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When social withdrawal in adolescence becomes extreme: the "hikikomori" phenomenon in Italy

Gdy wycofanie społeczne przybiera postać skrajną: zjawisko „hikikomori" we Włoszech

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Abstract

"Hikikomori syndrome," or extreme social withdrawal, determines a refusal to go to school or work where one's life style is centred around the home. In Japan *hikikomoris*, also called "family hermits" or "bedroom hermits," were first identified in the late seventies. In the West (USA, France, UK, Spain, Italy) clinical psychologists are treating an increasing number of adolescents and young *hikikomoris*. Over the last few years, the *Unità Funzionale Salute Mentale Infanzia Adolescenza* (UFSMIA) in Arezzo has received a number of requests for treating young people who present strong similarities with *hikikomoris* as well as teenagers in early adolescence "on their way to social withdrawal." The signs of the syndrome are largely similar to the Japanese description, with some differences linked to the Italian cultural context. As to treatment, a single clinical approach (e.g. individual or family psychotherapy) has not given the expected results. By combining different approaches it may be possible to create a network able to stimulate the subject's resources and those of his or her family. Findings reveal the need to develop more in depth clinical knowledge on this social withdrawal syndrome and create new protocols which will be useful for future psychological and psychotherapeutic programmes.

Key words: hikikomori, extreme social withdrawal, adolescent mental health, psychotherapy

Streszczenie

Zespół hikikomori, czyli zespół skrajnego wycofania społecznego, polega na rezygnacji z udziału w życiu społecznym łącznie z odmową uczęszczania do szkoły lub pracy, a życie osoby nim dotkniętej ogranicza się do przebywania we własnym domu. W Japonii przypadki „hikikomori", nazywanych również „domowymi pustelnikami" (chory przebywa jedynie we własnym domu lub nawet tylko we własnym pokoju), po raz pierwszy zidentyfikowano i opisano w późnych latach 70. XX wieku. Obecnie w krajach zachodnich, takich jak USA, Francja, Wielka Brytania, Hiszpania i Włochy, obserwuje się rosnącą liczbę pacjentów „hikikomori" w okresie dojrzewania oraz młodych dorosłych trafiających do psychologów klinicznych. W minionych kilku latach do naszej Poradni Zdrowia Psychicznego Wieku Dziecięcego i Wieku Dojrzewania w Arezzo (*Unità Funzionale Salute Mentale Infanzia Adolescenza*, UFSMIA) skierowano pewną liczbę młodych pacjentów wykazujących znaczące podobieństwo do japońskich „hikikomori", jak również nastoletnich pacjentów we wczesnej fazie wieku dojrzewania „zmierzających w kierunku wycofania społecznego". Objawy zespołu, z którym mamy do czynienia, w dużej mierze pokrywają się z opisem japońskim, z uwzględnieniem pewnych różnic uwarunkowanych włoskim kontekstem kulturowym. W leczeniu wspomnianych przypadków zastosowanie jednego konkretnego podejścia klinicznego, takiego jak np. psychoterapia indywidualna lub psychoterapia rodzinna, nie przyniosło oczekiwanych efektów. Poprzez połączenie różnych sposobów postępowania w przypadku poszczególnych pacjentów możliwe wydaje się stworzenie sieci pomocy stymulującej zasoby własne pacjenta oraz jego rodziny. Wyniki badań wskazują na potrzebę poszerzenia wiedzy klinicznej dotyczącej tego zespołu wycofania społecznego, jak również stworzenia nowych protokołów terapeutycznych pomocnych w stosowanych w przyszłości programach psychologicznych i terapeutycznych.

Słowa kluczowe: hikikomori, skrajne wycofanie społeczne, zdrowie psychiczne w wieku dojrzewania, psychoterapia

