Loneliness in modern world: A case study of Hikikomori from Turkey

Modern dünyadaki yalnızlık: Türkiye'den bir Hikikomori vakası

Meryem Kasak[1], Cafer Doğan Hacıosmanoglu[2], Selma Tural Hesapcioglu[3], Mehmet Fatih Ceylan[4]

[1]M.D.,Department of Child and Adolescent Psychiatry, Ankara City Hospital, Ankara, Turkey https://orcid.org/0000-0003-0176-868X
[2]M.D., [3]Assoc.Prof., [4]Prof.,Department of Child and Adolescent Psychiatry, Ankara Yildirim Beyazit University, Faculty of Medicine, Ankara, Turkey https://orcid.org/0000-0002-4364-9542-https://orcid.org/0000-0002-4816-0228-https://orcid.org/0000-0002-8391-8508

SUMMARY

Hikikomori is a psychopathological and social syndrome characterized by a complete withdrawal from society for at least six months, lack of interest or willingness to attend school/work, and lack of interest in personal relationships. The Hikikomori phenomenon has often been considered a condition specific to the Japanese context, namely, cultural-bound syndrome. Recently, there are also been very few case reports of HS from other countries. In this case, a 15-year-old male adolescent, who has not been in school for about a year, does not leave his room except for physical needs, and cuts off social communication with everyone, including his family, is presented. As a result of clinical examination and applied scales, the patient's social isolation was associated with Hikikomori syndrome, and then the patient underwent psychosocial training to prevent social isolation. Hikikomori syndrome harms individuals' mental health, social participation, and educational and workforce stability, making it an important global issue. This case is the first report of hikikomori in Turkey and it is important to support hikikomori as an intercultural syndrome.

Keywords: Hikikomori, social isolation, social withdrawal, culture-bound syndrome, adolescent

ÖZET

Hikikomori, toplumdan en az altı ay boyunca tamamen geri çekilme, okula/işe gitme konusunda ilgisizlik veya isteksizlik ve kişisel ilişkilere ilgisizlik ile karakterize psikopatolojik ve sosyal bir sendromdur. Hikikomori fenomeni, genellikle Japon bağlamına özgü, yani kültere bağlı bir sendrom olarak kabul edilir. Son zamanlarda, Hikikomori'nin diğer ülkelerden de olgu bildirimleri bulunmaktadır. Bu yazıda yaklaşık 1 yıldır okula gitmeyen, fiziksel ihtiyaçları dışında odasından çıkmayan ve ailesi dahil herkesle sosyal iletişimini kesen 15 yaşındaki bir erkek ergen sunulmaktadır. Yapılan klinik muayene ve uygulanan ölçekler sonucunda hastanın sosyal izolasyonu hikikomori sendromu ile ilişkili bulunmuştur. Hasta, sosyal izolasyonun önlenmesi için psikososyal eğitim almıştır. Hikikomori sendromunun sadece ruh sağlığı ve bireyin sosyal katılımı üzerinde değil, aynı zamanda eğitim ve işgücü istikrarı üzerinde de olumsuz bir etkisi vardır, bu da onu önemli bir küresel sorun haline getirmektedir. Bu olgu, hikikomori'nin Türkiye'deki ilk bildirimidir ve hikikomori'nin kültürlerarası bir sendrom olarak desteklenmesi açısından önemlidir.

Anahtar Kelimeler: Hikikomori, sosyal izolasyon, sosyal geri çekilme, kültüre bağlı sendrom, ergen

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INTRODUCTION

Adolescence is a critical transition period when many developmental changes first appear. Although social isolation and social withdrawal are not exceptional, they can sometimes be problematic. When technological advances interfere with our accustomed interpersonal interaction patterns, it is very challenging to distinguish what is developmentally normal from abnormal. Young people who hide in their rooms and refuse to attend school and their workplaces are becoming increasingly concerned, especially in developing countries (1). An extreme form of the refutation of natural social interactions with others is entitled to Hikikomori Syndrome (HS) (2). HS is a psychosocial and familial pathological picture first defined in Japan and is marked by long-term social withdrawal (3).

