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HIKIKOMORI, IS IT A CULTURE-REACTIVE OR CULTURE-BOUND SYNDROME? NIDOTHERAPY AND A CLINICAL VIGNETTE FROM OMAN

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ABSTRACT

Hikikomori, a form of acute social withdrawal, is becoming a silent epidemic in Japan. As it has not been reported from other parts of the world, hikikomori fulfills the criteria for "a culture-bound syndrome." We report a case from Oman, in the southern part of Arabia, with all the essential features of hikikomori. We speculate that the social environment of Japanese and Omani society could reinforce behavior akin to hikikomori although this condition may also transcend geography and ethnicity.

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Key Words: hikikomori, social withdrawal, culture-reactive syndrome, culture-bound syndrome

INTRODUCTION

A predisposition toward fear in social situations, when coupled with shyness, can lead to behavioral inhibition [1]. Because of this, these individuals have decreased

social interaction and their avoidant behavior and anti-social nature lead to a diminished quality of life. Worldwide studies have shown that different groups vary in their level of social interaction [2]. Such differences in temperament across different ethnic groups indicate that sociocultural factors may play a role in shaping antisocial and avoidant behavior. Child rearing practices and other methods of socialization such as education and religion have been suggested as possible factors [3]. In Japan, Hikikomori is a recently described condition characterized by antisocial and avoidant functioning leading to school non-attendance or withdrawal from society [4, 5]. Community surveys have suggested it as a silent epidemic and it has become the subject of media coverage and a recent novel in which the leading figure suffers from Hikikomori [6]. It is considered to be a culture bound trait unique to Japan and linked to the hermetic nature of traditional Japanese society and its value placed on the nobility of solitude [4]. We describe a clinical vignette from Oman that is characterized by social isolation and a reclusive lifestyle. Evaluation did not reveal the presence of any pervasive and persistent distress. To our knowledge, this is the first case of hikikomori reported outside Japan.

CLINICAL PRESENTATION

SD is a 24-year-old Omani who was "coerced" by a family member to seek consultation at the Department of Behavioral Medicine, Sultan Qaboos University Hospital, Muscat, Oman. A relative said that SD suffered from "prolonged reclusiveness and loneliness" for the previous five years that resulted in him having minimal contact with people including his family. Family members noted that he was resistant to doing work that was arranged by the family. Similarly, he did not want to go to vocational training. Inquiry into his personal life revealed normal developmental milestones. He was described as being shy since childhood. There was no history of psychiatric or neurological disorders in the family.

On a subsequent visit, when rapport was established and the interview was conducted without accompanying family members, SD was more proactive. He denied symptoms indicative of psychological disorder, adverse life experience or presence of substance abuse. His complaint was simply a preference to be alone. He had stopped socializing and mingling with other people after being bullied by other students from his class. In one incident, a teacher abruptly asked him to give a comment on the topic under discussion in the classroom. He stammered when attempting to reply and the subsequent cajoling from his peers caused him to become even more reclusive. He kept these incidents to himself. Although he had a dependent relationship with his mother, he was worried that his domineering father would despise him for "not fighting back" or for being overly "sensitive

like a woman." Despite his dislike of school, he nevertheless completed secondary education with an average performance.

SD was unsuccessful in finding a job and gradually drifted further into reclusiveness. He described himself as having no desire for a close bond with his nuclear family, relatives from his large extended family, or other people in general. He preferred to spend his time in his own room and to be left alone undisturbed. The father often knocked on his door to scold him for being lazy and condemn him for not praying or doing something meaningful for himself. He told us that he preferred staying in the dark. He slept during the day time and stayed awake at night watching satellite television or playing video games. Food was left at his door and he returned the trays when finished. When family members were away during working hours or at sleep at night, he was noted to tiptoe into the kitchen to replenish his supplies for his room.

During our meetings with him, SD complained that his family had taken him to various hospitals in Oman and nearby countries to get him "treated," which he strongly disliked. He had been diagnosed as having "depression" and "negative type schizophrenia." But information on how such diagnoses were reached was patchy. Various psychotropic medications were prescribed but he never took them. In accordance with the local explanatory model of illness in Oman [7], his behavior was thought to be instigated by spirit possession, so the family also consulted various religious healers but to no avail. At one point, a local shaman was consulted with no benefit. On the whole, both traditional and biomedical interventions made little impact on his interpersonal functioning that deviated markedly from the expectations of his family.

