When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context

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Abstract

In the late 1990s, a new form of social withdrawal started raising concerns among the Japanese society. The expression "hikikomori", composed by the terms "hiku" (to pull back) e "komoru" (island), is used to refer to this condition that, today, does not involve only the Japan but appears to have spread also in other countries, including Italy. Since its advent, health specialists have engaged in a debate on whether such a phenomenon should be considered a mental illness or a social condition. The present paper, after a brief excursus on the proposed criteria for a clinical diagnosis of hikikomori, poses the role of the socio-cultural context in influencing the way the behaviour is shaped, experienced, communicated, and responded to by others. The assumption framing this work is that the context may work as a source of malaise, lacking resources and opportunities and making hikikomori a kind of "silent" reaction to the difficulty to reach the paces and the standards of performance required by family, school, and society in general. The role of Internet in this extreme form of social withdrawal will be focused, considering that the hikikomori may over-indulge in the internet as a way to compensate his/her social isolation, as well as the excessive internet use may lead to prefer online social interactions till to a complete social withdrawal. Finally, future directions in intervention policies will be discussed.

Keywords: *hikikomori; socio-cultural context; psychosocial malaise; problematic internet use.*

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Introduction

In the late 1990s, a new form of social withdrawal started raising concerns among the Japanese society. The phenomenon mostly involved adolescents and young adults who voluntarily decide not to participate in the life of society, up to confining themselves at home or rather in their own room. The Japanese psychiatric Takami Saitō (1998) introduced the expression "hikikomori", composed by the terms ""hiku" (to pull back) e "komoru" (island), to refer to this condition that, today, does not involve only the Japan but appears to have spread also in other countries, such as the near China and Korea (Wong et al., 2019), as well as Canada (Stip et al., 2016), Europe (Sarchione et al., 2015), U.S.A. and Australia (Stavropoulos et al., 2019).

Regarding the prevalence of the phenomenon in Japan, Koyama and colleagues (2010), through a survey, outlined how 1.2% of the interviewed individuals between 20- and 49-years experienced hikikomori in their life, and that 54.5% of such individuals also experienced previous psychiatric disorders (anxiety, mood, impulse control, or substance-related). More recently, the Cabinet Office of Japan (Tajan et al., 2017), during an epidemiologic study on hikikomori involving individuals between 15 and 39 years old, found 49 hikikomori cases that correspond to 1.6% of the sample. According to nippon.com (2019), the hikikomori cases between 15 and 39 years old should be around 541.300; between 40 and 64 years old, numbers are close to 613.000. Thus, the Japanese government estimates more than a million hikikomori cases in Japan. Hikikomori appears to be a typically male condition, with 90% of the affected individuals being male (Aguglia et al., 2010), whereas women's social withdrawal seems to be usually associated with other primary disorders (Lancini, 2019; Suwa & Suzuki, 2013).

Since the phenomenon broke out and began to spread in Japan, the majority of studies are conducted there; yet it will be interesting to analyse and reflect on forms of extreme social withdrawn also in Western contexts, where, although we lack detailed prevalence rates, European psychiatrists reported cases of people retired from social life (Kato et al., 2012). For instance, in Italy the "National Federation of Orders of Surgeons and Dentists" (Federazione Nazionale degli Ordini dei Medici Chirurghi e degli Odontoiatri, FNOMCeO) in 2013 suggested that may be almost 240.000 socially withdrawn individuals in the country. The Italian context will be recall throughout the present reflection of hikikomori.

Hikikomori: a matter of psychiatry or a matter of society?

