

# Hikikomori /Hidden Youth Symposium (23 Nov 2017, NUS, Singapore)



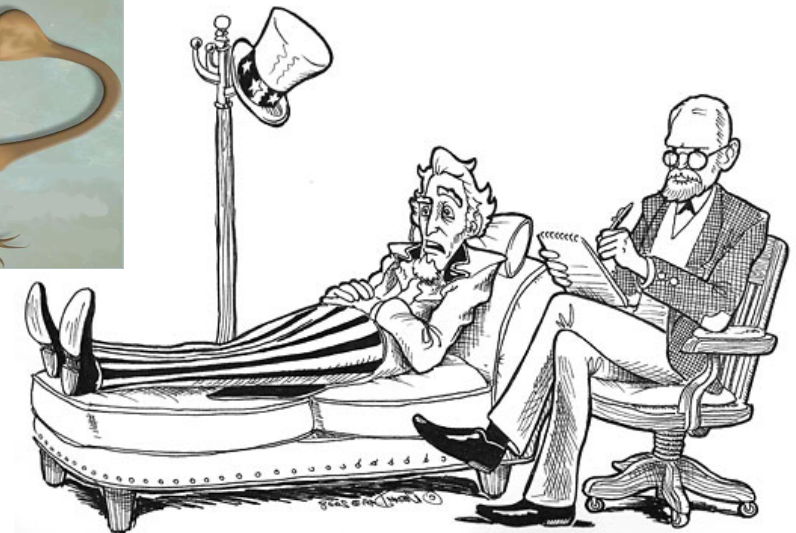
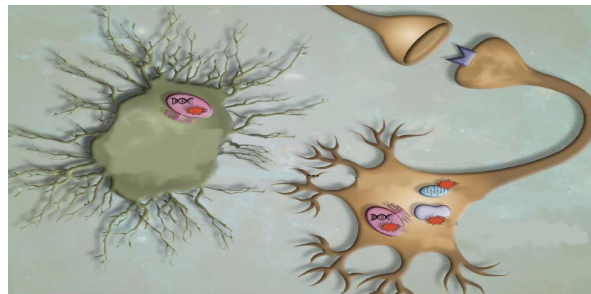
## Hikikomori/Hidden Youth:

**Multi-dimensional approach for assessment and treatment**

**Takahiro A. Kato, MD, PhD**

**Associate Professor**

**Department of Neuropsychiatry, Graduate school of Medical Sciences,  
Kyushu University, Fukuoka, Japan**



# Statement of Potential Conflicts of Interest

Relating to this presentation, there are no relationships that could be perceived as potential conflict of interests.

**Takahiro A. Kato, M.D., Ph.D.**

Associate Professor

Department of Neuropsychiatry, Graduate School of Medical Sciences, Kyushu University

3-1-1 Maidashi Higashi-ku, Fukuoka 812-8582, Japan

**E-mail: [takahiro@npsych.med.kyushu-u.ac.jp](mailto:takahiro@npsych.med.kyushu-u.ac.jp)**



## HEALTH &amp; WELLNESS

# The Fight to Save Japan's Young Shut-Ins

*Continued from the prior page*

fields phone calls from hikikomori or, more often, their worried parents. It also offers support groups for hikikomori and their parents. However, only a small number of hikikomori actually show up at the center. Of those, a minority are treated successfully, staffers say.

Takahiro Kato, a professor in the neuropsychiatry department at Kyushu University in Fukuoka, is working with the support center to study hikikomori in a more rigorous and systematic way. Dr. Kato and a team of Japanese and international collaborators that includes Alan Teo, a psychiatry professor at Oregon Health & Science University, want to better define what hikikomori is. They also hope to understand the social and bi-

ological underpinnings of the condition to improve treatments.

People who consider themselves hikikomori exhibit a wide range of symptoms, including depressive, autistic and obsessive-compulsive tendencies. A minority appear addicted to the Internet, says Dr. Kato, a 40-year-old psychiatrist.

Yoshy, 31, came for a recent hikikomori support group. He says he didn't leave his parents' house for six months after harassment from his boss at his speech therapy internship led him to quit. After that, he began to visit friends a bit and volunteer at a library. But after four years, he still hasn't held a full-time job.

Hikikomori appears to be a condition distinct from other mental illnesses, Japanese experts say. Only

about half of those with the condition would be diagnosed with a disorder in the U.S. psychiatric diagnostic manual commonly known as DSM-5, according to one survey of 4,134 Japanese residents published in *Psychiatry Research* in 2010. But large-scale survey data on hikikomori remains limited.

Dr. Teo, an American fluent in Japanese, has treated several hikikomori-like patients in the U.S. In 2010 he published proposed diagnostic criteria for the condition. It reported that hikikomori's core feature is social isolation. People should suffer for at least six months and should be unhappy about the isolation before being diagnosed with the condition.

Japanese experts point to strict parenting practices and pressure that children feel to succeed as contribut-



Yuta Onoda



Professor Kato Takahiro runs a series of diagnostic exams during an interview for hikikomori and depression.

## My Clinical and Research trial against Hikikomori/MTD

in Kyushu Univ. (Fukuoka, Japan)

- Clarifying the biopsychosocial cause
- Development of evaluation tools (psychometrics and PC-oriented games)
- Intervention Tool Development (Group psychotherapy, etc..)

ORIGINAL PAPER

# Does the ‘hikikomori’ syndrome of social withdrawal exist outside Japan? A preliminary international investigation

Takahiro A. Kato · Masaru Tateno · Naotaka Shinfuku · Daisuke Fujisawa · Alan R. Teo · Norman Sartorius · Tsuyoshi Akiyama · Tetsuya Ishida · Tae Young Choi · Yatan Pal Singh Balhara · Ryohhei Matsumoto · Anne Wand · Jane Pei-Chen Chang · R

We declare that we have no conflicts of interest.

\*S Mirza, M Hancock, K Meeran, A Dornhorst, N S Oliver  
smirza@imperial.ac.uk

Imperial Healthcare NHS Trust, Charing Cross Hospital, London W6 8RF, UK

1. Hansen R, John G. 2010 consensus statement on the worldwide standardization of the hemoglobin A1c measurement. Diabetes Care 2010; 33: 1903–04.

2. European Association for the Study of Diabetes. Report of the ADA/IASD/IDF Working Group of the HbA1c assay. London, UK, 20 January 2004. [http://www.diabetescare.org/files/2004\\_Diabetologia2004\\_46\\_151\\_54.pdf](http://www.diabetescare.org/files/2004_Diabetologia2004_46_151_54.pdf) [accessed Aug 3, 2011].

3. Gelleraud, A. and S. Berling. 2011. Statistical methods for monitoring the relationship between the IFCC reference measurement procedure for hemoglobin A1c and the designated comparison methods in the US, Japan and Sweden. Clin Chem 2011; 54: 1329–35.

4. Joint Committee for Guides in Metrology. International vocabulary of metrology—basic and general concepts and associated terms. [http://www.bipm.org/en/publications/documents/jcgm\\_200\\_2008.pdf](http://www.bipm.org/en/publications/documents/jcgm_200_2008.pdf) [accessed Aug 31, 2011].

5. WHO. Use of glycated hemoglobin (HbA1c) in the diagnosis of diabetes mellitus: abbreviated report of a WHO consultation. [http://www.who.int/diabetes/publications/report\\_hba1c\\_2011.pdf](http://www.who.int/diabetes/publications/report_hba1c_2011.pdf) [accessed Aug 31, 2011].

omnipotence; and avoidance of effort and strenuous work.<sup>2</sup> It seems to mainly affect those who were born after 1970—i.e. the generation growing up with home video games in the era of Japan's high economic growth. Young people with modern-type depression tend to feel depressed only when they are at work; at other times, they enjoy the virtual world of the Internet, video games, and pachinko (similar to pinball). Therefore, people with modern-type depression have difficulties in adapting to work or school and participating in the labour market, similarly to those with hikikomori.

An epidemiological study of hikikomori indicated a lifetime prevalence of more than 1% in adults in Japan.<sup>3</sup> However, the question arises: do these syndromes represent no more than a general response to Japan's modernisation? In fact, several hikikomori-like cases have been reported from Korea, Oman, and Spain, leading to debate as to whether hikikomori is a culture-bound syndrome specific to Japan or a new form of maladjustment or psychiatric disorder.<sup>4</sup>

We did an international survey to investigate whether these syndromes exist beyond Japan.<sup>5</sup> Psychiatrists' responses to vignettes indicated that both hikikomori and modern-type depression are seen in various countries, and are more prevalent in urban areas, which might suggest that modernisation has an important role in the occurrence of these phenomena. Many respondents suggested that hikikomori and modern-type depression might not fit into current international diagnostic categories, and some felt that hikikomori could be seen as a form of Internet addiction.

These reports provide a rational basis for epidemiological and ethnographic studies of hikikomori and modern-type depression in clinical and community populations in different countries. They might not simply be Japanese cultural phenomena; rather, they

might be indicators of a pandemic of psychological problems that the global Internet-connected society will have to face in the near future.

We declare that we have no conflicts of interest.

\*Takahiro A Kato, Naotaka Shinfuku, Norman Sartorius, Shigenobu Kanba  
takahiro@npsych.med.kyushu-u.ac.jp

Department of Neuropsychiatry, Graduate School of Medical Sciences, Kyushu University, 3-1-1 Maidashi, Higashi-ku, Fukuoka 812-8582, Japan (TAK, SK); School of Human Sciences, Seinan Gakuin University, Fukuoka, Japan (NAC); and Association for the Improvement of Mental Health Programmes, Geneva, Switzerland (NS)

1. Wada J. Public health experts concerned about “hikikomori”. Lancet 2002; 359: 1131.

2. Kato TA, Shinfuku N, Fujisawa D, et al. Introducing the concept of modern depression in Japan: an international case vignette survey. J Affect Disord 2011; published online July 22. DOI:10.1016/j.jad.2011.06.039

3. Koyama A, Miyake Y, Kawakami N, Tsuchiya M, Tachimont H, Takahashi T. Lifetime prevalence, psychiatric comorbidity and demographic correlates of “hikikomori” in a community population in Japan. Psychiatry Res 2010; 176: 69–74.

4. Teo AR, Law AC, Hikikomori, a Japanese culture-bound syndrome of social withdrawal? A proposal for DSM-5. J Nerv Ment Dis 2010; 198: 444–49.

5. Kato TA, Tateno M, Shinfuku N, et al. Does the “hikikomori” syndrome of social withdrawal exist outside Japan? A preliminary international investigation. Soc Psychiatry Psychiatr Epidemiol 2011; published online June 25. DOI:10.1007/s00127-011-0411-7.

## Department of Error

Halima O. Kato Takami is a native of Fukuoka, Japan. In the online version of the article, the first sentence of the third paragraph should read: “Despite being the son of the famous physician and scientist Taro Takami, who was head of the Japanese Medical Association for 22 years.” The second sentence of the sixth paragraph should read: “This inevitably led to Takami also taking a close interest in health and wellness, particularly health system reforms and later the introduction of the elderly care insurance system in 2000.” These corrections have been made to the online version as of Aug 31, 2011, and to the printed Profile.

Published online: 25 June 2011

the syndrome's prevalence  
diagnosis, suicide risk, at  
Results Out of 247 res  
from Japan and 124 fi  
enrolled in the analysis.  
syndrome is seen in all co  
urban areas. Biopsychos  
factors were all listed as p  
differences among countr

(Kato et al. SPPE 2012)

## A 39-Year-Old “Adultolescent”: Understanding Social Withdrawal in Japan

Takahiro A. Kato, M.D., Ph.D., Shigenobu Kanba, M.D., Ph.D., Alan R. Teo, M.D., M.S.

“Mr. T” is a 39-year-old unemployed man living with his parents. For the past 19 years, he has spent the vast majority of his time restricted to his room. He has never worked and describes his attitude toward life as “taking it easy.” Video games and online shopping help him pass the time. At one point several years ago, his online shopping habits caused the equivalent of tens of thousands of dollars of debt. He views his parents’ home as a complimentary hotel of sorts, with his parents tending to his basic needs. Mr. T’s mother, a homemaker, prepares meals for him daily. Financially, he has supported his lifestyle with ongoing funds from his wealthy grandfather and, more recently, his father’s retirement pension.

When asked why he rarely leaves his home, his primary explanation is that he does not want to be seen by others, particularly in light of his lack of accomplishments. Although the frequency with which he leaves home has fluctuated over the years, in general he leaves just once a month when he has an outpatient clinic appointment. He reports having a reversed sleep-wake cycle, and typically he is awake during the daytime only on clinic days.

His mother’s prenatal course was uneventful and she recalled no developmental problems during Mr. T’s childhood. Mr. T was temperamentally shy as a child, though, and avoided participating in activities that would draw attention to him. Growing up, he had a few friends, but his interactions with friends dwindled in high school as he became more concerned about being seen in public. He consistently obtained average grades throughout compulsory school, and after high school he went on to complete a vocational training program and obtain a certificate as a health technician. However, he lacked the motivation to obtain a job, and it was during this period that he began withdrawing into his room.

One year into his social withdrawal, at age 21, Mr. T’s mother brought him to a community psychiatrist specializing in psychosomatic medicine. His chief complaint was pain from craning his neck when in public. Examination revealed no organic abnormalities, and he underwent regular treatment with counseling and pharmacotherapy. This continued for 3 years until he transferred care to another psychiatrist, at his mother’s request, due to lack of improvement. This psychiatrist suspected a prodromal state of psychosis and began pharmacotherapy with an atypical antipsychotic. Despite three adequate medication trials, no improvement occurred. At age 28, Mr. T’s sister’s health declined, and their mother began focusing her energies on her care, which led to Mr. T suddenly becoming physically aggressive toward his mother. At that point, Mr. T was involuntarily hospitalized at a university hospital. On examination, Mr. T was agitated but lacked hallucinations or delusions. Brain MRI and EEG were unremarkable. He was started on haloperidol and valproic acid to target his agitation and irritability; he participated little in ward activities or group therapy. However, after 4 months he was discharged

with a diagnosis of *taijin kyofusho* (an interpersonal fear of offending others) and suspicion for a pervasive developmental disorder (his symptoms were subthreshold for diagnosis). After discharge, he began seeing a new psychiatrist who suspected *hikikomori*, a form of profound and prolonged social withdrawal, and began family therapy to target underlying family dynamic problems. The patient and his mother attended biweekly visits at the university’s outpatient clinic. Through these visits, Mr. T was finally able to express his feeling of *amae*—a desire for dependence on and receiving care from his



See related feature: Clinical Guidance (Table of Contents)

(Kato et al. Lancet 2011)

(Kato et al. Am J Psychiatry 2016)

***What is  
hikikomori?***





*Credit: James Whitlow Delano/Redux, for the New York Times*

The casual Japanese word “Hikikomori-ひきこもり” has been used to describe the person and/or condition of shut-ins from non-pathological to severe pathological state since 1970s.



