Hikikomori

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Definition

Hikikomori (引きこもり), also called "primary social withdrawal" (Suwa 諏訪 et al. 586), is a phenomenon that has, in recent years, become prevalent in Japan. Literally translated as "pulling inward," *hikikomori* describes someone who has stopped interacting with society. These predominately male individuals will often remain in their homes or rooms and rarely, if ever, leave (Suwa 78). The duration of this self-imposed isolation varies, but it is not uncommon for it to last for several years. The Ministry of Health, Labor, and Welfare has defined *hikikomori* as someone who mainly stays at home, cannot or does not engage in social activities such as going to school or working, and has no psychotic pathology nor significant mental retardation. Among those who fit these criteria, individuals who are symptomatic for less than 6 months and maintain any social relationships outside their immediate family are excluded (Suwa 27). However, when articles refer to this definition, the last criterion is occasionally omitted (Hattori 183; Krysinska 6). It is worth noting that the term *hikikomori* is both singular and plural, and it can refer to the associated behavior on an individual and cultural level.

There is uncertainty as to the number of *hikikomori* in Japan, due in part to the isolationistic nature of their behavior, which makes it hard to accurately measure their numbers. Current estimates vary; a survey created by the Tokyo government estimated that *hikikomori* make up 0.72% of the Japanese population (Tōkyōtosei 東京都政 http://www.metro.tokyo.jpt), which is about 900,000 people. Other researchers estimate the number to be at or above 1,000,000 (Suwa et al. 586). These people are often high school or college dropouts, but this is not always the case. Recent surveys have also shown that the average age of *hikikomori* may be increasing. The previously mentioned survey measured the 96.4% of *hikikomori* residing in Tokyo to be between the ages of 15 and 34 (Tōkyōtosei http://www.metro.tokyo.jp). In this

paper, I plan to examine and discuss possible causes, gender disparities, existing treatment options, potential forms of treatment, controversy regarding the definition and diagnosis, and social implications of this phenomenon.

Causes

In Japan, the education system is rigorous and great importance is placed on scholarship. Japanese society as a whole is sometimes called a *gakurekishakai* (学歴社会) which translates into "academic credential society." This means that the societal view in Japan is that students who do not graduate from a good university will never get a good job and thus will never amount to anything. The system is designed so that students will always be studying, which doesn't allow time for personal growth and development (Krysinska 78). Pressure to excel in the Japanese school system starts in elementary school, if not earlier. Compulsory education in Japan ends with middle school, so acceptance to both high school and university requires an entrance exam. To do well on these tests, students must go from a good elementary school to a top middle school. From there they must go to a competitive high school so admission into a high-ranking university is a possibility. Only after graduating from that last step do students have a chance to get a respectable job. In Japan, this is called the escalator system (Krysinska 77) and it demonstrates the competitiveness to which, even at an early age, the Japanese youth are exposed. Such a system obviously puts much stress on those in it. Furthermore, there is no acceptable alternative to the school system – the Japanese middle-class generally has strong beliefs about the direction one's life should take and doesn't allow for deviations from that plan (Toivonen et al. 5). The relentless stress and competition for their entire scholastic career is theorized to be too much for some individuals. Those who cannot adapt to or withstand the rigors of this system are at increased risk of becoming *hikikomori* (Krysinka 78-79).

The Japanese school system also focuses on conformity; for example, students are often forced to wear uniforms, constantly function as a group, and are forbidden to dye their hair. The rules of the school system extend into personal life as well and dictate the behavior of the students. For example, some schools don't allow students to sleep over at their friends' house (Krysinska 81). The phrase, "*Deru kui wa utareru*" (出る杭は打たれる) translating into, "The nail that sticks up gets hammered down," is often used to describe the Japanese school system (Todd 19) This philosophy lends itself to *ijime* (苛め), or bullying; more than 58% of middle schools reported serious incidents (Todd 19). In the Tokyo government survey, 39.3% of *hikikomori* reported being bullied by a friend (opposed to 18% from the non-*hikikomori* respondents)(Tōkyōtosei http://www.metro.tokyo.jp). There are reports of schools often doing little to stop *ijime*; the idea is that if someone is being bullied, then there is something wrong with the victim that the group needs to work out. Schools would rather that the students correct non-conformist behavior on their own so that they build a better group community (Todd 17). Also, the parents are often unlikely to offer comfort and assistance to the bullied students (Todd 19). I believe that the school's actions, along with the lack of support from parents, deprives the student of any place to seek aid and creates ideal conditions for breeding a feeling of helplessness. The only way for bullied children to avoid this is to not be different in any way; to repress their own identity in order to fit into the group (Todd 19). This is an extremely ego-dystonic (something causing internal distress) action, and it can cause students to withdraw (Hattori 195). The bullying, combined with the lack of support, both in school and at home, is often cited as a predominate reason for people becoming hikikomori (Todd 19; Takeuchi 竹内 449; Hattori 189).

A possible cause of the *hikikomori* phenomenon that is not related to the school system

involves the youth labor market. Before the economic bubble burst in Japan, it was expected that a company would offer lifetime employment for full-time workers, and this practice became commonplace. A company was expected to take care of its employees, so firings and layoffs were rare and hard to do legally (Toivonen et al. 3). The effects of the recession are still felt today, and as a result there is increased competition for jobs because large companies are hiring fewer people (Toivonen et al. 3). As a result, recent graduates have a single shot at getting a good job. If they are not hired immediately out of high school or college, their job prospects are exceedingly slim (Toivonen et al. 3). However, these youth are still culturally expected to get a good job and spend their life working for a big company. In general, someone who cannot or will not meet these societal expectations has a significantly higher than normal chance of becoming *hikikomori* (3-4). The labor market is resistant to change, as Japanese society encourages the internalization of these values and looks down on the vocalization of complaints. Thusly, as there is no public forum for the changing of these values, any reform movement is weak (Toivonen et al. 6, 9). Since there is no popular support for creating alternatives to the status quo, withdrawal becomes an appealing option.

