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## Moving past the culture bound syndrome : looking for acute social withdrawal outside Japan

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Evan Correy  
Moving Past the Culture Bound  
Syndrome: Looking for Acute Social  
Withdrawal Outside Japan

### **ABSTRACT**

The aim of this study was to determine whether acute social withdrawal (also known as hikikomori) is a culture bound syndrome, or if it exists in cultures outside Japan.

Surveys in both online and paper form were made available on Internet forums and were sent to Internet addiction clinics and private therapists across country. Questions on the survey assessed demographic information and included exploratory questions on treatment for hikikomori, a place for participants to provide information to the mental health community at large, and feedback from hikikomori participants regarding their lived experiences.

The demographic data indicated that acute social withdrawal is present in various countries outside Japan, and the open-ended questions provided information regarding potential treatments, positive and negative ideation toward treatment, and useful data for clinicians that may encounter individuals with acute social withdrawal/hikikomori.

**MOVING PAST THE CULTURE BOUND SYNDROME: LOOKING FOR ACUTE  
SOCIAL WITHDRAWAL OUTSIDE JAPAN**

A project based upon an independent investigation  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2016

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You all are the best.

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## **CHAPTER I**

### **Introduction**

In the past 20 years, there has been an emerging pattern of behavior in Japan that has, for the most part, escaped notice in the western world. This behavior is referred to as hikikomori (which translates into pulling inward) or, in more clinical terms, acute social withdrawal. Hikikomori describes individuals who will retreat into their room or home, refuse to leave, and cut off (face to face) social contact with others (Hattori, 2005). This behavior is commonly thought of as a culture bound syndrome (Teo & Gaw, 2010), which refers to a behavioral pattern that is considered to only be prevalent within a specific society or culture. However, current researchers are finding individuals who fit this behavioral pattern living outside of Japan (Teo, et al., 2015).

Acute social withdrawal affects individuals across a wide range of ages. Several articles have indicated that the behavior primarily occurs among adolescents and young adults, but other studies have found hikikomori who are well into their 30s. For example, Hattori (2005) reported that the mean age of his participants was 21.5, whereas Teo, et al., (2015) indicated that roughly a third of his participants were 30 or older. Additionally, Teo (2012), described a case study where a previously unaffected client who was in his 30s when he withdrew after developing feelings of disdain toward the world.

Individuals who exhibit hikikomori behavior are predominantly male (Todd, 2011). They often spend their time watching TV, reading books, playing computer games, watching movies or socializing via the Internet at night. This often becomes an entrenched behavioral pattern,

either incidentally or by choice, to the exclusion of other forms of social contact. Sometimes, individuals with hikikomori leave their home, but this is often at night and their interactions with other people are limited (Teo and Gaw, 2010).

Since the behavior was first identified in Japan, the terminology can be confusing to native English speakers. The Japanese term is hikikomori, which can refer to the pattern of behavior itself or to an individual who is exhibiting such behavior. Due to the word's etymology, there is no difference in its singular and plural forms. Hikikomori is commonly referred to in English clinical literature as acute social withdrawal, and current research uses these two names interchangeably.

The purpose of this research was to expand upon existing literature and to explore whether hikikomori exists outside of Japan. The phenomenon of social withdrawal can exist among many youth and adults today outside Japan, especially in a technology-driven society where many can escape into a world of computers and gaming. The individuals are sometimes referred to as “basement dwellers” or manage to avoid being noticed by the outside world entirely. Given the ease with which the hikikomori population can be overlooked, it is likely that acute social withdrawal is prevalent to some degree in the United States.

For purposes of this study, hikikomori – or acute social withdrawal – is defined as someone, who, within the past 5 years, has spent the majority of each day at home, has not regularly attended school or work, and has not had face-to-face conversations with friends or family at least once a week.

This thesis had two major limitations. The first was the survey method was used for data collection, which prevented direct contact with hikikomori sufferers. Additionally, the time constraints of the research project made a more in depth study infeasible. Therefore data

collected for this study was limited in content, was based upon responses to specific questions about hikikomori, and contained open expressions offered by hikikomori sufferers. I provide more detail on limitations in Chapter V of this thesis.

Chapter II provides an introduction to hikikomori, examines theories applicable to hikikomori and potential causes for this behavior.



## **CHAPTER II**

### **Literature Review**

The literature regarding acute social withdrawal is heavily conflicted. The source of these conflicts likely stems from the fact that this behavioral pattern is relatively new – the majority of research appears to have been published during the last 13 years. The current study examines theorized causes of acute social withdrawal, and includes evidence for and against it being classified as a culture bound syndrome.

There are researchers that claim acute social withdrawal is caused by other mental health diagnoses. For example, Kondo et al., (2012) assessed and treated 337 hikikomori, who were divided into control and intervention groups. Most subjects were classified on an existing Axis I diagnosis – primarily schizophrenia and mood disorders. Others were diagnosed with Axis II disorders, including schizotypal personality disorder. These diagnoses were given as evidence to disallow acute social withdrawal as a unique disorder rather than classify them as dual diagnoses. However, the authors found individuals who exhibited acute social withdrawal behavioral patterns without meeting the diagnostic criteria for a DSM or ICD diagnosis. These participants were excluded as outliers, which indicates a source of bias in the study.

Many researchers and clinicians who work with acute social withdrawal tend to give DSM and ICD diagnoses. For example in examining the epidemiology of hikikomori, Teo and Gaw (2010) reported that the majority of acute social withdrawal patients can fit an existing DSM diagnosis – primarily pervasive developmental disorder and generalized anxiety disorder. Additionally, Kato, et al. (2012), shared 2 hikikomori vignettes with mental health professionals

in various countries and requested their diagnosis. The respondents were mixed in their diagnoses. Some diagnosed the vignettes as having existing DSM/ICD diagnoses such as, “...adjustment disorder, anxiety disorder, autism spectrum disorders, conduct disorder, dysthymia, impulse control disorder, prodromal schizophrenia, schizoid personality disorder, simple schizophrenia, and social phobia” (Kato, et al., 2012, p 1068).

It is important to observe that none of the above researchers explained why individuals with widely varying diagnoses all exhibited the same specific pattern of behavior. They also did not address the possibility that acute social withdrawal could be co-morbid with other disorders without being caused by those disorders.

Conversely, some research also suggests that acute social withdrawal is a unique diagnosis. In the previously mentioned study by Kato, et al., (2012), the article reported that, while a large portion of respondents utilized an existing diagnosis, many clinicians (including 50% of respondents in Japan) felt that no existing ICD or DSM diagnosis explained the symptoms. Additionally, Wong, et al., (2014) performed a telephone survey looking for respondents who fit the diagnosis of acute social withdrawal in Hong-Kong. They found that more than half of their respondents did not meet the criteria for an existing DSM or ICD diagnosis. There are also instances where researchers ignored or dismissed individuals who meet hikikomori diagnostic criteria without fitting an existing diagnosis, such as in the study that was referenced earlier.

Some articles indicated that hikikomori may exist both as a possible result of an existing DSM or ICD diagnosis and as a unique disorder. In an attempt to clarify the research, Teo and Gaw (2010) discussed the concept of primary hikikomori, or individuals with acute social withdrawal that did not meet other diagnostic criteria. The number of primary hikikomori found

in research tends to vary depending on who conducted the research. For example, a study in Spain that surveyed individuals with acute social withdrawal found that 98.7% of its respondents had an existing mental health diagnosis, and 1.3% did not (Malagón-Amor, Córcoles-Martínez, Martín-López & Pérez-Solà, 2015), whereas the previously mentioned Wong, et al., (2014) study showed a percentage of individuals that were more than 30 times what Malagón-Amor et al. found who could be classified as primary hikikomori. While the latter study had almost twice as many respondents as the former, it does not account for the variation in results. Additionally, while none of the clinicians in these studies were specifically trained in working with or diagnosing acute social withdrawal, their clinical expertise and perceptions of the diagnosis are important to identifying the size and prevalence of the hikikomori population.

Other researchers indicated that family dynamics are the cause of acute social withdrawal. For example, Suwa, Suzuki, Hara, Watanabe, and Takahashi (2003) approached acute social withdrawal from a family perspective. They utilized the Family Adaptability and Cohesion Evaluation Scale (FACES) and found that hikikomori families have 3 main shared characteristics: well defined and strict, yet unspoken, family rules; an expectation for the children to share in the same values and sources of pride as the parents; and a lack of emotional and verbal exchange. These 3 combined characteristics lead to expectations that are difficult for a child to follow inside a family structure and does not leave space for the child to explore and confirm these values or to deviate from them. Their data indicate that this triggers developmental setbacks, which can in turn lead to a lack of connection between parents and children, resulting in an increased chance that hikikomori behaviors develop.

