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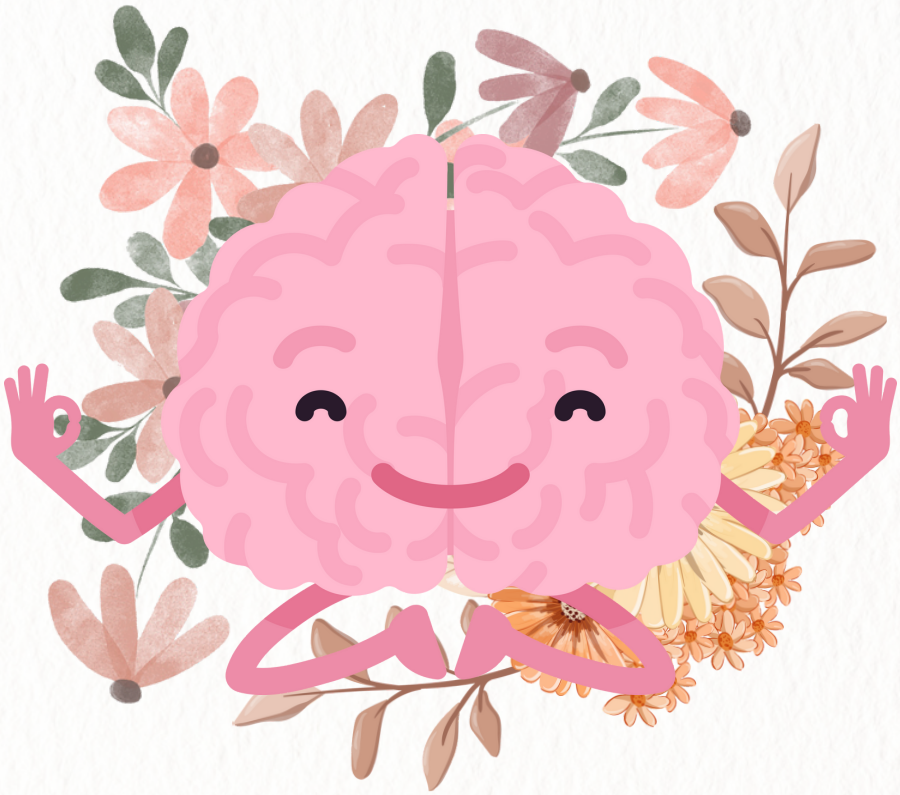

PROJECT RESOURCE KIT

BEYOND THE DOORSTEP

Erasmus+
Enriching lives, opening minds.

CONTENT:

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1. The project

"Beyond the Doorstep"

"Beyond the doorstep" project intends to raise awareness and work on prevention on the topic of Hikikomori in the 4 countries involved. Through non-formal methods in international workshops, local labs in schools and local Training of Trainers with educators, teachers, youth workers, the Consortium aims to work on prevention and awareness raising and on the correct representation and narrative of Hikikomori. Stakeholders, associations and institutions working on the topic will enrich the discussion and bring real cases and practices, which will be collected in an open access Toolkit and an OER translated in all languages.
This is a Capacity Building project and is funded by the program Erasmus+. This toolkit has been developed under the auspices of the project.

SPECIFIC AIMS

1. Raising awareness on the phenomenon of Hikikomori among youngsters, families, youth associations, schools and institutions, conveying a correct narrative of the phenomenon, its possible causes and dynamics;
2. Training youth workers, educators and teachers to work on prevention and identify the signals of social withdrawal, providing with knowledge, techniques and materials for their local action;
3. Creating a network at local and international level to foster the recognition of Hikikomori and its integration among local and national priorities;
4. Contributing to the implementation of EU Youth Strategy and Youth goals, and supporting the development of youth work, especially in partner countries.

The partnership

The project has been carried out by four partner organisations:

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2. Introduction to the Phenomenon of Hikikomori

First signs

The notion of hermits and recluses has existed in many cultures for time immemorial. However, in recent years a particularly severe syndrome of social withdrawal first identified in Japan has garnered the interest of researchers and the lay public alike. Called hikikomori, it has been defined as 'a phenomenon in which persons become recluses in their own homes, avoiding various social situations (e.g., attending school, working, having social interactions outside of the home, etc.) for at least six months' (Saito, 2010). Individuals with hikikomori are frequently reported to have social contact predominantly via the internet and some reports suggest overlap with heavy internet use (De Michele, Caredda, Delle Chiaie, Salviati, & Biondi, 2013; Lee, Lee, Choi, & Choi, 2013). An estimated 232,000 Japanese currently suffer from hikikomori, and 1.2% of community-residing Japanese between ages 20–49 have a lifetime history of hikikomori (Koyama et al., 2010). A combination of a shy personality, ambivalent attachment style and life experiences including rejection by peers and parents – among other factors – may promote the development of hikikomori (Krieg & Dickie, 2013). Furthermore, scientific studies point to genetic and other biological influences on sociality that, although not specific to hikikomori, could have implications for the study of the etiology of hikikomori (Meyer-Lindenberg & Tost, 2012). While researchers debate the merits of hikikomori as a psychiatric diagnosis (Teo & Gaw, 2010), practicing clinicians in Japan indicate they view hikikomori as a 'disorder' (Tateno, Park, Kato, Umene-Nakano, & Saito, 2012).

