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Letters to the Editor

Understanding the characteristics of prolonged social withdrawal (Hikikomori)

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Abstract

Mental and public health professionals have paid increasing attention to the hikikomori phenomenon. With this letter, we aim to extend scientific knowledge on the characteristics of hikikomori and pre-hikikomori as reported by Italian participants using previously unpublished data.

Presented findings suggest that stressful events and difficulties in interpersonal relationships and in adjusting to the increasing life-phase-related social demands may exert a prominent role in leading to hikikomori.

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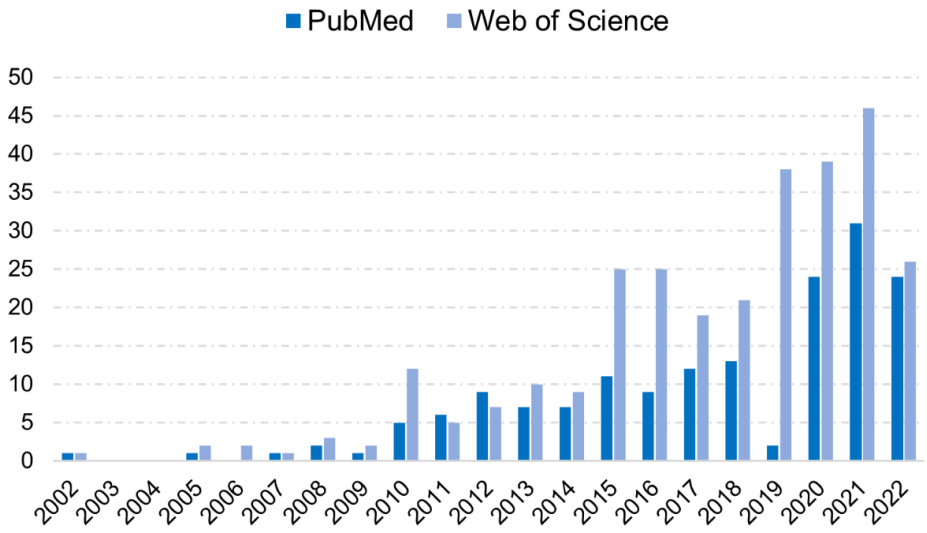
Dear Editor,

Public and scientific attention to the hikikomori phenomenon has constantly increased during the last decade (Figure 1). The term hikikomori refers to a behavioural and psychological condition characterized by severe and prolonged social withdrawal in one's home or bedroom that lasts for at least six months and is associated with significant impairment in individual, social and/or work/school functioning (Kato et al., 2019, 2020). The condition has been mainly studied in Japan and other Asian countries despite initial studies that have been published in western countries (Amendola et al., 2021; Bowker et al., 2019; Chauliac et al., 2017; Frankova, 2019; Malagón-Amor et al., 2015, 2018, 2020; Teo et al., 2015). Mental health professionals are concerned for its impact on both individual's physical and psychological functioning (De Michele et al., 2013; Stip et al., 2016).

Figure 1. The number of articles retrieved in PubMed and Web of Science searching for "hikikomori" (in all fields) up to September 22, 2022



In Italy, clinicians and researchers have mainly reported cases of adolescents with hikikomori (Filardi et al., 2021; Maglia, 2020; Ranieri, 2015; Ranieri & Luccherino, 2018). We have recently examined the properties of the Italian version of the 25-item Hikikomori Questionnaire (HQ-25) in community samples of adolescents (Amendola et al., 2022b) and adults (Amendola et al., 2022a) to foster the study of the phenomenon. The Italian versions of the HQ-25 were reviewed by the first author (Dr. Alan R. Teo) of the original HQ-25, who supervised the studies' planning and conduction. The HQ-25 showed adequate psychometric properties to help in investigating symptoms of hikikomori. We also highlighted the presence of self-reported lifetime episodes of hikikomori and *pre-hikikomori* (i.e., duration of prolonged social withdrawal longer than three months but less than six). With this letter, we would like to extend scientific knowledge on the characteristics of hikikomori and pre-hikikomori as reported by Italian participants using previously unpublished data.

In our recent studies (Amendola et al., 2022a, 2022b), six adolescents (3.4% of the subsample; among females: 4.3%, n= 3; among males: 2.9%, n= 3) reported lifetime episodes of hikikomori (n= 3, males n= 2) or pre-hikikomori (n= 3, males n= 1). Likewise, nine adults (2.4% of the sample; among females: 2.9%, n= 8; among males: 1%, n= 1) reported lifetime episodes of hikikomori (n= 4, males n= 1) or pre-hikikomori (n= 5, all females). As shown in Table 1, none of the adults reported a lifetime diagnosis of psychological disorder by a mental health professional. During the social withdrawal episode, nearly all participants showed no social participation (i.e., interrupted school or work attendance) and lack of social interactions with friends or colleagues in adults. Almost only adults revealed self- and other-directed aggressive

behaviours and one subject tried to commit suicide. The most frequently self-reported motivations included interpersonal difficulties in adolescence and some sort of detachment from the social/external environment in adults. Two participants reported the possible presence of a non-diagnosed psychological disorder as the main explanation for their withdrawal. Finally, no participants reported a physical or medical condition as the main reason for their withdrawal.

Table 1. Characteristics of participants who reported a lifetime period of hikikomori or pre-hikikomori, organized by age.