Except for his reclusiveness and antisocial behavior, his psychiatric and cognitive assessment elicited no abnormalities (*Mini-Mental State* Examination [8] and non-verbal test of intellectual functioning, *Raven's Standard Progressive Matrices* [9]). Neuropsychological testing that assessed his temporal organization of behavior and cognitive rigidity, such as the Modified *Wisconsin Card Sorting Task* and Verbal Fluency (*Controlled Oral Word Association Test*) [10], were all normal for his age and education. No neurological abnormalities were found.

We decided to use psychological measures to reduce his reclusiveness. However, he was resistant. His family sought advice on how they could do something in the house to help SD. The treating team invited the family for a session of nidotherapy [11]. Nidotherapy aims to modify the environment to minimize its impact on an individual's functioning. Rather than adopting a hostile attitude toward him, the family was encouraged to be accommodating and reduce their caustic tone whenever they encountered him in the house. The father stopped knocking on his door to wake him up. When family members reduced their criticisms of him, he began to selectively socialize with some of them. Occasionally he agreed to venture with a family member out for a

drive, picnic, or dining out. In the last year, when a job vacancy opened that entailed only evening shifts, he agreed to work. His evening shift had minimal interaction with other people. On our last contact with the family, seven years after SD had developed reclusive behavior and two years after being brought in for psychiatric consultation, he remains well and now has been given a full time job at his workplace.

DISCUSSION

The clinical vignette above describes a reclusive young man with insidious onset of Hikikomori syndrome, possibly triggered by some events in his schooling and amplified by his shyness. No protracted medical or formal psychiatric illness was found. He was noted to sleep all day, wake up in the evening, and stay up all night watching satellite television or playing video games. There was no indication that this was due to a delayed circadian rhythm disorder, though this was not formally explored [12]. Since the patient himself did not wish to have any treatment, as he did not see himself as having a problem, it was decided to modify his environment using Nidotherapy. Family members were advised on how to accommodate him using this approach. According to Tyler [11], nidotherapy tries to minimize the problems the targeted "misfit" creates for the outside world or vice versa. In contrast to traditional psychotherapeutic principle, nidotherapy requires the environment to adjust itself to the patient since he or she is intransigent to treatment or unable to change. It is worthwhile to speculate on why nidotherapy reduced social isolation, in this case from Oman. Antisocial behavior is characterized by fear of social-evaluation, so when family members ceased to put conditions on his behavior, he became less antagonist and more social, which, in turn, reduced his distress and suffering and improved functioning. When the family members adopted a stance of accommodating his reclusive interpersonal functioning, his distress that made him resort to his reclusive lifestyle gradually abated.

Are there socio or cultural factors that could have further facilitated recovery of the present case? In a collective-orientated cultural environment as in Oman, the social life of an individual is contingent upon his/her relationship with the family or tribe [13]. Individuals in such a society are forced to be conformist and may detach from their "authentic self" and thus submerge their own wishes in order to conform to social standards. Environment being central for emotional and social support, one implication of such a cultural pattern is that the individual's distress and stress would be reduced if the environment changes rather than the individual. This is particularly true in collective-oriented societies where afflictions are viewed as a misfortune directed towards the whole community rather than the sufferer alone. Jilek and Jilek-Aall have suggested that the chronic course of transient psychoses can be averted when the community responds to the initial psychotic episode by sympathetic acceptance, benevolently protective

attention and assistance in a culturally prescribed way [14]. Similarly, Koenig has suggested that the psychotherapeutic intervention is likely to be more effective when it heightens hope and faith and when it capitalizes on the sufferer's reliance on his or her social surroundings [15].