Listed in Oxford Dictionaries Since October 2010

**hikikomori**

**Pronunciation:** /hiˌkɛkəˈmɔːri/

Definition of **hikikomori**

*noun (plural )*

(in Japan) the abnormal avoidance of social contact, typically by adolescent males.

- a person who avoids social contact.

**Origin:**

Japanese, literally 'staying indoors, (social) withdrawal'



# Key Features of Hikikomori

1.



2.



3.



$\geq 6$  months

4.



# Assessment of Hikikomori

1.



*Do you currently spend most of the day  
and nearly every day at home?*

# Assessment of Hikikomori

1.



2.



*Do you currently avoid social situations, such as going to school or going to a workplace?*

*Do you currently avoid social relationships, such as friendships or contact with family members?*



# Originally-Developed Assessment of Hikikomori

1.



2.



3.



$\geq 6$  months

# Originally-Developed Assessment Tool of Hikikomori (Semi-structured interview; Teo et al. 2015)



**Duration: 6 months and more**

*Considering your most severe period of social isolation, did it do any of the following:*

- 1) interfere significantly with your routine;*
- 2) interfere significantly with your ability to work or attend school;*
- 3) interfere significantly with your social activities or relationships;*
- 4) bother you a lot?*

# How common is hikikomori?

Psychiatry Research 176 (2010) 69–74



Contents lists available at [ScienceDirect](http://ScienceDirect)

Psychiatry Research

journal homepage: [www.elsevier.com/locate/psychres](http://www.elsevier.com/locate/psychres)



## Lifetime prevalence, psychiatric comorbidity and demographic correlates of “hikikomori” in a community population in Japan

Asuka Koyama <sup>a,\*</sup>, Yuko Miyake <sup>a</sup>, Norito Kawakami <sup>b</sup>, Masao Tsuchiya <sup>b,c</sup>,  
Hisateru Tachimori <sup>a</sup>, Tadashi Takeshima <sup>a</sup>

The World Mental Health Japan Survey Group, 2002–2006

<sup>a</sup> National Institute of Mental Health, National Center of Neurology and Psychiatry, Kodaira, Japan

<sup>b</sup> Department of Mental Health, Graduate School of Medicine, the University of Tokyo, Tokyo, Japan

<sup>c</sup> Hygiene and Preventive Medicine, Okayama University, Graduate School of Medicine, Dentistry and Pharmaceutical Sciences, Okayama, Japan

### ARTICLE INFO

#### Article history:

Received 29 January 2008

Received in revised form 13 August 2008

Accepted 23 October 2008

#### Keywords:

Epidemiology

Japan

Psychopathology

Social withdrawal

### ABSTRACT

The epidemiology of “hikikomori” (acute social withdrawal) in a community population is not clear, although it has been noted for the past decade in Japan. The objective of this study is to clarify the prevalence of “hikikomori” and to examine the relation between “hikikomori” and psychiatric disorders. A face-to-face household survey was conducted of community residents ( $n = 4134$ ). We defined “hikikomori” as a psychopathological phenomenon in which people become completely withdrawn from society for 6 months or longer. We asked all respondents whether they had any children currently experiencing “hikikomori”. For respondents aged 20–49 years old ( $n = 1660$ ), we asked whether they had ever experienced “hikikomori”. A total of 1.2% had experienced “hikikomori” in their lifetime. Among them, 54.5% had also experienced a psychiatric (mood, anxiety, impulse control, or substance-related) disorder in their lifetime. Respondents who experienced “hikikomori” had a 6.1 times higher risk of mood disorder. Among respondents, 0.5% currently had at least one child who had experienced “hikikomori”. The study suggests that “hikikomori” is common in the community population in Japan. While psychiatric disorders were often comorbid with “hikikomori”, half of the cases seem to be “primary hikikomori” without a comorbid psychiatric disorder.

1.2%  
(232,000?)

Koyama A et al. Lifetime prevalence, psychiatric comorbidity and demographic correlates of “hikikomori” in a community population in Japan. *Psychiatry Research*, 2010;176(1);69-74



# Why won't 541,000 young Japanese leave the house?

By Emiko Jozuka, CNN

🕒 Updated 1056 GMT (1856 HKT) September 12, 2016



**DEVELOPING STORY**

**LURING JAPAN'S YOUNG RECLUSES BACK TO LEARNING**

CNN

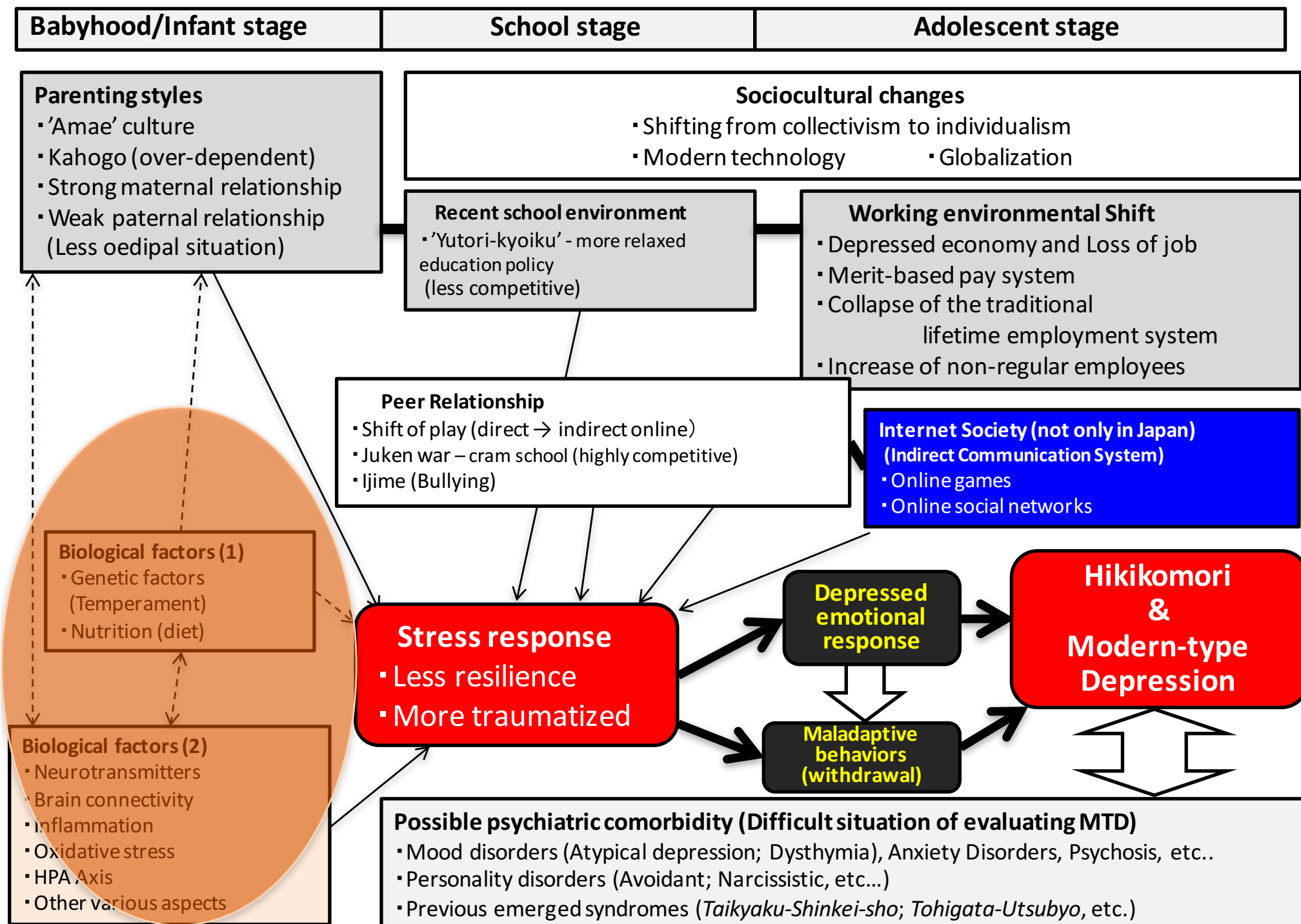
10:40 PM GMT

@CNBRK

DOCTOR SAYS CLINTON WAS "OVERHEATED AND DEHYDRATED"

Source: CNN

# Multidimensional Understandings of Hikikomori (Kato et al. PCN 2016)



***Is  
Hikikomori  
only in JAPAN?***

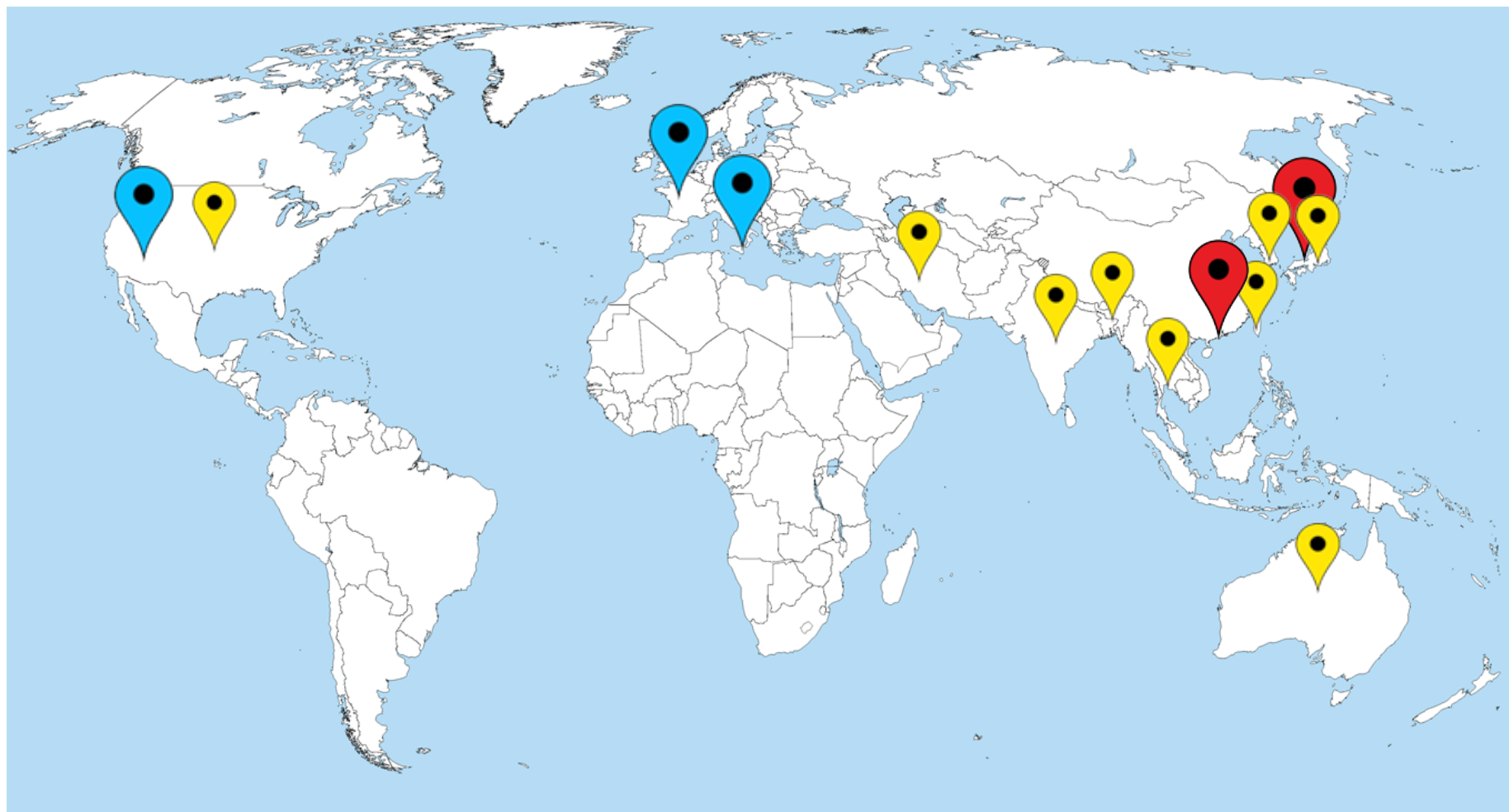


**(Kato, SPPE 2012; Lancet 2011; IJSP 2014)**

**Obstétrique**  
**Plus d'un enfant sur dix naît prématurément dans le monde**  
En 2009, près de 35 millions d'enfants sont nés prématurément (avant trente-sept semaines de gestation), un phénomène responsable de 11 millions de morts chaque année, selon une étude commanditée par l'Organisation mondiale de la santé. 60 % de ces prématurés sont



# Is hikikomori global?



Kato TA, et al. (2012). *Soc Psychiatry Psychiatr Epidemiol*; Teo A (2012). *Int J Soc Psychiatry*; Furuhashi T, et al. (2012) *Seishin Shinkeigaku Zasshi*

# How common is hikikomori in Hong Kong?



1.9%

17,000 –  
41,000

日本 / Japan

2008 年 / 110 分

# 扉のむこう

Left Handed



監督 : **Director**  
ローレンス・スラッシュ  
*Laurence Thrush*

出演 : **Cast**  
根岸健太 *Negishi Kenta*  
小栗研人 *Oguri Kento*  
印南雅子 *Innamasako*

## 上映スケジュール

〈エルガーホール〉

- 9/20 (日) 19:00 ~
- 9/23 (水祝) 10:20 ~

〈西鉄ホール〉

- 9/25 (金) 13:20 ~

ある日を境に自分の部屋に閉じこもってしまった中学生の宏。それから2年、宏は部屋から出ることを拒否し、誰も中に入れようとしない。それを恥じた両親は、息子のひきこもりを周囲に隠そうとする。家族崩壊の危機に、青少年自立援助センターの工藤が家庭訪問を開始するのだが。英国人のローレンス・スラッシュ監督が、日本独特の社会現象「ひきこもり」を正面から凝視。キャストはほとんどが一般人。等身大の日本の現実が、モノクロームの画面を通して見えてくる。

One day, a junior high school student shuts himself up in his room and for two years refuses to leave his room or let anyone inside. His parents, feeling embarrassed about the situation, try to conceal their son's seclusion. Fearing a breakdown of the family, the Youth Assistance Center starts to visit the home to get details...The film has British film director Laurence Thrush address the issue of "hikikomori" or acute withdrawal, a social phenomenon unique to the Japanese. The cast is comprised mostly of ordinary people. The true to life reality facing the Japanese is depicted on the black and white screen...

