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Existing but Not Living: A Discussion and Proposal for the Acute Social Withdrawal Syndrome Hikikomori in Japan

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Existing but Not Living: A Discussion and Proposal for the Acute Social Withdrawal Syndrome
Hikikomori in Japan

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by

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Table of Contents

Introduction

This senior project proposal will provide a look at the potential correlation between familial codependency in Japan and *hikikomori* syndrome. In doing so, it will explore what is currently known about *hikikomori* syndrome -- what it is, what it looks like, who it affects, how prevalent it is, and more; along with where it stands and how it is understood in terms of psychiatry and mental illness. This project will explore reasons for the focus on *hikikomori* in the context of the Japanese and why it is presented as an issue within the country of Japan; including a brief history of modern Japan, the development of Japanese society, and current social issues that are potentially tied to the existence and prevalence of *hikikomori* syndrome. This project will also cover the influence these things have over stigma and prejudice against topics like mental health and mental illness in Japan, as well as the positive and negative consequences of Japanese media and how it affects the country's relationship and understanding of *hikikomori* syndrome. Also to be included is discussion on the structure of family in Japan, the points of which will be used to guide the direction of the study's proposal that will examine the possibility of a potential relationship between family life and the existence and persistence of *hikikomori* syndrome in Japanese youth. The purpose of the following research and proposed study is to explore what is currently known about *hikikomori* syndrome and to use that information as a guide for a possible direction to take when considering future treatments for this phenomenon that, to this day, remains as somewhat of an enigma.

Part 1: *Hikikomori* in Japan

What is Hikikomori?

Hikikomori is a Japanese term that translates to social withdrawal in the English language. *Hikikomori* is defined as those who are confined to their homes (or other place of recluse) and withdrawn from society for a period of six months or longer (Koyama, Miyake, Kawakami, Tsuchiya, Tachimori, & Takeshima, 2010; Kaneko, 2006). Tamaki Saito, one of the most highly-influential Japanese researchers on the topic and the practitioner responsible for popularizing the phrase in the 1990s, describes *hikikomori* as being outside of employment and education and having no intimate relationships with anyone outside of the immediate family (Furlong, 2008). Saito also puts forth that *hikikomori* onset occurs around the latter half of a person's 30s, and that its primary symptoms of withdrawal are not capable of being better explained by another psychiatric disorder (Teo, 2010). Oftentimes, *hikikomori* are not attending school, nor are they employed anywhere. Instead, they usually take up residence with parents or other family.

It is difficult to state a specific prevalence for *hikikomori*, but estimates range from about a 1.2% to 1.4% percent lifetime prevalence within the Japanese population (Koyama et al., 2010). Shut-ins do not readily go to doctors to present themselves for treatment (Saito, 1998/2013), and those who seek out clinical help are not a good representation of the entire population, especially if they do so at health and welfare centers instead of clinics or hospitals, of which there are a decent amount in effect in Japan (Teo, 2010). There are likely many undetected cases as well, especially considering *hikikomori* by definition are socially isolative (Teo, 2010), and parents that care for children who are *hikikomori* are often ashamed of the fact (Saito,

1998/2013); therefore, there are likely many caretakers who are not very willing to disclose this information. Despite the scarce statistics, the often-quoted estimated guess that many experts agree on places the prevalence at upwards of one million cases (Teo, 2010; Furlong, 2008). Researchers like Saito Tamaki and Ogi Naoki, a frequent speaker on the Japanese educational system and adolescent problems, have used personal clinical experiences and surveys to estimate numbers that reach this high (between 800,000 and 1,200,000 more specifically). Again, the very nature of *hikikomori* renders it exceedingly difficult to pin down, as we are trying to account for a large group of people who are essentially invisible (Saito, 1998/2013).

Concerning *hikikomori* demographics, studies have found a heavy predominance of male-to-female cases with the number of *hikikomori* males outnumbering females by about 4:1. When measuring prevelence by sex, men have as high as a 1.8% lifetime prevelance compared to women's 0.4% (Koyama et al, 2010). It is an interesting fact that the majority of people affected are young men. It has been proposed that when women begin to withdraw from society, their behavior tends to not last for an extended period of time (Saito, 1998/2013), and thus there are far more women who are classified as pre-*hikikomori* (those who can relate to the feelings of *hikikomori* and may possess withdrawal symptoms and tendencies without being classifiable as a full-blown *hikikomori*) as a result (Figure 1.1).

In contrast to Saito's prediction, the onset of symptoms for most people seems to occur during the years of adolescence, ranging from around the ages of 20 to 27 according to Japanese government studies (Teo, 2010). The most recent survey done by the Japanese Cabinet Office revealed that self-reported onset age for *hikikomori* is generally 15 to 24 (Figure 1.2). When *hikikomori* and social withdrawal began to become a popularized term within Japan, it was most

widely thought to affect young people in their teens and twenties. These days, *hikikomori* is

beginning to reach those who are older. Currently, there are many *hikikomori* who are within the

age range of 30 to 39 (Figure 1.3).

The majority of *hikikomori* (67.8%) do not have employment of any kind -- whether that

be full time work, temporary work, part-time employment, self-employment, etc. (Figure 1.4).

Many also either do not attend or have dropped out of school; however, non-school attendance

does not have as much of a causal impact on *hikikomori* development as one might think given

this information. Being a student is still a somewhat common work-related occupation of

hikikomori (16.9%) (Figure 1.4), and never attending school is not a very common experience

amongst *hikikomori* or even pre-*hikikomori*. Truancy is not a main reason for how most

hikikomori say they ended up becoming *hikikomori* either (11.9%) (Figure 1.5). This suggests

that school attendance may be more of a side effect rather than an influencer of *hikikomori*

syndrome.

Defining emotional traits of *hikikomori* often include a desire to be of help but a low

sense of self-worth and confidence, anxiousness about not being able to assist one's family,

difficulty with communication, and anxiousness about speaking with or being around other

people (see Figures 1.6 and 1.7). *Hikikomori* is no longer the silent epidemic of suffering (Saito,

1998/2013) that it once was, but in terms of recognition and proper treatment, it still has a long

way to go. Thankfully, due to the emergence of media depiction and support organizations in

recent years, it has gained more traction as a social issue, but the problem of there being a large

number of people suffering silently from withdrawal and failing to receive treatment still

remains. Even if *hikikomori* is becoming more recognized, the millions of present *hikikomori*

will only continue to grow in number so long as they are not being helped.

Hikikomori vs NEET and Otaku
NEET

Before advancing further, it is helpful to discuss the concept of NEET in Japan, as this is

also a prominent term used within the society that is similar to *hikikomori*. The abbreviation

NEET stands for Not in Education, Employment, or Training. It was introduced in the early

2000s as a way to describe young people who fall into these categories and was used to talk

about ways to support the employment of young men and women who classify as such (Saito,

1998/2013). Today, some confuse NEETs and *hikikomori* as being one and the same, placing

them together in terms of general definition and behavior. In some ways, this is accurate. The

target age range of young people in their teens, twenties and thirties is quite similar to that of

hikikomori. Many NEETs are also outside of employment and are more likely than the general

population to possess tendencies that are similar to that of *hikikomori,* including withdrawal. In

addition, part of the definition of *hikikomori* is to demonstrate a rejection for attending school.

This is similar to NEETs, who are largely characterized by not being in education. Both NEETs

and *hikikomori* can lack jobs, current schooling, and the desire to pursue either.

Regardless of the fact that *hikikomori* and NEET are not the same thing, the social

reception that they receive is often in line with that of *hikikomori.* I say this to mean there is a

stigma surrounding NEETs in Japan as well. Interestingly enough, the Japanese government gave

NEET an even more precise definition of: young people from the ages of 15-34 years old who

are out of the labor force, single, not in education, and not keeping house (Inui, 2005). Just like

hikikomori, the concept of NEET exists outside of Japan and, in fact, the very same acronym is

well-known and utilized in the United Kingdom. Unlike the Japanese definition, the U.K.

definition encompasses a much larger range of unemployed young people -- such as those who

are long-term unemployed or just fleetingly, those who are taking a short break from school and

work, and those who are off caring for children or relatives in a home (Inui, 2005). Due to this,

the U.K.'s definition includes people who are unemployed but looking for work, whereas Japan's

definition does not. As a result, much of Japan's mass media presumes that NEETs have no will

to work (Inui, 2005). The defining lifestyle of a NEET is highly unattractive to many Japanese

citizens. Much like *hikikomori*, many people see it as being lazy or pitiful, but that is because

they do not take into account all of the possible circumstances of unemployment or consider the

fact that many may be between jobs or searching for work.

Despite the similarities, it is important to note the differences between *hikikomori* and

NEET as well. Simply because a NEET may be out of work and not attending school does not

necessarily mean that they demonstrate the extreme social withdrawal traits of a *hikikomori.* The

key word is *can.* NEETs *can* develop these traits, and many do -- but many also do not. Just like

with *hikikomori*, it is important not to generalize by applying all of the possible characteristics of

NEET to anyone who meets the criteria for the official definition. Japan's definition is limiting

because it lumps even those who are active in their unemployment into the category of NEET. At

the same time, the U.K.'s definition, because it is so broad, considers everyone without a job and

lumps those who are vulnerable and require distinct forms of policy intervention in with those

who are more privileged and require less help to get back on their feet (Inui, 2005). Inui says that

this interferes with society's recognition of problems, and I believe the same thing happens with *hikikomori.* To some, *hikikomori* might be viewed as an extension of those "lazy" people who refuse to find employment based on personal preference and not on circumstance.

The biggest thing to remember about the difference between the two is that *hikikomori* has little to do with whether the person is employed or not. It is characterized primarily by the anomalous inner workings of an individual's mind and how it impacts their life. NEETs are not as inherently characterized by these sorts of internal struggles. NEETs *do* have struggles that are similar or the same as *hikikomori* -- such as becoming discouraged because of lack of work and wishing to remain inside more often. But it is more accurate to say a NEET has the potential to become *hikikomori* (especially if out of work for an extended amount of time), rather than such a thing being definitive. There is a fine line that marks that transition -- such as change in a person's internal state and self-worth, months spent never leaving the house, or a loss of social ties -- but their definitions should still be kept separate when considering them.

Otaku

Otaku is a Japanese term that translates to a polite way of saying 'your home' or 'you' in English (Tobin, 1998). The term *otaku-zoku* (otaku-tribe) emerged in the 1980s, used to describe someone who becomes obsessed with a particular aspect of popular culture and is able to heavily indulge in their interests while rarely -- if ever -- leaving their rooms; most of them accomplishing this through the use of the internet and other technology (Tobin, 1998). Therefore, one can be an *anime* (Japanese animation) *otaku;* or a *manga* (Japanese comic books) *otaku*; or a pop idol-*otaku;* and so on. Similar to *hikikomori,* many *otaku* are classified as being young

people, the majority of whom are also male. *Otaku* is quite a widely-known term, commonly

used in a decent amount of mass media inside and outside of Japan; and has even been

popularized to the point of being a slang word to describe someone who enjoys spending large

amounts of time at home, or who has an excessive obsession with certain kinds of media --

comic books and *anime* specifically. *Otaku* can be regarded by mass media as "nerdy," "geeky,"

"weird," and even "creepy," but generally in Japan, there is not so much negative connotation

surrounding them. Most recognize that *hikikomori* syndrome is a problem and that those affected

should seek help, but *otaku* are taken more lightly. While the *otaku* lifestyle can still be

chastised, it is seen as more of an inconvenience and testament to somebody's laziness than a

pressing issue. Other times, it is even admired. For *otaku,* there is more of a risk of being a social

oddball than the deeper implications that come with being *hikikomori,* such as being socially

inept. As such, *otaku* are much more willing to self-proclaim what they are.

　　Moreover, being *otaku* is a far more active lifestyle amongst Japanese citizens than being

hikikomori, in that one can be a casual *otaku* but not so much a casual *hikikomori,* especially

considering the general criteria for being *hikikomori* includes being socially isolated for a period

of *at least* six months. *Hikikomori* syndrome is not brought upon by some controllable thing,

such as developing a keen interest in some form of media, a hobby, or a pastime like what

defines *otaku*. Additionally, the severity of *hikikomori* varies by case. For instance, some

hikikomori move quite frequently throughout their homes, while there have been reports of

others who have difficulty making it out of bed for long periods of time; or even the case of a

hikikomori who could not get themselves off of the couch to go to the bathroom. Despite the fact

that the severity of *otaku* cases can range, *otaku* can generally spend however many hours on

their pastimes without being so severely socially isolated. Even for those who are, that feeling of *incapability* to be social that is characteristic of many *hikikomori* is rarely present.

Of course, this does not mean that *otaku* cannot experience similar feelings at all; only that becoming an *otaku* is far more of a choice that is capable of being controlled. With a little effort, one is much more likely to pull themselves out of their lifestyle if they are *otaku* than if they are *hikikomori*. Being *hikikomori* normally does not happen by choice, but rather by circumstance. A person cannot as easily push aside their *hikikomori* tendencies like an *otaku* might be able to, because being *hikikomori* is linked to more than being infatuated with popular culture pastimes. Therefore, *hikikomori* is not synonymous with *otaku* because the existence of the *hikikomori* phenomenon does not depend on the existence of any type of hobby. This is similar to the way *hikikomori* is also not synonymous with NEET, because the existence of *hikikomori* does not primarily lie in the fact that someone is not working, in school, or outside of employment. There is a much more deeply rooted struggle living inside of the *hikikomori* population, and to classify it as either *otaku* or NEET would be simplifying it to a fault.

