OXFORD JOURNAL
OF STUDENT
SCHOLARSHIP

Beyond Saito's Threshold: The Conceptual Evolution of Hikikomori from Culture-bound Syndrome to Digitally-Mediated Withdrawal

Yuma Tamura
yumayuma2008@icloud.com

ABSTRACT

Hikikomori was first described by Saito (1998) as severe social withdrawal from education, employment, and relationships lasting more than six months. Hikikomori has developed from a phenomenon thought to be specific to Japan into an internationally recognised and contested concept. This review follows that development, looking at how hikikomori is defined, how it is classified diagnostically, its psychological characteristics, its causes, how it is treated, and how it has changed in a post-COVID, digitally mediated world. I drew on 38 sources to synthesise the literature thematically. Prevalence is estimated at around 1.2% in Japan (Koyama et al., 2010), and similar patterns have been identified in Hong Kong, South Korea and parts of Europe and North America (Kato et al., 2012; Wong et al., 2015; Eckardt, 2023). However, the literature surrounding hikikomori is fragmented. The six month criterion has little empirical justification and the distinction between primary and secondary hikikomori is weak due to widespread subthreshold distress. This supports dimensional models rather than categorical ones (Kato, Kanba & Teo, 2019). The causes of hikikomori are multifaceted, arising from the interaction of family dynamics, sociocultural expectations, structural economic conditions and individual vulnerability. No single treatment has proved to be consistently effective, but multidisciplinary approaches seem to be the most promising (Kato, Kanba & Teo, 2019). Recent research suggests that the internet acts as a contextual amplifier of withdrawal, not a direct cause of it (Esposito & Addeo, 2025; Calaresi et al., 2025). Ideas of "semi-withdrawal" also challenge the already-established diagnostic frameworks. This review concludes that hikikomori is best understood as a prolonged state of social non-participation. Future research should aim to reach a diagnostic consensus, develop assessment methods less reliant on self-report systems, and use dynamic models suited to the digital world.

INTRODUCTION

Hikikomori, first coined by Japanese psychiatrist Tamaki Saito in 1998, refers to severe social withdrawal characterised by avoidance of education, employment and personal relationships for a period exceeding 6 months (Saito, 1998). This time period has become a benchmark for identifying hikikomori and offers a practical temporal threshold. Historically, hikikomori has existed as a mixture of sociological description

and psychiatric diagnosis (Furlong, 2008; Kato et al., 2011). In 2010, the Japanese Ministry of Health, Labour and Welfare formally recognised hikikomori as a condition warranting public health intervention and issued official guidelines for assessment and treatment (Ministry of Health, Labour and Welfare, 2010). Despite this, its causes, prevalence and long-term impact still remain poorly understood.

Epidemiological studies in Japan estimate that lifetime prevalence of hikikomori is at around 1.2% with higher rates in young adult males (Koyama et al., 2010). These figures most likely underestimate the true amount, as many hikikomori sufferers do not take part in the surveys taken in studies due to their lack of interaction with the outside world. Whilst traditionally conceived as a culturally bound condition, hikikomori is increasingly recognised internationally. Similar patterns have been documented beyond Japan: a study in Hong Kong found that 1.9% of young people (an estimated 16,900–41,000 individuals) showed severe social withdrawal (Wong et al., 2015), 2.3% of Korean high school students have been identified as socially withdrawn (Lee et al., 2013), and comparable cases have been reported in the United States and Northern Europe (Kato et al., 2012; Eckardt, 2023). International recognition of hikikomori has grown with the spread of the socioeconomic conditions thought to contribute to it. This includes high youth unemployment, economic stagnation and extended parental financial support which are becoming increasingly prevalent across the broader Western world (Furlong, 2008; Eckardt, 2023).

Despite the growing recognition, hikikomori literature remains fragmented. There are debates over whether the condition constitutes a discrete psychiatric disorder, a culture-bound syndrome, or a behavioural expression of underlying psychological problems (Kato et al., 2011; Furlong, 2008). The attempts to resolve the ambiguity of it all through diagnostic sub-typing (the distinguishing of primary hikikomori from secondary: absence/prevalence of psychiatric comorbidity) have provided limited clarity as empirical evidence consistently results in heterogeneous presentations that resist categorical classification (Teo et al., 2015; Kato, Kanba & Teo, 2019). This methodological inconsistency across studies, including a variation in definitions, further limits the development of the knowledge of this subject (Teo, 2010; Tateno et al., 2012).

Alongside these definitional debates, the nature of hikikomori itself appears to be changing. The COVID-19 pandemic and the rapid growth of digital technology have moved much of everyday social life online, altering what withdrawal looks like: an individual may now be physically confined to the home yet remain socially active through digital channels. This raises the question of whether frameworks built around physical confinement can still capture hikikomori in its contemporary form.

The aim of this review is not only to define hikikomori or raise awareness of it, but to examine how the concept has evolved: from Saito's original formulation as a culturally specific form of social withdrawal to an internationally recognised and increasingly digitally mediated phenomenon. Clarifying how hikikomori is conceptualised matters because definitions determine who is identified and offered support. The review covers diagnostic classification, psychological characteristics, causes, biological findings and treatment approaches, before considering how COVID-19 and the shift to online life may reshape the presentation and study of hikikomori.