In the last decades, deservedly hikikomori has gained increasing attention from health specialists, engaged in a debate on whether such a phenomenon should be considered a mental illness or a social condition (Caresta, 2018; Chan & Lo, 2014; Ricci, 2015; Saitō, 1998). To date, there are no standard criteria for a hikikomori diagnosis (Aguglia, 2016; Nonaka, Shimada & Sakai, 2018), firstly because the international research on the subject is in its early stages, and, second, due to a multitude of different frameworks and conceptualizations (for a systematic review: Li & Wong, 2015). Adopting a psychiatric approach framed within the DSM-5 (American Psychiatric Association, 2012), at one side, cases of hikikomori seem to meet the diagnosis criteria for several psychiatric

disorders such as depression, obsessive-compulsive disorder and social phobia (Koyama et al., 2010; Teo & Gaw, 2010); from the other side, a strict psychiatric approach has shown some limits and inconsistencies, since a lot of hikikomori cases do not fully meet the criteria for a mental disorder diagnosis (Tan, Lee & Kato, 2021). This has led to differentiate between "primary hikikomori" and "secondary hikikomori" (Suwa & Suzuki, 2013): "secondary hikikomori" consists in the presence of social withdrawal associated with or caused by severe mental disorders such as anxiety disorder, obsessive-compulsive disorder or personality disorder; "primary hikikomori" does not involve symptoms which are enough severe to justify a mental illness diagnosis, rather the core marker is the significant impairment of the subject's life as he/she does not adapt to society rules and conventions, and does not participate to social interactions.

Starting from his pioneering observations on hikikomori cases, Saitō (1998), described as core symptoms of such condition the presence of social withdrawal and school dropout, inversion of the circadian rhythm, and lethargy. More recently, Kato and colleagues (2020) proposed a novel diagnostic set of criteria, that is: social withdrawal in the house, going out no more than three days per week; the social withdrawal goes on for at least six months; the social withdrawal effectively compromises the patient's life (work, relationships, health etc.).

It is reasonable to claim that reaching a widely shared set of criteria for the identification of hikikomori - as expected by a categorial and medicalized approach - if at one side may be useful for a rapid and replicable identification of a syndrome, at the other side lead to consider hikikomoris as representing a homogeneous group rather than as a multifaced group of people who withdraw for different reasons and who experience withdrawal in different ways (Furlong, 2008). Although undoubtedly hikikomoris may share some signs and characteristics, the insistence on common aspects is also critical, because it tends to obscure the differences related to the psychosocial factors, which may play a role in exposing them to the risk of PIU.

A more dynamic view of hikikomori is the one depicted by Kato, Kanba and Teo (2019) in their notable a bio-psycho-sociocultural model, spanning the hikikomori condition on a continuum which involves psychiatric issues (e.g. social anxiety, depression, personality disorders) and non-psychiatric issues (e.g. loneliness, low quality of the relationship with parents), so that a multi-dimension evaluation is needed to identify cases of hikikomori.

Furthermore, the authors outlined that some types of hikikomori might be a particular kind of coping strategy, namely an avoidance strategy in response to social situations and social judgments perceived as stressful. This means that such types of hikikomori may not be necessarily problematic, although they may evolve into a disorder if such condition persists over time.

Overall, hikikomori phenomenon seems to undermine a quite established tendency among scholars and clinicians to consider the "disease" as a static property of a sick individual (Reinarman, 2005); indeed, individuals who withdraw from society may differ for degree of severity of signs and symptoms as well as the degree of persistence over time and life impairment. The most popular interpretations of vulnerability to problematic behaviours, especially among youths, sees the preeminent role of intra-psychic characteristics: for instance, substance and behavioural addictions

are generally connected to the increased levels of sensation-seeking and low emotional stability connected to the developmental phase (e.g. Kelley, Schochet, & Landry, 2004; Kuss et al., 2014). Hikikomori itself is described from a psychoanalytic perspective as an evolutive issue: the subject cannot grow up beyond childhood and that is why the syndrome arises during puberty and teenage years, when the body grows up but the mind cannot, creating a short circuit that leads to social withdrawal. Growing up means leaving behind the infantile world, characterized by omnipotent and narcissistic features, to step into the adult world, which involves oedipic features, thus responsibilities towards others and themselves. The hikikomori's ordinary family composition (absent working father, overprotective stay-at-home mother, and only child) hints that the problem may reside into an unresolved Oedipus complex, since that the most important oedipic element (the father) is usually absent in the hikikomori's life and the mother-child relationship appears to be too encumbering and infantilizing to allow the individuation-separation phase (Wilson, 2010).

