Hikikomori: a hidden mental health need following the COVID-19 pandemic

As lockdown measures ease in several countries, returning to a life with dramatically altered economic and social circumstances will pose significant mental health challenges[1]. Early population prevalence data from China suggest that the COVID-19 pandemic may induce a fivefold increase in problems such as anxiety and depression[2]. However, these estimates will miss people who remain socially withdrawn but undetected by services because a defining feature of their condition is the desire to become invisible from society. We already know something of the phenomenology and social costs of this problem through studies of the syndrome known as hikikomori[3,4].

Hikikomori is a Japanese term, comprised of the verb *hiki*, "to withdraw", and *komori*, which means "to be inside". It was first introduced in the 1990s to describe young people who displayed extreme and long-term social withdrawal and an eschewing of social conventions around obtaining an education and pursuing a career[3]. It is currently viewed as a sociocultural mental health phenomenon, rather than a typical mental illness, but population prevalence data indicate that it is a significant public health issue.

The Japanese Cabinet Office estimates the presence of more than 1.1 million people with hikikomori in Japan, and there is now increasing recognition of the hikikomori phenotype in a variety of other countries and cultures[4,5]. With this increased international recognition, there has been debate about the relationship of hikikomori to autism spectrum disorders, mood disorders, social anxiety and agoraphobia[4]. The core diagnostic feature, however, is that the affected person has physically isolated himself/herself at home for at least 6 months, cut off from meaningful social relationships, with significant functional impairment and distress[4].

While many people will gladly emerge from enforced lockdown, those at risk of hikikomori will choose not to re-engage with their pre-COVID-19 life. Data from across cultures show that the typical onset of hikikomori is in late adolescence and early adulthood, often following an experience of shame or socio-culturally relevant defeat events (e.g., failing key academic examinations, not achieving a cherished job role). Hikikomori people avoid re-traumatization by choosing to opt out of the normative pathway set out for them by society[3-5].

In the wake of the COVID-19 pandemic, many young people will confront dramatically altered goals and aspirations, and they will be highly vulnerable to impacts arising from precarious employment and economic vulnerability. Many Japanese Hikikomori cases are seen as a product of the economic downturns of the 1990s, that severely restricted employment opportunities. The widespread economic and social consequences of COVID-19 are likely to far exceed any shock to the prospects of young people seen for generations.

As we write, the UK has been in the state of lockdown for over three months. In non-pandemic circumstances, social withdrawal for three months would equate to the pre-hikikomori stage, halfway to the minimum of six months of extreme social isolation proposed for a full diagnosis. This phase is sometimes recalled by those that go on to develop hikikomori as a period of solace, in which they were no longer exposed to the trauma that triggered the social withdrawal.

Not responding to the needs of this group will be hugely costly. Transnational studies of hikikomori show that without intervention the withdrawal period may last for years and in some cases the entire adult life. Japan now has had three decades of tracking the epidemiological trajectory of hikikomori, with many of those affected starting to outlive their parents. As lockdown measures are gradually lifted, we enter a critical period for identifying and preventing those who are vulnerable to following the classical hikikomori trajectory.

Because people with milder forms of hikikomori may leave home for non-social reasons two or three times a week[4], the COVID-19 social distancing rules may allow them to "hide in plain sight". This complicates the disentangling of behavioural adaptation to lockdown from

attempts to become invisible from society as a way of minimizing further mental trauma. Aspiring to social death and avoiding physical death is a core feature of people with hikikomori – they want society to forget them, but they cannot forget society[5]. Many of them will continue to passively observe the world via online gaming and social media and, as long as parents act to ensure that their child's basic living needs are met, there will be few natural triggers for help-seeking. External therapeutic attention typically takes years, and is most commonly triggered by a parent following a crisis. Addressing this type of largely invisible problem will require adapted help-seeking pathways.

This is now a global problem. Hikikomori has been described across diverse cultures and levels of per capita income[3,4,6]. As with so many problems of adaptive functioning, people at elevated risk will include those with pre-existing mental health problems, people affected by adverse childhood experiences[7], plus those whose life-path has been severely derailed by the pandemic. There is a clear and time-sensitive need for a proactive and multidisciplinary effort to respond to the mental health consequences of the COVID-19 pandemic[8]. But, because of the invisible nature of hikikomori, standard pathways to care will be unlikely to operate. Instead, coordinated multi-agency collaboration will be needed to identify those at risk of continuing to "shelter in place" instead of re-engaging with pre-pandemic roles.

Vigilance for school non-attendance or a failure to re-join work or training may signal a need for outreach to check if there is problematic social withdrawal. The increased use of digital options for accessing health and social care services should be leveraged to provide new ways of finding and supporting new hikikomori people before they become too entrenched. Experience in Japan suggests that the creation of digital peer networking may significantly improve engagement with sources of help and recovery.

Virtual reality and digitally-delivered psychological treatments may also be particularly suitable for this group, whose preferred medium for accessing the world is via the Internet. Finally, public mental health campaigns via digital means may prove particularly effective for reaching out to potential hikikomori people and their families to capitalize on the known interest in online activities of this group. Investing in the detection and support of new people with hikikomori should be added to the growing list of mental health research and treatment priorities in the post-COVID-19 era.

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