

# Diagnosing *hikikomori*

Social withdrawal in contemporary Japan

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## Abstract

*Hikikomori* ('social withdrawal') appeared in Japan at the end of the twentieth century, inciting public panic about a generation of Japanese youth who shun social contact and fail to engage in the age-appropriate activities of young adulthood. Widely cited as a 'condition' rather than a psychiatric symptom or disorder, hikikomori has functioned variously as a diagnosis of individuals, families, and society at large. Taking the polysemous (and controversial) nature of hikikomori as a starting point, we draw on fourteen months of ethnographic research to explore how families negotiate a diagnosis of hikikomori in everyday life. Our focus on families opens up fruitful questions about the moral economies of life under diagnosis, not simply for the diagnosed individual, but also for those who assume responsibility for that individual's health and wellbeing.

## Keywords

Japan, diagnosis, family, care, social withdrawal, hikikomori

## Introduction

On a Saturday afternoon in 2009, the first author (EBR, hereafter 'I') accompanied a psychiatrist who was presenting to a family support group on the release of a new antipsychotic medication in Japan. Following the psychiatrist's lecture, audience members had an opportunity to ask questions. The questions soon veered from his presentation topic to their

personal situations. As most of the audience members were parents of children with various psychiatric diagnoses, they used this opportunity to seek out a second opinion, detailing their children's symptoms and the treatments they had been prescribed. One father had just moved to Tokyo from Hokkaido, Japan's northernmost island, where his son had been diagnosed with schizophrenia at the age of thirteen. His son was now on powerful antipsychotics, and the father wanted to know how this medication would affect the boy as he aged: would there be irreparable damage to his still-developing brain?

This story struck a chord with the support group members, many of whom stayed after the psychiatrist's departure for tea, crackers, and discussion. The group dissected the boy's situation and the potential danger of psychiatric diagnoses. What if the diagnosis of schizophrenia was incorrect? The boy had passed the point of no return; as psychiatric logic goes, 'once a schizophrenic always a schizophrenic' (Harding and Zahniser 1994, 140). Sue Estroff (1981) and Tanya Luhrmann (2007) have written about how easy it is for individuals to be socialized into the role of the chronic psychiatric patient, someone who is marginalized, feared, and not-quite-human. Because this thirteen-year-old boy had been diagnosed as mentally ill, regardless of the accuracy of the diagnosis, the parents were sure he was likely already learning to identify himself in terms of his disorder.

One particularly outspoken woman interrupted to say that some doctors refuse to acknowledge the existence of schizophrenia in Japan, instead classifying psychotic symptoms as the result of a nutritional imbalance. Her comment sparked a fierce debate about other possible interpretations of schizophrenia, the main alternative being *hikikomori*. Hikikomori, often glossed as 'social withdrawal', indexes a condition in which a young adult, usually male, fails to participate in age-appropriate social activities, such as school or work.<sup>1</sup> Saitô Tamaki, the psychiatrist who popularized the term in a 1998 bestseller, wrote that hikikomori was a 'state' or 'condition' (*jôtai*) that was neither a psychiatric disorder nor a symptom thereof (1998, 25).<sup>2</sup> The parents at this meeting, however, were unconvinced. They saw hikikomori as a euphemism for mental illness, a way for people to normalize what should rightfully be seen as pathological behavior. One participant noted that parents would tolerate or overlook their hikikomori children's odd behavior because the children were not considered to be 'sick'. Another participant added that without a medical diagnosis, parents felt justified in not taking their children to the hospital – a time-consuming, laborious, and ultimately stigmatizing process. The entire family was thus spared the institutionalized medical machinery as well as the stigma of mental illness in the family. A 'diagnosis' of hikikomori, because it carried no

1 The term hikikomori can refer to either the person, singular or plural, or the condition.

2 Japanese names are written in the order of family name followed by given name.

clinical weight, also decreased the chances of a child being dosed with powerful perception-altering drugs, often the first line of treatment in Japanese psychiatry. Conversely, because hikikomori was not recognized as a ‘psychiatric disability’ (*seishin shōgai*) – unlike schizophrenia or depression – withdrawn individuals were not entitled to a disability pension or other welfare benefits. Much was at stake, then, in deciding whether or not to seek mental health treatment for a child’s behavioral troubles.

This article begins from the ambivalent interplay of psychiatry and society in considering the diagnosis of hikikomori and the ways in which this diagnosis is negotiated in everyday family life. Diagnoses travel far outside clinical contexts and become part of the cultural lexicon, creating new ways of being in the world. Emily Martin (2007) has written about ‘living under’ a diagnosis – in her case, bipolar disorder – and has argued that subjective and intersubjective illness experiences both extend beyond and are corralled by diagnostic classifications. Diagnosis has the power to refigure understandings of self and other as individuals map their lived experiences onto lists of symptom criteria. As Carolyn Smith-Morris (2016) argues, however, diagnoses may attempt to standardize and generalize, but they are ultimately incapable of capturing the infinite variations on human experience. In this article, we attend to these variations and extend Martin’s concept of ‘living under’ a diagnosis by examining how diagnoses function in families.