From our point of view, without neglecting the role of intra-psychic features as well as the ones related to the proximal context (i.e. family and peers), the behaviour does not occur in a socio-cultural vacuum: socio-cultural factors have a role in the onset and maintenance of hikikomori, for instance exposing the individual to experience psychosocial malaise and to adopt social withdrawal as a maladaptive and persistent way to face such malaise. Furthermore, the same behaviour may be interpreted, shaped, and responded, in almost-unlimited ways as many as the contexts within the behaviours unfold. With this regard, Venuleo and Salvatore (2008) suggest to recognize the "polysemic nature" of behaviours, that is the variant meanings it can assume through time and space.

Consistently, hikikomori has been defined as a "culture-bond syndrome" (Kato et al., 2012), namely a condition depending on the cultural context the subjected belongs to. This is not so common in the scientific literature on clinical conditions: when considering contextual features, scholars generally focused on the proximal relation context (i.e. family, peers) and only rarely on the wider socio-cultural context. In our perspective, the material and immaterial resources, the political and social processes, the social values and norms, seem to offer constraints to the multiple ways people can think and act (Valsiner & Rosa, 2007; Salvatore & Zittoun, 2011), including the willingness to engage in problematic behaviours (Venuleo & Marinaci, 2021). In few words, the social-cultural context i) may establish what people recognize as "problematic", that is when the social withdrawal starts to raise concerns among families, health care professionals, media and so on; ii) may base what a problematic behaviour means in people's life, for instance with social withdrawal representing an extreme coping strategy to face an environment lacking of opportunities; iii) may affect individual functional or impairment, for instance with a poor and detrimental environment increasing the psychosocial malaise associated to hikikomori condition. Support to the thesis that the historical, cultural, and social milieu influences the way a behaviour is shaped, experienced, communicated, and responded to by others can be found in some studies on problematic behaviours outlining how a macro social environment perceived as anomic, unreliable, and destined not to change at all, may influence

the risk of gambling, alcohol abuse, and problematic internet use (e.g. Sudhinaraset, Wigglesworth & Takeuchi, 2016; Venuleo et al., 2016). Furthermore, since the same behaviour may be interpreted, shaped, and responded, in almost-unlimited ways as many as the contexts within the behaviours unfold, as Venuleo and Salvatore (2008) suggested, we should recognize the "polysemic nature" of behaviours, that is the variant meanings it can assume through time and space.

Framed within such premises, the present paper aims to offer a socio-cultural understanding of hikikomori, highlighting how the propensity to this extreme form of social withdrawal can be intended as the precipitate of a specific modality of relationship between the individual and the context in which he/she is inscribed. As mentioned before, a reflection on the Italian context will be offered throughout the dissertation.

Hikikomoris, life contexts, and the culture

The role of the relational, social, and cultural sphere in the onset and maintenance of hikikomori is well recognized by that approaches which consider Hikikomori in terms of a social condition, paying attention to the context in which the subject is embedded for a better understanding of this extreme form of social withdrawal. For instance, it has been observed hikikomori's family is often characterised by an overprotective stay-at-home mother, and an absent and working father, belonging to the middle or upper class status, and the hikikomori is either the only child or the firstborn (Saitō, 1998).