In the Japanese language, the "hikikomori" term means "withdrawal and being prisoner". (3). The disorder mainly presents with the cessation of communication with the outside world, hiding and locking oneself in his/her room in their parents' house, using the internet for prolonged periods, and leaving their rooms solely for obligatory bodily needs for months and years. HS usually emerges in adolescent males with an estimated 1-2% prevalence in the Japanese population (4). HS typically begins around age 13 (5) and is common between the ages of 15 and 39 (6). The etiology of HS consists of various complex biopsychosocial factors such as introverted personality, temperamental shyness, avoidant or ambivalent attachment pattern, peer bullying, traumatic childhood experiences, rejection or overprotection by parents (7,8). In addition, social and cultural factors such as ''the fragmentation of social structures in the late modern period'', individualism, high youth unemployment rates, traditional value crisis, and the development of new virtual communication technologies may influence in the emergence of HS (9). These socio-cultural changes can cause a situation in the form of disengagement or dissociation from society as a reaction to the negative emotions experienced by individuals with a predisposition. At the last end of the spectrum of social disengagement is HS as social withdrawal (10).

After the HS was defined in Japan, two important questions arose. First, is it seen outside of Japan as well? Second, is it alone or secondary to other psychopathologies? In the light of these questions, the diagnostic criteria of HS were revised in 2020. For fulfilling a HS diagnose, the person must meet the following criteria: 1) Marked social isolation in one's home, 2) duration of continuous social isolation for at least six months and 3) significant functional impairment or distress associated with the social isolation (11). According to these diagnostic criteria, the presence of other psychiatric disorders no longer excludes this diagnosis (11). Psychiatric comorbidity is seen in 33%-54.5% of HS cases, while there is no psychiatric comorbidity in approximately half of the cases (12). The most common comorbid diagnoses include affective disorders, anxiety disorder (such as social phobia), schizophrenia, obsessive-compulsive disorder, personality disorders (such as schizoid or avoidant disorders), eating disorders, Internet addiction, and pervasive developmental disorders (10,12–14).

Social isolation can be seen in many of these psychiatric diseases. However, none of these diseases can adequately explain the social withdrawal that HS's main feature (15,16). Especially schizophrenia and internet addiction are difficult diseases in the differential diagnosis of HS (10). A condition similar to HS is usually observed in the prodromal phase of schizophrenia and during its negative symptoms (17). Social isolation, deterioration of hygiene, anxiety, irritability, depressed mood, sleep disturbance, and loss of concentration can be seen in both cases (1). However, unlike schizophrenia, HS patients do not experience behavioural oddity, and other negative symptoms such as cognitive deficit (18). The majority of people with HS spend their time using the internet (10). For this reason, many researchers stated that there is comorbidity between HS and internet addiction, and both of them may cause the development of each other (15,19,20). For example, Lee et al. (20) found that 56% of individuals with HS in South Korea were at risk of internet addiction, while 9% were addicted to the internet. However, unlike people with internet addiction, using the internet for hikikomori can help them connect with people with similar interests and problems (21). Therefore, since many individuals with HS use the internet as a window to the

outside world (22), internet use can be considered a positive factor rather than a comorbidity (10). However, it should not be forgotten that developments in technology can increase social withdrawal (23).

In the early period, it was claimed that HS was a culture-bound syndrome found only in Japan; therefore, most cases with HS were reported from Japan. However, there are also very few case reports of HS from other countries as well Oman (24), Spain (3,5), Italy (19), South Korea (25), Hong Kong (26), India (22), France (27,28), and the United States (29). In addition to these case reports, some studies have shown that HS occurs in countries other than Japan, especially in Australia, Bangladesh, Iran, Thailand, and Taiwan (15). Thus HS now appears to be an intercultural situation (10,19). These studies and case reports have described prolonged social withdrawal phenomenologically, alike cases of HS described in Japan. Although there is no consensus among psychiatrists of different countries about the causes, diagnosis, and therapeutic interventions for HS, HS is a universally valid concept. In this case, we present a case of hikikomori detected in a child and adolescent psychiatry inpatient service in Ankara, Turkey's capital, the first case reported in our country.

