SOCIAL WITHDRAWAL AND SUICIDE RISK: A DESCRIPTIVE STUDY

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INTRODUCTION

Social withdrawal is a major health problem that has been related with higher morbidity and mortality rates. There are few studies about the relationship between suicidal behavior and social isolation.

AIM

To describe the existence of suicidal risk in subjects with social isolation.

METHOD

Participants were 184 subjects referred to a Crisis Resolution Home Treatment (CRHT) because of social isolation. The definition of social withdrawal, also defined as *hikikomori*, was the state of avoiding social engagement with generally persistent withdrawal into one's residence for at least 6 months. Suicide risk was assessed by the item of the Severity of Psychiatric Illness (SPI), dividing in four groups (from absence to high suicide risk). Socio-demographic and clinical data were also analysed. Due to the limited number of subjects, statistical analysis was also performed by dividing in two groups: no autolytic risk (SPI score of 0) and autolytic risk (SPI score of 1, 2 and 3).

RESULTS

Table 1. Sociodemographic and clinical characteristics of socially isolated cases.

Variables	No suicide risk (SPI=0) (N=128)	Low suicide risk (SPI=!) (N=40)	Mild suicide risk (SPI=2) (N=11)	High suicide risk (SPI=3) (N=5)	p
Age, mean (SD)	38,42 (18,21)	43,25 (18,42)	41,00 (19,48)	33,20 (13,18)	0,23**
Gender, Male, N (%)	96 (75)	27 (67,5)	7 (63,6)	4 (80,0)	0,316*
Socially withdrawn period, months mean (SD)	42,69 (56,28)	26,3 (25,99)	45 (85,67)	34,8 (19,16)	0,16**
Age at onset of social isolation, mean (SD)	34,9 (17,66)	41,9 (18,82)	34,13 (19,4)	32 (13,34)	0,13**
Child abuse history, N (%)	25 (22,1)	8 (22,2)	2 (22,2)	0 (0)	0,761*
Psychiatric history, N (%)	81 (63,3)	28 (70)	6 (54,5)	3 (60)	0,717*
Suicide attempt history, N (%)	9 (7)	6 (15)	3 (27,3)	1 (20)	0,026*
Previous psychiatric hospitalization, N (%)	46 (35,9)	21 (52,5)	4 (36,4)	1 (20)	0,18*
Diagnosis, N (%)					
• Drug use disorder	5 (3,9%)	3 (7,5)	0 (0)	0 (0)	**0,226***
• Psychotic disorder	50 (39,1)	14 (35)	7 (63,6)	3 (60)	
• Affective disorder	16 (12,5)	9 (22,5)	2 (18,2)	1 (20)	
• Anxiety disorder	23 (18)	9 (22,5)	1 (9,1)	1 (20)	
• Personality disorder	25 (19,5)	5 (12,5)	1 (9,1)	0 (0)	
• Other	8 (6,3)	0 (0)	0 (0)	0 (0)	
• No diagnosis	1 (,8)	0 (0)	0 (0)	0 (0)	
Referred service by the CRHT, N (%)					0,073*
• Medical outpatient team	20 (17,9)	6 (18,2)	0 (0)	0 (0)	
• Psychiatric outpatient team	44 (39,3)	15 (45,5)	2 (25)	1 (25)	
• Hospitalization	29 (25,9)	10 (30,3)	6 (75)	3 (75)	
• Other	19 (17)	2 (6,1)	0 (0)	0 (0)	
SPI total score, mean (SD)	11,26 (4,48)	13,70 (4,6)	16 (2,88)	22,75 (8,34)	**<0,001****
GAF score, mean (SD)	43,8 (14,71)	35,83 (12,7)	32,73 (14,6)	18 (8,37)	**<0,001****
CGIS score, mean (SD)	3,91 (1,1)	4,64 (0,99)	5,11 (1,05)	5,4 (0,89)	**<0,001****
WHODAS score, mean (SD)	12,35 (3,8)	13,58 (3,34)	14,73 (3,9)	15,2 (3,9)	**0,008****

* Chi-squared test; ** t-test; SD: Standard Deviation. SPI: Severity of Psychiatric Illness Scale GAF: Global Assessment of Functioning Scale; CGIS: Clinical Global Impression Severity Scale; WHO/DAS: World Health Organization Dissability Assessment Scale; CRHT: Crisis Resolution Home Treatment.

CONCLUSIONS

- This is, to our knowledge, the first study about suicide risk in hikikomori patients.
- These patients, overall, do not have high frequency of suicide risk.
- Cases with higher suicide risk are younger and have a shorter period of isolation. This group had also lower rates of child abuse history.
- The more frequent diagnosis in all groups were psychotic, affective and anxiety disorders. Those cases with mild and high suicide risk needed more frequently hospitalization.
- Patients with suicide risk had statistically significant higher severity scores in SPI, GAF, CGIS and WHO / DAS scales, as well as higher frequency of suicide attempt history.
- These data can be influenced by the characteristics of functioning of CRHT and the small sample size.

REFERENCES

- Kato, T. A., Tateno, M., Shinfuku, N., Fujisawa, D., Teo, A. R., Sartorius, N., ... Kanba, S. (2012). Does the "hikikomori" syndrome of social withdrawal exist outside Japan? A preliminary international investigation. *Social Psychiatry and Psychiatric Epidemiology*, 47(7), 1061–1075.
- Teo, A. R., Stufflebam, K., Saha, S., Fetters, M. D., Tateno, M., Kanba, S., & Kato, T. A. (2015). Psychopathology associated with social withdrawal: Idiopathic and comorbid presentations. *Psychiatry Research*. http://doi.org/10.1016/j.psychres.2015.04.033
- Wong, P. W., Li, T. M., Chan, M., Law, Y., Chau, M., Cheng, C., ... Yip, P. S. (2014). The prevalence and correlates of severe social withdrawal (hikikomori) in Hong Kong: A cross-sectional telephone-based survey study. *The International Journal of Social Psychiatry*. http://doi.org/10.1177/0020764014543711 .

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