Previous reports suggest hikikomori may exist outside of Japan. For instance, case reports have described the presence of hikikomori in several other countries (Furuhashi et al., 2012; Garcia-Campayo, Alda, Sobradiel, & Sanz Abos, 2007; Sakamoto, Martin, Kumano, Kuboki, & Al-Adawi, 2005; Teo, 2013). When presented with vignettes of hikikomori, psychiatrists from nine countries around the world indicated that such cases existed in their clinical practices (Kato et al., 2012). Nonetheless, cross-national studies designed to identify hikikomori have been lacking. Reasons for the lack of recognition have included ambiguity about the features of hikikomori (Tateno et al., 2012; Watts, 2002), and inconsistent or insufficiently detailed definitions of hikikomori (Furuhashi et al., 2011; Garcia-Campayo et al., 2007; Sakamoto et al., 2005).

This has caused concern that researchers may not be referring to the same phenomenon. We have previously proposed a research-grade definition of hikikomori, but this definition has not been empirically tested (Teo & Gaw, 2010). Additionally, prior reports of hikikomori have focused on assessment of psychopathology (Lee et al., 2013; Nagata et al., 2013) but fewer studies – especially outside of Japan – have examined psychosocial features more broadly, despite the common belief that sociocultural factors are important contributors to hikikomori (Kato et al., 2012). Finally, prior research has examined treatment recommendations for hikikomori by psychiatrists, but we are unaware of studies that have explored patients' treatment preferences (Kato et al., 2012). In recent systematic reviews, hikikomori has been defined as a 6-month or longer period of living at home and avoiding social situations and relationships, along with significant distress and impairment. Almost half of the patients with hikikomori who visit health centres are diagnosed with mood and anxiety disorders, personality disorders, sleep loss disorders, pervasive developmental disorders, or schizophrenia.

The results from our cross-sectional multiple regression analysis revealed that the following independent variables were correlated with hikikomori severity: "somatic complaints," "anxious/depressed," "overuse of the Internet," and "lack of communication between parents". It is interesting to note that "lack of communication between parents" was a correlate, but "conflict between parents" was not. Could this indicate that regardless of whether parents frequently quarrelled, more communication between parents could be a protective factor for adolescents with a tendency toward hikikomori? A more sensitive measure of the quality of the communication, such as the Family Assessment Device [60], would be useful to interrogate this further.

The relationship between somatic complaints and hikikomori is also unclear. Somatization could be related to non-specific genetic vulnerabilities mentioned above (e.g. low stress tolerance). As a result of somatization, those with early hikikomori may frequently visit paediatricians about undefined complaints, which presents an opportunity for early detection. Although early screening for hikikomori may be difficult, the symptom of "school refusal" seems to be highly indicative [34,35,36]. One must also consider others on the hikikomori spectrum, who may have no problems attending school but communicate very little with people other than the members of their own families (the "hikikomori affinity group").

Some examples of social withdrawal include:

a) Avoiding social activities that a person previously enjoyed
b) Turning down invitations to spend time with others
c) Making excuses to be alone
d) Being less talkative in group settings
e) Avoiding situations that involve meeting new people
f) Not initiating conversations and avoiding open-ended questions when talking to others
g) Not wanting to try new things
h) Avoiding any unfamiliar setting or situation
i) Taking jobs or tasks that require solitary work
j) Preferring to stay home and engage in solitary activities.

Social withdrawal syndrome, first described in Japan and termed "hikikomori," involves confining oneself at home for six months or longer while severely limiting communication with other people. The phenomenon has since been observed in other countries and cultures as well. While more research is needed to understand better the causes and treatments for hikikomori, a 2022 study identified several metabolic biomarkers of social withdrawal syndrome. Such findings may aid in better identification and treatment.

It is also essential to talk to a mental health professional, particularly if you are experiencing other symptoms such as anxiety, loss of interest, fatigue, low mood, substance use, or thoughts of suicide. A therapist can evaluate your symptoms, make a diagnosis, and recommend treatments that can help combat withdrawal behaviours.

Hikikomori was seen by most respondents as a reaction to difficulties faced in daily living, people, job demands, personal demands, disability, disappointment, unpleasant situations, and fear and mistrust, among other things. Two categories comprised this theme of coping difficulties: stasis and expression. As a result of conflicting demands and reduced autonomy, respondents experienced stasis, which prevented them from moving forward; as they failed to move forward, “hiding” or “avoiding” heightened the expression of their behaviours. The informants felt that they had stopped moving forward, and going online expressed their attempts to maintain the stasis situation.

This is the first study to explore in-depth experiences of people currently suffering from, or with past experiences of, hikikomori syndrome. This is also the first attempt to analyse non-clinical data. We argue that hikikomori syndrome is not the result of asocial tendencies, but rather an anomic response to a situation that people feel powerless to change and from which they can see no way out. Feelings of hopelessness and relationship fatigue may be overcome by introducing a relaxed social environment that people can control during rehabilitation from hikikomori. Exposing sufferers to new, interesting ideas and allowing them to try (and fail) may widen their perspectives and help them to overcome fear. Treatment remedies should focus on regaining trust and monitoring the anxiety symptoms that prevent them from trying new things.

Risk factors of Hikikomori

The best-known risk factors for hikikomori are the presence of a psychiatric disorder, developmental disorder, substance-related or behavioural addictive disorders (including internet and gaming misuse), and poor psychosocial contexts. Various risk factors that emerge from the literature are universal among the East Asian regions, including male gender, insecure attachment, and psychiatric conditions. Conversely, other risk factors achieve less consensus. Family may play an important role in the origin, maintenance, and treatment of people with social withdrawal. Studies on clinically detected hikikomori in Japan, for example, demonstrate that high educational status of families, especially fathers, is reported to increase the risk of hikikomori. However, it has been suggested that these studies of clinically detected hikikomori may not represent hikikomori receiving assistance from non-profit organizations or no assistance at all.

