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Hikikomori, A Japanese Culture-Bound Syndrome of Social Withdrawal? A Proposal for DSM-V

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Abstract

A form of severe social withdrawal, called *hikikomori*, has been frequently described in Japan and is characterized by adolescents and young adults who become recluses in their parents' homes, unable to work or go to school for months or years. The aim of this study was to review the evidence for *hikikomori* as a new psychiatric disorder. Electronic and manual literatures searches were used to gather information on social withdrawal and hikikomori, including studies examining case definitions, epidemiology, and diagnosis. A number of recent empiric studies have emerged from Japan. The majority of such cases of hikikomori are classifiable as a variety of existing DSM-IV-TR (or ICD-10) psychiatric disorders. However, a notable subset of cases with substantial psychopathology do not meet criteria for any existing psychiatric disorder. We suggest hikikomori may be considered a culture-bound syndrome and merits further international research into whether it meets accepted criteria as a new psychiatric disorder. Research diagnostic criteria for the condition are proposed.

Keywords

hikikomori; social withdrawal; diagnosis; culture-bound syndrome

INTRODUCTION

Case Report

The patient is a 14-year-old Japanese boy who complains of not wanting to attend school. He had no significant problems or difficulties during elementary school, but suddenly and without any apparent trigger, ceased attending school during the last quarter of the first year of middle school. He likewise stopped any attempts at studying. His parents became concerned and sought psychiatric evaluation. At the time of initial evaluation, the patient was noted to have normal hygiene and grooming. He greeted the clinician and responded appropriately to questioning, but stated "I just don't want to go to school."

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The patient has no medical history of note. Developmental history is notable for mild language delay. His first words were late compared to peers, and he did not use grammatical structures including particles like “to” until age six. Family history is notable only for the patient’s 48-year-old mother who has panic disorder and is treated by a psychiatrist. The patient’s father, also age 48, and his older brother, age 16, are both healthy. Routine laboratory testing (including complete blood count, basic chemistry panel, liver enzymes, and urinalysis) were within normal limits. On neuropsychiatric testing, the patient’s total IQ was 88, divided further into 75 and 106 on verbal and performance subscales, respectively, on the Wechsler Intelligence Scale Third for Children Third Edition (WISC-III).

The patient presented for follow-up once, but thereafter remained at home. His father and mother returned for follow-up every two to four weeks for family therapy, providing updates on the state of their son and receiving advice from the psychiatrist. In particular, the psychiatrist provided suggestions on how to interact with their son. The parents proactively followed these suggestions, changing their style of interaction with their son from one of reprimanding and ordering him to one of patiently waiting for the patient to initiate conversation or actions. They also arranged for the patient’s homeroom teacher to regularly visit the patient at home as he refused to attend school. During home visits, the teacher also waited until the patient would initiate conversation. The boy never directly received treatment from a mental health professional. The patient would only leave home once a week on Sunday’s with his father to rent DVDs at a local video store. This living situation continued for two years. Then, at the time of entrance into high school, the patient suddenly reported that he wanted to return to school. He entered a vocational school specializing in design and since then has regularly attended classes.

Per the psychiatrist providing family therapy, though the patient’s decision superficially appeared sudden, it actually developed gradually in stages. Over the two-year period of social withdrawal, the patient reportedly spent much time deliberating his future, ambitions, and unsustainability of his isolation. Though he rarely shared his decision-making process, he ultimately developed the capacity to express his wishes to his parents.

Historical Background

Cases such as the above have been described as *hikikomori* in Japan for the last two decades. However, related phenomena have been described even prior to the emergence of the term hikikomori. In 1978, Kasahara described cases of “withdrawal neurosis” or *taikyaku shinkeishou*.(Kasahara, 1978) In the 1980s, Lock described several cases of what she aptly termed “school refusal syndrome.”(Lock, 1986) Both bear a resemblance to contemporary hikikomori. However, in neither case were they followed by substantial literature examining them. In contrast, attention to hikikomori built to a crescendo in the 1990s and now appears to have stabilized. At first, Japanese psychiatrists(Saito, 1998) described hikikomori. Mainstream media, in Japan and internationally, cast further light upon the shadowy hikikomori.(Jones, 2006; Murakami, 2000) Later, Western academics provided in-depth review and analysis, and their works provided more detailed background.(Borovoy, 2008; Furlong; Teo, 2009)