CASE

A fifteen-year-old male was involuntarily admitted to our child and adolescent psychiatry inpatient service by his family with the complaints of not leaving his room, not communicating with anyone, including family members, and not attending school for more than one year. There was no precipitating factor before the beginning of social isolation. His symptoms emerged one year before the dawn of high school. His first complaints were withdrawal from communication with his family and friends. He started to use electronic devices more commonly, and his social isolation became more pronounced. High school examination results were not as good as he expected, and his family was disappointed. This was the first failure in his life, enhancing his social isolation. Parents stated that they wanted to seek medical help for these complaints before, but the patient resisted, and they could not insist. He never went to school in 9th grade. In this process, the family held frequent interviews with school management so that the patient did not repeat the class. For six months, he refused to leave his room except for obligatory physical needs such as eating food and going to the toilet. Then, his family started to put his food at his door because he refused to leave the room. He only gets out of his room while his family members were at work or sleeping at night to store meals or drink from the kitchen. He slept during the daytime and stayed awake at night by watching satellite television or playing video games. He became aggressive and irritable when his family tried to discuss his behaviour and again refused treatment requests. He stayed in his room with closed curtains and placed a cupboard against the door so that nobody can enter his room. His self-care was sufficient until ten days ago, after which he did not leave his room even for eating. Despite removing his internet connection and computer from his family, the patient continued to stay in his room. As a result of his family's increasing insistence on getting psychiatric help, he started to urinate in bottles in his room within three days before his hospitalization to reduce his encounter with them.

In developmental history, it was learned that he completed language and motor developmental steps on time. His social communication with his peers was weak from kindergarten on, and he did not have any friends with whom he spent time and was of introverted nature. His academic achievement has always been over the class averages. The patient has a sister who went to college, his mom is an engineer, and his father is a teacher. There is no history of psychiatric disorders in the family. His parents had a permissive attitude and did not impose any limits on his behaviour. Their academic expectations from the patients were high, so they did not give any responsibilities.

In the psychiatric examination at his first admission, his self-care was low, and he was agitated. Risperidone 0.5 mg/ day was prescribed for his irritability. On the subsequent days, his defensive attitude was relaxed, and he became more open to communication. In this assessment, he was euthymic and had no delusional thoughts or hallu-

cinations. Although he conducted the psychiatric interview, he refused to see his isolation as a problem and regarded it as an ordinary event.

The patient was thoroughly evaluated via standard diagnostic tools. WISC-R (Wechsler Intelligence Scale for Children-Revised), The Scale for the Assessment of Positive Symptoms (SAPS), The Scale for the Assessment of Negative Symptoms (SANS), K-SADS (Schedule for Affective Disorders and Schizophrenia for School-Aged Children Present and Lifetime Version), Children Depression Rating Scale (CDRS), Screen for Child Anxiety Related Disorders (SCARED), were applied and did not indicate any neurodevelopmental, affective, or psychotic disorder.

His family was undergone in counseling for parenting skills, especially for imposing limits. His communication developed, and he was able to express his feeling and thoughts. He started to have insight into how social isolation changed his life. After one month, he was discharged from the hospital. He is transferred to our outpatient clinic and is under regular visits. His family relations improved and, he spent more time with his family out of his room. He also rarely goes out of the home with his family. Unfortunately, he still does not attend his school but is looking for a new school to make a fresh start.

Written informed consent was obtained from the patient and his parents.

DISCUSSION

We present the case of a Turkish adolescent male with prolonged social withdrawal lasting more than one year. Our aim in making this case report is to emphasize that HS may not be a culture-dependent phenomenon. Instead, it may become a global public health problem.

The main feature of HS is social withdrawal and isolation. However, severe social withdrawal can also occur in various psychiatric disorders such as schizophrenia, social anxiety disorder, major depressive disorder, or psychotic disorders (1). This patient underwent rigorous clinical examination and diagnostic assessment using research-quality diagnostic instruments. It can be that his symptoms were due to a prodromal phase of psychosis or schizophrenia. These were ruled out since clinical psychosis was not observed during the inpatient stay, nor did family members report previous psychotic symptoms. No adverse symptoms were observed that would lead us to think of simple schizophrenia. The patient's irritability and urination in bottles were considered a reaction to his family's medical help recommendation. Hence, the psychotic disorder was not considered. Depressive disorder diagnosis was eliminated given the interviews made, scale results, and lack of depressive mood. In social phobia evaluation, the patient did not experience any anxiety when entering social environments or engaging in an activity with people he did not know before, ruling out social phobia. Finally, as he had limited social interaction from childhood, he was evaluated for autism spectrum disorder. In interviews, he was observed to establish eye contact, used mimics and gestures suitably, and had no problems communicating with other patients and health personnel in the clinic. Furthermore, there was no delay in developmental stages, and as he did not display stereotypic movements, insistence on routines, and limited interests, Autism spectrum disorders were excluded. Internet addiction was also considered, although, in this case, the intense and prolonged daily use of the Internet seemed to have arisen secondarily to his protracted social withdrawal. The removal of his computer and Internet access did not cause a change in his behaviour or his social withdrawal. He was diagnosed with HS syndrome since he was markedly isolated in his room, this isolation lasted for more than six months, and there was substantial dysfunction in his life.

