MODERN HERMITS: HIKIKOMORI

by

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This thesis is a literature review on hikikomori and the debate surrounding its classification. Primary focus will be on the compilation and analysis of research that pertains to hikikomori as either a Japanese culture-bound syndrome or a psychiatric disorder. I also raise a third possibility that hikikomori is a collectivist-culture bound syndrome. I analyze literature that provide evidence that hikikomori are found primarily in collectivist countries such as Japan, Hong Kong, and Spain. As well as studies that suggest collectivist cultural traits, such as interdependence, perpetuate the issue. In addition, Japanese cultural traits that bolster hikikomori such as haji/shame culture, academic pressure, and toxic work culture will also be explored.

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Introduction

Hikikomori is a Japanese phenomenon characterized by people who do not leave their homes for more than 6 months (Yong & Nomura, 2019). Hikikomori is a unique term as it is used interchangeably between the name of the condition and the individuals affected. Part of the reason why Hikikomori remains largely unaddressed is because Japan does not have a long history of treating "invisible" illnesses. The prevalence of mental health service use in Japan was found to be lower in comparison to high-income countries such as the U.S and Europe (Nishi et al., 2019). Therefore, the ignorance surrounding hikikomori is not surprising as Japan has yet to take strong steps to prevent or treat this issue. And the lack of willingness to address these issues as a real adverse health risk is detrimental to the hikikomori population.

To help hikikomori individuals, a deep understanding of Japanese and collectivist culture is integral to the process of healing. The rise of hikikomori cases is a symptom of an incredibly deep-rooted problem embedded within Japanese society. In order to address, solve, and help the hikikomori population, an in-depth look at Japanese culture and societal outlook on mental health is needed. Before steps can be taken to address hikikomori, there needs to be a consensus on the classification of hikikomori. The psychological and cultural aspects of hikikomori have created a significant debate on whether hikikomori is a mental disorder or a defect resulting from Japanese cultural practices. Most reported hikikomori cases are from Japan, however, there are other cases abroad. For example, Hong Kong was estimated to have a hikikomori prevalence rate of 2% (Wong et al., 2014).

In this paper, I have compiled literature that will address arguments for categorizing hikikomori as a Japanese culture-bound syndrome, collectivist culture-bound syndrome, and psychiatric disorder. Because there is a large emphasis on Japanese and collectivist society, appropriate cultural literature will be also be analyzed in the context of hikikomori being a culture-bound syndrome. Emphasis is put on classification because in order to establish treatment and healing for the hikikomori population, researchers need to define hikikomori in clearer terms. As of now, the categorization is rather vague, thus affected individuals may not be getting a proper diagnosis. Hence, the overall goal of this literature review is to establish a summary of what we know so far about this under-researched issue and to illustrate the central debate on the classifications of hikikomori. I argue that hikikomori is most prevalent in Japan due to specific Japanese cultural practices. However, the same symptoms can be seen elsewhere when Japanese cultural practices overlap with other collectivistic cultural practices typically under the name of collectivism. Hikikomori is primarily collectivist culture-based and cannot be applied universally. Hikikomori should not be classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) because it does not align with traditional psychiatric disorders, and there is simply not enough research on the etiology of hikikomori.

On May 28th, 2019, Ryuichi Iwasaki went on a stabbing spree in Kawasaki city, injuring eighteen people and ultimately killing two. The murder victims were Satoshi Oyama, a 39-year-old ministry worker, and Hanako Kuribayashi, an eleven-year-old student. The majority of the injured were elementary school students who were waiting in line at a local bus stop with several adults. This tragedy ended abruptly by Iwasaki

committing suicide. Later investigations revealed that Iwasaki was a hikikomori. This tragedy caused a media uproar, stigmatizing hikikomori as a high-risk group. The Kawasaki case subsequently brought light to an understudied issue that has been plaguing Japan.