METHOD

Electronic and manual literatures searches were used to gather information on the existence of social withdrawal and hikikomori. As the aim was to evaluate the evidence for hikikomori as a unique and new psychiatric condition, studies examined included those addressing case definitions, epidemiology, and diagnosis of hikikomori. PubMed was searched up to 13 October 2009 using the following search string: hikikomori OR (social withdrawal AND Japan) OR (social isolation AND Japan). No language restriction was placed. An analogous search strategy was employed for PsycINFO and searched up to 22 October 2009. The Japanese electronic database *Ichushi* for medical literature was searched using the term hikikomori up to 18 November 2008. The reference lists of all relevant papers were checked. This search was supplemented with contact with an expert in the field who furnished additional manuscripts.

RESULTS

Definition

A consensus definition of hikikomori has not been reached. The word, now part of the everyday lexicon in Japanese, can refer to either the afflicted (i.e., the person or people) or the phenomenon (i.e., the symptom of withdrawal). More specific and operationalized definitions have been developed by Japanese psychiatrists and are presented here.

First, in 2003, the Japanese Ministry of Health, Labor, and Welfare established the following criteria for hikikomori: 1) a lifestyle centered at home; 2) no interest or willingness to attend school or work; 3) symptom duration of at least six months; 4) schizophrenia, mental retardation or other mental disorders have been excluded; 5) among those with no interest or willingness to attend school or work, those who maintain personal relationships (e.g., friendships) have been excluded.(Ministry of Health Labor and Welfare) Second, a national research taskforce further condensed this definition into the following description: “the state of avoiding social engagement (e.g., education, employment, and friendships) with generally persistent withdrawal into one’s residence for at least six months as a result of various factors.”(Saito, 2008)

Epidemiology

Very limited reliable data exist on the epidemiology of hikikomori. The strongest data come from a review that summarized three population-based studies involving a total of 12 cities and 3,951 people. Using a standardized definition, it showed between 0.9% and 3.8% had a history of hikikomori.(Kiyota et al, 2008) Another survey by Okinawan researchers of over 1,600 families in 2002 found 14 cases, which, if extrapolated to the entire nation, would be 410,000 cases.(Furlong, 2008) Though undoubtedly a vast underestimation due to selected sample sites, incidence has been examined by a government study of consultations (mostly by parents) regarding hikikomori at all official mental health and welfare centers across Japan, which showed over 14,000 in a one-year period.(Ministry of Health Labor and Welfare, 2003) Symptom onset typically occurs during adolescence,(Kondo, 1997; Takahata,

2003) while age at first presentation is usually in the 20s.(Kondo et al, 2008; Ministry of Health Labor and Welfare, 2003; Saito, 1998; Takahata, 2003)

Differential Diagnosis

The core feature of hikikomori is social withdrawal or isolation. This, in and of itself, of course has a wide differential diagnosis: psychotic illness such as schizophrenia; anxiety disorders such as posttraumatic stress disorder or social anxiety disorder; major depressive disorder or other mood disorders; and personality disorders, such as schizoid personality disorder or avoidant personality disorder, are among the many considerations.

Recently, some mental health professionals have begun attempting to classify hikikomori according to accepted diagnostic categories. A relatively large three-month prospective study conducted by Japanese child psychiatrists examined 463 cases of youth less than 21 years old with a current or past history of the research taskforce definition hikikomori. According to DSM-IV-TR criteria, the top six diagnoses (with multiple diagnoses possible) were: pervasive development disorder (31%), generalized anxiety disorder (10%), dysthymia disorder (10%), adjustment disorder (9%), obsessive-compulsive disorder (9%), and schizophrenia (9%).(Watabe et al, 2008)