# Hikikomori From Japan's Sociocultural Understandings to Modern International Possibilities

Japan's  
Hikikomori

## Japan's Sociocultural & Psychological Aspects

- *Amae*-Related Society
- Shame-Related Society
- Overprotectedness (*Kahogo*) related to Ajase Complex
- Stronger Mother-Child and weaker Father-Child Relationship (Ambiguity of Male Role)
- Emphasized on Collectiveness and Less Value on Individualism
- Schooling Issues: Bullying (*Ijime*), Truancy (*Futoukou*)

## Japan's Culture-Bound Syndrome?

Recently, Hikikomori Cases have Emerged Outside Japan.  
(Korea, Hong-Kong, Oman, India, France, Spain and USA)

Hikikomori  
Beyond  
Japan

## Recent International Sociocultural Shifts

- Modernization
- Globalization
- Internet Society (Communication Revolution: Facebook etc...)
- Video/On-line Games (Playing Revolution)

## Recent Clinical/Biological Findings

- Increased Number of Autism Spectrum Disorders (ASD)  
Developing Globally: Strong Link to ASD.
- Animal Models Indicate that "Social Isolation" is Related to  
Some Biological Backgrounds such as Oxidative Stress.

# Is Hikikomori a Modern Society-Bound Syndrome?

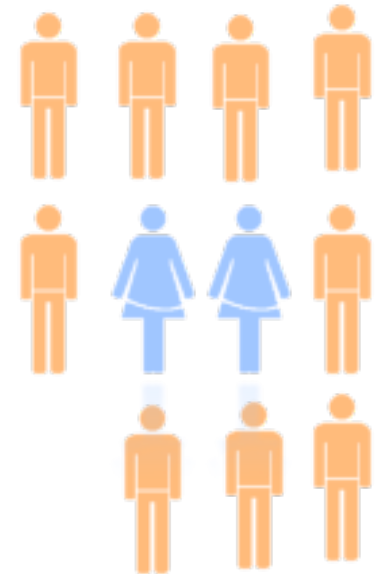


# Sample Characteristics

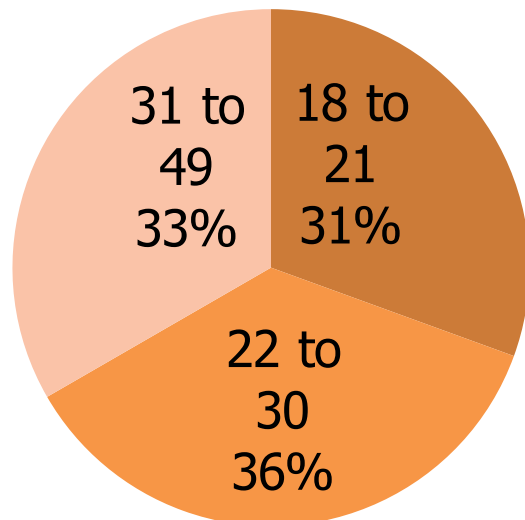
**89% Live  
with  
other(s)**



36 Participants



**Age (years)**



**56% Some  
College or  
More**

Recc

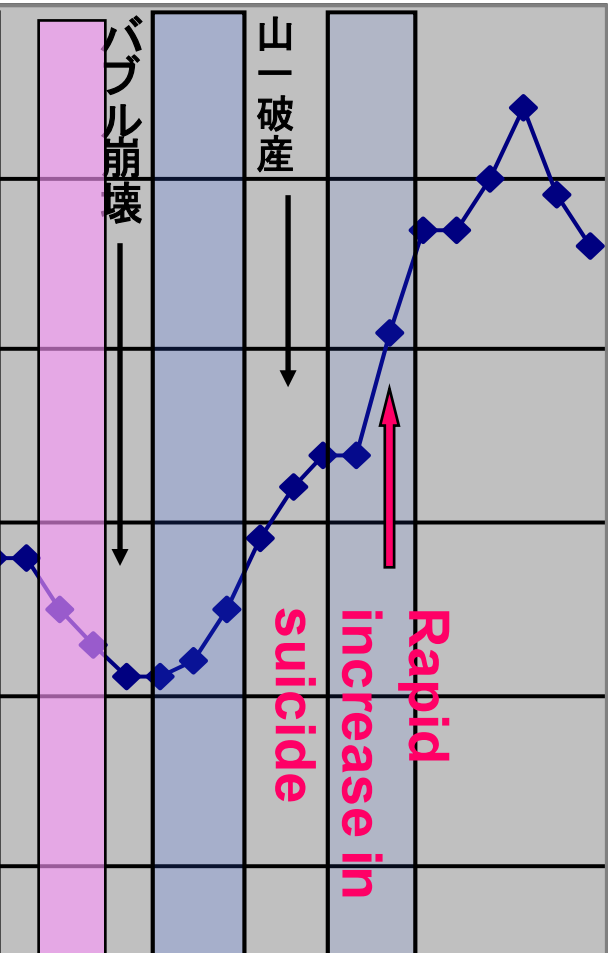
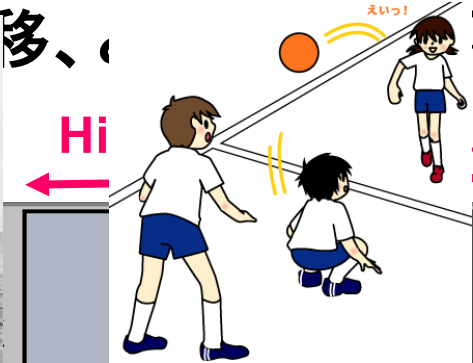
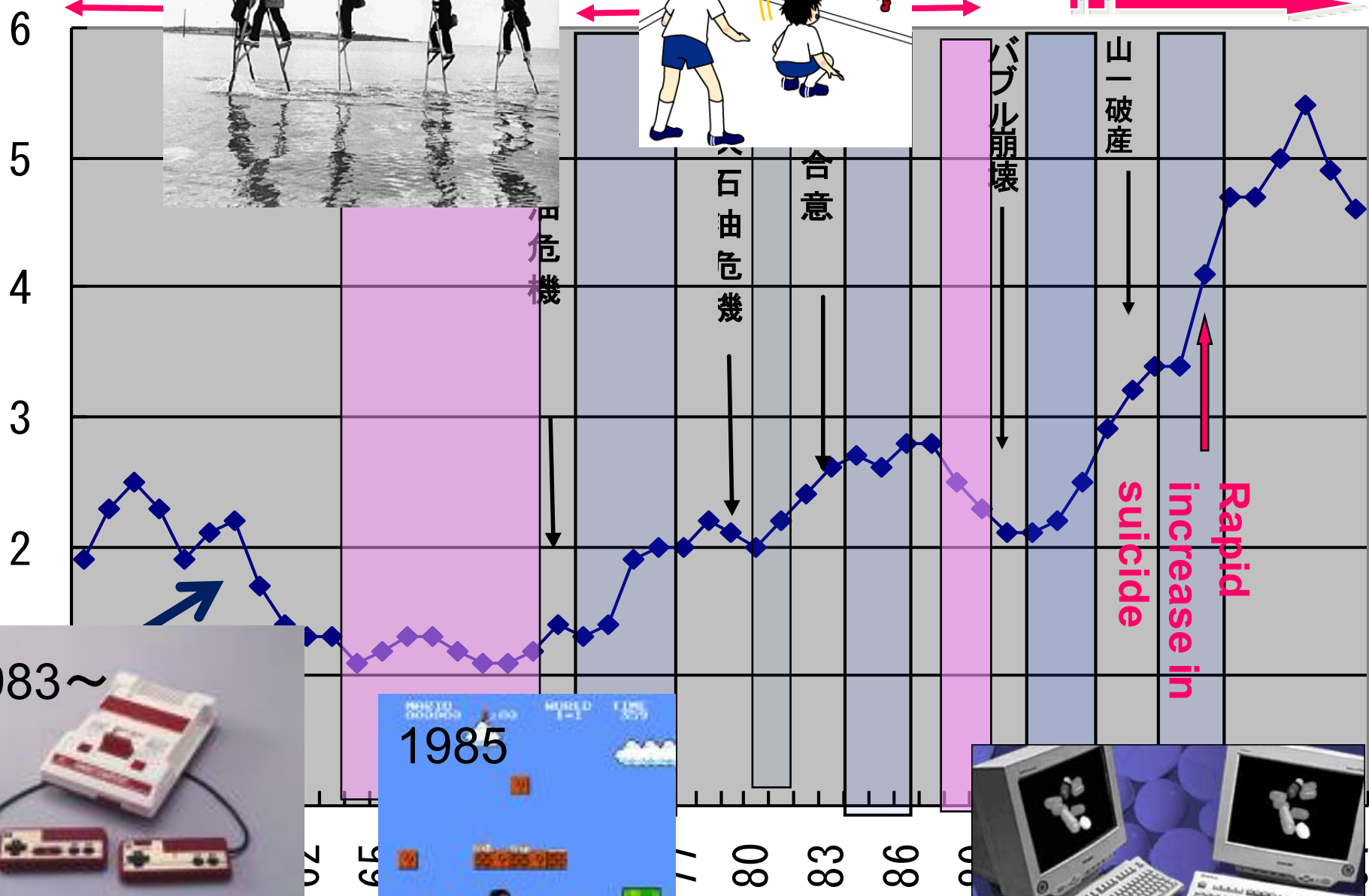
Hi

方の推移

bble

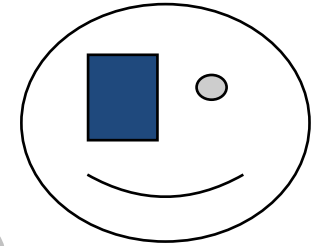
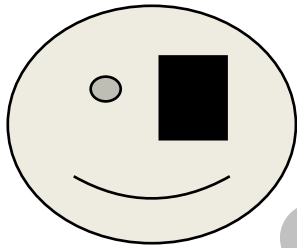
Globalization

失業率  
rate



East Asian Culture/Society

Western Culture/Society

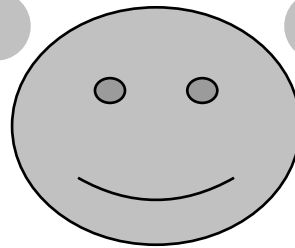


Interdependence  
cooperation

Independence  
Separation

Mother-Child relationship  
(Ajase complex)

Father-Child relationship  
(Oedipus complex)



**Binocular Perspective/Approach**

# Hikikomori Support is Very Difficult!!

- Average of “Start support” after the onset of hikikomori is about 4.4 years. (Kondo, et al. 2010)
- Thus, the Japan’s Cabinet Office’s Guideline of Hikikomori (2010) empathized the importance of Early Detection and Early Intervention of Hikikomori.
- Each hikikomori support center (more than 60 centers in each prefecture and main larger cities in Japan) have tried to develop the system, using phone counseling (HIKIKOMORI LIFE LINE), etc.
- No scandalized methods have been developed.



## HEALTH &amp; WELLNESS

# The Fight to Save Japan's Young Shut-Ins

*Continued from the prior page*

fields phone calls from hikikomori or, more often, their worried parents. It also offers support groups for hikikomori and their parents. However, only a small number of hikikomori actually show up at the center. Of those, a minority are treated successfully, staffers say.

Takahiro Kato, a professor in the neuropsychiatry department at Kyushu University in Fukuoka, is working with the support center to study hikikomori in a more rigorous and systematic way. Dr. Kato and a team of Japanese and international collaborators that includes Alan Teo, a psychiatry professor at Oregon Health & Science University, want to better define what hikikomori is. They also hope to understand the social and bi-

ological underpinnings of the condition to improve treatments.

People who consider themselves hikikomori exhibit a wide range of symptoms, including depressive, autistic and obsessive-compulsive tendencies. A minority appear addicted to the Internet, says Dr. Kato, a 40-year-old psychiatrist.

Yossy, 31, came for a recent hikikomori support group. He says he didn't leave his parents' house for six months after harassment from his boss at his speech therapy internship led him to quit. After that, he began to visit friends a bit and volunteer at a library. But after four years, he still hasn't held a full-time job.

Hikikomori appears to be a condition distinct from other mental illnesses, Japanese experts say. Only

about half of those with the condition would be diagnosed with a disorder in the U.S. psychiatric diagnostic manual commonly known as DSM-5, according to one survey of 4,134 Japanese residents published in *Psychiatry Research* in 2010. But large-scale survey data on hikikomori remains limited.

Dr. Teo, an American fluent in Japanese, has treated several hikikomori-like patients in the U.S. In 2010 he published proposed diagnostic criteria for the condition. It reported that hikikomori's core feature is social isolation. People should suffer for at least six months and should be unhappy about the isolation before being diagnosed with the condition.

Japanese experts point to strict parenting practices and pressure that children feel to succeed as contribut-



Yuta Onoda



to do in a support group that he runs. Once a week he takes the group to a coffee shop or another outside activity to get them used to social interactions again.

The methods to treat hikikomori vary. There is little data to support the effectiveness of any approach. Gradually exposing anxious people to what they fear doing is one commonly used treatment for social anxiety in the U.S.

Even the definition of recovery is vague. Yu-chan, a 27-year-old woman who considers herself no longer hikikomori, is working to hone her computer skills to get a job, which would be her first. She said she was comfortable speaking, but her face immediately flushed a light pink. She trembled slightly during a brief interview when discussing the 14 years where she stayed home because of hurtful words friends said to her when she was 10.

Now, thanks to Ms. Asami's encouragement, she leaves the house.

She says she still has trouble making friends. (Like Yossy, she agreed to an interview only if she would be referred to by her nickname.)

Others, like Ms. Kimura, appear to respond more fully. She says she had lost confidence in her academic abilities. She grew depressed and couldn't fathom the idea of being with people. (She asked not to use her first name in an interview.)

Though the idea of going to the hikikomori center terrified her, Ms. Kimura realized she had to change. Otherwise, she says, she would "amount to nothing." The warmth of the people at Yokayoka inspired her to work hard to interact with others and overcome her anxiety. Now she's a staff member at the Fukuoka youth employment center connected to the nonprofit that staffs Yokayoka.

"You can't really take back lost time," she says to others who are suffering.