Hikikomori in Hong Kong detected through social service platforms, for instance, emerges in diversified contexts including low socioeconomic status (SES) families with single parents. However, 80% of cases from Hong Kong emerge from middle to high SES families, mirroring trends observed in Japan. In countries with high costs of living such as Hong Kong and Singapore, a family with high SES may accommodate financial burden of the hikikomori individual. For anomalies with low SES, several clinicians at the HRTRS anecdotally hypothesized that they may possess specific attributes, such as high cognitive function or remote earning capabilities. Furthermore, low familial support and maternal mental disorder were also positively associated with hikikomori.

Factors like high frequency of family psychiatric history, dysfunctional family dynamics, and traumatic events in childhood (family maltreatment), are closely interrelated, highlighting the potential role of family in the development and maintenance of social withdrawal. Also, poor communication between partners and between parents and child can play a very important role in the development of hikikomori. Some researches of environmental factors that may be associated with the occurrence of hikikomori found that the prevalence of psychiatric disorders among parents was significantly higher in the hikikomori group. This indicated that there may be some genetic predisposition; perhaps related to stress tolerance, coping ability, or resilience; preventing adolescents with hikikomori from adequately coping with stressors such as interpersonal problems at school or poor academic performance. One preliminary study has shown blood biomarkers uric acid and high-density lipoprotein cholesterol as possibly correlated with an underlying biological pathology of hikikomori. Individual psychological factors, including interpersonal problems. Coping difficulties, conflicting demands, reduced autonomy, low self-esteem, and a predisposed introverted personality have been shown to play some role in hikikomori propensity.

Dependent behaviour described as “amae” in Japanese parent– child relationships has been hypothesized to play a role in developing social withdrawal by normalizing and encouraging the acceptance of their socially withdrawn child (HRTRS) staying at home. These mechanisms await further investigation in the various regions. East Asian parenting styles tend to embody the mother–child relationship as interdependent cooperation, in contrast to the focus on evolving independence and autonomy in Western regions. In Korea, the youth culture incorporates a strong sense of cohesion and engagement through social gatherings. When individuals are isolated for more than 6 months, it is perceived as a sign of mental illness. Lastly, preliminary studies in Japan and physical health parameters, respectively, that may eventually contribute to early identification.

Furthermore, studies point to the overlap between social withdrawal and Internet and gaming addiction. The avoidance and social withdrawal as a persistent maladaptive reaction in a patient with an anxious–avoidant insecure attachment plays a key role in the emergence and persistence of Internet gaming disorder. Overuse of the Internet could be important risk factors for hikikomori, but could also be a result of the hikikomori itself. Lastly, the stigma surrounding mental illness diagnoses may result in preference for hikikomori labelling to mask psychiatric conditions.

Profile of a Potential Hikikomori Person

The profile of a hikikomori person is complex to recognize, due to the similarities it has with other mental illnesses. Hikikomori is not the same as depression, however they have very similar episodes. High emotional sensitivity that is present on a daily basis interferes with a person's functioning, but it is important to understand that hikikomori is a complex condition that encompasses several aspects, including social isolation, withdrawal from society and often refusal to participate in wider social life.

An avalanche of intense emotions: people with high emotional sensitivity experience emotions more intensely than others. This can include deep feelings of shame, sadness, anxiety or fear. Strong emotions make it difficult to cope with social situations, which leads to withdrawal. High emotional sensitivity leads to experiencing a higher level of stress in potential social situations, which are very rare in this condition. Striving for perfectionism and the desire to meet high standards is also one of the criteria that satisfies hikikomori. It is important to understand that there is not just one cause for hikikomori, but rather it is a complex condition involving various factors. Perfectionism often involves setting high standards for yourself and fearing failure. If a person with hikikomori syndrome has a perfectionist approach to life, they may have difficulty dealing with the realities of failure or failure to meet those high standards, which may contribute to withdrawal into isolation. Individuals often feel pressure to present themselves in a positive light in society. Fear of failure in front of others and worry about acceptance can lead to social anxiety. Hikikomori syndrome can represent the avoidance of social situations in order to avoid anxiety - because of this, individuals lose the real picture of the life they live and withdraw into a virtual space that seems to provide greater security than the real social environment.

Constant self-criticism further complicates the daily life of hikikomori people - very often they have inner voices of self-criticism that remind them of their supposed failures. Constant self-critical inner monologue contributes to feelings of hopelessness and reduced self-confidence, which can lead to withdrawal. Hikikomori syndrome can be difficult to recognize in general, but there are several 'red flags' or signs that may indicate that a person may be suffering from the condition.

These signs can vary in intensity and are not universal for every individual.

Extreme social anxiety: absence or minimal contact with friends, family or other people; avoiding social gatherings and activities.

Prolonged withdrawal to one's own space: spending long periods of time indoors, usually in one's own home, preferring one room that serves as isolation from others; refusing to leave home, even for basic needs such as school, work or other obligations.

Loss of interest in the outside world: reduced or complete loss of interest in work, school, hobbies, or other activities that were once important; a feeling of indifference or apathy towards the outside world.

Communication difficulties: absence or limited communication skills; if a person communicates with others, it can be through the Internet or other virtual means.

Behavioural changes: sleep changes that include irregular sleep patterns: weight loss or gain, as well as other changes in behaviour and habits.

Symptoms of depression or anxiety:. The appearance of symptoms of depression, anxiety or other mental health problems; feeling helpless, worthless, or sad.

School or work absence: absence from work or school, failure to initiate or maintain social or professional responsibilities.

Use of the virtual world: excessive use of the Internet, video games or other virtual activities; using the virtual world as a substitute for real social interactions.

We would briefly refer to treatments for treating and helping hikikomori people.