Other researchers examined the relationship between the hikikomori and their parents. Hattori (2005) found that individuals with acute social withdrawal tend to feel a lack of support

from their parents. For example, a lack of communication about emotions, to avoiding eye contact, and children being blamed for having been bullied at school. Additionally, many study respondents surveyed felt that they were unimportant to their parents, who cared more about their jobs than their children. Some respondents stated that they felt that at least one of their parents was uninvolved in their upbringing, or that their parents did not show affection to each other. Hattori (2005) also found reports of individuals with acute social withdrawal acting hostile toward their parents. This included yelling and physical assault, occasionally resulting in broken bones. Several parents surveyed indicated that they felt threatened by their child, and some confessed to carrying concealed weapons for protection.

Hattori's and Suwa's findings fit with a study by Umeda and Kawakami (2012), which examined the family history structure of individuals who at one point met criteria for acute social withdrawal. They found that 2 significant correlations - highly educated parents and maternal psychiatric diagnoses – were correlated with increased risk of hikikomori behavior. If parents are highly educated, they are more likely to have jobs, which would leave less time to communicate with their child. A mother with a psychiatric disorder may be less likely to engage in emotionally laden conversation with her child. In a similar vein, the previously referenced research conducted in Spain cited a disruption in family dynamics as a potential cause, citing that 60% of the families they surveyed had a history of mental health disorders. They also noted that often times the family assessment groups utilized in their research were refused entry into the houses of potential hikikomori (Malagón-Amor, Córcoles-Martínez, Martín-López & Pérez-Solà, 2015). However, it would be remiss to place the blame solely on the family – bad mothering has been blamed as the cause of disorders from schizophrenia to autism, causing great stress to the

families involved, before further research indicated other precipitating factors. Care should be taken here to avoid making similar mistakes.

Other research looks toward sociocultural factors as a cause. For example, some researchers state that bullying, which is often not stopped or discouraged in the Japanese school system in order to facilitate integration into a collective society (i.e., the nail that sticks up gets hammered down), is the cause of withdrawal. This can cause a reluctance to attend school. In order to avoid being bullied, some children must strive to not be different in any way. Those who cannot or will not tolerate the ego-dystonic state induced by these behaviors can develop acute social withdrawal (Todd, 2011).

Different studies claim that individuals who do not wish to accept the social norms and expectations passed down to them, but are unable (or unwilling) to actively rebel against them, can become hikikomori. For example, in Japan, a cultural expectation is for individuals to do well in high school, get into a good college, and find a job at a respected company. Japanese society has structures in place that make it hard to proceed if an individual fails at any of these steps – i.e., respected companies tend to hire relatively few recent graduates since the economy slowed in the 1990s, which gives prospective employees one chance to get a job. Those who fail to achieve the ideal societal progression, or who rebel against it, are theorized to be more likely to develop acute social withdrawal (Toivonen, Norasakkunkit, and Uchida, 2011).

The problem with sociocultural explanations is that they either have to make broad assumptions regarding worldwide cultural practices, or implicitly confine acute social withdrawal to existing in a single culture. The more widespread acute social withdrawal becomes, the less useful these explanations are. More recent research studies are increasingly

finding hikikomori cases outside of Japan; therefore the need for cross-cultural research is increasingly necessary.

Another area of debate is whether or not acute social withdrawal meets criteria for a culture bound syndrome, or if it is more accurately described by a mental health diagnosis. Teo and Gaw (2010) posed two arguments:

The first is that hikikomori is a comfortable fit for the criteria of a culture bound syndrome. They stated that the criteria for a culture bound syndrome are:

- (1) The disorder must be a discrete, well-defined syndrome;
- (2) It must be recognized as a specific illness in the culture with which it is primarily associated;
- (3) The disorder must be expected, recognized, and to some degree sanctioned as a response to certain precipitants in the particular culture; and
- (4) A higher incidence or prevalence of the disorder must exist in societies in which the disorder is culturally recognized, in comparison with other societies (p. 446).

The authors argued that the fourth criteria distinctively classified acute social withdrawal as a culture bound syndrome due to its high prevalence in Japan and relatively low prevalence elsewhere. At the time that their research was published, there were two confirmed cases outside of Japan, which more current findings suggest is woefully short of the actual numbers.

The second argument that Teo and Gaw (2010) posed was that it is too early to rule out acute social withdrawal as a psychiatric diagnosis, as there is not sufficient data to say with certainty one way or the other. In order to rectify this, Teo, et al. (2015) expanded their work by looking for a hikikomori population in other countries. The researchers found 36 individuals in four countries that met their operational definition of acute social withdrawal. The article also

reported high amounts of loneliness, which has not been found in previous research. The article is very open about its flaws. For example, the researchers noted that their sample was small and was obtained through an online advertisement, which introduces sampling bias. Additionally, the authors admitted that since the population was in treatment and were no longer reclusive, it was not representative of the hikikomori population at large (Teo, 2012).

Other researchers examined the issue of whether or not acute social withdrawal constitutes a culture bound syndrome. The study in Hong-Kong found a hikikomori population in its telephone survey, and concluded that hikikomori is not a culture bound syndrome. However, they did note that Japan and Hong-Kong have multiple cultural similarities (Wong, et al., 2014), which indicates the necessity for a broader approach. The study in Spain also found populations of acute social withdrawal outside Japan, and reached a similar conclusion (Malagón-Amor, Córcoles-Martínez, Martín-López & Pérez-Solà, 2015). Kato, et al., (2012) sent out hikikomori vignettes to clinicians in Japan, Korea, the United States, Australia, Taiwan, Bangladesh, Iran, India, and Thailand who diagnosed the behavior in the vignettes as acute social withdrawal from these clinicians. However, this does not necessarily indicate that acute social withdrawal exists within these countries, but rather that clinicians can conceptualize and recognize its symptomatology.

Overall, while there is no consensus on the cause of acute social withdrawal – whether seen as a result of family interaction or a new expression of an old psychiatric disorder – its prevalence cannot be ignored. In Japan it is estimated that over 1 million youth meet criteria for hikikomori (Hattori, 2005) and with such little data on worldwide prevalence, the number of affected individuals could be staggering. In Hong-Kong alone, it is estimated that there are between 16,900 and 42,000 individuals affected by acute social withdrawal (Wong, et al., 2014).

These findings support why the current study is so important – the implications of acute social withdrawal are large. This study aimed to replicate findings that acute social withdrawal exists in non-Japanese populations, and to refute the notion that acute social withdrawal meets the definition for a culture bound syndrome. By identifying populations of hikikomori outside of Japan, it not only challenges the idea that it is more prevalent inside Japan than elsewhere; it raises awareness of the disorder elsewhere. This would challenge the third criteria for a culture bound syndrome, and if acute social withdrawal is globally recognized, this study could help set the groundwork for the development of services and appropriate modalities for working with hikikomori who seek treatment. Additionally, this study can potentially lay the groundwork for future studies that could identify what resources this population want and need, and how to best support them as a whole.

Chapter III, which follows, provides the methodological overview for this research by describing the research purpose and design, data, method of collection, and method of analysis.



## **CHAPTER III**

### **Methodology**

#### **Purpose and Design:**

The purpose of this study was to expand upon existing literature and to explore whether hikikomori exists with any significant prevalence outside of Japan.

This study utilized a mixed methods survey, collecting quantitative demographic data and qualitative exploratory data for statistical and content analysis. The survey was available online and a paper copy was available at various treatment centers. This approach was implemented in an attempt to minimize the researcher's personal bias and to obtain relevant in-depth information. All procedures were approved by the Smith School for Social Work Internal Review Board (IRB) prior to conducting the study.

The terms hikikomori and acute social withdrawal were operationalized, based on the existing literature, as someone who:

1. Spends the majority of each day at home
2. Consistently avoids school, work, or other social situations (including friendships or family contact, but not including social contact via the Internet)
3. Experiences distress or impairment related to the withdrawal
4. Symptomatology persists for a period of six months or longer (Teo, et al., 2015).

Data was collected through Qualtrics, an online survey creation and distribution platform, stored in an encrypted file, and analyzed through R – a program for statistical computing and graphical rendering. Demographic data was compiled and compared to existing

data to determine if a representative sample was obtained. Ultimately, this data was used to address the research question and determine whether people who met the proposed diagnostic criteria for hikikomori exist outside Japan. The open-ended questions located at the end of the survey were analyzed thematically and categorically.

**Sample:**

Due to the difficulty of exploring a research question with a population that is reclusive by definition, this study had a relatively small sample size ( $n = 65$ ). After responses were excluded for either not containing data or for not meeting inclusion criteria, the remaining number of subjects was 61. The sample was obtained via convenience and snowball sampling methods. These were chosen primarily for feasibility issues, as demographic data for the sample outside Japan was unknown, and the difficulty associated with locating willing subjects in this population group added another level of complexity. Subjects were offered the chance to be entered into a raffle for a \$20 amazon gift card as a reward for participating in the study. They were informed that participating in the raffle would break confidentiality, and were assured that the researcher would keep all identifying information confidential.

