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**Magnifying core differences in symptomatic display of
hikikomori from a cross cultural perspective.**

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Magnifying core differences in symptomatic display of hikikomori from a cross cultural perspective.

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Abstract:

In answer to areas of doubt that surface in the ongoing debate as to whether or not ‘hikikomori’ can or cannot be defined as a culture bound or culture reactive syndrome, this paper looks very briefly but closely at five important core differences in characteristics that vary in hikikomori in Japan vis-a-vis social withdrawal in other countries; and in doing so draws from psychiatric definitions, observations from clinical psychiatrists worldwide, and touches on how societal attitude and treatment approaches differ, in an attempt at continuity of support to the claim that hikikomori is indeed a culture reactive symptom.

Introduction:

In this paper I would like to define and further address five of the key points that arose from question and answer session at the international IAFOR Psychiatry and Behavioral Science Conference in Osaka, March 2014. I presented the opinion that hikikomori is a Japanese culture bound symptom and had the fortune to speak with many clinical psychiatrists from New Zealand, Australia, Taiwan, India, UK, Korea, and USA afterwards regarding my claim. In doing so I was able to clearly see the weakness’ of some of my arguments and validity of others, and was then able to narrow down the **five areas** that I believe are key in identifying hikikomori as a specifically culture bound phenomena, in other words a Japanese- specific psychiatric symptom.

The following 5 key points that are discussed herein are summarized as follows:

1. The confusion and definitive boundary definition lines of hikikomori and *agoraphobia* or *acute social withdrawal* which are synonymously used as other definitive descriptions of hikikomori in the US and UK.
2. The fact that **80%** of hikikomori sufferers in Japan only, are male.
3. The specific connection that Japanese hikikomori has with prior school **truancy** V the very low percentage of this being a trigger factor in other countries.
4. The extreme length/**duration** of hikikomori withdrawal in Japan V other countries.
5. The absence of key symptoms such as **panic** and lack of **social stigma** that are present in social withdrawal and agoraphobia as defined in Western Psychiatry but not in hikikomori.

Key Difference #1 : Confusion of definition.

William Foreman from Michigan in USA(2012:3) writes:

*Hikikomori **overlaps with** several Western mental health diagnoses including pervasive developmental disorders, avoidant personality disorder, PTSD and other anxiety disorders. I will outline some of the comparisons to agoraphobia and social phobia.*

*Hikikomori is similar in many respects to severe agoraphobia. While many people with agoraphobia are afraid only of **specific clusters of activity** such as driving or attending crowded events, others are afraid to leave home at all. Hikikomori is defined as a state of complete social withdrawal that lasts at least three months in Korea or six months in Japan. In both disorders, sufferers typically do not communicate with anyone outside the home.*

*A major difference between hikikomori and agoraphobia is **the age of onset**. Hikikomori is strictly a disorder of young adults. Those who were in the first group to be diagnosed are, as of 2013, not yet 40 years old. To be initially diagnosed, the sufferer must be no older than 30*

This is just one of many clinical psychiatrist's observations that specific differences do exist in the actual semantic clarity of definitive status between hikikomori and similar psychiatric symptoms elsewhere. Foreman writes "*overlaps with*" and I believe this is an accurate assessment that indicates the uniquely cultural bound nature of hikikomori. There are too many other examples to list here but time and again in published definitions found in psychiatric journals¹ both social withdrawal and agoraphobia are defined with elements or key components missing *when compared with* the Japanese definition of hikikomori²

While some of the psychiatrists I have spoken with and mailed with, have claimed to have seen patients who are suffering from 'hikikomori', their interpretation of the term does not include some of the components I believe to be Japanese specific and therefore, like the name itself include the background cultural-specific elements of true hikikomori;

- the extreme reluctance of families to take part in behavioral therapy at initial onset- where it is proven to be most effective (may affect Key Difference #4: duration).
- the pressure on first born and often male children in Japan to follow one educational path toward job fulfilment (cf: for example in New Zealand it is now *expected* statistically for a person in their twenties to change jobs up to 5 times in their lifetime).
- the prevalence of truancy preceding hikikomori, the history of Japanese mind set "retreat/ignore" as a defense position; the unique social stigma magnified by proximity of neighbors in a small land space and many others (Sugai:2013).

Many psychiatrists from other countries that I spoke with claimed that the treatment of what they felt was hikikomori or its equivalent, necessitated a strong approach by bringing the young adult out of his room with force into group therapy; interestingly the ways felt appropriate to broach treatment and healing of hikikomori symptoms vary distinctly from country to country meaning the ways felt appropriate to treat hikikomori

are also culturally specific; this is in itself an indication that there is little reason not to assume that the opposite is true; that the definition and manifestation of hikikomori is also culturally specific.

Key Difference #2 : Predominantly male factor.