Saito (1998) is credited for coining the term hikikomori in his book and is known to be an important catalyst that started the conversation of hikikomori as a large-scale issue. His book was controversial to several scholars and psychologists due to his assertion that one cannot be a hikikomori if social isolation comes from a place of mental illness. Saito made it clear that he did not believe that mental illness is a causal factor for hikikomori: "Many people with *hikikomori* are known to have other psychiatric conditions such as schizophrenia, anxiety and obsessive-compulsive disorder. However, Saitō argues that a substantial proportion of these psychiatric conditions are secondary to *hikikomori*, not its cause.". Saito (1998) essentially claimed that Japanese culture and society play a large role in perpetuating hikikomori, but he also asserted that hikikomori is not culturally bound. Saito (1998) noted that countries such as Taiwan, South Korea, and China with similar collectivist ideologies, societal rules, and expectations also exhibited hikikomori symptoms in their populations.

Not only was Saito (1998) an influential figure in the hikikomori research community, but he also was also an activist who was against the wrongful media portrayal of hikikomori. For example, a popular subcategory of T.V shows in Japan called *Variety* had a controversial segment on hikikomori. The television staff documented a 41-year old male hikikomori who was violently removed from his room in order to receive disciplining measures. Because this recording insinuated that force

and violence were the answer to help him, notable individuals such as Saito filed complaints to the Japanese Broadcasting Ethics & Program Improvement Organization. Saito recognized that there was an alarming pattern of the wrongful and negative portrayal of hikikomori on Japanese national broadcasts.

There are several other representations of hikikomori in pop culture most notably shown in anime and manga. Hikikomori and otakus (people who are obsessed with popular media such as anime and manga) are commonly associated together in media due to the stereotype that otakus are typically not productive members of society. The most famous example is an animated show titled *Welcome to N.H.K* which depicts the life of a hikikomori who struggles with delusions, paranoia, and is an otaku. Another popular media example is *Rozen Maiden* whose main character was driven to become a hikikomori due to a traumatizing experience at school. Other animated examples of the hikikomori-otaku stereotype include *Chaos; Head, Btooom!, Denpa Kyoushi,* and *No Game No Life*. Hikikomori characters in media are typically shown to be an otaku, but it is important to recognize that such representation does not depict the hikikomori population in its entirety. Although there are some otakus who are hikikomori, many others come from a place of mental illness, trauma, and/or societal pressures unrelated to obsessions and hobbies with popular media and manga.

Japan has a problematic past of portraying mental illnesses in a negative light. DeVylder et al. (2020) addressed the stigma surrounding labels of schizophrenia, depression, and hikikomori in Japan. The researchers primarily focused on the differences of stigma in schizophrenia labels between "mind-split disease" and "integration disorder". The label of mind-split disease held social connotations, while

integration disorder suggests a biological basis for schizophrenia. Data was collected from 192 Japanese adults who completed 4 case vignettes and questionnaires. All participants received the same case vignettes in a randomized order, but diagnosis for each vignette differed. The case labels were assigned as mind-split disease, integration disorder, depression, and hikikomori. None of the participants, however, were provided the label or diagnosis.

Participants did not rate integration disorder or mind-split disease differently in levels of stigma as hypothesized. And level of stigma did not vary significantly between all four labels. But perceived unpredictability was higher in both schizophrenia labels than either depression or hikikomori labels. Results further indicated that all three labels (integration disorder, mind-split disease, and depression) were identified to have a greater need for treatment than hikikomori. In addition, both hikikomori and depression were labeled to be socially caused, while both labels of schizophrenia was thought to have a stronger biological basis. According to DeVylder et al. (2020), hikikomori is not seen as a physical threat, and is not taken as seriously as perceived biologically based disorders such as schizophrenia.

Defining Hikikomori

According to a nationwide Japanese cabinet survey, there are approximately one million reported cases of hikikomori between the ages of 15 to 65 (Cabinet Office of Japan, 2016). Seventy-seven percent of hikikomori were males. Interestingly, the prior survey indicated that there was a higher percentage of female hikikomori at 37%, which suggests that there has been a significant decrease in female hikikomori cases or at least the reporting of female hikikomori cases. The ages of onset were found to be distributed evenly, with an average of 20% between each age quadrant of 40, 45, 50, 55, and 65 years old. But it is worth noting that only middle to elderly ages (40-65 years) was examined in this survey. Younger individuals from the ages of 15 to 39 also had a minimal variance in their rates by age in a prior cabinet survey in 2015.