Following Monika Büscher and colleagues (2010), we take a wider view of diagnosis as something that can and does occur outside of medical settings, and thus we do not limit ourselves to clinicians’ claims to hikikomori. We find ourselves tacking between medical and non-medical settings as we trace the manifold meanings of hikikomori, always in pursuit of the sense-making activities in which social actors engage. We are not interested in whether or not hikikomori is a ‘real’ medical issue or whether it is shorthand or euphemism for a known psychiatric disorder; rather, we are interested in how and why parents use the concept of hikikomori to make sense of their children’s behavior and whether or not they choose to engage with psychiatry, as well as how these decisions influence parental care practices. As such, we focus on the process of ‘diagnostic work’ (Büscher, Goodwin, and Mesman 2010) – a contingent process through which new moral subjects and subjectivities emerge – and the resultant diagnosis of hikikomori as a social, medical, and sociomedical condition. We describe the sociohistorical and economic contexts that have allowed hikikomori to flourish as a descriptor of affective and material reality for hundreds of thousands of Japanese youth, as well as how some families come to reconcile their lived realities through the explanatory framework that hikikomori offers. Using ethnographic observations and interview data, we explore hikikomori as a window onto how ongoing diagnostic work reconfigures caring relations as part of everyday family life. Our focus on families opens up fruitful questions about the moral economies of life under diagnosis, not simply for the diagnosed individual, but also for those who assume responsibility for that individual’s health and wellbeing.

## Diagnosis in and out of the clinic

Diagnosing behaviors as indicative of social or emotional distress, psychopathology, or mere eccentricity occurs across contexts; it is only through identifying the abnormal that we come to acknowledge what is normal. Diagnosis has been a central concern in psychiatric anthropology for decades, given the historical stigma attached to mental illness. Concerns about both the slippage between disease and person (Estroff 1989) and disease supplanting personhood (Jenkins 2015; Jenkins and Barrett 2004) have pointed to the power that diagnosis yields. These studies did not interrogate diagnosis itself but rather emphasized its consequences. Other work, however, has paid distinct attention to how diagnoses come into being, particularly for contested or controversial ills, such as chronic fatigue syndrome (Dumit 2006; Sachs 2016). In analyzing the creation of the clinical diagnosis of ‘burnout’ in Sweden, Torbjörn Friberg (2009) emphasizes the ‘legitimization processes’ of empiricism, quantification, and standardization that enable ‘burnout’ to move from personal descriptor to clinical category.

Diagnosis as both event and process (Blaxter 1978; Jutel and Nettleton 2011) has the potential to validate certain forms of suffering while delegitimizing others (Jutel 2018). This differential access to resources has caused Carolyn Smith-Morris to describe diagnosis as ‘the tipping point in the processes of encompassment and exclusion in health care’ (2016, 19). In examining the diagnostic potential of hikikomori, we follow recent anthropological work exploring diagnostic processes that are intertwined with, yet occur apart from, the medical clinic (Büscher, Goodwin, and Mesman 2010; Nissen and Risør 2018). While attention to diagnostic practices outside the clinic is not new – Atwood Gaines (1979), for example, has argued psychiatrists do not originate diagnoses but rather refine the lay diagnoses attributed to individuals by family and friends – recent research has turned to exploring the processes of ‘diagnostic work’ (Büscher, Goodwin, and Mesman 2010) to emphasize diagnosis as unstable and uncertain (Nissen and Risør 2018). In *Ethnographies of Diagnostic Work*, Büscher and colleagues (2010) untether diagnosis from the clinic by using examples from a variety of non-medical settings in which people absorb a large amount of information and then narrow their focus to a single definition of the situation (a ‘diagnosis’) that enables appropriate action. The commonality across these disparate settings is the diagnostic process, an assemblage of ‘sense-making, assessment and action’ as well as ‘diverse social, embodied and material interactions’ from experts and laypeople alike (Büscher, Goodwin, and Mesman 2010, 3). The authors argue that diagnosing is a moral practice, ‘premised on value judgements about what constitutes a worthwhile future and so privileges some things and people over others’ (ibid.). Nissen and Risør’s (2018) recent anthology furthers the concept of diagnostic work by attending to its negotiations, contestations, and (re)interpretations, all of which complicate a seemingly logical and linear process.

In the clinical realm, diagnoses are prognosticative, indicating what the course of disease might look like in the future. It is a type of ‘speculative forecast’ and defines the contours of a future that is both knowable and yet still uncertain (Adams et al. 2009). The potential for a better future, whether through cultural healing or biomedical cure, incites action in the present. Present action is often oriented around care, whether from treatment providers, therapeutic agents, or loved ones. Care has increasingly become an object of analytical attention, particularly as informal caregiving relations transform in light of the shift from hospital- to home-based care (Heinemann 2015, 2016; Karasaki, Warren, and Manderson 2017). Tatjana Thelen (2015) has argued against assuming care to be an a priori quality of social relations and suggests care itself is constitutive of these relations. Care as practice thus (re)constitutes social relations on an ongoing basis. In linking care to diagnostic work, we suggest the two are mutually constitutive; that is, parental care reinforces the sense of ‘living under’ a diagnosis even as proper care holds the promise of transcending a diagnosis’s predictive power. Care functions as a way to overcome the reality prescribed by diagnosis while unwittingly reinscribing its power to dictate everyday life. Our ethnography demonstrates how parents grapple with ongoing diagnostic work – surrounding their children, themselves, and Japan – as well as how the resulting diagnosis of hikikomori informs their care practices.

## The rise of the hikikomori phenomenon

Hikikomori emerged in Japan at the end of the twentieth century and has continued to preoccupy the nation. Existing in the murky territory between psychiatric disorder and social ill, hikikomori’s polysemous nature has made it ripe for public discussion and policy decisions. Etiological explanations range from individual psychopathology to dysfunctional family relations, and from a lack of employment opportunities for youth to societal pressure to succeed in a narrowly prescribed path. Recognized as a social problem but not a medical diagnosis, being hikikomori does not entitle one to a disability pension or welfare benefits. All the same, government and non-government agencies alike continue to pour resources into building social and vocational programs to rehabilitate the estimated hundreds of thousands of hikikomori youth so they can become productive members of society.