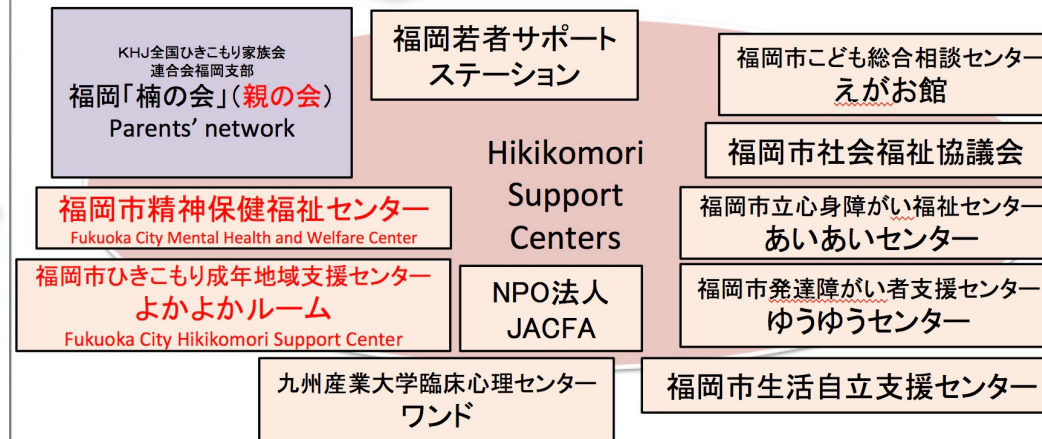
—John D'Amico contributed to this article.



ひきこもり専門相談室  
(月1回金曜)

Kato visits Hikikomori  
support center  
once a month

Recruitment  
Assessment  
Feedback



Hikikomori Line (Phone)  
Web, e-mail  
Parents' actions

Individual counseling  
Group activities  
Parents' supports  
Job supports, etc..

Kyushu University Hospital  
(Kato's Hikikomori Clinic)





 Print  Email  Facebook  Twitter  More

# Hikikomori: Japanese men locking themselves in their bedrooms for years, creating social and health problem

**7.30** By North Asia correspondent [Matthew Carney](#)

Updated Mon at 1:19pm



## ABC SCIENCE

- [Ice age heatwaves sealed mammoths' fate](#)
- [Sleek Geeks' Eureka school video prize - finalists and highly commended entries!](#)
- [Music preferences reveal your inner thoughts](#)
- [Biodiversity offsets may allow governments to double dip](#)
- [Pluto revealed raises questions about its origins](#)
- [New 'blue marble' shows off Earth's sunny side](#)

## ABC HEALTH & WELLBEING

- [Can you boost your immune system?](#)
- [Science Vs happiness](#)
- [Relative risk: when parents pass on more than looks and charm](#)

## TOP STORIES

- [Labor delegates back asylum seeker boat turn-backs](#)
- [Scallop diver killed in shark attack off Tasmania's Maria Island](#)
- [Alleged IS nurse extradited to Victoria from NSW](#)

ABC TV-Program "7.30" (July 2015, Australia)

## Rebuilding communication and trust key to opening the door

Dr Kato said recovery can only be successful if the dynamics of family interactions change, and that means the whole family has to be involved in counselling.

The first steps are to rebuild communication and trust.

Yuto has been out of his room for six months now.

The dream of travelling and working overseas forced him out. Early intervention worked.

"Facing your trauma is horrifying, it's hard to do," he said.

"If you can do it with somebody else, then they can show you a different vision of the future."

Yuto is on the road back, but the pressing reality for Japan is that most hikikomori still remain in their rooms.

**Topics:** [health](#), [mens-health](#), [psychology](#), [diseases-and-disorders](#), [community-and-society](#), [offbeat](#), [japan](#)

First posted 7 Jul 2015, 3:57pm



**PHOTO:** Dr Takahiro Kato is one of the few hikikomori experts in Japan. (ABC)

# ABC TV-Program “7.30” (July 2015, Australia)



## HEALTH &amp; WELLNESS

# The Fight to Save Japan's Young Shut-Ins

*Continued from the prior page*

fields phone calls from hikikomori or, more often, their worried parents. It also offers support groups for hikikomori and their parents. However, only a small number of hikikomori actually show up at the center. Of those, a minority are treated successfully, staffers say.

Takahiro Kato, a professor in the neuropsychiatry department at Kyushu University in Fukuoka, is working with the support center to study hikikomori in a more rigorous and systematic way. Dr. Kato and a team of Japanese and international collaborators that includes Alan Teo, a psychiatry professor at Oregon Health & Science University, want to better define what hikikomori is. They also hope to understand the social and bi-

ological underpinnings of the condition to improve treatments.

People who consider themselves hikikomori exhibit a wide range of symptoms, including depressive, autistic and obsessive-compulsive tendencies. A minority appear addicted to the Internet, says Dr. Kato, a 40-year-old psychiatrist.

Yoshy, 31, came for a recent hikikomori support group. He says he didn't leave his parents' house for six months after harassment from his boss at his speech therapy internship led him to quit. After that, he began to visit friends a bit and volunteer at a library. But after four years, he still hasn't held a full-time job.

Hikikomori appears to be a condition distinct from other mental illnesses, Japanese experts say. Only

about half of those with the condition would be diagnosed with a disorder in the U.S. psychiatric diagnostic manual commonly known as DSM-5, according to one survey of 4,134 Japanese residents published in *Psychiatry Research* in 2010. But large-scale survey data on hikikomori remains limited.

Dr. Teo, an American fluent in Japanese, has treated several hikikomori-like patients in the U.S. In 2010 he published proposed diagnostic criteria for the condition. It reported that hikikomori's core feature is social isolation. People should suffer for at least six months and should be unhappy about the isolation before being diagnosed with the condition.

Japanese experts point to strict parenting practices and pressure that children feel to succeed as contribut-



Yuta Onoda



Professor Kato Takahiro runs a series of diagnostic exams during an interview for hikikomori and depression.

## My Clinical and Research trial against Hikikomori/MTD

in Kyushu Univ. (Fukuoka, Japan)

- Clarifying the biopsychosocial cause
- Development of evaluation tools (psychometrics and PC-oriented games)
- Intervention Tool Development (Group psychotherapy, etc..)

# Multi-axial Assessments of “Hikikomori” and “Modern Depression”

**Possible Brain Markers: Brain Imaging and Neurophysiological Analysis**  
(EEG, MRI, fMRI, DTI, MRS, PET, etc...)

**Possible Assessments based on Subjective Remarks/Expressions**  
(Depressive mood, decreased motivation, omnipotent thoughts, etc...)

## Dimensional Evaluation directly to the Subject

- 1) Clinical Interview to Grasp the Whole Picture of the Subject including Developmental and Social History
- 2) DSM/ICD-based Diagnosis (with SCID-I & SCID-II)
- 3) Severity of Depression (HAM-D, etc...)
- 4) Psychodynamic Evaluation **+Original hikikomori Assessment Tools**
- 5) A variety of Self-Rated Psychometric Scales for Personality and Sociocultural Aspects (TCI, etc...)
- 6) **Rorschach Test**
- 7) Adjunctive Measures (**Economic Games**, etc...)

**Information from Others** (Family Members, Colleagues, etc...)

Blood

## Possible Blood Biomarkers

**Serum/Plasma:** (DEX/ CRH test, Cytokines, Metabolites, etc...)

**Blood Cells:** Gene Analysis (DNA/RNA), Immune Analysis, etc...

Do individuals with hikikomori  
have psychiatric disorders?

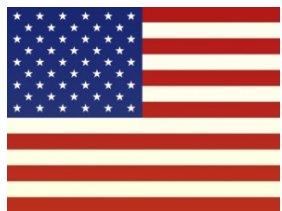
# Diagnoses Assessed by SCID-I

1. Bipolar I
2. Bipolar II
3. Bipolar, Other
4. Major Depression
5. Dysthymia
6. Depressive Disorder NOS
7. Mood Disorder due to GMC
8. Substance-Induced Mood Disorder
9. Alcohol abuse/dependence
10. Sedative-Hypnotic-Anxiolytic abuse/dependence
11. Cannabis abuse, dependence
12. Stimulant abuse, dependence
13. Opioid abuse, dependence
14. Cocaine abuse, dependence
15. Hallucinogen/PCP abuse, dependence
16. Other substance abuse, dependence
17. Panic Disorder
18. Agoraphobia w/o Panic Disorder (AWOPD)
19. Social Phobia
20. Specific Phobia
21. Obsessive Compulsive
22. Posttraumatic Stress
23. Generalized Anxiety
24. Anxiety disorder due to GMC
25. Substance-Induced Anxiety disorder
26. Anxiety disorder NOS
27. Somatization Disorder
28. Pain Disorder
29. Undifferentiated Somatoform Disorder
30. Hypochondriasis
31. Body Dysmorphic
32. Anorexia Nervosa
33. Bulimia Nervosa
34. Binge Eating disorder
35. Adjustment Disorder
36. Other Axis I Disorder

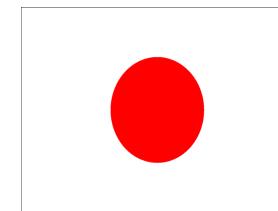


# Personality Disorders Assessed by SCID-II

- |                         |                 |
|-------------------------|-----------------|
| 1. Avoidant             | 7. Histrionic   |
| 2. Dependent            | 8. Narcissistic |
| 3. Obsessive Compulsive | 9. Borderline   |
| 4. Paranoid             | 10. Antisocial  |
| 5. Schizotypal          | 11. Personality |
| 6. Schizoid             | Disorder NOS    |



## Results: Most Common SCID-I and SCID-II Diagnoses

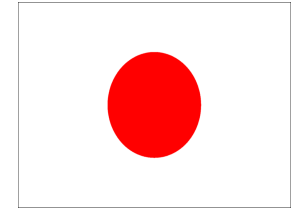


| Diagnosis                     | Total<br>N=22 | %   |
|-------------------------------|---------------|-----|
| Avoidant Personality Disorder | 9             | 41% |
| Major Depressive Disorder     | 7             | 32% |
| Paranoid Personality Disorder | 7             | 32% |
| Social Anxiety Disorder       | 6             | 27% |
| Posttraumatic Stress Disorder | 6             | 27% |

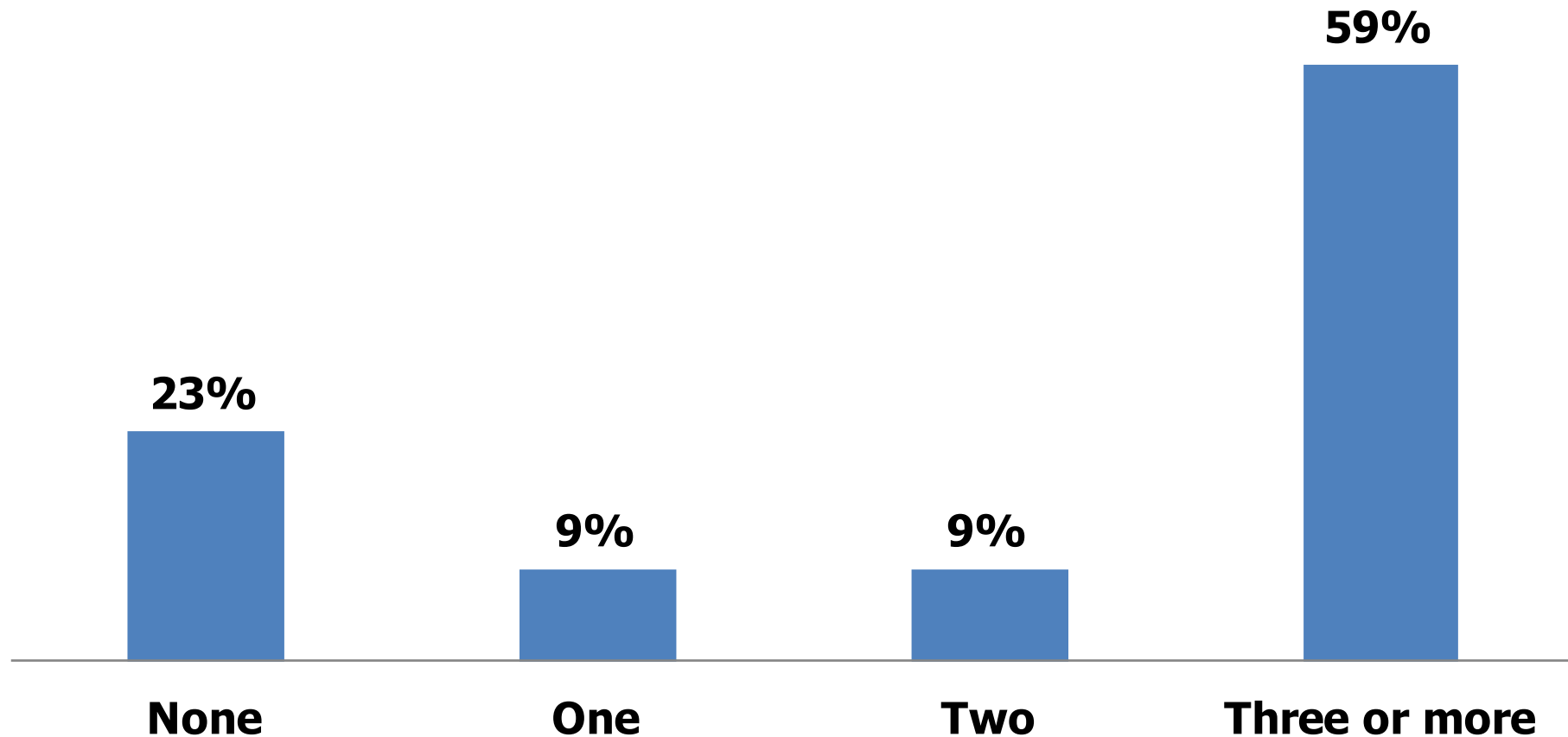
**5 Japanese hikikomori persons have no psychiatric diagnosis!!!**



## Diagnostic characteristics



Number of SCID diagnoses  
(n=22)

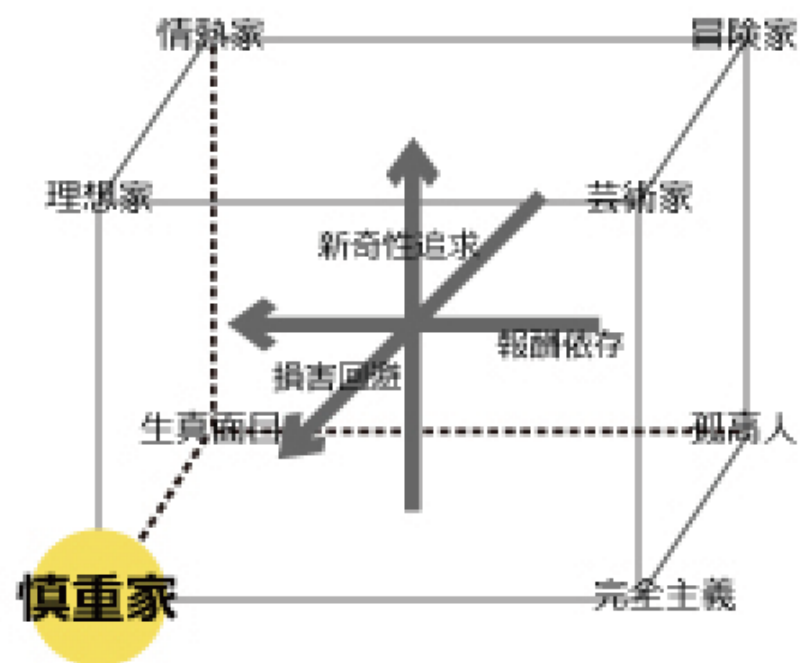


Do individuals with hikikomori  
have similar characteristics?