METHODS

This is a narrative literature review paper. The relevant papers were identified through searches of PubMed, Science Direct and Google Scholar, using the keyword "hikikomori". Sources were further identified by following the reference lists of relevant articles. Sources were selected for their relevance to: conceptualisation, diagnostic classification, psychological characteristics, causes and treatment of hikikomori, plus its recent development in the context of COVID-19 and digital technology. A small number of additional sources were included to describe the measurement instruments (e.g. the Toronto Alexithymia Scale and Buss-Durkee Hostility Inventory), theoretical frameworks (e.g. the I-PACE model) and diagnostic context (the DSM-5-TR) referred to in the reviewed studies.

In total, 38 sources published between 1957 and 2025 were included. These comprised empirical studies, review articles, commentaries, books and official guidelines. The literature was then organised thematically into the areas presented in the Findings below.

FINDINGS

Conceptual Origins and the Problem of Definition

The conceptualisation of hikikomori has evolved considerably from its origins, reflecting the shifts in cultural factors, diagnostic categorisation, and recognition internationally.

The term *hikikomori* was introduced to describe individuals who withdraw almost entirely from social participation. They remain confined to their homes for a period exceeding 6 months (Saito, 1998). This definition then became the foundation of this field and is cited often as the conceptual origin of hikikomori research (Kato, Kanba & Teo, 2019). The six month duration criterion acts as the primary baseline across all studies, however there is still the absence of empirical justification for this specific threshold (Saito, 1998; Kato, Kanba & Teo, 2019). On the individual level, hikikomori is associated with psychological distress and psychiatric comorbidity: depression, schizophrenia and social anxiety disorder (Teo et al., 2015; Kato, Kanba & Teo, 2019; Kato, Shinfuku & Tateno, 2020). On the family level, isolation is maintained within the household: the individual spends most of their time at home, often supported by parents who accommodate the withdrawal rather than challenge it (Kato, Kanba & Teo, 2019). The societal level poses hikikomori as a growing public health concern. There is an estimated prevalence of 1.2% in Japan and increasing global recognition in the form of severe social isolation (Koyama et al., 2010; Kato et al., 2012; Kato, Kanba & Teo, 2019). Social and environmental factors, such as the COVID-19 pandemic, are risks for withdrawal: they enhance social isolation and disrupt participation in education and employment (Kato, Sartorius & Shinfuku, 2020). These levels position hikikomori as more than an individual pathology. It is a multi-faceted phenomenon that exists through interactions between psychological, familial and societal processes.

Early conceptualisations defined hikikomori as different from conventional psychiatric disorders, emphasising prolonged social withdrawal in the absence of overt psychosis, intellectual disability or

severe mood disorder (Saito, 1998; Teo & Gaw, 2010). Instead, Saito originally viewed hikikomori as a phenomenon embedded within Japanese social and cultural conditions (Saito, 1998). Increasing internationalisation has changed this with the view that it interacts with culture and is caused by a set of cultural, social, and individual conditions common across the developed West.

This contributes to ongoing debates regarding what hikikomori truly represents: a culture-bound syndrome – a condition whose presentation/meaning are understood as specific to its cultural context – a discrete psychiatric entity, or simply an accumulation of existing psychopathology expressed through social withdrawal (Kato et al., 2011; Furlong, 2008).

Along with the internationalisation of the concept, the categorisation of hikikomori has also evolved. Researchers have proposed distinctions such as primary (Type 1) and secondary (Type 2) hikikomori to differentiate the withdrawal: absence vs presence of secondary conditions (e.g. depression, schizophrenia) (Teo et al., 2015) which I discuss at length in the next section. Beyond this, hikikomori has been re-conceptualised as a multidimensional condition. The cluster analysis of blood metabolic data identifies metabolically distinct subgroups within the hikikomori population (Setoyama et al., 2021).

Despite these developments, the definition of hikikomori remains problematic. The six-month duration threshold does provide a practical temporal marker, but it defines hikikomori primarily by time. This draws focus away from the psychological mechanism that causes the withdrawal. This is a meaningful distinction: an individual may be experiencing significant distress and social disengagement well before the six-month point, yet fall outside the scope of formal recognition entirely. Defining the condition in this way increases the risk of excluding individuals in early stages of withdrawal who might benefit from some sort of timely intervention (Kato, Kanba & Teo, 2019).

These definitional problems are compounded by methodological ones. Hikikomori holds an ambiguous position between sociological description and psychiatric diagnosis. This leads to methodological inconsistency across literature surrounding the subject which, in turn, limits the cumulative development of knowledge in this field (Kato et al., 2011). Studies vary in their definitions, sampling strategies and outcome measures in ways that make direct comparison difficult. Institutional recognition – such as the Ministry of Health guidelines issued in 2010 – represents an important step, but formal acknowledgement without accompanying diagnostic consensus may result in an ill-defined construct rather than resolve the conceptual ambiguity (Kato et al., 2011).

Diagnostic Types: Primary vs Secondary Hikikomori

Primary (Type 1) and Secondary (Type 2) hikikomori is a distinction that aims to categorise hikikomori effectively. Primary hikikomori refers to prolonged social withdrawal that occurs in the absence of a primary psychiatric disorder (Teo et al., 2015). Secondary hikikomori is withdrawal that occurs secondary to conditions such as depression or schizophrenia (Teo et al., 2015). The studies performed on the basis of this ideology typically rely on structured psychiatric interviews: Structured Clinical Interviews for DSM

Disorders (SCID) or the Mini International Neuropsychiatric Interview (MINI) (Teo et al., 2015). This aims to preserve hikikomori as a clinical phenomenon while accounting for high rates of psychiatric comorbidity.