In addition to the structural and socio-economical features of hikikomoris' families, other lectures of the phenomenon more deeply considered the phenomenon in the light of Japanese culture, for instance referring to the concept of "amae" (Doi, 1971). "Amae" refers to an overdependence, to the desire to be taken care of, in the same way a parent takes care of his child as the child actively seeks such sweet dependence. While in Western culture the one who shows such behaviour is considered being immature and spoiled, Japan's culture sees it as a culturally accepted dependence, as every Japanese social structure involves various degree of amae, where those at the bottom depend on those higher in the social structure, such as employee and employer. The presence of hikikomori can be related to a distorted amae, expressed in a symbiotic relationship of the mother-child dyad, which leads to excessive maternal attachment and contributes to establishing a certain narcissistic fragility (Malagón-Amor et al., 2020). More precisely, the following relational dynamic can be seen: the child needs the mother for his development and to satisfy his narcissistic needs, and the mother needs the social successes of the child to be, in turn, satisfied. When the child does not prove to be able of achieving the required high standards of performance, the parent transforms him into a debt collector, causing a short circuit that generates high levels of anxiety within the adolescent. Furthermore, a prolonged and close bond to the mother may affect the development of independence as well as social skills, enhancing the vulnerability to stress in school and workplace environments and at last leading to escape from social situations (Teo et al., 2015).

In this regard, Ricci (2015) suggests that there are some similarities between Japan's and Italy's family culture, such as families overprotecting their own children, narcissism, close relationship between mother and child,

and uncertainty caused by social conditions, which may lead some individuals to withdraw socially, especially those who are emotionally fragile. Bagnato (2017) explains how there are differences between Northern and Southern hikikomori in Italy: the latter are present in middle-lower class families too, and such families may have more siblings. Moreover, Southern hikikomori appears to have more violent outbursts when compared to Northern hikikomori; such violence is expressed particularly towards their own mothers. Southern mothers are more overprotective, thus symbiotic relationships between mother and child are more likely to occur, with more violent outbursts. North and South Italy show notable differences regarding culture and economic status, and more research is needed on how said factors are related to the hikikomori condition. Piotti (2015) suggests that Italian and Japanese hikikomori share three factors: school phobia, similar relationship dynamics with their mothers, and hobbies revolving around imagination (comic books, cartoons, videogames, internet etc.).

Expanding the focus over the family context to consider the wider socio-cultural context, it may be highlighted how the socio-cultural milieu influences the multiple ways people can think and act, including the willingness to seek such an extreme social withdrawal. It is reasonable that the context may work as a source of malaise, for instance constraining people's life and lacks resources and opportunities. In particular, social psychologists, sociologists, and anthropologists (e.g., Kaneko, 2006; Meligrana, 2013; Teo, 2010) claim that hikikomori seems a way to avoid pressures from family, school, and society in general; it is a kind of "silent" reaction to the paces and the standards of performance that are expected from them in a world that, by the way, do not show so much opportunities and penalize the new generations, for example in the job market.

Back in the 2008 – in the middle of the worldwide economic crisis – Furlong (2008) outlined that there was a link between the historical time people were living in and the hikikomori condition. He claimed that "in a situation where traditional opportunities have all but collapsed for large sections of the younger population in the space of around a decade, where previous predictabilities have been undermined, signposts become obscure and traditional sources of advice rendered useless, the preconditions for a classic situation of anomie are all present […]. A situation where many young people are forced to navigate a sea of uncertainty. Under such circumstances, it should not surprise anyone when large numbers of anxious travellers withdraw from social and economic life" (Furlong, 2008; pp. 320-321). Indeed, uncertainty can be seen as a natural condition of human experience (De Luca Picione & Lozzi, 2021), investing future, identity, sociability, and leading to a crisis of meaning: in this scenario, every effort to get by is useless, the standard proposed by the society are impossible to reach, so that it is not surprising if some individuals decide to retire from the social and economical world. This idea finds support also in studies conducted among young adults and adult population in which gambling, drinking, and problematic internet use were associated with a negative and anomic view of the social environment, suggesting that social disruption can encourage problematic, disadaptive behaviours as a sort of reaction to such condition (Venuleo et al., 2015; 2016). A further support is offered by the Dressler's (2007) "cultural consensus" theory – arguing that negative health outcome can be the result of the lack of approximation