Another group that is commonly blamed for playing a role in the creation of a *hikikomori*, is the parents (Krysinska 70). People suffering from primary social withdrawal are usually seen to have come from "ostensibly 'good' families of middle- to upper-middle-class backgrounds with highly involved mothers" (Teo 3). These families are generally respectable and in good social standing but do not necessarily get along or communicate well. The Tokyo government's survey reported that 35.7% of *hikikomori* (opposed to 10% of the non-*hikikomori* population) reported that they had a poor relationship with their parents, 32.1% (opposed to 65.6%) said they talk frequently to their family, and 28.7% (opposed 62.9%) felt they received enough love from

their parents (Tōkyōtosei http://www.metro.tokyo.jp)

Parents of *hikikomori* may also be indirectly causing the withdrawal behavior by supporting it financially. The website hikiculture.net is a forum for "reclusive people," and it contains a discussion of how the members maintain their withdrawn lifestyle. The majority report they get financial support from their family (Hikiculture: A forum for reclusive people hikiculture.net). The nature of primary social withdrawal limits the ability of *hikikomori* to be self-sufficient. Therefore, most people often require outside help to maintain their lifestyle. I believe that, in many cases, parents who want to show their love for their child and don't want to risk a major confrontation will demonstrate their support by enabling the withdrawal behavior financially.

A discussion of *hikikomori* in the medical community also placed blame on the parents. It was posited that, although children normally start experiencing interpersonal problems around middle school, those with the potential of becoming *hikikomori* do not know how to cope. Their parents also do not know how to solve these problems and thus are unable to help. Since there are no good alternatives, withdrawal becomes an appealing option (Yamazaki 山崎 283). In order to interrupt the pattern of withdrawal, an intervention is needed. However, if this becomes a heated confrontation, it is likely to escalate the situation and increase the likelihood of isolation (Yamazaki, 283-284). It is also noted that many children who become *hikikomori* demonstrate a lower-than-normal level of assertiveness in elementary school, especially when it comes to interpersonal relationships (Yamazaki 284). This indicates to me that withdrawal originates early in life, even if the characteristic symptoms appear at a later age.

In another study pertaining to family influence, 27 families with members suffering from primary social withdrawal were compared to a control group of 20 non-suffering families. Using

the FACES (Family Adaptability and Cohesion Evaluation Scale) (Suwa 27), 4 significant similarities were found among afflicted families that are not present in the control group. The first was the existence of unspoken rules, set by either the mother or father, that place family members in specific roles (Suwa 27). The second commonality among these families was a sharing of "values and unfounded pride" (Suwa 27), where the children are expected to internalize and take pride in their parents' ideals instead of forming their own. Third was "a lack of emotional exchange within the family"; this made it "difficult for members to sympathize with each other's negative feelings" (Suwa et al. 592). Finally, there was an extreme lack of verbal communication (Suwa 27), so that members had trouble speaking face to face and reading each other emotionally (Suwa et al. 591-592). These similarities indicate a familial structure that is significantly different from that of the typical Japanese family.

A different study, conducted by Yuichi Hattori, also found that parents play a large role in the development of *hikikomori* behaviors. He stated that many *hikikomori* reported a lack of interfamilial communication – emotions were ignored by parents, and even eye contact might be avoided (Hattori 188). Many of the patients who were bullied did not get support from their families, and some were told that "you must have reasons to be blamed by others" (Hattori 189). Hattori claimed that these instances cause individuals who exhibit *hikikomori* behavior to assume that everyone's personality has a dark side (189). I believe this would encourage withdrawal because a distrust of people could cause *hikikomori* to limit the extent of their interpersonal relationships. The article also found that "in 100% of the cases, the clients experienced loss of attachment to their parents, which they expressed as a distrust of their parents. The loss of secure attachment was also related to inhibition of self-expression (89%) and a childhood fear of [the parents] (80%)" (Hattori 189).

In addition to this commonality with Suwa's experiment, Hattori's study also described many similarities among families with members suffering from primary social withdrawal. These commonalities might act as triggers for the manifestation of *hikikomori* behavior. Hostility toward the parents was common; 43% of the subjects wanted to kill their parents. 23% physically attacked their mothers while attempting to initiate a genuine conversation – one *hikikomori* had his mother held up against a wall, screaming, "tell me how you feel about me" (Hattori 190-191). There are at least 3 recorded instances where a *hikikomori* fractured the parent's ribs, and several parents confided that they carried knives or bats to protect themselves from their child (Hattori 190).[1] 91% of the subjects described their fathers as caring more about their job than their family and 66% claimed their mothers were emotionally uninvolved in their upbringing. The same study also found most of the families (86%) had marital difficulties, though only a few (6%) were divorced – well below the national average. It was rare for the parents' marital discord to manifest itself in physical violence, but there was often an unaffectionate relationship between the parents (191-192). It was not uncommon for the child to be used as a substitute for affection by the mother, as her emotional needs were not met by her spouse – some clients reported a parent using them like a "teddy bear" to satisfy emotional needs (Hattori 197).

Hattori suggested that the cause of *hikikomori* behavior is a dissociative mental disorder – which can include everything from feeling that reality isn't real, to the fracturing, repression, and

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1 The Ministry of Health, Labor, and Welfare says that rate of domestic violence among hikikomori is 20.9% (2009) and of that, 17.6% was violence against family (Kōseirōdōshō 厚生労働省 http://www.mhlw.go.jp). Overall, there were 20,494,000 Japanese youths, aged 15-29 in that same year, (Sōmushō tōkeikyoku 総務省統計局 http://www.stat.go.jp). During that time, there were 11,497 arrests for violent crimes (murder, assault, injury, or murder or injury while omitting robbery) by people in that age group. This averages to a 0.056% violent crime rate. Despite the fact that a large percentage of *hikikomori* behavior occurs between the ages of 30 and 34, the only available crime data is for the age group 30-39, so that age group was disregarded. Also, considering that there is a strong fear of social ostracization in Japan, it is likely that a significant number of those incidents go unreported and are thus not included in this statistic. So while this data isn't exact, it gives a rough idea of the crime rate among a comparable demographic.

uncontrollable expression of personality aspects (Hattori 199). Hattori's orientation is psychological, with a basis in the Text Revision edition of the fourth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) which is the common standard used by mental health professionals around the world for the diagnosis of mental disorders. He claimed that *hikikomori* is actually a symptom of Dissociative Disorder Not Otherwise Specified (DDNOS) (Hattori 199). Hattori reached this conclusion using a sample of 35 patients in his own practice. Patients took the Dissociative Experience Scale (DES) questionnaire, which is considered to be accurate in identifying dissociative symptoms. The results of the survey showed that all respondents had difficulty connecting to other people. It also reported that 71% of the patients had dual personalities, with "both overt and covert symptoms" (Hattori 185).