Empirical investigations suggest that psychological profiles differ in degree rather than kind across subtypes. Primary hikikomori has been associated with higher levels of verbal and physical hostility (Frankova, 2019). In contrast, secondary hikikomori demonstrates higher level of anxiety, dysthymia, and excitability as personality traits (Frankova, 2019). Frankova further reported that aggression in primary cases tends to appear behaviourally, whereas in secondary cases it seems reflective of underlying instability. Although presentations may appear broadly similar at the level of observable withdrawal, these findings suggest potentially different therapeutic targets across subtypes (Frankova, 2019).

Despite its clinical utility, the primary-secondary distinction has been questioned by researchers including Kato, Kanba and Teo (2019). The framework assumes that psychiatric comorbidity – with conditions such as depression, anxiety disorders, autism spectrum disorder and schizophrenia – can serve as a reliable dividing line between the two types, cleanly separating cases with an identifiable psychiatric basis from those without. In practice, however, this boundary is considerably harder to draw. The difficulty is not simply that comorbid conditions are common, but that subclinical symptoms are widespread even among individuals who do not meet full diagnostic thresholds for any secondary disorder. Many individuals with hikikomori report depressive or anxious symptoms without meeting the full diagnostic criteria for a psychiatric disorder (Kato, Kanba & Teo, 2019). The primary category – theoretically free of psychiatric comorbidity – therefore contains many individuals experiencing significant, if subthreshold, psychological distress, which undermines the assumption that the two types are meaningfully distinct. This pattern reinforces the heterogeneity of hikikomori presentations (Kato, Kanba & Teo, 2019) and lends support to dimensional rather than categorical models of psychopathology, in which social withdrawal and associated distress exist along a spectrum rather than within discrete diagnostic types (Kato, Kanba & Teo, 2019).

Psychological Characteristics and Experience

Early accounts of hikikomori describe broad psychological characteristics such as emotional withdrawal, irritability and impaired psycho-social functioning. However, there has been an increased complexity around international generalisability and heterogeneity within the condition.

These early descriptions have since been examined empirically (Frankova, 2019). Frankova (2019) reported that individuals with hikikomori exhibit elevated levels of hostility, emotional dysregulation and reduced (subjective) quality of life. Emotional processing difficulties are frequently operationalised as alexithymia and assessed using the Toronto Alexithymia Scale (TAS-26). This is a validated self-report instrument that measures the difficulty identifying and verbalising emotions (Taylor et al., 1985). Hostility is commonly measured using the Buss-Durkee Hostility Inventory (BDHI), which assesses multiple dimensions of hostility and resentment (Buss and Durkee, 1957). The quality-of-life aspect is typically

assessed using the Comprehensive Quality of Life Scale (CQLS), which notes the perceived wellbeing across multiple life domains (Chaban et al., 2016).

As discussed above, primary and secondary subtypes differ in hostility and emotional instability, but these differences are of degree rather than kind (Frankova, 2019). Many individuals with hikikomori report depressive or anxious symptoms without meeting full diagnostic criteria for a psychiatric disorder (Kato, Kanba & Teo, 2019). This challenges categorical sub-typing and aligns with dimensional models of psychopathology, in which distress exists along a spectrum rather than within discrete boundaries.

Causes

Socioeconomic causes

The causes of hikikomori are multifaceted. They encompass familial dynamics, sociocultural expectations, and structural economic conditions, with no single factor occurring in isolation (Kato, Kanba & Teo, 2019; Furlong, 2008).

Familial

Family dynamics play a significant role in the early conceptual models of hikikomori, particularly in Saito's original model (Saito, 1998). Primary hikikomori has been associated with the over-investment of parents in the context of the success of their child combined with an avoidance of conflict and failure (Suwa et al., 2003). Withdrawal has been interpreted as a strategy to preserve familial harmony and avoid shame within relationships characterised by high levels of pressure (Suwa & Suzuki, 2013). In this model, hikikomori may function as an adaptive response to the demands parents may expect rather than a simple behavioural avoidance (Suwa & Suzuki, 2013). Attachment-based models propose that insecure or avoidant attachment styles increase an individual's vulnerability to social withdrawal, particularly during the developmental transition stages such as school completion or entry into the working world (Krieg & Dickie, 2013). These findings are based on a questionnaire study that included attachment theory ideas (Krieg & Dickie, 2013). However, similar attachment patterns are also implicated in depression, anxiety and personality disorders, limiting their specificity to hikikomori (Krieg & Dickie, 2013).

Japan's comparatively strong family safety net, in which parents may financially support adult children for extended periods, has been identified as an enabling factor in withdrawal (Borovoy, 2008; Kato, Kanba & Teo, 2019). In this context, family economic capacity may sustain withdrawal once it has begun, even if it does not directly cause it (Borovoy, 2008; Kato, Kanba & Teo, 2019).

Social

Hikikomori is often associated with socio-cultural expectations regarding productivity, independence and a successful transition into adulthood. The epidemiological studies consistently report a higher prevalence

among males – particularly during adolescence and early adulthood (Koyama et al., 2010; Tateno et al., 2012). This distribution in gender is interpreted as a reflection of male vulnerability and the consequence of gender expectations regarding employment, autonomy and social performance (Furlong, 2008; Borovoy, 2008). However, the gender differences may reflect variation of behaviour, where women may express withdrawal through relational dependency or internal distress that is less likely to classify as hikikomori (Furlong, 2008; Borovoy, 2008).