While some cultural critics insist on hikikomori as a legitimate life choice and recommend giving hikikomori individuals time to discover their own place in the world, psychiatry’s emphasis on early intervention and treatment makes this ‘wait and see’ approach untenable. Thus, despite being a sociomedical condition, approaches to hikikomori have remained distinctly social *or* medical, with little opportunity to recognize the complex of factors that have enabled its emergence. Ana Vinea’s (2018) exploration of *wahm* in Egypt provides a useful point of comparison. *Wahm* emerges in the space between religion and the psy sciences, two domains believed to be dichotomous. Its very existence speaks to the enduring power of binary

thinking while also creating emergent critiques. With hikikomori, two dichotomous interpretations result, one reflecting broad social concerns and the other individual pathology. This polarized thinking leads carers, primarily parents, to stake their interpretive claims to hikikomori by virtue of their actions. As we illustrate below, depending on where parents seek help, explanatory frameworks, therapies, and access to material resources vary greatly (see also Rubinstein 2016).

Hikikomori came to be seen as a new social problem among Japanese young adults, with media reports linking hikikomori to a rash of violent crimes in 1999-2000, sparking a moral panic (Takayama 2008). It came to signify a rejection of contemporary society, whether by choice or necessity, leaving a host of social actors – including parents, policymakers, and psychiatrists – to figure out what this rejection might mean. Similar youth problems had been debated in professional and popular literature since the start of Japan's postwar recovery in the 1950s, when rapid modernization and urbanization included the decline of the three-generation agricultural household in favor of a nuclear family comprised of a 'ricewinner husband, homemaker housewife, and two samurai-student children' (Kelly 1986, 604). The entire nation shared a dream of becoming middle class, a prospect that seemed attainable through hard work and perseverance (Vogel 1963), with no recognition of the socioeconomic and material inequalities that made such mass upward mobility impossible (Borovoy 2008). Family, school, and work functioned as key identity-forming institutions, with school serving as the medium through which children were oriented away from their families and toward the community (Kiefer 1970). Entrance to tertiary education was regulated through brutal university entrance exams, and, for men, matriculation at a top-tier university all but guaranteed lifetime employment as a 'salaryman', or white-collar company employee (Rohlen 1974, 1983). Women were encouraged to find fulfillment through managing the household and raising the next generation of productive Japanese citizens (Allison 1991).

There was little reason to question these normative pathways during the postwar period of economic growth and prosperity, although cracks in the veneer were evident in the proliferation of 'diseases of civilization', allegedly caused by the breakdown of traditional social ties (Lock 1988a). One example was school refusal – students who suffered from somatic symptoms when they were on campus and thus ended up skipping classes or, more problematically, days or weeks of school. One Japanese sociologist argued that school refusal was a result of 'privatization', as people shifted from devoting themselves to the collective good of rebuilding the nation to valuing personal satisfaction (Morita 1991). Women in particular came under increased scrutiny for their presumed moral influence over their children, with one psychiatrist coining the term *bogenbyō*, or 'diseases caused by the mother' (Kyûtoku 1979). Men were also faulted for their absence from family affairs (Lock 1986, 1988b).

Arguments about pathogenic families had their place in hikikomori discourse as well, with some mental health professionals arguing that hikikomori was a response to traumatic events such as emotional neglect from family members, a lack of parent-child communication, or an inability to express oneself to one's parents (Hattori 2006; Mutoh 2001).<sup>3</sup> Some of the hikikomori support groups I visited during fieldwork stopped short of blaming parents for causing their children to withdraw, while others folded a critique of childrearing into a more general critique of the development of postwar Japan. Counselors described hikikomori children as the unfortunate offspring of a generation of parents who knew only how to study hard and work hard. This generation, the argument went, had lacked suitable role models and thus had never learned how to be good parents. One mental health counselor who had written on hikikomori several years before it became a national obsession maintained that hikikomori was at heart a communicational issue (Tomita 2000). Hikikomori were children who longed for a connection with others, he wrote, but struggled with communication and therefore tried to survive by withdrawing from situations requiring human interaction. Some family support groups instructed parents to socialize their children with neighbors and spend time practicing face-to-face communication so as to bolster the social skills eroded by television and the internet.

When the economic recession hit in the 1990s, ushering in the 'post-postwar' era, the seemingly solid social structures that had enabled Japan's rapid modernization began to falter (Allison 2013), and hikikomori came to public attention against the backdrop of decreasing job opportunities for youth (Furlong 2008). By the 2000s, Japan's four major government agencies were promoting solutions to job insecurity as a way to combat the large number of hikikomori (Murasawa 2017). Anne Allison (2013) has described hikikomori as a symptom of social and economic precarity in a nation whose youth lack both job opportunities and social connectedness. The rise in what she terms 'ordinary refugeism' reflects the affective state of a country where many Japanese no longer have a sense of 'home', whether they are literally homeless (and pay an hourly rate to sleep at all-night cafés) or whether they lack a space of social belonging in what were once the key identity-forming institutions of family, school, and work. For Allison, hikikomori embody the disintegration of Japan's postwar social structures, revealing the social and emotional barrenness of a 'post-welfare, post-family, post-relational Japan' (2013, 59).