Hikikomori is typically identified by the duration of their self-quarantine of 6 months or more (Teo & Gaw, 2010). However, identifying hikikomori is complicated, as scholars have yet to decide if it is a psychiatric disorder or a culture-bound syndrome. Popular sentiment leans toward hikikomori as a culture-bound syndrome, due to Japan's specific cultural practices that seem to exacerbate the hikikomori population. Rosenthal and Zimmerman (2012) claimed that there are several common triggers such as pressure from school, work, and other societal factors: "These interviewees stress issues such as pressure in school, lack of acceptance of differences in Japanese society, changes in the nature of work in Japan, frustration, and disappointment in lack of opportunities in recession-plagued Japan, or the hikikomori's disappointment with their lack of

immediate success." (p. 89). However, they also state that some hikikomori may also have comorbid mental illnesses such as depression or anxiety.

The term "NEET" was officially coined by The Ministry of Health, Labor, and Welfare in Japan to describe individuals who are not students, employed, homemakers, or actively seeking a job. NEETs are typically compared to hikikomori because both center around the lack of engaging in social activity. Because of their similarities, Uchida and Norasakkunkit (2015) argued that NEETs and hikikomori are distinct ends of the same spectrum. The researchers conducted two studies, the first one being the development of the NEET-Hikikomori Risk Factors scale, and the second analyzing the classification differences between the Japanese government and the NHR scale. Study 1 identified the three shared risks through the NHR scale as freeter (part-time job) lifestyle preference, lack of self-competence, and having unclear ambitions for the future. In order to develop the scale, the researchers studied 66 Japanese college students with an age range of 18 to 23 years old. The survey had 53 items ranked on a seven-point Likert scale ranging from "Completely Disagree" to "Completely Agree".

In Study 2, Uchida and Norasakkunkit (2015) analyzed the Japanese government NEET/Hikikomori criteria and the NHR scale's relationship with employment, socioeconomic status, well-being, and community. Results indicated that the NHR scale had a higher inverse association with well being, health status, job satisfaction, and relationships. Furthermore, the spectrum approach in the NHR scale had stronger association with subjective well-being than the nominal classification approach. Overall, Uchida and Norasakkunkit (2015) emphasized that instead of viewing NEETs and hikikomori as separate diagnoses, they should be considered two

ends on the same spectrum due to varying degrees of marginalization identified in the NHR scale.

Uchida and Norasakkunkit (2015) addressed some possible limitations on the scale. The main concern was that the scale may represent already known psychological disorders, such as depression, even though depression was not assessed in this study. They counter this by citing other sources that claim that although some hikikomori may have mild forms of depression, severe depression was relatively rare (Koyama et al., 2010). In other words, most severely depressed individuals were not hikikomori, and most hikikomori were not severely depressed. Uchida and Norasakkunkit (2015) also highlighted how Japanese people tend to be interdependent and sensitive to social harmony. They suggest that these typically collectivist cultural factors may play a role in the similarities between NEETs and hikikomori.

Ishii and Uchida (2016) stated that NEETs' social withdrawal tendencies stem from a rejection of interdependence found in Japanese culture. The study builds upon previous research from Uchida and Norasakkunkit (2011) in that NEETs are less likely to adhere to Japanese standards of interdependence, such as displaying inappropriate responses to failure (e.g., social withdrawal). Ishii and Uchida (2016) also discussed how globalization plays a role in perpetuating NEET behavior. Because globalization emphasizes independence and is a homogenizing force, it is predicted that some aggressive behaviors in marginalized youth are directed by their rebellion against interdependence.

The Koyama et al. (2008) study addressed the prevalence of hikikomori as well as its relationship/comorbidity with psychiatric disorders. The researchers analyzed data

provided by The World Mental Health Japan (WMH-J) which is a face to face survey conducted in metropolitan, urban, and rural cities in Japan. The participants, who were above the age of 20, where randomly selected from each survey site and 4134 interviews were obtained. The response rate was calculated to be around 55% and tended to be younger females. The assessment was categorized into two sections, namely lifetime experience of hikikomori and current experience of hikikomori found in children of the respondents. The 3.0 Japanese version of the WHO Composite International Diagnostic Interview was used to diagnose psychiatric disorders. In order to examine comorbidity with hikikomori and psychiatric disorders such as mood disorders, anxiety disorders, and intermittent explosive disorders, researchers created three categories: occurrence of psychiatric disorders before, during, and after becoming a hikikomori.