Hikikomori is usually categorised as a phenomenon among the youth and is associated with rejection from schools or difficulty of transitioning into employment (Teo, 2010; Wong, 2009). However, there is an increasing recognition of cases in middle-aged/older individuals which challenges this framework (Kato, Kanba & Teo, 2019; Eckardt, 2023). These findings indicate that hikikomori may represent a long-term state of social non-participation rather than a developmental delay (Kato, Kanba & Teo, 2019; Eckardt, 2023).

Economics

Early literature describes hikikomori as a culture-bound syndrome rooted in Japanese norms such as collectivism, shame-based regulation and intense educational pressure (Teo & Gaw, 2010; Todd, 2011). Economic stagnation that followed the collapse of Japan's asset bubble has also been implicated, especially in relation to precarious employment and delayed adulthood (Furlong, 2008). While these socioeconomic conditions may increase vulnerability, similar withdrawal patterns have been documented internationally in South Korea, Canada and the United States (Kato et al., 2012; Chong & Chan, 2012; Wu et al., 2019) as well as raising concerns in Northern Europe, including Denmark (Eckardt, 2023). These cross-cultural observations indicate that hikikomori is not geographically confined to Japan (Kato et al., 2012; Eckardt, 2023).

The impact of structural tolerance on individual vulnerability is therefore emphasised - Japan's strong family safety net may not cause hikikomori but it makes it easier to sustain - and in contexts where prolonged non-participation carries little immediate social or economic consequence, the pressure to re-engage is correspondingly reduced (Borovoy, 2008; Kato, Kanba & Teo, 2019).

Individual

Psychological

Psychological models highlight relational vulnerability and developmental stressors as individual-level contributors. Insecure or avoidant attachment patterns have been associated with increased risk of withdrawal during transitions in life (Krieg & Dickie, 2013). Gendered developmental expectations may further influence how withdrawal manifests and is recognised (Furlong, 2008; Borovoy, 2008).

Biological

Recent research has explored biological correlates of hikikomori using blood biochemical tests and plasma metabolome analysis (Setoyama et al., 2021). In a sample of 42 drug-free patients and 41 healthy

controls, individuals with hikikomori showed markedly higher long-chain acylcarnitine levels, and metabolic data could distinguish cases from controls and predict hikikomori severity (Setoyama et al., 2021). However, the sample was small, and the markers identified have not been shown to be specific to hikikomori. In the absence of disorder-specific biomarkers, current biological findings lack diagnostic discriminability.

Treatment Approaches and the Absence of a Cure

The literature behind hikikomori highlights a constant tension between the efforts to define it as a diagnosable condition and the objective reality of heterogeneity, comorbidity and strong contextual dependence (Teo et al., 2015; Kato, Kanba & Teo, 2019). There is no universally accepted diagnostic criterion, and this lack of clarity complicates the attempts to establish a definitive diagnostic criteria or identify a consistent treatment approach.

Several researchers have argued that hikikomori is better understood as a state of prolonged social non-participation than as a discrete psychiatric disorder, given that it can come about through many different pathways; plus also being sustained by a combination of relational, economic and psychological factors (Kato, Kanba & Teo, 2019; Harding, 2018). In this perspective, the absence of a single unifying diagnosis may reflect the nature of the condition itself rather than simply a gap in the literature.

A broad range of interventions has been used including pharmacotherapy, psychotherapy, family-based approaches, home visits and community support programs (Lee et al., 2013). Pharmacological interventions typically target comorbid conditions such as depression or anxiety instead of the social withdrawal itself (Nagata et al., 2013). Multidisciplinary approaches are the most promising – especially those combining gradual exposure, family support and vocational assistance (Kato, Kanba & Teo, 2019).

However, there is no single treatment that has demonstrated consistent effectiveness across cases, highlighting a limitation within the current literature. The diversity of therapeutic approaches signifies the broader diagnostic ambiguity and the uncertainty about what is, in fact, being treated. While medication may alleviate the associated symptoms, it does not directly address the wider issue of social reintegration. This raises an important question as to whether hikikomori can be considered curable in the absence of structural change. Furthermore, treatment success is often defined pragmatically as increased participation in education, work or social life, rather than full symptom remission. Such outcome measures suggest the ongoing uncertainty surrounding therapeutic goals and the conceptual complexity that continues to shape the understanding of hikikomori.

COVID-19

The enforced isolation of the pandemic was expected to increase the number of people at risk of hikikomori (Kato, Sartorius & Shinfuku, 2020; Rooksby et al., 2020). The biological roots of the isolation have been highlighted during this period; research showed significant correlations between social

isolation, loneliness, and chronic systemic inflammation in the Japanese population during the pandemic (Koyama et al., 2021). Kato, Sartorius & Shinfuku (2020) drew direct parallels between the lived experience of the pandemic (isolation) and hikikomori. They argued that the social mechanisms behind both of the phenomena are deeply interconnected and learnings from clinical hikikomori research are directly applicable to understanding the mental health consequences of COVID-19-related withdrawal (Kato, Sartorius & Shinfuku, 2020). The pandemic, therefore, broadened the global reach of hikikomori as a clinical concern and renewed urgency around developing the correct tools for identifying and supporting those experiencing hikikomori (Rooksby et al., 2020).

Shifting landscape

A lot of the literature on hikikomori categorises withdrawal as spatial. It depicts the individuals as confined to their homes and cut off from education, work or society. Two relatively recent studies, Esposito & Addeo (2025) and Calaresi et al., (2025), raise questions that challenge these ideas present in older models of hikikomori.