Dr. Saito Tamaki, who coined the term hikikomori back in 1998, and with whom I had the great pleasure of meeting in his Funabashi clinic in March 2014, claims in his book (Adolescence without End: 9) that hikikomori is culture bound due to the epic number (over one million) who have chosen to stay in their rooms in an act of seeming defiance against cultural expectations that do not exist in the exact same way in other countries. This was an area I felt to be one connected to the history and language and social etiquette that is linked to the unique culture of Japanese people. In a culture that is so very different from Western culture, how can we expect psychological disorders to be the same ?

Moreover, research that Dr. Saito conducted with patients estimated 80% of hikikomori are male and Of those 80% are first born male. As explained in detail in my last paper in a 98% male dominated value index country (Hofstede :) this fact alone could be enough to label hikikomori as Japanese culture bound given the pressure for Japanese males to get work and stay in that same work and the devotion above all to the company versus family. Conversely, Western society has the similar symptoms of “social withdrawal” standing at equal part male versus female and “agoraphobia” being statistically mainly female.

Quoting Foreman again (ibid):

Identified in 1998, it appears to be culturally linked to changing labor market realities in Asia. Under the traditional system, middle and upper-class youths follow a highly structured path from adolescence to adulthood. They are expected to rigorously apply

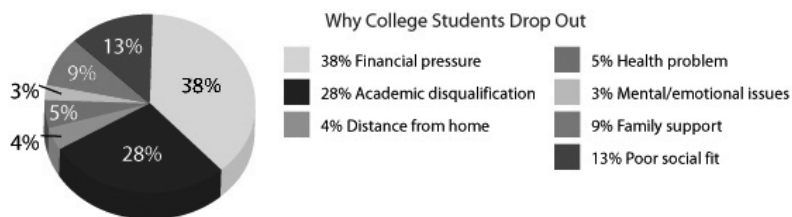
themselves in high school and college, and then immediately take a professional job. The job market has traditionally been secure, and the first employer out of college is expected to be the company that the young adult will remain with until retirement.

Increased globalization and changing labor markets have made this ideal unattainable for many youth. Many adolescents follow the expected path through college only to discover that they are unable to find a job, or can only find one for which they are vastly overqualified. For some young people, the realization that they did everything right but cannot reap the benefits leads them to shut down. Hikikomori overlaps with several Western mental health diagnoses including pervasive developmental disorders, avoidant personality disorder, PTSD and other anxiety disorders..

Key Difference #3 : the connection of truancy/bullying and social misfit triggers.

In the following diagram, it can be seen the main reasons for “dropping out” of college in the US.

The validity of this diagram is to serve as a reminder that ONLY 13% count “social misfit” or “Poor social fit” as a factor for opting out, where in all surveys of hikikomori I have yet to read this has been the PRIMARY cause and trigger for hikikomori. Not necessarily with truancy - usually caused by bullying or a feeling of misfit - but also from failing to adapt to expectations within societal norms.



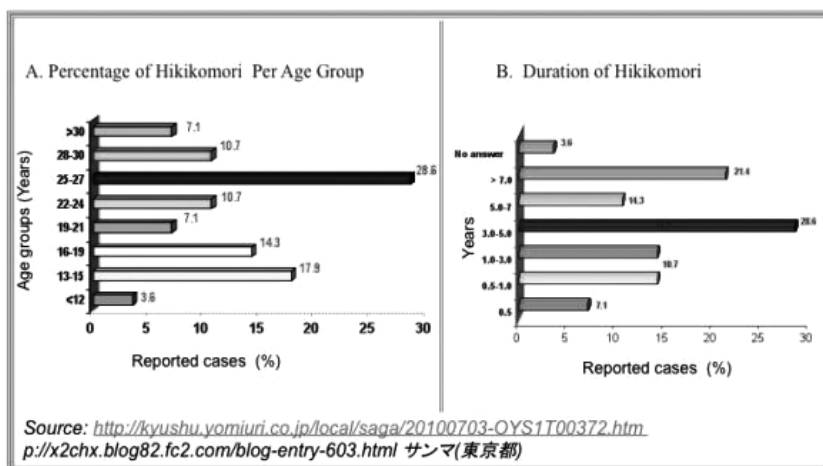
Survey conducted 4th quarter 2007 in a survey of 14,500 students at fifteen colleges by Duck9. Error Margin +/- 2%

Key Difference #4 : differences in duration of shutting in/hikikomori/hiding.

In the following diagram we can see the extreme endurance that families have in dealing with hikikomori and the extreme length of time that sufferers will retreat to their rooms for.

When I have presented this slide to clinical psychiatrists, they have found time and again, this to be one of the most alarming and single handedly most clearly differentiating factors in manifestation of social withdrawal.

The average length of time as a one off comparison in the USA for hikikomori or its sister name social withdrawal (not counting addiction or schizophrenic related withdrawal but focusing on withdrawal from societal pressure) is considered to average at approximately 2 months to four years (www.health.harvard.edu/newsweek).