Despite competing interpretations of the phenomenon, medicalization has been a pervasive thread in hikikomori discourse. It was, after all, a psychiatrist who first popularized the term (Saitô 1998), despite his claims that hikikomori was not a psychiatric disorder. The first set of

3 See Horiguchi (2011) for an extensive review of the literature on hikikomori and the family.

government guidelines on hikikomori closely followed the psychiatrist's description of 'a state [jôtai] in which, for various reasons, an individual fails to lead a life that consists of activities outside of one's home, such as school or work' (Kôseirôdôshô 2003). The diversity of experiences that could conceivably lead to hikikomori made it an attention-worthy 'mental health' issue. The second set of guidelines, released in 2010, made more explicit reference to mental illness, while continuing to acknowledge hikikomori's fuzzy etiology: 'In general, hikikomori has been defined as a non-psychotic condition, thereby excluding individuals who withdraw as a result of positive or negative symptoms of schizophrenia. However, there is a significant chance that individuals who have yet to receive a confirmed diagnosis of schizophrenia are included in the hikikomori population' (Kôseirôdôshô 2010). Early estimates placed the number of hikikomori in Japan close to one million (Saitô 1998), although a recent government survey revised that number to 541,000 hikikomori among young adults aged fifteen to thirty-nine (Naikakufu 2016), with no information on hikikomori outside of that demographic.

Social interpretations of hikikomori offer a potent critique of contemporary Japan. However, it is difficult to compete with the engines of medicalization as an increasing number of international psychiatrists and psychologists claim the existence of hikikomori in other countries (e.g., Abe and Kobayashi 2010; Stip et al. 2016) and seek to delineate specific behavioral criteria for use in epidemiological surveys, clinical protocols, and treatment options (Tateno et al. 2012; Teo et al. 2018). Lost in all of these studies is an understanding of the lived experience of hikikomori for individuals and families. We seek in part to remedy that absence.

## Methods and sample

This article is based on fourteen months of ethnographic research I completed in Tokyo and its environs in 2010-11. The project began as a comparative study of the communities of care that had developed around the presumed universal psychiatric disorder of schizophrenia and the alleged 'culture-bound syndrome' of hikikomori (Rubinstein 2012). Fieldwork consisted of attending support group meetings and public lectures, and conducting semi-structured and open-ended interviews with parents and treatment providers in the two communities.<sup>4</sup> In interviewing the parents of hikikomori and in attending their support and study groups, it became clear that hikikomori provided an important analytical lens for understanding ethnographically how diagnosed individuals and their families interact with powerful institutions, both governmental and biomedical, in framing non-normative behavior. Hikikomori thus offers a case study for analyzing how behavioral abnormality is interpreted

4 These methods have been described in more detail elsewhere (Rubinstein 2016, 2018).

across actors and institutions. Parental carers drew from multiple social and medical explanatory frameworks, sometimes concurrently, to make sense of both their children's behavior and their own role in promoting a harmful or healing home environment.

I had no intention of doing further research or writing about hikikomori, but the phenomenon has proved to have extraordinary staying power, especially in psychiatry. When an article on hikikomori appeared in *The Lancet*, an international medical journal, in early 2018 (Harding 2018), I approached the second author (RVS) about writing an article together. Rae V. Sakakibara, who is bilingual and bicultural, became an essential partner in the work, providing a new perspective on the meanings that parents ascribed to their children's behavior and offering thoughtful, nuanced interpretations of the effects on care. We returned to my original data to focus on how hikikomori functioned as a diagnosis and how parents responded through creative care practices. Of the twenty-one parents who were interviewed during fieldwork, nine described some aspect of their child's (or, sometimes, children's) experiences in terms of hikikomori. We began to analyze the transcripts for how parents had arrived at a diagnosis of hikikomori and what they understood hikikomori to mean. Data analysis then proceeded iteratively through successive readings and discussions of interview notes and transcripts (Bernard and Gravlee 2014) as we refined our argument and chose two case studies to illustrate the dramatically different ways hikikomori could reconfigure families' everyday lives.

## Circumventing psychiatry to create social belonging

Mr. Watanabe was a sixty-eight-year-old retired salaryman (white-collar company employee) who identified his thirty-five-year-old son as hikikomori.<sup>5</sup> Mr. Watanabe was an enthusiastic participant in several different support and study groups about hikikomori and had developed strong opinions about its link to the fault lines within a homogeneous Japanese nation-state. At group meetings, after-parties, and interviews, he interspersed personal anecdotes with sweeping criticisms of Japan. He liked to write as he spoke, partly to ensure his meaning was clear to the foreign anthropologist, and partly to lend gravitas to his proclamations. Japan, he believed, was a country of imitators, dating back to the early 600s when envoys were first sent to China to import knowledge from abroad. That spirit of imitation, he said, meant people were comfortable only when they were doing the same thing as everyone else, as was evident in adherence to a single life trajectory (for men) of 'good middle school, good high school,

5 Some details of the Watanabes' story have also been recounted elsewhere (Rubinstein 2016).

good university, good company, good bride, good marriage, good grandchildren'. Mr. Watanabe had followed this exact path, which he felt entitled him to criticize it.

Mr. Watanabe's criticisms of Japanese society were second only to his criticisms of psychiatry, an institution with which he and his wife had become familiar because of their son, the middle child of three, whose troubles began when he dropped out of his third and final year of high school. School refusal was a known social issue, 'something that could happen to anyone', as Mr. Watanabe said, and thus did not lead the Watanabes to seek professional help. But the son also refused to leave the house, and such 'odd' behavior – in the early 1990s, before hikikomori had exploded onto the national stage – encouraged Mrs. Watanabe to seek out a family group 'for people who have a hard time communicating'. She continued: 'It was like a consultation group [*sodankai*] to make it easier to live with these issues. There are women who get bullied by their mothers-in-law, or people with marital issues... It's not just these things. There are also people who have children who don't want to go to school or have other trouble'.

