Published in final edited form as:
Int J Soc Psychiatry. 2013 June ; 59(4): 339–341. doi:10.1177/0020764012437128.

Social isolation associated with depression: A case report of *hikikomori*

Alan R Teo
Department of Psychiatry, University of Michigan, USA

Abstract

Background—Social isolation is associated with significant morbidity and mortality. A severe form of social isolation or social withdrawal, called *hikikomori* in Japan, has been described, but controversy over the etiology and universality of the phenomenon remains.

Method—Case report.

Results—Diagnostic assessment by structured clinical interview and psychometric tools revealed *hikikomori* and underlying bipolar disorder, in which the patient's social withdrawal occurred exclusively during major depressive episodes. The patient declined pharmacotherapy, but his *hikikomori* and depression went into remission after 25 sessions of cognitive behavioural therapy targeting his social isolation.

Conclusions—This is the first reported case of *hikikomori* in the Americas. It illustrates the association between *hikikomori* and a mood disorder, and suggests the importance of international study of the prevalence and potential treatment strategies for severe social isolation.

Keywords

Social isolation; social withdrawal; bipolar disorder; *hikikomori*

Introduction

Social isolation is of great relevance to psychiatry both because of the severity of its sequelae and its association with mental disorder. Holt-Lunstad, Smith and Layton's (2010) impeccably conducted meta-analysis of over 300,000 patients concluded that social isolation is as deadly as excessive alcohol consumption and smoking. Besides contributing to mortality, social isolation is also associated with increased morbidity. For instance, a study of loneliness and low social support found these factors predict a poorer outcome for depressed patients (van Beljouw, Verhaak, Cuijpers, van Marwijk, & Penninx, 2010). Socially isolated people also appear to be at higher risk for mental illness. For instance, an American study of over 33,000 adult community residents found socially isolated adults

Corresponding author: Alan R Teo, University of Michigan, R. W. J. Clinical Scholars Program, 6312 Medical Science Building I, 1150 W. Medical Center Drive, Ann Arbor, MI 48109-0604, USA. ; Email: alanteo@umich.edu; ; Email: alan.teo@stanfordalumni.org

(defined by absence of close friends) to have increased risk of major depressive disorder, dysthymic disorder, social anxiety disorder and generalized anxiety disorder.

In recent years, a particularly severe form of social isolation, called *hikikomori*, has been described, mostly in Japan (Teo, 2010). *Hikikomori* is typically defined as not going to work or school, not leaving one's residence more than occasionally, and not communicating with people other than family members for at least six months. Two key controversies with *hikikomori* currently exist. First, does it occur outside Japan? Second, is it a unique disorder or secondary to other psychopathology? Cross-national comparative data and controlled studies of *hikikomori* have not yet emerged – hence, the existence of these controversies. Malagon, Alvaro, Corcoles, Martin-Lopez and Bulbena (2010) described a case of *hikikomori* in Spain that was secondary to obsessive compulsive disorder. I present the first known case of *hikikomori* in the Americas, and examine the relationship between social isolation and depression.

Case report

History

'Mr H' was a 30-year-old white man who presented complaining of three years of continuous isolation in his apartment. During the first and most severe year, he remained within a walk-in closet, ate only ready-to-eat food, did not bathe, and urinated and defecated in jars and bottles. He passed time surfing the internet and playing video games. A housemate helped supply food. He felt conflicted about his social withdrawal. While he explained his reason for withdrawal as a moral disdain of society, he was simultaneously ego-dystonic about his isolation, expressing a desire to go out and gain insight into his lack of motivation for social interaction. He reported one similar multi-year episode of withdrawal in his early 20s.

Concomitant with these episodes, he endorsed severe depression characterized by amotivation and anhedonia. Immediately prior to each depressive episode, he endorsed prolonged periods of elevated mood, grandiosity, decreased sleep, increased goal-directed activity and risk-taking behaviour. None of these episodes had been treated by a mental health professional.

Family and social history were notable for both his parents having substance abuse histories and being 'drug dealers', a history of childhood trauma (observing physical abuse of his mother by his father), leaving home to live alone at age 15, and a spiritual identification as a Buddhist.

Testing and examination

On mental status examination, he was dressed in all black with long fingernails. His speech was articulate but bombastic; he described his mood using the neologism 'equanimous' and affect was euthymic. Thought content was notable for various eccentric beliefs and chronic suicidal ideation (visualizations of stabbing himself) without intent or a plan. The patient was unable to complete laboratory testing for organic etiologies due to a phlebotomy phobia.

The patient underwent comprehensive diagnostic assessment using both clinical interview and validated research instruments, and information provided by the patient was corroborated by collateral. The SCID-I/NP revealed bipolar disorder type I, and tobacco and cannabis dependence. Substance use was not associated in time with his social isolation. Additional screening with the Social Phobia Inventory, Yale-Brown Obsessive-Compulsive Scale and Prodrome Questionnaire-B were negative. The SCID-II showed obsessive-compulsive and schizoid personality traits. Additionally, he met criteria for *hikikomori* per the World Mental Health Japan version of the *hikikomori* section questionnaire (Koyama et al., 2010). Beck Depression Inventory II score at intake was 17/63 and Sheehan Disability Scale total score was 22/30, indicating moderate depression and severe functional disability.

Clinical course

The patient declined pharmacotherapy for bipolar disorder but was interested in cognitive behavioural therapy (CBT). CBT targeted the social withdrawal and included psychoeducation, exposure and response prevention, cognitive restructuring, goal setting and coping strategies. After 20 sessions, the patient had achieved a Clinical Global Impression – Global Improvement (CGI–I) Scale score of 2 (‘much improved’). He expressed interest in further treatment so adjunctive D-cylcoserine was added to boost CBT response. All treatment was provided by a single psychiatrist. After 25 weekly sessions, the patient's social isolation and depression were in remission. He went out daily and had acquired a part-time job. Sheehan Disability Scale score was 0/30 and Patient Health Questionnaire (PHQ-9) score was 0/27.