between individual's behaviours and belief, and cultural models; similarly, sociological and anthropological studies (e.g., Bjarnason, 1998, 2009) outline that the incidence of problematic behaviours should be related to the present-day condition characterized by rapid changes, instability, and uncertain future. With this regard, René Kaës in his book "Le Malêtre" (2012) stated that the instability which concerns social bonds, ideologies, beliefs, authorities, has undermined commitment to social norms, values, and beliefs, and disrupts social ties. This led to a state of anomie, which is properly characterized by 'the general idea that the absence of clear rules of behaviour and ambiguity in rules and goals create a state where the individual faces uncertain, conflicting expectations and ambiguous norms and values' (Thorlindsson & Bernburg, 2004; p. 274).

The idea that problematic behaviours may be understood as a way to face psychosocial malaise finds support the self-medication hypothesis of addiction (Khantzian, 1997), according to which addictive behaviours have to be considered a maladaptive response (i.e. a "medicine") when the individual is facing excessively difficult states of emotions or stress. A leading example could be the problematic use of Internet: according to a recent approach known as "compensatory model" (Kardefelt-Winther, 2014; 2017), it occurs as the result of an unhealthy, persistent, rigid use of internet to deal with negative affective experiences and to compensate the lack of personal and relational resources. As demonstrated in several studies, the presence of psychosocial malaise in terms, for example, of depression, social anxiety, and loneliness (e.g. Gu, 2020; Venuleo, Ferrante & Rollo, 2020) leads to use internet to escape from problems and gain relief (Young, 1998), coping with difficult life experiences (Griffiths, 2005), or regulating moods (Caplan, 2010).

Overall, this vision is consistent with the growing body of empirical evidence and assumptions made by the contemporary literature on psychopathology which holds that adaptive and maladaptive psychological phenomena differ not in kind (that is, presence or absence of given signs and symptoms) but in degree; continuity exists between adaptive and maladaptive functioning so that an "abnormal" behaviour is the extreme, persistent and impairing form of a same behaviour (Forbush & Watson, 2013; Røysamb et al., 2011). Accordingly, more recent perspectives on hikikomori (Teo et al., 2015) as well as on problematic internet use (Stavropoulos et al., 2016) conceptualize the phenomenon as a *continuum* ranging from minimum to maximum severity of symptoms; furthermore, the focus has been shifted from the behaviour *itself* (that is, the identification of criteria for a diagnosis) to the life problems which may explain its onset and maintenance, that is why a behaviour turns into a maladaptive strategy and why it persists although its negative outcomes.

Which "social network" for hikikomoris?

Another largely explored theme in the research on hikikomori, triggering false beliefs and sometimes alarmism, is the relationship between social withdrawal and extensive internet use. Kato and his colleagues (2020) brilliantly describe such a link in terms of "the chicken and egg dilemma", referring to the unclear direction of relationship, namely the debate on whether pathological social with-

drawal creates internet overuse (till to addiction) or internet overuse creates hikikomori. According to the authors, both the possibilities exist: indeed - keeping in mind the over mentioned idea that both internet and hikikomori can be strategy to cope with life difficulties - it is reasonable that stressful life events (for example, difficulties at school/job market) lead to avoiding or self-help reactions, namely the social withdrawal as well as the use of internet; furthermore, the hikikomori may over-indulge in the internet as a way to compensate his/her social isolation, as well as the excessive internet use may lead to prefer online social interactions (Caplan, 2010) till to a complete social withdrawal. According to our view, this help us to support two ideas: 1) *the "polysemic nature" of a given behaviour* (Venuleo & Salvatore, 2008), namely internet for hikikomoris: if at one side may negatively impact hikikomoris' life, it may also be a way to compensate the sense of loneliness and disconnectedness, giving the possibility of leading a social life online without the sufferings and duties of the "real world". 2) *the recognition of the negative outcomes of a behaviour depends at last on the historical, cultural, and social context in which such behaviour is shaped, experienced, communicated, and responded to by others* (Venuleo et al., 2016; Venuleo, Salvatore, & Mossi, 2015): social discourses, for instance printed and online media, tend to empathize the "dark side" of internet, assuming that the extensive use of technological devices and applications, especially among youths, is the direct causes of negative episodes/events, such as the extreme social withdrawal as well as suicides and risky behaviours like online challenges. It is in a certain way claimed that "the problem is in the mean" (i.e., internet), as if the social and cultural environment is not implicated in shaping and orienting people's behaviours as well as their evaluation of risk (Ferrante, 2020; Valsiner, 2007; Venuleo, Mossi & Marinaci, 2017), and in encouraging or not also problematic actions, including the likelihood to recur to internet use and social withdrawal as a way to counteract their psychosocial malaise. Therefore, the individuals' capacity to respond adaptively to the demand of the social and interpersonal environmental is the reflex of the way they interpret their social experience (Venuleo et al., 2020a).