HS syndrome is a sign of the process of becoming lonelier, involving all world rapidly. In this era, people are forced to join an eternal struggle to become more happy, accessible, and prosperous, leading to psychological and mental attrition in time. According to Kaneko, HS is a kind of reaction to this pressure and social role performance expectations. These individuals are hesitant and unwilling to identify their problems, find solutions for them, and act upon them. Also, dysfunctional

family dynamics, including preventing the child from assuming responsibility, being overprotective, and lack of problem-solving skills in parents, play an essential part in developing this disorder (14,30). Therefore, to escape from dominant social discourse, they attempt to remain alone and isolated after a certain period. They construct a virtual life for themselves in their small room worlds (16,31). The patient who separated himself socially instead of exerting effort to overcome problems sought asylum in his identity in the virtual environment. His family has taken responsibility for himself and forgiven him under all circumstances in every period of his life. Besides, individuals with HS wake up at night and sleep during the day in response to society's time pressure and are disturbed even by sunlight coming from outside (16). In our case, staying awake at night, sleeping during the day, and spending time in his room with the curtains closed can explain this reaction.

The limitation of our case report is that executive functions were not evaluated with psychometric tests in the differentiation of HS and psychotic disorders. However, this is the first case report of hikikomori in Turkey, adding to other reports in many countries. The fact that this case was reported in our country, which is the gateway of Asia to Europe, is essential in supporting that hikikomori is an intercultural syndrome.

Social isolation is becoming increasingly common in the modern world due to technological developments and changing socio-cultural factors. This has led us to face a silent, rising epidemic called the "modern behavioural epidemic of loneliness" (32). Similarly, while hikikomori is considered a silent epidemic that rises with the changes in the modern world, the increase in physical and social isolation, especially with the COVID-19 pandemic, seems to increase the spread of this epidemic (33). Thus, HS has an adverse impact not only on the mental health and social participation of the individual but also on educational and workforce stability, which renders it an important global issue. Therefore, it is an influential agenda subject to be recognized by clinicians worldwide and perform appropriate social and psychoeducational interventions.

Correspondence address: M.D. Meryem Kasak Department of Child and Adolescent Psychiatry, Ankara City Hospital, Ankara, Turkey meryemkasak90@gmail.com

REFERENCES

1. Li TMH, Wong PWC. Youth social withdrawal behavior (hikikomori): A systematic review of qualitative and quantitative studies. Aust N Z J Psychiatry 2015; 49:595–609.

2. Kato TA, Shinfuku N, Sartorius N, Kanba S. Are Japan's hikikomori and depression in young people spreading abroad? The Lancet 2011; 378:1070.

3. Ovejero S, Caro-Cañizares I, De León-Martínez V, Baca-Garcia E. Prolonged social withdrawal disorder: A hikikomori case in Spain. Int J Soc Psychiatry 2014; 60:562–565.

4. Kato TA, Kanba S, Teo AR. Hikikomori: Multidimensional understanding, assessment, and future international perspectives. Psychiatry and Clinical Neurosciences 2019; 73:427–440.

5. Malagón-Amor Á, Córcoles-Martínez D, Martín-López LM, Pérez-Solà V. Hikikomori in Spain: A descriptive study. International Journal of Social Psychiatry 2015; 61:475-483.

6. Tajan N, Yukiko H, Pionnié-Dax N. Hikikomori: the Japanese Cabinet Office's 2016 survey of acute social withdrawal. Asia Pacific J 2017; 15:1.

7. Krieg A, Dickie JR. Attachment and hikikomori: A psychosocial developmental model. Int J Soc Psychiatry 2013; 59:61–72.

8. Meyer-Lindenberg A, Tost H. Neural mechanisms of social risk for psychiatric disorders. Nat Neurosci 2012; 15:663–668.

9. Furlong A. The Japanese hikikomori phenomenon: acute social withdrawal among young people. Sociol Rev 2008; 56:309–325.

10. Stip E, Thibault A, Beauchamp-Chatel A, Kisely S. Internet addiction, hikikomori syndrome, and the prodromal phase of psychosis. Front psychiatry 2016; 7:6.

11. Kato TA, Kanba S, Teo AR. Defining pathological social withdrawal: proposed diagnostic criteria for hikikomori. World Psychiatry 2020; 19:116–117.

