are seen as victims of elite’s globalisation. The growing prevalence of a precarious secondary sector has led to a situation in which deeply rooted norms are undermined, and young people are forced to find new ways of dealing with a high-pressured and rigid system. Under these circumstances, withdrawal often represents response to a situation where tradition no longer provides adequate clues to appropriate behaviours (10).

Moreover, the Internet could represent a sort of “emergency exit” to the difficulties that adolescents and young adults may face at these stages of life, allowing them to completely replace real social interaction and finally live their own way. Such a use of technology becomes, therefore, dysfunctional, providing a “pathological solution” to “physiological problems”. Young *hikikomoris* choose social withdrawal to preserve themselves from the risk of being ashamed by their own inadequacy; according to psychiatrist Pietropolli Charmet, this is due to the diffuse tenden-

cy to replace the “old” Oedipal guilt with a feeling of narcissistic shame. The antidote to the fear of being considered “not good enough” and being despised is to vanish from any potential shameful situation. Seclusion protects from the look of others, and the Internet is a valid compromise to provide sustainable relationships (64).

The spread of the *hikikomori* phenomenon in Western countries may therefore be ascribed to a variety of global cultural and social aspects: individualism, lack of abnegation, high unemployment/underemployment rates especially among youths, crisis of the traditional values, and diffusion of new communication technologies concurred to the growth of the number of young *hikikomoris* worldwide.

Conclusions

Hikikomori is more than a medical and psychiatric disease: it is a complex cultural condition that requires a multidimensional explication to be fully understood. Scientific literature regarding both epidemiological and psychopathological issues is still lacking. Even an unambiguous definition and universally accepted diagnostic criteria have not been established so far. Different terms, such as acute social withdrawal, prolonged social withdrawal, severe social withdrawal and social isolation, are in fact currently used by researchers to describe *hikikomori* and *hikikomori*-like cases. A broad and all-encompassing interpretation of the phenomenon has not been established yet: can it be interpreted as a culture-bound syndrome, solely connected to Japanese culture? Or is it already a worldwide diffuse nosologic entity, linked to rich and hyper-technologized societies? Does it need to be placed in an appropriate diagnostic framework, or should it be considered as related to other psychiatric diseases, such as schizophrenia, mood, anxiety and personality disorders, as their cause or consequence?

Answering these questions is nowadays still difficult, and more scientific researches are required. It is clear that epidemiological studies on social withdrawal across cultures are a priority, in order to better understand *hikikomori* and similar clinical entities.

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