RECOGNIZING HIKIKOMORI AS A CLINICAL TERM IN PSYCHIATRY

MOVING BEYOND A CULTURAL IDIOM OF DISTRESS

Thomas Nguyen
Hikikomori refers to a state of prolonged social withdrawal for 6 months or longer in adolescents and young adults. Marked by social isolation in one’s home, it may result in functional impairment, psychological distress as well as a lack of social participation and attendance at school and or work.[1,2] Made prominent in the late 1990s by Japanese psychiatrist, Tamaki Saito, the term Hikikomori is a portmanteau of the words ‘hiku’ (to pull back) and ‘komoru’ (to seclude oneself).[1] In 2010, Koyama et al. estimated that 1.2% of Japanese people were of Hikikomori status using a community-based survey.[3] Though once thought to be a phenomenon only affecting those living in Japan, reports have identified cases in other countries such as Oman and Spain and a telephone survey in Hong Kong identified a prevalence rate of 1.9%. [4–6]

Whilst it has been established that individuals with Hikikomori have high incidence levels of psychiatric comorbidity, which may be brought on or exacerbated by their state of prolonged social withdrawal, its place within current psychiatric nosology remains ambiguous.[7] This editorial will first describe the status of cultural syndromes (formerly culture-bound syndromes) in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Using this framework, it will discuss why Hikikomori has been labelled as a cultural idiom of distress and warrant its case for inclusion in future classifications of psychiatric illnesses through highlighting the relevance of recent research developments.

The classification of cultural concepts of distress in DSM–5

Formerly referred to as “culture-bound syndromes” in DSM-IV, the phrase was revised in DSM-5 to “cultural concepts of distress” to remove the exaggeration of the local confinement and exoticism inferred through its naming.[8] The phrase “cultural concepts of distress” is defined in DSM-5 as the “ways that cultural groups experience, understand and communicate suffering, behavioral problems, or troubling thoughts and emotions.”[9] These cultural concepts of distress are further subclassified into “cultural syndromes”, “cultural idioms of distress” and “cultural explanations”:[9]

“Cultural syndromes” are locally recognized patterns of experience, symptoms and attributions that co-occur amongst those in specific cultural groups, communities or contexts.[9] Whilst “cultural idioms of distress” do not include symptoms or syndromes, they refer specifically to collective ways of communicating and experiencing personal or social concerns.[9] Lastly, “cultural explanations” refers to an explanatory model that integrates a “culturally recognized meaning or etiology for symptoms, illness, or distress.”[9] Whilst DSM-IV included 25 cultural-bound syndromes, the DSM-5 reclassification into cultural concepts of distress narrowed its predecessor’s list down to 9 cultural syndromes. Interestingly, taijin kyofusho, being the fear of offending others through either perceived physical defect or awkward social interaction, is a cultural syndrome that prevails mainly in Japanese society.[9] Whilst taijin kyofusho affects a similar age group to Hikikomori and also has a significant psychiatric comorbidity, the understanding of its epidemiology is poor, despite its firmer establishment in psychiatric nosology.[10,11]

Responses to arguments against recognizing Hikikomori as a clinical term in psychiatry

Due to its non-inclusion as a cultural syndrome in DSM-5, Hikikomori is widely regarded as a cultural idiom of distress. Sociologists view Hikikomori as an anomic response to post-industrialist societal changes such as the casualization and instability within the labour force as well as the rise of indirect communication via the internet.[12] This view suggests that the idiomatic response to experiencing these stressful life events is communicated by what Tajan calls a “passive resistance” which is manifested by remaining at home and withdrawing from society.[13] However, these patterns of experience which can lead to functional impairment and a clinical course of symptomatic psychological distress such as passive aggression and a loss of motivation are all factors that are also synonymous with a cultural syndrome.[1] Whilst it is now known that cases of Hikikomori exist outside Japan, cases of other cultural syndromes such as Dhat syndrome and taijin kyofusho have also been identified outside their respective cultural origins.

Whilst it is now known that cases of Hikikomori exist outside Japan, cases of other cultural syndromes such as Dhat syndrome and taijin kyofusho have also been identified outside their respective cultural origins.