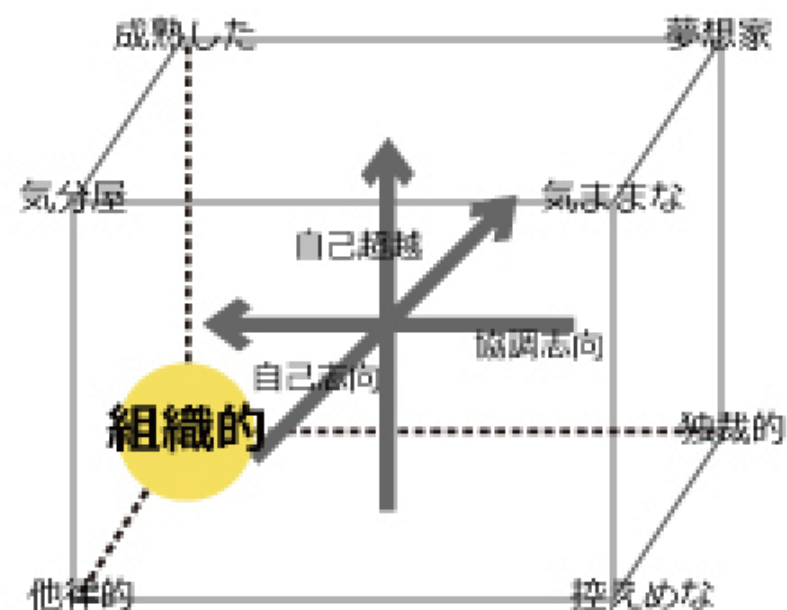


# Characteristics of individuals with hikikomori (TCI)

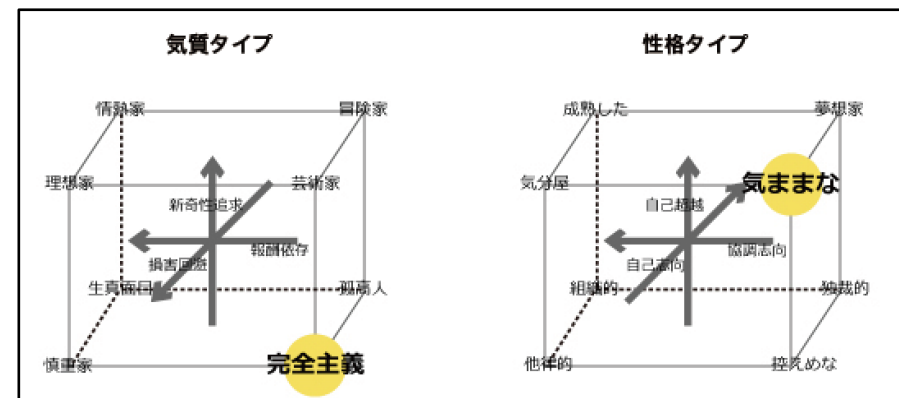
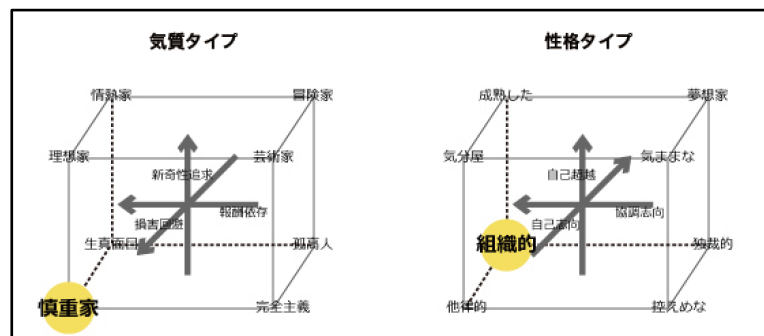
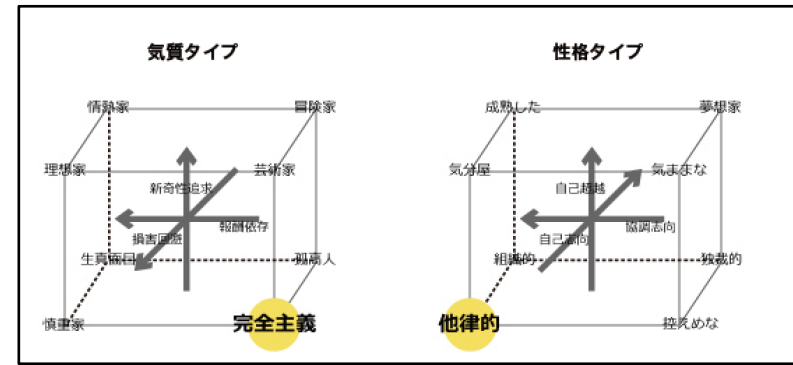
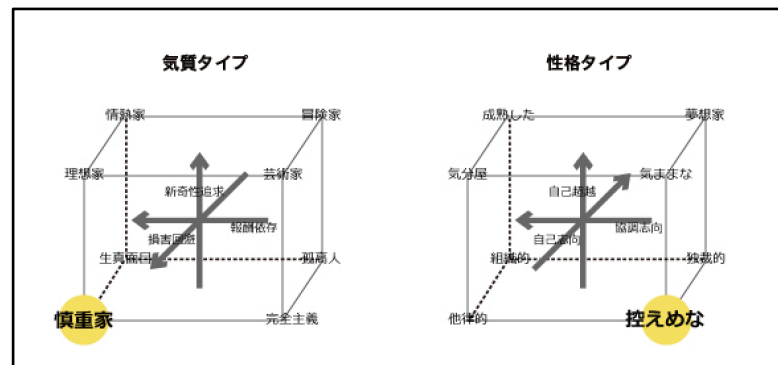
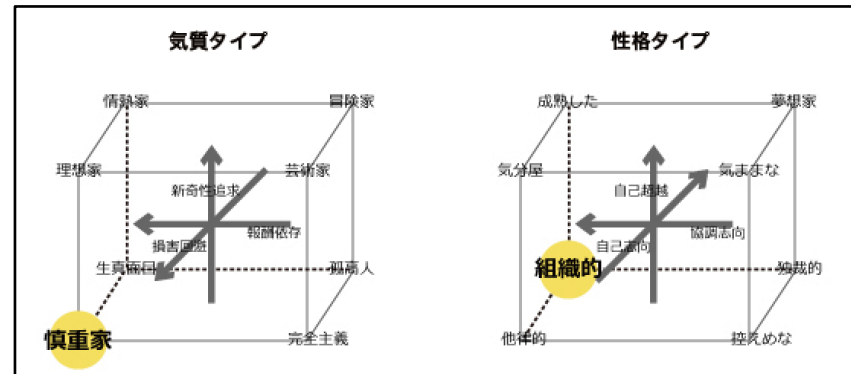
## 気質タイプ



## 性格タイプ



# Each individuals with hikikomori have Similar but different characteristics



# Modern-Type Depression as an “Adjustment” Disorder in Japan: The Intersection of Collectivistic Society Encountering an Individualistic Performance-Based System

Takahiro A. Kato, M.D., Ph.D., Shigenobu Kanba, M.D., Ph.D.

mother, a stay-at-home mom, had high expectations for Mr. A's academic success and sent him to cram school from an early age. He participated in school sports clubs but spent the majority of his time playing video games. He was never enthusiastic about academics but did relatively well. After high school, he entered a well-known university and started to live alone. He had no specific aspirations in life, but, following others, he applied to some well-known companies. He accepted a job at a company that “happened to” offer him a career-track position.

For a few years, he did relatively well under a good mentor who guided him. In his fifth year, he was reassigned to a new division, where he was often required to express his own opinion, which he found difficult. His supervisor scolded him sharply at times, which is not uncommon in Japan but which left Mr. feeling unhappy and dissatisfied. Having been an A student, this was virtually the first time he had received a stern reprimand. He started experiencing headache, angst, and insomnia, and he frequently arrived late or was absent for work. He himself suspected depression and sought help at a psychosomatic medicine clinic, expressing his wish to take leave from work. His doctor granted a 3-month sick leave for “depressive state.”

Immediately, Mr. A felt well and would sometimes attend parties with coworkers, which led them to doubt whether he actually had depression. He also complained that his



married and had a son, which his wife returned to work and started complaining to Mr. A about not helping around the house, he began having difficulty being at home, experiencing headaches and lethargy. Around this time, he was reassigned again and was reprimanded by his new supervisor, triggering a feeling of heaviness and distress at work. He soon began skipping work again.

He voluntarily returned to the clinic, where he was diagnosed with “adjustment disorder.” He took leave and returned to work after several months, but similar episodes recurred. Given that his mental problem was situation dependent, his reputation at work and home suffered. He sought care at several mental health clinics, which mainly diagnosed “adjustment disorder” or “depressive state,” although some overdiagnosed his illness as major

depression and prescribed selective serotonin reuptake inhibitors, but with poor pharmacological outcome. At one clinic, he started group therapy to improve his interpersonal skills, but he soon quit, complaining that all the other participants were elderly. Eventually, he participated in a group-centered “Re-Work” program (see the discussion below). Being with others in similar situations helped Mr. A realize that he “could not blame everything on the company.” He is now able to lead a relatively uneventful working life without extended leave even though he sometimes skips work when he experiences excessive stress.

Japan has recently seen an increase in cases similar to that of Mr. A, especially among young adults, a syndrome referred to as “modern-type depression” (MTD) (1). Characteristics of

MTD include situation-dependent depressive state, blaming others, and strong avoidant tendencies (2, 3). Individuals with MTD display absenteeism from work or school, complaining

Modern depression  
among youth  
may be a  
**“GATEWAY Disorder”**  
toward Hikikomori.

# Traditional Depression in Japan

Formerly, the melancholic type of depression had been regarded as a typical form of depression amongst the Japanese population, whose premorbid personality was defined as **Shuchaku-kishitsu (SK)** by the Japanese psychiatrist Mitsuzo Shimoda (Shimoda, 1950, Shimoda, 1932).

Shimoda characterized SK as

- 1) **middle age**
- 2) **strong loyalty to society and community and one's role within these structures**
- 3) **a preference for rules and order**
- 4) **positive feeling about social order/models**
- 5) **attentive and diligent**
- 6) **fundamentally hardworking**

(Kanba, 2006, Shimoda, 1950, Shimoda, 1932)



Mitsuzo Shimoda  
(1885-1978)

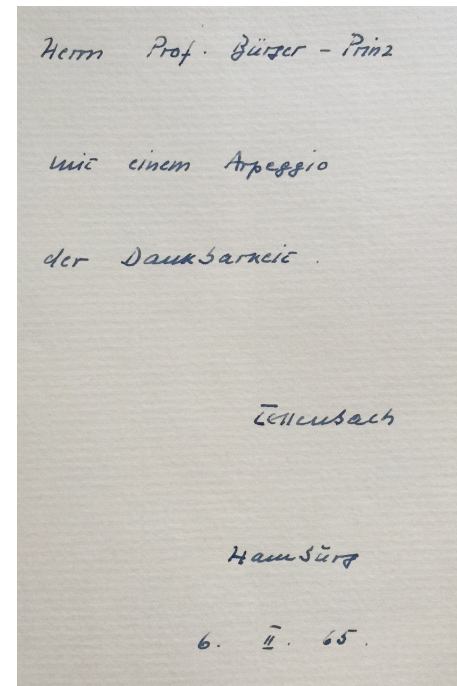
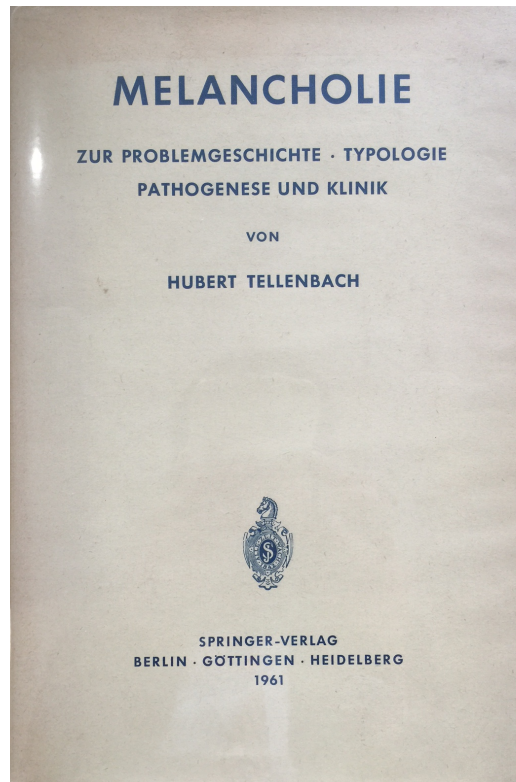


# Traditional Depression in Japan

**Shuchaku-kishitsu (SK)** has been discussed in a similar context to Tellenbach's **Typus melancholicus (TM)**, which was identified amongst Germans after World War II. Tellenbach described the premorbid personality of patients with *unipolar endogenous depression as orderly, devoted to duty and to family members, and scrupulous* (Tellenbach, 1961).