Esposito & Addeo (2025) argued for a re-conceptualisation of hikikomori in this digital age. They introduced the idea of "digital hikikomori", where the internet actively shapes the isolation instead of accompanying it. Drawing on Castells' (2004) Network Society, they argued that hikikomori is not pure physical confinement where social lives start to be represented off/online. To unpack this multidimensional aspect of social interaction, Esposito & Addeo employed a three-phased sequential investigation (Esposito & Addeo, 2025). They combined a national survey (n = 399), a netnographic observation of a Telegram group over 6 months, and a Delphi consultation with 21 experts (Esposito & Addeo, 2025). The survey found that 71% of individuals with hikikomori engage in intensive internet use. This suggests that within this hikikomori population digital participation is closer to the norm than expected (Esposito & Addeo, 2025). Internet use could also be associated with shorter periods of isolation (Cramer's $V = 0.433$, $p = 0.04$). This indicates a possible buffering effect of the internet on withdrawal (although, as the finding is correlational, causality cannot be confirmed) (Esposito & Addeo, 2025). The analysis of approximately 90,000 messages in the Telegram group presented that individuals with hikikomori can form real relationships online, particularly ones between those who share similar experiences (Esposito & Addeo, 2025). The anonymity of these interactions offers privacy and control over the social exposure for the individual, and this decreases the risks of rejection - offline contact rarely provides this (Esposito & Addeo, 2025). However, attempts to convert digital relationships into offline ones can result in shame and renewed withdrawal (Esposito & Addeo, 2025). This suggests that social interaction that is online can ease the condition but create difficulties when trying to convert these relationships into offline ones (Esposito & Addeo, 2025).

Calaresi et al. (2025) approached the question by tracking hikikomori behaviours alongside Internet Gaming Disorder (IGD). This is a condition characterised by the compulsive over-use of internet games leading to significant impairment/distress in daily life (Calaresi et al., 2025). It is listed in Section III of the DSM-5-TR as a condition requiring further study (APA, 2022). Using the I-PACE model (Brand et al., 2016), the study used models to examine bi-directional relationships between emotional neglect, hikikomori behaviours and IGD (Calaresi et al., 2025). The findings challenge the assumption that

excessive internet use drives withdrawal. Emotional neglect consistently predicted both hikikomori behaviours and IGD, and hikikomori behaviours consistently predicted IGD, but there was no reciprocal pathway from IGD back to either hikikomori behaviours or emotional neglect (Calaresi et al., 2025). Therefore, the direction of influence ran one way: early emotional neglect contributed to social withdrawal, and social withdrawal then contributed to problematic gaming, but gaming did not worsen withdrawal or neglect. This therefore recategorises IGD not as a cause of hikikomori but as a consequence; something that develops within an already-established withdrawal rather than something causing or sustaining it (Calaresi et al., 2025). The authors note that online gaming may offer a means of emotional regulation and social connection for adolescents who have already disengaged from face-to-face life (Calaresi et al., 2025).

Both of these studies suggest the internet is better understood as a contextual amplifier than an aetiological driver of hikikomori. Esposito and Addeo's (2025) Delphi experts described the internet as a 'last window to the world' - a space where individuals feel more comfortable and less exposed to social judgement. The internet acts as a medium of social interaction that supports identity experimentation, social connection and educational participation. At the same time, both studies are clear that digital environments can entrench withdrawal: Esposito and Addeo (2025) describe the internet as a 'comfortable container' that reduces immediate distress of hikikomori behaviours without addressing their underlying sources, while Calaresi et al. (2025) note that once IGD develops it is maintained independently of the neglect and withdrawal that initially fostered it.

Both of these findings offer new ideas for how hikikomori is classified. Esposito and Addeo (2025) report that experts are already identifying cases of 'semi-withdrawal' where individuals maintain partial connections to education, work or therapy through digital channels. The concept of 'digital migration' – a gradual inhabitation of online spaces that requires no physical exposure and involves little normative social influence – raises questions about whether diagnostic criteria of hikikomori will remain viable as digital environments develop (Esposito & Addeo, 2025). Both studies suggest a dynamic and process-based framework is better suited to today’s modern picture than fixed models (Esposito & Addeo, 2025; Calaresi et al., 2025). This progression is summarised in Figure 1.