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[Segment Figures 1.1-1.7]
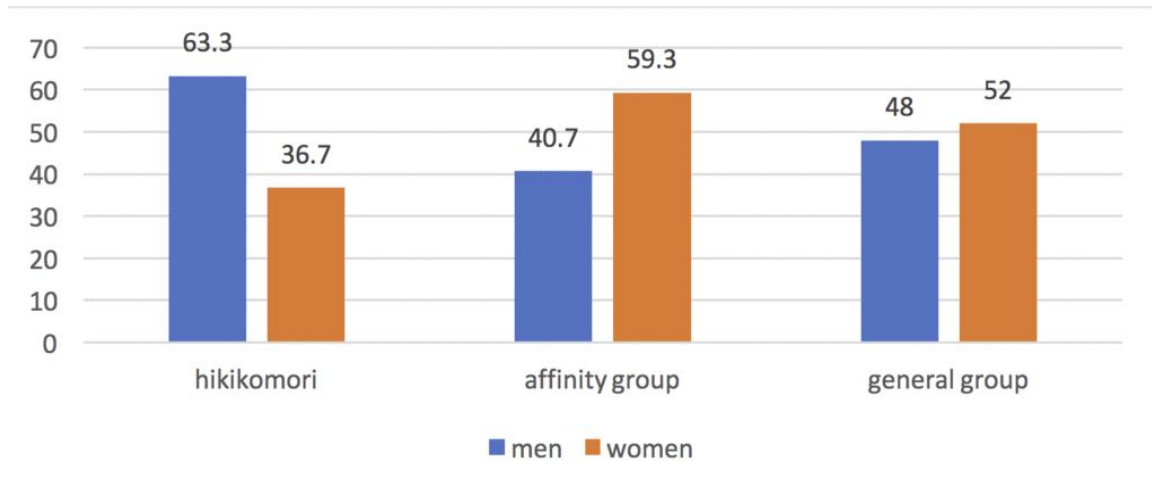
Figure 1.1. Gender. This figure shows the gender of hikikomori, the hikikomori affinity group/pre-hikikomori, and the general Japanese population in percentages (Japanese Cabinet Office, 2016; Tajan, Yukiko & Pionnié-Dax, 2017).
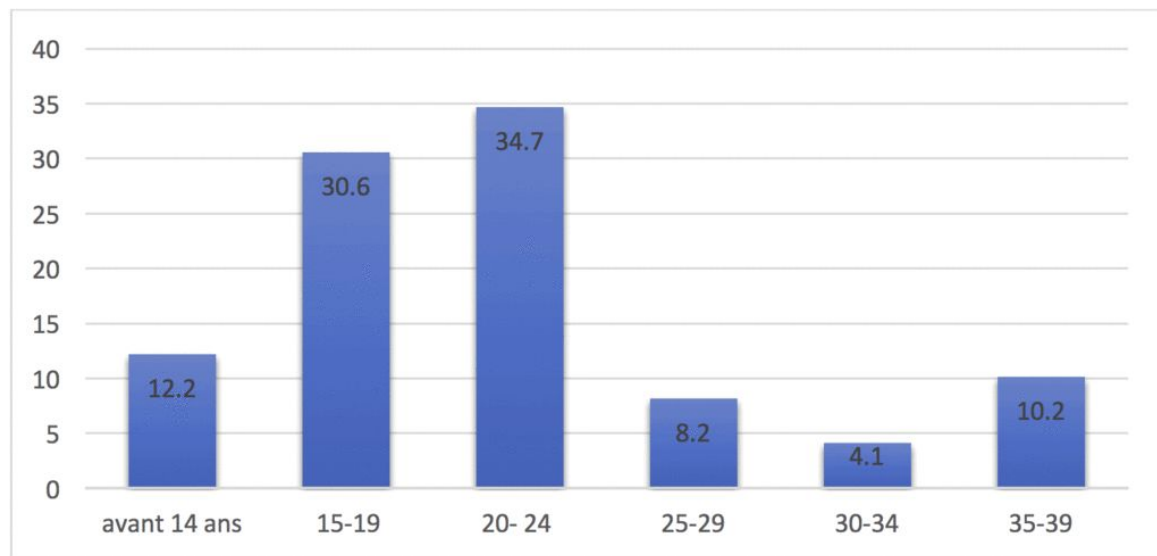
Figure 1.2. Age of Hikikomori Onset. This figure shows the age of hikikomori onset in percentages. (Japanese Cabinet Office, 2016; Tajan, Yukiko & Pionnié-Dax, 2017).
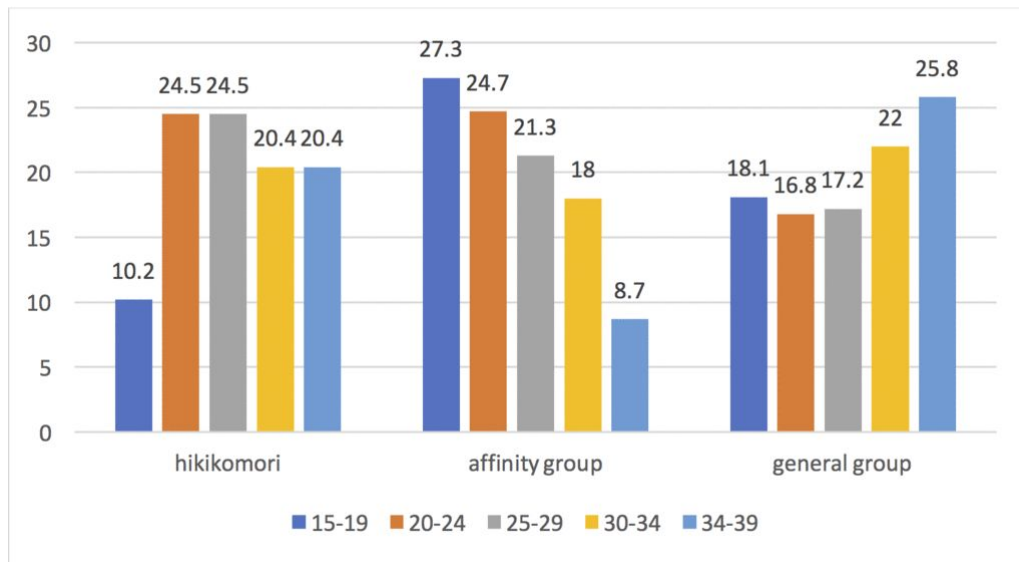
Figure 1.3. Hikikomori Age Range. This figure shows the age groups of hikikomori in percentages (Japanese Cabinet Office, 2016; Tajan, Yukiko & Pionnié-Dax, 2017).
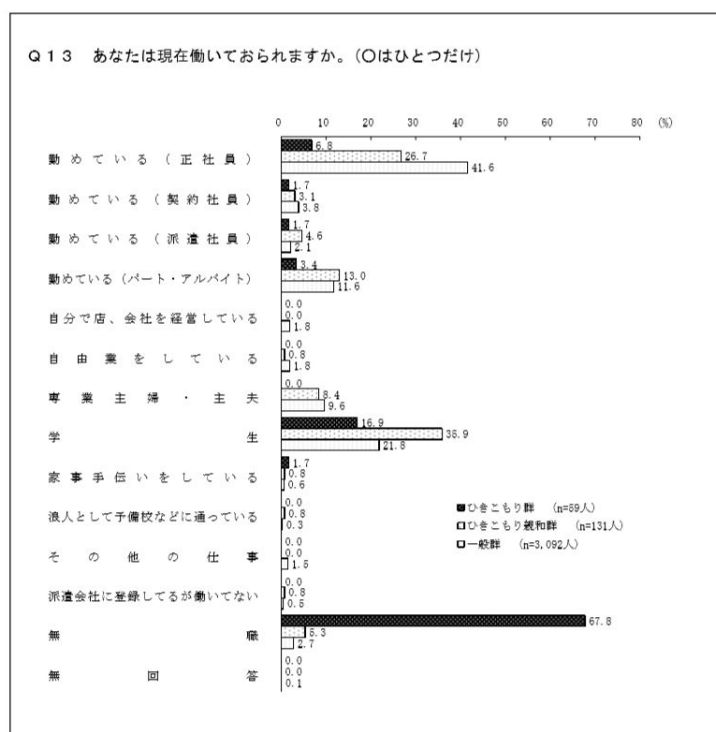
Figure 1.4. "Currently Working." This figure shows the percentages of different occupations of hikikomori (Japanese Cabinet Office, 2010).

Top Bar = Hikikomori (n=59)
Middle Bar: Affinity Group/Pre-Hikikomori (n=131)
Bottom Bar: General Population (n=3,092)

Translation (top to bottom):
-Regular employee
-Contract agreement employee
-Temporary employee
-Part-time job
-Owner of a store or company
-Self-employed
-Housewife/husband
-Student
-Domestic helper
-Failed entrance exams and is in cram school while waiting
-A different job
-Registered with a temporary agency but not working
-Without employment
-No response

Ｑ２３　現在の状態になったきっかけは何ですか。（〇はいくつでも）

職場になじめなかった	23.7
病気	23.7
就職活動がうまくいかなかった	20.3
不登校（小学校・中学校・高校）	11.9
人間関係がうまくいかなかった	11.9
大学になじめなかった	6.8
受験に失敗した（高校・大学）	1.7
妊娠した	
その他	25.4
無回答	3.4

■ひきこもり群　（n=59人,M.T.=128.8%）
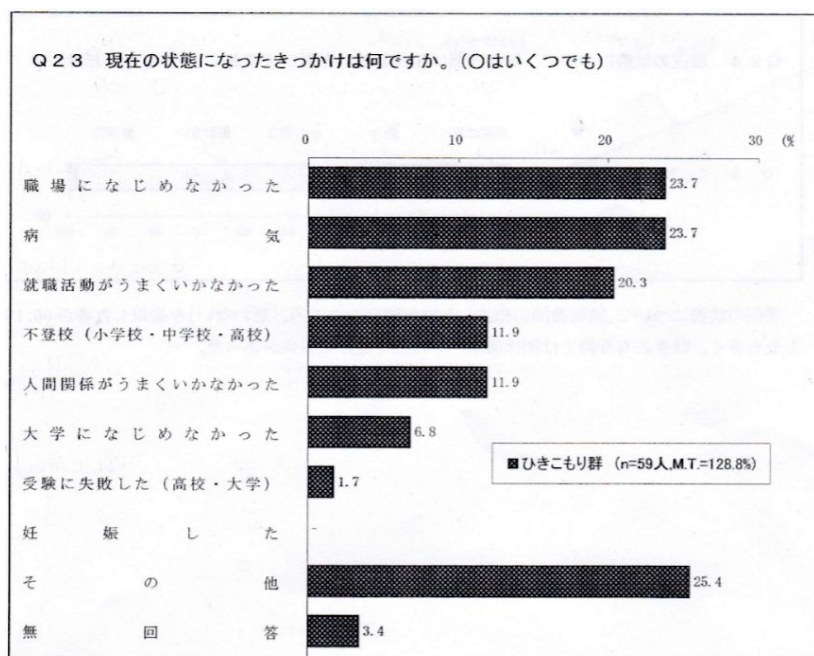
Figure 1.5. "How did you get to the current state?" This figure shows hikikomori responses to how they became hikikomori (Japanese Cabinet Office, 2010).

Translation (top to bottom):
-Didn't fit in at workplace
-Illness
-Job hunting didn't go well
-School non-attendance; truancy
-Human relationships didn't work
-Didn't fit in at college
-Failed to take an exam
-Pregnancy
-Other
-No Answer
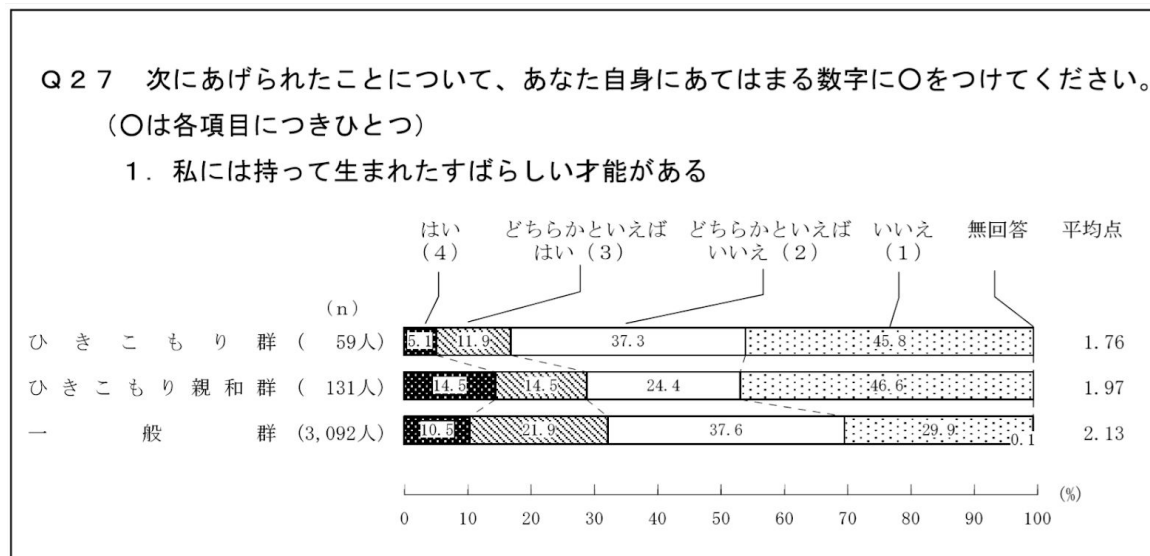
Figure 1.6. "I consider myself to be a great talent." This figure shows hikikomori responses to a question of self-worth (Japanese Cabinet Office, 2010).

Top Bar = Hikikomori (n=59)
Middle Bar: Affinity Group/Pre-Hikikomori (n=131)
Bottom Bar: General Population (n=3,092)

Translation: 1. I consider myself to be a great talent.

Response options from left to right: 'Yes'; 'If I had to choose, yes'; 'If I had to choose, no'; 'No'; 'No response'
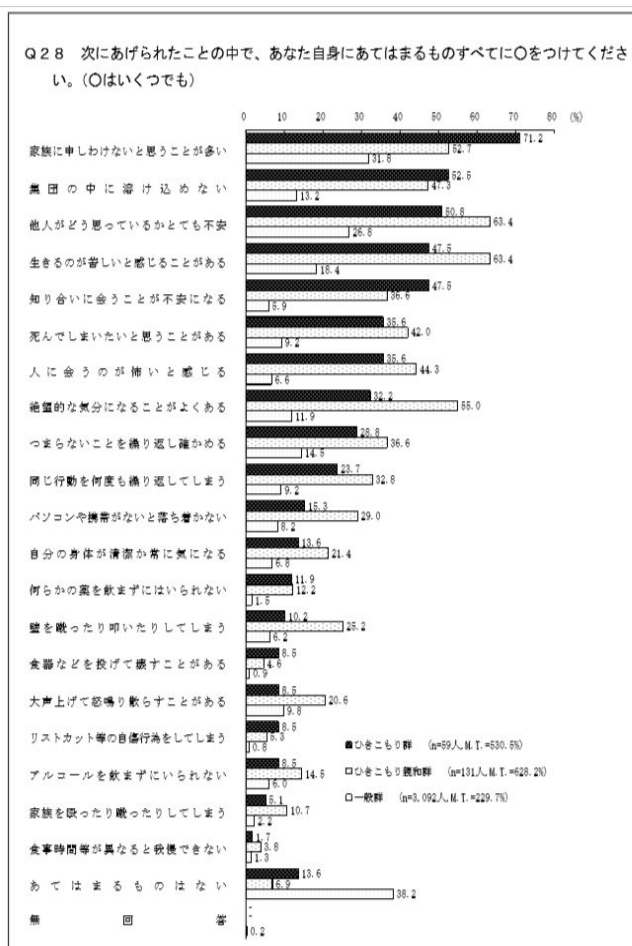
Figure 1.7. "Applying Anxiety Factors." This figure shows the types of anxieties or experiences that hikikomori report having (Japanese Cabinet Office, 2010).

Top Bar = Hikikomori (n=59)
Middle Bar: Affinity Group/Pre-Hikikomori (n=131)
Bottom Bar: General Population (n=3,092)

Translation (top to bottom):
-I often think I can't help my family.
-I don't fit into groups.
-I have anxiety around other people.
-I live with difficult feelings.
-I become anxious about meeting acquaintances.
-Sometimes I want to die.
-Meeting people makes me feel dread.
-I normally have a dreadful feeling.
-I often experience boredom.
-I repeat the same kinds of actions.
-I can't settle without a PC or mobile phone.
-I always care if my body is clean.

