

The Hikikomori phenomenon: when your bedroom becomes a prison cell

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Abstract. Hikikomori is a Japanese word that describes a condition in which adolescents or young adults live in isolation from the world, shut inside their bedrooms for months or years. There is significant variability in terms of behaviour, both in the time spent using a computer, and the degree of isolation observed. This syndrome was described in Japan in the early seventies. In the West (USA, Canada, France, UK, Spain, and Italy), clinical psychologists are treating an ever-increasing number of young Hikikomori. In this article, we consider two cases of serious social withdrawal whose features are very similar to those of Hikikomori described by Japanese colleagues.

We will focus on the Japanese family structure that produces Hikikomori and examine the structural elements common to those in Italian families. What emerges is a reliance on the mother figure and an absence of a strong father figure to introduce the child into society: therefore, the family structure seems very similar to that observed by Japanese researchers.

Keywords: Hikikomori, Family, Teenagers, Addiction, Internet.

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Introduction

Adolescence is that time in a human being's life when the mental foundations established in very early infancy are recalled in order to construct a new and permanent identity. This phase sees many adjustments come into play and unfortunately, some adolescents do not manage to cross the threshold into adult life, encountering varying degrees of malaise and mental disorders that may mean an interruption of the developmental process towards adult identity.

Some symptoms are insidious and vague and both families and schools, or other educational or health institutions, often find it difficult to flag them and initiate support or help services. Social withdrawal and isolation certainly fall into this category. Especially in this day and age, with the development of new technologies, it is becoming increasingly difficult to distinguish between a normal teenage process and an interruption in the developmental path dominated by symptoms such as Internet addiction, isolation, social phobia, personality disorders, and depression, among others. A new and harmful form of malaise seems to be taking over the lives of some adolescents: the social withdrawal of young people (especially boys) who stop going to school and spending time with their peers only to shut themselves in their bedrooms for months or years.

From the year 1970 onwards, the Japanese saw a particular kind of extreme social withdrawal (Severe Social Withdrawal) which they called Hikikomori, a Japanese word which describes social and family dysfunction (Stip, Thibault, Beauchamp-Chatel, & Kisely, 2016; Watts, 2002; Kato, Shinfuku, Sartorius, & Kanba, 2011).

The first to use the term Hikikomori was Saitō Tamaki in 1998 (Saitō, 1998): "Sometimes when students skip school for whatever reason and this continues for an extended period of time, they are expelled from school and end up spending their time at home, remaining there well into their twenties. Some of these former students who remain at home – perhaps even the majority – eventually reach a state of withdrawal in which they lose almost all connection to society whatsoever.

The words *shakaiteki hikikomori* that are used to refer to this state are a direct translation of the English words *social withdrawal*. In Japanese, these words do not feel like a very idiomatic translation, but it is not hard to understand what it means – the *shakai* meaning "society" is used here to refer to relationships with other people in general. In other words, the term refers to the act of retreating from society and avoiding contact with all people other than one's own family. That is what is meant by *shakaiteki hikikomori* or "social withdrawal".

According to Saitō Tamaki, skipping school is not the only thing that might lead to a state of withdrawal, in his experience the overwhelming numbers of cases begin when a student starts skipping school and his or her period of absence grows increasingly longer.

The malaise mainly affects adolescents or young adults (14-30 years of age) who live cut off from the world, shut in their bedrooms for months or years. They often refuse to communicate even with their own family, are sometimes aggressive (especially with the mother), use the Internet heavily, read Manga comics, and only leave their rooms for the most pressing of needs. Some have their food left outside the door, while others go out at night to get something to eat in nearby supermarkets. There is significant variability in terms of behaviour, both in the time spent using a computer, and the degree of isolation observed. None of them attend school or go to work. Withdrawal from school is often explained by acts of bullying, which is a widespread phenomenon in Japan.