Other studies have also taken a similar psychologically based approach to determine the cause of the *hikikomori* issue. One such study, led by Naoji Kondo, studied over 300 *hikikomori* and concluded that the subjects fit into a myriad of diagnostic categories, including psychotic, anxiety, developmental, and personality disorders (Kondo et al. 5). There was a single patient who was not able to be classified into a diagnostic category. From this, Kondo concluded that existing mental disorders need to be considered as the cause of *hikikomori* behavior, along with social and cultural factors (Kondo et al. 7). Similarly, another study found that many *hikikomori* have symptoms of existing psychopathologies. The diagnoses included phobic anxiety disorders, adjustment disorders, somatoform disorders, problems with psychological development, and other behavioral or emotional disorders. (Teo and Gaw 445).

However, not all sources agree that the cause of *hikikomori* behavior is psychological. One study demonstrated that a majority of Japanese psychiatrists believe that no diagnosis in the DSM-IV-TR fully describes the *hikikomori* phenomenon (Teo 182). They are supported by the

existence of patients who do not fit into any diagnostic category. Furthermore, the Japanese Ministry of Health, Labor, and Welfare has stated that roughly a third of *hikikomori* are comorbid (suffering from two or more disorders simultaneously) with another disorder (Teo 182). This lends support to the idea that *hikikomori* is not currently diagnosable, as studies which claim this behavior is caused by specific disorders must now consider comorbidity.

There is also a study that utilized the methodology pioneered by Carl Rogers, which stated that *hikikomori* is the result of the patient's ideal self being in conflict with the actual self (Takahashi 高橋 127). However, this separation is generally assumed to cause distress, such as anxiety, depression, etc. The discussion in the article about how the separation causes self-loathing supported this idea (Takahashi 131). However, I hypothesize that as *hikikomori* behavior is often ego-syntonic (actions, impulses, and behaviors that are seen by an individual to be acceptable and allows one to feel good about oneself), it seems unlikely that the ideal and actual selves are separated to the degree necessary to cause such extreme symptoms. This suggests that this aspect of Rogers' theory is not applicable to *hikikomori.*

Though the available clinical studies provide fascinating and important information on various aspects of *hikikomori*, none of them are without flaws. The study led by Mami Suwa that examined *hikikomori* family types had, aside from a small sample size, a single problematic aspect: a loose definition of *hikikomori* (some subjects would talk normally to their parents, go outside to spend time with their friends on the weekend, or have a part time job (589)). These traits were inconsistent with the government's definition of *hikikomori* and the article's own findings, because if a *hikikomori* talks normally to his or her parents, then it is unlikely that there would be a lack of verbal communication between them.

The studies that examined psychological causes of withdrawal have various flaws as well.

The study led by Yuichi Hattori that diagnosed the patients with DDNOS or PTSD has a small sample size, a large dropout rate, and was at high risk of confirmation bias (the tendency to only search for data that supports one's claims and ignore the rest). The study that examined 300 *hikikomori*, led by Naoji Kondo, claimed that most *hikikomori* who visited the center could be diagnosed according to the DSM (6). However, only 15.3% of subjects were able to achieve "social participation" – which is the standard the study used for recovery (Kondo et al. 8). The subjects were in treatment for 20 or more months (7) – most of the diagnostic categories patients were assigned to have better treatment outcomes after that length of time. Another scholar criticized this study saying that it had a "lack of a reported definition of *hikikomori* and lack of specific diagnoses (beyond diagnostic categories)" (Teo and Gaw 445). A different study, examined by Teo and Gaw, which also diagnosed particpants with a variety of disorders, was found to be problematic in that it has a small sample size – 52 subjects (100 or more would be preferable) – and that the diagnoses were made by one clinician based upon a single session (Teo and Gaw 445). So while these studies provide valuable information, their conclusions and information should be interpreted with skepticism.

From the available research, I believe that the currently accepted causes of the *hikikomori* phenomenon are not sufficient to fully explain the behavior. Parents are commonly blamed for the behavior; however, attributing the source all of *hikikomori* cases to familial problems seems unfair. It is unlikely that all Japanese households with poor communication will create a *hikikomori.* Furthermore, *c*ases of children growing up with families who are distant and cold almost certainly exist in other countries, as do cultural expectations and bullying, yet primary social withdrawal does not frequently occur outside of Japan's borders. Psychological examinations of the withdrawal behavior are inconsistent and problematic in their execution, and

they fail to explain why these disorders exist elsewhere without similar symptoms.

However, this does not mean that there are no cultural or psychological influences on the development of *hikikomori.* There are many ways someone can develop a mental disorder. For example, depression can arise from severe grief, persistently stressful and emotionally negative aspects of life, and sometimes there is no apparent environmental trigger, which suggests a genetic predisposition. I believe that *hikikomori* behavior is similar; there is not one single cause. Different people may be driven to withdrawal by unique triggers or by any combination of triggers. In the Tokyo survey, less than 40% of surveyed *hikikomori* reported experiencing bullying or poor familial communication (Tōkyōtosei http://www.metro.tokyo.jp); these low numbers support the idea that there isn't a single cause.

I hypothesize that there is no single cause of the *hikikomori* phenomenon, and that the behavior can be triggered by various stressors, including, but not limited to, the previously discussed cultural and social influences. I also believe that citizens of any sufficiently advanced nation (where daily survival is not a concern) can potentially suffer from primary social withdrawal. However the family structure, societal expectations, school system, and other cultural factors in Japan are more conducive to the creation of *hikikomori* than the same factors are in other countries. There is also a strong possibility that there is an unknown factor involved, such as a genetic vulnerability. These vulnerabilities can exist, but may only be triggered by environmental stressors, meaning someone who is genetically predisposed to withdrawal may never manifest the behavior, or only do so during a period of extreme stress.