Treatment of the syndrome usually requires a multidisciplinary approach that may include different types of interventions. Here are some steps that are often taken in treatment: psychological counselling and therapy, which includes individual counselling and family therapy; medication treatment, strengthening of social skills and environmental support, provision of educational and professional resources, gradual approach to reintegration, community support, work on self-confidence and efficiency.

3. The Role of the Schools

What could be done?

In recent decades, hikikomori has garnered attention among health experts, sparking debates about its classification as a mental illness or a social phenomenon[1].
Currently, there are no standardised criteria for diagnosing hikikomori[2]. This is due to early-stage international research and diverse frameworks.
On one hand, according to some studies, hikikomori cases align with the diagnostic criteria of various psychiatric disorders like obsessive-compulsive disorder and social phobia[3]. On the other hand, this strict psychiatric approach has shown many limitations. Hence, the distinction between "primary" and "secondary" hikikomori has been considered necessary[4]: "secondary" hikikomori involves social withdrawal linked to severe mental disorders, while "primary" hikikomori focuses on significant life impairment due to non-conformity with societal norms and social isolation.
Kato, Kanba, and Teo (2019)[1] offer a dynamic perspective with their bio-psycho-sociocultural model, viewing hikikomori on a continuum. This includes psychiatric issues (e.g., social anxiety, depression, personality disorders) and non-psychiatric factors (e.g., loneliness). Identifying hikikomori cases requires a comprehensive evaluation.

In general, hikikomori is often termed a "culture-bound syndrome"[6], namely a condition depending on the cultural context the subjects belong to.
Social, political, and cultural factors influence perceptions of the problem, the role of problematic behaviour, and its impact on individuals[7].
In essence, the social-cultural context:
i) Determines what's seen as "problematic" when social withdrawal concerns families, healthcare professionals, and the media.
ii) Shapes the meaning of problematic behaviour, with social withdrawal as an extreme coping strategy in an environment lacking opportunities.

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1 Caresta, 2018; Chan & Lo, 2014; Ricci, 2015; Saitō, 1998 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.
2 Aguglia, 2016; Nonaka, Shimada & Sakai, 2018 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.
3 Koyama et al., 2010; Teo & Gaw, 2010 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.
4 Suwa & Suzuki, 2013 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.
5. Kato, Kanba, and Teo (2019) in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.
6. Kato and colleagues (2020) in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.
7. Venuleo & Salvatore, 2008 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.

iii) Impacts individual functioning, with a poor environment exacerbating the psychosocial distress associated with hikikomori.

An important research theme in hikikomori examines the connection between social withdrawal and extensive internet usage, often leading to misconceptions and occasional alarmism. Kato and colleagues (2020)[8] describe this relationship as a "chicken and egg dilemma," questioning whether pathological social withdrawal causes internet overuse (even addiction) or if excessive internet use leads to hikikomori. According to the authors, both scenarios are possible. Stressful life events may trigger avoidance behaviours like social withdrawal and increased internet use. Additionally, hikikomori individuals may turn to the internet to compensate for their social isolation.

This perspective supports two ideas:

1) The "polysemic nature" of certain behaviours[9], such as internet use for hikikomori. While it may negatively impact their lives, it can also serve as a coping mechanism to alleviate loneliness and disconnection.

2) The recognition of the consequences of a behaviour depends on the historical, cultural, and social context in which it occurs[10]. Social discourses, including media, tend to emphasise the "dark side" of the internet, assuming it directly causes negative outcomes like extreme social withdrawal. However, this overlooks the role of the social and cultural environment in shaping behaviours and risk evaluations. The ability of individuals to adapt to social demands reflects their interpretation of their social experiences.

In summary, Hikikomori can be seen as a maladaptive process influenced by individuals, their life circumstances, and the surrounding culture.

WHAT VOLUNTARY SOCIAL WITHDRAWAL IS NOT

- It is not social phobia
- It is not anxiety disorder
- It is not depression
- It is not internet addiction

8. Venuleo et al., 2016; Venuleo, Salvatore, & Mossi, 2015 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.

9. Venuleo et al., 2020a in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.

10. Venuleo et al., 2016; Venuleo, Salvatore, & Mossi, 2015 in: Ferrante, L., & D'Elia, V. (2022). When the "disease" concerns the social bond: the case of hikikomori syndrome in the Japanese and Italian context. International Journal of Psychoanalysis and Education: Subject, Action & Society, 2(1), 85–103. https://doi.org/10.32111/SAS.2022.2.1.6.

The School[1]

The school is the environment in which the teenager starts to experiment affective symbolizations such as:

- Social birth
- Function of separation from the family model and internalisation of new models
- Experimentation of one's own resources and abilities outside the protected nest
- Function of building one's own future
- First experimentation of ingroup/outgroup dynamics
- Social comparison with the models internalised by the internet

The school environment is a place experienced with particular suffering by the Hikikomori. It is no coincidence that most of them begin their isolation during the middle and high school years. For the Hikikomori, dropping out of school is symbolic of their need to get away from the pain caused by the gaze of others and their fear of failure and shame.

The discomfort and suffering that Hikikomori feels towards the school environment is compounded by more complex evaluative feelings such as disgust, distrust and disappointment. Sad feelings are directed towards a place and the people in it, whose values seem very distant from those of the Hikikomori. The Hikikomori deem the school as a competitive environment where individuality is lost, therefore in a way the hikikomori aims at regaining it through self-isolating at home. They quickly move from rejection of school to isolation, not only because school represents almost the entirety of social life for them, but also because they end up generalising the suffering and negative aspects experienced in the school environment to society as a whole, thinking that such feelings are to be experienced everywhere and that there couldn't be an alternative environment for them to feel good and accepted.