Does this case fit any of the existing criteria for a psychiatric disorder? In the Diagnostic and Statistical Manual of Mental Disorders (DSM) [16], personality disorders are depicted as enduring patterns of inner experiences and behaviors that deviate markedly from the expectations of an individual's culture. SD's reclusive behavior appears pervasive and constitutes culturally devalued conduct. In DSM, the tendency for detachment in the present case would suggest a diagnosis of schizoid personality disorder [17]. Other possible diagnoses could include anxiety disorder and their variants and chronic or simple schizophrenia. To our knowledge, this is the first case outside Japan of antisocial functioning and avoidant behavior that meets the criteria for hikikomori reported from Japan. Both hikikomori cases from Japan and this case from Oman appear to have an enmeshed family background with a strong maternal relationship [5]. Evidence from Japan suggests that psychosocial correlates of hikikomori include aversive childhood experiences. The case presented here from Oman was related to the patient being bullied, cajoled by his peer group, and his inadequate academic performance. The majority of those afflicted with hikikomori are male and the eldest child in the home, as in the present case from Oman. Similarly, there is a tendency to prefer darkness, with a reversal of the sleep/wake schedules. This issue may need to be explored further as hikikomori could be mediated by a disturbed circadian rhythm as has been reported elsewhere [18]. Being egosyntonic, antagonistic, and resistant to psychotherapeutic intervention, persons with hikikomori will not seek medical care and are more likely to be overlooked in clinical settings [19].

Illness or distress are often experienced in a social and cultural context. It is therefore worthwhile to speculate on cultural variables that are common in both Oman and Japan that could influence the expression of antisocial behavior such as hikikomori. Although it is often thought that cultural patterns and beliefs protect individuals against various adjustment difficulties, such protection is apparently eroding with the rising tide of acculturation and globalization. In the words of Watts, the "generation that has been made vulnerable by affluence and technological advances" [19, p. 1131]. As a result of this new climate, both Japanese and Omanis are likely to experience what Emile Durkheim called a breakdown of social cohesion [20]. One obvious consequence of such changes, according to the Durkheimian model, is the creation of social drift, alienation, and the proliferation of social misfits. However, another possible cultural explanation involves the Japanese and Omani ideas of shame, language complexity, and moral codes. In both Japan and Oman there is a tendency to regard shame as an important emotional experience [21, 22]. Although it is an important and adaptive from a cultural perspective, the social prescription of shame could push

some individuals' behavior toward social phobia or, for that matter, hikikomori. In those societies where shaming is an integral part of socialization, it appears that something akin to social phobia can occur as shame generates concealment out of the fear of rendering the self unacceptable. Okano [23], writing on shame and guilt, expressed the view that shame could lead to avoidance of social intercourse while guilt was likely to invite confession and forgiveness.

Secondly, various factors, including language and social ideals, reinforce how individuals should conduct themselves in society. Although language facilitates the expression of emotions, the presence of rich metaphors and abstractions may promote a feeling that one is been evaluated by others. This is consistent with the view that ambiguity in language, as in Arabic and Japanese, often fosters the fear of being misunderstood during social discourse [23, 24]. Some studies have suggested a strong association between those languages that have an inherent tendency for ambiguity and a preoccupation with shame and fear [25].

Finally, the more moral or ethical codes and customs a society carries, the more likely it is for its people to succumb to fear of being embarrassed, scrutinized, judged, or humiliated in public. Excessive introspection of the self might result in a preoccupation with self-presentation in social situation that, in turn, could lead to phobic avoidance of interpersonal relationships. As moral and ethical standards are insidiously socialized, any individual who falls short of the norm is likely to feel a sense of inadequacy and fear of evaluation by others, possibly leading to antisocial and avoidant behavior.

Considering that culture influences maladjustment, does hikikomori constitute a culture-bound syndrome? According to Kiev [26], the "hardware" or pathology of diseases remains relatively constant throughout the world, irrespective of the cultural context in which they appear. Reactions to illness (such as the unique manifestation of hikikomori) is a by-product of socio-cultural factors. On this basis, one could classify various reactions to stress as "culture-bound disorders" within the diagnostic categories of the biomedical model. For example, hikikomori would be similar to social phobia or personality disorder. Because of the existence of hikikomori in Japan and Oman and its association to prevailing social-cultural factors, it is possible hikikomori constitutes a form of distress that transcends culture and ethnic factors.

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