Subjects were recruited via three approaches. The first was through the Internet forum hikkichan.com, which is an anonymous board that may attract individuals who identify as hikikomori. An IRB approved recruitment statement that contained a link to the survey was available on the website, and users of the website could take the survey if they desired.

The second way participants were recruited was by reaching out to mental health professionals working in fields whose clients may have symptoms that potentially overlap with a primary social withdrawal diagnosis. Contact was made with members of Internet and gaming addiction clinics. In order to facilitate the speed and feasibility of data collection, centers with

internal review boards were not approached. Rather, the Smith College School for Social Work IRB was considered sufficient to ensure that ethical and compliance concerns were met. Once contact was made, the researcher gave an overview of the research study to the agency and inquired if any of the clients met the inclusion criteria. The researcher then requested that a link to the survey be made available for clients to take the survey should they choose to do so.

Numerous centers were contacted, but the response rate was low. However, reSTART Center for Technology Sustainability in Washington, and the Center for Internet Addiction – organizations that provide inpatient treatment and training in the field of Internet addiction – both responded and agreed to make my survey available to their clients. I was able to work closely with Hilarie Cash Ph.D., L.H.M.C., who is the CCO and founding member of reSTART. After conferring with her, a paper copy of the survey was created and distributed so individuals in the first stage of treatment at reSTART, who do not have access to an Internet connection, could participate if they chose to do so.

The third method of distribution involved contacting individual therapists whose names were given in the belief that they might be able to make the survey available to their clients. These clinicians were contacted through an IRB approved template. There were no responses from this form of outreach. The thesis advisor, Narviar C. Barker, M.S.W., Ph.D., also requested paper surveys to distribute the survey locally to a professional colleague in private practice who treated some young adults with hikikomori.

While these are non-probability sampling methods, which limited the generalizability of the study, they were necessary to find and engage a population that is not officially recognized in the English-speaking world. The lack of detailed demographics about the population outside of Japan also makes probability sampling difficult because the sample cannot be matched to

represent the population at large since one does not exist. Matching the data with the demographic data available in Japan introduces potential confounding variables due to cultural differences.

Inclusion for this study was based upon currently meeting, or having met in the past 5 years, any of the following criteria: self-identification with the label of hikikomori or acute social withdrawal; a diagnosis of acute social withdrawal, or being referred by a mental health professional based upon diagnostic criteria of acute social withdrawal; and being English speaking. Participants were excluded from this study if they were unable to ethically consent to research participation in the country in which they hold citizenship. Finally, individuals who did not meet at least 2 of the 4 diagnostic criteria were excluded.

There were various ethical considerations in doing research on individuals who have symptoms that are congruent with acute social withdrawal. This study was available online and in paper format. Ensuring anonymity and confidentiality was more difficult. The paper copy of the informed consent required the signature of the participant, which de-anonymized the response if that individual chose to participate in the raffle. However, the informed consent pages and the responses were separated before data was analyzed, which made it impossible for the researcher to connect responses to a particular individual. Additionally, this population could be considered vulnerable, as some of them may meet proposed diagnostic criteria for hikikomori, and specifically one that can make social interaction difficult. This was addressed by taking care to not sound judgmental in the questions that were asked, contacting potential subjects indirectly (through the Internet and through treatment centers) rather than through face-to-face interviews, and by trying to involve the hikikomori community in a positive way. If the participants felt stressed or that their condition worsened because of their involvement in the research study, they

were given the contact information of the National Alliance of Mental Illness, which links to mental health providers all over the country. Additionally, they were given the contact information of 2-1-1, a telephone based service which allows individuals without access to the Internet to find services if needed.

### **Data Collection Methods:**

The survey itself contained both qualitative and quantitative questions. Demographic data was primarily quantitative - including country, province, and city of residence, age, gender, and ethnicity. The survey also contained the question “Do you support yourself financially?” which assessed social class. This was the minimum amount of demographic information assessed while guaranteeing maximum anonymity. In order to fulfill the inclusion criteria, the survey contained a quantitative measure of assessing acute social withdrawal. This consisted of questions such as: “Currently, or within the past 5 years, was there a time where you spent the majority of each day at home?” “Currently, or within the past 5 years, was there a time where you did not regularly attend school or work?” and, “Currently, or within the past 5 years, was there a time where you did not have face-to-face contact with friends or family at least once a week?”

The questionnaire also contained qualitative open-ended questions including “What are your thoughts on seeking treatment for hikikomori/acute social withdrawal?” and “Is there anything you'd like the mental health community to know about hikikomori/acute social withdrawal, or your experience? If yes, please specify.”

### **Data Analysis:**

Data for this study was analyzed in various ways. Demographic data was analyzed using descriptive statistics. The open-ended questions were analyzed thematically and categorically.

Specifically, the researcher looked for common themes across respondents, especially regarding what participants thought was important, and their views on seeking treatment.

Data was downloaded from Qualtrics, and the paper surveys were entered onto the data sheet. Two participants who did not answer the diagnostic questions had their responses deleted from the survey, as did two respondents who reported that they were below the age of 18, which was the minimum set for inclusion and participation in the survey.

Demographic and diagnostic data were input into tables describing the number of responses for each variable and the associated percentage. The first two open ended questions were analyzed, and then grouped categorically; the last open-ended question was grouped thematically. Specifically, the responses for how individuals supported themselves were grouped into those who received government assistance, those who received support from family, those who lived off personal savings or inheritances, and those who worked from home. Responses for the question assessing thoughts on seeking treatment were placed into 7 thematic categories, which were then separated into negative and positive feelings toward treatment. Participants whose responses fell into more than one category were classified into all respective categories. Responses to what participants wanted mental health professionals to know about acute social withdrawal were analyzed thematically, summarized and compared to other available research.

Chapter IV, which follows, presents the findings. The chapter discusses the demographic data, as well as the categorical and thematic analysis of the open-ended questions.

## Chapter IV

### Findings

This chapter provides data on survey responses and participant demographics. Regarding participant responses to the identification of acute social withdrawal diagnostic questions, 100% (n = 61) of the respondents indicated that they had, within the past 5 years, spent the majority of each day at home. 98% (n = 60) of the respondents reported that within the past 5 years, they did not regularly attend school or work. Lastly, 77% percent (n = 47) indicated that, within the past 5 years, there was a period of time they did not have face-to-face contact with friends or family at least one a week. (See Table 1 below.)

**Table 1. Symptomatology/Diagnosis of Hikikomori**

QUESTION	YES	NO	TOTAL	%
Currently, or within the past 5 years, was there a time where you spent the majority of each day at home	61	0	61	100%
Currently, or within the past 5 years, was there a time where you did not regularly attend school or work?	60	1	61	98%
Currently, or within the past 5 years, was there a time where you did not have face-to-face contact with friends or family at least once a week?	47	14	61	77%

In terms of being self-sufficient, 26% (n = 16) reported they supported themselves financially; 62% (n = 38) reported they did not; and 10% (n = 6) reported that they supported themselves in part. (See Table 2.) Findings from this research suggest that hikikomori does exist outside of Japan and that specifically acute social withdrawal/hikikomori does exist in Western populations.

**Table 2. Financial Self-Sufficiency Report**

<b>Question: Do you support yourself financially?</b>		
<b>Response</b>	<b>Number</b>	<b>Percent</b>
Yes	16	26%
No	38	62%
Yes, in part	6	10%

There were 18 participants who disclosed how they supported themselves, either fully or in part. After analyzing these responses for common themes, 4 categories became apparent.

Category 1: Individuals who support themselves via assistance from the government.

Category 2: Individuals who support themselves via assistance from their family.

Category 3: Individuals who support themselves via their savings.

Category 4: Individuals who support themselves via wages/salary.

There were a total of 24 entries across the 4 categories (some respondents fit across 2 or more categories, which accounts for the greater number of entries compared to respondents).

There was a relatively even spread among the categories. Twenty percent of the responses fell into category 1. Most of the respondents in this group indicated that they received assistance in the form of SSI or other programs designed to help those with a mental illness diagnosis. Some of these participants indicated that they were in treatment solely to receive money to support their lifestyle. Category 2 contains another 20% of entries. Participants here indicated they received free meals, room and board, or direct financial support from their parents or romantic partners. Twenty-five percent were in Category 3, who indicated they were being



supported by some type of savings. The majority of participants in this grouping indicated that the sources of their savings were earned before they became symptomatic. However, some reported they were living off academic financial awards, and others were living off of inheritances from deceased relatives. Finally, Category 4 contained the most responses – 33%. Respondents in this grouping demonstrated that they either supported themselves entirely, or with outside help, by working. Five entries in this category indicated the subjects worked from home, either running web design or similar businesses, or by working as administrators on forums or other websites. Others worked night shifts or do “on and off” part-time work. This category also included those who were recently unemployed.