If in the course of development it has been possible to structure solid narcissistic foundations and the adolescent process is not experienced as too threatening, then new skills can be positively invested in self-restructuring. On the contrary, thought runs the risk of not developing adequately and of remaining hooked to operational and concrete methods. External reality becomes a framework in which to externalise conflicts that cannot be thought of, with a particular focus on the failure of the separation process- individuation and social birth.

"If I separate from my family, will I make it in the world?", that would be a classic thought of a student. School can be a narcissistic reinforcer or a persecutory object. A mind that cannot think and metallize fears, acts them with the body.

[1] All the material from which information was taken in this chapter were provided by experts from organization Hikikomori Italia, https://www.hikikomoriitalia.it/

Thought blocking, stuttering, silent scene, memory lapses, stomach ache, panic attacks are configured as extreme defences of protection from internal expectations and from the reference context. The most dramatic mode is school phobia, namely fear or aversion towards the school that activates large quotas of anxiety and that the subject tries to manage with avoidance behaviours. This is characterised by emotions that escape the adolescent's control and that protect him unconsciously from the fear of being a failure, especially in a context of society marked by popularity and success.

Teachers

When a hikikomori feels taunted and threatened by his peers, he consciously or unconsciously expects his reference adult to support him. If the child does not feel protected by the teacher, his distrust of people, relationships and, consequently, of society, becomes such that it causes him a serious loss of motivation to pursue any school, work or social career. Thus, the role of teachers in addressing and understanding hikikomori is important, as they often have a unique perspective on their students' behaviour and well-being. They can have in particular an important role in detecting/identifying cases of hikikomori or better to support and prevent some student becoming a hikikomori.

In particular, they should observe:

- Posture
- Relations with peers
- Relations with teachers
- Sharing moments (recreation, physical education)
- Excessive perfectionism
- Repeated absences, entering later, leaving earlier
- Physical discomfort
- Reaction to social situations

And if they detect specific anomalies, they need to help students.
Apart from helping those already perceived as hikikomori, it is also important to train and educate students about this common practice. They can indeed provide some training and awareness programs, also to better understand mental health issues. Moreover, teachers can be involved in preventive efforts by promoting a positive and inclusive classroom environment. Encouraging peer support, addressing bullying, and reducing academic pressure can contribute to preventing social withdrawal.
And lastly, teachers can also engage with students' families to better understand the home environment and family dynamics. Collaboration with parents and guardians is vital for a holistic approach to addressing hikikomori.

The role of the schools in tackling the Hikikomori issue

Here are several ways in which schools can contribute to addressing hikikomori:

Early detection and intervention: Schools can play a role in identifying students who may be at risk of becoming hikikomori. Educators and counsellors should receive training to recognize signs of withdrawal, social anxiety, or other psychological issues. By intervening early, schools can help prevent the problem from worsening.

Foster a supportive environment: Schools should strive to create an inclusive and supportive environment where students feel accepted and comfortable. This can involve promoting a positive school culture, nurturing strong student-teacher relationships, and implementing measures to prevent bullying.

Mental health education and resources: Schools can integrate mental health education into their curriculum to raise awareness about hikikomori and other mental health issues. By providing information and resources on mental health services, schools can assist students and their families in seeking appropriate help when needed.

Counselling services: Schools can offer counselling services staffed by trained professionals who can provide support to students facing social withdrawal or other mental health challenges. These counsellors can work closely with students, families, and external mental health providers to address underlying issues and develop strategies for reintegration.

Collaboration with external organisations: Schools should collaborate with external agencies such as mental health clinics, social workers, youth workers or community organisations to ensure a comprehensive approach to hikikomori. Through these partnerships, schools can facilitate referrals, access additional resources, and coordinate efforts to support affected students.

Reintegration programs: Schools can develop reintegration programs aimed at helping hikikomori students gradually reintegrate into society. These programs may involve personalised plans, gradual exposure to social situations, and support in developing essential life and soft skills.

In addition, schools might also be able to:

- Obtain in-depth information on the subject and about the familiar situation of the student at risk (not overcoming though the limit of discretion and privacy of the family).
- Act promptly in supporting the children and their families by making its own resources available to them.
- Not push the hikikomori to return to school immediately, but to activate tools in order to support her or him, for example with absence waivers and alternative forms of education.
- Siding decisively with the victim in cases of bullying, including psychological or subtle bullying.
- Create opportunities for dialogue with the student to grasp needs and help him/her express them.
- Share with the student objectives and actions for the realisation of his or her well-being and educational pathway.
- Co-designing personalised work, assessment and evaluation objectives and strategies; personalising times, places and teaching and evaluation strategies (e.g.: distance learning; at home; in "protected school spaces"...).
- Use of digital technologies and methodologies for inclusion: E-learning platforms; connections via Skype; video lessons.
- Presence of home teachers, extracurricular teaching hours.
- Tracking the response and reaction of the students, as well as their feedback and interactions with the surrounding environment.
- Putting its own resources at their disposal.

However, schools cannot single-handedly solve the problem, but they can contribute significantly by creating a supportive environment, identifying at-risk students, providing resources, and collaborating with other professionals to effectively address hikikomori.

Specific measures from the Governement - ITALY CASE

Dropping out of school is closely related to the phenomenon, therefore schools needs for sure to take special measures in order to prevent the problem or to support student at risk. In this chapter, we will deal with specific regulations that governments of partner countries provide in order to establish a common strategy to act.