Saitō lists the signs that may distinguish the Hikikomori syndrome: social withdrawal for at least six months, phobia of and withdrawal from school, obsessive and compulsive symptoms, social avoidance, lethargy, depression, inversion of sleep-wake rhythm and violent behaviour towards family members, especially towards the mother. Hikikomori are defined as “family hermits” (Saitō, 1998) or “bedroom hermits” (Ryall, 2003) or even more recently, “metropolitan hermits” (Charmet cit. in Spiniello, Piotti, & Comazzi, 2015), due to the fact that the phenomenon seems to occur more often in urban areas.

Lots of Hikikomori spend up to 12 hours on the computer, and many authors believe Internet dependence to be primary to social withdrawal (Y. S. Lee, J. Y. Lee, T. Y. Choi, & J. T. Choi, 2013; Teo et al., 2015), while others (Stip et al., 2016) believe it to be secondary and that using the Internet and social networks is, in fact, the only way in which the withdrawn young person maintains a particular connection with the rest of the world.

The concept of Hikikomori is contentious. Most studies show the absence of a clear definition of the term, and there is no consensus on the diagnostic criteria to identify a well-defined syndrome (Li & Wong, 2015).

Furthermore, while many authors consider this malaise to be a specific cultural response (*a cultural bound syndrome*) (Aguglia, Signorelli, Pollicino, Arcidiacono, & Petralia, 2010) to changes that have occurred in Japan in recent years, and link the emergence of this disorder to the social, family and cultural structures of Japan (Furlong, 2008), others consider it an emergent psychiatric symptom that is also present in other countries (Tateno, Park, Kato, Umene-Nakano, & Saito, 2012).

In recent years, there have been many publications on the spread of this phenomenon outside Japan. Descriptions of comparable cases in completely different and distant countries such as Spain, France, the United States, Australia and Great Britain have caused the initial definition according to which Hikikomori was an exclusively Japanese syndrome to be abandoned, and have returned to the idea that this phenomenon transcends the cultural context to which it belongs while also being influenced by it (Kato et al., 2012). Indeed culture is not considered external to the individual, but as a specific structure of social origin which both contains and enables the functioning of the psychic apparatus. There can be no mental process without the existence of a cultural filter that organises and provides the necessary instruments for the person to interact with the world (Aguglia et al., 2002).

The situation in Italy

A number of articles and publications in Italy have reported cases of adolescents with very similar behaviour to that of the young people in Japan. Particularly from 2008 forward, the number of cases of acute social withdrawal has continued to grow (Spiniello et al., 2015) and colleagues in various parts of Italy have observed this phenomenon, despite the fact that precise quantification remains an issue.

Initially, a number of Hikikomori cases were reported in the South, where the matriarchal family structure reflects the Japanese one. According to Saitō Tamaki, there is an aspect where a comparison can be drawn between Japanese and Italian culture, namely the tendency of parents to “keep” their children at home beyond a certain age, a situation which seems to increase the likelihood of exhibiting this young people’s malaise through the Hikikomori characteristic of shutting themselves away, rather than more aggressive ways such as bullying or “pack behaviour” (Ricci, 2008).

Although an estimate published on the FNOMCeO (Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri) [National Federation of the Orders of Surgeons and Dentists] website speaks of 240,000 cases, it equates social withdrawal to Internet dependency, and is based on a criterion (the fact that the subjects spend more than three hours a day using their PC) that seems excessively restrictive, taking into account recent online developments. In fact, due to the spread of new technology in recent times, many adolescents and young adults (digital natives), use the Internet and social networks to study, play or communicate, but this fact does not necessarily need to be labelled in a clinical sense (Spiniello, 2015).

In recent research (Di Lorenzo, Lancini, Suttora, & Zanella, 2013) the Cooperativa Sociale Minotauro di Milano [The Minotaur Social Cooperative in Milan] examined the link between overuse of the Internet and the presence of significant mental disorders and the authors estimated the number of serious social withdrawals at approximately 30,000 subjects. However, Antonio Piotti (Spiniello et al., 2015) deduces that this research estimate excludes those subjects who display serious social withdrawal behaviour, though they do not use the Internet; he therefore places the size of the phenomenon somewhere in between the two proposed estimates, in other words between 60,000 and 100,000 cases in Italy. The fact remains that we still do not have reliable quantitative research data.