A multicenter study examining somewhat older cases of hikikomori found somewhat similar diagnostic heterogeneity but also included undiagnosable cases.(Kondo et al, 2008) To be included patients had to be aged 16–35 with onset of social isolation before age 30 and meet a clear definition of at least six months of social and occupational withdrawal. Of the 181 cases that met these criteria, 97 (54%) were cases in which the patient actually presented. (Getting hikikomori to present to a health care provider, let alone psychiatrist, is challenging due to the very nature of the primary symptom.) Diagnosis was made according to DSM-IV-TR criteria during a “diagnostic conference” attended by at least one psychiatrist and three other allied mental health professionals. Patients could have more than one Axis I or II condition. Results indicated that: 8/97 (8%) had schizophrenia; 25/97 (26%) had an anxiety disorder (including 11 with social phobia, 6 with obsessive-compulsive disorder, and 3 with generalized anxiety disorder); 8/97 (8%) had a mood disorder; 7/97 (7%) had an adjustment disorder; 22/97 (23%) had a personality disorder (including 6 with avoidant personality disorder, 6 with schizoid personality disorder, and 4 with obsessive-compulsive personality disorder); 27/97 (28%) had a disorder usually first diagnosed in infancy, childhood, or adolescence (including 10 with mental retardation, 7 with autism, 5 with Asperger syndrome, 3 with pervasive developmental disorder); and 6/97 (6%) had other conditions (e.g., dissociative disorder, eating disorder).

Two studies have examined diagnosis using an ICD-10 model. One unique retrospective study was conducted at a single large Japanese acute psychiatric facility.(Nakajima et al, 2008) Researchers conducted a chart review of all patients under 30 years of age who presented to their center in 2006. Of the 308 eligible patients, 68 reported social withdrawal/isolation. Using ICD-10 diagnostic guidelines, the three most common diagnostic categories were: neurotic, stress, and somatoform disorders (27%); schizophrenia-spectrum and delusional disorders (24%); and developmental disorders (22%). This study was unique in that it only included those who actually presented and could therefore be assessed in-person

for diagnosis. Weaknesses of the study, though, included lack of a reported definition of hikikomori and lack of specific diagnoses (beyond diagnostic categories). Only one patient (1/68) did not fall into one of the nine major ICD-10 mental health diagnostic categories, and this patient was not described. Another smaller study of 52 outpatients categorized all patients as having an ICD-10 diagnosis. The top six diagnoses were as follows: 35% had phobic anxiety disorders; 19% had reaction to severe stress, and adjustment disorders; 12% had mood (affective) disorders; 10% had somatoform disorders; 6% had disorders of psychological development; and 6% had behavioral and emotional disorders with onset usually occurring in childhood or adolescence.(Tsujimoto et al, 2007) There were several key limitations of this study. The authors offered no description of the method for diagnosis, the sample was a convenience sample increasing the likelihood of a nonrepresentative sample, and all diagnoses were made by a single psychiatrist based on a single visit.

DISCUSSION

The irony of the term hikikomori is that it has achieved such popularity in use and recognition that it may now be unwittingly obfuscating diagnosis. Both the general public and mental health providers commonly use the term hikikomori in conversation and writing. Such broad use of a term can ultimately led to its demise amongst clinicians, as happened with the term neurasthenia in the early 20th century.(Schuster, 2003)

In a society where it is highly stigmatizing to use words like clinical depression (*utsubyou*), let alone schizophrenia (*tougou shicchoushou*), the term hikikomori has broad appeal as a socially acceptable term. The public may use the term hikikomori not so much as camouflage for another disorder, as much as an uneducated substitution for the “proper” terminology of the mental disorder it is symptomatic of. Mental health professionals may use the term with patients and their families as a softer, gentler proxy for an underlying mental disorder. Borovoy, an anthropologist and expert on Japan, posits that there is a “web of ideas and institutions that mitigate against pathologizing the individual…” and that Japanese doctors “avoid diagnosing major psychopathology to the extent that it is possible.” (Borovoy, 2008) Public surveys likewise have found Japanese averse to using psychiatric labels.(Jorm et al, 2005) Such use of a ‘disguised diagnosis’ has been described before in Japan.(Munakata, 1986) In short, we suspect that hikikomori, as a term, has flourished in no small part because it is less stigmatizing than other terms for mental illness.