Discussion

Although severe social isolation has been mostly described in Japan, this case provides growing anecdotal evidence of *hikikomori* in other culturally distinct areas of the world. This is the first case report of *hikikomori* in the USA, adding to other reports in Spain, Italy and Korea (Aguglia, Signorelli, Pollicino, Arcidiacono, & Petralia, 2010; Lee, Lee, & Choi, in press; Malagon et al., 2010). Moreover, a recent international survey of psychiatrists suggests that patients with *hikikomori* features are seen in all nine countries studied (Kato et al., 2011). Given this, it would seem time for an epidemiologic study of social withdrawal across cultures.

This patient underwent rigorous clinical examination and diagnostic assessment using research-quality diagnostic instruments. The results suggest that his social isolation was most closely associated, at least proximally, with major depressive episodes. His developmental history and personality traits may have contributed in indirect ways, but depression best explains the source of his acute social isolation. This is consistent with results from the largest and best-designed epidemiologic study of *hikikomori*. In this study of over 1,600 Japanese adults residing in the community, Koyama and colleagues (2010) found that those with a history of *hikikomori* were six times more likely to have a mood disorder than the general population, much higher than any other psychiatric disorder examined and the only type of disorder with a statistically significant correlation with *hikikomori*.

Some aspects of this case differ from typical Japanese *hikikomori*. First, this patient was raised in an overtly dys-functional family, whereas most Japanese *hikikomori* come from ostensibly 'good' families of middle- to upper-middle-class backgrounds with highly involved mothers (Saito, 1998). Second, it is perhaps surprising that the patient's social isolation and depression went into remission primarily due to a psychosocial intervention. Reviews of CBT have found some evidence of benefit on bipolar depression, but it has only been studied as an adjunctive therapy (Miklowitz & Scott, 2009). Many *hikikomori* refuse to go out of their home or meet with clinicians conducting home visits, making CBT impractical in such cases. Moreover, prospective efforts to treat the deleterious effects of social isolation in medical populations have largely failed (Berkman et al., 2003). However, such studies only detect group differences and do not apply to all individuals, as this case illustrates. Given the morbidity and mortality associated with social isolation and concerns over growing disconnectedness in modern society (Olds & Schwartz, 2009), study of treatment approaches targeting social isolation in psychiatric disorders is important.

Acknowledgements

Dr Teo reports no competing interests. This paper was supported in part by an APA/SAMHSA Minority Fellowship, an NIMH R25 training grant (MH060482) and the Robert Wood Johnson Foundation Clinical Scholars Program.

References

Aguglia E, Signorelli MS, Pollicino C, Arcidiacono E, Petralia A. Il fenomeno dell'hikikomori: Cultural bound o quadro psicopatologico emergente? Giornale Italiano Di Psicopatologia. 2010; 16:1–8.

Berkman LF, Blumenthal J, Burg M, Carney RM, Catellier D, Cowan MJ, Enhancing Recovery in Coronary Heart Disease Patients Investigators (ENRICHD). Effects of treating depression and low perceived social support on clinical events after myocardial infarction: The Enhancing Recovery in Coronary Heart Disease Patients (ENRICHD) Randomized Trial. Journal of the American Medical Association. 2003; 289:3106–3116. [PubMed: 12813116]

Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: A meta-analytic review. PLoS Medicine. 2010; 7:e1000316. DOI: 10.1371/journal.pmed. 1000334. [PubMed: 20668659]

Kato TA, Tateno M, Shinfuku N, Fujisawa D, Teo AR, Sartorius N, Kanba S. Does the 'hikikomori' syndrome of social withdrawal exist outside Japan? A preliminary international investigation. Social Psychiatry and Psychiatric Epidemiology. Jun 25.2011 [Epub ahead of print].

Koyama A, Miyake Y, Kawakami N, Tsuchiya M, Tachimori H, Takeshima T. Lifetime prevalence, psychiatric comorbidity and demographic correlates of 'hikikomori' in a community population in Japan. Psychiatry Research. 2010; 176:69–74. [PubMed: 20074814]

Lee YS, Lee JY, Choi TY. Home visit program for detecting, evaluating, and treating socially withdrawn youth in Korea. Psychiatry and Clinical Neurosciences. in press.

Malagon A, Alvaro P, Corcoles D, Martin-Lopez LM, Bulbena A. 'Hikikomori': A new diagnosis or a syndrome associated with a psychiatric diagnosis? International Journal of Social Psychiatry. 2010; 56:558–559. [PubMed: 20826504]

Miklowitz DJ, Scott J. Psychosocial treatments for bipolar disorder: Cost-effectiveness, mediating mechanisms, and future directions. Bipolar Disorders. 2009; 11(Suppl 2):110–122. [PubMed: 19538690]

Olds, J.; Schwartz, RS. The lonely American: Drifting apart in the twenty-first century. Beacon Press; Boston, MA: 2009.

Saito, T. Shakaiteki hikikomori: Owaranai shishunki [Social withdrawal: A neverending adolescence]. PHP Shinsho; Tokyo: 1998.

Teo AR. A new form of social withdrawal in Japan: A review of hikikomori. International Journal of Social Psychiatry. 2010; 56:178–185. [PubMed: 19567455]

van Beljouw IM, Verhaak PF, Cuijpers P, van Marwijk HW, Penninx BW. The course of untreated anxiety and depression, and determinants of poor one-year outcome: A one-year cohort study. BMC Psychiatry. 2010; 10:86. DOI: 10.1186/1471-244X-10-86. [PubMed: 20961414]