Italy

The Italian government considers the phenomenon of hikikomori within the category of SPECIAL EDUCATIONAL NEEDS S.E.N.: "every pupil, in continuity or for certain periods, may manifest Special Educational Needs: either for physical, biological, physiological reasons or also for psychological or social reasons, with respect to which schools must provide an adequate and personalised response". A S.E.N. is "any developmental difficulty in functioning, permanent or transient, in the educational and/or learning sphere, due to the interaction of various health factors according to ICF model of WHO, and which requires individualised special education".

A hikikomori child could in fact manifest existential, relational and social distress, hence we are facing an S.E.N. The presence of expression of emotional and psychological fragility that negatively affects his or her relationship with the environment and people, which prevents effective participation in the learning process. The regulation therefore consolidates conditions of real marginality, which end up leading to failure and dropping out of school. Basically, in Italy, there are already certain measures that can be undertaken to tackle the issue of hikikomori in more vulnerable individuals.

4. Educational Tools for Youth Workers

Hikikomori is a relatively new concept which is still little known to students, teachers, public institutions, and even to professionals like social workers or psychologists. The first step to be undertaken is increasing awareness in this topic and spreading knowledge on the effects and impact starting with the primary and secondary schools where the initial signs are being noticed and even developed.

The main aim of this chapter is to introduce know how, non-formal education methods, tips on how to raise awareness in order to promote in school the awareness about the issue of social withdrawal and hikikomori. The methodology may be used by teachers, social workers, youth workers, etc. in activities with young people.

What is essential in this chapter?

- To raise awareness about the risks of social withdrawal and hikikomori
- To offer indications for preventing students' social withdrawal
- To create impact on the students
- To encourage communication within the class

The target group addressed includes primary and middle school students. They will be informed about the existence and early manifestations of Hikikomori syndrome and creating the adequate environment to speak up about mental health and their concerns.

The methods proposed in this chapter are interactive, communicative, mainly based on the paradigm of "learning by doing".

How to address the topic to primary and secondary school students?

Non-formal education is particularly important to improve young people's information to recognise hikikomori and raise awareness on this matter. It pays a significant role in reducing stigma around mental health problems and seek for help when needed. Creating space to provide an opportunity to promote positive mental health to young people especially to disadvantage groups is a great step to play a role in the society.

Benefits of non- formal education to young people:

- Develop a better understanding of the Hikikomori phenomena and its causes
- Improve their knowledge in this topic and skills
- Integrate the knowledge gained in their community, family, with their peers etc
- Breaking stereotypes on mental health and speaking up their needs
- Network with peers

Using participatory approaches as much as possible is essential. A variety of methodologies could be used, including lecture/presentation, discussions, group work, questions and answers, demonstrations, case studies, and practical sessions (hands-on practice). The methodology may be used in activities such as trainings and workshops.

BEFORE YOU BEGIN, KEEP IN MIND

- **Build a Safe Environment**

Both the physical and emotional safety of young people is a critical foundation for any youth setting. Safe environments provide a positive emotional climate that is free from bias whereby all young people feel supported, respected and comfortable

- **Create a Supportive Environment**

A supportive environment is one where young people feel welcomed and where they are encouraged and supported to learn and grow. Make sure to provide young people with opportunities for active learning, developing new skills and building healthy relationships.

- **Interaction and Engagement**

High-quality interaction with others is key to the social and emotional development of young people. Interactions provide opportunities for young people to share ideas, give and receive constructive criticism and participate in discussions.

Youth engagement is a core principle of the chosen activities. By engaging young people as active participants in their development, social and emotional skills become more meaningful and young people are more motivated to adopt these skills in their everyday life.

- **Manage limits**

Setting limits is essential for building healthy relationships – setting clear boundaries of what is and isn't permitted.

This helps creating a safe space and invite an attitude of respect and freedom within the group.

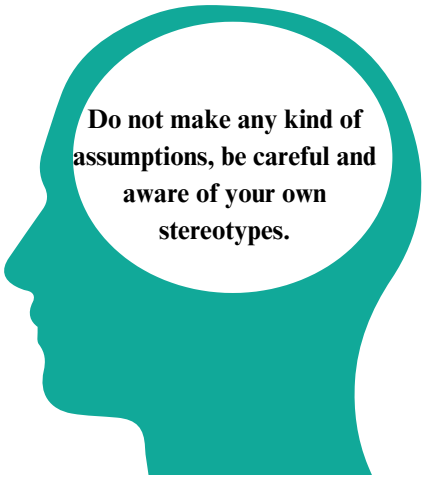
- **Listen without judgment**

It is essential to listen carefully to what young people have to say and try to understand their point of view and be open minded to what they could share.

- **Make sure that everyone understands the aim of the activity**

- **Make sure that enough time is provided to each young people to understand the tasks and expressing oneself.**

- **Make sure that every activity includes a debriefing and evaluation session**



TOOLS FOR DELIVERING ACTIVITIES

NAME GAME

- Get all the participants to a circle
- The facilitator can start off the activity and be the first person who can go to the center of the circle;
- Ask the person to introduce themselves by their first name, but instruct them to make some movement or do an action which may represent them
- Each person in the group repeat the person's names before them while also mimicking the actions they performed;

ENERGIZERS

- **MUSICAL CHAIR GAME**

- Set up the chairs in a circle according to the number of the participants (you should start with one less chair than the amount of players);
- Set up the seat of the chair facing the outside of the circle;
- Choose a song and make the participants walk around the chairs when the music starts; You need to instruct the participants to find a chair to sit in when the music stops.
- When the music stops, each player needs to find a chair to sit down in. There will be one player left without a chair to sit in because there is one less chair than players; The participant that didn't find a chair to sit it is out of the game.