In follow-up intervention research on the adolescent problem of social withdrawal, also carried out by the Minotaur Cooperative, between January 2012 and April 2014, the Milanese Service took on 139 subjects between the ages of 9 and 24 years old. Approximately half of the subjects demonstrated behaviour ascribable to that of Hikikomori.

In a 2015 study, Ranieri et al (Ranieri et al., 2015) carried out an epidemiological investigation to quantify social withdrawal behaviour among adolescents in Arezzo. This research reveals that about 1% of those registered in the middle schools do not attend lessons and that some of them do not go to school because they shut themselves into their own homes, displaying behaviour highly similar to that described in the literature as Hikikomori.

The objective of this article is to put forward the hypothesis that serious social withdrawal (Hikikomori) is a clinically significant form of malaise, which manifests itself in the subject following the difficult phase of adolescence, and whose origins may be sought within the interactions of the family.

I am going to describe two cases of extreme social withdrawal that came to the Family clinic at the Centro Italiano Femminile (CIF) [Italian Female Centre] in Padua.

Case description 1

This is the case of F., a 15-year-old boy who has not attended school or any other educational institution and has not met friends or mates in two years. He spends his days locked in his room, connected to the Internet playing role-playing or video games, even for very long periods a day. F has a twin sister who does not show signs of malaise.

The consultation is sought by his mother, who comes to the CIF Clinic accompanied by F.'s former catechism teacher. I am shown the documents

relating to the actions undertaken up to that point: a psychologist from another Public service had gone to F.'s home for 10 months to talk with him, without success. Even the teachers and the principal of the school had tried many times to establish a constructive relationship with F., to no avail. The teenager had completed middle school with great difficulty and his parents had turned to a private school in an attempt to help him. Since infancy, attending nursery school had been hard and the teachers often called his mother because F. was refusing to stay at school and wanted to go home, displaying wide ranging distress, with fits of crying and anguish. Regardless of all this, he performs well both at primary and secondary schools. His parents suspect that F. may have been bullied between the ages of 11 and 12, though the boy has never explicitly talked about it. The only activity that seems to interest him in the least is cooking with his mother.

F. has never slept in his bed alone: up to the age of 12 he insisted on sleeping with his mother, and when she refused, serious physical arguments ensued. It is only then that his father intervened to force the situation, but F. went into a fit of rage on every occasion. The situation grew so unbearable that his parents eventually gave in and F. insisted on sleeping in the bed with the father every night, after spending a long period at the foot of the bed. The situation at home is so tense that the young man is even bitten by the family dog on several occasions.

The Team decides to summon F.'s father and after ascertaining his willingness to work on his own behalf and that of his son, we proceed with both parents. The theoretical-clinical approach of this family counselling is psychoanalysis-based.

What we established was that the teenager's social withdrawal behaviour is a response to the problems inherent in the family, which find an explicit symptomatic outlet in the child's malaise.

F. is the designated patient in an apparently functional family in which the roles are confusing and strongly characterised by hidden aggression. The bond with his mother, in particular, seems to be of a fusional nature, while the father proves to be a marginal figure, with little influence on the family environment. As the therapy takes its course, we discover that his father also suffered from social isolation as an adolescent, but never to the same extent as F. Even at the time of the consultation, his father does not have any friendships and admits he finds it hard to talk with both his wife and his children. The parental relationship appears to be characterised by a fusional bond, which does not leave room for others. As therapy progresses, both the acute difficulty of the father to assume any form of a rule-enforcing or rule-making position, and the position of the mother, who "holds" the husband and son in a regressive, infantile and dependant type of bond, distinctly

emerge. The position of the mother is steeped in intense separation anxiety, clearly evident when the father begins to allow himself to leave the home with the son to meet some friends, as part of the treatment process. When this happens, the mother displays violent opposition and begins to suffer from panic attacks. The main objective of this psychotherapy was to “unbind” the family members from one another, working on the one hand on maternal separation anguish and on the other hand on the paternal metaphor, with an aim to allowing the father to fully assume his role with regard to his son.