-I can't stop myself from taking medicine.
-I have regretfully kicked/hit a wall.
-I have thrown/demolished tableware.
-I have raised my voice and ranted.
-I have cut my wrists or engaged in self-mutilation.
-I can't stop myself from drinking alcohol.
-I have regretfully kicked or struck my parents.
-I can't stand it if mealtimes are different.
-Nothing Applicable.
-No Answer.

Part 2: *Hikikomori* & Psychiatry in Japan

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the most relevant and widely-used tool for analyzing, diagnosing and treating psychological disorders in the United States. While the most recent installation of the DSM, the DSM-5, was published in 2013, the official translated Japanese version was released a year later in 2014. Japan utilizes the most recent revision of the International Classification of Diseases (ICD-10) in order to categorize disorders and determine treatment; although, the DSM has become prominent in research and educational settings in Japan since the release of the DSM-3 (Kuroki, Isitobi, Kamio, Sugihara, Murai, Motomura, Ogasawara, Kimura, Aleksic, Ozaki, Nakao, Yamada, Yoshiuchi, Kiriike, Ishikawa, Kubo, Matsunaga, Miyata, Asada, & Kanba, 2016). Now, both the ICD and the DSM are referred to for nearly all clinical research in Japan (Kuroki et al., 2016).

The DSM has included other culture-bound syndromes in the past. While *hikikomori* is not currently included as a diagnosable disorder in the DSM-5 — nor has it been listed in any version of the DSM prior as a diagnostic category (Saito, 1998/2013) — some researchers have come out with guidelines for the syndrome to help identify it. Among them, the Japanese Ministry of Health, Labor and Welfare came out with their own description of *hikikomori*, including points such as: a home-centered lifestyle, no interest or willingness to attend school or work, persistence beyond six months, other mental disorders excluded, those who maintain personal relationships excluded (Teo, 2010). Similar to diagnostic criteria in the DSM, this also serves to classify *hikikomori* into its own category. Teo and Gaw (2010) have proposed potential diagnostic criteria for *hikikomori* syndrome (Figure 2.1) to be used in a future version of the DSM, as have some other researchers. Most of those who analyze *hikikomori* have slightly

differing ideas about the factors that determine if a person has it or not, and that is not the only thing researchers conflict over.

There is conflict concerning whether or not *hikikomori* should belong in the DSM as a diagnosable disorder at all. There has been speculation over the possible triggers of *hikikomori* syndrome, including dysfunctional familial relations and clinically diagnosable disorders such as depression (Furlong, 2008). There are many who think it possible that a large majority of the cases that surface for *hikikomori* are classifiable as an existing DSM psychiatric disorder (Teo and Gaw, 2010). Then there are others who think it important to question if *hikikomori* is really a mental disorder by considering subgroups like primary *hikikomori* (*hikikomori* without a mental disorder) and secondary *hikikomori* (*hikikomori* with a mental disorder) (Tajan, 2015). With this, certain propositions can be made for psychiatrists to consider. Such as: *hikikomori* individuals always have an existing mental disorder available in the DSM-5; some portion of the *hikikomori* population possesses an existing mental disorder, while the rest do not (primary vs secondary *hikikomori*); or a portion of the *hikikomori* population have an existing mental disorder while the rest suffers from a new pathology — enter: culture-bound syndromes (Tajan, 2015).

This type of socially-withdrawn behavior is nothing particularly new in postmodern Japanese society. The first documentation of it in Japan can be traced back to the 1970s when withdrawal neurosis — termed *taikyaku shinkeishou* — first came to light in cases described by researcher Yoshimi Kasahara (Teo, 2010). Soon, that term fell out of style, and a new one emerged during the 80s to describe the increasing phenomenon of young people refusing to attend school and/or dropping out of school; coined "school refusal syndrome" or *futoukou* (Teo, 2010). By the 1990s, the term *hikikomori* began appearing in various forms of psychiatric

literature to describe children retreating to their rooms. It has since then stuck and has been used consistently to translate to social withdrawal syndrome (Teo, 2010).

Rather than to say that *hikikomori* avoid all social interaction with others, it is more accurate to say that there is a certain avoidance of communication. Current and former *hikikomori* have expressed a discomfort with the act of communicating with other people and find it preferable to simply avoid doing it altogether if they can (Asian Boss, 2017). Another common misconception can be that *hikikomori* stay in their homes at all times, never to be seen by the outside world again. While it is accurate to say that many do spend a large portion of their time indoors, there are others who venture outside — on a regular basis, even (Furlong, 2008). Granted, this might be during the evening or early in the morning when the chances of running into a classmate or colleague is slimmer, but making regular trips outdoors is certainly not unheard of for all *hikikomori* (Furlong, 2008).

There are very many things to consider, and to be able to thoroughly examine *hikikomori,* we must attempt to understand on a deeper level just what it is that separates it from classifiable mental disorders and why *hikikomori* is not marked as one of them. For all intents and purposes, it appears as though it should be. *Hikikomori* reasonably fits into the category, but one could argue that because there is still much to be learned about *hikikomori*, it remains as a bit of an enigma to the psychiatric world. Even so, there are disorders that exist within the DSM-V that do not have much written about them at all. Sometimes they are mentioned in accordance with another disorder rather than having their own individual sections; yet they still, at the very least, get mentioned. Therefore, a lack of research on *hikikomori* does not seem enough to rule it out of

consideration completely. My best guess is that there is a lack of applicable diagnosable criteria to go by for *hikikomori.*

Although, even assigning criteria to *hikikomori* could have its setbacks. The most widely-accepted description of *hikikomori* syndrome is the general definition popularized by Saito (1998/2013). Saito's definition could potentially act as criteria, but realistically only about three criteria: remain in the home (or other place of recluse) for a period of six months or longer; be outside of work/school/employment; and have no intimate relationships outside of immediate family. The problem with having such a small number of "criteria" is that it would indicate that every case (or at least the vast majority of cases) could fall under them. The majority of disorders available in the DSM-V have longer lists with only a certain number needing to be met in order for a person to be classified as having it. For *hikikomori*, people would need to meet all three of those points. Having so little to go off of in terms of diagnostic criteria would put a significant amount of weight on those three. It would be a mistake to lump all *hikikomori* cases under them, as broad and varied as *hikikomori* cases are now. In addition to this, even the existing definition for *hikikomori* is somewhat vague. It does not mention the length of time for which someone is not employed or attending school, or if a person can be *hikikomori* and do one of those things at some point within their period of isolation. It also does not mention exceptions to the rule of having social relationships, as some *hikikomori* may have connections with those outside of their families; nor does it account for the possibility of things like virtual connections. It does not allow for the possibility of there being someone who has only been confined to their home for a period of, say, five months instead of six, but still displays all the other traits of a *hikikomori.* There are also *hikikomori* who leave their homes at certain points, as well as *hikikomori* who live

alone as well as with family. There are *hikikomori* who have preexisting mental illness and those who do not. In sum, the three part definition really leaves no room for exceptions outside of those points and is therefore not entirely inclusive of the broad range of *hikikomori* cases that exist. The existing definition does not capture the true complexities of what *hikikomori* syndrome is.

That being said, there are so many factors at play when it comes to *hikikomori* that it becomes difficult to compress them into a list of criteria that is overall representative in the same way as with disorders in the DSM-V. Take PTSD (Post-Traumatic Stress Disorder) as an example. If someone is suspected to be suffering from PTSD, the official criteria gets referenced. One of the defining criteria for this disorder is that someone has undergone a traumatic experience. The majority of PTSD patients meet this criteria, and it is almost guaranteed that someone cannot have PTSD without this kind of experience. Then, the person must meet at least a certain number of other related criteria. In the end, those who are diagnosed with PTSD have met criteria that is characteristic of the disorder, and most cases are all nearly the same in terms of basic diagnosis. DSM-V-official mental disorders have a blueprint. Perhaps *hikikomori* is not marked as one because it does not. Unlike something like PTSD, where all cases closely mimic one another, *hikikomori* cases are more dissimilar and vague. They look different and can be brought upon by different things. For instance, it is fascinating that there seems to not be a single personality trait that manifests itself into every single case (Saito, 1998/2013). The severity also varies across cases (although, this is also the case with many DSM-V mental illnesses). *Hikikomori* could benefit from having better, more extensive and clear criteria that does its best

to encompass what the phenomenon is as a whole. Yet, this still does not mean that the solution is for *hikikomori* to be officially classified as a mental disorder.

The Problem with Labeling Hikikomori as a Mental Disorder

Having set diagnostic criteria for *hikikomori* could further a deeper, broader understanding of what *hikikomori* is; however, labeling *hikikomori* as a mental disorder may be just as damaging as it being underrepresented as a serious health issue is. A mental illness is officially defined by the American Psychiatric Association as health conditions that involve changes in emotion, thinking or behavior (or any combination of these). They are also associated with distress and/or problems functioning in social, work or family activities (American Psychiatric Association, 2020). By definition of what a mental disorder is, *hikikomori* has all the makings for one. It affects people's ability to participate in life the way they may want to, it can be distressing, and it certainly affects emotion and behavior; however, *hikikomori* is a special case that is characterized by a specific series of symptoms that do not easily fit under any identifiable medical cause (Angles/Saito, 1998/2013). Marking it as a specific disorder with specific criteria would risk these widely varied cases being incorrectly dealt with. *Hikikomori* needs to be better understood, and more clearly mapped out as to what its factors and inner workings are, but approaching it from the viewpoint of a mental disorder puts it in a position of being approached from the wrong angle.

Saito justifies *hikikomori* as being distinct from mental illnesses by saying the latter is an issue with the inner workings of the brain, but the former is an issue of the mind (1998/2013). To label it as a mental illness would essentially be classifying withdrawal itself as a disorder.

Hikikomori syndrome is not a psychological symptom and cannot be compared to something like clinical depression, for example, even though depression is quite a common symptom for those dealing with withdrawal (Saito, 1998/2013). It is quite easy for *hikikomori* to fall into depressive states, but clinical cases of depression are rarely present in them (Saito, 1998/2013). If *hikikomori* syndrome gets treated as something it is not, the core issue is not truly being helped. A big difference in clinical depression versus the type of depression *hikikomori* face, for instance, is that clinically depressed patients often have the sense that nothing has meaning, while *hikikomori* are more internally conflicted, thinking that they could have a new start if they could get back onto their feet (Saito, 1998/2013). Unfortunately, they also rarely feel they have the time or space to do these things, and what should be a hopeful mindset morphs into irritation and despair (Saito, 1998/2013) *Hikikomori* syndrome can look like many things and therefore can get confused for them, even by professionals. Psychiatrists take their best educated guesses based on the symptoms that they are presented with, but the diagnosis they give could end up being more applicable to a separate issue entirely. Saito even mentioned that many of the fellow psychiatrists he spoke to about *hikikomori* syndrome had themselves never encountered a patient needing to be treated for it or acute withdrawal (1998/2013).

Additionally, Avoidant Personality Disorder — marked by nervousness, fear of being judged by others, and low self-esteem — has been found to be the most prevalent personality disorder in Japan (Teo, 2010), in comparison to the United States. Here, Obsessive Compulsive Personality Disorders are among the most prevalent, standing at 7.9% of community samples, while Avoidant Personality Disorder stands at 2.4% (Sansone and Sansone, 2011) (Figure 2.2). AvPD has been used by clinicians as the diagnosis for social withdrawal in the past (Saito,

1998/2013), and this is not necessarily wrong. Much of the criteria for it applies to *hikikomori*.

Preoccupation with being criticized or rejected in social situations; viewing the self as inept,

unappealing or inferior to others; and reluctance to take personal risks for fear of embarrassment

all apply in many cases of withdrawal (Saito, 1998/2013). But again, determining that all cases

of *hikikomori* syndrome are cases of a personality disorder could also not be accurate. There are

suspected to be millions of Japanese cases, yet they are tough to pin down because so many

hikikomori are silent about it. Even the cases that are available for study are so varied it can be

difficult to discover common enough characteristics that would strengthen its viability enough to

become a set diagnosable disorder. And in the end, classifying *hikikomori* syndrome as a

disorder may grant it more recognition than it currently has; however, if most people still refuse

to seek treatment, the numbers will just continue to grow. Saying it is a mental disorder is just

assigning it a label.

Reception/Stigma of Hikikomori and Mental Disorders in Japan

In Japan, there is much stigma surrounding *hikikomori*. In general, a lot of it is accredited

to the Japanese media and its representation of *hikikomori*. In the past, there have been reports of

serious acts of violence committed by people who were categorized as being withdrawn from

society. There was a case about a *hikikomori* who stayed with his parents but who grew

increasingly aggressive and ended up beating them to death with a baseball bat. There have been

multiple reported instances of those who are *hikikomori* or who possess *hikikomori*-like traits

engaging in similar acts of violence, including the 2000 discovery of a thirty-seven year old

hikikomori male who kept a girl -- age nineteen when she was found -- captive in his room for

over nine years (Saito, 1998/2013). There was another incident of a seventeen year old with a

history of withdrawal who hijacked a bus in Saga Prefecture, Japan (Saito, 1998/2013.)

Aggression can be a real trait amongst social recluses, and incidents such as these being known

to the public only serve to further paint *hikikomori* in a negative light. After occurrences like the

ones above, people began talking about *hikikomori* like they were dangerous criminals, which is

a shame as very rarely do *hikikomori* possess violent tendencies (see again Figure 1.7). What

makes this even worse is that these negative instances -- what people see represented in news and

TV shows and literature -- are what many come to associate *hikikomori* to be like.

For a large number of people, what is presented to them through the media is likely all

that they know about the syndrome. *Hikikomori* is already severely underrepresented, and now it

also runs the risk of being misrepresented. A real life *hikikomori* wrote a blog post about their

thoughts on *Welcome to the NHK,* a Japanese *anime* that focuses on the life of Tatsuhiro Satou, a

22-year old *hikikomori* who feels as though life is a conspiracy created by the NHK. A bit of this

person's thoughts are below:

> Even if the subject matter is withdrawal, fiction is still just fiction. When you are a real,
>
> unemployed *hikikomori,* that world (of *Welcome to the NHK*) is just a shining paradise. In
>
> reality, there is no beautiful girl who will try to help you, no kind and understanding
>
> parents, and no senior (*senpai*) that you can rely on. When you become unemployed,
>
> from that point on your old friendships fade away. You are separated from society, and it
>
> becomes very lonely. [...] If you can't appropriately communicate with different people in
>
> a variety of environments, things won't work out. [...] Since the author experienced
>
> withdrawal, it is better than the usual stereotype of *hikikomori* that often comes out.