- **STILL IMAGES**

- Participants stand in a circle
- On your clapping they freeze in statues - that is, they make a stationary sculpture of their body, which shows a slogan given by you.
- The slogans may be as follows (you may choose others depending on the needs of the target group):
- enthusiasm
- challenge
- support
- success
- balance
- stress

- Each time the participants freeze in sculptures tell them, out of the corner of their eye, to look around and check how the other participants have shown the given slogan

PRACTICAL TOOL: DRAW YOUR MIND

ACTIVITY TITLE- DRAW YOUR MIND

ACTIVITY PURPOSE /GOAL

The main goal of the activity is to both allow the facilitator to understand how much the participants know about given phenomena and to allow the participants to raise awareness/learn about the problem.

ACTIVITY DURATION

Around 45 min

NUMBER OF PARTICIPANT

15-25

MATERIALS

3 paper sheets per participants (a small sized is enough) Colorful markers/pens

DESCRIPTION OF THE ACTIVITY

The activity consists of 3 rounds. Each round is characterized by a specific topic. These 3 topics are chosen by the facilitators who have to have the knowledge about the topics.
The topics could be:
• Social withdraw • Hikikomori • Bullying and so on
Each participant gets a sheet of paper and colorful markers and/or pens on which he/she has to represent in the way they better want (drawing, writing a word, etc.) the first association that comes to their mind about the topic.
During the explanation part the facilitators have to underline that the participant can even leave the paper blank in the case they don't have any association regarding the given topic. And after that each of them have to show their paper to the others. If some of participants want to share why they've represented the topic in a specific manner, they are very welcomed to do so because it will allow to talk about the topic and discuss further about ideas, stereotypes, or anything else that is in the participant minds. In the end, the facilitator will give the participants a brief explanation what the social phenomena is.

PRACTICAL TOOL: THE WORLD CAFÉ

ACTIVITY TITLE- THE WORLD CAFÉ

ACTIVITY PURPOSE /GOAL
Participants analyze the topics given and start thinking about them.

ACTIVITY DURATION
60 min +

NUMBER OF PARTICIPANT
10-30 participants (divide participants into 4 groups)

MATERIALS
Flipchart papers; Markers

DESCRIPTION OF THE ACTIVITY
1) Setting: Create a "special" environment, most often
modeled after a café, i.e., small round tables with a flipchart paper, pens and colorful markers. There should be four chairs at each
table (optimally) – and no more than seven.
2) Welcome and Introduction: The host begins with a warm welcome and an introduction to the World Café process, setting the context, sharing the Café Etiquette, and putting participants at ease.
3) Small-Group Rounds: The process begins with the first twenty-minute round of conversation for small groups seated around a table. There are four tables, and each has a discussion topic: Emotional challenges, Resilience, Social Integration, Gratitude. Participants have to write down in the flipchart their thoughts in the topic.
4) Questions: At the end of the 10 minutes, each group
moves to a different new table. Each group members should carefully read the table paper, discuss the topic, sum-up their answers and write down on the flipchart paper.
5) Harvest: rotating teams may choose one person as the
"Team Captain", each group should visit all the 4 tables
and discuss all the 4 topics. At the end of the activity
the captains of the groups will present what the participants wrote on the flipcharts.
6) Give opportunity to the participant to discuss what they wrote and if they agree or disagree with the others opinions

PRACTICAL TOOL: THEATRE PLAY

ACTIVITY TITLE- THEATRE PLAY

ACTIVITY PURPOSE /GOAL

- To sensitize people on the ways they could communicate with the others in order to make them feel comfortable
- To improve their social skills
- To develop their awareness on Hikikomori

ACTIVITY DURATION

60 min +

NUMBER OF PARTICIPANT

Up to 30 participants (divide participants into 4 groups)

MATERIALS

A4 paper with the scenario written for each one of the 4 teams

DESCRIPTION OF THE ACTIVITY

The participants are split in 4 groups. The facilitators give to each group a paper with a scenario, and they need to prepare a theatre play based on it. The facilitators say to the participants that they should focus on the mental health of the people in the scene and the social skills they have or have not developed enough. After 15 minutes, the groups start to present their improvised acts. Each time the group plays their scene and then they have to play it one second time and someone from the audience can say 'stop' and enter the scene, in order to change the plot according to his/her point of view.

The given scenarios are:

1. New student who wants to get to know the others, go out for a coffee together and one of them says he/she/ is depressed.

2. A student constantly being bullied by his peers and not finding support by the teachers.

3. A student in a wheelchair who is communicating less in the classroom and not participating in leisure activities with his/her friends

4. A young people who only communicates through social media and is experiencing difficult period in his/her family.

After this phase is completed, the participants make a circle and the facilitators make these questions:
- How was it for you?
- What did you observe?
- How did you feel?
- Would you change something in the way you behave?
- What will you remember after this?

PRACTICAL TOOL: THE TIMELINE

ACTIVITY TITLE- THE TIMELINE

ACTIVITY PURPOSE /GOAL
The main goal of the activity is to reflect on the past period and put the attention to the topic of wellbeing.

ACTIVITY DURATION
Depending on the participants number

NUMBER OF PARTICIPANT
-

MATERIALS
Paper and pencils

DESCRIPTION OF THE ACTIVITY
Each participant sketch a timeline, showing the time that has elapsed in the last three months (could be a longer period of time). They are then encouraged to find key moments where they felt their well-being was affected during this period and record them to the timeline.
Then, they discuss this moments and how they felt back then and now. Has things changed? How these moments affected their life?

PRACTICAL TOOL: LETTER TO MYSELF

ACTIVITY TITLE- LETTER TO MYSELF

ACTIVITY PURPOSE /GOAL

The main goal of the activity is to reflect to our own wellbeing.