The course of psychotherapy with his parents was successful: after a few months, the family environment changed and F. agreed to attend a vocational school.

Case description 2

T. is a 32-year-old man who arrives at the Clinic acting on the advice of his father, who comes with him on his first visit. He has not worked or studied for about five years: he spends his days in his bedroom, on his computer, in chatrooms or on Skype. He says that he has a girlfriend who he has been “seeing” for six months. The couple have never met, but T. believes their relationship to be very solid. The reason why he has turned to the Service is that the girl has ended the relationship, as she feels stifled by the oppressive nature of the bond with T. The two young people would spend up to 12 hours a day on the computer; they shared a passion for Japanese comics, languages (they often talked in English) and role-playing games. Neither of them ever left their homes, except for occasional visits to nearby comic shops.

Now that the relationship is over, T. is overcome with sadness and does not know what to do: he feels lost without the virtual and continuing relationship with that girl, whom he only knows by her nickname. For T., on-line relationships are the only “social connections” he has with the outside world.

The young man is an only child and describes his family as a “perfect place to live”. He speaks of his mother as a “real psychologist”, with whom he shares many of his thoughts and his passion for reading. He also has a good relationship with his father, although nothing compares to the intimacy he shares with his mother. His father has also spent many years abroad for work, coming home only for short periods. Now he has lost his job and is spending more time with the family, although the mother-son bond has already taken a very precise turn and the father himself maintains that the two have a symbiotic bond.

There were significant bullying episodes during adolescence, which caused the loss of self-esteem and of confidence in relationships with peers.

The Clinic team decides to take on the young man, who seems collaborative and willing to undertake a course of psychotherapy: T. has to work through his fusional relationship with his mother and reconsider his own image as an adult male. The theoretical-clinical nature of this treatment is psychoanalytical and the young man came to the Clinic on a regular basis for two sessions a week. The main objective was to develop and examine the grandiose image of himself that T. presented, as a son who had been idealised by a mother who often found herself alone and seemed to seek in her own son a substitute for her partner.

The father also requested a course of therapy: he felt that he had many unanswered questions and his son's illness made him feel very guilty. Therapy with the father brought about a readjustment of family roles in a relatively short time. The father's worries were predominantly linked to a narcissistic dimension that was highly undervalued and imagined to be lacking, mainly to do with his working role, with little or no focus on the family level. Father and son found themselves in direct opposition and reciprocal competition, leading to confusion of their roles and intense hidden aggression.

Sincere will to undergo in-depth therapy represented a valid element of being willing to change and a strong motivation to achieve personal growth.

Following about one and a half years of treatment, T. managed to get a job in a travel agency and move to Japan, thereby fulfilling his teenage dream and his genuine passion for the Land of the Rising Sun.

Pathogenetic hypotheses

Japanese researchers have formulated various hypotheses regarding the pathogenesis of Hikikomori, traceable to the family system (from the symbiotic bond with the mother, the concept of Amai developed by Takeo Doi, 1971 to the absence of a father figure), to the school system (from bullying, to very pressured competitiveness in schools and workplaces), all the way to the very structure of Japanese society itself (Aguglia et al., 2010). As regards the studies on the family in particular, there seems to be a link between the onset of the disorder and dysfunctional dynamics (Lee, 2013; Maia, Figueiredo, Ponnié-Dax, & Vellut, 2014; Teo, 2010; Chan & Lo, 2014; Suwa & Suzuki, 2013), parental rejection (Krieg & Dickie, 2013) or overprotection (Li & Wong, 2015) and parental psychopathology (Malagon-Amor, Córcoles-Martínez, Martín-López, & Pérez-Solà, 2014; Umeda & Kawakami, 2012).