Koyama et al.'s (2008) results showed that 1% of community residents experienced symptoms of hikikomori, and the age of onset was 22 years old. In terms of comorbidity, 55% of hikikomori cases had at least one psychiatric disorder in their lifetime and 35% of the participants were identified with having any psychiatric disorder before the onset of hikikomori. In terms of disorders seen throughout their lifetime, generalized anxiety disorder was the most likely to be diagnosed. Interestingly, Koyama et al. (2008) found that there was a 6 times higher risk for people with hikikomori of developing mood disorders than any other disorder. Within the same year of the onset, 16% of the participants were reported to have major depressive episodes.

Forty-six percent of those with hikikomori in Koyama et al.'s (2008) sample exhibited hikikomori symptoms and no other symptoms. Hence Koyama et al. (2008) concluded that hikikomori is not derived from pre-existing psychiatric disorders. Koyama et al. (2008) suggested that there must be social/cultural factors that perpetuate hikikomori but there is simply not enough evidence to label it as culturally bound. More research is needed to better understand the psychopathology of hikikomori and its relation to psychiatric disorders.

Although definitions of hikikomori continue to vary, researchers have developed a survey in order to increase accurate diagnosis. Teo et al. (2018) developed a self-report 25-item Hikikomori Questionnaire (HQ-25) that included socialization, isolation, and emotional support factors. Data used for the development of the HQ-25 was from participant interviews, item pools, and self-report surveys on hikikomori. The researchers studied healthy volunteers from Kyushu University and patients from psychiatric hospitals and clinics. Teo et al. (2018) found that their scale was reliable and accurate in distinguishing those diagnosed with hikikomori from the control volunteers. HQ-25 is recommended to be utilized in clinical research settings to assess hikikomori.

Hikikomori Diagnosis and Categorization

Teo and Gaw (2010) reviewed the literature on hikikomori and the debate on its categorization utilizing both Japanese and English databases. Teo and Gaw (2010) indicated that the term itself may be viewed as a more palatable way of characterizing depression (which is *utsubyo* in Japanese): "In a society where it is highly stigmatizing to use words like clinical depression (*utsubyou*), let alone schizophrenia (*tougou shicchoushou*), the term hikikomori has broad appeal as a socially acceptable term...Mental health professionals may use the term with patients and their families as a softer, gentler proxy for an underlying mental disorder.". *Utsubyo* is a highly stigmatized word and many Japanese are reluctant to ascribe the term due to its negative social associations. According to Jorm et al. (2015), Japanese (in comparison to Australian samples) were found to be less likely to use psychiatric labels for themselves.

Teo and Gaw (2010) addressed three popular arguments in regards to how hikikomori should be defined. The first argument is that hikikomori is not a unique disorder, and is in fact an amalgamation of preexisting disorders. The second defines hikikomori as a culture-bound syndrome, and the third suggests the possibility that hikikomori is an entirely new psychiatric disorder. Although the researchers concluded

hikikomori is likely to be a culture-bound syndrome, they recognized that a large portion of hikikomori suffer from an Axis I or II disorder. Because hikikomori and mental illnesses such as depression and anxiety are found to be comorbid, it seems that the first argument (an amalgam of preexisting disorders) may be correct. However, as discussed previously, nearly half of hikikomori who are not diagnosed/affiliated with a mental disorder (Koyama et al., 2008).

According to Gaw (2001), there are four requisites in order for a syndrome to become culture-bound. First, the syndrome must be concrete and well-defined. Second, the syndrome has to be associated with a specific culture. Third, the syndrome must be understood as a response to certain aspects of a culture. And lastly, the syndrome needs to be recognized as a specific illness in a country. Teo and Gaw (2010) argued that hikikomori at least meets the first three out of four criteria for the culture-bound syndrome. The last criterion, however, is controversial. Teo and Gaw (2010) highlighted that Japanese government officials have refused to label hikikomori as a psychological disorder, while not offering any alternative. The language used to define hikikomori in the past has been purposefully vague with no clear categorization.