Gender

As mentioned earlier, *hikikomori* is primarily observed in young males (Todd 24). The previously mentioned study led by Hattori recorded 10 of its 35 subjects as being female (Hattori

104); a clinic in Korea reported that 34 of 107 patients were female (Ro롬 89), and the survey conducted by the Tokyo government found that, in Tokyo, 28.6% of *hikikomori* were women (Tōkyōtosei http://www.metro.tokyo.jp). One suggested reason for this gender disparity is that, in Japan (and possibly world-wide) a reclusive female is more culturally acceptable than a reclusive male, so incidents of female *hikikomori* go underreported (Todd 25). A woman who starts to withdraw may be described as someone who helps around the house (especially if a family is trying to avoid being ostracized by their neighbors), which is a description that would not fit male *hikikomori* as easily. It is also possible that societal expectations are still divided among gender lines, with young males expected to succeed at any cost. However, as one news article describes, if a young woman doesn't succeed, it is culturally appropriate for her to choose marriage and homemaking (Chikirin ちきりん http://bizmakoto.jp). This difference in expectations would exclude many young women from the societal and academic pressure that is a commonly cited cause of *hikikomori*. However, this choice is not available to all young women for financial and personal reasons; they would still be subjected to the same pressures as their male counterparts. While the difference in societal expectations might account for some of the gender disparity in *hikikomori* gender, it is unlikely to account for it all.

Kathleen Hunter Lea Todd suggests that the *hikikomori* phenomenon involves no psychopathology and is instead a rebellion against modern society (an idea which Toivonen supports). This hypothesis states that women usually rebel in a different way – instead of withdrawing, they remain childless (Todd 24). While this may be true, in that more women are starting to choose careers over children or are becoming parasite singles (young women who live at home, often work part time, and use the money they save to buy things for themselves), I think that crediting the *hikikomori* phenomenon as the catalyst for this behavior is off base. If primary

social withdrawal was the source, it would imply that, if a woman becomes a professional in some field or successful in business, it is likely that she got to where she is because she experienced bullying, issues with parental communication, or cultural pressures (all of which are theorized causes of *hikikomori* behavior). These are usually obstacles to becoming successful, not triggers for it.

In general, it is not uncommon for mental disorders to primarily affect one gender. For example, according to the DSM-IV-TR, 90% of anorexia and bulimia diagnoses are female and women are up to twice as likely to develop depression. Both genders are equally likely to be diagnosed with some form of bipolar disorder, and men are more likely to develop Narcissistic Personality Disorder. I believe that the male dominant *hikikomori* population may be indicative of this disparity instead of being caused solely by societal pressures.

Treatment

It is difficult to treat *hikikomori* behavior due to the isolationistic nature of the symptoms. Of the existing treatments, many are almost paradoxically based on some form of group interaction. This allows the *hikikomori* to initially interact with like-minded and non-judgmental people before having to re-emerge into society. There are also individual treatments, which allow for specific therapies that are tailored to the needs of their patients. Other plans combine group and individual therapies which result in an intense treatment program.

One treatment method that is favored by specialists is group psychotherapy (Bandō 板東 109) According to Bandō, this type of outpatient therapy usually occurs in a medical facility, where a small group of patients – often numbering between 3 and 8 – is led by a psychiatrist. This type of therapy often focuses on teaching social skills to the *hikikomori* through immediate feedback from their peers. Drama or conflict between the group members is expected, but it is

seen as beneficial to overall progress of the treatment. Initially, the bestowing of therapeutic influence to the *hikikomori* is the responsibility of the professional who is leading the session, but the intention is that the patients will eventually benefit from each other (109). The effectiveness of this type of treatment has been questioned by the Japanese Ministry of Health, Labor, and Welfare who critiqued a lack of motivation in *hikikomori* to develop social skills for use in their day to day lives (Bandō 109-110).

Another form of group therapy used to treat the *hikikomori* phenomenon is *seishinka deikea* (精神科デイケア) or "psychiatric daycare." This is an outpatient program that offers a flexible schedule of attendance and focuses on creating a recreational and low stress area for patients (Bandō 110). Although, according to Bandō, this type of program was originally intended for people suffering from psychotic disorders, such as schizophrenia, the *seishinka deikea* model has been modified to treat non-psychotic *hikikomori*. Psychiatric daycare, similar to group psychotherapy, is held in a professional setting, usually a psychiatric hospital or a smaller, local, clinic. This treatment encourages the *hikikomori* to participate in group activities and acquire friends, and it has been called an intermediary between family counseling or individual therapy and full reintroduction into society (Bandō 110). *Seishinka deikea* has been effective in increasing the social interaction and communication in over 80% of the involved *hikikomori*, and it catalyzed over 50% of the patients to start behaviors such as job seeking or reapplication to schools (Bandō 110). However, since psychiatric daycare can be thought of as a stepping stone for the treatment of *hikikomori*, it is possible that some patients who enter into psychiatric daycare programs have already committed to recovery, which might artificially inflate the success rate.

A third type of group treatment is *ibasho katsudō* (居場所活動) or, loosely translated,

"activities in a place one belongs." Hereafter referred to as "*ibasho* activities," this method of treatment is seen as a complement to other therapy, and like psychiatric daycare, is used as an intermediary between hospitalization and the real world (Bandō 110). According to Bandō's article, *ibasho* activities involve gathering at a certain place, which is provided by a third party. There are no specific goals; rather, the intent of the treatment is to be at the place itself. The type of location can vary, such as a karaoke camp or a farm. The hope is that the participating individuals will begin to form relationships with other members and will be able to use these interactions to increase their comfort with others (Bandō, 110). While this treatment method has been reported to increase societal activity and reintegration into society (Teo 183), no specific statistics were mentioned.

The final types of common group treatments are self help and support groups. They are similar in their approach and structure and both are usually small, informal, and voluntary with the primary benefit coming from the interaction among patients, including receiving help through the act of actively helping others (Bandō 111-112). According to Bandō, these two treatments try to create a relaxed, friendly environment, similar to the previously mentioned *ibasho* activities, which results in less resistance from the participants. Self help and support groups are also primarily lead by group members rather than a mental health specialist. These methods also have similar problems – the primary of which is ensuring adequate treatment for the members and of people dropping out. Due to the relatively unstructured nature of self help and support groups, it is hard to ensure that someone is getting the desired level of help and support. Also, the informal atmosphere and high levels of freedom that the clients experience can make it difficult to convince *hikikomori* to show up if they do not want to, as they may feel that nonattendance is acceptable (111-112).