Nevertheless, it is a two-dimensional story no matter how you spin it. The sense of unemployed *hikikomori's* despair seems to be fading. (Real *Hikikomori* Watches Welcome to the NHK, 2017)

The author of the blog also mentioned the show had a lot of common reviews from viewers that usually stated things like, "Try to avoid becoming like this," "Because the main character is a good-for-nothing, I was sympathetic," and "A masterful depiction of realistic withdrawal." It is clear that shows like this can be good for entertainment but do not do a great job at lessening negative opinion and stigma towards socially-withdrawn individuals. It is not as though it is the show creator's obligation to make the subject matter informative; however, the media's stylized depictions do not afford many favors to the very real problems they are depicting. It can fool people into believing this is what the phenomenon is really like -- real and weird but not actually that distressing to the individual. The images that are put into the minds of others that this syndrome is something alien and odd, something to be turned into a joke and laughed at, is not a positive one at all. Like the author of the blog post said, it takes away from the distress that *hikikomori* causes, the seriousness of which gets lost underneath the comedy and wacky story. Very many people do not know or truly understand what *hikikomori* is, nor do they take it upon themselves to further self-educate once they do hear about it. An episode of *Welcome to the NHK,* a news segment on *hikikomori,* or an isolated incident of violence committed by someone withdrawn from society might be the only information that much of the public gains on the overall topic of the syndrome, and many people may think that any one or all of those things tell them exactly what they need to know.

Granted, in recent years, *hikikomori* is slowly but surely getting a different kind of recognition in Japan. There are those coming forward to raise awareness of the syndrome and provide more accurate portrayals of what it really is and how it is affecting people. The NHK is a real national broadcasting organization in Japan, and it covers relevant news and stories about the country. It has also done stories on *hikikomori* syndrome, informing people about what it is and keeping an updated status on it within Japan. In 2003, it started a year long *Hikikomori Support Campaign*, creating a webpage to provide support and networking special programs about the syndrome (Saito, 1998/2013). Organizations such as this provide reliably researched information on a topic to help spread news about it in a positive way. Back in 2009, the Japanese Ministry of Health, Labor, and Welfare formed a plan to help support *hikikomori* at a local level, setting up systems in each prefecture and certain cities and dedicating resources to problems of withdrawal as a first line of defense (Saito, 1998/2013). It published the results of a survey in 2001 in the preliminary version of *Guidelines of Activities to Preserve Psychological Help at the Local Level, Especially in Regards to Social Withdrawal Among People in Their Teens and Twenties*, distributing their findings to psychology and healing centers throughout the country (Saito, 1998/2013). The Ministry also started an outreach-style program in 2011 that centered on going into the households of *hikikomori* (Saito, 1998/2013). Today, there are various counseling services and independent programs dedicated to helping *hikikomori* victims. The cultural research organization *Asian Boss* has done a few video segments on *hikikomori* and social withdrawal. They even covered a story on their popular Youtube channel about Yoshida Masashi, a man who is running a rehab center for *hikikomori*. He facilitates activities designed to

put people to work and keep them busy, as well as provide group therapy sessions and designated meal times.

Despite these steps in a progressive direction, the stigmatized view of *hikikomori* remains, and I believe it to be a branch of the stigmatized view of mental health and mental illness in Japan overall. More so than their American counterparts, the Japanese population may generally be more prone to social distancing from those with mental illnesses, based on responses to a survey that compared Japanese and American citizens' views on those with schizophrenia (Richards, 2014). This could be explained by other things, of course. For one, there is said to be a greater social distance amongst Japanese citizens than United States citizens in general. For another, long-term hospitalized care is far more normalized in Japan, with hospital stays lasting for up to three times longer than other countries (Henke, Kadonaga & Kanzler, 2009). It is probable that more negative attitudes toward mental illness in Japan could spawn from the Japanese having less contact with those who classify as mentally ill (Richards, 2014). Research has shown that stigma surrounding mental illness decreases upon more contact with individuals with mental illness (Richards, 2014). Much of the Japanese population might be missing this exposure compared to other countries, whether because of the tendency for social distancing, the country's marked lengthy institutionalization, or something else.

Even if *hikikomori* syndrome is not officially regarded as a mental illness within the country, it is the idea of this abnormal behavior and how it affects people that makes it unappealing to the general population. Because of this, if citizens of Japan are suffering from something that falls into the category of being mentally deviant -- whether that be *hikikomori* syndrome or something different -- many people will opt not to seek out psychiatric help for fear

of exposing themselves or of word getting around. Even having a confidential figure like a psychiatrist know might evoke a sense of shame in a person. The majority of *hikikomori* claim that they do not wish to seek counseling from any professional organizations (66.1%) (Figure 2.3), preferring not to speak to anyone about the difficult things they are going through. This suggests that *hikikomori* are more likely to attempt to deal with stress alone than go to counseling or therapy, and that most *hikikomori* will not ever go at all.

Japanese Hikikomori & International Equivalents

Another point that should be addressed is why many view *hikikomori* to be a syndrome culturally bound to Japan. The truth is *hikikomori* syndrome is not unique to Japan. While the term may have originally been coined by the Japanese, there are several countries around the world that have a number of citizens who are no strangers to social withdrawal. There are documented cases of the syndrome encountered in South Korea, Hong Kong, Australia, the United States, Spain, Italy, the Oman Kingdom, France (Tajan, 2015; Teo, 2010), and likely many more. Italy, for example, has started treating withdrawal as a social issue; and according to Korean psychiatrists, there were about 300,000 cases in South Korea in 2013 (Saito, 1998/2013), and that number is likely even larger these days. With that in mind, in the context of this study, there has to be a reason that supports the decision to focus solely on examining *hikikomori* in Japan rather than *hikikomori* as a general world phenomenon. There is no basis for studying a phenomenon if there is no logical reason to believe that a certain population is unique in its receival of it (Heine and Norenzayan, 2006). There has to be a reason to believe that a given population would perform differently and yield noticeably significant results should it be tested.

So, if it is the case that *hikikomori* is not a phenomenon found strictly in Japan, what is the purpose of observing it in the context of the Japanese?

The way in which a social phenomenon such as *hikikomori* is going to be received across various populations is dependent on that society and a number of factors that are unique to it. For example: what that place values in terms of its citizens, how prominent of an issue it is there, how many people are affected by it, what is accepted as the cultural and behavioral norm, and more. It is also of great relevance to know of a nation's existing social issues to understand why the phenomenon might be affecting it in such a specific way. *Hikikomori* is a syndrome that negatively impacts youth populations across the globe in many similar ways; however, being a separate country with a separate history with separate social values (just as all individual countries are), Japan's unique societal and socioeconomic conditions make it an interesting population to explore under the lens of this particular issue. Consider the Fukushima disaster that took place in Japan in 2011. Already-existing negative moods, mental disorders and/or anxieties have previously been mentioned as strong potential candidates for a person to become *hikikomori,* and while this holds true in any population, the events that transpire in Japan will impact its citizens in a different way than anyone else. A former Japanese *hikikomori* was interviewed in a video for *Asian Boss,* a company that focuses on exploring news, cultural trends, and social issues across Asia. The person was asked about how they became *hikikomori* and expressed that, in the aftermath of the events of the 2011 Fukushima earthquake, tsunami and nuclear disaster, they began to feel depressed. All of the negative news coverage that was constantly being broadcasted on television channels began getting to them, and their resulting unmotivated state caused them to withdraw into their home, spending days sleeping and playing

video games and not much else (Asian Boss, 2017). Others have linked their reasons for being

hikikomori to past experiences of bullying (Teo, 2010). Bullying is a prominent problem in

Japan, and many *hikikomori* admit being shunned by social circles, taunted, and even physically

abused in school settings (Teo, 2010). There is a theory that bullying in Japan leads to *futoukou*

— school refusal — in young people. In terms of current social issues unique to Japan, declining

birth and marriage rates and precarious work are also contributing factors, and they will be

discussed in a later section. *Hikikomori* can be studied in any country and be a completely

different study every time. Even if the issues and events themselves are not exceptional, the

consequences vary depending on where they happen. Japan's particular brand of *hikikomori* is

simply a product of specific environmental factors. It is how the Japanese culture treats a

withdrawn person and handles the situation that is likely a reason for withdrawn individuals in

Japan progressing in certain, distinctive directions (Saito, 1998/2013).

Culture-bound Syndromes and Cultural Contexts

As a final note, I want to speak briefly about the concept of culture-bound syndromes.

Hikikomori is often termed a "culture-bound" syndrome, and that title may have played a role in

why *hikikomori* is still widely considered to be an affliction specific to the Japanese.

Culture-bound syndromes are outlined in the DSM-V and in the ICD-10 (Paniagua, 2018), which

are good actions to take because extending knowledge of these syndromes to Western

psychiatrists can help them to consider the large role culture plays in the manifestation of mental

disorders (Üstün and Ho, 2017). Mainly these sections showcase syndromes that are deeply

embedded in cultural contexts not common in the West, such as traits like magic, voodoo, curses,

etc; but also history, society and traditions. Some psychological processes utilized in the West might not generalize well to the rest of the world (Heine and Norenzayan, 2006), which is why psychiatrists who are unfamiliar with how a culture explains these traits can misconstrue the severity of symptoms that sound like they are tied to certain disorders and end up giving improper diagnosis (Paniagua, 2018). The DSM does alert psychiatrists to consider the possible impact cultural syndromes can have on diagnosis (Paniagua, 2018). Even so, many of the studies published in North America that focus on different cultures often utilize a research team composed of Westerners — most of whom will have grown up with completely different cultural mindsets than someone coming from another place likely has (Heine and Norenzayan, 2006). Because of this, there is always the potential to conduct biased research, even if researchers are mindful of other cultures. The most influential manuals on psychiatric disorders are products of Western culture, which presents the question of why the disorders that appear in manuals like the DSM -- identified and coded in the West -- are considered the "main" disorders and not culture-bound themselves (Yamada and Marsella, 2013). This could be because it is known as fact that mental illnesses like schizophrenia and anxiety disorder exist in many places outside of the West, and so most DSM-classified disorders cannot be culture-bound. If that is the case, by now the same thing can be said for *hikikomori*. I think referring to *hikikomori* as a culture-bound syndrome should be done away with, considering it is clear that it is not bound to any specific culture -- not to Japan and not even to Asia.

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[Segment Figures 2.1-2.3]

Figure 2.1. Proposed Diagnostic Criteria for Hikikomori Syndrome. This figure shows proposed diagnostic criteria for hikikomori syndrome, put forth by Teo and Graw (Teo and Gaw, 2010).

Figure 2.2. Prevalence of Personality Disorders in U.S. Community Samples. This figure shows the results of a community sample about the most prevalent personality disorders in the United States (Sansone and Sansone, 2011).
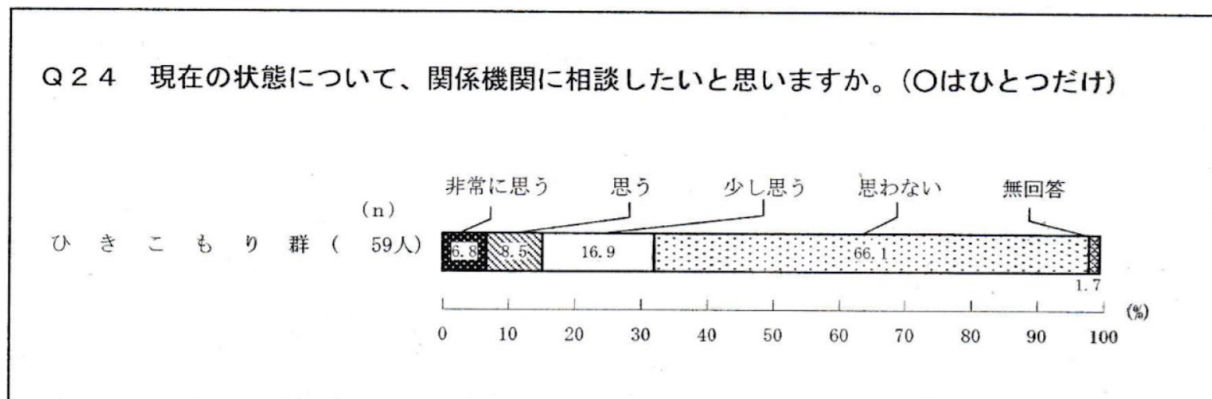
Figure 2.3. "I would like to consult with related organizations about the current situation." This figure shows hikikomori preference for seeking professional help (Japanese Cabinet Office, 2010).

Response options from left to right: 'I very much do'; 'I do'; 'I kind of do'; 'I don't'; 'No Response'

Part 3: Family & the *Hikikomori* Issue

What Family Means in Japan

Family life in Japan is influenced by what is known as the "ie" system. The word *ie* in Japanese translates to house in English, and the "ie" system is a model for a Japanese household that is considerably more traditional and reminiscent of ideals from Confucian culture. Long ago, the "blueprint" for this kind of family looked like the eldest son bringing home a wife to live together with his parents until the two of them began having kids of their own and subsequently moved out. Once the father passed, the son (essentially the "heir") would inherit a large portion of the family's property and proceed to take over the position as the head of the family (Tsuya and Bumpass, 2004). This type of familial structure put a large emphasis on marriage and childbearing and the continuation of lineage. So much so that issues like divorce were not left to individual men and women alone but to the head of household (the family heir). Of course, these days, this sort of strict familial structure has either been greatly altered or is nonexistent (Tsuya and Bumpass, 2004), but remnants of its influence still remain. For instance, Japan still has certain hierarchical systems in place, many of which inherently see the husband as the head of household -- for which he often feels like he has to provide. There are more obligations to the family in Japan compared to somewhere like America, where egalitarian values and an individualistic cultural mindset reign supreme. This makes Japanese families comparably closer and more interconnected with things like decision-making, which are more likely to involve the entire family rather than an individual.

A big sense of feeling accomplished for Western kids comes from leaving the house. For Japanese kids, it is staying with family (Saito, 1998/2013). In contrast to the characteristics of the

"ie" system, America's familial structure was built from a culture where establishing a degree of independence for the self and acquiring an independent household are seen as positives. In the U.S., family is often not viewed as an "enduring entity" but rather a structure for individual family members (Tsuya and Bumpass, 2004). This does not mean that keeping ties within the family household is all it takes to evoke this sense of accomplishment in the Japanese. If that was the case, then many *hikikomori* who stay with family would feel quite the opposite of how they normally do on a day-to-day basis -- like they are incapable of accomplishing much at all (see again Figure 1.7). No, a sense of accomplishment goes beyond simply staying at home. It is about children being able to make something of themselves and provide if they do. Providing for the family is overall more important than staying near the family, yet the fact that many Japanese kids do remain near their families even after entering adulthood is potentially another product of cultural history.