Although Teo and Gaw (2010) seem to lean toward hikikomori as a culture-bound disorder, their conclusion states that there is not enough evidence for this. They addressed the lack of clinical data and research in the field and how more information on social history, family, interactions, and risk factors would be beneficial. Nonetheless, the Teo and Gaw (2010) research is an integral summary of the main arguments on the diagnosis and categorization of hikikomori. Although the review was conducted a

decade ago, the hikikomori research community has yet to reach a consensus on its categorization (culture-bound or psychiatric disorder).

Uchida and Norasakkunkit (2014) argued that hikikomori youths tend to reject collectivist cultural values (such as harmony-seeking) and have different motivational styles. The researchers assessed hikikomori risk among Japanese college students by using the Hikikomori Risk Factor Scale (HRFC) developed by the same researchers for a previous study. The Willingness to Comply (WTC) survey was used to determine willingness to complete a marketing survey. One of the versions of WTC assessed the likelihood of completing the request given the information that other classmates had completed it. The second version asks if the participant would comply if they had already completed a similar survey in the past.

Uchida and Norasakkunkit (2014) also included the Local-Global Identity Scale (Zhang & Khare, 2009). Local identity is defined as relating to specific cultural environments and a strong sense of nationality. Global identity derives from the consciousness of the global community while not losing one's own nationality. Uchida and Norasakkunkit (2014) also included the Measure of Harmony-Seeking that essentially measures collectivist values.

Uchida and Norasakkunkit's (2014) results indicated that there were no significant differences between low- and high-risk hikikomori groups on the perceived consensus of harmony-seeking. However, the high-risk group had significantly lower levels of harmony seeking than the low-risk group. The high-risk group also was found to be motivated on the basis of not conforming to other's beliefs. The high-risk group was less motivated to act in commitment consistency and scored lower on local identity.

Uchida and Norasakkunkit (2014) interpreted this rejection of conformity by the high-risk group to mean that hikikomori was motivated by acts of rebellion against collectivist society. Although Uchida and Norasakkunkit (2014) stated that hikikomori is not a culture-bound syndrome, they allowed that common cultural traits across countries (such as the seniority system) should be taken into consideration when categorizing hikikomori. For example, instead of labeling hikikomori as a specific Japanese disorder, perhaps its more accurate to understand hikikomori as a collectivist culture-bound disorder seen in several countries.

Hikikomori Outside Japan

Kato et al. (2011) conducted a survey to find cases of hikikomori in Japan and other countries including Korea, Oman, and Spain. All participants were either psychiatric residents or psychiatrists in varying ages. The participants were asked to analyze two case vignettes then answer a questionnaire relevant to the cases. The results showed that hikikomori was indeed present in other countries (vs. Japan), and the cases tended to concentrate in urban areas. Thus Kato et al. (2011) further suggested that hikikomori is not Japanese culture-bound and instead a possible indicator of a worldwide psychological issue. However, they also clarify that there has yet to be a consensus on the causes, diagnosis, and interventions for hikikomori worldwide.

Wong, Lee, and Chang (2014) found that hikikomori prevalence in Hong Kong is comparable to Japan. Data were obtained through surveying 1,010 12 to 29 year old participants by phone from a sample of 80,000 randomly generated mobile phone numbers. The low response rate mainly stems from 23,000 invalid numbers and the 30,000 who were unable to answer, which is a limitation of the study. Wong, Lee, and

Chang (2014) identified hikikomori/withdrawal symptoms by the diagnostic criteria created by Teo and Gaw (2010). In addition, the participants were asked if they had any prior diagnosis of social phobia, major depressive disorder, schizophrenia, or avoidant personality disorder. Wong, Lee, and Chang (2014) then categorized their results by more than 6 months of withdrawal, less than 6 months of withdrawal, and self-perceived unproblematic withdrawal. Wong, Lee, and Chang (2014) argued that their results provided evidence that hikikomori is not a culture-bound syndrome because the prevalence of withdrawal (longer than 6 months) was comparable to Japan. Similar to Japan, males were more likely to become hikikomori. Wong, Lee, and Chang (2014) explained the gender difference by claiming that males have a stronger desire to achieve success and to save face.