Demographic data were also analyzed. Seventy-nine percent (n = 48) of respondents identified as male; 13% (n = 8) indicated they were female; 3% (n = 2) indicated they were male-to-female transgender, and 2% (n = 1) indicated that they did not “feel like any gender.” In regard to age, 44% (n = 27) indicated they were between 18 and 21; 33% (n = 20) were between 22 and 25; 11% (n = 7) reported they were between 26 and 29, and 8% (n = 5) were over the age of 30. In terms of ethnicity, participants identified themselves as: 56% percent (n = 34) White/Caucasian, 20% (n = 12) African American/Black, 8% (n = 5) Asian/Pacific Islander, 8% (n = 5) Hispanic/Latino, and 5% (n = 3) mixed race. Specifically, 2 participants reported being “White/Asian” and 1 reported being “Black/Caucasian.” Additionally, 64% percent (n = 39) of participants indicated they lived in North America. Fifty-nine percent of this subgroup of respondents reported living in the United States, with the rest living in Canada. Twenty-five percent (n = 15) reported that they lived in Europe – 40% of which reported living in the United Kingdom. The rest were scattered all across the continent – Russia, Spain, France, Sweden, Portugal, Romania, Croatia, Italy, and Finland. Five percent (n = 3) of all participants reported

they were residing in Asia; the specific countries being Turkey, Bangladesh, and Singapore. One respondent identified as coming from Costa Rica in South America. Additionally, 2 individuals declined to provide any demographic information. (See Table 3.)

**Table 3. Participant Race/Ethnicity and Area of Residence**

<b>Variable</b>	<b>Number</b>	<b>Percentage</b>
<i>Race/Ethnicity</i>		
African American/African/Black/Caribbean	12	20%
Asian/Pacific Islander	5	8%
Caucasian/White	34	56%
Hispanic/Latino	5	8%
Mixed Race	3	5%
<i>Area of Residence</i>		
North America	39	64%
Europe	15	23.9%
Asia	3	5%
South America	1	2%

An open-ended question was used to illicit the thoughts of participants regarding their feelings about seeking treatment for hikikomori. Their responses proved to generate a broad and diverse range of answers. Sixty of 61 participants responded to this question, which provided a 98% response rate. Some participants fit into multiple categories, creating 71 entries across the following 8 categories.

Category 1: Respondent does not want to seek treatment, or sees treatment as pointless.

Category 2: Respondent sought or is in treatment and found/finds it ineffective

Category 3: Respondent believes that there is no viable treatment outside of Japan

Category 4: Respondent believes that hikikomori is a symptom of other disorders.

Category 5: Respondent is currently in treatment and feels neutral or positive about it.

Category 6: Respondent wants to seek treatment but cannot or does not.

Category 7: Respondent believes in, or utilizes, self-treatment.

Category 8: Respondent believes that treatment is a good idea but hasn't sought it yet.

Categories were then placed into two groups: positive feelings toward treatment, and negative feelings toward treatment. Categories 1 through 3 were grouped into the group that felt negatively toward treatment. Categories 4 through 8 were grouped into those who felt neutral or positively toward treatment or reducing symptoms. Category 4 was included in this grouping as it was frequently referenced in terms of creating or having successful treatment.

In the negative group, the first category consisted of those who had a negative view of treatment – this included short responses such as “useless” or “not positive,” and longer responses such as “Would be hard to go because doubt they [sic] actually care about me.” This was the largest single category with 24 entries, making up 34% of all responses. Entries in the second category, which constituted 11% of total responses, consisted of individuals who were in treatment and felt it was not working, or who stopped seeking treatment because it did not work. This included participants who said that therapy felt stalled, as well as those who tried various types of mental health programs before stopping due to lack of progress. The third category, which was home to 14% of all entries, described individuals who stated that they could not seek therapy because there were no viable treatment options in their location. This ranged from

mental health professionals not knowing how to work with their presenting concerns to the lack of mental health workers or programs that specialize in acute social withdrawal. Collectively, the negative category contained approximately 59% of the responses, indicating that the majority of respondents felt negative about seeking treatment or believed they could not benefit from treatment.

In the positive grouping, entries in the fourth category, which made up 7% of all entries, indicated that the participants felt that acute social withdrawal was a result of underlying mental health conditions that needed to be addressed before the hikikomori behavior can be remedied. Responses ranged from people feeling that the withdrawal was entirely as a result of their depression/anxiety, to individuals feeling that depression stopped them from seeking treatment and had to be addressed before they could make progress in coming out into the world. Category five described those who were currently in treatment and felt it was working, and contained 14% of the entries. Participants were in treatment via online therapy, medication, and in-person therapy. The sixth category reflected those who felt they wanted to seek treatment but were afraid to do so or otherwise could not bring themselves to take the steps involved in seeking professional help. Thirteen percent of the entries fell into this category. It included respondents who wanted help, but perceived the local mental health workers as uncaring, those who couldn't force themselves to seek help, and those who couldn't overcome the lifestyle of "isolation and atrophy." The seventh category, which contained 4% of responses, consisted of entries that indicated the participant thought it was up to the individual to reflect on their behavior and elect to make different choices, or that the respondent was undergoing self-analysis. The eighth category, which also made up 4 percent of total responses, consisted of entries where the participant indicated that mental health treatment seemed like a good idea for others, but not for

themselves. For example, “Great in theory, hasn't helped personally” or even “I think it is great.” Overall, the positive grouping consisted of approximately 42% of the responses (positive and negative percentages do not equal 100% due to rounding), indicating that a many, although not the majority, felt that some form of treatment was necessary.

The final question on the survey asked the respondent if there was anything they wanted the mental health community to know about acute social withdrawal/hikikomori. This question had a 77% response rate. There were a variety of entries, ranging from a simple “No” to short essays over 800 words long. These responses were organized into themes, which are briefly summarized here and are explored with more depth in the discussion section. Several respondents had suggestions for how to best reach this population, including studying various anonymous message boards or Tumblr groups, or by creating chat or therapy apps. Many others wanted the mental health community to know that they are not crazy, lazy, slobs, or withdrawing by choice. Others wanted the community to know that they liked their lifestyle and that they felt misunderstood by others. Another theme that was somewhat prevalent was one of hopelessness and/or terror – over not being prepared for the future, not feeling that life is worth living, or there simply not being enough time left in this world. Many also postulated as to the causes of acute social withdrawal, including lack of confidence, a lack of purpose or drive (despite having many opportunities), trauma in their childhood, and a history of mental illness.

Chapter V, which follows, discusses the data in a more in-depth fashion, in addition to connecting it to other research in this field.

## **CHAPTER V**

### **Discussion**

This is not the first study to address the question of whether or not acute social withdrawal exists outside of Japan. Between this study's conceptualization and time of writing, several articles that identified instances of acute social withdrawal in the United States and other parts of the world have been published. The aim of this study was initially to expand the area in which acute social withdrawal has been found. Now it both replicates and expands the existing literature by finding the presence of acute social withdrawal across a large number of cultures. Additionally, the responses to the open-ended questions in the survey provided a trove of information that helps individuals understand what the hikikomori community feels and what they want from the mental health community.

Given the results discussed in Chapter IV, the research question of whether acute social withdrawal exists outside Japan can be addressed. This data suggest that it does. Sixty-three percent of the respondents indicated that they met all three hikikomori diagnostic criteria. Additionally, not a single participant noted their country of residence as Japan, where this behavior can be considered a culture bound syndrome (Teo & Gaw, 2010). In this study, there were participants who met the diagnostic criteria in 16 different countries on 5 continents. To the current researcher's knowledge and at the time of this writing, no single study found instances of acute social withdrawal over such a wide area. This finding makes the current study one of the most expansive studies to date. Other research has found acute social withdrawal in China (Wong, et al., 2014), South Korea, India, and America (Teo, et al., 2015). None of the

participants in the current study listed their country of residence as China, South Korea, or India. Therefore the current data expands the existing literature and affirms that acute social withdrawal exists all around the world.

This study also aimed to address whether or not acute social withdrawal is a culture bound syndrome. There are 4 criteria for a culture bound syndrome, which were listed in Chapter II. The third criteria for a culture bound syndrome requires that the behavior be recognizable in a specific location and be precipitated by factors unique to the culture in which it resides. Again, the widespread prevalence of acute social withdrawal indicate that its precipitants are not relegated to a single culture. The fourth criteria indicates that the prevalence of a culture bound syndrome must be higher in the country with which the syndrome is associated. The current study certainly did not find the 1 million hikikomori estimated to be in Japan (Suwa, et al., 2003). However, it was conducted with no budget and over the Internet. A dedicated research team with financial backing and research assistants could likely produce a much higher level of participation that would indicate a prevalence that is similar to that of Japan. With more research and more attention to the behavior in other parts of the world, this acute social withdrawal is likely to no longer meet this criterion.