As a caveat, I think it necessary to mention that not all Japanese families are structured this way. In fact, today more than ever the "traditional" setup is changing, and many Japanese households do not demonstrate this kind of format. This study is not trying to perpetuate a homogenous wiring of the Japanese culture, nor is it trying to say the same of individualism in the United States. One study by Markus and Kitayama examining independent versus interdependent relationships proposes that, in the case of some cultures, the individual will cease to be the central unit of consciousness (1991). Instead, it makes more sense to say that the *relationship* will serve as the central unit of conscious reflection, due to the strength of the sense of belongingness to a social relation (Markus and Kitayama, 1991). In countries like Japan, where there is a comparative emphasis on social relationships than in countries like the United

States, how people think about themselves and others may ride more on the status of a relationship than the individual as a whole.

Therefore, rather than saying Japan is a strictly collectivist society — homogenous in population as well as in mindset — it is more accurate to say that individualism reveals itself only in specific contexts; and that cultural differences as a whole are mostly evident with the inclusion of certain variables (Heine and Norenzayan, 2006). In fact, the results of a different cross-cultural research study have suggested that cultural differences tend to reveal themselves more through study of people's implicit psychological tendencies and behaviors than through explicit self-reported ratings of cultural values (Heine and Norenzayan, 2006). Despite the general truths we may believe we know about the types of cultures we are a part of, reality is rarely so black and white. However, cultural differences can have important implications for the diagnosis and treatment of psychological disorders, and therefore it can be beneficial to look for and highlight them for the purpose of locating significant variables. This project wants to explore how such differences impact the condition of *hikikomori* syndrome and its geological convergence, with a focus on a unique kind of family relationship being a potential source influencer of not only *hikikomori* prominence but also its persistence and severity.

Influence of Family on Hikikomori

There is a possibility that certain family relationships cultivate a reclusive lifestyle. Although there is no definitive causal factor of *hikikomori* syndrome, I do want to acknowledge that it is, in large part, able to happen because of a very particular kind of family dynamic. The *hikikomori* lifestyle nearly depends on family, and family members' (mostly parents') allowance

to let their children stay around while also doting on them makes withdrawal an easier trap to fall into. Consider the fact that *hikikomori* are recluses inside of a home. The amount of *hikikomori* who are living with parents or other family members outnumbers the amount of *hikikomori* living alone for the simple fact that less of them would be feasibly able to live without any kind of support. Granted, this does depend on the severity of the particular *hikikomori* case. Even so, without support, it would be nearly impossible for a person, who does nothing of much productivity during their days, to sustain accommodations themselves.

However, there are exceptions to everything, and this includes *hikikomori* living and financial support. This is not to say that all *hikikomori* depend on parents or guardians. A small percentage (6.8%) of Japanese *hikikomori* are considered to be the head of their household (Figure 3.1). They have the means to provide income, whether that is by making ends meet through some form of job or employment or receiving livelihood protection through social security benefits, to name a couple possible examples. Be that as it may, it remains clear that the main breadwinners of *hikikomori* households are more often than not the parents -- specifically the fathers (66.1%). Even in general population households (43.3%) and households that harbor pre-*hikikomori* (49.6%) this is the case -- and even if the trend for children to become the breadwinners is higher in these instances. Keep in mind that most Japanese households are composed of nuclear families -- families made up of a set of parents and their children -- and that most households in Japan are not single occupancy (Figure 3.2). It is most common that *hikikomori* receive some level of support from family in one way or another, whether they share the same household with the family members or not.

This implies that there is a certain level of dependency that *hikikomori* have on others -- particularly on those within their families. Now take this and consider the emphasis on closeness of family within the Japanese culture fostering a strong sense of codependency in Japanese children (Saito, 1998/2013). We have talked about potential reasons why Japan has become so associated with *hikikomori* syndrome out of all the countries that also experience acute social withdrawal, and this could be another defining factor. A syndrome that relies heavily on persisting family relationships can thrive more easily in a country that has a larger distribution of these types of households. The structure of the Japanese setup (along with other countries with household and family ideals that follow a similar model, such as South Korea) could be what allows for such a high concentration of *hikikomori* there.

Hikikomori syndrome can be likened to being fixed in an early developmental stage, despite the recluse having the physical age of an adult. The minds of those who are severely socially withdrawn are more akin to an adolescent's (Teo, 2019). This is demonstrated through a heavier reliance on things like food, accommodations, finances, etc. This idea puts forth a potential reason for the drastically different kind of mindset observed in many *hikikomori* and helps explain why most *hikikomori* are so dependent on caretakers. This idea is also consistent with the fact that parents play a potentially very large role in *hikikomori* development and persistence. How caretakers govern a child's home life from a young age may very well help determine whether or not they become victims of withdrawal or withdrawal-like symptoms (which of course is also dependent on other factors like an individual's susceptibility to it). While there are many reasons *hikikomori* think and behave as they do, I think it would be beneficial to observe the problem with family in mind as the common denominator. If there is, in

fact, a correlation between the two, the parents' large role may be what makes them one of the strongest potential countermeasures to *hikikomori.* And if not the parents then a child's household environment by extension.

We have talked about how seeking psychiatric help or even assistance from systems designed to aid those with withdrawal are often routes *hikikomori* prefer to avoid. This general preference to not seek outside help is why the syndrome is sometimes referred to as 'the silent epidemic of suffering.' Even though Japan is putting more and more systems into place to assist those with withdrawal tendencies, the problem will persist if those being affected still refuse to go. This is why I think it is notable that *hikikomori* are the most willing to consult with parents (40.7%) about the things that trouble and distress them, even more than they wish to speak to no one (Figure 3.3). This provides some hope that an effective method of treatment is within reach. If therapy and organizational help feels to *hikikomori* like something too daunting, out of reach, or impersonal, a solution may be hidden within the family. Once one considers how essential Japanese interpersonal relationships within the family are to an individual, not only in their early lives but throughout their adolescent and young adult years, studying the inner workings of family life -- with special attention paid to which ones produce *hikikomori* -- could yield promising information about some of the syndrome's more determinant factors. And as a bonus, as long as any potential treatment or counseling is centered around or involves the family, it might appeal to a larger number of *hikikomori* as something they may want to try. Many people are adolescents when they experience *hikikomori* onset, so they experience this severe withdrawal at a pivotal time in their lives when they are undergoing a lot of developmental changes. This could be around the time when an unbalanced codependence between them and

their caretakers occurs and only persists as they continue to grow up. I suspect it may be helpful to try and reverse this by restoring a sense of independence that many *hikikomori* lose along the way. Therefore, examining the operations of family life and level of interdependence vs autonomy within *hikikomori* households may prove to be beneficial.

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[Segment Figures 3.1-3.3]

Q5 あなたの家の生計を立てているのは主にどなたですか。生計を立てている方が複数いる場合は、もっとも多く家計を負担している人をお答えください。また、主に仕送りで生計を立てている方は、その仕送りを主にしてくれている人をお答えください。（○はひとつだけ）
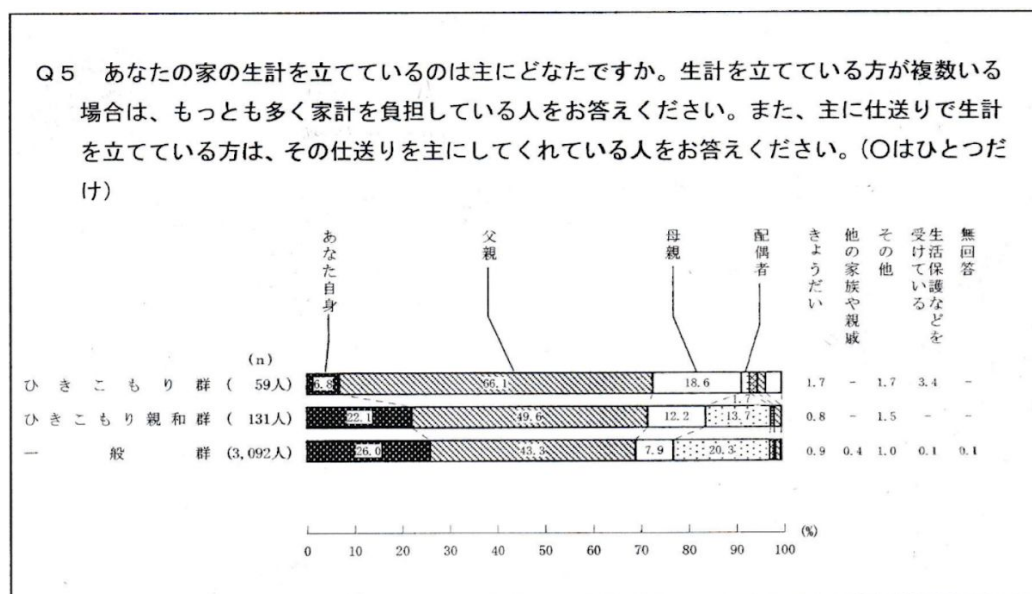
Figure 3.1. "Who is the head of household?" This figure shows the responses of hikikomori concerning who the head of their household is (Japanese Cabinet Office, 2010).

Top Bar: Hikikomori (n=59)
Middle Bar: Affinity Group/Pre-Hikikomori (n=131)
Bottom Bar: General Population (n=3,092)

Response options from left to right: 'Myself'; 'Father'; 'Mother'; 'Spouse'; 'Sibling'; 'A different family member/relative'; 'Other'; 'I receive livelihood protection'; 'No Response'

Changes in Household Composition
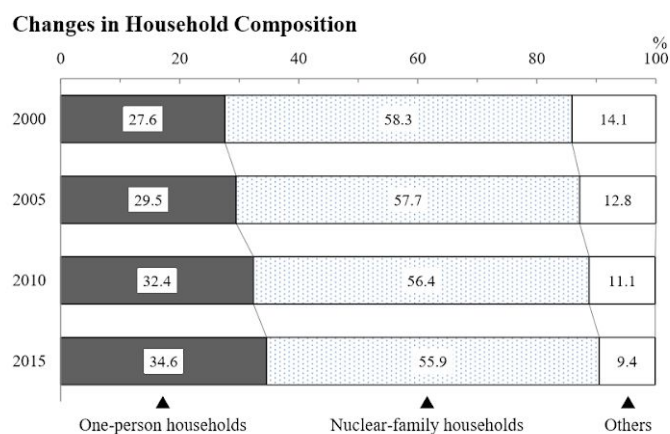
Figure 3.2. Changes in Household Composition in Japan. This figure shows the percentages of one-person households vs nuclear-family households in Japan (Statistics Bureau, MIC, 2019).
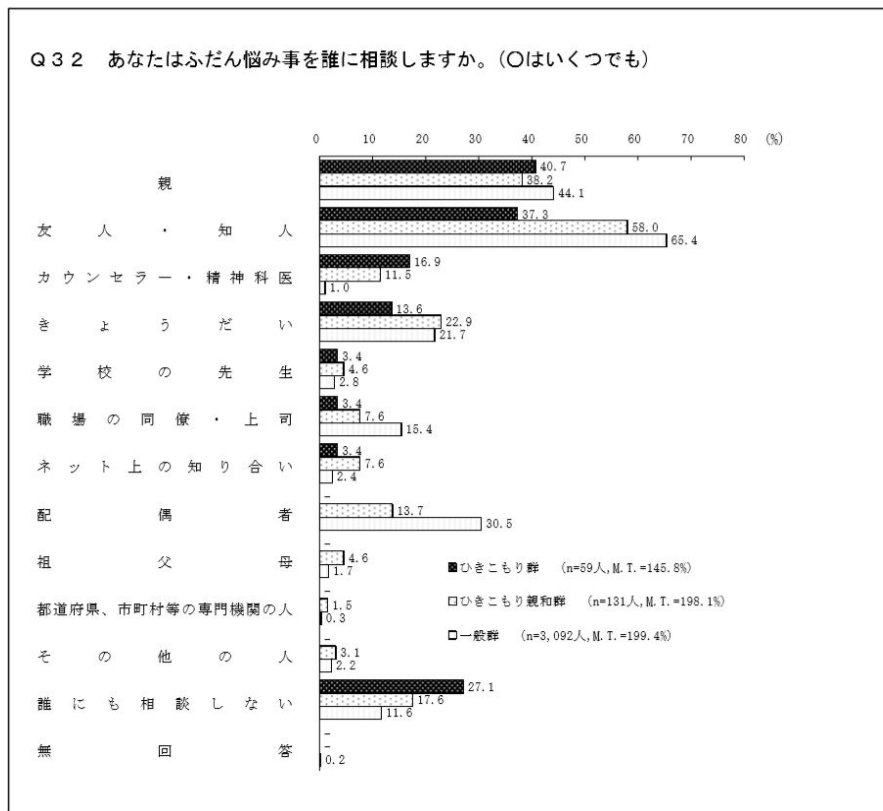
Figure 3.3. "Who do you consult for stressful matters?" This figure shows hikikomori response for who they prefer to consult for stressful matters (Japanese Cabinet Office, 2010).

Top Bar: Hikikomori (n=59)
Middle Bar: Affinity Group/Pre-Hikikomori (n=131)
Bottom Bar: General Population (n=3,092)

Translation (top to bottom):
-Parent
-Friend/Acquaintance
-Counselor/Psychiatrist
-Siblings
-School Teachers
-Workplace Colleague/Boss
-Acquaintances on the internet
-Spouse/Partner
-Grandparents
-Administrative Divisions of Japan; city & town specialty mechanisms
-Others
-Don't consult anyone
-No Answer

Part 4: Consequences of the Economic Bubble Burst in Japan & *Hikikomori* Today

There is a time in Japanese history that is referred to as Japan's "bubble economy." The bubble economy existed from the years 1986-1991, in which an economic price bubble was responsible for inflating the country's stock market and real estate prices. This was a time of thriving business and economic prosperity, only for all of it to abruptly come to an end when the price bubble burst in the early 1990s. With this burst came the end of the bubble economy period and began what has come to be referred to as Japan's Lost Decade — the years following the burst that brought with it a multitude of societal changes that still greatly affect the country today. It was the kickoff of issues such as a declining fertility rate and a subsequent rapidly ageing society; the growth of non-regular employment patterns for both men and women; and the rapidly increasing proportion of men and women who get married later, if they do at all (Aoyama, Dales & Dasgupta, 2016). It also greatly altered the relationship between Japanese baby boomers and the upcoming generation. This was around the time when school refusal, withdrawal, and rebelliousness began to be recognized in Japanese youth.

