Commentary on "One month version of Hikikomori Questionnaire-25 (HQ-25M): Development and initial validation"

Simone Amendola, PhD (Orcid ID: 0000-0002-1950-4351)

Department of Applied Psychology, Zurich University of Applied Sciences, Zurich, Switzerland

amen@zhaw.ch

Rita Cerutti, PsyD

Department of Dynamic and Clinical Psychology, and Health Studies, Sapienza – University of Rome, Rome, Italy

rita.cerutti@uniroma1.it

Correspondence to:

Dr. Simone Amendola

Zurich University of Applied Sciences

Department of Applied Psychology

Pfingstweidstrasse 96

CH-8005 Zurich

Switzerland

Email: amen@zhaw.ch

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Dear Editor,

We would like to comment on the recent Letter about the One-month version of the Hikikomori Questionnaire-25 (HQ-25M) (Kato et al., 2022). The authors proposed the HQ-25M to examine symptoms of hikikomori during *the last month* instead of *the last six months*, like the original Hikikomori Questionnaire (HQ-25) (Teo et al., 2018). This is the only difference between the two instruments (the content of the items is unchanged). The authors advocated for the use of the HQ-25M to "*evaluate social withdrawal at an earlier stage […] to help detect and potentially prevent hikikomori*" (Kato et al., 2022) (p.1). Accordingly, the added value of the instrument over the HQ-25 should be its ability to timely identify those participants who would develop hikikomori (i.e., predictive validity).

The authors examined the psychometric properties of the HQ-25M showing that a confirmatory factor analysis provided evidence for a good fit of the three-factor model to the data, despite item factor loadings and latent correlations were not reported. Moderate associations between HQ-25M scores, duration of social withdrawal, and Kessler Psychological Distress Scale scores were found. Further, the authors explored the presence of social withdrawal by asking participants "*how often they went out on a daily basis, and if they answered "usually stay at home", they were considered to be in "social withdrawal".*" (Kato et al., 2022) (Supporting information, p.2). Participants with social withdrawal for six months or more were included in the hikikomori group; those with social withdrawal duration between "less than one month" and "less than six months" in the pre-hikikomori group; and those with no social withdrawal in the non-hikikomori group. The hikikomori group differed from the others on both HQ-25M total score and sub-scores. On the contrary, the pre-hikikomori group did not differ from the group of participants with no social withdrawal except for the isolation sub-score. The authors concluded that their study "*provides preliminarily validation of the HQ-25M as a tool that may support early detection of hikikomori*" (Kato et al., 2022) (p.2).

The study, co-authored by some leading experts in the field of hikikomori, addressed a relevant research objective, that is, using the HQ-25 for the evaluation of *"social withdrawal at an earlier stage […] to help detect and potentially prevent hikikomori*" or "*early detection of hikikomori*" (Kato et al., 2022) (p.1). We believe that scientific knowledge could benefit from increased efforts to examine the ability of the hikikomori questionnaires in discriminating hikikomori from other psychopathologies (e.g., adjustment, depression, anxiety, psychotic, and personality disorders) (Kato et al., 2019; Teo et al., 2020) and the unique impact of hikikomori symptoms on functioning. Such future research may advance the debate on hikikomori as a potential distinct psychopathological condition from those already included in the main diagnostic manuals of mental disorders. However, brief periods of social withdrawal could be associated with different psychosocial conditions and not develop in hikikomori. Crucially, the (predictive) validity of the HQ-25M needs by definition to be tested by prospective studies.

This correspondence aims to comment on some aspects and limitations of the original study. The sample involved consisted of unemployed Japanese males that filled in the questionnaires in March 2022. It is interesting to speculate whether unemployed participants may have been reasonably more prone to report "*usually* staying at home" without this corresponding to a hikikomori condition or being associated with and/or causing functional impairment or dysfunction (Wakefield et al., 2005). Additionally, could the spread of COVID-19 infections and national restrictive measures, together with the hikikomori definition applied, have influenced the results (e.g., 72.5% of participants with hikikomori, participants' responses on items)?

Contrary to what might have been expected, the pre-hikikomori group did not differ from that of participants with no social withdrawal on HQ-25M scores except for isolation. Considering the question used to examine social withdrawal, group difference on isolation was a predictable result. In light of the study objective, it could have been of interest to analyse separately HQ-25M scores of participants with social withdrawal lasting for less than three months (e.g., brief social withdrawal group).

To note, the study tested the psychometric properties of the HQ-25M in exploring symptoms of hikikomori during the previous month in participants with social withdrawal longer than a month rather than examining the validity of the instrument in *predicting* at an earlier stage of social withdrawal the subsequent emergence of hikikomori.

In summary, further testing of the HQ-25M is needed, especially to support its predictive validity for the early identification of hikikomori. Additional research is required to clarify the added value of the HQ-25M compared to the HQ-25 in helping detect and prevent hikikomori.

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Conflict of Interest

The authors co-authored the Italian versions of the 25-item Hikikomori Questionnaire. The authors co-authored three publications with one of the authors of the HQ-25M.

Ethics approval statement

Not applicable.

Author contributions

SA drafted the first version of the manuscript. All authors commented on and contributed to the final version of the manuscript. All authors read and approved the final version.

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