Herein, we make three arguments about hikikomori and psychiatric diagnosis:

1. Cases of hikikomori are often, but not always, classifiable as a variety of existing DSM-IV-TR (or ICD-10) psychiatric disorders.
2. Hikikomori may be considered a culture-bound syndrome.
3. Hikikomori merits further consideration and research into whether it is a new psychiatric disorder.

It should be noted that at least one Western sociologist has suggested that hikikomori is not a psychological or psychiatric condition at all; rather it is fundamentally a transient

phenomenon caused by social factors.(Furlong, 2008) We do not endorse this view and exploration of it is beyond the scope of this article.

Argument 1: Cases of hikikomori are often, but not always, classifiable as a variety of existing DSM-IV-TR (or ICD-10) psychiatric disorders

We argue that the majority of hikikomori indeed suffer from some form of established Axis I or II disorder. As has been noted in past debate over the validity of various culture-bound syndromes, it is crucial to determine whether hikikomori represents a superficially-atypical variant of conventional psychiatric diagnosis.(Alarcon et al, 2002) If the dramatic and severe withdrawal is merely a Japanese-specific emphasis on the quality of withdrawal—a symptom that may be part of an underlying anxiety, mood, developmental, or other disorder—then one way to classify them would be as a more pervasive, existing clinical entity with social withdrawal as a clinical feature. Such cases exhibit *hikikomori-like states* but are not true hikikomori as described herein. Beyond these theoretical justifications, the empirical studies described above(Kondo et al, 2008; Nakajima et al, 2008; Watabe et al, 2008) are strong enough to persuasively argue that the majority of hikikomori manifest some form of psychiatric disorder.

Argument 2: Hikikomori may be considered a culture-bound syndrome

For the remaining subset of hikikomori cases that do not fall into an existing Axis I or II disorder, we believe the data on hikikomori are sufficiently strong to designate hikikomori a culture-bound syndrome. Also termed culture-specific disorder or culture-related specific psychiatric syndrome, it is a “recurrent, locality specific patterns of aberrant behavior and troubling experience”(American Psychiatric Association, 2000) best understood and managed primarily from the cultural perspective from which it originates. Gaw further clarified the definition for culture-bound syndrome by stipulating four requisite characteristics: 1) the disorder must be a discrete, well-define syndrome; 2) it must be recognized as a specific illness in the culture with which it is primarily associated; 3) the disorder must be expected, recognized, and to some degree sanctioned as a response to certain precipitants in the particular culture; and 4) a higher incidence or prevalence of the disorder must exist in societies in which the disorder is culturally recognized, compared with other societies.(Gaw, 2001)

Hikikomori easily meets three of the four culture-bound syndrome criteria–and arguably all four. First, the Japanese government and research taskforce definitions described above fulfill the first criterion. Second, cultural characteristics within Japan that promote the formation of social withdrawal behavior have been explored at length in prior reviews of hikikomori, fulfilling the third criterion.(Furlong, 2008; Kawanishi, 2004; Teo, 2009) Third, as far as the fourth criterion, the vast majority of reported cases are in Japan, with only two cases of hikikomori reported elsewhere.(Garcia-Campayo et al, 2007; Sakamoto et al, 2005) And though anecdotally many psychiatrists would agree with having seen cases similar to the one described at the outset of this article, prevalence figures for Japan like those described above(Kiyota et al, 2008) are surely distinctly higher than other countries.

Whether hikikomori fulfills the fourth criterion of culture-bound syndromes—that hikikomori be recognized as a specific illness in Japan—is somewhat controversial. Certainly, the vast majority of Japanese experts agree that hikikomori is a disabling condition worthy of clinical attention. However, the government experts who provided one of the definitions of hikikomori were quick to insist that hikikomori was not a psychiatric *diagnosis* per se. But they offered no alternative as to what it might be and even acknowledged that in many cases presenting to health centers, the behavior cannot be attributed to any known medical or psychiatric pathology.(Ministry of Health Labor and Welfare, 2003) Furthermore, the research taskforce case definition uses the conspicuously vague description ("as a result of various factors") to describe etiology of hikikomori. This suggests ambivalence—if not outright confusion—as to how to reconcile hikikomori with psychiatric disorder. Indeed, one informal survey of 103 Japanese child and adult psychiatrists conducted in 1992 found that 57% thought traditional diagnostic categories do not completely capture the notion of hikikomori, and 22% felt a new diagnostic category was warranted.(Saito, 1998)