Young People & Employment

Freeter is a term that was coined in Japan in the 1980s. It combines the words 'freelance' and 'albeiter' (a slang term taken from the Japanese word *arubaito*, meaning 'part-time job') (Inui, 2005). It translates roughly to "permanent part-timer," and it refers to the Japanese youth that desire to live freely (Genda, 2013). This term rose in popularity during the late 1990s following the economic bubble burst, when there was suddenly much less demand for young labor. The structure of the Japanese economy and employment system changed a lot during these

times, and the precarious situation saw employers desiring more experienced workers. As a result, many young Japanese fell into precarious work situations where it was extremely difficult or impossible for them to find jobs. If they did acquire work, their employment likely did not last very long. Currently, there is still an ongoing struggle in Japan wherein too many people are trapped in precarious work situations. People are struggling to keep their jobs for more than a few months at a time, rendering it difficult to bring in steady income and provide for households. Even though the circumstances of the Lost Decade were out of anyone's hands, much of the older generation began to view the younger generation as lazy because of this. They thought the youth ought to have a better work ethic. Even though Japanese youth often refer to themselves as *freeter* -- as it is a term that fits their sense (Inui, 2005) -- due to the rocky relationship between the baby boomers and the millennials in Japan following the economic bubble burst, it is a term that has become synonymous with being a freeloader, as many believed — and still believe — youths who do not chase after work to be. The media takes the increase in number of *freeters* as of late to be indicative of young people's attitudes towards work and presume they prefer temporary or part-time jobs as a way to avoid prolonged, hard work (Inui, 2005). It is especially tied to young people who still live at home with parents, for they are considered to be mooching off of them to live easier lives without providing them help in any way. This is a complex problem when one considers the situation of recluses and *hikikomori,* many of whom also get viewed as such even though their circumstances are similarly out of their control.

Marriage and Birth Rate

Japan is currently experiencing a problem with a decline in marriages and a severe drop in birth rate. Since Japan's slight marriage boom in the 1970s, marriage rates have been on the decline. The mean age for first-time marriage has risen by over 2 years for both grooms and brides in the past 20 twenty years, and there has also been an increase in the proportion of those who have never been married until the age of 50 (Figure 4.1 & 4.2) (Ministry of Health, Labour and Welfare, 2019). Marriage in Japan has been a conventional thing for a long time, but as we have seen with the emergence of *freeters,* the up and coming generation is becoming less conventional, and many are refusing marriage and even relationships. Lower marriage rates and higher marrying ages could be contributing to Japan's dropping birth rate (Ministry of International Affairs and Communications, 2019), which in turn has an impact on Japan's growing elderly population. The birth rate in Japan has also continued to fall since the 1970s (Figure 4.3), after experiencing a baby boom from 1971-1973 (Ministry of Health, Labour and Welfare, 2019). The fertility rate was at an all-time low in 2018 (Figure 4.3), with the age women are at when they have their first child reaching an all-time high -- jumping up from 25.6 years in the 1970s to 30.7 years in 2018 (Figure 4.4) (Ministry of Health, Labour and Welfare, 2019). Not to mention the influx of *hikikomori* is likely negatively impacting the amount of intimate relationships being formed amongst young people, which can also contribute to this decrease in birth and marriage rates.

Elderly Population

The amount of people aged 65 years and older in Japan exceeded 10% by 1985. At this time, places like the USA, Sweden and Germany already had elderly populations that exceeded 10% years before Japan did; however, in 2015, the percentage of the Japanese population aged 65 years and over was 26.6 percent, exceeding the U.S.A., France, Sweden, Germany, and Italy (Ministry of International Affairs and Communications, 2019). This suggests that, compared to America and other European societies, the aging society in Japan is progressing quite quickly. When coupled with the declining birth rate in Japan, this has the makings for a concerning situation. It indicates that there are less people being born and more people becoming old, which already puts a strain on human resources even before considering the effects of a population threaded through with *hikikomori.*

From 1950 to 2018, there was a significant increase in the amount of people who became elderly and stayed elderly for longer (Figure 4.5); along with a significant decrease in births. In 2018, the aged population (65 years old and over) was 35.6 million, constituting 28.1 percent of the total population (i.e., 1 in every 4 persons) (Statistics Bureau, MIC; Ministry of Health, Labour and Welfare, 2019). This was a record high for the country, and it is predicted that if this trend persists, there will be an undesirable elderly-to-non-elderly ratio where those aged 65 and over outnumber not only the amount of babies being born but also begin to overtake the general population of Japan. What's more is that a larger percentage of the Japanese elderly population are becoming *hikikomori.* Not only does this spawn from extreme cases of *hikikomori* syndrome that can last for upwards of twenty years, but there are more cases of withdrawal that are starting to come after a person has found employment (Saito, 1998/2013). As we have seen, not all

hikikomori-classified persons are without some form of employment, but this can also mean that people who have worked during their lives are now retiring and becoming reclusive -- as opposed to younger *hikikomori* who only worked for a short amount of time or never started working at all. For these elderly *hikikomori* who often require extra help to get around in life, it is easier to just stay at home. This only contributes to the problem of the overall number of *hikikomori* in Japan. There are many Japanese families who are currently coping with the challenge of caring for their aging relatives, and sometimes not even the household members of a family are enough support (Aoyama, Dales & Dasgupta, 2016).

Moving into the Future

All of this has an effect on Japanese society today, and the society influences reclusive behaviors in turn. (For instance, if Japan is experiencing a problem with precarious work, *hikikomori* might be even less motivated to try for a job). There is also a need to consider the effects of what is referred to in Japan as the "2030 problem." This saying is in reference to the large number of people who will officially become elderly around the year 2030 and what this might mean for the future of the Japanese economy. Keep in mind that many of those who will become elderly at this time are the current parents of *hikikomori.* This includes guardians, caretakers, and providers of *hikikomori* as well. There is cause to wonder what the government will provide for these people who will no longer be able to provide for themselves. It is expected that the *hikikomori* children of these elderly persons will take over the responsibility of caring for them, but realistically those who have been socially withdrawn for so long would not be fit to care for someone -- either emotionally or financially. What's more -- what will the safety net be

for *hikikomori* who, in some cases, have not set foot outside of the home or had any kind of employment for years and years? As things currently are, it is looking more and more like *hikikomori* will not be equipped to help other people who need it -- in this case, the growing elderly population -- any more than they will be able to help themselves. This could cause a large problem in the near future when there are a significant number of elderly-aged people and not enough able working bodies to provide them with the care that they need. Add this onto the chance that there will be a significant number of people from the younger generation who *should* be taking over the economy and the job market at this time but who will lack the human capital to do so.

Just as Japan's current social issues persist as a residual effect of the 80s bubble burst, so too do these intergenerational complications. These issues created tension between the older and younger Japanese generations that has not completely dissipated. With them comes a very strict expectation of the up and coming youths of Japan that unfortunately can and has breeded a rebellious resistance from younger Japanese as well as a tendency to crumble underneath the pressure. It is true that there has been an increasing number of Japanese youths who are not necessarily eager to follow the path of their parents. Several have expressed fear over having their lives be dominated by nothing other than work, effectively taking away from any enjoyment they might get out of something else, such as raising a family of their own (Allison, 2013). One person recounted how their father was hardly ever home, barely in their life because he was constantly working to provide for their family. Ironically, in doing so, the family almost never saw the father, putting a strain on their relationship in his efforts to make sure they had good lives. The child resolved that they did not wish to be like their father in that way —

working so tirelessly that there was room for little else (Allison, 2013). The concept of Japanese youth appearing "lazy" to their elders is, therefore, not completely made on baseless ground. Although the term "lazy" is a bit harsh and assumptive to certain circumstances, there certainly exist those who have no desire to work and refuse to try. However, as has been said in a previous section, lumping those individuals who have the privilege of not working together with those who do not have the choice distracts from the actual issues at hand. It hurts those who are vulnerable and require the implementation of policies that will assist them rather than chastise them. Unfortunately, it would be unrealistic to expect these social stigmas to go away -- at least any time soon. However, there are more young people (and older people, too) who are *hikikomori,* NEET, and *freeters* in Japanese society today than is probably known, so it is most productive to focus on innovative ways to help those who are at risk of breaking to cope with these unique struggles in their lives -- especially when they make up a number that is likely growing every day.

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[Segment Figures 4.1-4.5]

Mean Age of First Marriage

Year	Grooms	Brides
1950	25.9	23.0
1955	26.6	23.8
1960	27.2	24.4
1965	27.2	24.5
1970	26.9	24.2
1975	27.0	24.7
1980	27.8	25.2
1985	28.2	25.5
1990	28.4	25.9
1995	28.5	26.3
2000	28.8	27.0
2005	29.8	28.0
2010	30.5	28.8
2015	31.1	29.4
2016	31.1	29.4
2017	31.1	29.4
2018*	31.1	29.4

Proportion of Never Married at Exact Age 50 by Sex [1]

		(%)
Year	Males	Females
1950	1.5	1.4
1960	1.3	1.9
1970	1.7	3.3
1980	2.6	4.5
1990	5.6	4.3
2000	12.6	5.8
2005	16.0	7.3
2010	20.1	10.6
2015	23.4	14.1

1) The Proportion is computed as the mean value of the proportion remaining single at ages 45-49 and 50-54.
Source: National Institute of Population and Social Security Research.

Figures 4.1 and 4.2. Mean Age of First Marriage (left) and Proportion of Never Married by Age 50 (right). These figures show the mean age of first marriages in Japan and the proportion of those who have never been married by age 50 in Japan, respectively (Ministry of Health, Labour and Welfare, 2019).

Year	Rates per 1,000 population [1]				Total fertility rate [2]	Life expectancy at birth (years)	
	Live births	Deaths	Infant mortality	Natural change		Males	Females
1950	28.1	10.9	60.1	17.2	3.65	a) 59.57	a) 62.97
1955	19.4	7.8	39.8	11.6	2.37	63.60	67.75
1960	17.2	7.6	30.7	9.6	2.00	65.32	70.19
1965	18.6	7.1	18.5	11.4	2.14	67.74	72.92
1970	18.8	6.9	13.1	11.8	2.13	69.31	74.66
1975	17.1	6.3	10.0	10.8	1.91	71.73	76.89
1980	13.6	6.2	7.5	7.3	1.75	73.35	78.76
1985	11.9	6.3	5.5	5.6	1.76	74.78	80.48
1990	10.0	6.7	4.6	3.3	1.54	75.92	81.90
1995	9.6	7.4	4.3	2.1	1.42	76.38	82.85
2000	9.5	7.7	3.2	1.8	1.36	77.72	84.60
2005	8.4	8.6	2.8	-0.2	1.26	78.56	85.52
2010	8.5	9.5	2.3	-1.0	1.39	79.55	86.30
2015	8.0	10.3	1.9	-2.3	1.45	80.75	86.99
2016	7.8	10.5	2.0	-2.6	1.44	80.98	87.14
2017	7.6	10.8	1.9	-3.2	1.43	81.09	87.26
2018*	7.4	11.0	1.9	-3.6	1.42	...	...

1) The infant mortality rate is per 1,000 live births.
2) The sum of the age-specific fertility rates from age 15 to 49 years old.
a) 1950-1952 period.

Figure 4.3. Birth, Fertility Rate and Life Expectancy. This figure shows birth, fertility rate and life expectancy trends in Japan from 1950 to 2018 (Ministry of Health, Labour and Welfare, 2019).

Changes of Mothers' Age at Childbirth

Year	Number of births (1,000) [1]	Distribution of mothers' age (%) [2]						Mean age bearing first child
		Under 19	20-24	25-29	30-34	35-39	40 and over	
1970	1,934	1.0	26.5	49.2	18.5	4.2	0.5	25.6
1980	1,577	0.9	18.8	51.4	24.7	3.7	0.5	26.4
1990	1,222	1.4	15.7	45.1	29.1	7.6	1.0	27.0
2000	1,191	1.7	13.6	39.5	33.3	10.6	1.3	28.0
2010	1,071	1.3	10.4	28.6	35.9	20.5	3.3	29.9
2015	1,006	1.2	8.4	26.1	36.3	22.7	5.4	30.7
2016	977	1.1	8.4	25.7	36.3	22.9	5.6	30.7
2017	946	1.0	8.4	25.5	36.5	22.9	5.7	30.7
2018*	918	1.0	8.4	25.5	36.5	23.0	5.8	30.7

1) Including mothers' ages that were not reported.   2) Percentage in relation to number of births, excluding those for which mothers' ages were not reported.

Figure 4.4. Mothers' Ages at Childbirth. This figure shows the changes in Japanese mothers' ages at childbirth (Ministry of Health, Labour and Welfare, 2019).
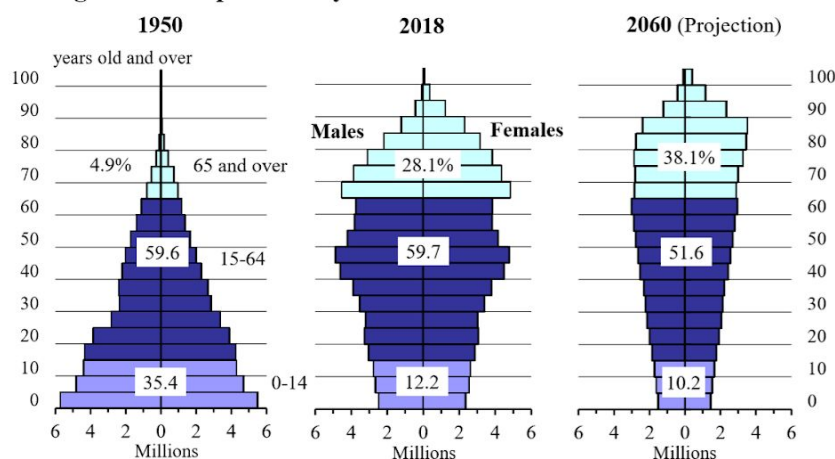

Figure 4.5. Changes in Population. This figure shows changes in the Japanese population from 1950 to 2018, as well as a projection for 2060. There are trends of fewer births and longer life expectancy (Statistics Bureau, MIC; Ministry of Health, Labour and Welfare, 2019).

Proposal

Abstract

In this proposed study, I want to discern if there is indeed a correlation between the amount of support one receives from parents or caretakers and *hikikomori* traits. For a period of six months, *hikikomori* participants will either complete a certain amount of life tasks a week by themselves or have those activities done for them by a parent or caretaker. Hypothesis 1 states that *hikikomori* who live more independently would be significantly more likely to come out of withdrawal tendencies prior to the study period than those who live more interdependently. Likewise, Hypothesis 2 states that those *hikikomori* who live more codependently would be significantly less likely to come out of withdrawal tendencies after the study than those who live more independently. This experiment would also want to consider a main effect of only child *hikikomori* versus *hikikomori* with siblings. It is anticipated that there will be a significant main effect of siblings, in that those *hikikomori* with siblings are predicted to be less likely to have persisting *hikikomori* symptoms, while those without siblings are predicted to be more likely to possess these persisting symptoms. I also would want to account for what an increased level of communication might do for *hikikomori* symptoms. This experiment will include an optional opportunity for periods of engaged communication between the participants and their caretakers. It is anticipated that there will be a significant main effect of communication; i.e. those who engage in active communication with parents or caretakers for the allotted weekly amount of time would present less persisting *hikikomori* symptoms during the period following the study than those who did not. The purpose of this proposed study is to examine if there is a potential relationship between how codependent a *hikikomori* is with their caretaker(s) and the severity and longevity of their withdrawal symptoms. If the hypotheses were to be met, it may suggest that a potential countermeasure to the *hikikomori* problem of today is a larger sense of independence and responsibility for those who are affected.