As time passed, the son's mood and behavior worsened, culminating in a suicide attempt and violence against his parents, which led to arrest, hospitalization, and an eventual diagnosis of schizophrenia at the age of nineteen. The Watanabes sought help wherever they could, including a variety of support groups and mental healthcare professionals. Mr. Watanabe remained unimpressed by the latter, describing hospitals as 'a place of internment', dismissing medication for 'only suppress[ing] symptoms' rather than treating disease, and belittling psychiatrists for their inability to 'cure' mental illness. His distrust in the psychiatric profession seemed justified by the confusion surrounding the son's initial diagnosis, which the Watanabes believed the son had manipulated by changing his answers to the psychiatrist's clinical questions. 'With mental illness', Mr. Watanabe said, 'it's not like you can use a machine that gives you exact measurements to determine a diagnosis'. In a single clinical encounter, the son's diagnosis had fluctuated between hysteria and schizophrenia as the son attempted to avoid the latter, more troubling diagnosis. As Mr. Watanabe explained:

In Japan, it's hard to accept you have schizophrenia. It's like you're being given a death sentence, or he probably thought [the doctor] was saying there was no hope for him, so he didn't want to accept the diagnosis and thought it was something different. He said he had all these different symptoms, and he kept listing them off to the doctor, so the doctor thought maybe it wasn't schizophrenia... These illnesses are diagnosed by asking questions, so when my son's answers were this and that, the doctor may have thought he'd made a mistake in diagnosing schizophrenia and instead thought maybe it was hysteria.

The diagnostic process continued beyond the clinic as the Watanabes re-evaluated their son's strange behaviors, such as standing in a local park on a rainy day without an umbrella or shoes, in light of his potential psychiatric disorder. 'Neither my wife nor I knew a lot about mental illness', Mr. Watanabe said. 'When I think about it now, it was strange that he was just standing in the middle of the park on a rainy day. When I think about these things, I think maybe he could have schizophrenia'. Mrs. Watanabe added: 'Looking at his actions and speech after that, there were things that made me think maybe he had schizophrenia. He would say that someone in the neighborhood could be setting up a listening device, which seems to be a typical symptom of schizophrenia. Looking back, he would say things like that. Things we didn't notice at the time'.

When their son was diagnosed with schizophrenia, the Watanabes were able to make sense of some of his previous odd behaviors as symptoms of a developing disorder. Even so, schizophrenia did not provide an entirely satisfactory framework for understanding their son. The psychiatrist assured the Watanabes that the son's case was 'mild', and Mr. Watanabe concurred that his son did not act like a 'so-called sick person'. The psychiatrist told the Watanabes they should encourage their son to return to social life, either through school or employment. The son passed a university entrance exam after being discharged from the hospital, which enabled him to matriculate at a lower-tier university despite having dropped out of high school. He eventually dropped out of college, too, and worked several part-time jobs, none lasting longer than a few days because of violent outbursts and an inability to perform his work functions. By the time I met the Watanabes, he no longer worked and instead received a disability pension while residing with his parents.

Perhaps because of the presumed mildness of the son's schizophrenia, or perhaps because they had little respect for psychiatry, it was the son's hikikomori behavior that most concerned his parents. Hikikomori, Mr. Watanabe insisted, was a 'condition', albeit one that was rife with nosological ambiguity:

It's not a disease, but people who can't go outside are hikikomori. Well, in a way, if you can't leave your house, you're probably sick – but the question is, can it be cured? Isn't a disease something that has a cure? Or maybe not. Because there are incurable diseases. But if I'm asked if hikikomori is a disease or symptom, I don't think it's a symptom caused by a disease. If it is a disease... Well, I wonder what kind of symptoms people with schizophrenia exhibit in the US. I wonder if they remain in their house and stay under the covers.

For the Watanabes, schizophrenia and hikikomori were two distinct entities, despite the obvious potential for overlap, which Mr. Watanabe himself acknowledged. But the Watanabes chose to cleave the two conditions apart to capitalize on their ability to affect their son's future.

Whereas schizophrenia was a biomedical disease that psychiatry had no ability to cure, hikikomori indexed the interplay between their son's individual psychology – his pride, coupled with an inferiority complex when comparing himself to his peers – and the strictures against social difference in Japanese society. As Mr. Watanabe explained, spaces for individuals like his son, who fell outside the mainstream, were lacking, which exacerbated the hikikomori phenomenon:

People should be encouraged and provided with generous support, and be reminded that what they're doing is enough. Instead, they're given a manual and yelled at to follow the steps laid out for them. The Japanese don't think with their heads, they just do what they're told. They just look around at other people, doing the same thing as the next person, but with a competitive attitude. The competition is fierce. They don't think for themselves. This is no good. It's my own country, but it's no good.

Hikikomori, then, was a diagnosis of society rather than of the individual. Indeed, what Mr. Watanabe described in his condemnation of Japanese society was hikikomori as a form of 'social suffering', which 'results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems' (Kleinman, Das, and Lock 1996, xi). Hikikomori offered the Watanabes a way to articulate the harms of an exclusionary society rendered possible by intense pressure to excel in school, lack of opportunities for people with disabilities, and lack of alternative spaces for people who did not fit the narrowly prescribed norm. This type of suffering necessitated social repair rather than mental health treatment; even counseling was suspect because it removed the individual from his social surroundings. The Watanabes therefore focused their care practices on creating ways for their son to become a socially recognized individual. Mr. Watanabe had encouraged his son to matriculate at university simply so he could experience university life. In Japan's so-called 'academic pedigree' society, Mr. Watanabe felt that passing the university entrance exam and starting college would help elevate his son's chances for social legitimacy:

[I]n a society where so many people have a college degree, if you're a high school dropout, or there's a chance for you to go to college but you don't, then there's this sense that you're an inferior member of society. I thought if he didn't go to college he would feel the sting of this reality, so knowing it would be a challenge for him to graduate, and knowing it was a wasted [financial] investment, I had him take the entrance exam and even paid for his tuition.