A proposal for hikikomori as a culture-bound syndrome is reminiscent of the psychiatric literature's discussion of *taijin kyofusho* in prior decades. A well-established Japanese psychiatric diagnosis, taijin kyofusho is also entombed in the DSM-IV TR appendix of culture-bound syndromes.(American Psychiatric Association, 2000) Epidemiologically, the two conditions are strikingly similar. Taijin kyofusho is known to predominate among the same youthful age group, have symptoms often regressing after age 30, and have the same bias towards males.(Russell, 1989) One psychiatrist reporting a case series of 24 consecutive taijin kyofusho treated on an inpatient unit described seven (29%) of the patients as fitting what he deemed a "hikikomori subtype" of the disorder.(Nakamura et al, 1997) However, taijin kyofusho's core feature is fear of offending or hurting others through awkward social interaction or due to perceived physical defect.(Kirmayer, 1991) Body odor, blushing, and eye-to-eye contact are among the most common fears. Therefore, neither the core feature nor most common clinical manifestations are typical of hikikomori. Kirmayer described taijin kyofusho as a "pathological amplification of culture-specific concerns about the social presentation of self and the impact of improper conduct on the well-being of others." (Kirmayer, 1991) In contrast, hikikomori may be an amplification of Japanese-specific concerns about the quality and quantity of one's social interactions.

What is similar between these two conditions is that some cases, when viewed through the nosological lens of the DSM, meet criteria for other psychiatric disorders. Severe cases of taijin kyofusho, for instance, often turn out be major mental illnesses like psychotic disorders.(Russell, 1989) A study of DSM diagnosis of taijin kyofusho by American mental health practitioners' revealed a tendency to apply a range of personality, anxiety, and psychotic diagnostic labels.(Tanaka-Matsumi, 1979) Perhaps, then, these findings are akin to results in the hikikomori diagnostic studies cited above in the Differential Diagnosis section.

In summary, a reasonable number of Japanese experts endorse a new diagnostic category for hikikomori, epidemiologic data show widespread cases limited to Japan, and a clear, succinct case definition of hikikomori is available. Hikikomori is distinct from taijin kyofusho, but deserves its place in the company of its culture-bound syndrome cousin.

Despite the debate regarding the historical legacy of culture-bound syndromes as “foreign” and “exotic,” the reasonable criticism of the entire notion of culture-bound syndromes(Sumathipala et al, 2004), and the unclear future of them in DSM-V, we believe hikikomori would fit well in the category of culture-bound syndromes.

Argument 3: Hikikomori merits further consideration and research into whether it is a new psychiatric disorder

We suggest that a small but notable subset of hikikomori suffer from persistent and disabling social isolation but lack other notable psychopathology. Recall, for instance, the care report described at the start of this article. This case illustrates some features typical of hikikomori that distinguish it from other disorders on the differential diagnosis. The patient’s behavior was ego-syntonic, he did not recognizes his disinclination to go outside as unreasonable or excessive, and did not fear he would act in a way that will be humiliating or embarrassing, distinguishing it from social anxiety disorder. The patient’s symptoms, though lasting over two years, were not lifelong, thus ruling out schizoid, avoidant or other personality disorders, as well as autistic or pervasive developmental disorders. Though some hikikomori do go on to develop a primary psychotic illness, again in this illustrative case vignette, the patient recovered with no residual symptoms, ruling out schizophrenia spectrum illness. An exhaustive examination of a differential diagnosis is beyond the scope of this article, but further discussion of differential diagnosis in hikikomori has been considered elsewhere. (Teo, 2009)

