Understanding *hikikomori* syndrome in clinical settings: a case series

Ji Hyun An, Sohee Park, Jin Young Jung, Jin Pyo Hong

Department of Psychiatry, Samsung Medical Center, Sungkyunkwan University School of Medicine, Seoul, Korea

**ABSTRACT**

*Hikikomori* syndrome (HS), a phenomenon characterized by social withdrawal and isolation, has attracted significant attention in both academic and clinical settings. However, understanding the diverse nature of HS remains a challenge due to its multifaceted etiology and presentation. This paper aims to shed light on this phenomenon by examining three representative typologies of HS in clinical settings. Through detailed case analyses, we categorize HS into three main types: HS associated with neurodevelopmental disorders; HS triggered by the onset of mental illness; and HS emerging gradually with age-related challenges. By elucidating these typologies, we provide insights into the complex interplay of psychological, social, and developmental factors contributing to HS, thereby facilitating more tailored approaches for the evaluation of and intervention into this syndrome in clinical practice.

**Keywords:** Hikikomori; Mental disorders; Mental health; Social isolation

**INTRODUCTION**

The term “*hikikomori*” in *hikikomori* syndrome (HS) refers to a specific state of prolonged and severe social isolation. Although researchers may differ in their specific definitions of HS, it is typically defined as isolation from society, with affected individuals primarily staying at home, and a lack of social interactions for a period of at least 6 months [1,2]. These individuals share a common trait of enduring isolation and avoiding social relationships, while finding it difficult to extricate themselves from their reclusive state. However, they do not constitute a homogeneous group but rather disparate groups exhibiting similar states. HS tends to manifest predominantly in late adolescence to late 20s, although it can occur at any age [3]. While previously considered a cultural phenomenon confined to Japan, HS is increasingly recognized as a universal phenomenon transcending cultural boundaries [4]. Findings from a national epidemiologic study of social withdrawal in Korea revealed a lifetime prevalence of HS at 0.94%, with a current prevalence of 0.59%. Studies have also revealed that HS is prevalent in young males in their 20’s, with an average duration of isolation of 38.7 months [5].

Although whether HS is associated with specific psychiatric disorders remains a point of contention, recent studies suggest a significant prevalence of psychiatric diagnoses in individuals...
with HS [3,6]. A recent Korean study found that approximately 70% of HS cases were accompanied by one or more psychiatric diagnoses. Major depressive episodes were the most commonly reported psychiatric condition in individuals with HS, with 63.3% experiencing lifetime episodes. Comorbidities, including bipolar disorder and anxiety disorders (e.g., panic disorder, agoraphobia, social phobia, and generalized anxiety disorder), were also reported. Furthermore, 63.3% of the individuals with HS were diagnosed with one or more personality disorders, with avoidant personality disorder being the most commonly reported (50%).

However, despite a tendency to exhibit psychiatric diagnoses, individuals with HS cannot simply be characterized by singular psychiatric or personality disorders [7]. Rather, these individuals represent a heterogeneous group characterized by various causes and behaviors, encompassing social, cultural, and psychiatric issues alike. Since the dynamics of the initiation and maintenance of HS vary between individuals, evaluating HS requires a comprehensive and individualized approach that considers a range of multifaceted factors, including innate temperament, personality, interpersonal skills, and upbringing.

This study provides insights into HS gained through the characterization of three representative types of the HS. The case interviews that form the basis of these examinations were conducted between September 1, 2019 and December 31, 2020, and were approved by International Review Board of Samsung Medical Center (SMC 2020-05-145). Written informed consent was obtained from all participants.

CASE REPORTS

Case report 1
Mr. A, a 20-year-old male, has been socially isolated for over 2 years. He exhibited delayed motor and language development compared to peers in childhood and described himself as sensitive, prone to crying, and stubborn, experiencing severe separation anxiety at an early age. At age 5, he exhibited aggressive behavior and reluctance to attend kindergarten, leading to a diagnosis of anxiety disorder and mental retardation. Treatment with fluoxetine 10 mg, play therapy, and counseling was initiated for about a year, but was lost to follow-up thereafter.