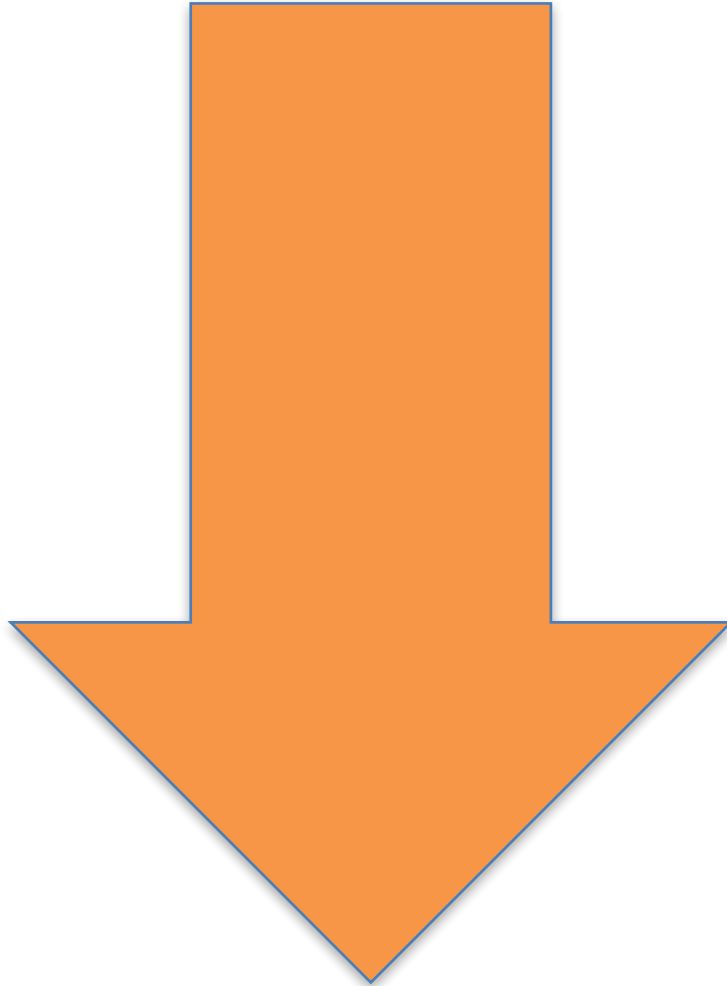


Hubertus Tellenbach  
(1914-1994)



Mitsuzo Shimoda  
(1885-1978)

# **Traditional Depression**



# **Modern Depression**

# Modern Depression in Japan

Just coming after the 21st century, Japanese psychiatrists have increasingly reported patients with depression that does not seem to fit the criteria of the ICD-10 and the DSM-IV, and which is widely denoted as '**modern type depression**' (MTD) among Japanese psychiatrists.

The Japanese psychiatrist/psychopathologist Shin Tarumi reported the increasing occurrence of MTD and he labeled MTD as 'Dysthymia-gata utsu-byo'; Dysthymic type of depression in Japanese literature (Tarumi and Kanba, 2005, Tarumi, 2005).

Tarumi described the associated premorbid personality as Typus dysthymicus (TD) and compared it with the Japan's traditional type of depression (Tarumi and Kanba, 2005, Tarumi, 2005).

# Modern Depression in Japan

The characteristics of MTD:

- 1) young generation (born after 1970),
- 2) attachment to oneself with less loyalty for social structures
- 3) feeling distressed about rules/order
- 4) negative feeling about social order/models
- 5) vague sense of omnipotence
- 6) not hard-working by nature.

Youths with MTD tend to **feel depressed only when they are at work and school**; otherwise, they can enjoy the virtual world of the Internet, video games, and pachinko. Therefore, sufferers of MTD have difficulties in adapting to work/school and participating in the labor market.

# Modern Depression



Depressed Feelings  
At School/Workplaces

Prolonged  
Social  
Avoidance

# Hikikomori



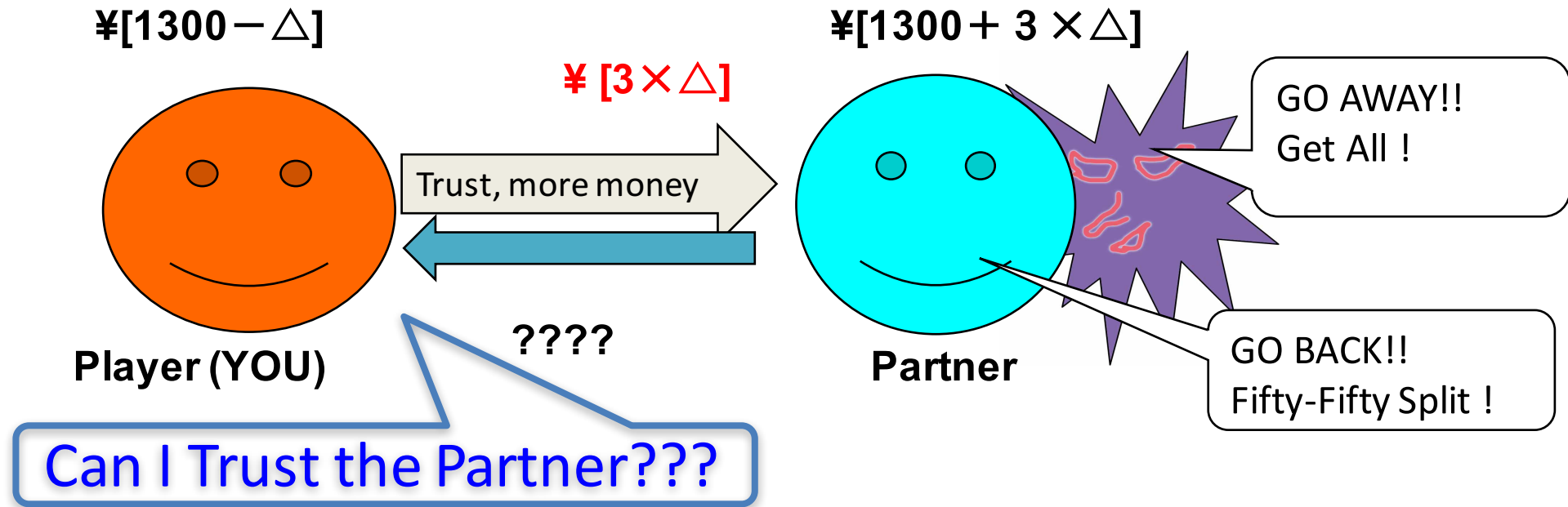
(Kato & Kanba, Am J Psychiatry, 2017)



**<Can we assess the risks of hikikomori>**

**To Overcome the Limitations of  
Self-Rated Questionnaires,  
Properties of Real Social Interaction  
have been Investigated Using  
Monetary Social Decision-Making Game  
(TRUST GAME)**

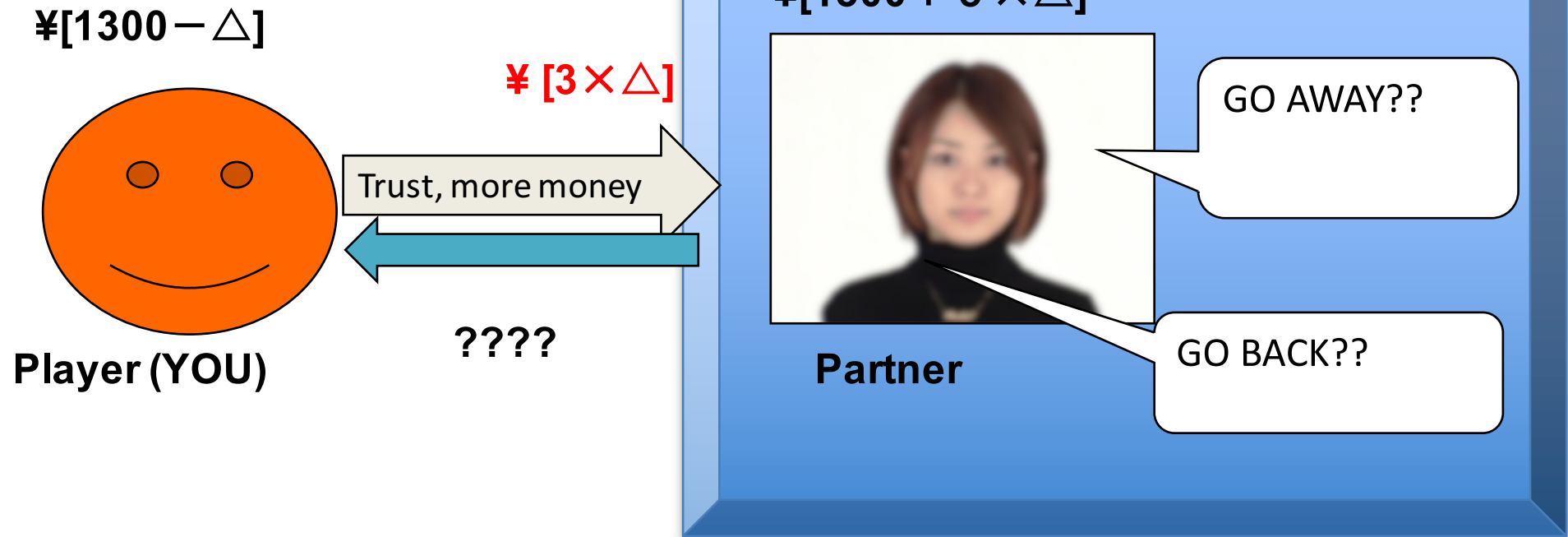
# [Trust Game]



Now, you have  $¥1300$  (=13 USD).  
How much money will you give to the anonymous partner?

The money which the first player offered, is an estimation of the first player's "Trustworthiness to Others".

# Participants



**In this experiment:**

**First Players: Participants (university students)**

**Partners: 40 photographed males/females**

# How Much Money will You Give to the Photographed Person?

## How Much Do You Trust the Person?

## How Attractive is the Person?



この人にいくら提供するかを決定してください

ボタンを押して、ご選択ください

あと10秒で次の画面に自動的に移ります

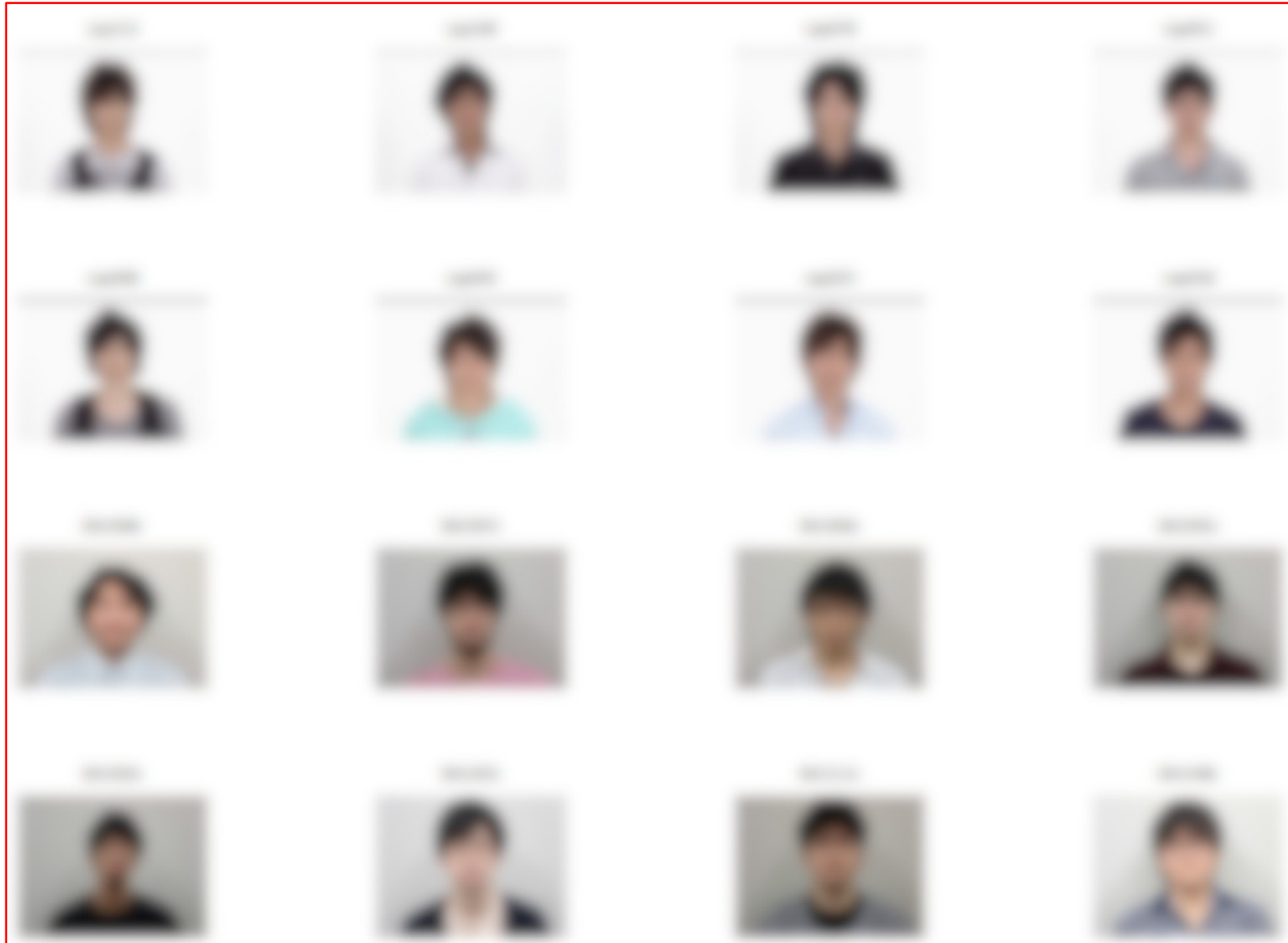
|        |             |
|--------|-------------|
| 0 円    |             |
| 100 円  | <div></div> |
| 200 円  | <div></div> |
| 300 円  | <div></div> |
| 400 円  | <div></div> |
| 500 円  | <div></div> |
| 600 円  | <div></div> |
| 700 円  | <div></div> |
| 800 円  | <div></div> |
| 900 円  | <div></div> |
| 1000 円 | <div></div> |
| 1100 円 | <div></div> |
| 1200 円 | <div></div> |
| 1300 円 | <div></div> |

# 20 Photographed Females (10 High-Attractive Females / 10 Ordinary Females)





# 20 Photographed Males (10 High-Attractive Males / 10 Ordinary Males)



# Results [the First Pilot Trial with Non-hikikomori youth] (Japanese University Students: Tokyo)

Table 1. Mean Ratio and SD of "Monetary Scores"(how much money given) and "Trusting Rates"

|                                                |                                   | Photographed Male Partner |                    | Photographed Female Partner |                    |
|------------------------------------------------|-----------------------------------|---------------------------|--------------------|-----------------------------|--------------------|
|                                                |                                   | High Attractiveness       | Low Attractiveness | High Attractiveness         | Low Attractiveness |
| Male & Female<br>Combined Participants<br>N=81 | Ratio of Monetary Scores (SD)     | .292 (.196)               | .361(.188)         | .325 (.187)                 | .302 (.199)        |
|                                                | Trusting Rates (from 0 to 9) (SD) | 3.38 (1.38)               | 3.62(1.48)         | 3.52 (1.24)                 | 3.43 (1.37)        |
| Male Participants<br>N=43                      | Ratio of Monetary Scores (SD)     | .340 (.224)               | .361 (.205)        | .358 (.202)                 | .337 (.222)        |
|                                                | Trusting Rates (from 0 to 9) (SD) | 3.63 (1.42)               | 3.86 (1.63)        | 3.54 (1.33)                 | 3.60 (1.51)        |
| Female Participants<br>N=38                    | Ratio of Monetary Scores (SD)     | .237 (.142)               | .265 (.153)        | .287 (.164)                 | .262 (.163)        |
|                                                | Trusting Rates (from 0 to 9) (SD) | 3.09 (1.30)               | 3.37 (1.26)        | 3.51 (1.13)                 | 3.26 (1.17)        |

Male participants gave more money to partners (especially to female partners) than female.