The primary difference between these treatments is the level of outside support. Self help groups are usually organized by their members and don't have a specialist (Bandō, 110-111). Support groups, on the other hand, usually have a volunteer specialist who directs conversation when needed. This type of treatment is often run by some sort of clinic or hospital, and while the conversation is often lead by *hikikomori*, there are instances of staff leadership (although it is kept to a minimum) (Bandō, 112). No statistics for effectiveness were given for either treatment option.

A type of individual treatment that has been used to treat *hikikomori* is described in the study led by Hattori which diagnosed *hikikomori* patients with either DDNOS (Dissociative Disorder Not Otherwise Specified) or PTSD (Post Traumatic Stress Disorder)(193). He utilized "psychotherapy for processing the past traumas, taking both DDNOS and PTSD into consideration" (Hattori 193), and it focused on developing trust and a feeling of safety. The therapy was a tricky process. In this study, patients would often spend as much as a year testing the therapist to see how he or she reacted to provocation, often in an attempt to see the dark side of his or her personality. The clients engaged in "pseudo-therapeutic" behavior (such as lying to the therapist or telling the clinician what he or she wanted to hear), or refused to show their actual emotions in treatment (Hattori 193). Hattori claims frustration and anger is unconsciously built up towards the therapist; one clinician said that working with *hikikomori* felt like "walking in a minefield," in that the client could blow up at the therapist without warning (193).

The DDNOS diagnosis was given because Hattori claimed there were two personalities: the original, which was emotionally starved and forced to retreat, and the front personality – created to deal with the distant parents. Thus the first goal of treatment was to attempt to recover repressed emotions. The next step is to recover and create a new attachment to the original

personality. Finally a general rehabilitation program is started, which takes about 2 years to complete and focuses on the development of social skills and reintroduction into society (Hattori, 193-195). The subjects in this study who were not diagnosed with DDNOS demonstrated PTSD symptoms and were treated in a similar manner to the other patients; there was no search for the original personality as it was never repressed in the first place (Hattori 193). Despite the difficulties in treatment, Hattori claimed that *hikikomori* had a positive prognosis if caught early, but the prognosis was more guarded if the individual has been in seclusion for many years due to the difficulty of memory recovery (199).

A case study, written by Noriyuki Sakamoto and others, examined a clinical treatment called nidotherapy. This treatment aimsto change the effect that the surrounding environment (such as life at home, school, etc.) has on the patient's behavior and mental functioning – it works on the idea that a *hikikomori*, in his or her current state, will be naturally resistant to change. Instead of trying to modify the behavior, the therapist instead tries to make the outside world more pleasant (Sakamoto et al. 194). In this particular case the patient was a *hikikomori* who was refusing treatment and the clinician worked with the family to create a more supportive environment. The parents were encouraged to stop criticizing their child and to be less intrusive in his life in general. Gradually, the patient started having more contact with his family, eventually agreeing to leave the house with them for short outings.

After being in treatment for 2 years, the patient got an evening job which had minimal human contact. At this time, the therapy ended (Sakamoto et al. 193-194). While this study demonstrates an effective treatment of a *hikikomori*, it has a few problems. The first is that, as a case study, the results are non-generalizable to the larger *hikikomori* population. It is impossible to discern whether or not a therapy is generally effective from a single case. Another problematic

aspect of the study is its definition of recovery, which entailed a job with minimal human contact. While going from full isolation to a low exposure workplace certainly is good progress, it seems that the goal of the treatment was set underwhelmingly low. It also seems possible that this could backfire with severe cases, where the *hikikomori* sees the improved environment as acceptance for isolated behavior. This treatment also does not account for the possibility of a relapse; if the subject begins to withdraw once again, the environment can no longer be improved. Finally, without a control group, it is impossible to determine whether the treatment was actually helpful, or if the subject recovered under his or her own power.

A more extreme treatment method that combines individual and group therapies is hospitalization. In this inpatient treatment, a patient moves to a hospital and slowly starts to interact with the staff, participates in group and individual therapy, and begins recreational activities (Bandō 111). In order to facilitate later recovery, the hospital staff tries to interfere with the life of newly admitted *hikikomori* as little as possible. In fact, immediately after being hospitalized, patients are often allowed to withdraw in order to create a place that feels safe inside the hospital. Despite this precaution, patient resistance is high (Bandō, 111). According to Bandō, after 3 months of inpatient care, *hikikomori* are able to connect with others on a basic level (111). However, no third party statistics on effectiveness have been listed.

The last type of treatment that will be discussed is admittance into *shukuhakugata shisetsu* (宿泊型施設) or accommodation facilities. These areas are almost always run by non-mental-health-specialists and are usually funded by private donors (Bandō, 111-112). According to Bandō, these programs, which frequently offer accommodations in the form of dorm rooms, focus on the development of skills that are applicable in the real world. For example, emphasis is placed on achieving economic independence, accepting the world for what it really is, and facing

one's family (111-112). S*hukuhakugata shisetsu* have achieved international recognition; a facility called New Start was the focus of a New York Times article. New Start's treatments includes group meals, living in a dorm, and group therapy, and although no efficacy data was mentioned, many of the interviewed subjects believed they had made significant progress (Jones nytimes.com). An interesting strategy of the outreach program was the use of "rental sisters." Rental sisters are women, usually between 20 and 30 years old, who were hired by New Start to convince *hikikomori* to undergo treatment. These individuals are useful because they can represent a very positive force in the life of a *hikikomori.* The rental sisters won't bully or tease the subjects (which is often linked to their withdrawal) and they can have positive communication with the patient (which may be lacking in the *hikikomori*'s family life). Rental sisters repeatedly visited the subjects and attempted to establish communication – some even sat outside the door and refused to leave until the *hikikomori* agreed to talk to them (Jones nytimes.com). Once sufficient contact had been established, which might take several months, the rental sisters talked about the outreach program and attempted to bring subjects into the program's group home. Many of the *hikikomori* who were interviewed attributed their going into treatment to the intervention of these sisters (Jones nytimes.com).