Wu et al. (2020) investigated if pathological social withdrawal (PSW) is present in Taiwan in an online survey of 1,046 Taiwanese residents aged over 18 years. PSW is similar to hikikomori because its major factor is social withdrawal but PSW also applies to NEETs who exhibit less severe symptoms. PSW participants had higher scores than non-PSW participants on the NEET/Hikikomori risk (NHR) scale. A higher score on the scale is directly related to greater risk of developing hikikomori. Thus, PSW participants were more similar to hikikomori than to NEETs because hikikomori have stronger PSW tendencies. Overall, 9% of respondents identified with having PSW for at least 6 months and 20% of these respondents struggled with psychiatric disorders. Furthermore, those who reported PSW also claimed poor mental health, lower confidence, and lack of social skills.

Malagon-Amor et al. (2018) studied the 12-month course of hikikomori among 190 participants in Spain. Spain is considered to be a collectivist culture within European countries, but less so in comparison to the rest of the world. Data were collected by the Crisis Resolution Home Treatment (CRHT) team accompanied by two psychiatrists and two nurses. The researchers identified six diagnostic groups labeled as affective, anxiety, psychotic, personality, drug use, and other Axis 1 disorders. Similar to results shown by Koyama et al. (2008), anxiety was found to be the most chronic disorder within hikikomori populations. However, the presence of anxiety was noted to have lower severity in comparison to the other disorders in the study by Malagon-Amor et al. (2018).

Malagon-Amor et al. (2018) found that men with little to no social network were the most common in their sample. However, in terms of age, they identified that there was a wide range meaning older populations were susceptible as well. These findings align with the data collected by the Japanese cabinet survey in 2016. For comorbidity, anxiety disorders were the most predominant while disorders such as autism were less common. After the initial data collection, Malagon-Amor et al. (2018) conducted a 12-month follow-up and found that participants who were engaging in intensive care were more likely to improve than those who had little to no intervention. Malagon-Amor et al. (2018) concluded that because hikikomori are likely to demonstrate relapse and fragility (especially in the anxiety-affective subgroup), intensive treatment is needed.

Influence of Culture

Collectivist cultures put emphasis on interpersonal relationships and prioritize the group needs over individualistic needs (Hoorn, 2014). Collectivist cultures typically can be found in Africa, Asia, Central America, and South America. On the opposite side of the culture spectrum there are individualistic cultures that operate on autonomy and success-oriented values. For example, North America and Western Europe tend to culminate in individualistic cultures. Japan is classified as a collectivist culture, similar to most Asian countries. Yamawaki (2011) developed a scale to measure the degree of collectivism in prefectures in Japan. The Japanese Collectivism Scale (JCS) identifies key indicators that include divorce to marriage ratio, percentage elderly living alone, percentage nuclear family, percentage living alone, and percentage of three-generation households. Yamawaki (2011) reported that according to the JCS, there is within-culture variability of collectivism in Japan. Specifically, the Tohoku (north) and Chubu (central) district of Japan had the highest concentration of collectivist characteristics.

Yamawaki (2011) suggested that because modern large cities tend to have lower levels of collectivism, urbanization may be an influential factor that affects the level of

collectivism in an area. I analyzed the data provided by The Ministry of Health Labor on the most recent reported cases of hikikomori by prefecture. There were more reported cases in the Tohoku and Chubu districts than in areas with larger cities such as Tokyo and Osaka. Prefectures that were less urbanized with higher levels of collectivism tended to have higher reported cases of hikikomori. However, it is important to note that there are some limitations to the data provided by the Ministry and Health Labor. Not all data provided were collected from the same year, and methods of obtaining data (e.g. face-to-face, phone) differed across prefectures. Furthermore, sample sizes, while similar, were not the same in every prefecture. Because of these substantial limitations there needs to be a revised national survey that has a proportionate sample size and the same methods for each prefecture conducted in the same year. Teo and Gaw (2010) had also observed the lack of systematically collected data on hikikomori populations in Japan.