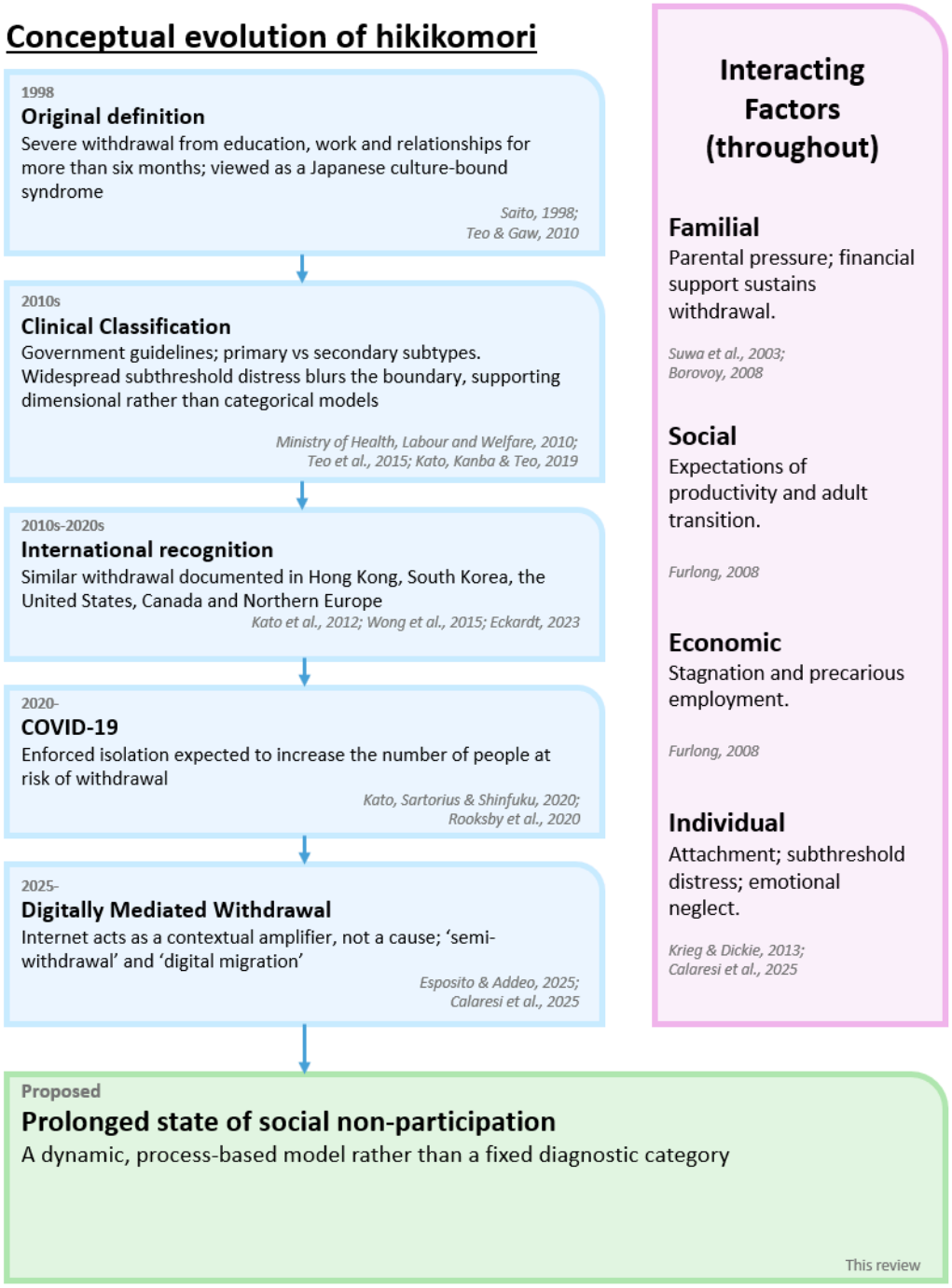


Figure 1. Conceptual evolution of hikikomori from culture-bound syndrome to digitally mediated withdrawal.
Source: author's synthesis of the reviewed literature (made in PowerPoint)

DISCUSSION

At the broader level, there have been concerns raised regarding the risk of over-pathologisation in social withdrawal; particularly in societies where prolonged non-participation may be structurally tolerated/aided (Eckardt, 2023). Eckardt (2023) highlights the ethical tensions inherent in formalising hikikomori as a psychiatric entity without clear diagnostic boundaries. Therefore, while the primary-secondary model offers a clinical structure, its conceptual/ethical limitations suggest the need for cautious interpretation and further refinement.

Further evidence that questions the practical relevance of the primary-secondary distinction comes from subjective outcome measures. Frankova (2019) reported that almost half of individuals with hikikomori rated their quality of life as poor with minimal differences observed between primary and secondary subtypes. The similarity in subjective suffering across the diagnostic categories suggests that diagnostic distinctions may have limited relevance compared to lived experience, even if they hold some clinical significance.

The heavy reliance on self-report instruments in this piece of literature represents the significant methodological limitation. Measures of alexithymia, hostility and quality of life depend on accurate introspection and emotional awareness. However, alexithymia (emotional blindness) and emotional avoidance - both commonly reported in hikikomori populations - may hinder the ability to accurately recognise and report internal states (Taylor et al., 1985; Frankova, 2019). This reliance on self-report risks underestimating the severity of emotional impairment and highlights the need for complementary assessment approaches for future research projects (Frankova, 2019).

This review has several limitations. As a narrative rather than systematic review, sources were selected for relevance rather than through a fixed protocol, which may introduce selection bias. Searches were limited to three databases and one main keyword, and were carried out by a single author. The review also relied mainly on English-language sources, despite the substantial Japanese-language literature on hikikomori.

CONCLUSION

This review aims to address the conceptual evolution of hikikomori from Saito’s (1998) original categorisation of prolonged social withdrawal to its current status as an internationally recognised, definitionally contested phenomenon. The most consistent theme across the literature is not a clear clinical condition, but a condition most categorised by heterogeneity. The six month duration criterion provides practical use, but it lacks empirical justification and risks excluding a hidden population within the early stages of withdrawal (Saito, 1998; Kato, Kanba & Teo, 2019). The primary/secondary distinction offers clinical structure. However this can be undermined by the widespread presence of sub-threshold psychological distress within cases that are comorbidity-free – supporting dimensional models for hikikomori rather than categorical ones (Kato, Kanba & Teo, 2019).

The causes of hikikomori are best understood as multifaceted. They can arise from an interaction between familial dynamics, sociocultural expectations, structural economic conditions and individual vulnerability (Kato, Kanba & Teo, 2019; Furlong, 2008). The documentation across South Korea, Hong Kong, Europe and North America confirms that hikikomori is not geographically confined to Japan, but appears where similar socioeconomic conditions are present (Kato et al., 2012; Wong et al., 2015; Eckardt, 2023). No single treatment has provided reliable effectiveness and this is consistent with its aetiological complexity, meaning that a multidisciplinary approach is the most promising (Kato, Kanba & Teo, 2019).