The duration of hiding is one of the most important core differences in cultural comparison for reasons discussed in copious previous documented newspaper and psychiatric journal articles.

Key Difference #5 : specific symptoms within the main symptom.

I will now take a closer look at the very detailed exact symptoms that are presented in the related non Japanese disorders that involve social withdrawal and appear on the surface to most closely mirror the outward appearance of hikikomori.

The closest three I believe to be these:

- Avoidant Personality Disorder
- Acute social Withdrawal
- Agorophobia

According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), a person diagnosed with avoidant personality disorder needs to show at least four of the following criteria:

- Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection.*
- Is unwilling to get involved with people unless they are certain of being liked.*
- Shows restraint within intimate relationships because of the fear of being shamed or ridiculed.*
- Is preoccupied with being criticized or rejected in social situations.*
- Is inhibited in new interpersonal situations because of feelings of inadequacy.*
- Views self as socially inept, personally unappealing, or inferior to others.*
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.*

Hikikomori typically does not involve all of these criteria. Many hikikomori people are for example in fact highly intelligent and do not feel themselves inferior to others. In fact some have feelings of 'higher intelligence or non main-stream intelligence' (Zeilinger : 2006) They may or may not have a fear of being disliked, it is certainly not a critical factor in defining hikikomori. Hikikomori are NOT unusually reluctant to

engage in new activities because they may prove embarrassing or avoid personal risk - since statistics of suicide are very high among hikikomori sufferers, and violence is not unknown. Finally, the core “hiding” feature of hikikomori does not necessarily involve a complete breakdown of the willingness to interact because of fears of shame or being criticized. I think these have often been experienced previously but are now not always part of the shut in world and so, in this way “hikikomori” could be seen as an end game or aftermath of such feelings that then mould themselves into a lifestyle ritual- in which sufferers find a way out of all feelings, not just those of shame and embarrassment.

Acute Social Withdrawal.

This is most commonly a *secondary symptom* definition in psychiatric terms.

It arises out of specific triggers which are most commonly:

- Depression
- Bi-polar
- AIDS or other serious illness diagnosis
- Seasonal Affective Disorder
- Dementia
- Schizophrenia or other schizoid affective disorder
- Autism

In all these cases **symptoms are resolved when the primary trigger is resolved or addressed.**

None of these primary triggers moreover address the *NON COMMUNICATING* (refusal or extreme reluctance to open up and talk) aspect and **deep central theme in ALL cases of hikikomori.**

In other words, being able to identify the primary cause allows a treatment plan to be more easily mapped than hikikomori where so many unknowns and variables are inexplicable because they are unexplained by the patient. The lack of communication, the ambiguity of the very language itself in conversation could be seen as a cultural stumbling block: but most importantly, how can we treat a mental symptom when the sufferer will not talk about it? If (as in social withdrawal) the primary trigger is clear-

there is a start line- there is a crack in the wall that an outsider can enter and heal or help mend which in turn will heal the secondary symptom of hiding away.

Agoraphobia.

Here is a definition of agoraphobia (Forsyth:1998)

*Agoraphobia is just one type of phobia, or irrational fear. People with phobias feel dread or panic when they face certain objects, situations, or activities. People with agoraphobia frequently also experience panic attacks, but panic attacks, or panic disorder, are not a requirement for a diagnosis of agoraphobia. The defining feature of agoraphobia is **anxiety** about being in places from which escape might be embarrassing or difficult, or in which help might be unavailable. The person suffering from agoraphobia usually avoids the anxiety-provoking situation and may become totally housebound.*

*Agoraphobia is the most common type of phobia, and it is estimated to affect between 5-12% of Americans within their lifetime. **Agoraphobia is twice as common in women as in men** and usually strikes between the ages of 15-35.*

It is clear from this definition that agoraphobia, often also called *Acute social withdrawal*, usually involves panic attacks as a core symptom, but not always; and always involves anxiety attack or extreme anxiety as a psychiatric disorder that hikikomori adolescents, children and adults do not in the majority suffer from as a primary symptom (saito:75). Moreover anxiety is something that a fair number of people experience for short periods of time- seldom for extended years and decades.

Conclusion

In this paper, I have looked at what I believe to be just 5 of the main differences in the symptom of Japanese hikikomori versus the definition of hikikomori and or its synonyms in other countries. There is clearly much more to research and much more to be discussed, including a far wider range of research involving a wider selection of

countries and cases. However, I hope that this brief introduction to five of the areas I think need further investigation will provide a platform for further research into my hypothesis that hikikomori is without doubt, a Japanese culture reactive or culture bound syndrome, not to be seen as simply withdrawal and retreat by an individual with a mental health issue, but instead an expression of how the system of education in Japan and expectations in society need to change before we can come closer to reducing hikikomori numbers and ending the immense suffering for hikikomori people and all those families who have been and continue to be prisoners to the powerful destruction of life in the shadow of hikikomori.

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