An important aspect to consider is one of demographics – did my participants in the current study represent a population similar to those found in other studies? Teo, et al., (2015) reported from their sample that 81% of the sample was identified as male. In terms of age, 32% of their participants were between the ages of 18 and 21, 32% were between 22 and 30, and 35% were 31 or older. The gender of respondents in the current study is similar to that of Teo, et al., (2015) – 79% of participants identified as male. The slight difference may be accounted for in that the current study reported transgender and gender non-conforming participants, while Teo,

et al., (2015) did not. However, the age differences between Teo, et al., (2015) and this study are large. In this study, 46% of respondents were between 18 and 21, 44% were between 22 and 29, and merely 8% were 30 or older. This is a large difference, which may be explained by the way data were collected. For example, Teo, et al. (2015) recruited participants who were already in treatment at inpatient or community facilities. In the current study, which was primarily conducted over the Internet, many of the participants indicated they were not in any form of treatment. This implies that younger hikikomori are less likely to seek treatment than older ones.

A significant challenge faced by individuals with acute social withdrawal is how they support themselves while maintaining a reclusive lifestyle. Usually, people need to work in order to earn money and maintain a reclusive lifestyle, but how is that possible while avoiding social interaction? Twenty-five percent of the respondents indicated they were living off savings or inheritances. Without another source of income (or a very large savings account) this is a limited method of sustaining a reclusive lifestyle. When the savings account is empty, the individual is faced with a choice: re-enter into the world or starve.

A way that 20% of those surveyed rectified this problem was through government assistance. Most respondents did not indicate why they were receiving government stipends (another limitation of the online survey method). However, 2 indicated they received payments for being on a disability assistance program, 1 of whom noted it was for mental health problems. A separate respondent, in response to why she was in therapy, indicated that it was only to receive benefits to support her lifestyle. This indicates that engaging in governmental systems enough to receive benefits is a possible way of maintaining a reclusive lifestyle.

A method of self-support that was surprisingly common, given the nature of acute social withdrawal, was working a job. Thirty-three percent of entries said that they supported



themselves in this way. Some participants worked entirely from home – using skills such as web or graphical design to make a living. Others indicated they had found employment elsewhere online, such as by working as an administrator on an Internet forum. Certain participants would end the withdrawal temporarily to work at night or part-time (though some maintained they didn't socialize at work), and spend the rest of the time withdrawn. This arguably violates the criteria for hikikomori, specifically involving those who withdraw from school or work. However, these participants indicated that they had done so for an extended period within the past 5 years. Additionally, the proposed diagnostic criteria for hikikomori set forth by Teo & Gaw (2010) is written to include individuals who do not fully withdraw and who leave their domiciles at night or when it is unlikely for them to be noticed.

In what may be the most expected manner of getting support, 20% of respondents indicated that they received financial assistance from their families/partners. Many indicated that they lived with their parents, or received a check from their parents to help pay rent. Another indicated that her boyfriend is “very generous and helps me out.”

It is important to note that such a low number of individuals with acute social withdrawal received outside help this way. Given advances in technology, it has become more and more feasible to support oneself with minimal to no contact with the outside world. Additionally, many respondents fell into more than a single category – some worked online and received additional funds from their family or the government.

The variety of responses indicates how prevalent acute social withdrawal may be outside of Japan without it being recognized. For example, 20% of respondents noted that they support themselves, at least in part, and thus stay off the radar of most academic and governmental programs. This suggests that the behavior will not garner much public attention, and awareness

of the prevalence of hikikomori will not increase. Additionally, acute social withdrawal does not have physical symptoms, so its presence would not be immediately obvious and would be easily dismissed as shyness or social anxiety. Given these factors, it would not be surprising if there were large numbers of hikikomori outside Japan who are simply adept at supporting themselves and staying below the public's awareness.

When asked about what they thought about seeking help, 59% of the participants reported that they felt negatively about treatment in general. Many responses were simply stated, “No thx [sic].” However, other responses were more in depth. Several participants indicated that they liked their life, didn't want to change, or thought that the issue was with everyone else, not themselves. In a similar vein, a few respondents indicated that they thought some other hikikomori may need help, but not themselves. More still offered insight that many hikikomori see their withdrawal as a source of pride. Additionally, there were themes of hopelessness. Some respondents expressed that seeking treatment did not seem possible – the thought of having to interact with others, in addition to the other problems that arise when seeking treatment, made attempting to find help too difficult. Others were concerned that professionals would not care about them – that they would simply be a client, not a whole person, in the eyes of an uncaring mental health worker. One participant indicated that he would seek treatment if, “the person in charge is capable of understanding my situation and not some random outsider that took some course and thinks they're a know-it-all.” Many other participants indicated a worry of being labeled as crazy, either by their therapist, society, or themselves.

However, there are those who do want to seek treatment. For example, 11% of participants indicated that they did seek treatment, but that it was not going well, or they had terminated it due to lack of progress. One participant felt that, despite going in twice a week for

therapy, "...my doctor isn't sure how to help me anymore. The medications haven't really been doing much either, and if anything [sic] made things worse. It seems people in America aren't very well equipped to handle this sort of issue." Another stated acute social withdrawal is a "...serious problem. We are alone, isolated, misunderstood, and you people know how to help us." The difficulty for those who do wish to seek treatment is that the dearth of clinicians who are familiar with acute social withdrawal decreases the chance that individuals who want to change will be able to locate assistance in doing so.

The lack of potential treatments also appears to create a sense of futility. Many participants who might otherwise want to seek treatment stated that they didn't think a treatment option for hikikomori existed outside Japan. One participant said,

"Perhaps just an awareness that there are people like myself out there, in homes, alone who will not take the steps necessary to reach out for help by themselves. In Japan clearly it is enough of a problem that the population have [sic] taken steps to address the issue. If more people know about it then more can be done."

The lack of availability contributes to the sense of futility in that stories of successful treatment are rare. For example, a participant stated that he didn't think he could get better because he had never heard of anyone else doing so. If more treatments were available, then there would be more stories of hikikomori recovering.

This demonstrates the severe consequences that come from the lack of awareness of acute social withdrawal. Fourteen percent of participants indicated that there were no viable local options for treatment. While some of this was due to individuals lacking insurance or a source of funds for treatment, a large part of it was that, while the Japanese government has taken specific steps to try and help the members of its population who have acute social withdrawal, no other

government has done so. Many of the possible solutions, such as Internet addiction clinics, are expensive, and clinicians who understand what a hikikomori client is going through are few and far between. This indicates that good treatment is often difficult to find, or is entirely out of reach. Without more public awareness of centers to treat individuals with hikikomori, many of the participants who noted they were interested in treatment won't be able to get it.

Many respondents to this survey made it abundantly clear that they don't want to receive help, that they like their life, and that they are happy with the way things are. This is their choice, and is one that should be respected. However, even among those who felt negative toward treatment, many felt that it was hopeless, for various reasons. If treatment options increase, if awareness of acute social withdrawal increases, if clinicians start specializing in this form of treatment, maybe we can create some hope.

When working with a specific population, it is useful to involve them in creating the services and resources. In the current study, when asked what they wanted the mental health community to know, many participants had useful information or insight to contribute. For example, many respondents offered how web-therapy was something they found helpful, or was something they wanted to try. Others indicated that providing outreach or therapy through apps would be helpful. For example, one participant noted that,

“It will be hard to diagnose [sic] because we shun people so most people will not actually even be aware of us. We are like ghosts. The best way to help someone like this would be via the Internet because it's the main medium we use.”

This is certainly a useful idea – it would lower the barrier to entering therapy and it could offer support to individuals who need it without forcing them to move too quickly. Another participant suggested “an all-encompassing 'holistic' approach needs to be taken in

helping individuals ascend beyond hikikomoria.” Others wanted to make sure that the community knows recovery is difficult and that everyone's case is unique. A factor that could be keeping individuals from seeking treatment was one of stigma. One participant stated “We are not crazy!” Spreading awareness and reducing stigma could certainly help with that.

A second pattern, perhaps related to the first, was the concern that people – friends, family, mental health workers – do not understand their suffering. Responses such as, “Isolation is terrible,” “It is a mental illness. Do not underestimate it,” “It is a real illness. It affects every aspect of my life,” “I don't want to be this way, it is not my choice,” and “Indolence and acute social withdrawal should not be conflated. I have dreams and ambitions for my life.” With these experiences, it seems no small wonder that many did not wish to seek treatment, or view intrusions into their world with open hostility. As one respondent so succinctly put it “Please go fuck yourselves [sic] you irritating privileged tourists.” The thought that a researcher would be genuinely concerned with the respondent's well-being was either alien or unwanted.