Method

Participants

100 Japanese participants sampled from Hokkaido, Kansai, Kanto, and Kyushu (different regions) in Japan and who identify as *hikikomori* will be selected to participate in this study. The participants will complete a survey to confirm that they are classifiable as *hikikomori.* Required criteria to be considered *hikikomori* for this study must include all of the following: never or rarely leaving the house to go outside, only going for a specific task or hobby if one does leave the house, having no more than 2 social ties outside of immediate family, and having one's condition persist for at least six months. Each *hikikomori* becomes withdrawn through a variety of individual circumstances, but all participants must not have any preexisting or pre-diagnosed medical conditions or mental illnesses; nor must the birth of a child, domestic professions (such as housewife/husband) or giving or receiving home education be reasons for withdrawal. Participants will be within the age range of 15-39 years old, as a sizable amount of *hikikomori* are often included in this range.

An example of some possible characteristics for participants: The shortest time a participant's condition has existed is eight months and two weeks and the longest time is nine years. The majority of the participants (98) will have been *hikikomori* for 3 years or less. There are 2 participants who will qualify as outliers -- 1 as a 5-year *hikikomori* and 1 as a 9-year *hikikomori.* Of the 100 participants, 80 of them will live with a parent, guardian, or family member (65 with 1 parent, 10 with both parents, and 5 with different kinds of family members -- 3 with a grandparent or grandparents, 1 with a cousin, 1 with a sibling) at the time of the study. The remaining 20 participants will be living alone. All of the participants will have had the same

living arrangements from the time they became *hikikomori* until the present. Each participant

will have been receiving help/outside support from family in order to maintain their reclusive

lifestyles.

90 of the participants will be male, and 10 will be female. None of the female participants

will be living alone. All participants will have become withdrawn between the ages of 15-30. 50

participants will be only children and 50 will have at least 1 other sibling. Of the 50 only

children, 37 will have grown up in a single-parent household. Of the 50 children with siblings,

42 will have grown up in a two-parent household.

Materials and Procedure

Participants will be divided into three groups: the autonomy group, the codependency

group, and the control group. Across versions of this experiment, some adjustments might have

to be made to account for the kind of *hikikomori* participants and their circumstances. Due to the

diversified nature of this syndrome -- while also taking into account locating *hikikomori* and then

getting them to agree to do a study -- it may be difficult to find roughly the same amount of

hikikomori that fit the descriptions outlined in the proposed Participants section. For instance,

finding 20 live-alone *hikikomori* and 80 co-habitant *hikikomori.* In the case of this proposal, I

think it would be best to have the 20 live-alone *hikikomori* make up the control group. The

control group will not have any changes in how they live their lives as *hikikomori.* Whatever it

has been for however long they have been withdrawn, they should make no alterations to that

routine. Perhaps this means not doing much, or doing only little. Some *hikikomori* might live a

more active lifestyle that includes constantly doing chores and activities around their

accommodations, and this is fine, too. The control group is the group that will receive no kind of

task or "treatment." I think it is better to have this group be the *hikikomori* who live alone in this

case because, seeing as the other groups will implement changes into their routine that may

involve a caretaker to perform household duties and chores for them, this eliminates some of the

possibility that this was already being done for a *hikikomori* who lives with somebody else.

Those who live with *hikikomori* are likely doing things for them, such as tidying up or making

them meals -- especially if they are parents. Even if this is not the case, those living under the

same roof as *hikikomori* are likely doing some number of tasks to ensure that the place is

habitable for themselves, if nothing else. I simply do not want the possibility of being in the

group that will involve caretakers to perform tasks for the *hikikomori* participants to clash with

what may have been the norm for them anyway. This is my way of accounting for that. However,

recreations of this proposal might see it difficult or impossible to not have cohabitant *hikikomori*

make up the baseline. Adjustments to the study would have to be made in that case, or even

having cohabitant *hikikomori* be in the control group would be fine. This is just the ideal

placement. The remaining 80 participants will be randomly assigned placement in either the

autonomy group (40 participants) or the codependency group (40 participants).

Autonomy Group

This is the group that will have a focus on independent living and responsibility practice.

The "treatment" for this group will involve a routine that sees them completing a certain amount

of active tasks a week. These tasks include doing laundry (including their own), cleaning up a

room in the house (including their own), washing, drying and putting away dishes (including

ones they use), sweeping the house (including theirs), mopping floors (including theirs if they

can), taking out the trash (including their own), and preparing meals for themselves. Participants

will complete a different one of these tasks each day of the week for a period of six months.

Those who are cohabiting with the *hikikomori* participants can choose to engage in any of the

regular household activities that they want, so long as the participant has a way to adequately do

each of them once a week. For example, a fair amount of dishes would count as at least five

different dishes (not including utensils). Also, the participant should make at least one meal on

whatever day that they choose; however, instant meals and/or snacks do not count. The idea of

regularly performing tasks that help out around the house is to encourage a sense of

independence and taking care of the self. At the end of each week on Saturday evenings,

participants will fill out a self-evaluation survey to document how they are feeling and to check

the current state of their withdrawal symptoms.

Codependency Group

This is the group that will have a focus on a more passive lifestyle with an emphasis on

codependency. The "treatment" for this group will consist of the parents or caretakers of the

participant completing the same tasks as the autonomy group without the participant doing any

of them (even if they normally would in their regular everyday lives). Again, these tasks include

doing laundry, cleaning up a room in the house, washing, drying and putting away dishes,

sweeping the house, mopping floors, taking out the trash, and preparing meals for the participant.

Similar to the autonomy group, those who are doing these things for the participant will do one

of them each day for a period of six months. Different from the autonomy group, the tasks being

done for in the codependency group would have to be more directly linked to the benefit of the *hikikomori* participant. That would mean that each week the parent or caretaker would make sure that they are doing the participant's laundry, or cleaning up their room (or a bathroom they use), or taking out their trash, or washing dishes that they use, etc. While the participants in the autonomy group can and should do the tasks for themselves as well as for the benefit of others in the household (i.e. taking out the family trash or doing a load of everyone's laundry), it is more important for the parents/caretakers of the *hikikomori* in the codependency group to make sure that the tasks they do directly affect the participant. I believe the feeling of intense reliability on someone else would be more emphasized if the *hikikomori* participant is able to consistently have a tidy room, clean clothes, and ready meals without doing anything to make those things happen for themselves. The purpose of this group is so that *hikikomori* in it can get used to a routine that involves having personally beneficial things done for them. Just like the autonomy group, the codependency group will fill out a self-evaluation form at the end of each week on Saturday evenings to document how they are feeling and to check the current state of their withdrawal symptoms.

Optional Communication Sessions

Both the autonomy and the codependency groups will have the recommended option of engaging in active communication sessions with a person of their choosing. Most likely it will be a parent or somebody staying with them, but it can also be other friends, family, acquaintances, etc. who are not. It does not have to be the same person each time. These periods of engaging in communication with someone can happen face-to-face or via a phone call. Any method of

nonverbal communication (such as texting or letter writing) will not count. Should participants

want to take part, they should do so at least three times a week for a minimum of 30 minutes.

Since it is not a requirement, any participant who does the communication sessions will also

record how many minutes they spent participating in sessions that week in addition to their

self-evaluation.

Before the start of the study, all participants from the three groups will fill out the

self-evaluation survey, and all participants from all three groups will fill the same survey out

weekly for the duration of the six-month trial. The experimental period will be over after six

months. After this, participants will cease their respective "treatments" and continue on about

their lives normally. Following the study, there will be a total of 4 check-ins. The first will occur

2 months prior to the end of the everyone's "treatment" routine. Each participant from each

group will fill out and send in the self-evaluation survey again. They will do the same thing 4

months prior to the study, and then 6, and finally 12 -- the final check-in being one year prior to

the completion of the study. Each time, the participant will provide an update on their *hikikomori*

tendencies.

Hikikomori Self-Evaluation Survey

This survey is a self-report form with a Likert scale response format. It consists of 15 questions

designed to help evaluate feelings on the self, feelings towards others, confidence, comfortability

with communication, and tendency to engage in activity outside of the room. It is split into three

parts of 5 questions each: evaluation on the *hikikomori's* Outside Activity, Communication, and

Self-Value. This is the survey that all participant groups fill out before beginning the study, at weekly intervals throughout the study, and at the four intervals following the study. The questions that will be on this scale are as follows:

Outside Activity

- How often do you leave your room?

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

- How often do you leave your house?

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

- How many hours a day do you spend outside of the house?

  1 30 mins or less   2 ~1 hour   3 >1 hour   4 ~2 hours   5 >2 hours

- These days, I feel bored in my room.

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

- I want to go outside more.

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

Communication

- How often do you engage in social communication? (No non-verbal communication such as texting or letters; but face-to-face meetings, phone calls, and even head-set communication over games are acceptable.)

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

- I would feel comfortable to talk to the first person I see.

  1 Not at all   2 Probably not   3 Maybe   4 Probably   5 Definitely

- I am good at expressing my feelings.

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

- The thought of talking with someone brings me feelings of anxiety or dread.

  1 Always   2 Often   3 Sometimes   4 Rarely   5 Never

- I want to make more friends/acquaintances.

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

Self-Value

- I think I am capable of helping my family.

  1 Not at all   2 Not really   3 Maybe   4 A little   5 Definitely

- I think I have talent.

  1 Not at all   2 Not really   3 Maybe   4 A little   5 Definitely

- I am content with my life.

  1 Not at all   2 Not really   3 Maybe   4 A little   5 Definitely

- I would like to do more than I am currently doing.

  1 Never   2 Rarely   3 Sometimes   4 Often   5 Always

- I am confident in my ability to find work.

  1 Not at all   2 Not really   3 Maybe   4 A little   5 Definitely

Proposed Results

If Hypothesis 1 is met, we will see that the autonomy group shows not only improvement of withdrawal symptoms throughout the course of the study, but also significant improvement of withdrawal symptoms in the months following the end of the study in comparison to the codependency group and control group. This may also include participants reporting a greater acceptance of the self and a larger sense of purpose. This would suggest that developing a routine consisting of regular self-serving tasks may reward those struggling with withdrawal symptoms and help deplete long term *hikikomori* tendencies. Figure 1 shows a curve of Outside Activity and Communication beginning to decrease again during the period following the study. It is feasible that this could happen in some, if not all, areas over time as routines get back to normal, but the hope is that the overall mean evaluations for the Autonomy Group would not drop as low as or below the starting point.

Figure 1. This figure shows the proposed trends for the autonomy group results based on Likert scale responses at certain check-in points. (Note: 'Start' indicates the evaluation given right before the beginning of the study as the autonomy group's baseline evaluation. 'End' indicates the final weekly evaluation before the study ends. '4 Months' is the evaluation 4 months prior to the end of the study. '12 Months' is the evaluation 12 months prior to the end of the study and the final one.)

If Hypothesis 2 is met, we will see that the codependency group shows significantly less improvement of withdrawal symptoms throughout the course of the study, as well as what is likely to also be significantly less improvement of withdrawal symptoms in the months following the end of the study compared to the autonomy and control groups. This may include participants reporting a decreased sense of self-worth and a lesser sense of purpose. This would suggest that *hikikomori* living by a routine that involves regularly allowing others to do things for them and take care of them to a certain extent may result in no improvement of withdrawal symptoms and potentially even a worsening of symptoms. This would also suggest that a similar kind of passive lifestyle does not serve to help deplete long term *hikikomori* tendencies. Figure 2 shows an increase in Self-Value after the end of the study, which could feasibly happen in the Codependency Group. After six months of what is predicted to be a counterproductive familial relationship, coming out of it may result in a temporary improvement in self-evaluation scores.
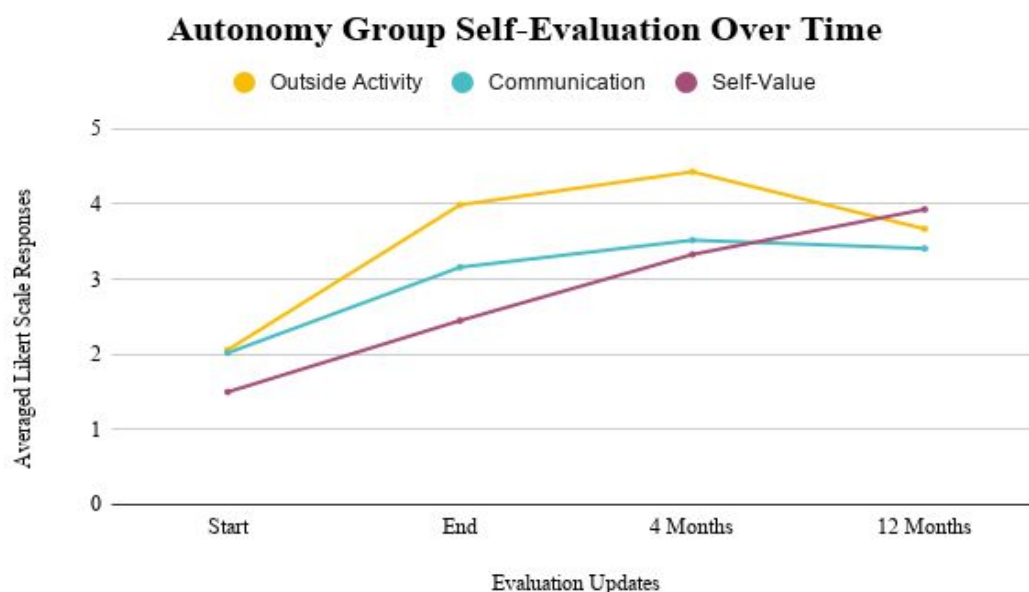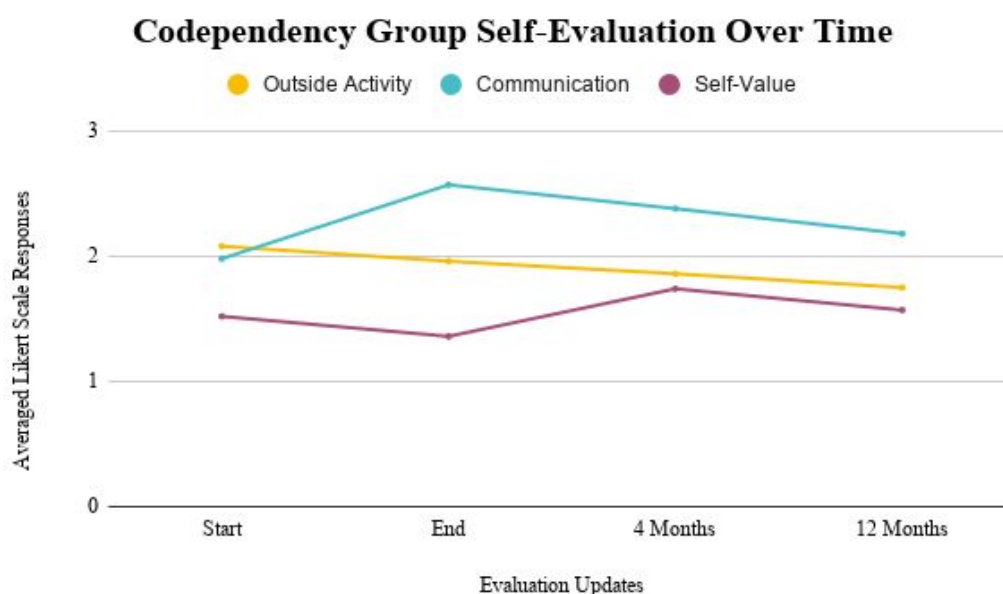

Figure 2. This figure shows the proposed trends for the codependency group results based on Likert scale responses at certain check-in points.(Note: 'Start' indicates the evaluation given right before the beginning of the study as the autonomy group's baseline evaluation. 'End' indicates the final weekly evaluation before the study ends. '4 Months' is the evaluation 4 months prior to the end of the study. '12 Months' is the evaluation 12 months prior to the end of the study and the final one.)