Hikikomori undoubtedly exists in a shifting landscape. COVID-19 broadened the global reach of withdrawal as a clinical concern (Kato, Sartorius & Shinfuku, 2020; Rooksby et al., 2020) and research around 'digital hikikomori' directly challenges ideas from older models by posing the internet as a contextual amplifier rather than a driver of withdrawal (Esposito & Addeo, 2025; Calaresi et al., 2025). The contemporary ideas of 'semi-withdrawal' and 'digital migration' also question the viability of current fixed diagnostic frameworks (Esposito & Addeo, 2025). This means that future research must then prioritise reaching a diagnostic consensus and developing assessment methods less reliant on self-reporting. It is crucial that they adopt a dynamic model that is able to capture hikikomori as it exists in a digitally-mediated world. Until then, hikikomori is ultimately best understood as a prolonged state of social non-participation sustained by the interaction of psychological, familial and structural factors (Kato, Kanba & Teo, 2019; Harding, 2018).

REFERENCES

[American Psychiatric Association (2022) *Diagnostic and statistical manual of mental disorders*. 5th edn, text rev. Washington, DC: American Psychiatric Association.

Borovoy, A. (2008) 'Japan's hidden youths: mainstreaming the emotionally distressed in Japan', *Culture, Medicine and Psychiatry*, 32(4), pp. 552–576. doi: 10.1007/s11013-008-9106-2.

Brand, M., Young, K.S., Laier, C., Wölfling, K. and Potenza, M.N. (2016) 'Integrating psychological and neurobiological considerations regarding the development and maintenance of specific Internet-use disorders: an Interaction of Person-Affect-Cognition-Execution (I-PACE) model', *Neuroscience & Biobehavioral Reviews*, 71, pp. 252–266. doi: 10.1016/j.neubiorev.2016.08.033.

Buss, A.H. and Durkee, A. (1957) 'An inventory for assessing different kinds of hostility', *Journal of Consulting Psychology*, 21(4), pp. 343–349. doi: 10.1037/h0046900.

Calaresi, D., Verrastro, V., Giordano, F. and Saladino, V. (2025) 'Emotional neglect, hikikomori behaviors and internet gaming disorder in adolescents: a three-wave longitudinal study', *Journal of Affective Disorders*, 390, 119850. doi: 10.1016/j.jad.2025.119850.

Castells, M. (2004) 'Informationalism, networks, and the network society: a theoretical blueprint', in Castells, M. (ed.) *The network society: a cross-cultural perspective*. Cheltenham: Edward Elgar, pp. 3–45. doi: 10.4337/9781845421663.00010.

Chaban, O., Khaustova, O. and Bezsheyko, V. (2016) 'New quality of life scale in Ukraine: reliability and validity', *Indian Journal of Social Psychiatry*, 32(4), pp. 473–478.

Chong, S. and Chan, K.M. (2012) 'A case study of a Chinese "hikikomorian" in Canada: theorizing the process of hikikomorization', *Journal of Special Education and Rehabilitation*, 13(3–4), pp. 99–114. doi: 10.2478/v10215-011-0028-0.

Eckardt, J.P. (2023) 'Does the hikikomori syndrome of social withdrawal exist in Denmark? A research request', *JMA Journal*, 6(1), pp. 86–87. doi: 10.31662/jmaj.2021-0217.

Esposito, V. and Addeo, F. (2025) 'Hikikomori 2.0: a mixed method investigation to reconceptualization the social withdrawal in the digital age', *Societies*, 15(9), 260. doi: 10.3390/soc15090260.

Frankova, I. (2019) 'Similar but different: psychological and psychopathological features of primary and secondary hikikomori', *Frontiers in Psychiatry*, 10, 558. doi: 10.3389/fpsyt.2019.00558.

Furlong, A. (2008) 'The Japanese hikikomori phenomenon: acute social withdrawal among young people', *The Sociological Review*, 56(2), pp. 309–325. doi: 10.1111/j.1467-954X.2008.00790.x.

Harding, C. (2018) 'Hikikomori', *The Lancet Psychiatry*, 5(1), pp. 28–29. doi: 10.1016/S2215-0366(17)30491-1.

Kato, T.A., Kanba, S. and Teo, A.R. (2019) 'Hikikomori: multidimensional understanding, assessment, and future international perspectives', *Psychiatry and Clinical Neurosciences*, 73(8), pp. 427–440. doi: 10.1111/pcn.12895.

Kato, T.A., Sartorius, N. and Shinfuku, N. (2020) 'Forced social isolation due to COVID-19 and consideration for hikikomori', *Asia-Pacific Psychiatry*, 12(3), e12392. doi: 10.1111/appy.12392.

Kato, T.A., Shinfuku, N., Sartorius, N. and Kanba, S. (2011) 'Are Japan's hikikomori and depression in young people spreading abroad?', *The Lancet*, 378(9796), p. 1070. doi: 10.1016/S0140-6736(11)61475-X.

Kato, T.A., Shinfuku, N. and Tateno, M. (2020) 'Internet society, internet addiction, and pathological social withdrawal: the chicken and egg dilemma for internet addiction and hikikomori', *Current Opinion in Psychiatry*, 33(3), pp. 264–270. doi: 10.1097/YCO.0000000000000601.

Kato, T.A. et al. (2012) 'Does the "hikikomori" syndrome of social withdrawal exist outside Japan? A preliminary international investigation', *Social Psychiatry and Psychiatric Epidemiology*, 47(7), pp. 1061–1075. doi: 10.1007/s00127-011-0411-7.