Consistently with these two tenets, Hikikomori can be understood as a maladaptive process that occurs among individuals, their life context, and the culture in which they are embedded.

Implications for policies

As previously stated, there are a multitude of theoretical frameworks regarding the hikikomori condition, which implies different conceptualizations and, therefore, therapeutic interventions. Japan was the first country to deal with the hikikomori condition, so that the scientific literature on hikikomori interventions and policies mostly refer to Japan's solutions.

A first large differentiation, reflecting the debate on hikikomori conceptualization, is the one outline by Katsumata (2011), that recognizes two main model, namely the "clinical model" and "non-clinical model": the "clinical model" is practised mostly by psychiatrists, that is the employment of drugs and medicine along with counselling sessions; the "non-clinical model" is used by non-professional helpers (usually hikikomoris' parents and ex-hikikomoris) who focus on social features, therefore interventions are mostly

based on socialization. Both of this model's goal is to reintegrate the hikikomori into society. A common strategy based on socialization and used in Japan is the "rental onesan" in Japan, the "older sister for hire" (Ricci, 2009): she is a young woman without any particular training to deal with the hikikomori condition, and her purpose is simply to try to socialize with the hikikomori without being invasive. Once a contact has been established, if the hikikomori wishes it, the "rental onesan" will accompany him to a centre where he/she can start rehabilitation. Home visitation programs incorporating brief psychotherapy interventions seems to be promising indeed (Lee et al., 2013).

We cannot hide that such differentiation is the reflex of two different way to intend clinical conditions in general: at one side, the problem is set in the head of the individual, who is ultimately the only target of the intervention; at the other side, the "disease" seems to concern the social bond, which also becomes the mean and the recipient of the intervention. The first is a common tendency in the clinical field, especially with regard to problematic behaviour. For instance, with respect to problem gambling, it has been outlined how the absence of the expected behaviour (i.e., a rational, suitable form of game) is usually interpreted as an expression of emotional or irrational subjectivity of the individual (his or her disease, its distorted cognitive patterns, etc.) (Venuleo, Salvatore, & Mossi, 2015; Venuleo & Marinaci, 2021); such view suggests that neither the government nor the social network (family, peers, neighbourhood) is responsible for restricting its consumption (Reith, 2007), or for reflecting on the ways they fuel or constrain individual attitudes towards gambling. On a clinical plane, the consequence is that the individual becomes the privileged target of the intervention in psychotherapy, rather than for example the settings and systems within which the encounter between the individual and problem behaviour takes place (Reith, 2007; Venuleo & Marinaci, 2017).