In this work, we will mainly consider the Japanese family structure that produces Hikikomori and we will attempt to investigate any structural elements shared with those of Italian families in which the problem of serious social withdrawal appears.

The Japanese family structure and Amae

It might be useful to examine the many articles and volumes establishing the particular structure of the Japanese family and especially the concept of Amae as the basis of the malaise of the young people who go into a state of Hikikomori.

Our hypothesis is that the malaise of the young person with severe social withdrawal is traceable within family interactions, and specifically in a symbiotic relationship with the mother that was never grown out of, as is maintained by many researchers (Ricci, 2008; Aguglia et al., 2010; Doi, 1971; Saitō, 1998; Saitou, 2011).

The concept of Amae can be attributed to the mother-son relationship established during the newborn's first months, which can be seen as "one and the same, mother-son" (Doi, 1971). When he starts to become more aware of the environment, and of being separated from his mother, that is when Amae comes into play: even if the baby accepts physical separation from the mother's body, he perceives proximity to her as essential, he wants to stay near her and he predisposes himself to being dependant, which in turn is tolerated and sustained by the mother.

In Japanese families, for instance, encouraging a baby to be independent and making him sleep alone is considered cruel: there is a bedroom for the child, but up to the age of around 10 it is only used for studying and games, and at night everyone sleeps together in the parents' bedroom. Maternal behaviour is that of complete dedication to her son, who absorbs an awareness of the mother's goodness and of her sacrifice as he grows, and develops a sense of obligation, which is then transferred to all social relationships and remains strong for life (Doi, 1971). The ideal to strive for is amaeru-amae, that is "a desire to be indulgent" on the one hand, and "a desire to be dependent on the other", something imperative to strive for, though it is hard to achieve, as it expresses a harmonious condition. In the Japanese tradition, a friendship or a romantic relationship is therefore considered more genuine and profound the more similar it is to that parent-child, telepathic, pre-linguistic relationship, free from all forms of secrecy. A kind of relationship that is totally different from that among *tanin*, "all the others", that is all those excluded from the intimate complicity developed in

Amae, and that creates the difference between relationships experienced *uchi* – inside and *soto* – outside (Ricci, 2008).

In other words, in the culture of the Land of the Rising Sun, the imperative for a harmonious life is “the desire to depend on another”: any relationship is considered more genuine and profound the more similar it is to that between parent and child (Doi, 1971). Dependence and conformism are seen as a unifying force of the social group striving for harmony: these ideals heavily influence the structure of the Japanese community. Through this logic, we are able to understand the choice made by the young Japanese who descend into Hikikomori, linked as it is to a dichotomy inherent in Japanese social structures in both the *uchi/soto* (inside/outside) environments. In the young Hikikomori, this dichotomy transforms into safe/dangerous and this is how the world outside their own bedroom is seen as unbearable, perilous and subject to the rules of peer pressure. The young Hikikomori, and all of his family, endure a sense of shame for not being able to manage the strain and the request for efficiency. Shame is the predominant feeling in this malaise: they are ashamed of not being able to participate in their peer group, and ashamed of their sense of incompleteness and the inadequacy of their very existence (Sakuta, 1967). However, with this shame comes omnipotence, which Japanese children experience from early infancy within the family structure, where it is the very same feeling of Amae, of dependence, that guides their vision of the world. The Japanese Amae mentality can be defined as the “attempt to deny separation from the mother on a psychological level [...] but in situations where the psychology of Amae predominates, conflict and anxiety associated with this separation lay in wait”. Therefore, the grandeur and the sense of omnipotence are consequential to the perfection of the primary mother-child couple dominated by Amae (Sakuta & Saikou, 1967).

