Facing and treating hikikomori *(pathological social withdrawal)*

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[Ricevuto il 15 maggio 2021
Accettato il 1 giugno 2021]

Abstract

Hikikomori is a form of pathological social withdrawal or social isolation whose essential feature is physical isolation in one's home. The 2010 Japanese guidelines define that a person must meet the following criteria to be diagnosed with hikiikomori: a) marked social isolation in one's home; b) duration of continuous social isolation of at least 6 months; c) significant functional impairment or distress associated with the social isolation. Advances in the conceptualization and treatment plan are discussed.

Key words: hikikomori, social isolation, social withdrawal, depression, modern-type depression.

Sommario

*Gestire e trattare l'*hikikomori *(ritiro sociale patologico)*

L'*hikikomori* è una forma di ritiro sociale o isolamento sociale patologico la cui caratteristica essenziale è l'isolamento fisico nella propria casa. Le linee guida giapponesi del 2010 definiscono che una persona deve soddisfare i seguenti criteri per essere diagnosticata

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Quaderni di Psicoterapia Cognitiva (ISSN 1127-6347, ISSNe 2281-6046), n. 48/2021
DOI: 10.3280/qpc48-2021oa12137

con *hikikomori*: a) isolamento sociale marcato nella propria casa; b) durata dell'isolamento sociale continuativo di almeno 6 mesi; c) significativa compromissione funzionale o disagio associato all'isolamento sociale. Vengono discussi i progressi nella concettualizzazione e nel piano di trattamento.

Parole chiave: hikikomori, isolamento sociale, ritiro sociale, depressione, depressione di tipo moderno.

Hikikomori, a form of pathological social withdrawal has long been highlighted especially among young people in Japan since around the 1970s, who stopped going to school or the workplace and spent most of the day shut into their rooms for more than a half year (Kato *et al*., 2019). Tamaki Saito, a Japanese psychiatrist, has named this phenomenon to "*Shakaiteki hikikomori* (or social withdrawal)" in 1998 (Saito, 1998). A WHO community-based survey 2002-2006 targeting individuals aged between 15 and 49 years in Japan has estimated that the prevalence of *hikikomori* is approximately 1.2% (Koyama *et al*., 2010). A survey by Japan's Cabinet Office in 2016 estimated that *hikikomori* sufferers aged between 15 and 39 number 540,000 in Japan. Moreover, the Cabinet Office has recently estimated the number of *hikikomori* between 40 and 65 to be 610,000. Thus, at least more than one million people are suffering from social withdrawal condition in Japan. Thus, prolonged and ageing *hikikomori* is becoming a novel social issue, called the 80-50 problem (*hikikomori* sufferers in their 50s living with parents in their 80s). In addition, *hikikomori* has also been reported in various countries outside Japan (Kato *et al*., 2019; Teo, 2015). *Hikikomori* negatively influences not only the individual's mental health and social participation, but also wider education and workforce stability, and as such is an urgent global issue.

In the 2010 guideline of *hikikomori* for evaluation and supports by the Ministry of Health, Labour and Welfare (MHLW), *hikikomori* is characterized as 1) staying at home for most of the day, 2) avoidance of social participation (e.g. working and schooling), and 3) these conditions continue at least six months (Saito, 2010a). Based on this 2010 guidelines, *hikikomori* is a concept that does not generally include schizophrenia, but according to a survey by Kondo *et al*. conducted before the establishment of guidelines, the DSM-IV-based psychiatric diagnosis of sufferers under the condition of *hikikomori* attending mental health welfare centers showed a wide coexistence with psychiatric disorders including schizophrenia, mood disorders, anxiety disorders, personality disorders, and pervasive developmental disorder (Kondo *et al*., 2013). Our survey based on the *hikikomori* research clinic at

Kyushu University has shown that a variety of psychiatric disorders especially depression, social anxiety, personality disorder and autism spectrum disorder (ASD) are common comorbid disorders in *hikikomori* (Katsuki *et al*., 2020; Teo *et al*., 2015). Even in the absence of a clear diagnosis of psychiatric disorders, many persons with *hikikomori* find themselves in a "gray zone" and the fact that no formal diagnosis of psychiatric disorders has been made does not equate to the absence of mental suffering (distress), and therefore we strongly believe that above all due consideration should be made of this suffering.