Overall, the data on treatment is somewhat contradictory. For example, the Kondo study, as well as one of the studies cited by Teo, concluded that *hikikomori* is a symptom of other disorders. However, the Hattori study claimed that this is due to, in part, the misdiagnosis of agoraphobia or anxiety disorders (Hattori 196). The same article also claimed that group therapy is not effective (Hattori 198). However, the group psychotherapy, self help and support groups, psychiatric daycare, and *ibasho* activities seemed effective in helping reduce *hikikomori* symptoms. The patients at New Start claimed that group therapy was helpful to them (Jones

nytimes.com). However, none of these methods have been clinically demonstrated to be effective. Patients who seek treatment are likely to want to recover, and the data from people who drop out of a treatment program is often ignored – both of these are problems which could make a treatment appear more effective than it really is. These issues may call the validity of the studies into question.

Potential Treatments

There is no readily available information from mental health professionals on ideas for potential treatments. However, because currently there are no clearly effective treatments, I will suggest a possible therapy. As with most individuals afflicted by mental disorders, *hikikomori* either seek treatment on their own, or someone close to them seeks it on their behalf; the type of therapy should be adjusted to fit the situation.

Giving treatment to a patient who does not want it is inherently difficult but is still possible. Under these circumstances, the treatment should not focus only on the *hikikomori*, but should include the family as well. Here, nidotherapy is a good start, but instead of just making the outside world more friendly, one can also make the room where the *hikikomori* resides more unappealing by incrementally doing things such as confiscating entertainment items or shutting off the power. Enabling behavior on the part of the parents should be stopped as well. For example, if the *hikikomori* relies on a living stipend, the family can stop supplying it. However, being supportive of the *hikikomori* once they start breaking the behavioral pattern is also important. Providing positive reinforcement for familial interactions, such as the return of entertainment items, would be a good way of encouraging the *hikikomori* to re-emerge into the world.

If the *hikikomori* seeks out treatment, an interdisciplinary outreach program would be

useful. Rental sisters can be utilized in an attempt to encourage those who are initially resistant to treatment to enter the accommodation facility. Once the subject is in the group home and has started group counseling (in a manner similar to the existing outreach programs), one-on-one therapy can begin. The idea is that the atmosphere of the group home would create an environment which would encourage more openness to one-on-one counseling. Newcomers could see the benefit to their peers and also be encouraged by like-minded individuals to try something new.

This individual therapy would focus on changing maladaptive behaviors and thoughts and on desensitization to the outside world. In addition to the benefits of the group setting, the one-on-one treatment would assist *hikikomori* in getting help for their own specific problems from a trained professional. However, I think it is also important that a large portion of the societal reintroduction should occur outside of a clinical setting. Participation in group therapy is not sufficient if the only social interaction is from that therapy. Patients would be encouraged, with a concrete reward system, to place themselves inside various events in society, such as joining a group going to a movie theater or beach. These social situations would change as the patient shows progress, going from more recreational activities to more serious ones – such as taking a practice entrance exam with a non-*hikikomori* population, or going through mock job interviews with a professional. These events would prepare the *hikikomori* for some of the more stressful events they might face in society. Rewards for participation could include access to the internet, gaming platforms, television, books, and music. The purpose of awarding these privileges is to teach the *hikikomori* how to engage in these behaviors moderately.

Controversy

There is much controversy surrounding the *hikikomori* phenomenon. Even the most basic

aspect of this disorder, the definition of the term *hikikomori*, is debated. There is an official definition from the Japanese government (which is noted at the start of this paper), but this is often viewed as a guideline instead actual diagnostic criteria. In fact, many Japanese psychiatrists use the term *hikikomori* in place of other disorders when they are trying to ease the social burden on a family (Teo and Gaw 446). Even the government's definition is unclear, with some sources claiming that it excludes those who socialize with friends (Suwa 27), and others who make no mention of that addendum (Hattori, 183; Krysinska 6). There have also been studies that include subjects who have part-time jobs; this is in conflict with both of the previous definitions (Suwa et al. 589).

The closest thing to a psychological definition is the diagnostic criteria suggested for the DSM-V (being released in 2013) which states:

> "The essential feature of this disorder is protracted social withdrawal. The person spends most of the day and nearly every day confined to a single room, typically his or her bedroom. There is marked avoidance of social situations and interpersonal relationships. The person may leave his or her room only at night when unlikely to be noticed by others and often spends time using the internet, reading, or playing video games"
>
> (Teo and Gaw 447)

The isolation has to interfere "significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships." The *hikikomori* behavior also has to be seen as ego-syntonic. If the individual is less than 18 years old, he or she has to be symptomatic for at least 6 months to meet the diagnostic criteria. Finally, the behavior can't be "better accounted for by another mental disorder" (Teo and Gaw, 447). This definition, however, does not address the question of dual diagnoses.

Another contested point in the discussion of the *hikikomori* phenomenon is whether or not it is a culture-bound syndrome. A culture-bound syndrome is defined by the APA (American Psychological Association) as “recurrent, locality specific patterns of aberrant behavior and troubling experience” (Teo and Gaw 446) and is often considered to be a reaction to stress or other mental illness. As mental disorders manifest in people all around the world (Sakamoto et al. 196), and since *hikikomori* are primarily found in Japan, some studies claim this type of behavior is a culture bound syndrome (Teo and Gaw, 446).

However, I believe that *hikikomori* is not a culture bound syndrome. There are various instances of *hikikomori* behavior occurring in other countries. One such example is a facility in Korea that has reported working with 107 cases of *hikikomori,* which the clinic called *ettori* (ウェットリ). The article described working with two types of *ettori* – *intongata* (隠遁型), reclusive type, and *katsudōgata* (活動型), active type. *Intongata ettori*, of which there were 41 cases, would be considered a *hikikomori* under strict diagnostic criteria (Ro 89 – 90). *Katsudōgata ettori,* of which there were 66, fit into the *hikikomori* definition more loosely. They were primarily withdrawn but would sometimes go outside to the nearby convenience store, occasionally loiter near their house at night, or even have a part-time job (Ro 89). The attributed causes of *ettori* and *hikikomori* were similar: poor relationship with family (Ro 89), bullying (91) and societal pressures (90). Since this behavior is being treated in Korea, it is possible that the *hikikomori* phenomenon isn't restricted to only Japan.