	Adolescents		Adults	
	Hikikomori (N= 3)	Pre-hikikomori (N= 3)	Hikikomori (N= 4)	Pre-hikikomori (N= 5)
	n (%)	n (%)	n (%)	n (%)
Lifetime diagnosis of psychological disorder (self-reported)	0*	0*	0	0
Social withdrawal characteristics				
Duration in months (*M* ± *SD*)	20 ± 6.9	4 ± 1	9 ± 3.5	3.6 ± 0.9
Lack of social participation	3 (100)	3 (100)	3 (75)	4 (80)
Lack of in-person social interaction	na	na	4 (100)	4 (100)
Physical aggression towards others	0	0	0	2 (40)
Self-injury	1 (33.3)	0	0	2 (40)
Suicidal ideation	0	0	3 (75)	5 (100)
Suicidal attempt	0	0	0	1 (20)
Self-reported withdrawal motivation				
Low self-esteem	1 (33.3)	0	0	0
Bullying episodes	1 (33.3)	0	1 (25)	0
Interpersonal difficulties	2 (66.6)	2(66.6)	0	0
Family problems	0	1 (33.3)	0	0
Mourning	1 (33.3)	0	0	0
Feeling safe only at home	0	0	1 (25)	3 (60)
Feeling difficulty in doing things	0	0	0	1 (20)
Rejection of society's rules and values	0	0	1 (25)	0
Psychological disorder	0	1 (33.3)	1 (25)	1 (20)
Physical/medical condition	0	0	0	0

Note. Participants were evaluated for lifetime episodes of hikikomori or pre-hikikomori. Participants may have reported more than one self-reported withdrawal motivation (i.e., total percentage > 100).
*: information, as reported by parents, were available for one of the three participants, *na:* information not available.

Thus, relational stressors generally preceded hikikomori and pre-hikikomori episodes during adolescence. This aids in the understanding of the hikikomori phenomenon providing support for the conceptualization of hikikomori as a reaction to stress separate from the existence or nonexistence of mental health disorders in the narrow sense (Kato et al., 2019). Despite the fact that previous evidence has highlighted no differences in childhood traumatic experiences between individuals with and without hikikomori (Umeda & Kawakami, 2012) those with hikikomori showed other stressful or adverse events (Lee et al., 2013; Tajan et al., 2017; Wong et al., 2015) in line with our data. Taken together, those findings point to the role of interpersonal sensitivity, dysfunctional communication and family dynamics as risk factors for hikikomori (Lee et al., 2013; Saito, 2013; Suwa et al., 2003; Tajan et al., 2017). In accordance

with Kato et al. (2019), some types of hikikomori may be similar to an avoidance strategy and do not constitute a disorder in themselves. However, if the withdrawal behaviour persists for an extended period it may stabilize as a disorder and cause other difficulties (Kato et al., 2019).

On the other hand, difficulties in exploring the environment and in adjusting to the increasing life-phase-related social demands may exert a prominent role in leading to hikikomori in adulthood in line with findings from initial studies (Amendola et al., 2022a; Hihara et al., 2021; Krieg & Dickie, 2013). Recent qualitative research (Caputo, 2020) on the narratives of 17 individuals who wrote on a public online forum about hikikomori discussed on the role of interpersonal distress, retreat to passivity, refusal of intimacy and performance anxiety as withdrawal motivations, although the study did not include an examination of hikikomori symptoms and/or criteria. According to Erikson (1968), a state of acute identity confusion usually occurs when the young person feels exposed to a combination of experiences that require his or her simultaneous commitment to physical intimacy, final choice of work, competition and psychosocial self-affirmation. Whether or not the resulting tension causes a state of paralysis depends primarily on a latent condition of psychological risk or identity functioning (Erikson, 1968). Thus, hikikomori may be the consequence of an altered psychosocial development in the areas of identity formation and intimate and relational functioning (Amendola et al., 2021, 2022a). In accordance, De Luca et al. (2020) highlighted the "need to consider the symptoms [of hikikomori] as a sign of the individual's psychic processing capabilities being overwhelmed" (p. 20) and social withdrawal behaviour as a strategy to deal with internal and/or external conflicts.

Our data is limited by the use of participants' self-report information. Two participants revealed the possible presence of a non-diagnosed psychological disorder as the main explanation for their withdrawal. However, none of the adults reported a lifetime diagnosis of psychological disorder by a mental health professional. This adds initial evidence on the presence of primary hikikomori in Italy and/or on the lack of access to and utilization of mental health services (Amendola et al., 2021). Studies conducted in Spain (Malagón-Amor et al., 2015), France (Chauliac et al., 2017) and Ukraine (Frankova, 2019) have also supported the presence of both primary and secondary hikikomori. As such, epidemiological studies with representative samples are needed to reliably estimate the prevalence of hikikomori and to clarify its diagnostic validity. Further, longitudinal studies are crucial to identify risk factors (e.g., interpersonal sensitivity, anxiety, stressful events, and family dynamics) and prodromal symptoms (e.g., school refusal, excessive and/or problematic use of technologies) as well as outcomes and trajectories. The link

between hikikomori and self- and other-directed aggression should be expanded (Gómez-Tabares et al., 2022; Yong & Nomura, 2019). Importantly, online surveys may be a useful methodology to reach socially isolated individuals that do not seek help for their condition (Amendola et al., 2021, 2022a; Liu et al., 2018). In conclusion, despite the fact that the validity of hikikomori as a separate diagnostic entity necessitates close examination, it nonetheless represents a form of silent and hidden suffering that deserves clinical and research attention (Cerutti et al., 2021).

Ethical approval * : The study was approved by the Ethics Committee of the Department of Dynamic and Clinical Psychology, and Health Studies (Sapienza – Università di Roma).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement *: The dataset analysed during the current study is available from the corresponding author upon reasonable request.

Conflict of interest statement *: The authors declare that they have no conflict of interest.

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Author Contributions * : All authors designed the study. SA wrote the first draft of the letter. All authors critically revised it and approved its final version.

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