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PRESS RELEASE (2020/04/02)

Revisiting what defines hikikomori as cases rise internationally

Critical to being able to treat a condition, especially in the field of psychiatry, is the ability to first diagnose it. To that end, researchers from Kyushu University in collaboration with the Oregon Health & Science University have now proposed updated criteria for a form of social withdrawal called "hikikomori" with the hope of standardizing evaluation and improving response in the future.

Hikikomori has been strongly associated with Japan as increasing cases of adolescents staying at home—sometimes in a single room—and avoiding social activities such as school and work since the late 1990s began to gain national attention. However, reports of hikikomori-like cases from around the world have indicated that hikikomori is not isolated to one culture or country and is an international issue.

To better understand, define, and treat the condition, Takahiro Kato and his colleagues established the Mood Disorder/Hikikomori Research Clinic at the Kyushu University Hospital, where they have been working with patients suffering from hikikomori and their families and developing new methods of support.

"Since the Ministry of Health, Labor and Welfare issued some of the early guidelines for diagnosing hikikomori in 2010, we have made tremendous progress in understanding the common characteristics among those with the condition," says Kato.

"In addition, we have identified several points of confusion in the early guidelines and have proposed a new set of diagnostic criteria for hikikomori that better reflect our current understanding for international acceptance."

At the core of the new criteria, which were published this January in *World Psychiatry*, is social isolation in one's home for a duration of more than six months accompanied with significant functional impairment or distress stemming from the isolation.

The new definition gives further guidance on the severity of social isolation, with hikikomori being classified as mild, moderate, or severe depending on whether the person leaves home up to three days a week, leaves home one or less days per week, or rarely leaves a single room.

Missing from these criteria is an avoidance of social situations.

"Talking to those with hikikomori, we often hear that avoiding social interaction is not an underlying motive, which may distinguish hikikomori from social anxiety disorder," notes Kato.

This definition also acknowledges that hikikomori can co-exist with other psychiatric disorders.

Previous guidelines have excluded hikikomori from being diagnosed if other conditions are present, but the researchers have found that co-occurrence is quite common.

Furthermore, the researchers recommend that similar social isolation lasting for between three to six months as being classified as pre-hikikomori.

“By adding the ‘pre-hikikomori’ status to the evaluation criteria, we expect that a new support system for early prevention will be established,” says Kato.

The researchers hope that these criteria will allow people to more easily evaluate if someone is in a withdrawal situation that requires assistance. In addition, they expect that providing appropriate support based on each individual's condition will become easier using the additional specifiers they proposed for further characterizing individual cases of hikikomori.

“By using these criteria in international epidemiological surveys to understand the phenomenon of youth hikikomori as it spreads overseas, we expect that a better picture of the internationalization of hikikomori and the global problem of social isolation will emerge,” states Kato.

For more information about this research, see “Defining pathological social withdrawal: proposed diagnostic criteria for hikikomori,” Takahiro A. Kato, Shigenobu Kanba, and Alan R. Teo, *World Psychiatry, 19(1), 116–117,* 2020 Feb, https://doi.org/10.1002/wps.20705

Also, see “Hikikomori: Multidimensional understanding, assessment and future international perspectives,” Takahiro A. Kato, Shigenobu Kanba, and Alan R. Teo, *Psychiatry and Clinical Neurosciences*, 73(8):427–440, 2019 Aug, https://doi.org/10.1111/pcn.12895

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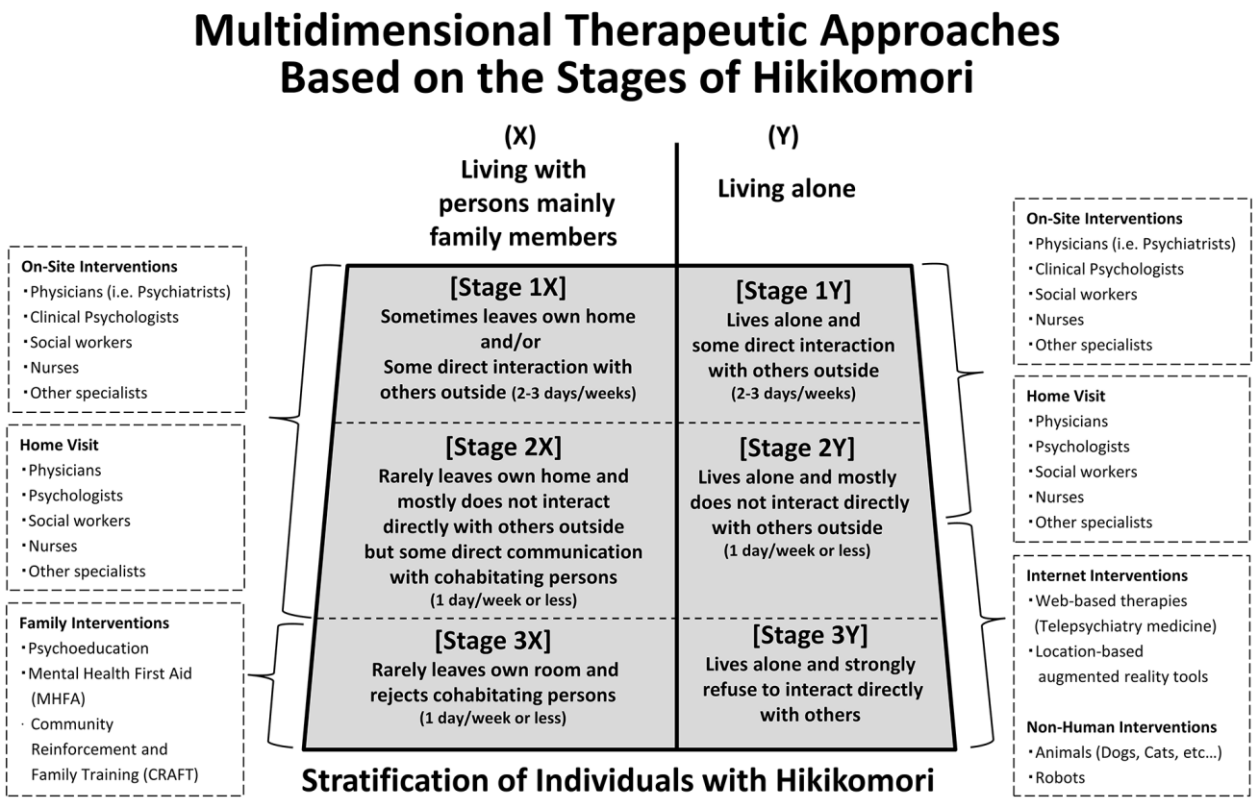