Because Korea and Japan have similar cultures, they may manifest similar behavior. However, there are reported cases of *hikikomori* in America, Oman, and Spain (Teo 179; Sakamoto et al. 192). The associated causes of primary social withdrawal in Japan is similar to those experienced by the *hikikomori* from Oman – he had been bullied in school and had a

distant and unpleasant relationship with his father. The subject stopped going to school, going to work, and instead would stay in his room and play video games all day. It was also expressed that he no longer had any desire to socialize with his immediate or extended family (Sakamoto et al. 192-193). This case, as well as the ones in America and Spain, are clinically documented, and if they exist cross-culturally, then *hikikomori*, by definition, cannot be culture-bound (Sakamoto et al. 192).

It is also possible that there are instances of *hikikomori* outside of Japan under different diagnoses. In a study led by Takahiro Kato, two fictional *hikikomori* case reports were sent to therapists across the world, including Japan, Korea, America, Thailand, Iran and India, for assessment and diagnosis (Kato et al. 1061). 124 mental health professionals outside of Japan responded. Some psychologists in America, Korea, Taiwan, and Thailand made a diagnosis of *hikikomori*. However, the majority of respondents used a variety of other diagnoses, including adjustment disorder, anxiety disorder, dysthymia, social phobia, various types of schizophrenia and impulse control disorder. Some Korean psychiatrists diagnosed the cases as internet addiction (Kato et al. 1068). In Japan, 30% of respondents diagnosed both cases with *hikikomori*, 20% diagnosed one, and 50% of mental health professionals believed that neither case fit the criteria (Kato et al. 1064). It is my interpretation that this mixture of results suggests that either *hikikomori* behavior exists in other countries but is diagnosed as something else or that *hikikomori* does not exist anywhere, and that it is misdiagnosed in Japan. However, it is my opinion that the high numbers of people exhibiting this behavior in Japan make the latter possibility unlikely. This confusion could be due to mental health workers being unfamiliar with diagnostic criteria, not recognizing symptomatic behavior when it appears, and, in some countries, the idea of *hikikomori* behavior itself being unknown, no one seeks treatment.

An interview I conducted with a person who lives in Ontario, Canada supports the idea that *hikikomori* behavior exists outside of Japan. This individual, hereafter referred to as "Frank," is in his early 20s and started exhibiting symptoms of primary social withdrawal in late April, 2012. From the onset until early July, Frank stayed home and spent most of his time playing video games. He would only leave the house when required to do so by his parents (often to make a trip to the local grocery store), which happened less than once per week. In July, Frank's behavior altered when he started going to the gym regularly with a friend of his (though he would occasionally make excuses not to go). This behavior lasted until mid-August, when he went on a 6 day canoeing trip with a group of friends. Shortly after this, Frank started attending classes, and he attributes his ability to do so successfully to the canoeing excursion. He is currently attending classes at his local college but expresses worry that he will relapse into withdrawal, and he maintains minimal social contact with others outside of class.

Like many *hikikomori*, Frank was bullied as a child. This occurred in middle school – mostly in the form of jokes about his name and the occasional ethnic slur (he had emigrated from Eastern Europe at the start of 6th grade) – and ended once he entered high school. Since the age of 15, he has avoided speaking to his father whenever possible due to his normally disparaging manner. Frank does have a healthy relationship with his mother, however, who is supportive but not enabling of maladaptive behavior (she still does not know that he did not attend classes during the summer).

At the start of his withdrawal, Frank fit the criteria for the strictest definitions of *hikikomori* (if one disregards the excursions to perform occasional errands). His behavior from July until the end of August (or arguably the present day), is congruent with *katsudōgata ettori* and the looser definitions of primary social withdrawal. Frank displayed both symptoms of, and

experienced many of the trigger conditions associated with, primary social withdrawal. Since this occurred when he was in a society markedly different from Japan's, his behavior supports the idea that *hikikomori* is not a culturally bound syndrome.

I have also been in contact with Dr. Hilarie Cash who runs a clinic treating video game and internet addiction in the state of Washington. Her patients are typically teenagers or college aged males; many have exhibited behavior that is similar to *hikikomori* symptomatology, albeit at a lower level of intensity and with a specific focus on playing video games and using the internet. In our discussion, she mentioned two cases that seem to meet diagnostic criteria for the stricter definitions of *hikikomori*. One is a 22 year old male who, for 5 semesters, enrolled and then withdrew from classes so he could play games. He would forge transcripts so his parents did not know his situation and was eventually kicked out of the university and disowned by his parents. Following this, he spent all his time playing games until he could no longer support himself with his savings, at which point he started seeking treatment and is now almost fully recovered. The other case is described as someone who lived primarily in his basement, would not leave unless forced to, and would constantly skype, read, and play games. These cases bear a striking resemblance to both Frank and the *hikikomori* phenomenon, and while two instances are not indicative of a trend, it is not hard to imagine that, because the data was retrieved from a single clinic, there are people exhibiting this behavior on a wider scale than is currently realized.

A final piece of evidence that suggests that *hikikomori* behavior exists outside of Japan is the previously mentioned hikiculture.net. This place, where people who identify as reclusive – many of whom claim to be *hikikomori* – hold open discussions with like-minded peers, is primarily English speaking and boasts 2074 members at the time of writing (Hikiculture: A forum for reclusive people, hikiculture.net). The message boards have many topics, including

writing, art, depression, love, school and work. Some of the threads are helpful and positive and offer tips on how to get a job with no experience and whether to take AP or IB classes. Others encourage maladaptive tendencies, such as how to get a job that doesn't require leaving one's room or how to convince one's parents to accept the withdrawal behavior. While a full survey of all of the members is not feasible, many of the users have their location set to Canada or America (Hikiculture: A forum for reclusive people, hikiculture.net). Although it is likely that many of these members do not carry a clinical diagnosis of *hikikomori*, it is still indicative of the fact that this behavior is not limited to Japan, and in fact exists all over the world.

There is also controversy regarding whether or not the *hikikomori* phenomenon, if it is not a culture bound syndrome, should be categorized as a mental disorder. It is argued that, as this behavior is ego-syntonic, there was no distress to the subject, which rules out all Axis 1 disorders (a classification of diagnostic categories in DSM-IV-TR that is defined, in part, by distress to the patient). Since there were case studies where the *hikikomori* behavior has completely remitted, it is not always a lifelong affliction, which rules out all Axis 2 disorders (a grouping of mental disorders which include learning disabilities and personality disorders; the latter does not cause distress to the patient but rather to people surrounding the afflicted person) (Teo and Gaw 447).