Koyama, A., Miyake, Y., Kawakami, N., Tsuchiya, M., Tachimori, H. and Takeshima, T. (2010) 'Lifetime prevalence, psychiatric comorbidity and demographic correlates of "hikikomori" in a community population in Japan', *Psychiatry Research*, 176(1), pp. 69–74. doi: 10.1016/j.psychres.2008.10.019.

Koyama, Y. et al. (2021) 'Interplay between social isolation and loneliness and chronic systemic inflammation during the COVID-19 pandemic in Japan: results from U-CORONA study', *Brain, Behavior, and Immunity*, 94, pp. 51–59. doi: 10.1016/j.bbi.2021.03.007.

Krieg, A. and Dickie, J.R. (2013) 'Attachment and hikikomori: a psychosocial developmental model', *International Journal of Social Psychiatry*, 59(1), pp. 61–72. doi: 10.1177/0020764011423182.

Lee, Y.S., Lee, J.Y., Choi, T.Y. and Choi, J.T. (2013) 'Home visitation program for detecting, evaluating and treating socially withdrawn youth in Korea', *Psychiatry and Clinical Neurosciences*, 67(4), pp. 193–202. doi: 10.1111/pcn.12043.

Ministry of Health, Labour and Welfare (2010) *Guidelines for hikikomori assessment and support*. Tokyo: Ministry of Health, Labour and Welfare.

Nagata, T., Yamada, H., Teo, A.R., Yoshimura, C., Nakajima, T. and van Vliet, I. (2013) 'Comorbid social withdrawal (hikikomori) in outpatients with social anxiety disorder: clinical characteristics and treatment response in a case series', *International Journal of Social Psychiatry*, 59(1), pp. 73–78. doi: 10.1177/0020764011423184.

Rooksby, M., Furuhashi, T. and McLeod, H.J. (2020) 'Hikikomori: a hidden mental health need following the COVID-19 pandemic', *World Psychiatry*, 19(3), pp. 399–400. doi: 10.1002/wps.20804.

Saito, T. (1998) *Shakaiteki hikikomori: owaranai shishunki* [Social withdrawal: a never-ending adolescence]. Tokyo: PHP Kenkyujo.

Setoyama, D., Matsushima, T., Hayakawa, K., Nakao, T., Kanba, S., Kang, D. and Kato, T.A. (2021) 'Blood metabolic signatures of hikikomori, pathological social withdrawal', *Dialogues in Clinical Neuroscience*, 23(1), pp. 14–28. doi: 10.1080/19585969.2022.2046978.

Suwa, M. and Suzuki, K. (2013) 'The phenomenon of "hikikomori" (social withdrawal) and the socio-cultural situation in Japan today', *Journal of Psychopathology*, 19, pp. 191–198.

Suwa, M., Suzuki, K., Hara, K., Watanabe, H. and Takahashi, T. (2003) 'Family features in primary social withdrawal among young adults', *Psychiatry and Clinical Neurosciences*, 57(6), pp. 586–594. doi: 10.1046/j.1440-1819.2003.01172.x.

Tateno, M., Park, T.W., Kato, T.A., Umene-Nakano, W. and Saito, T. (2012) 'Hikikomori as a possible clinical term in psychiatry: a questionnaire survey', *BMC Psychiatry*, 12, 169. doi: 10.1186/1471-244X-12-169.

Taylor, G.J., Ryan, D. and Bagby, R.M. (1985) 'Toward the development of a new self-report alexithymia scale', *Psychotherapy and Psychosomatics*, 44(4), pp. 191–199. doi: 10.1159/000287912.

Teo, A.R. (2010) 'A new form of social withdrawal in Japan: a review of hikikomori', *International Journal of Social Psychiatry*, 56(2), pp. 178–185. doi: 10.1177/0020764008100629.

Teo, A.R. and Gaw, A.C. (2010) 'Hikikomori, a Japanese culture-bound syndrome of social withdrawal? A proposal for DSM-5', *Journal of Nervous and Mental Disease*, 198(6), pp. 444–449. doi: 10.1097/NMD.0b013e3181e086b1.

Teo, A.R., Stufflebam, K., Saha, S., Fetters, M.D., Tateno, M., Kanba, S. and Kato, T.A. (2015) 'Psychopathology associated with social withdrawal: idiopathic and comorbid presentations', *Psychiatry Research*, 228(1), pp. 182–183. doi: 10.1016/j.psychres.2015.04.033.

Todd, K.H.L. (2011) 'Hikikomania: existential horror or national malaise?', *Southeast Review of Asian Studies*, 33, pp. 135–147.

Wong, P.W.C. et al. (2015) 'The prevalence and correlates of severe social withdrawal (hikikomori) in Hong Kong: a cross-sectional telephone-based survey study', *International Journal of Social Psychiatry*, 61(4), pp. 330–342. doi: 10.1177/0020764014543711.

Wong, V. (2009) 'Youth locked in time and space? Defining features of social withdrawal and practice implications', *Journal of Social Work Practice*, 23(3), pp. 337–352. doi: 10.1080/02650530903102692.

Wu, A.F.W., Ooi, J., Wong, P.W.C., Catmur, C. and Lau, J.Y.F. (2019) 'Evidence of pathological social withdrawal in non-Asian countries: a global health problem?', *The Lancet Psychiatry*, 6(3), pp. 195–196. doi: 10.1016/S2215-0366(18)30428-0.