Studies that have examined diagnosis among hikikomori have come to the same result: a small portion of hikikomori do not fit classification within a traditional psychiatric disorder. For instance, in one of the best-designed prospective studies of youth with social isolation of at least six months’ duration and onset before age 30, fully 20% (19/97) of patients examined were undiagnosable with any existing Axis I or II disorders.(Kondo et al, 2008; Suwa et al, 2002) Another small study classified two out of 14 (14%) cases of young adults meeting criteria for hikikomori but not fulfilling full diagnostic criteria for any disorder (though they were noted to have schizoid, avoidant, and narcissistic personality traits).(Suwa et al, 2002) Twenty-seven patients with hikikomori undergoing group psychotherapy at a community mental health center were diagnosed based solely on extensive collateral information gathered from patients’ parents. While acknowledging the limitation of this approach, the authors’ provisionally diagnosed ten out of 27 as not meeting criteria for any DSM IV disorder and therefore having “primary social withdrawal.”(Suwa et al, 2003) Without saying so, Japanese government experts’ data can be construed as suggesting this too; they acknowledged many cases presenting to health centers cannot be attributed to any known medical or psychiatric pathology.(Ministry of Health Labor and Welfare, 2003) Taken together, this suggests the existence of a “pure” form of hikikomori—that is social withdrawal with substantial psychopathology but no other apparent etiology—which was first introduced as *ichijisei hikikomori* in Japanese(Kinugasa, 1998) and may be called primary social withdrawal.

We believe that it would be premature to propose that hikikomori is a disorder that should be included in DSM-V. First, the results show heterogeneity of DSM-IV TR and ICD-10

diagnoses with widely varying prevalence figures. Only a few studies document person-to-person interviews, and standardized tools such as the Structured Clinical Interview for DSM Disorders (SCID) were not described in studies, leading one to surmise that other psychopathology may have be missed in some of the "pure" hikikomori cases. Longer followup of cases of primary social withdrawal might have led to discovery of illnesses like schizophrenia with prodromal periods. Second, hikikomori does not yet meet the high threshold for labeling as a disease or disorder. An appropriate analogy here might be the ongoing debate on "internet addiction." Like hikikomori in Japan, internet addiction has been widely studied in South Korea, and the country considers it one of its most serious public health issues.(Block, 2008) Yet, as one commentator argues, internet addiction cannot be considered a bona fide disorder—a "specific disease entity"—until at least one of the following conditions is established:

1. A pattern of genetic transmission.
2. A reasonably well-understood etiology, pathophysiology, and/or pathologic anatomy.
3. A relatively predictable and consistent course, prognosis, stability, and response to treatment across many different populations.(Pies, 2009)

Quite simply, there is insufficient robust evidence for hikikomori meeting any of these criteria. However, rejecting hikikomori at this point due to lack of data would be the statistical equivalent of a type II error. That is, it very well might meet one or more of these criteria and further prospective research to clarify this issue warranted. Additionally, more systematically collected clinical data across populations, including developmental and social history, familial interactions, and risk factors associated with this phenomenon are essential. To fill this knowledge gap, multi-year longitudinal prospective population-based studies applying consistent methodologies are needed. To aid in further investigation, we propose research-oriented diagnostic criteria for hikikomori. Table 1 contains our proposed research definition of hikikomori. Figure 1 provides a diagnostic algorithm for classifying cases that present with marked social withdrawal as a method for isolating hikikomori from other conditions. Any suggestion of new culture-bound syndrome and the possibility of a new psychiatric disorder is an open invitation to a healthy dose of skepticism and vigorous critique. Nonetheless, we suggest that the combination of the large scale of hikikomori described in Japan, the persistence of such reports across multiple decades, and recent empirical data supporting undiagnosable cases are persuasive evidence for the existence of a culture-bound syndrome of hikikomori and potentially a new psychiatric disorder that can be admitted into DSM and ICD nosology.

