Hikikomori in spain: a descriptive study. Preliminary data

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Introduction

Social isolation behaviour, first described in Japan as *hikikomori* syndrome, is a psychopathological and sociological phenomenon in which people, especially young, have a complete social isolation for more at least 6 months, a lifestyle centred at home, without any interest to attend school or work. It is a symptom observed in patients with very different severe mental disorders, such as schizophrenia, depression or severe anxiety disorders. In a subgroup of subjects, the social withdrawal is the only symptom, with no other diagnosis, called primary *hikikomori*.

The prevalence outside Japan is unknown, although cases have been reported in Oman, Korea, Italy and Spain. The difficulty of detection and access to these people, and the lack of specific services that treat these subjects, has probably underestimated its prevalence and magnitude. The creation of community psychiatric care services, such as the crisis resolution home treatment (EMSE) in Barcelona, has revealed a significant prevalence of social isolation behaviour.

Objective

To describe preliminary data from a descriptive study of *hikikomori* individuals in Spain.

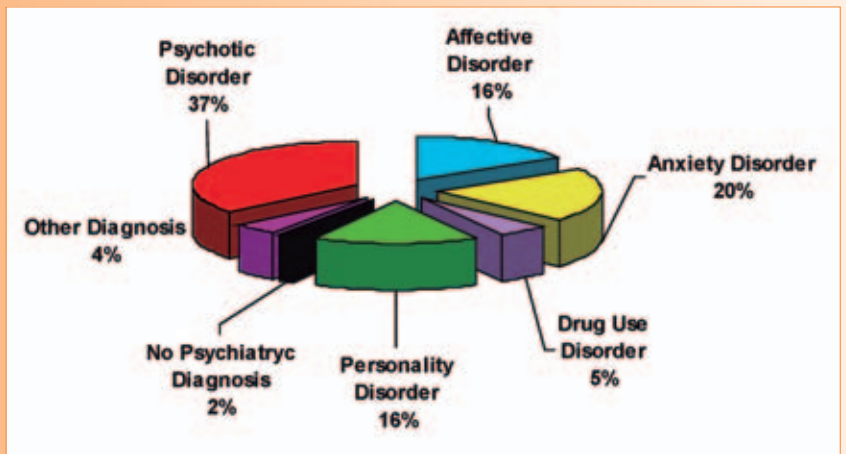
Methods

Participants were 1297 people attended at home by EMSE from years 2008 to 2013. In 200 participants the reason of referral was social withdrawal. 36 cases (18%) were not included due to family home visit refusal. Data collected included socio-demographic, clinical, social and therapeutic information. The Global Assessment of Functioning (GAF) and the Severity of Psychiatric Illness (SPI) score were also assessed.

Results

Hikikomori were predominantly young male, with the mean age at onset of *hikikomori* of 36 years old, and a mean socially withdrawn period of 3 years. Only three people had no symptoms suggestive of mental disorder, being psychotic and anxiety the most common comorbid disorders. The mean GAF score was 42.3, and the mean SPI was 12, which describes the presence of serious symptoms and serious impairment in social functioning.

Graphic 1. Estimated diagnosis of *hikikomori* cases



Graphic 2. Referred service by EMSE of *hikikomori* cases

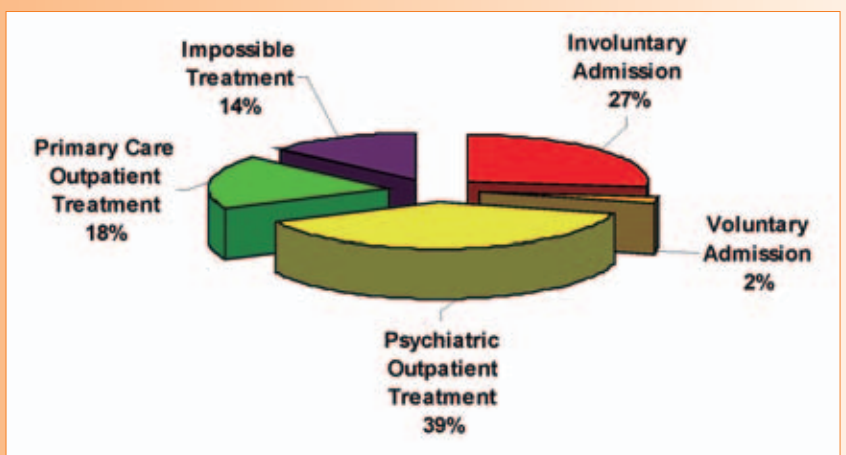


Table 1. Socio-demographic characteristics of *hikikomori* cases

Variables	N (%)
Male	121 (73.8)
Female	43 (26.2)
Age Mean (SD)	40 (18.3)
Age at onset of *hikikomori* Mean (SD)	36.6 (18)
Living situation	
Alone	23 (14)
Family	141 (86)
Psychiatric history	120 (74.5)
Psychotic disorder	41 (34.7)
Affective disorder	25 (21.1)
Anxiety disorder	26 (22)
Cognitive disorder	0 (0)
Drug use disorder	4 (3.4)
Personality disorder	9 (7.6)
Other	13 (11)
Previous psychiatric hospitalisation	55 (39.3)
Who detects social isolation	
Patient	3 (1.7)
Family	129 (72.9)
Social Services	7 (4)
Outpatient Teams	31 (17.5)
Other	7 (4)

Conclusions

- Social isolation behaviour is one of the most frequent reasons for referral to EMSE.
- This reveals that the prevalence of social isolation in our environment has been probably underestimated due to the lack of specific data and psychiatry specialized home care services that access to those subjects, such as EMSE.
- Highlights 2% of cases in which does not exist a psychiatric diagnosis, being social isolation the only symptom. So, there is a high comorbidity, being psychotic and anxiety disorders the most frequent.
- These patients have significant psychiatric severity with high opposition to treatment, making it difficult to treat them at home, and in one third of cases, they require involuntary treatment admissions.
- Future cross-national studies are needed in order to clearly describe its definition and psychopatology, and to investigate the association with other mental disorders.

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