This study also examined the question of whether or not acute social withdrawal is ego-syntonic. Some articles, such as Teo and Gaw (2010), in their proposed diagnostic criteria for acute social withdrawal, specified that the withdrawal is ego-syntonic. Others, such as Wong, et al., (2015) utilized criteria that specified withdrawal causing distress or shame, and thus being ego-dystonic. None of the questions in this survey directly addressed whether or not the participant enjoyed their withdrawal from society. However, by examining the responses regarding feelings toward treatment, it is possible to draw inferences about their experience.

Several respondents expressed that their experience was ego-syntonic: “I wish this lifestyle was easier to support,” “It starts slowly, almost feeling liberating...,”

“I don't think that because I like staying in the house by myself or because I watch television all day that there is something wrong with me. My therapist should not diagnosis me with a mental illness [sic]. I like my life,”

or even simply “Not all of us dislike it.” This strongly indicates that, at least for some, the withdrawal is syntonetic. If the outside world is such a horrible place, withdrawing from it is simply the most direct way to address the problem.

However, some individuals indicated that their withdrawal was ego-dystonic. For example, some stated that “The longer it went on, the worse the feeling of it was,” “Hikikomori are bound for suicide or homelessness once their guardian(s) are no longer able to support them.” “When you're pushed long enough, why the hell would you wan't [sic] to be with people?” and “Isolation is terrible.” Another participant indicated that the experience was similar to desperately trying to escape a rapidly closing cage, which certainly paints a bleak picture.

The data suggests that the withdrawal can be syntonetic or dystonic depending on the individual experiencing it. Once again, the limitations of the online survey format prevented more in-depth data from being obtained. However, there seem to be two possible explanations for the differences in the experience of acute social withdrawal. One is that the syntonetic portion of the withdrawal is a rationalization, where individuals convince themselves they're happy in order to make their current situation more tenable. This explanation is problematic for a number of reasons. Primarily of which is that the survey was not sufficient to make this kind of statement. Additionally, this argument makes the assumption that the researcher knows the participant better than the participant does, which is problematic on many levels.

The other explanation is that acute social withdrawal is complicated, and the individual experience varies greatly. If the outside world seems horrible, if being free of the obligations and

stressors is liberation, then not being in it would be the best possible option. If the client externalizes the difficulty, withdrawal could be seen as a coping mechanism and be ego syntonic. Individuals who internalize the difficulty are more likely to feel their withdrawal to be dystonic. This matches the data. For example, many participants described enjoying their withdrawal, and the word “liberation” was used by several participants. However, this was not true for all respondents. Many indicated a need to stop their withdrawal but did not know how. One participant indicated that he was a defect, unable to meet the expectations placed on him that he felt he should be able to meet. He saw everyone else in the world succeeding, while it was impossible for him to do so. The only possible result of trying was seen as failure, so his only option was to isolate himself, despite how horrible that felt.

A different area on which the literature has been widely divided is the cause of acute social withdrawal. In response to this study’s survey, several respondents identified as being diagnosed with various mental health disorders, the most prevalent of which were depression (with and without psychotic features) and/or anxiety. The reported diagnoses also included: autism spectrum disorder, gender dysphoria disorder, post-traumatic stress disorder, avoidant personality disorder, and co-dependent personalities. Many respondents indicated their withdrawal was due to these factors. Others did not report a diagnosis, but expressed world views that could indicate mental health difficulties. For example, some expressed the idea that there was a problem in their childhood that was causing their behavior, while another likened the withdrawal to addiction. However, due to the limitations of this study’s survey, it is impossible to determine causality. It is possible to postulate that depression and other symptoms manifested after the withdrawal began prior to acute social withdrawal rather than precipitating it.

Additionally, there were other responses that placed the cause elsewhere. Multiple responses revealed a sense of wrongness and hopelessness that pervaded their functioning. For example, this was described as a lack of confidence or self-esteem. One person indicated that he was not ready, and not prepared, to be an adult with the responsibilities placed upon him. He saw the world outside as wretched (the participant had worked several jobs for 40 hours a week for years and was unable to accumulate savings). Thinking about the future was so horrifying, that isolation was the only response. Another respondent indicated that, even in kindergarten, he had no ambitions and no drive to do anything in this world. The fact that he was expected to did not make sense to him at a deep psychological level. As mentioned previously, another participant felt he was so flawed that he couldn't participate adequately in the world. Other participants indicated similar themes. One participant stated

“When you spend extreme periods of time left with only yourself, the flow of time changes for you. Entire weeks feel like mere days going by. Entire months as weeks. That's when you realize death is quickly coming. Not enough time. Not enough time. Not enough time.”

Others noted that the, “world is simple and shitty to me, not worth living in this garbage,” or “I'm only happy when I'm asleep.”

There are two possible ways to interpret this. One way of looking at this would be to simply say the respondents appear depressed. The other links these responses together, and indicates that acute social withdrawal is a specific reaction to living in an uncaring world. In this interpretation, hikikomori see the world as a place with no hopes and dreams, or where there is no viable road to reach their hopes and dreams. In reaction to this, hikikomori withdraw as a direct response to the frustrations of the world and the expectations placed upon them.



Attachment theory notes that when infants are left alone for a long time, they will eventually stop crying and seeking help (Bowlby, 1977). Instead they withdraw and look inward for solace. A similar trend has appeared in hikikomori research. For example, Hattori (2005), in a case study of 35 hikikomori, indicated that 100% suffered a loss of attachment from the parent. However, through this interpretation, the withdrawal would not just be the result a broken parental attachment – it would be a result of a broken attachment with the world. This interpretation is supported by the data. One respondent indicated, “For me, it's just not wanting to be bothered with the outside world . . . feeling misunderstood. Better to just interact with my friends online.” Another said that he was fully aware that what he was doing wasn't healthy, but was worried about losing his personality if he stopped. It appears that the withdrawal of some participants is related to their attachment style. Breaking their isolation would mean losing whatever attachment they have.

This variety of responses are similar to what Toivonen, Norasakkunkit, and Yukiko (2011) postulate in their article. They argue that in Japan, where declining labor markets made it impossible for many youth to uphold the societal expectations placed upon them, youth have few options. One of the options is retreating – avoiding the negative stimuli. This explains why some respondents in this study felt liberated after their initial retreat – by retreating, they no longer had to confront their sense of futility. Toivonen, Norasakkunkit, and Yukiko (2011) also describe quiet mavericks who reject the goals of society, and engage with the world on their own terms. In this context the quiet mavericks describe those who find a way to work and otherwise uphold their secluded lifestyle, such as through engaging with the world enough to receive disability, or making a living online.

This approach also ties in with the sense of wrongness or hopelessness many participants expressed. For example, Hattori (2005) indicated that in his 35 hikikomori clients, 76% had families where parents were in prestigious positions. The expectations and pressure to succeed placed on the children by the parents would be significant and possibly overwhelming. Familial and societal pressures could create expectations with which individuals who withdraw simply can't cope.

Overall, this study had several limitations. The sample was obtained through non-random sampling, which decreases the generalizability of the subject. It was also intended to have exploratory elements in the form of qualitative questions, which are harder to reproduce. Additionally, the survey was distributed via the Internet and paper copies. It is possible that there are hikikomori who are reclusive to the extent that they don't want to fill out a survey and would not be represented by this study. Since the questions were not done in interview form, it was impossible to go into more depth with participants. As such, many of the inferences made by this study need further replication. It is important to note that these results were obtained through the Internet, Internet addiction clinics, and by contacting private practice therapists. Consequently, the sample may not be generalizable. For example, 2 large sources of data came from Washington and Georgia. As a result, the number of respondents from the United States, and the number of those seeking treatment, may not reflect the population at large.

Despite these limitations, this research brings more awareness to the hikikomori phenomenon, which many clinicians still do not understand. This alone is making a unique contribution to clinical social work practice. This research aimed to further spread awareness of hikikomori and acute social withdrawal within the clinical field. The more mental health workers who are aware that this phenomenon exists, the more options that can be made available for

those who wish to seek treatment. This research also attempted to give voice to the hikikomori community to allow their voices to be heard in the academic and clinical setting. Involving the hikikomori population in conversations about how to best serve them is a core social work value. This thesis also sets the foundation for more public conversations about hikikomori which is important to reduce stigma. I also hope that this research allows changes to be made that can bring at least a tiny bit of hope to those who have none.

Working with these individuals has been a privilege. I was astounded, not only by the number of responses, but also by their level of openness. The number of people who had something important to say, some who appeared to bare their soul to me, and the pain inherent in some of the comments, were staggering. The value and the importance of their responses is something I neither have time nor space to fully explore in this thesis, and what I have summarized here truly does not do them justice. I hope to have the opportunity to further serve this community in the future.