The Watanabes continued to pursue social solutions for their son by encouraging his attendance at Cooking House, a nonprofit facility for individuals with psychiatric disabilities

to cook, share meals together, and serve the public in a small restaurant. ‘They look after these people [with disabilities]’, he said, ‘and through the disability pension and social welfare, they can get on in life’. It was a way, in other words, to ensure his son could survive once his parents were gone.

Hikikomori, despite its challenges, liberated the Watanabes from the clutches of biomedical psychiatry. Although they were active participants in different support and study groups, they avoided associating with family groups for mental illness. They had tried attending one such group after their son’s schizophrenia diagnosis, but found the group’s goals incompatible with their own. As Mr. Watanabe explained:

We do want to send him out into society eventually. On the other hand, that group [we attended] for schizophrenia is a group that helps you think about how people [with schizophrenia] can get a disability pension and best live off of it. They’ve given up on people existing independently in society. As parents, we didn’t think like that.

The two conditions, schizophrenia and hikikomori, offered two possible futures for their son: one relegated him to a lifetime of psychiatric patienthood by ‘giving up’ on his ability to function in society; the other necessitated constructing an alternative path of social belonging. The Watanabes chose the latter, and they focused their care practices on providing their son with the trappings of mainstream life (his university experience) and helping him forge social ties outside of the mainstream (through Cooking House). Hikikomori therefore had important symbolic status to them because it offered an alternative to psychiatry and its seemingly useless suite of therapeutic technologies. In hikikomori there was flexibility and creativity; absent a medical prognosis about the future, anything was possible. The Watanabes capitalized on this sense of possibility to read into their son’s condition the failings of a nation, as well as to begin the work of repair through new configurations of social belonging.

## Interpretative uncertainty and a turn to self-care

Mrs. Tsushima was a gregarious fifty-seven-year-old who hailed from the countryside and had once worked as a university research assistant before quitting her job to care for her hikikomori daughter, now aged thirty-four. She was one of the few parents who had a long-term relationship with mental illness, dating back to her own childhood, which inevitably colored her interpretation of hikikomori. Her older brother, who had left home for Tokyo so that he could find a job to help support the family, had been institutionalized and diagnosed with schizophrenia in his early twenties. Her parents, who were poor and uneducated, did not understand he was ill and instead cursed his ‘bad character’, blaming him for causing trouble for the family. Mrs. Tsushima, six years his junior, had no awareness of what was wrong with

him. Angry and ashamed, she kept his illness hidden from her peers (although, since it was a small town, somehow everyone already knew) and wished he would ‘hurry up and die’. But when her daughter began exhibiting signs of social withdrawal at the age of twenty, Mrs. Tsushima started reading about mental illness and learned what her brother had gone through. She felt the discriminatory attitudes the family had expressed toward him had deeply affected her daughter, who feared she would turn out like him: ‘When we got back to our home to the countryside [after visiting him], we would talk about my brother and curse him. And my daughter was listening to those things, right? So she’s been living with this fear, thinking, *What will I do if I turn out that way? I don’t want to be that way*’.

In retrospect, Mrs. Tsushima had come to recognize her daughter’s concerns. Her daughter had been an easy child to look after, Mrs. Tsushima said. She preferred being alone to playing with others, but Mrs. Tsushima told her not to worry. Her daughter seemed to have trouble joining in on playtime activities like jump rope or origami, and Mrs. Tsushima thought she was perhaps a bit slow for her age. Still, she was able to advance through school and matriculate at university with her peers. She had a boyfriend during her first year at university, and when they broke up, Mrs. Tsushima took her daughter to counseling. In these initial appointments, which mother and daughter attended together, Mrs. Tsushima first heard her daughter talk about how worried she had been from a young age that she was ‘not right’ or ‘not normal’. Beyond those counseling sessions, the daughter began to seek out other treatment providers, mainly psychiatrists, all of whom diagnosed her with depression and prescribed medication:

My daughter just wanted someone to listen. But it’s a three-minute office visit, so [the doctor] just gave her medication and said, ‘How about I just prescribe you some medication? How’s that?’ My daughter said, ‘This won’t make me better [*naorana*], so I’m not going to the doctor anymore’. So then she tried counseling. Even with all of this going on, she still went to school and graduated. While she was in school she went to counseling and to several different hospitals, but the doctors didn’t understand.

She continued to attend her university classes, but she began to retreat from social life for fear of running into classmates who would ask about her career plans or find out about her counseling sessions. Mrs. Tsushima was familiar with hikikomori but did not associate the term with her daughter because her daughter continued to attend school. After graduating from university, however, the daughter withdrew completely into their home. Around this time, Mrs. Tsushima found a blog post her daughter had written: ‘I am hikikomori. I’m twenty-something years old, and I don’t work. I don’t go to school. What will happen to me? Surely there aren’t people who are as strange as me’.

Mrs. Tsushima was working as a research assistant at a university laboratory, but her daughter began to demand more and more of her time:

After coming home, I would make dinner, right? And she would say all these things like she wanted to take swimming lessons, or go to an elementary-level cram school. I thought these were strange requests, but I said okay. But she would say, 'I'm embarrassed to go because I'm so old', so she asked me to go with her. So I said okay, and we took swimming lessons... She started saying she wanted to do things for little kids. But [do them] together. So we did a lot of those things. And karate. She wanted to do that together. Then ballet. She wanted to do that together, too. So we would go after I got home from work, and I would be tired... Then we would come home and talk about things until 4 or 5 AM, then I would have to make breakfast, lunch, and dinner for everyone and head off to work. I would get one or two hours of sleep.