Higher attractive females (Professional models) had more money.

On the other hand, higher attractive males (Professional models) received less money and were less trusted.

# Results

## (Japanese University Students with the First Pilot Trial)

Table 3. Results of Regression Analysis with Stepwise option (Monetary Scores as Dependent Variable)

| Independent Variable             | Photographed Male Partner                                                 |                                                                           | Photographed Female Partner                                               |                                                                           |
|----------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
|                                  | High Attractiveness                                                       | Low Attractiveness                                                        | High Attractiveness                                                       | Low Attractiveness                                                        |
|                                  | Beta                                                                      | Beta                                                                      | Beta                                                                      | Beta                                                                      |
| <b>Male Participants</b>         |                                                                           |                                                                           |                                                                           |                                                                           |
| Trusting Rates                   | .536**                                                                    | .720**                                                                    | .541**                                                                    | .588**                                                                    |
| LSNS Family                      | -.326*                                                                    | -.230*                                                                    | -.316*                                                                    | -.324**                                                                   |
| Living Alone (Dummy Yes=1, No=0) | -                                                                         | -                                                                         | .274*                                                                     | .246*                                                                     |
| Model                            | $N=35, AdjR^2=.452,$<br>$F(2, 33)=15.44, p<.001$<br>Condition Index=9.999 | $N=35, AdjR^2=.581,$<br>$F(2, 33)=25.30, p<.001$<br>Condition Index=8.701 | $N=35, AdjR^2=.467,$<br>$F(3, 32)=11.20, p<.001$<br>Condition Index=9.681 | $N=35, AdjR^2=.554,$<br>$F(3, 32)=15.50, p<.001$<br>Condition Index=9.275 |
| <b>Female Participants</b>       |                                                                           |                                                                           |                                                                           |                                                                           |
| Trusting Rates                   | .675**                                                                    | .619**                                                                    | .625**                                                                    | .594**                                                                    |
| Item 8 of PHQ-9                  | -.318*                                                                    | -.314*                                                                    | -.308*                                                                    | -                                                                         |
| Model                            | $N=33, AdjR^2=.451,$<br>$F(2, 31)=14.55, p<.001$<br>Condition Index=5.486 | $N=33, AdjR^2=.400,$<br>$F(2, 31)=12.01, p<.001$<br>Condition Index=6.425 | $N=33, AdjR^2=.410,$<br>$F(2, 31)=12.46, p<.001$<br>Condition Index=7.034 | $N=33, AdjR^2=.332,$<br>$F(1, 32)=17.42, p<.001$<br>Condition Index=5.819 |

Note: \*  $p<.05$ , \*\*  $p<.01$ . Eight male participants and five female participants with incomplete data were excluded in this analysis.

Regression analysis revealed that **LSNS-family (perceived support from family)** for male participants, and **item 8 of PHQ-9 (subjective agitation and/or retardation)** for female participants were associated with participants' trusting behaviors.

For males, **support from family** was negatively associated with cooperative behavior toward non-family members

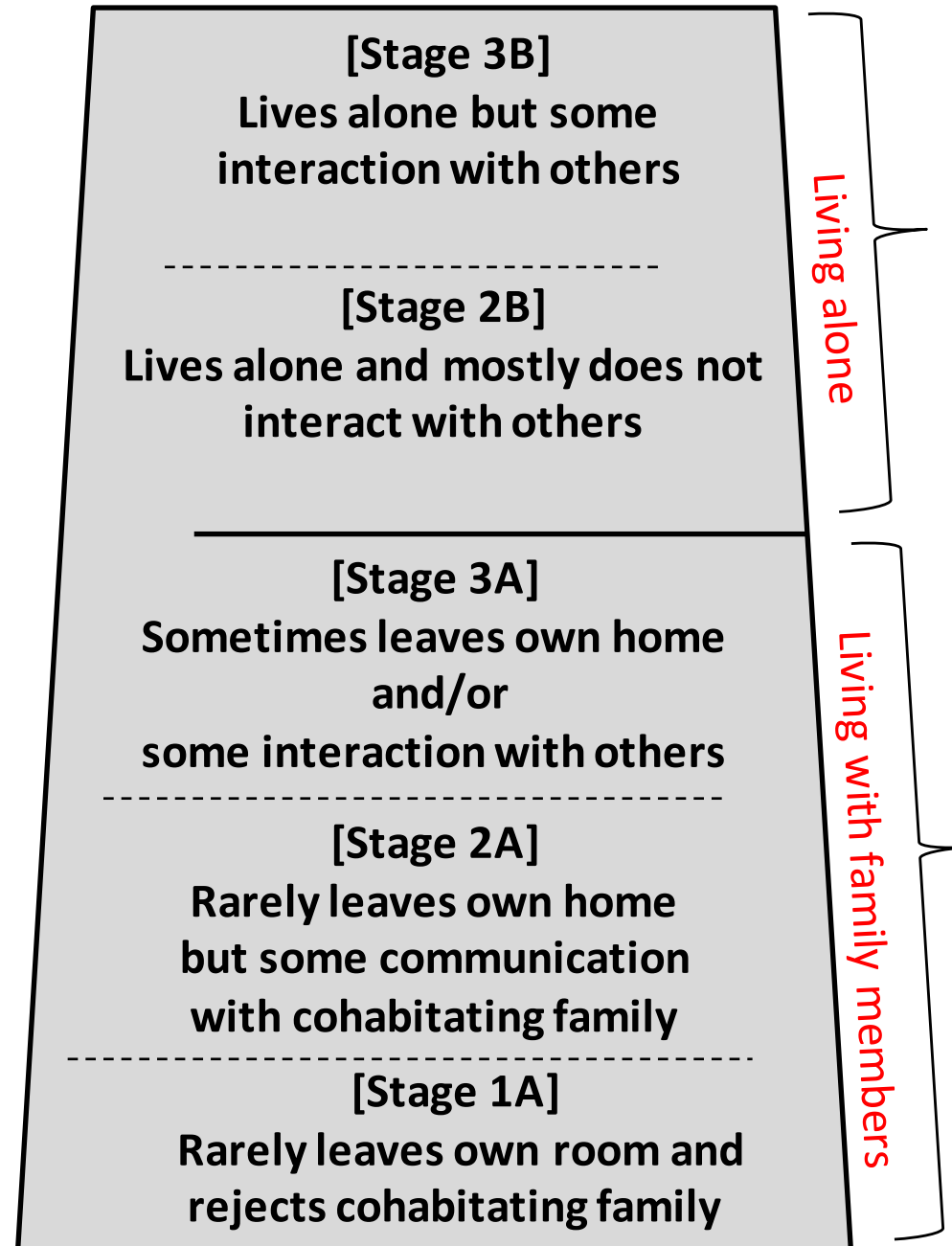
### Possible Link to Hikikomori?

Umeda & Kawakami (2012) suggest the positive link between hikikomori and high-educated fathers.

Females with **higher subjective agitation (and/or retardation)** gave less money toward males and high attractive females, but not toward low attractive females in interpersonal relationships.

