



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

Received: March 18, 2024

Revised: March 21, 2024

Accepted: March 22, 2024

Corresponding author:

Jin Pyo Hong

Department of Psychiatry,
Samsung Medical Center,
Sungkyunkwan University
School of Medicine, 81 Irwon-ro,
Gangnam-gu, Seoul 06351, Korea
Tel: +82-2-3410-3585
E-mail: suhurhong@gmail.com

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

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<https://creativecommons.org/licenses/by-nc/4.0/>).

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 judg-

ment. Despite not facing active bullying, he withdrew from social interactions due to difficulty initiating contact. 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 patient's 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

Table 1. Screening guidelines for *hikikomori* syndrome

-
1. Have you spent most of your time at home almost every day over the past month? (Current)
 - 1-1. Please write down the period during which you spent most of your time at home almost every day.
 2. Have you ever spent most of your time at home almost every day for more than a month? (Past)
 - 2-1. Please specify the period during which you spent most of your time at home almost every day for more than a month.
 3. Have you tried to avoid or minimize social activities, such as going to school or work, over the past month? (Current)
 - 3-1. Please specify the period during which you have avoided social activities.
 - 3-2. Please list any social activities you have been avoiding or have been reluctant to engage in (e.g., going to school, going to work).
 4. Have you ever avoided or tried to avoid social activities, such as going to school or work, for more than a month in the past? (Past)
 - 4-1. Please specify the period during which you avoided or tried to avoid social activities.
 - 4-2. Please list the social activities that you tried to avoid (e.g., going to school, going to work).
 5. Have you tried to avoid social relationships, such as meeting friends or avoiding contact with family members, in the past month? (Current)
 - 5-1. Please specify the period during which you attempted to avoid social relationships.
 - 5-2. Please specify which social relationships you attempted to avoid.
 6. Have you ever attempted to avoid social relationships, such as avoiding meeting friends or avoiding contact with family, for more than a month in the past? (Past)
 - 6-1. Please specify the period during which you attempted to avoid social relationships.
 - 6-2. Please specify the types of social relationships you attempted to avoid.
 7. Please select the option that best describes your usual level of going out.
 - 1=Go out every day for work or school.
 - 2=Go out for work or school 3–4 times a week.
 - 3=Go out frequently for leisure activities.
 - 4=Go out occasionally to meet people.
 - 5=Generally stay at home, but only go out for personal hobbies.
-

Hikikomori syndrome is defined as exhibiting, either currently or in the past, all three criteria for a period of 3 months or more.

described feeling emotionally flat and expressed a sense of contentment in his isolation. He experienced binge eating and oversleeping for nearly 20 hours a day in the past 3 months. He met the SCID-5 criteria for Bipolar II disorder, depressive episode, and the Korean Hikikomori Screening Tool. He is currently undergoing treatment for bipolar disorder, exhibiting a partial improvement in his symptoms to date.

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 mem-

bers. 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-

namics and job losses.

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.

ACKNOWLEDGMENTS

This work was supported by the Korea Healthcare Technology R&D project, Ministry of Health and Welfare, Republic of Korea (HL19C0018).

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.

REFERENCES

1. Saito K. Hikikomori no hyouka: Shien ni kansuru gaidorin (Evaluation and Support Guideline for Hikikomori). Ministry of Health, Labour and Welfare; 2010.
2. Malagon A, Alvaro P, Corcoles D, Martin-Lopez LM, Bulbena A. 'Hikikomori': a new diagnosis or a syndrome associated with a psychiatric diagnosis? *Int J Soc Psychiatry* 2010;56:558-9.
3. Koyama A, Miyake Y, Kawakami N, Tsuchiya M, Tachimori H, Takeshima T, et al. Lifetime prevalence, psychiatric comorbidity and demographic correlates of "hikikomori" in a community population in Japan. *Psychiatry Res* 2010;176:69-74.
4. Teo AR, Fetters MD, Stufflebam K, Tateno M, Balhara Y, Choi TY, et al. Identification of the hikikomori syndrome of social withdrawal: psychosocial features and treatment preferences in four countries. *Int J Soc Psychiatry* 2015;61:64-72.
5. Jung JY, An JH, Kim MH, Park SH, Hong JP. Prevalence of psychiatric diagnosis and related psychosocial characteristics among hikikomori (social withdrawal syndrome) in Korea. *J Korean Neuropsychiatr Assoc* 2023;62:164-72.
6. Pozza A, Coluccia A, Kato T, Gaetani M, Ferretti F. The 'hikikomori' syndrome: worldwide prevalence and co-occurring major psychiatric disorders: a systematic review and meta-analysis protocol. *BMJ Open* 2019;9:e025213.
7. Teo AR, Stufflebam K, Saha S, Fetters MD, Tateno M, Kanba S, et al. Psychopathology associated with social withdrawal: idiopathic and comorbid presentations. *Psychiatry Res* 2015;228:182-3.
8. First MB, Williams JBW, Karg RS, Spitzer RL. User's guide for the SCID-5-CV structured clinical interview for DSM-5® disorders: clinical version. American Psychiatric Publishing Inc.; 2016.
9. Wechsler D. Korean-Wechsler Adult Intelligence Scale-IV. Korean Psychological Association; 2012.
10. Baron-Cohen S, Wheelwright S, Skinner R, Martin J, Clubley E. The autism-spectrum quotient (AQ): evidence from Asperger syndrome/high-functioning autism, males and females, scientists and mathematicians. *J Autism Dev Disord* 2001;31:5-17.
11. Katsuki R, Tateno M, Kubo H, Kurahara K, Hayakawa K, Kuwano N, et al. Autism spectrum conditions in hikikomori: a pilot case-control study. *Psychiatry Clin Neurosci* 2020;74:652-8.
12. Teo AR. A new form of social withdrawal in Japan: a review of hikikomori. *Int J Soc Psychiatry* 2010;56:178-85.