This pattern continued for five years, straining spousal relations – Mrs. Tsushima and her husband, who thought she was taking things too far, separated for two years – and interfering with Mrs. Tsushima's work. The laboratory was only a five-minute drive from the Tsushimas' residence, but Mrs. Tsushima fell asleep at the wheel. This incident convinced her she could no longer work *and* tend to her daughter, and so she quit her job to 'seriously start spending time' with her and adopt her daughter's lifestyle. This, she said, was how she 'cared' for her daughter – 'keeping company' (*tsukeiau*) rather than 'caring for' (*kaigo suru*). She took her inspiration from a book written by an American special education teacher and translated into Japanese. As Mrs. Tsushima described it: 'This [teacher] sees children with mental disabilities over a long period of time, and by interacting with children who have been diagnosed with schizophrenia for a long time, she makes them normal'. Mrs. Tsushima hoped that living alongside her daughter and participating in every facet of her life might help her daughter recover, but 'then when I spent the whole day with her, I thought to myself, *I might kill her*'. Mrs. Tsushima decided she needed to turn her attention to caring for herself.

Through the teacher's book, Mrs. Tsushima learned of Saitô Satoru, a psychiatrist who made a name for himself researching and writing about addiction (Borovoy 2001). Dr. Saitô runs a clinic in Tokyo that specializes in issues arising from 'dysfunctional family relationships', including domestic violence, addiction, eating disorders, and school refusal. According to the clinic's website, Dr. Saitô's philosophy is that while traditional psychiatric treatment has its place, there needs to be an emphasis on self-recovery and growth, and he therefore incorporates self-help activities into treatment plans. He agreed to see Mrs. Tsushima without her daughter (the 'identified patient'), and he suggested Mrs. Tsushima needed her own 'healing' while offering a new interpretation of *hikikomori* for her to think about:

He said that hikikomori is an addiction. So that won't get better. He said unless she tries to fix it herself, it won't get better. He said you can't fix it with medication. Yes – but she can't do that. When I ask what we can do to fix this, he says the family must support her so that she can feel like she wants to fix it herself. He said the family has to lovingly watch over her, talk to her, and hear what she has to say so that she can feel like she wants to fix it herself.

His advice to Mrs. Tsushima was to attend clinic meetings where she could hear other people talk about their experiences. Mrs. Tsushima spent one day a week at the clinic for three years, and while she felt she had learned a lot, she was perturbed that her daughter had not attended with her. She had brought her daughter to the clinic once for a psychological assessment, which appeared to indicate she had a developmental disability.<sup>6</sup> However, the daughter refused any type of treatment, even when Dr. Saitô told her the 'treatment' consisted of nothing more than coming to the clinic every day. Although Mrs. Tsushima complied with Dr. Saitô's directives to 'lovingly watch over her, talk to her, and hear what she has to say', it seemed not to make any difference. Thus, while Dr. Saitô offered an interpretation of hikikomori that was social rather than biomedical, Mrs. Tsushima read the biomedical back into it:

My daughter's condition is an illness [*byōkei*]. At first I didn't think it was an illness, but I do now. She has a mental... She has some paranoia, so I think it may even be schizophrenia. I even thought maybe it was the negative symptoms of schizophrenia. But I do really think she may have depression, too. There are people like that [who have depression] in my family.

Mrs. Tsushima no longer attended Dr. Saitô's clinic meetings, but she was a frequent attendee at evening meetings of Tomodachi, a support group for families coping with mental illness (see Rubinstein 2018). Tomodachi, with its emphasis on biomedical understandings of mental distress, provided what she felt was a more appropriate framework for understanding her daughter. 'Tomodachi is the only group in Japan that has such a comprehensive and meaningful website', she said. 'It serves an important purpose, what's written on their website. It's something I find convincing, and it's something I can agree with'. She also attended a parents' group on hikikomori, but she compared it unfavorably with Tomodachi, frustrated

6 'Developmental disability' (*battatsu shōgai*) is not a diagnosis but is rather a term used in both lay and professional circles to index learning disabilities, attention deficit and hyperactivity disorder, and/or autism spectrum disorders, exclusive of intellectual disabilities (Teruyama 2014).

with what she saw as participants' lack of proactive behavior on behalf of their withdrawn children:

The mothers don't really understand. They say it'll be okay. If you give it some time, it'll be okay. But nothing changes after ten, twenty years. So the mothers are still at a loss. They say, 'What will these children do if we die? Will they still be inside the house all day?' I say, 'Let's just go see the doctor'.

The mothers who refused to seek medical help for their children's hikikomori condition bewildered Mrs. Tsushima. Caring for one's child meant being proactive and searching for answers; this was why she did not consider 'keeping company' with her daughter to be the same as providing care. Mrs. Tsushima also believed in biomedical possibility, despite her criticisms of psychiatrists for their three-minute medical exams and immediate recourse to medication. She felt psychiatrists could provide answers if they looked past the hikikomori behavior and instead searched for the underlying psychiatric disorder – in her daughter's case, potentially schizophrenia or depression. The lack of clinical certainty left Mrs. Tsushima feeling paralyzed, in contrast to her daughter, who was satisfied calling her condition 'this' (*kore*) rather than seeking a label to capture her psychological state. But Mrs. Tsushima wanted answers. She believed hikikomori was merely a placeholder for some kind of psychopathology – 'it's kind of like depression, a developmental disability, or autism', she said, the latter two conditions having more recently come to professional and popular attention – and she trusted there were biomedical therapies that could help:

I think it would be good to have a treatment method that doesn't rely on medication. My daughter keeps saying she doesn't want to use medication to suppress the feelings of stress or anxiety that keep her from going outside. She says these are important emotions, and she wants to get better by understanding how they come to be. I think maybe she's right. Now, anyway. But deep down, I do want her to take medication. Even the doctor she sees now says, 'A little bit of medication can make her feel better. Please try talking to her about it'. But my daughter refuses to take all medication.