Volume 13  Issue 2               October 2019

5
a person may verbalize their feelings of depression to communicate the experience of personal sadness.[9] Recently, Kato et al. suggested that Hikikomori should be subtyped or given its own specifier code in a future revision of psychiatric nosology.[1] In contrast to classifying Hikikomori as a cultural syndrome, subtyping or providing a specifier code would recognize its transcultural epidemiology and its underlying psychopathology as a reaction to the changing values of modern day society.

As the high psychiatric comorbidity of individuals with Hikikomori is well known, a key argument against its recognition as a clinical term comes from the view that the prolonged social withdrawal is a secondary effect of having a prior mental illness.[2] Studies have reported psychiatric comorbidity with social anxiety disorder, major depression and avoidance personality disorder and suggest overlapping symptomatology with autism spectrum disorder as well as the prodromal state of schizophrenia.[15,16]

However, in a 2010 community-based survey, Koyama et al. found that 16% of respondents developed a psychiatric disorder (namely generalized anxiety disorder, hypomanic episode, alcohol abuse or dependence) following the onset of Hikikomori.[3] Furthermore, the majority of individuals identified as Hikikomori in the 2015 Hong Kong telephone survey conducted by Wong et al. were also found to be primary Hikikomori (without previous psychiatric comorbidity) as opposed to secondary Hikikomori (psychiatric illness leading to social withdrawal).[6] Whilst these studies alone aren’t enough to refute this argument entirely, it paves the way for further research to delineate between primary and secondary Hikikomori in order to better understand the bidirectionality of these psychiatric comorbidities.

Tajan, in his 2015 review, asserts that the lack of definitional consensus for Hikikomori and the methodological inaccuracies in studies looking at the existence of Hikikomori outside Japan were reasons for its non-inclusion in DSM-5.[14] He refers specifically to two studies with one asking psychiatrists outside of Japan whether a clinical vignette of Hikikomori existed in their own country of practice.[14,17] He argues that the clinical vignettes used only represented a minority of Hikikomori cases, rendering the suggestion that Hikikomori is perceived to occur worldwide by Kato et al. as inconclusive.[14,17] Since the publication of his review, the Hikikomori Round Table and Regional Symposium was organized in late 2017, bringing together Hikikomori experts across East Asia.[2] The round table made constructive progress in forming a consensus definition for Hikikomori and addressing how heterogeneous, cross-cultural presentations of Hikikomori may be treated in the context of differing mental health service structures.[2] The discussion recommended adopting the Hikikomori Questionnaire (HQ-25) as a screening tool that offers promising psychometric properties.[2,18] Recently, Kato et al. have offered a revised definition of Hikikomori and a list of criteria that reflects the growing influence of the internet and a more realistic picture of the time course in psychological distress following social withdrawal.[1] With these advancements in the area of Hikikomori research, we are closer to ascertaining a universal definition for Hikikomori, backed up by a clearer cultural and biopsychosocial understanding of its psychopathology and thus its place in psychiatric nosology.

**Conclusion**

Precipitated by a range of socio-cultural, psychological and behavioural factors, Hikikomori refers to social withdrawal for a period of over 6 months. Emerging research in the area has revealed how these influences underlie its psychopathology and round table discussions have elucidated a better definitional basis for Hikikomori. Whilst more research must be undertaken to better understand its subtypes, cross-cultural epidemiology, bidirectionality of psychiatric comorbidities and effective, evidence-based treatments, Hikikomori should begin to be seen as more than just a cultural idiom of distress. Its clear syndromic features warrant further discussion regarding its recognition as a clinical term in psychiatry, particularly in context of its alarming prevalence levels in a growingly individualist and technology-reliant society.

Thomas is currently a second year medical student at Western Sydney University. His research interests lie at the intersection of psychiatry and minority group healthcare. He is currently collaborating on research within the areas of transgender medicine and mental health literacy.

**Acknowledgements**

None

**Conflicts of interest**

None declared

**Correspondence**

thomas.nguyen@amssa.org.au

**Image**


**References**

Perspectives, Challenges, and Opportunities for Social Health Agencies. Front Psychiatry. 2019;10(512).