This study also makes the prediction that there is a main effect of communication on the persistence of withdrawal symptoms, anticipating that regular communication with others will help with lessening of long-term *hikikomori* tendencies. If this prediction is upheld, there would be a positive correlation between the number of hours of active communication logged in by participants and marked improvement of those participants' self-reported withdrawal symptoms. This means that those who spent more hours working on active communication during the six month trial period will likely report better symptoms throughout and after the end of the study compared to those who spent little to no hours on communication. They would likely also report higher comfortability with communication/higher scores on the Communication scale than other participants.

This study also predicts a main effect of siblings on withdrawal symptoms, anticipating that being an only child is associated with being less likely to overcome long-term *hikikomori* tendencies, while having siblings is associated with being more likely to overcome long-term *hikikomori* tendencies. If this prediction is upheld, there will be a trend that shows those who are only children reporting persisting withdrawal symptoms both throughout the study and following the end of the study, as opposed to those who have siblings reporting improved withdrawal symptoms throughout the study and following the end of it.

Discussion

This study was formulated to examine the possibility of there being a potential relationship between how codependent a *hikikomori* is with their caretaker(s) and the resulting severity and longevity of their withdrawal symptoms. If the proposed hypotheses were to be met, it may suggest that a potential countermeasure to the persisting issue of *hikikomori* syndrome today is for those who are suffering from acute social withdrawal to take on a larger sense of duty and responsibility in order to build their independence and sense of self-worth. This can look like many things for different cases, yet the underlying idea of activeness rather than passiveness remains the same. This study is based around the theory that *hikikomori* is a form of extended adolescence -- suggesting that, from a young age, some *hikikomori* may have grown into a relationship that was too heavily reliant on another person. This or a similar idea can potentially be implemented and utilized a type of therapy tool for existing *hikikomori* and possibly even for those classified as pre-*hikikomori* -- those displaying signs of withdrawal symptoms but who have not yet fallen into the category of *hikikomori* -- to snuff it out before it has a chance to begin.

This study is important to the subject of *hikikomori* syndrome because not only does it provide a more in-depth look at a potential reason for why *hikikomori* might have a stunted sense of autonomy or even a regression into a more child-like state of mind, it also opens the door for possible new forms of *hikikomori* syndrome treatment. However, *hikikomori* is a challenging syndrome to treat, because the answer does not lie in medicine the same way it does for certain classifiable mental disorders. There is really no drug you can give to someone that could suddenly make them comfortable with interpersonal communication if they are not; or that

would make them comfortable and confident in themselves if they are not. The theory of the

difference between mental illness and *hikikomori* being a difference between the brain and the

mind (Saito, 1998/2013) makes sense when one considers the novelty of trying to treat

withdrawal itself as a disorder. It is difficult to make the distinction between what makes

withdrawal and other mental illnesses fundamentally different from one another, as isn't

someone with Anxiety Disorder also basically someone who is not comfortable with

communicating? Yes, in some cases. But the effects and challenges that accompany Anxiety

Disorder -- long-term and short-term -- look much different than the effects and challenges that

accompany *hikikomori* syndrome. In addition, most mental illnesses cannot be cured; however,

hikikomori, arguably, can be. There are many self-reported "past" *hikikomori* who once struggled

with the extreme withdrawal but no longer do. What is the difference between those who

overcame *hikikomori* and those who only find themselves sinking deeper into it? Right now, the

answer of how to cope with *hikikomori* and make it better for those who suffer from it is not

clear, but there is certainly a possibility that it can be done. Raising questions and exploring them

will continue to provide insight into how that might come to happen.

Even with what is implied with these proposed results, it is difficult to say what an

effective everyday solution might be. Is there a time when it would be better to transition

children from codependence into a more independent lifestyle? It would not exactly be viable to

say that one should begin extremely early. In fact, beginning too early would likely be

detrimental. After all, for a period, infants and toddlers and children do need most things

performed for them, as well as healthy amounts of attention and care. There is no "golden" age at

which to suddenly cease such actions and begin making it so that children begin to do everything

on their own; however, I do believe a takeaway from these expected results would be that parents and caretakers should be conscious of just how much they are doing for their child into their adolescent years and that there are potentially situations to look out for in which they can start to become more independent.

Granted, this is not to say that every child is the same, as we have seen time and time again that *hikikomori* syndrome is largely a documented set of very specific cases -- different across almost all individuals. One child who develops autonomy regularly under a parent's care could be a far cry from a child who grows to become *hikikomori* under that very same parent. This is why it is not foolproof to follow any specific formula. This project is only one way to look at codependence as a factor of *hikikomori* -- which is only one of a long list of potential factors at that. In the future, research could be done to explore codependence/family life and *hikikomori* through other means, angles and lenses. When it comes to combating it, these proposed results would only support that there is benefit in facilitating a sense of duty and responsibility in young people.

Some might have the question of whether having siblings still living in the house matters. Future studies might explore it further, but it is interesting to make note of here. The idea being explored here is that parents who have only one child pay copious amounts of attention to that child -- as opposed to more evenly-distributed attention across several children. The strength of the parent-child codependency may take root during the very early stages of the child's life. If, from a young age, a child is growing up in a household where they are not given constant attention or provided with everything they want or need all the time, they are more likely to develop natural autonomy at an appropriate age. Be that as it may, we must consider the age in

which *hikikomori* onset typically occurs. A review on a *hikikomori* study conducted by the

Japanese Cabinet Office found the most commonly-reported ages for onset to be between 15 and

24 years (Tajan, Yukiko, & Pionnié-Dax, 2017). Based on whether or not the *hikikomori* has

siblings, and how old they are, whether they remain in the household with them or not could be a

big factor. Say, for instance, the *hikikomori* child within this age range has a sibling who is

similar in age and heading off for college, meaning they will no longer take up residence within

the household. With the sibling away, the *hikikomori* would now be living in the house with the

parent(s) by themselves. Therefore, even though they were not an only child and their parent(s)

split their attention between the siblings growing up, all of a sudden they are alone in the house

with the parent(s) while they are susceptible to withdrawal. Even if autonomy had previously

been developing in them at a natural rate, this change in house dynamics could easily influence

the child becoming reclusive -- especially if the parent(s) falls into the "only-child trap" of

doting on the only kid they have around. On the other hand, it could also be the case that those

with more siblings feel overshadowed or even ignored because of them, and in turn that is what

gets them to withdraw over time. A sibling-focused study could be conducted in the future to

explore which scenario might be more common.

Anticipated Challenges

Anticipated challenges of this study include the difficulty of finding *hikikomori* in Japan,

and the even bigger challenge of seeking them out for participation in an experiment. Future

studies might find a way to look at larger sample sizes of *hikikomori,* as merely 100 participants

is not even scratching the surface of the true number of *hikikomori* out there. In order to have a

more accurate idea of the true efficacy of an experiment like this, larger sample sizes, while more difficult to gather, would be beneficial. There is also the added challenge of having the families/caretakers of the *hikikomori* participants participating as well. The role of family, like in real life, plays a large part in this study. Those around the participant would have to be consistent in their role in the study, and with so many more people to account for, there is always room for error. Self-report measurements always have to be taken with a grain of salt, and there is the possibility of a participant missing a check-in either during the study or after. There is also the possibility that not enough participants would opt into doing the communication sessions; and if they did do them, they could easily stop doing them at any point. Even if the communication sessions are not voluntary, difficulty with communication is a common challenge amongst the *hikikomori* population, so this study design allows for the chance that not enough information can be gathered about the effect of active communication because not enough participants logged in enough hours.

The amount of time in which a *hikikomori* is in withdrawal must also be considered. It is possible, or even likely, that those who have been reclusive for significantly longer periods of time will have a much more difficult time coming out of it (if they do at all). In the case of this experiment, there would be two *hikikomori* who would have been reclusive for a significantly longer amount of time than the majority of the other participants. Even if the 6-year *hikikomori* were to be a part of the codependency group and the 9-year *hikikomori* were to be a part of the autonomy group, neither of them would be predicted to come out of their *hikikomori* tendencies during the 12-month period following the experiment. Should this study be replicated, it is quite possible that similar demographics will be collected. There is no guarantee that sampled

hikikomori will all have relatively recent withdrawn lifestyles. In the recent survey of 49

hikikomori conducted by the Japanese Cabinet Office, the most common response to a question

asking about the duration of the respondents' condition was "more than 7 years" (34.7%). The

second-highest was "3-5 years" (28.6%), and both "5-7 years" and "6 months-1 year" sat at a

12.2% response (Tajan, Yukiko, & Pionnié-Dax, 2017). It is likely that more *hikikomori* have

been reclusive for longer than we realize, and it can affect the results of a study like this. These

proposed results are based on an experiment in which the majority of the participants would be

reclusive for a significantly shorter amount of time than that, and this should be taken into

account. It is expected that those who have been *hikikomori* for an exponentially longer amount

of time would not be as affected by the "treatment" in this study overall. Of course, this is not

known for sure. Those who have been trapped within a lifestyle for far longer than others may

feasibly require a different approach. Perhaps similar future studies might explore different

options, such as extending the time of the trial. This does raise the question of if there is a certain

period after which *hikikomori* are considered much harder to reach.

Looking Ahead

     In the literature portion of this project, I discussed the healthy amount of *hikikomori* from

other countries, and including them in testing in addition to those from Japan could also be

attempted in future studies. This would provide a look at the questions from a different angle and

allow for the testing of the idea that family life looks different in different parts of the world; and

that the greater or lesser amount of *hikikomori* recorded across countries could be correlated to

this fact. Perhaps American adolescents have a greater sense of independence and a desire for

earlier separation from codependency than Japanese children do overall. Is this evident in the existing cases of American *hikikomori*? Would a greater or fewer number of them end up breaking free of their withdrawal tendencies after a similar study than their Japanese equivalents? Age can also be examined as a factor. Does the age of *hikikomori* affect these results? What happens when we widen the age gap and observe participants who are older? Younger? In this study, the participant who was *hikikomori* for nine years would obviously be an outlier. We can look at elderly *hikikomori*, as they are becoming more and more saturated within the Japanese society. Recently, this has become a central topic for Japanese researchers and scholars. The government has even conducted surveys on the rising elderly *hikikomori* population. Its awareness within the country continues to grow as it evolves into a more prominent social issue, and potential information for future studies could come out of this newfound recognition. Gender is another factor that could be observed. The majority of *hikikomori* are male, but a study focused on the implications of male vs female *hikikomori* tendencies could also be interesting. The effects of those growing up in a 1-parent household versus a 2-parent household -- or with no parents at all -- on children's susceptibility to withdrawal could also be investigated. Foster home settings and different kinds of caregivers can all be interesting angles to observe.

This study does not account for many other possible existing factors for *hikikomori*, but future studies might. I proposed looking at family life and codependency in existing *hikikomori*, with possible significant effects of having siblings and facilitated communication with family members and caretakers. Other studies might look at other factors such as pre-existing mental illness, level of education, past trauma, etc. Even though most people, when talking about

hikikomori, make sure that the symptoms cannot be explained by any other illness or mental

disorder, that does not mean they should never be looked at in relation to one another. There are

likely many people who are rightly classified as *hikikomori* who also have a preexisting illness,

and they should not be excluded from the overall *hikikomori* population because of it. There is

much to be learned about *hikikomori* in order to implement more effective treatments and

decrease the number of those who are suffering.

Tricky as it is to gather enough *hikikomori* to participate in a study, it may be even more

challenging to gather younger children who are not necessarily part of the *hikikomori* group yet.

Still, it might be interesting if, in the future, a similar study could examine pre-*hikikomori.* Most

often, there are more people below the age of 20 who classify as pre-*hikikomori* than actual

hikikomori (Tajan, Yukiko, & Pionnié-Dax, 2017). Some do not become extremely socially

withdrawn, yet some do. It would be interesting if future studies looked more closely at these

pre-*hikikomori* and what the differences are between those who did not fall into a reclusive

lifestyle versus those who did. What are the factors at play? Similar to this study, future ones

might see if a stronger sense of independence versus a weaker one has an effect on if

pre-*hikikomori* are more susceptible to becoming full-blown *hikikomori* or not. Although

developmental stages are crucial in something like this, it should be taken into consideration that

it would not always be feasible to test something like this on all pre-*hikikomori*. In a sense, it

could be like trying to control how parents/guardians raise their children, and the participants

would likely be very young -- perhaps too young to be able to carry out many independent tasks

themselves. The method proposed in this study of trying these routines on older participants who

are already *hikikomori* allows a look at the main issue of codependence and autonomy without

doing any of that. However, while something like this might not be entirely morally doable, and families with young children may not want to partake, asking these kinds of questions can still benefit the cause. They are capable of producing a version of a study that will further research and understanding on the ever-evolving topic of *hikikomori* syndrome.

~

During the making of this project, I've realized that hikikomori -- whether or not it is referred to as such in any given situation -- is present in most places in the world today, in all of its many forms. Many kinds of situations can bring it upon a person, and while I considered a number of them during my research and construction of this project, I never would have guessed when I started working on it back in the fall of 2019 that it would become applicable to so many more people just several months later.

The current situation we are enduring with Covid-19 is not only astonishing in its nature but unsettling in what it could leave behind once all is said and done. On some level, it is intriguing to consider those who have become socially withdrawn not through any internal state of mind, but because of the conditions of the environment; because of the state of a virus no one has any control over; and because of government order, no less. Something that was once very specifically exclusive to a certain group of people is now impacting almost everyone in the world in some way. We hardly shifted into such a significant change in lifestyle gradually, and everything is even more jarring because of it. Of course, many are only becoming hikikomori-like by definition of self isolation right now, but how long before that starts to change? Many are finding a positive attitude difficult to keep. Wakako, one of my advisors for this thesis, mentioned to me that one of her students expressed to her their worry about the current state of things driving them back into their own hikikomori tendencies. What of all the people who have been battling their own cases of withdrawal but are now, in a way, being forced to succumb to them?

These are crazy times and crazy circumstances, and the world will certainly emerge from this pandemic feeling very changed. We can only stay strong and connected and wait it out, but once this is over, I have a feeling our perceptions of social isolation, withdrawal, and even hikikomori syndrome will have changed along with it.

~

End.

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