Mrs. Tsushima continued to believe in the potential for a biomedical explanation, but her daughter's own interpretation of her condition prevented her from doing much about it. 'She says this is something she was born with', Mrs. Tsushima said, 'and from other people's perspective it may look like she has an illness [*byōkei*], but this is just the way she is. So she wants others to let her be free. She says it's irritating [*meiwaku*] when she's forced to go outside'. Without the resources to support her position, Mrs. Tsushima had begun to accept that her daughter might not 'get better' but would simply 'mature gradually'. She admired her daughter's cleverness, her ability to work the system, as it were, continuing her visits to a psychiatrist who did not force her into treatment but maintained her clinical diagnosis of

depression, which entitled her to a disability pension. ‘It seems like for her, it’s okay if she doesn’t get better’, she said. ‘She’ll just learn how to exist in this world’. Care for Mrs. Tsushima was now less about her daughter than about herself; Tomodachi meetings gave her a place to speak freely about her daughter with others who understood the possibilities of psychiatry but criticized its practice. She wanted her daughter to participate in some sort of social life, too, which her daughter seemed to have found online. For the time being, that was the most Mrs. Tsushima could hope for. ‘She doesn’t have to get better’, she said. ‘I just want her to be close to people’.

## Conclusion

Our aim in this article has been to amplify understandings of hikikomori in Japan by exploring ethnographically parents’ ‘diagnostic work’ (Büscher, Goodwin, and Mesman 2010) in making sense of their children’s withdrawn behavior. This diagnostic work concentrates around the polysemous concept of hikikomori as a social, medical, and sociomedical condition. Our ethnography illustrates that alighting upon a diagnosis of hikikomori is only half the story, and families continue to refine their interpretations of hikikomori as they accrue new experiences and information. This ongoing diagnostic work gives shape to family life under a diagnosis of hikikomori; parental care helps engender that which it seeks to overcome.

What life under a diagnosis of hikikomori looks like depends on the family, and the Watanabes and Mrs. Tsushima offered competing interpretations. For the Watanabes, hikikomori proved a more satisfying framework to interpret their son’s current behavior and future possibilities than a clinical diagnosis of schizophrenia. They did not deny their son’s psychiatric disorder, but they sidestepped it to focus on what they felt was the more pressing condition, as well as the condition they had the potential to affect. They saw psychiatry as useless and schizophrenia as incurable, but there were ways to remedy their son’s asociality. Their desire for their son’s social recognition seemed to be incompatible with his psychiatric diagnosis – that, at least, was the takeaway from the schizophrenia support group they had attended, where parents had ‘given up on people existing independently in society’. Hikikomori, to them, was a form of social suffering caused by a rigid and uncaring society with no space for deviation from the norm. In interpreting their son’s behavior in these terms, they provided care by creating new spaces of social belonging.

Mrs. Tsushima did not find the same satisfaction in the hikikomori descriptor, perhaps because it harkened back to her parents’ small-town thinking when they blamed her older brother for his ‘bad character’ rather than recognizing his psychological suffering. While her daughter had come to terms with her own psychological state, insisting it was ‘something she was born with’ and would never change, Mrs. Tsushima believed there was some kind of underlying

psychopathology to treat. Hikikomori, to her, was a label that obscured as much as it revealed, and she saw it as an excuse for mothers in her hikikomori group to remain passive rather than actively seeking (biomedical) solutions. Even when a psychiatrist told her hikikomori was an addiction without a biomedical cure, and that she simply had to demonstrate empathy toward her daughter, Mrs. Tsushima remained skeptical. She yearned for a proactive approach to care, something more than ‘keeping company’, yet she was unable to find it. She turned to self-care, ensuring she had the social and emotional resources to be with her daughter, and accept her as she was, as the years passed.

Although we have focused here on parents’ social and psychiatric interpretations of hikikomori, we do not mean to suggest that hikikomori must always be interpreted as pathological. Some parents found ways to read hope into hikikomori and described their children as doing significant psychological and spiritual work during their periods of withdrawal (Rubinstein 2016). We draw attention to the nexus of social and psychiatric interpretations because it brings into sharp relief how the same diagnosis can engender vastly different lived experiences, undermining attempts to instill common meaning across local contexts (Smith-Morris 2016).

Hikikomori exists in a space of interpretive debate and possibility; its ambiguous status as a ‘condition’ leaves room for the term to be co-opted by a variety of actors and institutions, medical and non-medical alike. By attending to the parties, including parents, that have taken part in constructing the hikikomori phenomenon over the past two decades, we have illustrated the messiness of the ‘diagnostic work’ that continues to provide fodder for new meanings of hikikomori. As such, we revise Emily Martin’s (2007) concept of ‘living under a diagnosis’ to ‘living under diagnosing’ in recognition that a fixed diagnostic label may not be an endpoint but rather a waypoint, another stop along an interpretive journey. The paths parents chose from this waypoint continue to shape the contours of hikikomori as individual and familial occurrence and as national phenomenon.

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