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INTRODUCTION

At the end of the last century, the Japanese psychiatrist Saito coined the term "hikikomori" (1998) to define a particular form of social withdrawal widespread in Japan. Saito listed in his work the typical signs of this syndrome: social withdrawal and avoidance for at least six months, school phobia and school dropout, apathy, reversal of circadian rhythm of wakefulness-sleep, violent behavior in the family, especially towards one's mother. The main characteristic is the self-segregation on the part of the subject in his or her room (Teo, 2010). These teenagers and young adults avoid occasions that lead to direct eye contact, for example places where you are expected to greet people, such as bars, hairdressers etc. (Wong, 2009).
The widespread phenomenon among teenagers and young adults prompted the Japanese Ministry of Health to conduct a systematic study on hikikomori (Ministry of Health, Labour and Welfare, 2003). As a result of this research, it was found that in one year fourteen young people had turned to a mental health center due to hikikomori*. The Ministry has established some guidelines in order to identify hikikomori: lifestyle is centered around the home; complete withdrawal from the social context for six months or more; refusing to go to school and/or work; at the time of the occurrence of the phenomenon no diagnosis of schizophrenia, mental retardation or other major psychiatric disorders have been noticed. It is important to note, that people who do not go to school or work, but continue to maintain social relationships are not considered hikikomori.
The psychiatric debate in Japan focuses on two different points of view. The first supports the use of the diagnostic categories provided in the DSM (Kondo *et al.*, 2013). The second makes a distinction between two types of hikikomori: primary hikikomori is not defined as a mental disorder, but rather as a condition that implies behavioural problems, secondary hikikomori is characterised by a pervasive developmental disorder (Suwa and Suzuki, 2013; Suwa *et al.*, 2003). For this reason, according to other psychiatrists hikikomori should be identified via an independent diagnostic category, in order to legitimize an update of the DSM-5 (Teo and Gaw, 2010).
Studies conducted in Asian and Western countries have revealed that the hikikomori phenomenon is not unique to Japan (Mastropaolo, 2011), but also occurs in countries such as Spain, France, United States, Australia and the UK as well as in other Asian countries (Kato *et al.*, 2012). Some authors believe that hikikomori, although strongly influenced by Japanese culture, transcends the cultural context (Sakamoto *et al.*, 2005).

* Recent epidemiological data report approximately 410,000 cases in Japan (Furlong, 2008); indirect evaluation hypothesizes 600,000 cases among Japanese aged between 20 and 40 years old (Suwa and Suzuki, 2013), and over a million subjects if adolescents are included (Borovoy, 2008).

HIKIKOMORI IN ITALY

Several reports show evidence of teenagers in Italy with similar behaviour to those of their Japanese peers (Piotti, 2012). These studies reveal the existence of adolescents who reduce their engagement with the outside world to a minimum by communicating just through technology; sometimes they even avoid this last form of contact. Several public and private social services have started to treat hikikomori patients. The programme envisages two clinicians working in parallel with the parents and a therapist for the boy or girl. Due to the frequency with which these adolescent patients resist coming out of their rooms, the use of the telephone has proven to be a useful and effective first Approach (Ciufferi and Mancini, 2011). In Milan, the "Free Counseling Service for withdrawn teens who abuse technology" is conducting a study on social withdrawal in adolescence. The Counseling Service in Milan treated 139 youths between the ages of 9 and 24 in the period from January 2012 to April 2014. About half of the subjects manifested similar behavior to hikikomoris. Clinical treatment and social rehabilitation based on parental consultation, house visits, workshops, individual psychotherapy, has enabled the Service to collect a wealth of clinical knowledge (Cooperativa Minotauro, 2014).
Just recently several teenagers accompanied by their families in Arezzo were admitted to *Unità Funzionale Salute Mentale Infanzia Adolescenza* – UFSMIA (Child and Adolescence Mental Health Unit) due to severe social withdrawal. These admissions have led to an epidemiological study in order to quantify these behaviors among very young people, including 109 classes of middle schools, 2,694 students, aged 11–16. We investigated in particular the group named "great absences," constituting 27.1% of the students taking part in the research. The average age was 14.5 years, with males more numerous than females (59.3% against 40.7%); 66.6% of students had been rejected one, two or three times (Ranieri *et al.*, 2015a). These kids do not go to school and do not even leave the house. Such behaviour is accompanied by progressive withdrawal from relationships with others and gradual retreat to their bedrooms. The wakefulness-sleep cycle is strongly altered in all subjects. Time spent in one's bedroom flows by, doing nothing or, at best, engaging in solitary activities such as drawing, video games, reading comics, using internet and no contact within social networks. Family relations seem to have a typical and recurring pattern: a father who has been absent for a long time and, despite his willingness, does not manage to recover the family relationship in the present; a mother who is very attached to her son/daughter but for different reasons is constantly anxious. Her anxiety stems from her actions and choices, and she is unable to set limits. Almost all the boys and girls have one or more pets. No eating disorders were reported, nor symptoms that lead to psychopathological conditions such as psychosis, mental retardation, autism. The emotional fragility of the subjects requires