An important Japanese collectivist cultural trait is to have shame or *haji* which is perpetuated by etiquette and societal rules. In order to depict the importance of shame in Japanese society, the term "shame culture" was popularized by Ruth Benedict (2019), the author of *The Chrysanthemum and the Sword*. Benedict indicated that "True shame cultures rely on external sanctions for good behavior, not, as true guilt cultures do, on an internalized conviction of sin. Shame is a reaction to other people's criticism." (p. 223). A common example of shame culture can be seen by Japanese households who tend to hide any issues or wrongdoings from the public to protect their image. When a Japanese citizens experience haji, a common reaction would be to try their best to "disappear", such as hiding in their homes (Kato et al., 2019). This notion of

"disappearing" when shamed is represented even in Japanese ancient mythology. Kato et al. (2019) suggests this mindset contributes to hikikomori because hikikomori is primarily rooted in shunning oneself from scorns of society.

There is a famous Japanese proverb that describes such sentiment: "The nail that sticks out gets hammered down". Thus, outcasts are portrayed negatively. Mental health issues especially have been stigmatized and are largely avoided by the Japanese public since mental illness is commonly seen as incurable (Ando et al., 2013). The silencing of mentally unhealthy individuals is also made worse by Japanese society perceiving mental illness as a result of having a weak personality (Ando et al., 2013). Although hikikomori has yet to be defined in the Diagnostic and Statistical Manual of Mental Disorders as a psychological disorder, it clearly has roots in mental illness because it is not a physical illness per se. "Invisible" problems such as depression, anxiety, and hikikomori are harder to address and treat in Japan as mental illnesses are not commonly seen as an adverse health risk (Ando et al., 2013). Japanese society commonly dictates that it is wrongful to publicly announce internal issues due to shame culture and the emphasis to keep face. However, there seem to be generational differences in such degrees of shamefulness. Elderly individuals (65 years or older) tend to feel more embarrassment from disclosing they are receiving professional help for mental issues than younger individuals (Kido & Kawakami, 2015).

Shame/*haji* is a vital aspect of Japanese culture as Japanese culture is collectivistic and values group harmony. *Haji* also has a direct relationship with other Japanese cultural practices called *honne* and *tatemae* (Yau-Fai Ho et al., 2004). *Honne* is defined as true feelings, while *tatemae* is how one presents themselves to the world.

The practice of sacrificing one's *honne* is fundamental for promoting group cohesion and collectivity. It is considered shameful to not be able to master such duality, and thus it is a sign of maturity for those who can use *honne* and *tatemae* appropriately. However, such suppression of *honne* can prove to be detrimental to one's mental health, and not all Japanese citizens can engage and continue *honne* and *tatemae*. For example, many hikikomori lack the ability to conduct *honne* and *tatemae* because of their social ineptitude (Berman & Rizzo, 2018).

Social dualism is a common theme in Japanese culture that is constantly perpetuated in addition to *honne* and *tatemae*. There are other variants such as *omote* (front) and *ura* (back) as well as *giri* (duty) and *ninjo* (human emotions) which depict similar sentiments in that they all establish a line between feelings and social etiquette. However, it is not strictly Japanese to have rules catered to protect the public face. Collectivist societies, in general, tend to accommodate the wellbeing of the group and not the individual: "Collectivist societies stress the strict regulation of public interactions, assigning to everybody the moral duty to sustain harmony (*wa*) and protect each others "face" (*tatemae*)." (Takahashi, 1992). Hikikomori are individuals who have completely abandoned their *tatemae, omote,* and *giri* by receding into their inner lives, both physically and mentally.

Japanese academic culture is another factor that helps perpetuate hikikomori. School pressures and the fear of failure specifically play an role in youth/student hikikomori (Uchida, 2010). After school tutoring is the norm for many students and the failure of studies is commonly seen as a threat to one's livelihood and status. Therefore, falling behind classes, failing exams, and not doing well in school are all common traits

for people who end up being a hikikomori. For example, there is a phenomenon in Japan called "examination hell" which is defined as an intense period of time of study and preparation for the university entrance exams (Ono, 2007). The pressure to do well on the exams is especially burdensome as it can dictate one's quality of life and job opportunities in the future. There are also clear hierarchal differences between those who have academic success and those who become *ronin*. *Ronin* are the students who failed the examinations and are studying once again to retake the test (Ono, 2007). Hence the academic pressure and the threat of becoming a *ronin* increase stress for students. However, this is not to say that academic and social failure is a causal factor, rather there seems to be a strong correlation with the academic burden and the likelihood of withdrawing from society.