12. Koyama A, Miyake Y, Kawakami N, Tsuchiya M, Tachimori H, Takeshima T, & World Mental Health Japan Survey Group. Lifetime prevalence, psychiatric comorbidity and demographic correlates of "hikikomori" in a community population in Japan. Psychiatry research 2010; 176: 69-74.

13. Teo AR, Stufflebam K, Saha S, Fetters MD, Tateno M, Kanba S, Kato TA. Psychopathology associated with social withdrawal: Idiopathic and comorbid presentations. Psychiatry Res 2015; 228:182–183.

14. Schizoph EC, Sakai M, Josanjima M, Kondo N, Kuroda Y, Kiyota Y, Kitabata Y, Kurosawa M. General condition of hikikomori (prolonged social withdrawal) in Japan: Psychiatric diagnosis and outcome in mental health welfare centres. Int J Soc Psychiatry 2013; 59:79-86.

15. Kato TA, Tateno M, Shinfuku N, Fujisawa D, Teo AR, Sartorius N, et al. Does the “hikikomori” syndrome of social withdrawal exist outside Japan? A preliminary international investigation. Soc Psychiatry Psychiatr Epidemiol 2012; 47:1061–1075.

16. Kaneko S. Japan’s “Socially Withdrawn Youths” and Time Constraints in Japanese Society Management and conceptualization of time in a support group for “hikikomori.” Time & Society 2006; 15:233-249.

17. Daneault J-G, Stip E. Genealogy of instruments for prodrome evaluation of psychosis. Front psychiatry 2013; 4:25.

18. Schmits E, Quertemont E. So called" soft" drugs: cannabis and the amotivational syndrome. Rev Med Liege 2013; 68:281–286.

19. De Michele F, Caredda M, Delle Chiaie R, Salviati M, Biondi M. Hikikomori (ひきこもり): a culture-bound syndrome in the web 2.0 era. Riv. Psichiatr 2013; 48:354-358.

20. Lee YS, Lee JY, Choi TY, Choi JT. Home visitation program for detecting, evaluating and treating socially withdrawn youth in Korea. Psychiatry Clin Neurosci 2013; 67:193–202.

21. Taylor D. Critical policy evaluation and the question of values: a psychosocial approach. Crit Soc Policy 2006; 26:243–267.

22. Teo AR, Fetters MD, Stufflebam K, Tateno M, Balhara Y, Choi TY, Kanba S, Mathews AC, Kato TA. Identification of the hikikomori syndrome of social withdrawal: psychosocial features and treatment preferences in four countries. Int J Soc Psychiatry 2015; 61:64-72.

23. Kato TA, Teo AR, Tateno M, Watabe M, Kubo H, Kanba S. Can Pokémon GO rescue shut-ins (hikikomori) from their isolated world. Psychiatry Clin Neurosci 2017; 71:75–76.

24. Sakamoto N, Martin RG, Kumano H, Kuboki T, Al-Adawi S. Hikikomori, is it a culture-reactive or culture-bound syndrome? Nidotherapy and a clinical vignette from Oman. Int J Psychiatry Med 2005; 35:191–198.

25. Teo AR, Kato T. The prevalence and correlates of severe social withdrawal in Hong Kong. Int J Soc Psychiatry 2015; 61:102.

26. Chan GHY, Lo TW. Hidden youth services: What Hong Kong can learn from Japan. Children and Youth Services Review 2014; 42:118-126.

27. Guedj-Bourdiau MJ. Claustration à domicile de l’adolescent. Hikikomori. [Home confinement of the adolescent. Hikikomori.]. Ann Med Psychol 2011; 169:668-673.

28. Fansten M, Figueiredo C, Pionnié-Dax N. Hikikomori, ces adolescents en retrait. Paris: Armand Colin 2014.

29. Teo AR. Social isolation associated with depression: A case report of hikikomori. Int J Soc Psychiatry 2013; 59:339–341.

30. Dziesinski MJ, Investigations into the phenomenon of acute social withdrawal in contemporary Japan. M.Sc. Thesis, Sociology, University of Hawai’i, Manoa 2006.

31. Brinton MC. Lost in Transition Youth, Work, and Instability in Postindustrial Japan, first ed. Cambridge, New York.

32. Jeste D V, Lee EE, Cacioppo S. Battling the modern behavioral epidemic of loneliness: suggestions for research and interventions. JAMA psychiatry 2020; 77:553.

33. Roza TH, Spritzer DT, Gadelha A, Passos IC. Hikikomori and the COVID-19 pandemic: not leaving behind the socially withdrawn. Brazilian J Psychiatry 2020; 43:114–116.