

### Box 1 Challenges in examining parental alienation in child custody cases

1. The child is too young
2. Much time has passed since the allegations were made
3. Presence of severe personality disorders (PD) in parents
4. Dysfunctional personality traits in parents or children/adolescents
5. Delusional disorders in parents
6. Severe PD or delusional disorders in evaluatees with high intelligence

the twins continued to live with their father, and psychotherapy was recommended to all evaluatees.

These cases demonstrate that the assessment of parental alienation demands attentive study of the legal process, multiple evaluations carried out with different family members, and collateral sources of information. In a context of conjugal disputes and possible psychiatric disorders (in parents or children), it is mandatory to characterize the child behavior as consistent in rejecting one parent due to manipulation and indoctrination performed by the other – therefore, identifying incorporation of the alienating parent's speech. It is also important to identify in the child a phenomenon known as the “independent thinker”: the child consistently claims that his resistance to the unfavored parent is due to his own independent thought, and not the result of the other parent's influence.<sup>3</sup>

Additional challenges are listed in Box 1.<sup>4</sup> Moreover, the distinction between parental alienation and estrangement (justified rejection of one parent following a real history of neglect, physical and sexual abuse, or domestic violence)<sup>3</sup> must be made. Finally, the most important factor according to expert recommendations refers to a “potential harm to the child” criterion, related to developmental and psychological maladaptation.<sup>5</sup>

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## Multimodal treatment for a Brazilian case of *hikikomori*

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*Hikikomori* is defined as a condition of severe and prolonged social withdrawal apparently not explained by other severe psychiatric disorders, lasting for at least 6 months, in which the individual – usually a young adult – remains a recluse in his own house.<sup>1-3</sup> Initially described in Japan in the late 1990s as a cultural syndrome, *hikikomori* has been recently recognized as a prevalent pathological phenomenon worldwide, with reports from several countries.<sup>4-6</sup>

We report the case of a 35-year-old man who was referred to outpatient psychiatric treatment during his second *hikikomori* episode, which started soon after he left university. During the preceding 14 months, he reported barely leaving his apartment, having no friends nor romantic relationships, neglecting hygiene and self-care, spending 14 hours/day playing computer games and an additional 3-5 hours/day watching gameplay videos on internet websites. He complained of depressive symptoms of moderate to severe intensity (Hamilton Depression Rating Scale [HAM-D] = 26) for the last 3 months, precipitated by a switch in antidepressant from sertraline 200 mg/day to desvenlafaxine 100 mg/day, which was part of a treatment trial aiming to increase his energy levels. During the first 11 months of this second *hikikomori* episode, he did not complain about depression symptoms, using a combination of OROS methylphenidate 54 mg/day (started in 2011 as treatment for hypersomnolence) and sertraline 200 mg/day (started in 2009 for recurrent depressive disorder).

He described a normal neuro-developmental, social, and educational history, having friends, good grades at school, and even a girlfriend. His psychiatric history (as reported by himself and his mother) was negative until age 19, when he developed hypersomnolence and mild depressive symptoms. At that time, he was enrolled in university, and despite both problems, he maintained good social involvement and participated in many activities.

Around age 26, after breaking up a romantic relationship, he entered the most pronounced period of social withdrawal to date, which corresponded to the first episode of *hikikomori*. During that episode, he developed

significant social and functional impairment, which included giving up gym, not attending classes, losing contact with friends, spending most of the time at home (mainly in his bedroom) playing computer games for around 15 hours/day, and watching gameplays on internet websites for another 3 to 4 hours/day. This behavior persisted for at least 6 years, during which time he experienced only mild depressive symptoms and occasional sleep problems. After this time, he reported spontaneous improvement of social interactions, which lasted approximately 8 months, when he was actively engaged in routine university activities required for graduation. He took 12 years to complete his undergraduate degree, and has never been gainfully employed. A thorough psychiatric evaluation, which included his mother's report, was not consistent with autism, psychotic symptoms, bipolar disorder, social anxiety disorder, or schizoid personality disorder.

After clinical evaluation, we decided to switch desvenlafaxine to sertraline up to a dose of 200 mg/day. After 4 weeks, he achieved remission of the depressive episode (HAM-D = 6), but remained socially withdrawn. Cognitive-behavioral therapy (CBT) sessions were initiated, focusing on behavioral activation routines and planning of outdoor social activities. Family interventions focused on psychoeducation were delivered to the patient's mother. Moreover, motivational interviewing techniques were constantly applied during most sessions. After 4 months of this weekly multimodal treatment, he presented marked clinical improvement, being more involved in social activities with his family and friends; his gaming behavior diminished substantially, to around 1 hour/day; he started his first-ever (though part-time) job, as a driver (after 17 years without driving); and began looking for jobs in his field of expertise and seeking romantic relationships.

After this considerable clinical improvement, he continued to attend weekly psychotherapy sessions for 2 additional months, with a focus on relapse prevention. Subsequently, upon completion of 6 months of follow-up, he was discharged from outpatient care.