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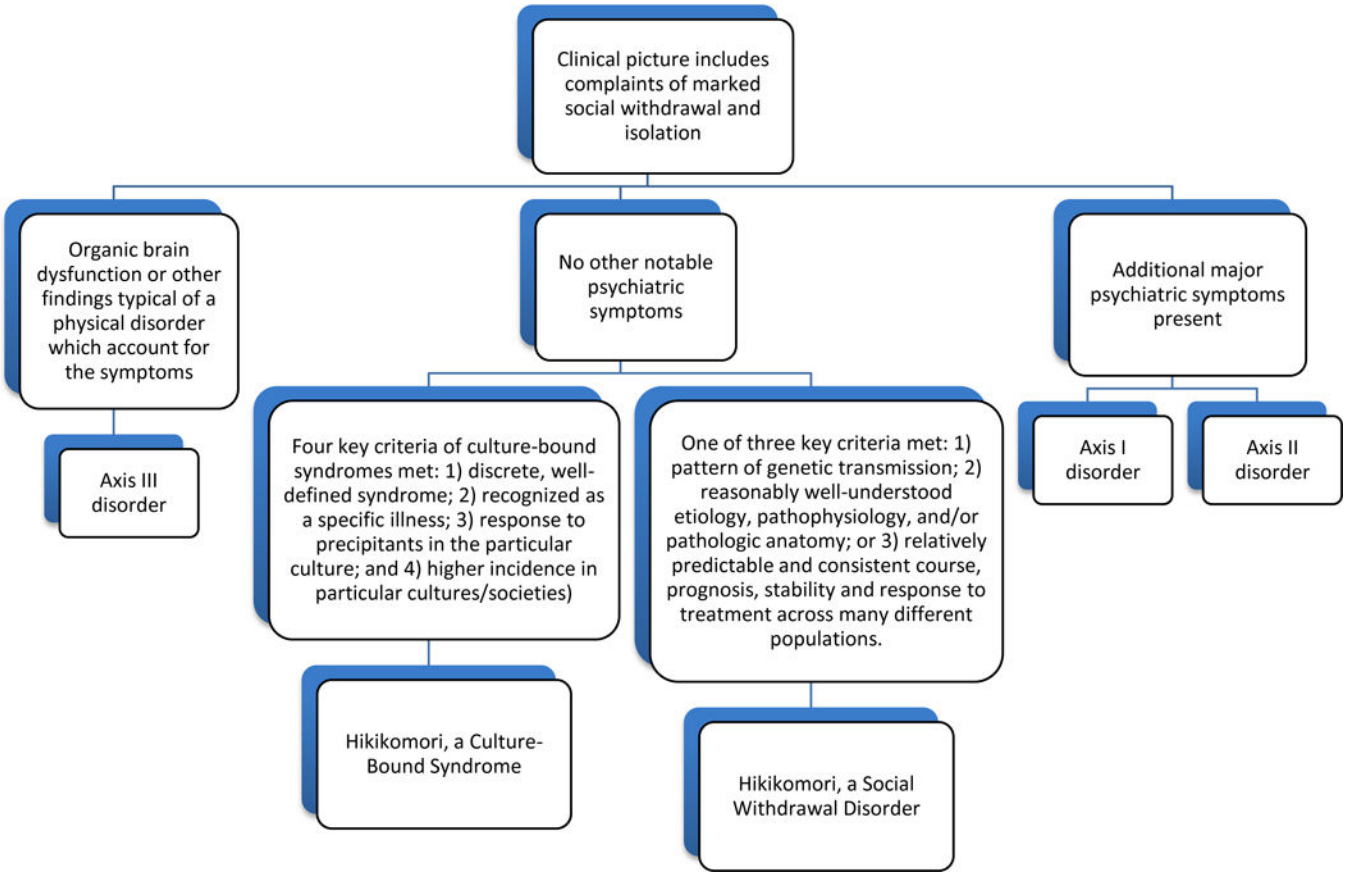

FIGURE 1.
Decision tree for hikikomori

Table 1

Proposed Research Diagnostic Criteria for Hikikomori

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. The person must meet each of the following six criteria:

A.	The person spends most of the day and nearly every day confined to home.
B.	Marked and persistent avoidance of social situations (e.g., attending school, working) and social relationships (e.g., friendships, contact with family members).
C.	The social withdrawal and avoidance interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships.
D.	The person perceives the withdrawal as ego-syntonic.
E.	In individuals under age 18 years, the duration is at least 6 months.
F.	The social withdrawal and avoidance are not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Major Depressive Disorder (e.g., avoidance of social situations as a reflection of neurovegetative symptoms), Schizophrenia (e.g., isolation due to negative symptoms of psychosis), or Avoidant Personality Disorder (e.g., isolation due to fears of criticism or rejection).