Throughout elementary school, he exhibited extreme shyness and struggled to make friends. In later grades, he experienced anxiety regarding peer acceptance, leading to periods of school avoidance for 1 to 2 months due to fear of judging himself as others could accomplish anything and even aspiring to become a chief executive officer if that mood persisted during treatment. His academic performance was below average, and he reported persistently low moods. After high school graduation, he remained socially disconnected, spending time at home playing video games and relying on food delivery services. No family history of psychiatric disorders was reported.

During an examination of the patients mental status, Mr. A, a tall, lean young man in his early 20s, displayed good hygiene but poor eye contact. He showed limited spontaneous speech, with extended pauses during questioning. He reported symptoms of depressed mood, intermittent insomnia, and fatigue, alongside difficulty expressing emotions and social fears. Using the Structured Clinical Interview for DSM-5 Disorders (SCID-5) [8] and the Korean Wechsler Adult Intelligence Scale-IV (K-WAIS-IV) [9], Mr. A received diagnoses of other specified depressive disorder, social anxiety disorder, and mild intellectual disability. Additionally, he scored high on the autism spectrum quotient [10] at 31 and met the research criteria for the Korean Hikikomori Screening (Table 1) [5]. Mr. A underwent a comprehensive treatment plan, including antidepressants, three months of daytime hospitalization, and 20 sessions of Social Skills Training focusing on life structuring, emotional recognition, and interpersonal skills. He demonstrated notable improvement, displaying reduced social avoidance behaviors and active engagement in therapy.

Case report 2
Mr. B, a 30-year-old male, has been socially isolated for approximately 8 years since graduating university. He had no developmental issues and maintained good relationships with peers, achieving academic success and holding leadership positions. In university, he engaged in various social activities but became gradually withdrawn, expressing a lack of motivation and spending prolonged periods indoors. His symptoms included diminished self-esteem, negative thoughts, and decreased contact with friends and church activities. For the past 5 years, Mr. B has been receiving treatment for suspected atypical depression with antidepressants. However, treatment has not alleviated his symptoms. He briefly experienced heightened confidence, including believing that he could accomplish anything and even aspiring to become a chief executive officer if that mood persisted during treatment. Family history includes suspected alcohol abuse in his uncle.

During the mental status examination, Mr. B appeared to have an average build with good hygiene and eye contact. He...
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Case report 3
Mr. C, a 42-year-old male, has been socially isolated for over 9 years since graduating university. The following description is based on statements provided by his father. He was described as sensitive with a lack of empathy and consideration for others. He lived in various foreign countries from childhood to high school due his father’s work. Despite normal development in infancy and early childhood, he struggled with social interactions as a result of frequent relocations, experienced bullying, and developed a stutter. His academic performance declined, and he avoided conversations with family members. After graduating from a Canadian university in computer science, he returned to Korea and began secluding himself at home, spending most of his time on the computer. His outings were limited, and he quit his job after one attempt. He visited a psychiatric hospital once but refuses further evaluation or treatment. His father reports that Mr. C meets SCID-5 criteria for avoidant personality disorder and the Korean Hikikomori Screening Tool.

DISCUSSION
HS presents diverse typologies across different age groups, offering insights into the multifaceted nature of this disorder. Through clinical observation and in-depth interviews, three primary typologies were identified.

Type 1: social withdrawal due to neurodevelopmental disorders
This type encompasses individuals who exhibit withdrawal
stemming from neurodevelopmental conditions, such as intellectual disability, autism spectrum disorder, and attention-deficit/hyperactivity disorder (ADHD). From early childhood, these individuals may face challenges in language, cognition, and social skills, predisposing them to difficulties in peer interactions and social adaptation. Despite mild presentations of these disorders, individuals may struggle with social rules and academic performance, leading to an increased risk of social rejection and isolation. Furthermore, their relatively low tolerance to stress may compel them to cope through withdrawal, seeking solace in solitude to manage their discomfort. Notably, a significant portion of individuals identified as at high risk for autism in studies also exhibit symptoms of ADHD, emphasizing the importance of a comprehensive evaluation for neurodevelopmental disorders in cases of social withdrawal [11].