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great caution on the part of the clinician in the early stages of therapy, before a significant therapeutic relationship is established.
At our unit, we met both girls and boys who could be defined as being "on their way to social withdrawal." Not all signs of discomfort were present in this case. There have been several situations where contact with their peers had essentially been interrupted, yet they still attended school, experiencing it as a solitary practice in a class of strangers. Unfortunately, the school was not able to identify the social withdrawal until they actually quit school. For this reason, teachers could provide information that will only partially be useful to the clinician.

CLINICAL EXPERIENCE

The aim was to identify, from the collected clinical data, the criteria useful for the design of a single therapeutic protocol (Ranieri *et al.*, 2015b, 2015c). This objective was not, in fact, met. Clinical experiences paved the way towards therapeutic and rehabilitation strategies, modulated from one case to another. On several occasions, a combination of individual psychotherapy and family counseling and/or family psychotherapy, sometimes associated with vocational education programmes, resulted in the desired effect of reactivating the social contacts and relationships with others. In other cases, alternative forms of intervention were activated, ranging from psychopharmacological treatment to social work, from signalling cases to the Juvenile Court, to temporary removal from the family and placement in a community. A given therapeutic and rehabilitation programme is progressively calibrated, mainly on the basis of the psychological and human resources of the family and of the individual adolescent, as well as depending on the degree of the impairment of family relations, and the response to the individual clinical interventions proposed. The clinical vignettes below attempt to explain why we have come to this conclusion.

Clinical case "A"

R. is a 13-year-old girl. When her parents arrived at the Mental Health Service, R. had quit school a few months previously, and was then rejected. R. lived in her bedroom and had no relations with the outside world, nor did she engage with social networks. Sometimes she also shut out her family. As the first step, the Service based treatment on interviews with R's parents. After about two months, the girl agreed to leave her bedroom to meet a psychologist. R. began individual psychotherapy, which unfortunately came to an end after about three months. Hence, the psychologist started home-visiting, in order to re-establish the relationship with R. Meanwhile, family psychotherapy continued. Subsequently, a professional educator was included in the programme three times a week. The educator met R. at her home. R. gradually accepted some short outings with the educator, and eventually resumed her sessions with the psychologist at the clinic. At present, R. still refuses to go back to school, but has resumed an acceptable level of social interaction for about a year now.

Clinical case "B"

V. is a 13-year-old girl. When she arrived at the Mental Health Service she presented the typical symptoms of a hikikomori, i.e. marked social withdrawal. V. totally refuses to meet or to engage in any kind of relationship with adults or peers. V. left school and failed the year, although she was considered a clever student. V. was offered individual psychotherapy at the UFSMIA, which she accepted. The therapy became for V. the only "coming out" of her bedroom. After eight months, the clinical team was able to claim that the psychotherapy had yielded good results, but no change in V's lifestyle was registered. Hence, family psychotherapy was integrated into V's individual therapy, and a professional educator was also called to action. The educator visited V. at her home in order to foster/harness contact with the outside world. The new programme yielded interesting results in just a few months. V. started going out, and after following the programme for two years, she finally was able to resumea good social life. She undertook private tuition, and passed her middle school leaving exam, but was not able to go back into classroom when it was time to go to secondary school. For the moment, the family and the clinicians have decided to get V. to try some professional training courses.

CONCLUSIONS

The two clinical case studies described above demonstrate that treating hikikomori patients is a complex process. A single approach (e.g. individual psychotherapy or family therapy) is not sufficient. With a combination of different clinical and educational approaches, it is possible to create a network able to promote the resources of the subject, of the family and of the social context. Social work is no less important. In this perspective, the home-based interventions which include more than just home visits are particularly suitable. Nevertheless, interventions require a new point of view and a change of the attitude of the local community towards the extreme social withdrawal of adolescents. Promoting new resources, the creation of groups of self and mutual help, and associations of voluntaries, requires the awareness of the hikikomori phenomenon, and seeing it as an emerging form of social disease.
Although the limitation of this paper is the sole presentation of experiences with very young people, some aspects could be interesting for many health workers. It would be useful, when a clinician listens to a description of social withdrawal (also in the case of older adolescents or adults), to look beyond the common diagnosis, exploring the intersection between culture, anthropology, and mental health. The results

of the present work highlight the need to increase the clinical knowledge of the syndrome of extreme social withdrawal, and to create new integrated programmes useful for the sake of treating such patients.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organizations which might negatively affect the content of this publication and/or claim authorship rights to this publication.