The situation does not improve with adolescence: although it is clear that the child has grown and “is busy forming his character and his sexuality, and that the latter cannot be achieved with care nor can it be found in the family, the mother continues to tempt her child-adolescent by saying “let me give you Amae”, transforming a natural bond into a distorted Amae, which the child comes to depend on and she is nourished by: a kind of secret love affair, since nobody else can access it, not even a therapist, whose words are not listened to as they represent an obstacle. All this can be defined as symbiosis: in fact, after violent episodes, the desperate and overcome child often apologises to the mother and she takes him back into her arms and forgives him; she welcomes him back to this calm place disregarding the fact that she does not have a child in her arms and that what this person needs is something totally different (Ricci, 2008).

Is this not a horrid form of love, of distorted amae that has lost all control and sense of distance? (Saito Tamaki, 1998)

The force of the absent father and the male world

This dependence/omnipotence system occurs at its strongest and most virulent in the first-born child. The first-born male child is the one who has all the responsibilities and expectations of the family projected and placed on his shoulders. The first-born male is the heir to the family tradition in social structure (not only in Japan): he is the successor and new head of the family, whose role is to support the family unit, as well as provide for elderly parents. There are considerable expectations of him and failing to deliver on these creates an enormous sense of shame and of guilt.

Ricci writes: “This tendency to sustain the idea of omnipotence mostly concerns the men who bear the highest social expectations and it is certainly no coincidence that over 90% of Hikikomori are men, and that they often express a wish to become famous, almost as if they were children who never grew up” (Ricci, 2008).

The Japanese male world is a world of absent fathers, men at the mercy of stifling social pressure due to competition and dedication to work, trapped in a society of silent emotions and placed within a family where the wife plays the leading role, managing the family, the children and all social relationships entirely on her own: this world is anything but patriarchal, and is now experiencing the development of social paradoxes such as RHS (*Retired Husband Syndrome*) (Moretti, 2010).

RHS (or Retired Husband Syndrome) can be observed in the wives of salaried men, the word used to describe employees in Japan. More than 60% of the wives of retired Japanese men develop illnesses that are sometimes very serious, such as hypertension or depression. According to the Japanese Ministry for Health, the women find it extremely difficult to bear the presence of the husband in their lives, as they are used to having a certain degree of independence, so much so that in Japan an alarming increase in the divorce rate between couples who have been married for twenty years or more has been recorded (Salomon, 2007).

Furthermore, the year 2005 saw approximately 35,000 cases of suicide in Japan, 16,000 of which were men between the ages of 40 and 60 years old (Ricci, 2008). Therefore, it is clear that in Japan it is not only the adolescents who are experiencing very profound malaise, but also their fathers. Unlike what is happening to the mothers, the men feel like they have no way out: “they are aware that their commitments and struggles cannot be

delegated or modified. If adolescents suffer from a malaise caused by a conflict between opposing situations, for fathers it stems from a disenchanting reality, with no prospect of choice or change, and for this reason they are passive and resigned to it.”

In the young Hikikomori “one of the conflicts arises from a failure to be like their father, or not at all wanting to be like him [...] As regards the relationship between the young Hikikomori and his father, even though society approves of the male role of showing total commitment to work, it is nevertheless aware that the absence of a father figure is amongst the causes of Hikikomori” (Ricci, 2008, p.52). The absence of a father figure is a recognised cause for descent into Hikikomori, if not the main cause, along with maternal Amai (Aguglia et al., 2010; Doi, 1971; Saitō, 1998; Saitou, 2011; Moretti, 2010; Ricci, 2008).

Saito Satoru demonstrates it is not only the physical lack of a father that causes the problem: there is a real physical absence, but there is also a presence of the patriarchal figure he represents. This presence is made explicit in the family as a silent and delicate violence, which can manifest itself in various ways: by frequently telling the father’s personal story, talking about his educational achievements and his commitment to work in order to make these a high ideal to strive for. This makes his presence powerful and intrusive, even when he is not physically there, which raises the whole family’s expectations of the son. Even the mother, who supports this project we might define as both familiar and social, contributes to all this, always holding up the father as an example and softly controlling the emotional journeys of her son, so she can worm her way inside until the generation gap is closed. This results in a form of attachment that contributes to the development of a sort of exaggerated narcissism in the child, who always finds himself in a “comfortable warm bed, cuddled and feeling special” (Saito, 2001).