Type 2: social withdrawal due to onset of mental illness
In this typology, individuals begin to withdraw socially because of mood disorders, anxiety disorders, or other psychiatric conditions, excluding social withdrawal arising from psychotic symptoms or schizophrenia. Individuals in this category typically demonstrate relatively normal social functioning before the onset of mental illness. However, as psychiatric symptoms emerge, individuals may experience a gradual decline in social engagement, marked by decreased motivation, feelings of worthlessness, and avoidance of social situations. For instance, those grappling with depression may withdraw due to diminished interest and energy, while individuals with anxiety disorders may shun social interactions out of fear and apprehension. Similarly, those with eating disorders may retreat into isolation to conceal their negative body image from others. Left untreated, these psychiatric conditions can exacerbate social withdrawal, potentially evolving into chronic patterns of isolation, underscoring the critical role of early intervention in mitigating adverse outcomes.

Type 3: age-related social withdrawal
This type pertains to individuals who progressively retreat from social interactions as they age, influenced by an amalgamation of factors, including academic struggles, family discord, unemployment, illness, or unmet career aspirations. Unlike the preceding typologies, age-related social withdrawal may not be readily apparent in early adulthood but intensifies as individuals traverse mid to late adulthood. As societal expectations for social engagement peak and aspirations for personal fulfillment remain unfulfilled, individuals may succumb to feelings of despair and inadequacy, withdrawing from social spheres as a coping mechanism. Moreover, this pattern of withdrawal may be compounded by addictive tendencies, such as alcohol or gaming addictions, warranting vigilant monitoring and intervention. The economic implications of social withdrawal are significant, with withdrawn middle-aged individuals often relying on familial support for sustenance. This can strain familial dynamics and increase the risk of solitary death, particularly in cases of familial breakdown or parental loss.

However, it is not always the case that HS falls neatly into these three classifications or is clearly delineated. Types 1 and 2 appear to be influenced to a greater extent by developmental and genetic factors, while type 3 seems to be influenced more by environmental factors such as stress or personal circumstances. Therefore, it may be more appropriate to understand HS as a spectrum. Due to the inherent nature of withdrawal in HS, evaluation and follow-up are challenging, and research on prognosis for these individuals has been limited. However, for cases where HS is triggered by the onset of mental illness or psychiatric symptoms, such as types 1 or 2, prompt treatment and intervention can prevent the condition from becoming chronic. In contrast, type 3 cases, which are often difficult to detect in centers or hospitals and are typically associated with familial and economic issues, prolonged withdrawal and entrenched avoidance tendencies upon detection may lead to the worst prognosis.

The notion of HS is not limited to specific psychiatric diagnoses. However, given its high co-occurrence with mental illness, psychiatric perspectives are crucial in its assessment and intervention. In Japan, where hikikomori support initiatives are prevalent, psychiatric evaluation is prioritized, and mental health interventions are integral to the health and welfare policies aimed at addressing this disorder [12].

The evaluation and classification of heterogeneous HS and their concurrent mental health conditions require meticulous assessment. Developmental abnormalities in infancy and childhood, such as language and motor development, are identified to determine if they meet criteria for neurodevelopmental disorders, given their role as predisposing factors for mental illness. Subsequent diagnostic interviews assess criteria for psychiatric disorders, including depression, anxiety, and coexisting disorders. Additionally, personality disorders and entrenched negative patterns of thinking, emotions, and behaviors are evaluated, along with environmental factors contributing to social withdrawal, such as poor family dy-
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In this study, various manifestations of HS were examined through representative clinical cases, emphasizing an integrated approach that took into account social, cultural, and psychiatric factors. Additionally, investigating how withdrawn individuals perceive and interpret the significance of their withdrawal can provide insights into HS to inform the formulation of effective interventions.

CONFLICTS OF INTEREST

No potential conflict of interest relevant to this article was reported.

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ORCID

Ji Hyun An https://orcid.org/0000-0002-1628-9617
Sohee Park https://orcid.org/0000-0002-7069-3186
Jin Young Jung https://orcid.org/0000-0002-9231-1740
Jin Pyo Hong https://orcid.org/0000-0001-5384-2605

AUTHOR CONTRIBUTIONS

Conception or design: JHA.
Acquisition, analysis, or interpretation of data: JHA, SP, JYJ.
Drafting the work or revising: JHA.
Final approval of the manuscript: JHA, SP, JYJ, JPH.

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