There have also been individuals who demonstrated all the characteristic symptoms of *hikikomori* but did not meet the criteria for any DSM-IV-TR diagnosis and are thus were not classifiable by current psychological definitions (Teo and Gaw 447). As a compromise, the term of *ichijisei* (一次性), or “pure,” *hikikomori* has been created to describe those individuals who displayed *hikikomori* behavior, but who had symptoms that cannot be explained by any existing mental disorder (Teo and Gaw 447). However, an issue with this definition is that it means there

are a myriad of separate mental disorders that have symptoms that entirely overlap with those of *hikikomori*. This would be problematic because if it is not classified as a mental disorder, it is less likely to be studied in depth, which could limit possible future treatment options and hurt the recovery of those who suffer from it. Treatment may also become troublesome as effective programs will be utilized less frequently because they do not fit the official classification.

In regard to the definition of *hikikomori*, I think the proposed DSM-V definition is the best fit. It provides the clearest definition of *hikikomori* and is the only one that provides definitive guidelines for diagnosis. However, I am somewhat concerned by the strictness of the definition. In particular, the criterion stating that *hikikomori* can only venture outside at night seems restrictive, as it is feasible to find deserted areas during the day – especially when most people are at work or in school. The requirement stating that it must interfere with occupational (or academic) functioning does not take into account working from home and online classes. Finally, the fact that it is necessary for patients under the age of 18 to be symptomatic for 6 months to meet the diagnostic criteria seems arbitrary and not to serve a specific purpose.

I also believe that *hikikomori* is not a culture-bound syndrome and should be classified, officially, as a mental disorder. It is true that, outside of Japan, the diagnosis of *hikikomori* is rare. However, I think this is because the term is not commonly known. In various studies, individual cases were given a myriad of diagnoses by a large number of mental health professionals from around the world. The fact that there is no consistent diagnosis among therapists suggests that something is wrong. Depression and other mental disorders can be correctly diagnosed across the entire world – the ability to do so is a key tenet of psychology – so if another disorder were the cause of *hikikomori* type behavior, it should be able to be universally diagnosed as well. It is true that *hikikomori* cannot currently be classified as mental disorder as it

does not fit on any diagnostic axis. However, since the DSM is updated to describe new disorders as the understanding of the psychological community increases, it is logical that if something is barred from admission simply because it eludes classification, the method of classification should be altered.

Implications

The trouble with discussing possible implications is that since *hikikomori* behavior has only manifested recently, there has been relatively little time for a cultural reaction. Accordingly, literature discussing the possible impact of the *hikikomori* phenomenon is sparse. Nonetheless, I hypothesize that this social withdrawal of Japan's youth will have major ramifications. Possibly the most important implication is the effect it will have on the economy. Since the number of old and retired people is steadily increasing in Japan, young people are needed to replace them in the workforce. Based on the Japanese census data for 2010, there are 20,075,000 Japanese between the ages of 15 and 29 (Sōmushō tōkeikyoku www.stat.go.jp), which is an age range that is both suitable for working and contains the majority of *hikikomori* cases. If estimates of *hikikomori* are placed at 1,000,000 it means that 4.98% of the potential labor market is inactive. This puts pressure on an already fragile economy with potentially disastrous consequences.

However, not all the implications of primary social withdrawal are negative. Businesses that sell entertainment goods online could potentially target *hikikomori* as a niche market. Also, websites that offer ways to make money via the internet might see a lot of business from *hikikomori*, some of whom try to make a living online because it means they will not have to leave their area of comfort. There is also the possibility for positive change. For example, the Japanese school system might see this behavior as a problem, and use it as a catalyst to create a more gentle method of education. The *hikikomori* phenomenon may also bring about social

change. Since more people are exhibiting this behavior, their views on society are slowly becoming more common. If the demand for it becomes loud enough, Japanese culture may begin to change. Overall, the possible implications of the *hikikomori* phenomenon are vast and unpredictable.

Conclusion

Hikikomori is a relatively new phenomenon (something similar first appeared in 1978 [Teo and Gaw 444], but there is practically no information predating the year 2000), and thus little definitive research has been done on this topic. There are many theorized causes, including the Japanese school system, which encourages conformity and often produces bullies (Todd 17). Another potential cause is societal pressures combined with the youth labor market, which limits the options of young workers while still expecting them to succeed (Toivonen 4-5). There is also the family of the *hikikomori*, which, as Suwa observed, is thought to be unfriendly and uncommunicative toward the person who has withdrawn from society. There are also theories stating that *hikikomori* is a symptom of an existing mental disorder (Teo and Gaw 446; Kondo et al. 4), or that it is frequently misdiagnosed as such (Kato et al. 1073). However, I believe that a combination of social and cultural stressors causes the behavior to manifest, both in Japan and other countries.

As *hikikomori* is so widespread, afflicting possibly over 1,000,000 Japanese people (Suwa et al. 586), there are a myriad of treatments. Variations of group therapy, including group psychotherapy, psychiatric daycare, *ibasho* activities, support groups, and self-help groups are a popular method of treatment. A seemingly effective treatment is nidotherapy, according to Sakamoto, which focuses on creating a welcoming environment for the *hikikomori*. Hospitalization is also an option for severe cases of withdrawal. Accommodation facilities, such

as New Start, offer group housing and therapy for those who seek treatment (Jones nytimes.com). I hypothesize that current treatment could include expanding on nidotherapy to make the *hikikomori*'s room less comfortable and by creating an environment that is more conducive to individual counseling, or it could combine group homes, therapy, and reward systems to accelerate rehabilitation.

This behavioral phenomenon is controversial – to the point where the identifying term does not have a clear definition. There are also arguments claiming that since *hikikomori* isn't found outside of Japan, that it is a culture bound disorder (Teo and Gaw 446), though other studies have found that this is not necessarily the case. (Kato et al. 1061; Sakamoto et al 194). I believe that *hikikomori* is not a culture bound syndrome, based on a review of literature and from the interviews I have conducted with an expert in internet and video game addiction and possible *hikikomori* in Canada. The implications of this behavior are far-reaching, and it could potentially destabilize Japan's economy, or permanently change the way Japan operates. Overall, the *hikikomori* phenomenon is a fascinating pattern of behavior; future research, as well as a clear definition of the term, is needed for true classification and to help all those who suffer from it.

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