Hikikomori: a world within a room

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Dear Editor,

Hikikomori is a condition characterized by prolonged and extreme social withdrawal lasting at least six months, resulting in substantial functional impairment or distress associated with this isolation.[1]

While the cultural roots of social withdrawal can be observed in Japanese mythology (*e.g.*, the sun goddess Amaterasu, a paramount deity in Shinto, exemplifies voluntary seclusion), the contemporary phenomenon of hikikomori emerged from what was often termed "truancy" or "school refusal" (*futoko*) during the 1970s and 1980s. The term "hikikomori" itself was first introduced by the psychologist Fujiya Tomita in 1985.[2] This term comes from the verb *hiki*, which means "to pull back", and *komoru*, which means "to seclude oneself".[3]

However, hikikomori did not gain widespread recognition within Japanese society until the publication of "*Shakaiteki Hikikomori-Owaranai Shishunki*" (Social Withdrawal: A Never-Ending Adolescence) by the psychiatrist Tamaki Saito in 1998.[2]

Currently, in Asia, an estimated 1% to 2% of adolescents and young adults are affected by hikikomori. This condition is demonstrating a global spread, with Japan reporting millions of cases, establishing hikikomori as a well-recognized pathological condition within the scientific community and a subject of significant global concern; in Italy, there are estimated between 100,000 and 120,000 individuals affected.[4] This condition predominantly impacts males (male-to-female ratio approximately 3:1), with the average duration of social withdrawal typically ranging from one to four years. However, cases exceeding a decade in duration have been documented.[1]

The hikikomori population encompasses individuals across various age groups, including adolescents, young adults, emerging adults, and even older adults, suggesting that untreated or inadequately addressed hikikomori can have long-term consequences and potentially persist throughout an individual's lifespan.[5]

Adolescence and young adulthood, the most involved ages, should represent the years of an individual's social birth, with increasing social integration and placement; however, in the hikikomori phenomenon, the exact opposite occurs, namely a kind of social suicide. This picture can, therefore, also be defined as a social phenomenon.

Although hikikomori has not been formally recognized as a psychiatric diagnosis, the Ministry of Health, Labour and Welfare in Japan, in collaboration with a research group, issued guidelines for the assessment and treatment of hikikomori in 2010.[6]

There has been an ongoing debate regarding the appropriate classification of hikikomori: whether it constitutes a distinct psychiatric disorder or primarily reflects a culturally-bound syndrome. Furthermore, if considered a psychiatric disorder, debate persists regarding its diagnosis in cases where the observed symptoms can be fully attributed to another underlying psychiatric condition.[1]

In the 2022 edition of the DSM-5-TR, hikikomori was included in the "Culture and Psychiatric Diagnosis" section, acknowledging its significance as a global mental health concern. However, it is currently classified solely as a culture-bound syndrome, and a consensus regarding diagnostic criteria remains elusive.[7]

The currently most widely accepted definition of hikikomori encompasses three core elements: i) pronounced social isolation within one's residence, characterized by physical withdrawal, absence of active participation in professional settings, and limited involvement in social relationships; ii) duration of social isolation lasting at least six months; and iii) significant functional impairment or distress associated with this social isolation.[3]

Two typologies of hikikomori have been proposed: i) primary hikikomori, characterized by social withdrawal in the absence of any co-occurring psychiatric disorder, and ii) secondary hikikomori, where social withdrawal is primarily attributable to an underlying psychiatric condition.[7]

Its aetiology is not clear, and several explanations have been proposed. Initially, hikikomori was primarily attributed to sociocultural factors specific to Japan, such as the nation's education system and economic realities. Specifically, the concept of "*emae*", a term describing the interdependent nature of Japanese parent-child relationships, was hypothesized to facilitate the development of hikikomori. However, hikikomori was also linked to specific sociocultural stressors, such as the pressure to fulfill demanding social expectations that some individuals of the younger generation perceived as insurmountable.[4,6] This condition is characterized by the youth's attempt to retreat into an idealized world when perceived societal standards of success are not met.[4]

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Frequently, the precipitating factor is the shattering of the adolescent's expectations, leading to a rapid decline in their condition and the emergence of the disorder.

While rebellion and transgression were once common correlates of adolescent distress, contemporary society presents a more complex picture. The current emphasis on idealized outcomes sets unrealistic expectations that, when not met, can contribute to feelings of personal failure and inadequacy. The prevalence of often fabricated models of success and popularity (exemplified by social media influencers) in contemporary society has led to a heightened emphasis on individualism and competition. To escape the pressures of society, the hikikomori individual constructs a virtual reality, providing an escape from the demands of the real world. Within the confines of their room, a PC and internet connection provide both a sanctuary and a means to forge and sustain virtual relationships, as real-world interactions are perceived as too challenging. These tools also serve as a lifeline to the external world.

Hikikomori frequently co-occurs with various mental health disorders, including anxiety disorders, depression, personality disorders, schizophrenia, and, notably, Internet Gaming Disorder (IGD). The literature extensively documents the intricate relationship between hikikomori and IGD, with researchers highlighting a potential bidirectional influence.[8]

Internet, video games, and social networks do not appear to be the cause of this withdrawal; however, without them, this phenomenon probably would not exist.

The SARS-CoV-2 pandemic has precipitated a significant upheaval in people's daily routines, dismantling traditional social structures and necessitating a reconfiguration of interpersonal relationships. The enforced social distancing during the pandemic may have inadvertently created a situation where the subsequent resumption of social interactions has led to a heightened sense of social anxiety and pressure.

It is noteworthy that individuals with Autism Spectrum Disorder (ASD), characterized by challenges in communication and social interaction, constitute a population at heightened risk of social isolation. However, research investigating the overlap between hikikomori and ASD remains limited. Studies have indicated that hikikomori may co-occur in approximately one-third of individuals diagnosed with ASD.[9]

According to Hayakawa *et al.*, individuals with hikikomori exhibited significantly higher avoidant personality scores in both sexes.[10]

A recent study by Setoyama *et al.,* involving 42 drug-free individuals with hikikomori and a healthy control group, reported significantly elevated levels of long-chain acylcarnitines in the hikikomori cohort. This finding is of particular interest given that acylcarnitines, crucial substrates for mitochondrial beta-oxidation, play a vital role in providing energy to the brain.[11]

Therapeutic interventions for hikikomori typically involve psychotherapeutic approaches. However, a multidisciplinary treatment plan, implemented by a team comprising psychiatrists, psychologists, nurses, and occupational therapists, may yield more favorable outcomes.[1]

Given that individuals with hikikomori primarily withdraw within their homes, treatment strategies must prioritize family involvement as a crucial intermediary between the individual and society. Home visits are considered essential for accurate assessment, evaluation, and the initiation of therapeutic interventions. While psychoanalysis and psychodynamic therapies, both individual and group-based, have demonstrated efficacy within a comprehensive treatment framework, other therapeutic modalities, including animal-assisted therapy, interventions utilizing robot pets and communication-assisting robots, physical activity programs, and even video games, have been explored as potential supplementary approaches.[2] Pharmacological interventions, such as the use of antipsychotic or antidepressant medications, are typically reserved for cases of severe secondary hikikomori.[4]

As the phenomenon has spread, there has been a corresponding increase in interest in hikikomori in recent years. While the pandemic has had a negative global impact, Wong *et al.* suggest that the lockdown may have inadvertently provided a unique opportunity for the general population to gain empathy for this condition by experiencing similar feelings of uncertainty, social anxiety, and isolation.

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