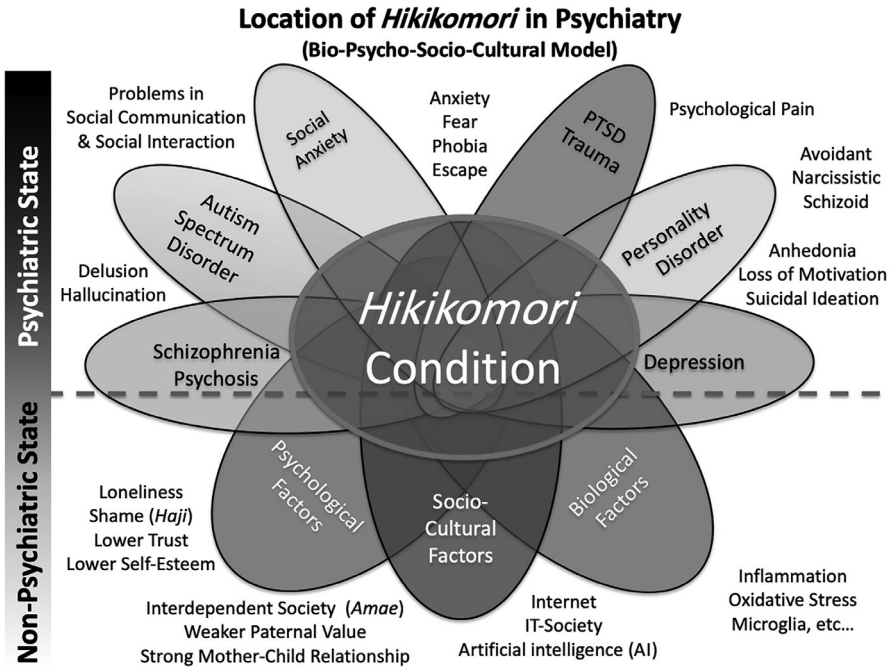
Beyond psychiatric conditions, sociocultural factors are also important to understand *hikikomori*. Japan's "*amae* (accepting overdependent behaviors)" and "shame"-based society, which have strongly permeated the Japanese cultural background, may exist as the underlying psychopathology (Kato *et al*., 2016; Katsuki *et al*., 2019). Generally, Japanese parent-child relationships have long been considered less paternal and characterized by absenting father and an extremely prolonged close connection to mother, which may result in difficulty to become independent (Kato *et al*., 2016). Especially in *hikikomori*, the establishment of fundamental interpersonal skills during the early stages of life seems to be insufficient, which can induce vulnerability to stress during later school/workplace environments and lead to escape from social situations (Kato *et al*., 2016). On the other hand, *hikikomori*-like cases have recently been reported in many other areas/countries of varying sociocultural and economic backgrounds[6]. Thus, *hikikomori* is now considered as having crossed the boundaries of a culture-bound phenomenon to an increasingly prevalent international condition. We hypothesize that major contributing factors behind *hikikomori* is link to a more interconnected world due to globalization and the growing importance of "(Inter)net society" especially as the evolution of communication shifts from the direct to the increasingly indirect and physically isolating (Kato and Kanba, 2016). Based on the above knowledge, we have proposed the current conceptualization model of *hikikomori* as shown in figure 1.

We have recently proposed the novel diagnostic criteria of *hikikomori* (Kato *et al*., 2019; Kato *et al*., 2020). The main points are as follows:

hikikomori is a form of pathological social withdrawal or social isolation whose essential feature is physical isolation in one's home. The person must meet the following criteria: 1) Marked social isolation in one's home, 2) Duration of continuous social isolation for at least 6 months, and 3) Significant functional impairment or distress associated with the social isolation. Individuals with a duration of continuous social withdrawal of at least 3 (but not 6) months should be noted as pre-*hikikomori*. We have

decided to exclude several specifiers (lack of social participation, lack of in-person social interaction, existence of loneliness and a co-occurring psychiatric condition) from the necessary criteria, however we suggest that these specifiers are significantly useful for additional characterization of *hikikomori* especially in the process of assessing the severity and considering the treatment strategy. It is important to remark that even though an individual has a certain psychiatric disorder, this definition can diagnose his/her as *hikikomori*.

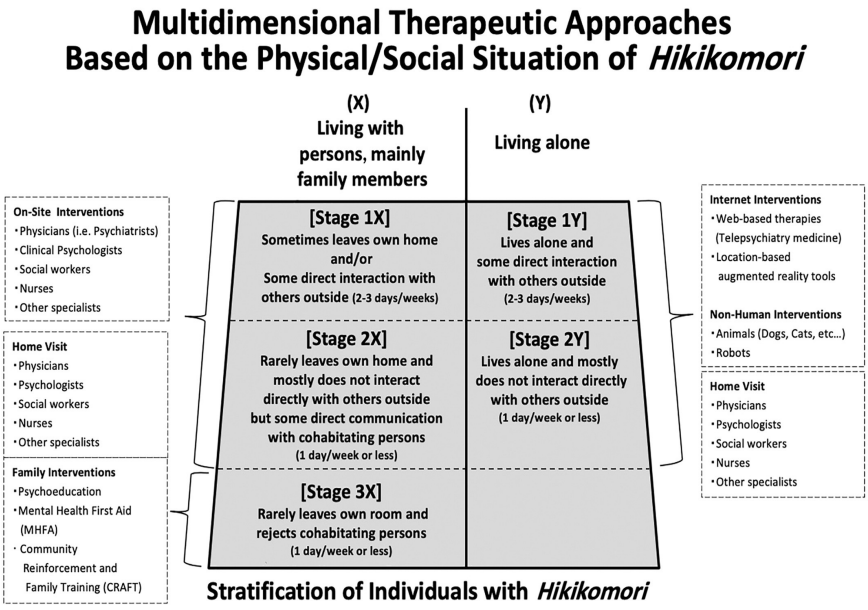
Figure 1 – Current conceptualization model of hikikomori *(Modified from Kato* et al., Psychiatry Clin. Neurosci*., 2019)*



