Psychopathology of Social Withdrawal in Japan

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Abstract: Active challenges to social withdrawal among young people have recently been implemented in Japan against the following background: 1) The number of cases of social withdrawal among young people has reportedly increased to some hundreds of thousands; and 2) As there are few clinical studies in the US and Europe, it is necessary to compile our own clinical experience to produce useful findings. The term “social withdrawal” is not a diagnosis, but means both a “phenomenon” of social withdrawal and a “pathology” of introverted withdrawal. Patients with social withdrawal can be further classified into a “secondary withdrawal group” due to some psychiatric disorders and a “primary withdrawal group” characterized by withdrawal itself (Kinugasa, 1998). A young patient with primary withdrawal rarely visits a psychiatrist for help, his or her family members should assist with patience.

Key words: Social withdrawal; Psychopathology; Japan; Adolescence; Young adult

Introduction

Two academic journals, Rinsho Seishin Igaku1–3) and Seishin Bunseki Kenkyu 4–6) had articles featuring social withdrawal in the past two years. This indicates, there has recently been an active response to the challenge of social withdrawal among young people in Japan against the background of an increase in the phenomenon.7) There are reported to be some hundreds of thousands of young people with this condition.8) As there are few clinical studies focusing on social withdrawal in the US and Europe, it is necessary to compile clinical experience in Japan in order to obtain useful findings.9) The present report addresses the challenges to clinical pioneers by reviewing the psychopathology of social withdrawal among young people at the present time.

1. “Phenomenon” and “pathology” of social withdrawal

The term “social withdrawal” is not a diagnosis for a specific psychiatric disorder. Withdrawal means both the phenomenon of social withdrawal and the pathology of introverted withdrawal. The former refers to the condition of staying in one’s own house to avoid relation-
2. Secondary withdrawal

Secondary withdrawal includes cases of a patient staying in his or her own house due to abulia and autism caused by schizophrenia. A patient with depression tends to withdraw, complaining of trouble in meeting with or talking to others in the period of serious depression. A patient with eating disorders, especially bulimia nervosa often withdraws to avoid the eyes of others, or disclosure of his or her figure when weight has been gained contrary to expectations. Due to the fear of a panic attack, patients with panic disorder tend to stay indoors to avoid places where there is no possibility of help in case of panic (such as trains and overcrowded streets). In this case, panic attack means “sudden development of symptoms including palpitations, dyspnea, and derealization with strong anxiety”.

Patients with serious anthropophobia are sometimes kept at home to avoid relationships with others, resulting from a feeling of guilt for giving an unpleasant impression to others because of their own perceptions and physical defects. According to Nakamura et al., however, an increasing number of patients without serious symptoms tend to avoid relationships with others. The clinical features include vague feelings of personal stress or oppression, strong fear of others and self-uncertainty, and sometimes depression and inertia.

3. Primary withdrawal

Anthropophobia characterized by avoidance and withdrawal reported by Nakamura et al. can be classified as primary withdrawal because the withdrawal itself is a major symptom.

Studies of primary withdrawal among the young in Japan date back to a study on “withdrawal neurosis” by Kasahara in the 1970s, originating from “student apathy” noticed in university students. The author proposed a new concept of neurosis characterized by inertia and partial retreat (social withdrawal). He described this type of neurotic as one who “does not ask for other’s help. Some of them do not visit a hospital even though their family members do”. This is exactly the condition that can be seen in the withdrawal of young people at the present time. In most cases, since the patient rarely visits the hospital voluntarily, the persistent support of family members is essential to making them appear.

In primary withdrawal at the present time, almost all patients are male and their clinical features often include personal stress, a sense of futility, inertia, and self-incompleteness. Some are struggling against withdrawal, while others are rather satisfied with it. They tend to underestimate themselves, and sometimes be impulsive. Behavior in some suggests the presence of trauma. They are often classified into schizoid personality disorder, avoidant personality, and narcissistic personality disorder specified in “DSM-IV, Diagnostic and Statistical Manual of Mental Disorders Fourth Edition.”

Kondo listed the following features of their families from his longtime experience: 1) Because parents tend to be anxious and keep up appearances, the patient comes to rationalize or deny the problem, leading to delayed responses and prolonged withdrawal; 2) Family members are too cautious to go into the internal feelings of each other; 3) The parent of the same sex also tends to withdraw; 4) There is little parental identification with the patient’s subjective experiences.

Conclusion

Local mental health welfare centers and
medical institutions have been implementing various measures against social withdrawal. It is expected that a deeper understanding of social withdrawal will be obtained based on these clinical practices.

REFERENCES