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## Appendix A

### HSR Approval



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#### School for Social Work

Smith College

Northampton, Massachusetts 01063

T (413) 585-7950 F (413) 585-7994

February 5, 2016

Evan Correy

Dear Evan,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

## Appendix B

### HSR Revision Proposal

#### RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

##### **Acute Social Withdrawal in non-Japanese Populations**

**Evan Correy**

**Narviar C. Barker, M.S.W., Ph.D**

.....

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

[DESCRIBE ALL PROTOCOL CHANGES BEING PROPOSED IN NUMERIC SEQUENCE; BE BRIEF AND SPECIFIC]

1. Modify part of the wording in the inclusion criteria from “currently meeting, or having met in the past **3** years, any of the following criteria...” to “currently meeting, or having met in the past **5** years, any of the following criteria...”
2. Create a paper version of the Qualtrics survey, with identical questions, to be made available to individuals at Internet addiction clinics who are denied access to computers and the Internet as part of their treatment. This is necessary to capture a significant group of eligible participants who, because of their addiction, are denied access to computers in stipulation for their treatment. The informed consent will be modified only as much as needed to reflect that the survey is taken with a pen and paper and not over Qualtrics.

Please find the survey questions below:

Currently, or within the past 3 years, was there a time where you spent the majority of each day at home?

- Yes
- No

Currently, or within the past 3 years, was there a time where you did not regularly attend school or work?

- Yes
- No

Currently, or within the past 3 years, was there a time where you did not have face-to-face contact with friends or family at least once a week?

- Yes
- No

What is your age?



Please describe your gender

Please describe your race/ethnicity

Please enter your country of residence

Please enter your city of residence

Do you support yourself financially?

- Yes
- No
- Yes, in part

If the answer to the previous question was "Yes, in part" please describe

What are your thoughts on seeking treatment for hikikomori/acute social withdrawal?

Is there anything you'd like the mental health community to know about hikikomori/acute social withdrawal, or your experience? If yes, please specify

If answering the questions in this survey has caused you distress, or you wish to find additional support, you can contact the following agencies:

The Alliance of Mental Illness (NAMI) can help you find mental health resources in your area. Reach them at 800-950-6264 The 2-1-1 Helpline is a free and confidential service that helps people find local resources. Dial 2-1-1 to contact them.

.....

- I understand that these proposed changes in protocol will be reviewed by the Committee.
- I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
- I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

**Signature of Researcher:** 

**Name of Researcher (PLEASE PRINT):** Evan Correy

**Date:** 2/28/16

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at [LWyman@smith.edu](mailto:LWyman@smith.edu) or to Lilly Hall Room 115.

**\*\*\*Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.**

.....

## Appendix C

### HSR Revision Approval



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**School for Social Work**  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

February 29, 2016  
Evan Correy

Dear Evan:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Narviar Barker, Research Advisor

## Appendix D

### Agency Recruitment Template

Dear: *Agency Director's Name*

My name is Evan Correy and I'm a second year graduate student at the Smith School for Social Work. I am contacting you to solicit your assistance in recruiting voluntary participants for my graduate thesis, which is a requirement for the Master of Social Work degree. I'm studying a behavioral pattern called acute social withdrawal (also known as hikikomori), which is a form of social isolation characterized by a refusal to venture outside one's room or domicile, or by pulling away and confining oneself from others for months at a time. This behavioral pattern is predominantly found in Japan, but my research intends to explore this phenomenon outside Japan in non-Japanese populations.

I am contacting you because this is a very difficult population to locate. Often times, individuals with acute social withdrawal tend to immerse themselves in alternate "realities" such as computer games, the Internet, manga (comic books), and anime (animation). For this reason, a popular though somewhat incorrect assumption is that sufferers of hikikomori tend to be "nerds," or "geeks" who spurn social interaction in favor of entertainment media. As such, they will often end up in Internet addiction or game addiction treatment centers. I would appreciate the opportunity to personally speak with you about the client population your agency serves and whether any of your practitioners work with clients who meet this criterion, if doing so does not violate internal protocols. If so, some of these clients may be eligible to volunteer to participate in my research study. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC). If further internal review would be required, please inform me, as time restraints may make an additional review process infeasible for my study.

If you are amiable to speaking with me, or if you have any questions, I can be reached at [REDACTED], or at [REDACTED].

I look forward to hearing from you.

Sincerely,

Evan Correy  
MSW Student  
Smith College School for Social Work

## Appendix E

### Online Forum Recruitment Template

Greetings Everyone

I am a graduate student at Smith College School for Social Work and I am working on my Master's Thesis. My research is on a behavior that is close to me – hikikomori, also known as acute social withdrawal. For those who aren't familiar with the more technical definition, acute social withdrawal describes someone who will remain in their room/house for months without leaving, often immersing themselves in video games, the Internet, anime, manga, or simply withdrawing from face to face social interaction. If this describes you (or someone you know), who is over 18, and you are interested in helping me with this research, please click on the link below to find out more about the study, your eligibility to participate in the study and the actual short survey. The survey is completely anonymous, and this study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC). If you are interested in being automatically entered into a raffle for a \$20 gift card for your participation, there will be instructions on how to do so at the end of the survey. The survey will require no more than 10 minutes of your time and includes assessment questions and demographic information. If you have any questions, please feel free to respond to this post, or e-mail me at [REDACTED] and I will answer them the best I can.

[https://qtrial2015q4az1.az1.qualtrics.com/SE/?SID=SV\\_bIcLnm9LklJujm5](https://qtrial2015q4az1.az1.qualtrics.com/SE/?SID=SV_bIcLnm9LklJujm5)

Thanks!

## Appendix F

### Webmaster Permission Template

Dear \*admin name\*

My name is Evan Correy, and I'm a graduate student at the Smith School for Social Work. I am contacting you seeking assistance in completing my graduation thesis. I'm studying something that's close to me – hikikomori. Specifically, I'm trying to demonstrate that it exists outside Japan. I was wondering whether you would be willing to allow me to post a link to a survey on your website. The survey would take less than 10 minutes to complete, and consists of a screening and informed consent page and a few assessment and demographic questions. The survey is completely anonymous, and participants would have the option of entering in a raffle for a gift card if they chose to do so. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC). No one would be in any way required to take the survey, and I am simply seeking your permission to make it available. If you are amiable to speaking with me, or have any questions or concerns, please contact me at [REDACTED]

If you want to examine the survey itself, you can find it here:  
[https://qtrial2015q4az1.az1.qualtrics.com/SE/?SID=SV\\_bIcLnm9LklJujm5](https://qtrial2015q4az1.az1.qualtrics.com/SE/?SID=SV_bIcLnm9LklJujm5)

Thank you for your time, and I look forward to hearing your response.

Sincerely,

Evan Correy

MSW Candidate

## Appendix G

### Therapist Recruitment Template

Dear: Referred Therapist:

My name is Evan Correy and I'm a second year graduate student at the Smith School for Social Work. I am contacting you to solicit your assistance in recruiting voluntary participants for my graduate thesis, which is a requirement for the Master of Social Work degree. I'm studying a behavioral pattern called acute social withdrawal (also known as hikikomori), which is a form of social isolation characterized by a refusal to venture outside one's room or domicile, or by pulling away and confining oneself from others for months at a time. This behavioral pattern is predominantly found in Japan, but my research intends to explore this phenomenon outside Japan in non-Japanese populations.

I am contacting you because this is a very difficult population to locate. Often times, individuals with acute social withdrawal tend to immerse themselves in alternate "realities" such as computer games, the Internet, manga (comic books), and anime (animation). For this reason, a popular, though somewhat incorrect, assumption is that sufferers of hikikomori tend to be "nerds," or "geeks" who spurn social interaction in favor of entertainment media. As such, they will often end up in treatment for Internet addiction or game addiction. I would appreciate the opportunity to personally speak with you about the client population you serve and whether any of your clients meet these criteria. If so, some of these clients may be eligible to volunteer to participate in my research study - which is an online survey that is completely anonymous. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

If you are amiable to speaking with me, or if you have any questions, I can be reached at [REDACTED], or at [REDACTED]

I look forward to hearing from you.

Sincerely,

Evan Correy  
MSW Student

**Appendix H**

Informed Consent – Online Survey

**2015-2016**

**Consent to Participate in a Research Study  
Smith College School for Social Work • Northampton, MA**

.....

**Title of Study: Crossing the Culture Bound Syndrome: Acute Social Withdrawal Outside Japan**

**Investigator:**

Evan Correy

Smith School for Social Work



.....

**Introduction**

You are being asked to be in a research study investigating the prevalence and cause of acute social withdrawal (also known as hikikomori), which was originally observed in Japan.

You were selected as a possible participant because you are over age 18 and either self-identifying as hikikomori, or have received a professional diagnosis, or a mental health professional thought you meet the diagnostic criteria and may be willing to participate in this study. You also were identified as speaking English, and having access to an Internet connection and computer in order to take this survey.