Saito Satoru presents the Japanese man as “virility-ill”, which in Japan means he is a calm, strong man who is focused on his job, in constant control of his feelings, and never lets his emotions show, a man who seldom speaks but whose words are judgements and the family depends on him both economically and psychologically.

“The virility-ill man is a man who is under a lot of stress, caused mainly by his superjob and by social pressure. He finds himself trapped in a world of mistaken emotions, he cuts close relationships with his family, and he avoids dialogue with himself and with others using the plausible excuse of work, and ends up being dragged into a self-destructive way of life. So he falls into a world of *alexithymia*, a lack of ability to express emotions; we can affirm that he excessively intensifies his image of virility, going from what was

controlling emotions as an acquired cultural practice, to totally losing these emotions” (Ricci, 2008, p.55-56).

According to Saito Satoru, this “virility illness” is contagious, since the alexithymia is spread to the son via that silent stress that leads the children to take their father’s values as their own, including the intensification of the virile man and the annihilation of emotional states.

According to Sheper-Hughes (2000), it may be plausible to say that the young people who seek refuge in Hikikomori are also shutting themselves into a world devoid of emotions, just like their fathers, enclosed in their alienation. However, there is a significant difference between the fathers and sons: those in Hikikomori are also expressing a form of social criticism. Unlike their fathers, those young people are probably trying to rediscover that lost world of emotions, and maybe they are attempting to listen to that wise body, subversive by nature, and want to purposely show this by producing rebellious symptoms.

The family structure of the young Hikikomori

From clinical observation of the cases briefly referred to above, a family structure very similar to that illustrated with reference to the Japanese Hikikomori emerges, though there are some variants.

In an interview (Pierdominici, 2008), Saitō Tamaki equates the social withdrawal phenomenon to those known in Italy as “i mammoni (the mammy’s boys)”, revealing how he has many requests for intervention concerning the Hikikomori phenomenon, especially from the south of Italy. He insists that while in Japan parents keep their children at home, still providing for them economically, until they are thirty, or even forty, due to the influence of Confucianism on culture and society, American or European parents send their adult child out of the home, this way he cannot become Hikikomori.

Therefore, after dedicating much of his professional life in the clinical environment to this grave form of social withdrawal, Saitō Tamaki attributes the origin of this malaise to a dependence on the parents, which is not obstructed in Japan, but is actually encouraged by the dominant social culture.

If we can state without any doubt that the social structures in the Land of the Rising Sun are profoundly different from those in the West, and in particular from those in Italy, we can nevertheless not ignore that the element of dependence on the parental figures is also present in the families that we analysed.

In actual fact, in the clinical cases referred to above, the elements of dependence on the maternal imago (known as *Amae* by the Japanese), and absence of a father figure are easily explained. It is not the physical absence of the father that produces this syndromal pattern as much as the momentous fragility of these fathers (which is therefore resolved by absence), who in turn have often suffered from social maladjustment, endured oppression, and encountered failure in the past.

Analysing the figures of the fathers who came to the Minotaur Clinic in Milan, Antonio Piotti (Spiniello et al., 2015) writes: “There is an element which all these fathers share, whatever their attitude may have been: the sense of having failed, of not having anything more to say, of bitterly being forced to realise that their function, more so than themselves as individuals, has been revealed as ineffective.” Furthermore: “The father of these young Hikikomori is not a hero, he is not a significant character, he is not an authoritative figure, he does not represent any ethical principle, meeting him does not bring about that historic leap of which Zoja speaks (2000) when he describes the cultural revolution carried out by fathers in the course of history. Instead, he is just the vacuum this leaves behind, a puppet, still honoured with the uniform of authority, and this is why it is not difficult to see the insufficiency that lies beneath: as if, at that crucial moment in adolescence, the father revealed himself as false and inadequate, so that all the infantile expectations and idealisations were destined to founder in one dramatic disillusionment”.