Karoshi is a term coined around the 1980s meaning death from overwork. Health issues such as heart disease, cerebral disease, and chronic fatigue are most commonly seen from victims of *karoshi*. Kanai (2008) provided an overview of the economic, employment, and working lifestyle conditions in Japan and how they perpetuate the trend of karoshi. Kanai (2008) contended that in order to address the issue of karoshi, there needs to be a reconceptualization of workers' human rights, both in the scale of the company and society as a whole. Karoshi has been an ongoing issue since the 1980s, however, there has been a lack of response from the Ministry of Health and Labor, the same ministry in charge of treating hikikomori today. Karoshi specifically highlights toxic Japanese work culture, such as overtime, workload, and mandatory drinking parties, and how such culture can affect one's health. Those who cannot withstand the pressure and the toxic work environment tend to leave their jobs to

become hikikomori (Yasuo, 2017). Yasuo (2017) further suggested that karoshi and hikikomori are similar due to the fact that both are labels for victims of mal-practice in the workforce.

Hikikomori as a Collectivistic Culture-Bound Syndrome

According to my analysis of available literature, the main area of debate is whether hikikomori is a Japanese culture-bound syndrome or a more general psychiatric disorder. There evidence suggests that hikikomori is neither, and instead is a ` culture-bound syndrome. Collectivism is inherently about group prioritization and actions of cohesion such as interdependence. As defined earlier, collectivism is wide-scale and can be seen in several different countries. Researchers such as Uchida and Norasakkunkit (2015) and Ishii and Uchida (2016) have claimed that NEETs and hikikomori tend to reject specific collectivist values by their inability to thrive in interdependent environments. This is also highlighted by the Uchida and Norasakkunkit (2014) study that found hikikomori high-risk groups were more likely to reject conformity.

In addition, Japanese cultural traits that are known to exacerbate hikikomori (such as shame culture, *honne/tatemae*, *ronin*, etc.) all stem from collectivist values, hence not making them uniquely Japanese. Shame culture is perpetuated by the need to keep face in order to promote group cohesion. And another example would by how

ronin are considered outcasts because they deviate from societal expectations/norms. Shame, the need to fit in, and other collectivist values are found worldwide. Cases of hikikomori have been documented in Hong Kong, China, Spain, and Taiwan, all of which considered as collectivist cultures (Kato et al., 2011; Wong et al., 2014).

As Teo and Gaw (2010) concluded, more research on hikikomori needs to be done. A better understanding of how collectivism and urbanization influence hikikomori populations is needed. Hikikomori cases worldwide are particularly interesting and should merit further research on how they may be influenced by collectivism.

Conclusion

Hikikomori is a relatively new issue, but the problem does not lie in the novelty but in the lack of both research and appropriate action from the Japanese government. Their nationwide surveys have several limitations such as inconsistencies in prefecture sample size and methods. Standardization efforts have been made by Teo et al. (2018) with their development of the HQ-25, but without a universally agreed definition of hikikomori, diagnosis and treatment is proving to be difficult. Hikikomori can be triggered by negative social interactions and rules, but it can also be comorbid with psychiatric disorders. Furthermore, the NEET-Hikikomori spectrum theory further complicates our understanding of where the line is between social withdrawal and hikikomori. Finally, the Japanese cultural-bound vs, collectivist-culture bound aspects of hikikomori are unresolved.

Hence, before actions can be taken from the government and the regular populace, more research is needed to be able to properly define, diagnose, and

categorize hikikomori universally. The current understanding of hikikomori is vague and quite frankly brushed under the rug in Japan. However, the Kawasaki stabbings served as a wake-up call for the Japanese citizens. The Kawasaki case is integral because it acts as a consequence of failing to address the hikikomori issue in Japan. By actively promoting a toxic system of neglect through shame culture and the refusal to acknowledge hikikomori as a significant problem, people will continue to suffer. Hikikomori is an extremely complicated issue and thus further research on how culture impacts one's mental health needs to be explored.

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