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Piśmiennictwo / References

Borovoy A: Japan's hidden youths: mainstreaming the emotionally distressed in Japan. Cult Med Psychiatry 2008; 32: 552–576.
Ciufferi MG, Mancini F: Esperienze terapeutiche con adolescenti che si isolano. In Sagliocco G (ed.): Hikikomori e adolescenza – Fenomenologia dell'autoreclusione. Mimesis, Milano – Udine 2011.
Cooperativa Minotauro: La bruttezza immaginaria – Intervento clinico con i ragazzi ritirati. Atti dell'evento culturale tenutosi a Milano il 9 e 10 maggio 2014. Available from: http://www.telecomitalia.com/content/dam/telecomitalia/Generalistic-images/Documenti/ricerca.pdf.
Furlong A: The Japanese hikikomori phenomenon: acute social withdrawal among young people. Sociol Rev 2008; 56: 309–325.
Kato TA, Tateno M, Shinfuku N *et al.*: Does the 'hikikomori' syndrome of social withdrawal exist outside Japan? A preliminary international investigation. Soc Psychiatry Psychiatr Epidemiol 2012; 47: 1061–1075.
Kondo N, Sakai M, Kuroda Y *et al.*: General condition of hikikomori (prolonged social withdrawal) in Japan: psychiatric diagnosis and outcome in mental health welfare centres. Int J Soc Psychiatry 2013; 59: 79–86.
Mastropaolo L: Nuove patologie adolescenziali o nuove emergenze sociali? L'hikikomori è solo giapponese? Terapia familiare 2011; 97: 31–57.
Ministry of Health, Labour and Welfare: Community mental health intervention guidelines aimed at socially withdrawn teenagers and young adults. Ministry of Health, Labour and Welfare, Tokyo 2003.
Piotti A: Il banco vuoto. Diario di un adolescente in estrema reclusione. FrancoAngeli, Milano 2012.
Ranieri F, Andreoli M, Bellagamba E *et al.*: Adolescenti tra abbandono scolastico e ritiro sociale: il fenomeno degli "hikikomori" ad Arezzo. Il Cesalpino 2015a; 14: 13–17.
Ranieri F, Andreoli M, Bellagamba E *et al.*: Early adolescents in social withdrawal: elements for the assessment of hikikomori syndrome. Proceedings of the 23rd EPA Congress of Psychiatry, European Congress of Psychiatry; Mar 28–31, 2015b; Vienna [Poster]. Elsevier Masson SAS.
Ranieri F, Andreoli M, Bellagamba E *et al.*: Early adolescence in social withdrawal: two hikikomori in treatment. Proceedings of the 23rd EPA Congress of Psychiatry, European Congress of Psychiatry; Mar 28–31, 2015c; Vienna [Poster]. Elsevier Masson SAS.
Saitō T: Shakaiteki hikikomori: owaranai shishunki [Social Withdrawal: A Neverending Adolescence]. PHP Shinsho, Tokio 1998.
Sakamoto N, Martin RG, Kumano H *et al.*: Hikikomori, is it a culture-reactive or culture-bound syndrome? Nidotherapy and a clinical vignette from Oman. Int J Psychiatry Med 2005; 35: 191–198.
Suwa M, Suzuki K: The phenomenon of "hikikomori" (social withdrawal) and the socio-cultural situation in Japan today. Journal of Psychopathology 2013; 19: 191–198.
Suwa M, Suzuki K, Hara K *et al.*: Family features in primary social withdrawal among young adults. Psychiatry Clin Neurosci 2003; 57: 586–594.
Teo AR: A new form of social withdrawal in Japan: a review of hikikomori. Int J Soc Psychiatry 2010; 56: 178–185.
Teo AR, Gaw AC: Hikikomori, a Japanese culture-bound syndrome of social withdrawal? A proposal for DSM-5. J Nerv Ment Dis 2010; 198: 444–449.
Wong V: Youth locked in time and space? Defining features of social withdrawal and practice implications. Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community 2009; 23: 337–352.