The fathers who we treated were not physically absent, in fact, they were very much present, but they were not able to fulfil the role of introduction to the outside world, and to society, of interpretation of the world, which the father figure must try to ensure. We were dealing with fathers affected by the same “virility illness” of which Saitou Satoru speaks.

The concept of alexithymia, in particular, has proven to be especially useful in order to understand the subjective position of the fathers mentioned in the two clinical cases above. These men appear divided and incapable of dealing with their own emotions, which in turn are anaesthetised by the potent mechanism of denial: anger, apprehension, fear, and desire are quite simply rendered “non-existent” and every element of subjectivation is just rejected by the psychic apparatus. They are effectively “empty vessels”, in other words individuals in whom the element of subjectivity is reduced to a minimum, individuals who do not permit themselves to be individuals. Their point of reference is their wife/mother, on whom they depend like children. The family structure is therefore compromised, as the position of the son is threatened by his own father, who in turn becomes a kind of incestuous older brother. A family revolving completely around the maternal imago, on whom

everybody depends, both father and children. It is the mother who is in charge, and sees to the desires and the needs of each family member. She readily accepts this kind of role, as it provides her with the narcissistic recognition that she craves. Therefore the therapy aimed to separate each individual subject from the other, providing each one with a way to find within themselves the necessary resources to survive independently. This is no easy task, as the fundamental issue here regards narcissistic recognition, which each member lacks. Each subject needs to be reconnected with their own desire, their own emotions, their own singularity. This normally requires years of treatment. In the two cases detailed above, the work is on-going, but the young Hikikomori have at least started the process of separating themselves a little from the family and trying to do something for themselves: one moving to the other side of the world and the other enrolling in a vocational school. Both have risked following one of their desires, allowing themselves to pursue it and let go of *Amae*, that incestuous maternal love which was imprisoning them in their own homes and bedrooms.

As Giulia Sagliocco states in her brief introduction “Adolescence as a *form* of existence” (Sagliocco, 2011) regarding family therapeutic intervention put in place with adolescent Hikikomori: “by transforming the close interdependence between parents and children into mutual recognition, it has been possible to open up the paradoxical communication between mother and son, beginning with understanding the meaning of a shield, represented here by the use of a computer, to watch the world through in order to avoid becoming immobilised. This opening up is just a brief interval in the interminable battle for recognition”.

Family members of Hikikomori are in a position of reciprocal dependence on one another; the son, who is caught in this immobilising grip, cannot go down the road of becoming a man, because he lacks a strong foothold to support him: so he decides to withdraw in silence into his bedroom until he figures out what to do, running the risk of getting trapped in there forever.

We therefore concur with Ricci (in Sagliocco, 2011, p.39): “In my opinion, Hikikomori represent the first resounding results of a state of crisis, primarily of the family, a family that has done nothing but keep them warm and take care of them without providing the appropriate tools to make a life of their own, however nonconformist it may be”.

Conclusions

The two clinical cases described above demonstrate that treatment of Hikikomori patients is a complex process. In fact, it concerns subjects who

do not illustrate any clear request for treatment and who do not appear to ask for anything of their surrounding environment. For this reason, it is particularly hard to provide them with care. The literature contains numerous and varied recommendations for treatment ranging from the educational approach, to mutual help groups, to family therapy, to voluntary associations. This study has described the features of family issues, in particular a dependence on the mother figure and an absence of a father figure who is influential enough to guide the young boy along the path of developing his adult identity. As also Funakoshi and Miyamoto state (2015) the involvement and support of the father figure is crucial, as is encouraging both parents to resolve their issues together. Therefore, we believe it is fundamental to press the parents to find a new style of relationship with their son, in order to open a passage to the outside world for the young boy who has retreated from the challenge the world presents.

Notes

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