We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

The purpose of the study is to determine whether or not there are people who can be diagnosed with acute social withdrawal (or as hikikomori) that live outside of Japan.

This study is being conducted as a research requirement for my master's in social work degree.

Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

If you agree to be in this study, you will be asked to do the following things: Fill out a short survey which will include a short assessment based on the most recent proposed diagnostic criteria for acute social withdrawal, questions asking about demographic information, and questions asking for your feedback and opinions on acute social withdrawal. This survey will be taken once, and will likely take no more than 10 minutes.

**Risks/Discomforts of Being in this Study**

The study has the following risk: answering these questions may bring up feelings of discomfort or distress.

If there are feelings of distress, you can find a mental health provider in your area by visiting the National Alliance of Mental Illness' (NAMI) website at [www.nami.org](http://www.nami.org) to find a provider in your area. If NAMI

does not have a provider in your area, you can contact 2-1-1 Helpline, which is a free and confidential service that helps people across North America find the local resources they need for help.

Participants should print or take a screenshot of the consent and resource page for their records.

### **Benefits of Being in the Study**

Your voluntary participation in this study will inform clinical practitioners and health care professionals about acute social withdrawal and may ultimately help to improve their effectiveness in service delivery to individuals suffering from acute social withdrawal.

The potential benefits to yourself are: you have the chance to get what you think is important into the research available about hikikomori/acute social withdrawal, and you may come to possess insight into your behavior.

The benefits to social work/society are: The field of Social Work, and mental health in general, are not familiar with acute social withdrawal. By acknowledging that acute social withdrawal exists outside Japan, allows more providers may learn about acute social withdrawal and become more competent and able to work with you if you seek treatment.

### **Confidentiality**

- This study is anonymous. We will not be collecting or retaining any information about your identity.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

### **Payments/gift**

Participants who wish to do so will be able to contact the researcher via e-mail. Those who do will be entered into a raffle. The winner will have a \$20 gift certificate to Amazon (or equivalent monetary reward) e-mailed to the address they use to contact the researcher. Anyone participating in the raffle will no longer be anonymous. However, there will be no way for the researcher to connect participants' responses to their e-mail addresses. Any identifying information will be kept confidential by the researcher.

### **Right to Refuse or Withdraw**

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time (up to the submission of the survey) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to stop participating once you start the survey. If you choose to stop participating, I will withdraw your answers by discarding any incomplete surveys, and I will not use any of your information in the study. After submitting the survey, it is impossible for you to withdraw, since Qualtrics will save your responses. If you choose to withdraw, After the survey is submitted, your information will be part of the thesis, dissertation or final report.

### **Right to Ask Questions and Report Concerns**

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Evan Correy, at [ecorrey@smith.edu](mailto:ecorrey@smith.edu). If you would like a summary of the study results, one will be sent to you once the study is completed provided you provide a forwarding address. If you have any other concerns about your rights as a research participant, or if you have any



problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

Your clicking the “>>” icon below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You should keep print take a screenshot of this page as a record. You will also be given resources to find referrals and information if you experience emotional issues related to your participation in this study.

>>

**Appendix I**

Informed Consent – Paper Survey

**2015-2016**

**Consent to Participate in a Research Study  
Smith College School for Social Work • Northampton, MA**

.....

**Title of Study: Crossing the Culture Bound Syndrome: Acute Social Withdrawal Outside Japan**

**Investigator:**

Evan Correy  
Smith School for Social Work  
XXX-XXX-XXXX

.....

**Introduction**

You are being asked to be in a research study investigating the prevalence and cause of acute social withdrawal (also known as hikikomori), which was originally observed in Japan. You were selected as a possible participant because you are over age 18 and either self-identifying as hikikomori, or have received a professional diagnosis, or a mental health professional thought you meet the diagnostic criteria and may be willing to participate in this study. You also were identified as speaking English, and having access to an Internet connection and computer in order to take this survey.

We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

**Purpose of Study**

The purpose of the study is to determine whether or not there are people who can be diagnosed with acute social withdrawal (or as hikikomori) that live outside of Japan.

This study is being conducted as a research requirement for my master's in social work degree. Ultimately, this research may be published or presented at professional conferences.

**Description of the Study Procedures**

If you agree to be in this study, you will be asked to do the following things: Fill out a short survey which will include a short assessment based on the most recent proposed diagnostic criteria for acute social withdrawal, questions asking about demographic information, and questions asking for your feedback and opinions on acute social withdrawal. This survey will be taken once, and will likely take no more than 10 minutes.

**Risks/Discomforts of Being in this Study**

The study has the following risk: answering these questions may bring up feelings of discomfort or distress.

If there are feelings of distress, you can find a mental health provider in your area by visiting the National Alliance of Mental Illness' (NAMI) website at [www.nami.org](http://www.nami.org) to find a provider in your area. If NAMI does not have a provider in your area, you can contact 2-1-1 Helpline, which is a free and confidential service that helps people across North America find the local resources they need for help.

Participants make a copy of the consent and resource page for their records.

### **Benefits of Being in the Study**

Your voluntary participation in this study will inform clinical practitioners and health care professionals about acute social withdrawal and may ultimately help to improve their effectiveness in service delivery to individuals suffering from acute social withdrawal.

The potential benefits to yourself are: you have the chance to get what you think is important into the research available about hikikomori/acute social withdrawal, and you may come to possess insight into your behavior.

The benefits to social work/society are: The field of Social Work, and mental health in general, are not familiar with acute social withdrawal. By acknowledging that acute social withdrawal exists outside Japan, allows more providers may learn about acute social withdrawal and become more competent and able to work with you if you seek treatment.

### **Confidentiality**

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

### **Payments/gift**

Participants who wish to do so will be able to provide the researcher with a phone number or address Those who do will be entered into a raffle. The winner will receive a \$20 gift certificate to Amazon r. Anyone participating in the raffle will will no longer be anonymous. The signed informed consent page will be separated from the survey before the responses are viewed, which will anonymize your responses, meaning the researcher will be unable to connect participants' responses to their contact information. Any identifying information will be kept confidential by the researcher.

If you wish to be entered into the raffle, please list a phone number or an address where the researcher can contact you if you win.

Phone \_\_\_\_\_

Address \_\_\_\_\_

### **Right to Refuse or Withdraw**

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time (up to the submission of the survey) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to stop participating once you start the survey. If you choose to stop participating, I will withdraw your answers by discarding any incomplete surveys, and I will not use any of your information in the study. After submitting the survey, it is impossible for you to withdraw, since Qualtrics will save your responses. If you choose to withdraw, After the survey is submitted, your information will be part of the thesis, dissertation or final report.

**Right to Ask Questions and Report Concerns**

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Evan Correy, at [ecorrey@smith.edu](mailto:ecorrey@smith.edu). If you would like a summary of the study results, one will be sent to you once the study is completed provided you provide a forwarding address. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You also attest that you are of 18 years of age, speak English, and have, currently or within the past 5 years, self-identified as a hikikomori OR have been identified as potentially meeting its symptoms by a mental health professional. You can keep print or save a copy of this page as a record. You will also be given resources to find referrals and information if you experience emotional issues related to your participation in this study.

.....

Name of Participant (print): \_\_\_\_\_  
Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

.....

## Appendix J

### Survey Questions

Currently, or within the past 5 years, was there a time where you spent the majority of each day at home?

- Yes
- No

Currently, or within the past 5 years, was there a time where you did not regularly attend school or work?

- Yes
- No

Currently, or within the past 5 years, was there a time where you did not have face-to-face contact with friends or family at least once a week?

- Yes
  
- No

>>

What is your age?

Please describe your gender

Please describe your race/ethnicity

Please enter your country of residence

Please enter your city of residence

Do you support yourself financially?

- Yes
- No

Yes, in part

If the answer to the previous question was "Yes, in part" please describe

What are your thoughts on seeking treatment for hikikomori/acute social withdrawal?

Is there anything you'd like the mental health community to know about hikikomori/acute social withdrawal, or your experience? If yes, please specify

If you want to be entered into a raffle to win a \$20 Amazon gift certificate, please send me an e-mail at [ecorrey@smith.edu](mailto:ecorrey@smith.edu) with the subject line "Raffle Contact E-mail." Your e-mail address will be used to enter the raffle, and I will send it to that e-mail address if you win.

Doing this means that I will know whoever at that e-mail address took the survey, but I will have no way of knowing which response is yours.

>>

If answering the questions in this survey has caused you distress, or you wish to find additional support, you can contact the following agencies:

The Alliance of Mental Illness (NAMI) can help you find mental health resources in your area. Reach them at [www.nami.org](http://www.nami.org) or by phone at 800-950-6264

The 2-1-1 Helpline is a free and confidential service that helps people find local resources. Dial 2-1-1 to contact them.

>>

We thank you for your time spent taking this survey.  
Your response has been recorded.