Hikikomori intervention is indeed challenging because of difficulty in bringing *hikikomori* sufferers into outer therapeutic spaces. Now, there are more than 50 MHLW-funded community support centers for *hikikomori* located throughout the prefectures of Japan, providing services such as telephone consultations for family members, the creation of "meeting spaces" for people with *hikikomori* and job placement support. In addition, various private institutions provide support for *hikikomori* sufferers, but there is yet to be an unified evidence-based method for these public/private

interventions. A 4-step intervention is recommended by the 2010 MHLW guideline for *hikikomori*; [Step 1; S1] family support, first contact with the individual and his/her evaluation, [S2] individual support, [S3] training with intermediate-transient group situation (such as group therapy) and [S4] social participation trial (Saito, 2010). As a pioneering project, we have recently established the *hikikomori* clinical research clinic in Kyushu university hospital to develop evidence-based therapeutic approaches with collaboration of public/private *hikikomori* support centers, based on the *hikikomori* stages (figure 2) (Kato *et al*., 2019).

Figure 2 – Stage-based interventional approach for hikikomori *(modified from Kato* et al., Psychiatry Clin. Neurosci*., 2019)*



As a first step, we have developed an evidence-based educational program for parents of individuals with *hikikomori* because in the majority of cases the first consultation is made by parents. Due to a lack of knowledge (about mental illnesses and *hikikomori*) and prejudices against such mental conditions, in many cases family members cannot respond directly to individuals with these ailments, are unable to intervene at all, and tend to turn a blind eye for many years without seeking help. Thus, we believe that education for parents in appropriate knowledge and skills to deal with *hikikomori* sufferers is essential for early intervention. We have applied two

intervention concepts to the program: Mental Health First Aid (MHFA) and Community Reinforcement and Family Training (CRAFT). MHFA is one of the most well-validated educational programs encouraging lay people such as family members, to support close persons suffering from various mental conditions such as depression, anxiety and suicidal behaviors (Hadlaczky *et al*., 2014). CRAFT was originally developed for substance use disorders as a family intervention method based on cognitive behavioral therapy (CBT) (Meyers *et al*., 1998). Sakai and his colleagues modified the original CRAFT program for parents with *hikikomori* sufferers to encourage help-seeking behaviors (Sakai *et al*., 2015). At first, we developed an 5-day educational program for family members of *hikikomori* sufferers based on MHFA and CRAFT with role-play and homework (Kubo *et al*., 2020). As a single-arm trial, 21 parents living with *hikikomori* sufferers participated in our program with five once-a-week sessions (two hours per session) and six monthly follow-ups. Interestingly, perceived skills toward a depressed *hikikomori* case vignette, stigma held by participants, and subscales of two problematic and one adaptive behaviors of *hikikomori* sufferers were improved throughout the sessions and follow-ups. In addition, positive behavioral changes of *hikikomori* sufferers such as improved social participation were reported by participants. Just recently, we have modified the family based 5-day program to 3-day program (180min fortnightly), and examined the effectiveness of the program (Kubo *et al*., 2021). Our pilot trial has indicated that mental health among participants and their *hikikomori* sufferers improved. Furthermore, short-term improvements in perceived skills and actual social participation or utilization of support were observed. We believe that our newly developed program has positive effects on family members in their contact and support of *hikikomori* sufferers. On the other hand, we have proposed that IoT-based technologies and remote robots should be applied to rescue *hikikomori* sufferers (Kumazaki *et al*., 2021; Yoshikawa *et al*., 2021).

As a next step, when individuals with *hikikomori* can directly visit support centers, we propose that not only pharmacotherapy but also psychotherapy are effective toward them (Kato *et al*., 2019). Based on my personal clinical experiences, the combination of CBT and psychodynamic approaches are especially effective toward individuals with *hikikomori* to resolve their difficulties in interpersonal relationships between family members and school/workplace colleagues in real world.

Conclusions

The pandemic of Covid-19 has forced a worldwide lockdown with huge numbers of citizens confined to their homes, often resulting in social isolation which may lead to mental health problems especially *hikikomori* (Kato *et al*., 2020). Covid-19 may be changing global society in fundamental ways, leading to the online revolution as virtual spaces and environment. The pandemic may cause an epidemic of *hikikomori*, and we need to face the forthcoming crisis with the combined efforts of various experts in psychiatry, psychology, sociology, epidemiology, and technology.

Acknowledgement

Our studies shown in this paper is partially supported by the Japan Agency for Medical Research and Development (AMED: JP19dk0307073, JP20dk0307075, JP21wm0425010) and the Japan Society for the Promotion of Science (JSPS: JP19K21591, JP20H01773, JP16H06403).

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