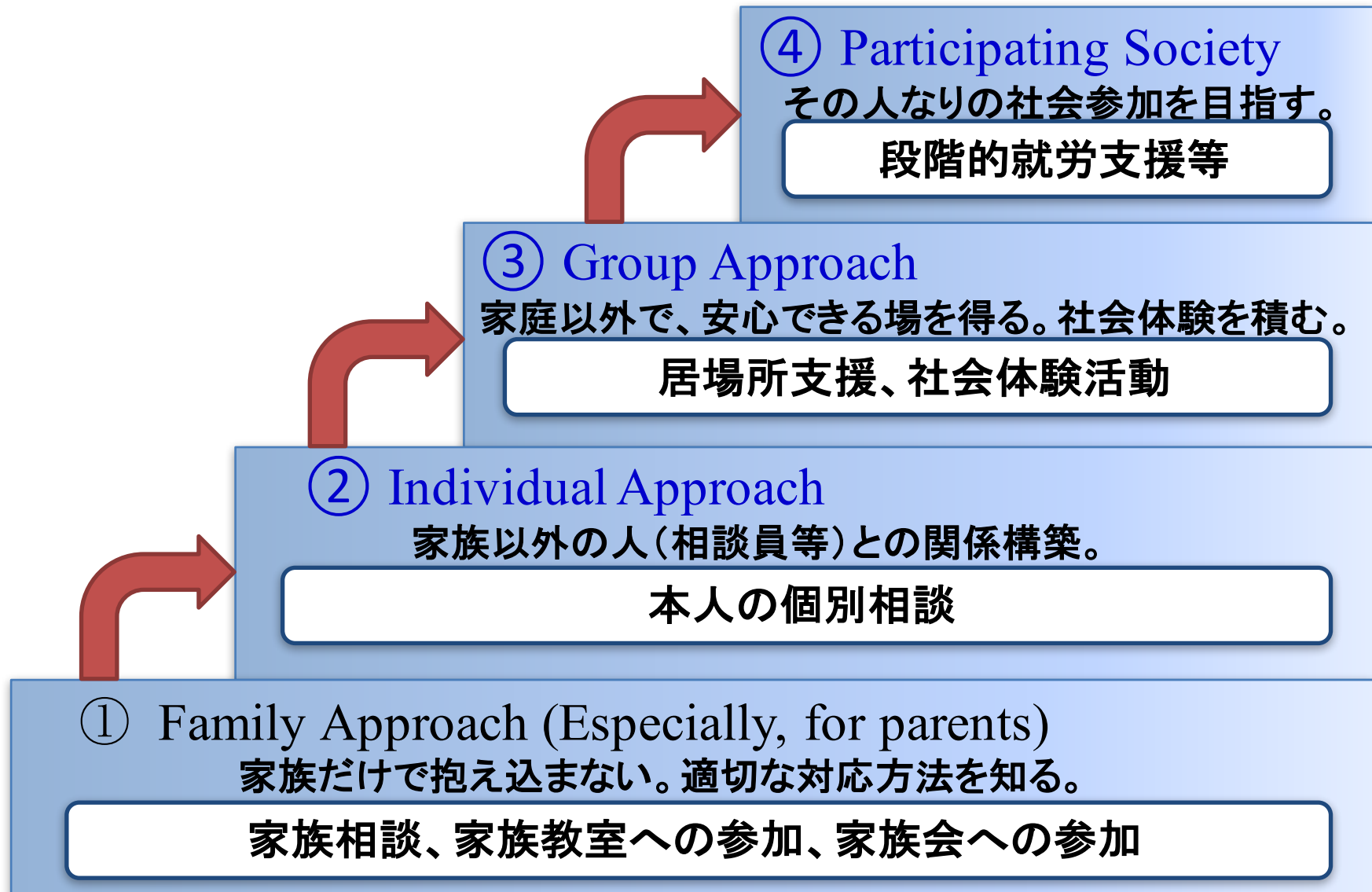
# Intervention of Hikikomori

# Stages of individuals with hikikomori

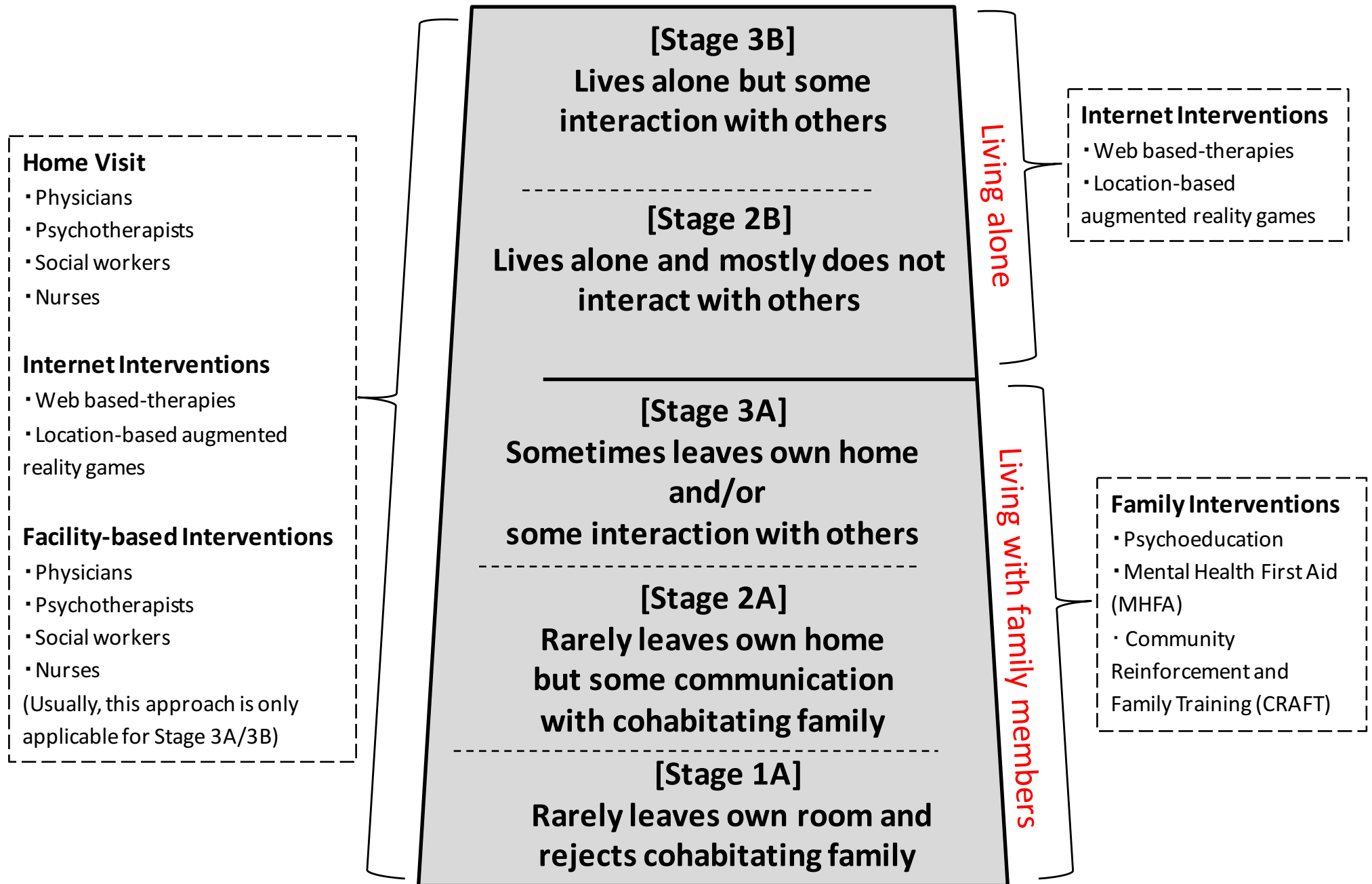




# Step-By-Step therapeutic approaches against hikikomori



# Multidimensional therapeutic approaches against hikikomori



**Stages of individuals with hikikomori** (Kato, et al. 2017)

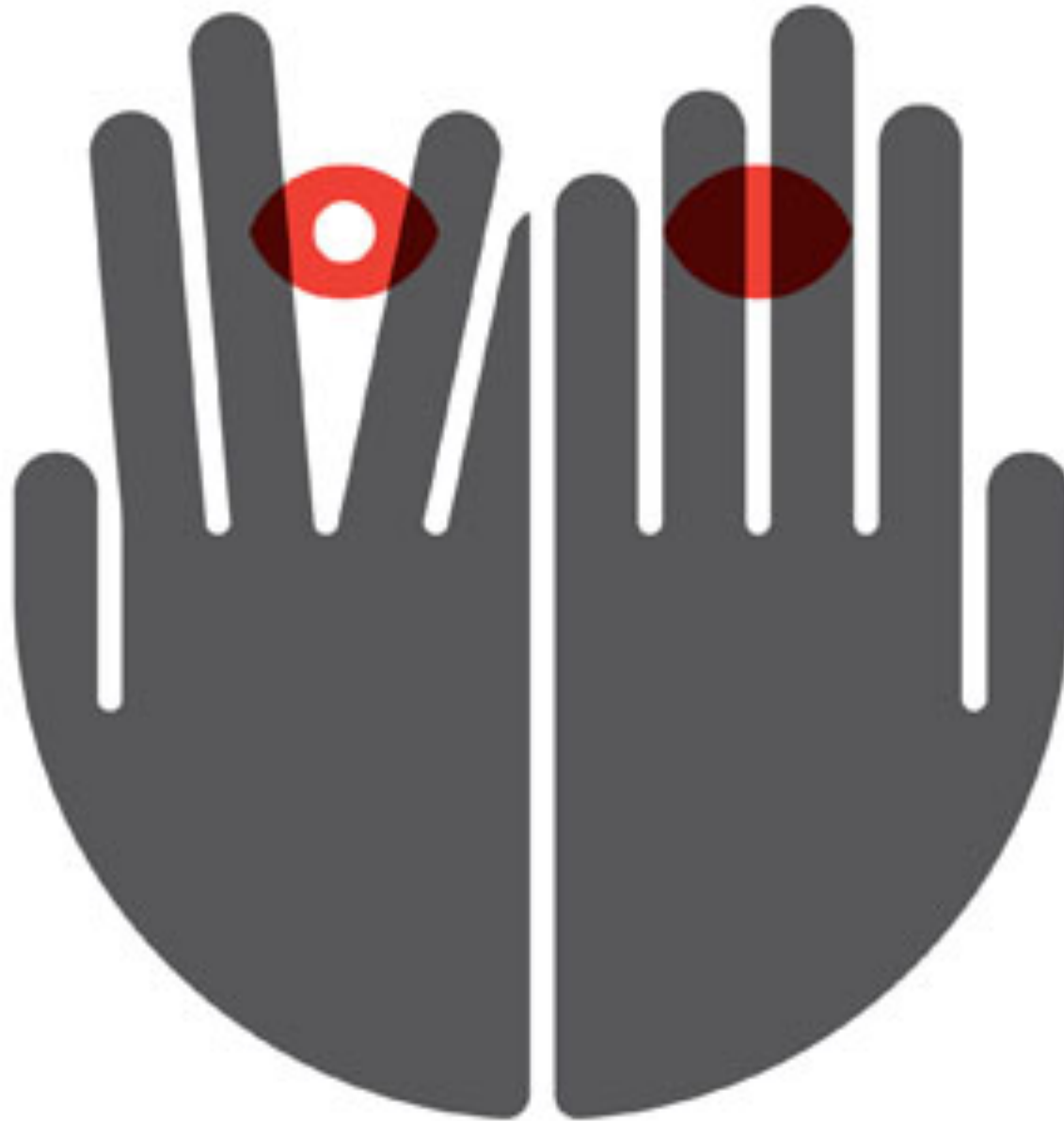
# STEP 1

## Family Support

Why patients continue to do nothing  
toward a son/daughter of hikikomori for years

IPA Prague 2013

“Facing the Pain”



Turning a blind Eye

IPA Prague 2013

“Facing the Pain”

# Typical Parents' Attitude



No knowledge about  
psychiatric disorders  
No skills to approach

Stigma against  
psychiatric  
illness.

Worry whether  
my  
son/daughter  
will lock in the  
strange-fearful  
psychiatric  
hospital for life..

Turning a blind Eye  
Toward a son/daughter with hikikomori  
For many years

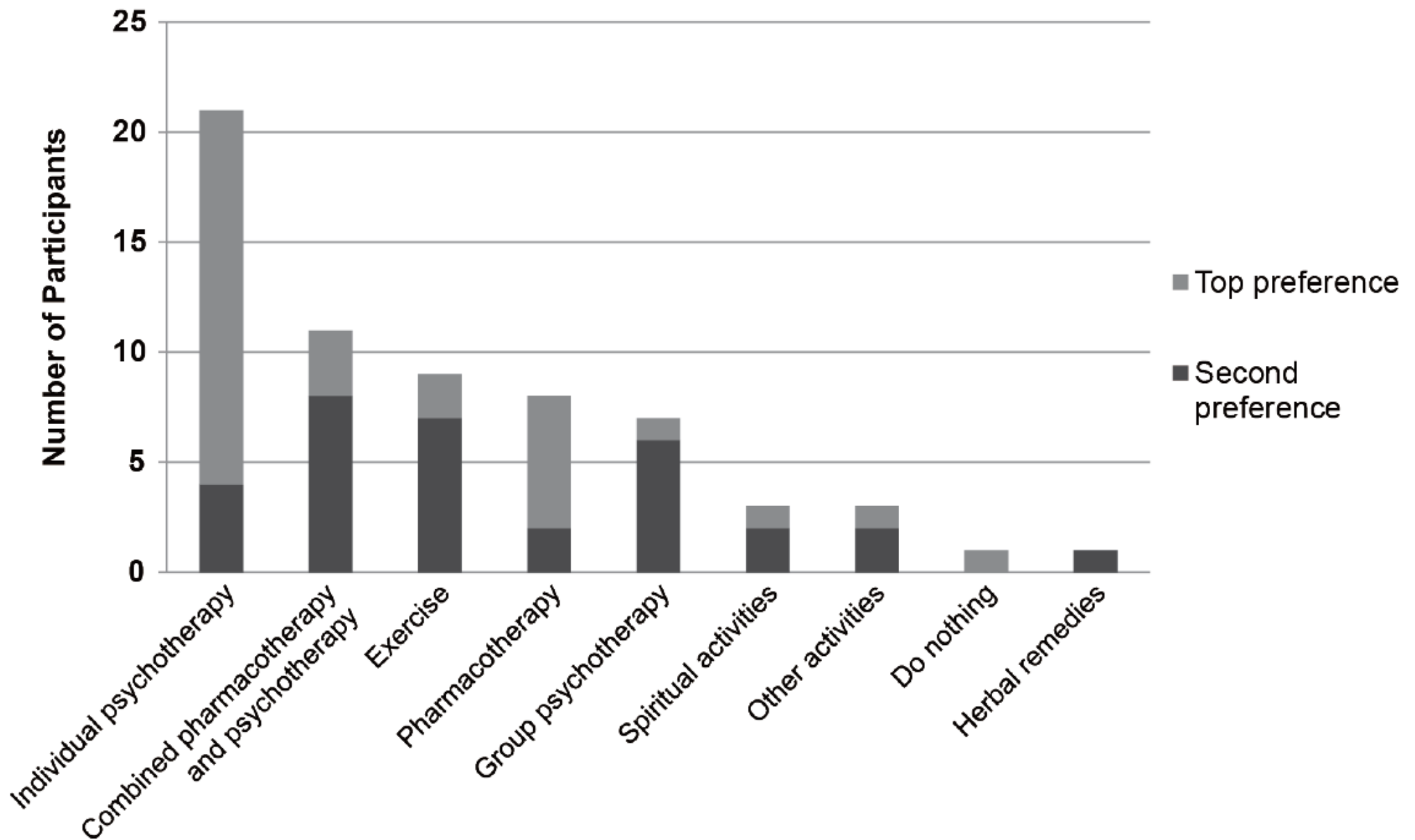


5-day Family educational program  
For patients with Hikikomori  
(@ Kyushu University Hospital: A pilot trial)

| DAY | Contents                                                                     | Teacher                        |
|-----|------------------------------------------------------------------------------|--------------------------------|
| 1   | What is Hikikomori, Understanding of Psychiatric Disorders, Introducing MHFA | Psychiatrist<br>(Kato)         |
| 2   | How to evaluate a son/daughter of hikikomori condition                       | Psychologists<br>(Kubo, Urata) |
| 3   | How to communicate with them                                                 | Psychologists<br>(Kubo, Urata) |
| 4   | How to bring them<br>to specialized support center/clinic                    | Psychologists<br>(Kubo, Urata) |
| 5   | Review: Tips to intervene them appropriately                                 | Psychiatrist<br>(Kato)         |

Nest Step  
Direct Support

# What kinds of treatments do individuals with hikikomori want?



# Bio-Psycho-Social Interventions for individuals with hikikomori

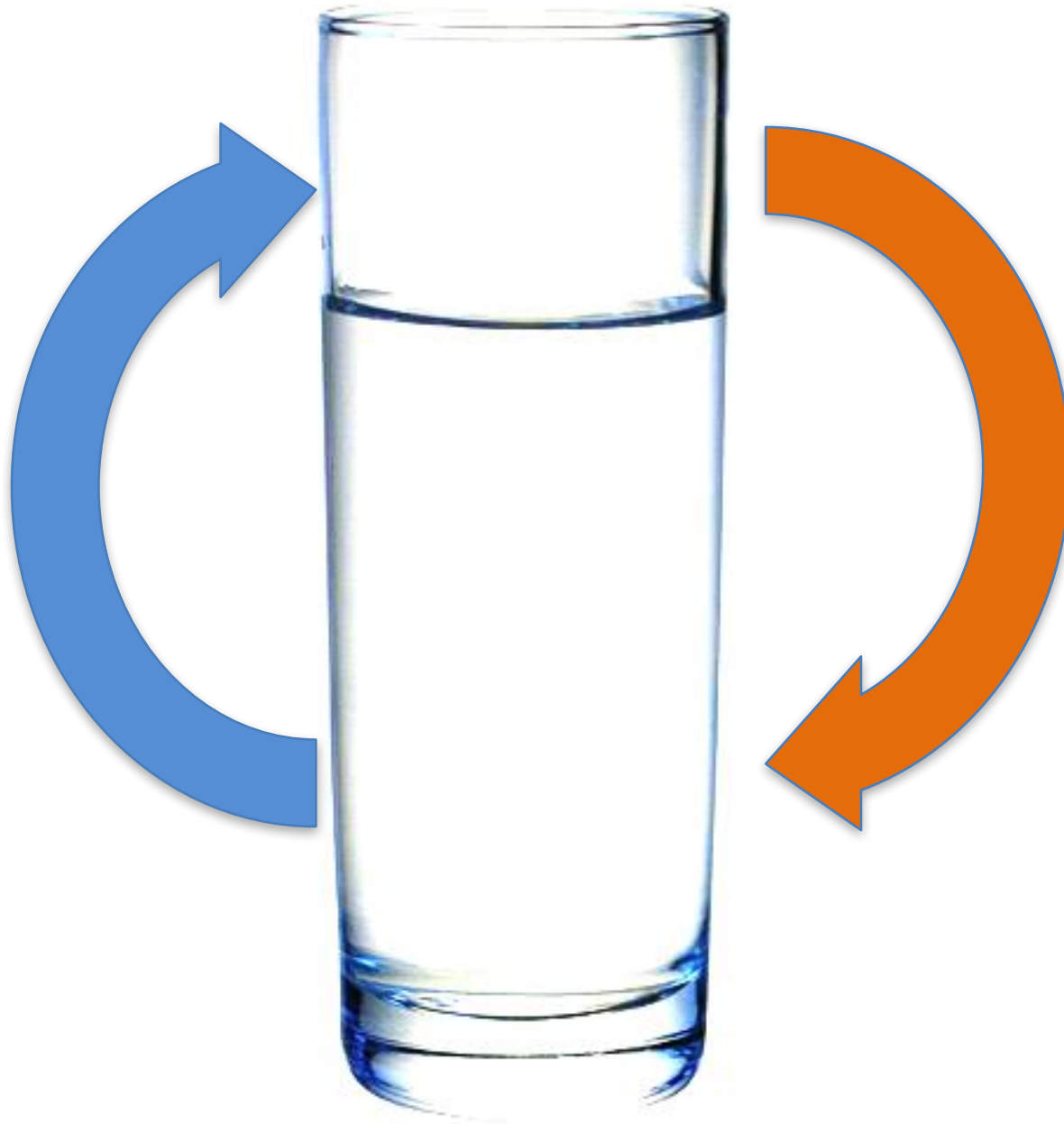
- If they have some psychiatric disorders, follow the guidelines of each disorder; pharmacotherapy, psychotherapy, etc...
- In majority of cases, only pharmacotherapy is not enough, and psychosocial approach is strongly recommended.

# Psychotherapy for hikikomori

- Supportive therapy
- CBT
- Psychodynamic psychotherapy (including Psychoanalysis)
- Group therapy
- Family therapy



What do you think/feel about this water in the cup?





Multiple complex factors induce hikikomori??



Psychotherapy?  
Drug?  
Diet?



**Psychological and Biological Understandings & Psychotherapeutic Psychopharmacological Approach may Rescue People with Social Isolation (Hikikomori)**