In the case of hikikomori, a useful strategy can be an intervention that involves at the same time the subject's different spheres of life, namely for instance family and school. This aspect appears to be particularly critical when the ultimate goal of the research is to design preventive, more than therapeutic, strategies (Marinaci et. al, 2021): whereas individual risk factors such as impulsivity, depression, hyperactivity, and anxiety are often difficult for parents and teachers to improve, risk and protective factors within the relationship and the community can guide prevention initiatives addressed not only to youths but also to their relational environment. Therefore, parent and teacher training can be for instance aimed to improve that skills highlighted by the literature as associated to hikikomori syndrome, such as parent-child communication (Yong & Kaneko, 2016), family support (Nonaka, Shimada & Sakai, 2020), and bullying at school (Tajan, 2015). As highlighted in the paragraphs above, also the wider socio-cultural context has a role in the development and maintenance of hikikomoris, thus it should be taken into consideration when thinking on how to prevent and contrast such condition. Indeed, the individual, the family, the school are all systems interacting each other and interacting with the wider social environment in a synergic way (Bronfenbrenner & Morris, 2006; Salvatore et al., 2021) - just think of social, economic, and political measures (for instance, in terms of resources allocated) which impact families and schools' life. This kind of

interventions require a multi-systemic approach. Furthermore, if hikikomori is a culture-bond syndrome, framed within a historical, social, and cultural scenario of uncertainty and loss of meaning, settings of intervention should be thought as "safe spaces" where people can experience significant interpersonal ties and systems as something meaningful and concrete for their life (Salvatore et al., 2021): a concrete form of this kind of interventions are the so-called "intermediate settings" (i.e. context of interventions between life worlds and institutions), based on the culturalist and psychoanalyst view of the performativity of cognition, namely the idea that the meanings at the basis of social and individual life reproduce themselves by the social practices they frame (Cremaschi et al, 2021; Salvatore et al, 2021). As suggested by Zittoun (2021), meanings can be built for instance through art, fiction, and imagination activities, activities that we wish to mention since they may be particularly effective for hikikomoris (Ari & Mari, 2021).

Whereas, a notable example of families' involvement in hikikomori treatment comes from Italy with the model proposed by Buday, Lancini and Turuani (2019) and based on the adolescent evolutive goals: such model states that any teenager, in order to become an adult, must adjust his own mental representations regarding four areas, namely generative body, separation-individuation from parents, social life, and values; facing issues in one or more of these areas will arrest the development of the teenager, causing a "developmental arrest", which leads, among other things, to social withdraw and suicidal tendencies. The treatment involves a team of psychologists who works in tandem, the hikikomoris and his/her family, who gets separate counselling, namely mother and father on one hand, and hikikomori on the other hand. The school may get involved too, depending on the case. The goal of such intervention is to adjust the patient's and the parent's own mental representations regarding each other and lift the "developmental arrest", which eventually allows the patient to resume development, enter adulthood and recover from social withdrawal.

Another point that worth to be highlighted respect to the intervention is the importance of a interdisciplinary approach, as suggested by Saitō (1998). The scholar states that an interdisciplinary which involves both psychiatry and society, is necessary for the intervention on hikikomori: the employment of psychiatric methods and facilities should be accompanied by the involvement social institutions (schools, business companies, etc.) as well as the hikikomori's, all working together in order to facilitate the subject's opening up towards the world.

In conclusion, we suggest how productive it might be to go beyond strategies of intervention addressed to the individual, and thus towards strategies aimed at taking into account the relationship between individuals and their specific cultural and social world, which offer the conditions, the instruments, the meanings through which hikikomori is developed and maintained. As long as we interpret problematic behaviours as a matter of individual health, neither the community nor the proximal social network are responsible for reflecting on the ways they fuel or constrain individual attitudes and behaviours. Yet the presence of a disadaptive behaviour is the signal of a pathology that concerns the social bonds, so we need to overcome the split between who (usually psychiatrics and clinicians) takes care of patients facing their "internal ghosts" and those who take care of the

social reality, reclaiming which inter-subjectively and culturally shared premises favour a problematic behaviour such as the extreme social withdrawal. Second, we think that hikikomori can be understood as a meaningful action that conveys points of view not only on the target behaviours but, broadly, on people's social experience and identity, so that the focus should be shifted from the behaviour itself to the semiotic context which feeds and shapes such behaviour.

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