In a telephone follow-up evaluation 4 months after outpatient discharge, he remained in remission from his depressive episode (HAM-D = 5), did not report any sleep problems, and only spent 1 hour/day playing computer games. He reported driving at least twice a week (even though he was no longer working as a driver), being more socially active with his family, and still seeking romantic relationships and jobs in his field.

This is the third case of *hikikomori* described in Brazil, with the first reporting spontaneous recovery after 29 years of social withdrawal,<sup>7</sup> and the second presenting partial clinical improvement after 9 months of weekly psychoanalytical psychotherapy.<sup>8</sup> Nevertheless, this is the first Brazilian case of recurrent *hikikomori*, and the first in which a multimodal treatment approach was applied.

Recently, a group of researchers proposed updated diagnostic criteria for *hikikomori* and a severity classification based on the weekly frequency with which the patient leaves his room or home.<sup>9</sup> According to their definition, the central feature of *hikikomori* is physical isolation in the individual's home, and the condition can be diagnosed when the following three criteria are met: "a) marked

social isolation in one's home; b) duration of continuous social isolation of at least 6 months; c) significant functional impairment or distress associated with the social isolation."<sup>9</sup> According to these criteria, individuals leaving home 4 or more days/week, are not defined as *hikikomori*; additionally, the presence of other psychiatric disorders no longer excludes this diagnosis.<sup>9</sup> The patient described in this report meets all three criteria, and could be further classified as "moderate *hikikomori*" before the treatment of his second episode, according to this new diagnostic proposition.

Potential treatments for *hikikomori* already described in scientific literature consist of family interventions, different psychotherapeutic approaches, social-skills training, group activities, support groups, planning of activities (on a flexible schedule) in order to take the affected individual out of the home, and physical activity, among others; however, the quality of the evidence for treatment strategies is low.<sup>1-3,10-12</sup> The role of pharmacological treatment – mainly antidepressants – in *hikikomori* is still uncertain. Better response rates are achieved in the treatment of comorbidities than in treatment of *hikikomori* itself<sup>10-12</sup>; the reported case herein follows this pattern.

This brief clinical report illustrates once more the occurrence of *hikikomori* in Brazil, and is the first to describe multimodal treatment of a Brazilian patient. Our approach, combining family psychoeducation, different psychotherapeutic approaches, and pharmacotherapy for comorbidities, may be a promising strategy for patients presenting with this syndrome.

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## Measures to reduce smoking: Brazil takes the lead

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Smoking remains a major global public health challenge. About 8 million people die every year from tobacco use worldwide, of which 7 million occur from tobacco use and about 1.2 million non-smokers die due to passive consumption. Tobacco is also responsible for a high economic outlay, since smoking costs about USD 1.4 trillion each year, including health and productivity expenditures.<sup>1</sup>

The 7th edition of the Global Tobacco Epidemic Report, recently published by the World Health Organization (WHO),<sup>2</sup> shows that several countries are making efforts to implement tobacco control policies. Since the adoption of the WHO Convention on Tobacco Control Framework (WHO FCTC) in 2003, much progress has been made in fighting smoking. Among the various articles of this convention, MPOWER tobacco control is an essential tool for helping countries adopt measures to reduce smoking. It is an evidence-based intervention instrument and, so far, 23 countries have adopted these guidelines, reaching a population of 24 billion people.<sup>3</sup>

The meaning of the acronym MPOWER is: M – monitoring tobacco use and prevention policy; P – protecting people from tobacco smoke; O – offering help to quit tobacco use; W – warning about the dangers of tobacco; E – enforcing bans on tobacco advertising, promotion, and sponsorship; and R – raising taxes on tobacco.

Only two countries worldwide have adopted all MPOWER measures at the best practice level: Brazil and Turkey.<sup>2</sup> Figure 1A shows the chronology of the MPOWER measures adopted in Brazil.

Epidemiological studies on drug use in Brazil show that implementing these smoking control measures shows good results. Figure 1B shows the prevalence of lifetime use and heavy tobacco use (20 or more times in the last month) among elementary, middle and high school students (ages 10-18). The Centro Brasileiro de Informações sobre Drogas (CEBRID) conducted six epidemiological studies using the WHO's methodology.<sup>4</sup> Students filled out self-completion questionnaires in the classroom anonymously, so their confidentiality would be ensured. The surveys conducted among public school students in the 10 largest Brazilian state capitals occurred in: 1987 (16,324 students), 1989 (8,993 students), 1993 (24,634 students), 1997 (15,501 students), 2004 (48,155 students), and 2010 (31,280 students).<sup>5</sup> The results showed decreasing percentages of lifetime use only in the 2004 survey. Heavy tobacco use also had the same downward trend (Cochran-Armitage test for trend,  $p < 0.05$ ).

The decrease in lifetime tobacco use between 2004 and 2010 is also consistent for both genders: from