Fig. 1. Chart showing the different therapeutic approaches for hikikomori depending on the stage of the condition.

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Addendum: Proposing diagnostic criteria for *hikikomori (Feb 2020)*

(Cited/modified from Kato et al. World Psychiatry 2020 & Psychiatry and Clinical Neuroscience 2019)

[Definition] *Hikikomori* is a form of pathological social withdrawal or social isolation whose essential feature is physical isolation in one's home.

The person must meet the following criteria:

1. **Marked social isolation in one's home.**
2. **Duration of continuous social isolation for at least 6 months.**
3. **Significant functional impairment or distress associated with the social isolation.**

The behavior of staying confined to home—the physical aspect of withdrawing and remaining socially isolated—is the hikikomori's central and defining feature. Individuals who *occasionally* leave their home (2–3 days/week), *rarely* leave their home (1 day/week or less), and *rarely* leave a single room may be characterized as mild, moderate, and severe, respectively. Individuals who leave their home *frequently* (4 or more days/week), by definition, do not meet criteria for *hikikomori*. The estimated continuous duration of social withdrawal should be noted (e.g., 8 months). Individuals with a duration of continuous social withdrawal of at least 3 (but not 6) months should be noted as pre-*hikikomori*.

The requirements for avoidance of social situations and relationships are not mandatory features. Distress or functional impairment should be carefully evaluated. While impairment in the individual's functioning is vital to hikikomori being a pathological condition, subjective distress may not be present. Many patients feel content in their social withdrawal, particularly in the earlier phase of the condition. Not a few patients frequently describe a sense of relief at being able to escape from the painful realities of life outside the boundaries of their home. As the duration of social withdrawal gets longer, most patients begin endorsing distress, such as feelings of loneliness. Patients tends to co-occur with other psychiatric conditions, while comorbidity of other psychiatric disorders are not as an exclusionary criterion for hikikomori.

The following **specifiers** are not mandatory criteria; however, they may be useful for additional characterization of *hikikomori*:

A) With lack of social participation. The individual occasionally (2–3 days/week) or rarely (1 day/week or less) participates in activities, such as attending school, going to a workplace, or going to medical appointments. This specifier would likely apply to hikikomori who are also not in education, employment, or training (i.e., 'NEET').

B) With lack of in-person social interaction. The individual occasionally (2–3 days/week) or rarely (1 day/week or less) has meaningful in-person social interactions (conversations) with people outside home. In severe cases, the individual rarely has in-person social interaction even with cohabitating people, such as family members. This specifier would likely apply to individuals with hikikomori who have social interactions that primarily occur via digital communication technologies (e.g., social media, online gaming).

C) Indirect communication. Due to the proliferation of the Internet in modern society, 'indirect'

communication via web-based or other technologies is increasingly common. Thus, such indirect communication should be assessed in accordance with direct communication. Some cases have daily bidirectional indirect communication via online tools such as social networking services and/or online games.

D) With loneliness. The individual endorses feeling lonely. The presence of loneliness tends to be more common as the length of hikikomori increases.

E) With a co-occurring condition. Hikikomori may co-occur with numerous psychiatric disorders, such as avoidant personality disorder (e.g., isolation due to fears of criticism or rejection), social anxiety disorder (e.g., avoidance of social situations because of fear of embarrassment), major depressive disorder (e.g., avoidance of social situations as a reflection of neurovegetative symptoms), autism spectrum disorder (deficits in social interactions and communication), or schizophrenia (e.g., isolation due to positive and negative symptoms of psychosis).

F) Age of onset. In many cases, the age at onset is adolescence and early adulthood; however, cases with onset after the third decade are not rare.

G) Family pattern and dynamics. Socioeconomic status and parenting styles may influence the development of hikikomori. For instance, overprotective parenting and/or absence of paternal involvement are suggested to be linked to the occurrence of this phenomenon.

H) Cultural background. Pathological social withdrawal was originally characterized and described in Japan and more recently has been identified in other countries, especially in East Asia and Europe. Sociocultural situation may influence this condition.

I) Intervention. Even though no evidence-based interventions have been established, pharmacotherapy (if the individuals are comorbid with psychiatric disorders), a variety of psychotherapy, social work, and family approach have been provided. Precision (individualized) approach is recommended based on the above assessments.