ACTIVITY DURATION

Depending on the participants number

NUMBER OF PARTICIPANT

-

MATERIALS

Paper and pencils

DESCRIPTION OF THE ACTIVITY

The participants are asked to think about their own well-being and write a letter to themselves. What they would wish for themselves one year later, how they could take care about themselves.

Tell them to write 5 things on this matter and if they feel comfortable to read out loud in front of all the participants.

References:

https://www.salto-youth.net/downloads/toolbox_tool_download-file-1792/Booklet-compressed.pdf

https://www.salto-youth.net/downloads/toolbox_tool_download-file-2910/Toolkit_DEVELOPING%20MENTAL%20HEALTH%20THROUGH%20YOUTH%20WORK%20AND%20NON-FORMAL%20EDUCATION.pdf?

http://peopleinfocus.org/en/drama-and-theatre-in-education/

https://fondationdaniellemitterrand.org/wp-content/uploads/2022/07/facilitators-guidebook.pdf

5. CASES

CASE 1

A patient who was 24 years old was living with his parents, his older brother and his younger sister. He had a normal development and pleasant memories about his childhood. His mother was a little bit overprotective, while his father was rather relaxed. He was enjoying spending much more time with his sister rather than his brother. He had no problems with his friends in his preschool and elementary school years. He could make friends and participate in social events. However, after he became a teenager, he started to stutter. Because of that, his classmates at high school started to make fun of him and bullying. He felt defective and started to withdraw from school and social relations. He started to spend more time at home by playing video games and communicating less with friends. He was thinking that school is a hell-like place. After graduating from high school, he rather continued to stay at home and didn't try to enter a college.

Throughout 2 years, he stayed in his room by surfing on the Internet and playing games except the times he needed to go to the toilet or bathroom. Because he started to experience problems with his family members because of his overuse of computers, he started to lock himself in the room by putting furniture behind the door in order to stop anyone from entering the room. At the end, his sister called the ambulance and he was taken to the emergency department. For at least three years, he was eating, drinking, sleeping and playing games in his room and didn't leave his room unless he had to. After coming to emergency, he went through some procedures like Clinical Global Impression scale (CGI), Electroencephalography (EEG), Computed Tomography (CT), laboratory testing and psychological assessment tests. According to test results, there was no abnormality in brain, he had an average IQ score of 105 points. He had increased aggressiveness and depression, low scores in sociability and uncontrollability. As for the treatment, he started to use pharmacotherapy with low doses of olanzapine and low doses of lorazepam in order to lower anxiety level and raise adjustment level. He also went through psychoeducation (once weekly), CBT (cognitive behavioural therapy), community therapy, individual and group psychodynamic therapy. One of his family members also attended the sessions and he sometimes got homework like keeping diaries, going out instead of using the computer. After some time, the Internet was used as a reward for socialization and fulfilling his responsibilities. It was found that he felt anger because of being excluded from society and he rather stayed at home to feel safe before treatment. As he continued his sessions, he improved and also made some friends at hospital and started to meet them outside the hospital.

CASE 2

The other case is a 15-year-old boy from Türkiye. He lived with his sister, his mother who was an engineer and his father who was a teacher. He experienced a normal childhood but when he started school he communicated less with his friends and experienced difficulty while making friends. In the first years of school, his school achievements were above average but when he entered high school, he was not able to get good grades. Because his parents had higher expectations from him, he felt failure and withdrew from school and his social life. He didn't go to school and rarely went out of his room. At first, he only went out for his physical needs like eating, having a bath and going to the toilet. He spent most of the time playing games and surfing on the Internet in his room. After a while, because his parents started arguments about his behaviours, he got aggressive and quit going out of his room. So, his family started to put his food before his room door. He kept the curtains closed and put furniture behind the door in order to not let parents come into his room. Even he started to urinate in the bottles and didn't go out of his room to eat food because of his parents' arguments. After his parents cut the Internet connection and took computers and technological devices away, he still refused to leave his room. After some time, because his parents worried about him, he was taken to a clinic for treatment.

Firstly, he took some psychological assessment tests like WISC-R (Wechsler Intelligence Scale for Children-Revised), SAPS (The Scale for the Assessment of Positive Symptoms), SANS (The Scale for the Assessment of Negative Symptoms), K-SADS (Schedule for Affective Disorders and Schizophrenia for School-Aged Children Present and Lifetime Version), CDRS (Children Depression Rating Scale) and SCARED (Screen for Child Anxiety Related Disorders). According to the results, it was understood that he didn't have any disorders such as neurodevelopmental, psychotic and affective disorders.

He didn't have a psychotic disease like schizophrenia because he didn't show symptoms like hallucinations and delusions.
He didn't have social anxiety disorder because he didn't feel anxious in a new environment.
He didn't have autism spectrum disorder because he was able to communicate and have eye contact with other people while having conversation.

As a result, his symptoms were more similar to Hikikomori. He distanced himself from people around him and didn't leave his own room even for his needs for more than 6 months. He was sleeping in the daytime and staying awake in the night by playing video games. He refused to leave his room even after his parents took electronic devices away. After examinations, he started to take Risperidone 0.5 mg/ day and go to therapy. At first, he didn't think there was a problem. He seemed like he didn't want to talk but after some time he started to communicate. The family also got counselling about how to behave with the patient and they improved their parenting skills. After a while, the patient spent more time out of the room with his family and improved.

CASE 3

The other case is a 38-year-old man. In his childhood, he showed a development consistent with the developmental stages. In the first years of school, he could make friends and have a social circle. However, because he wanted to copy a comedian, he made stuttering a habit. After some time, his classmates started to make fun of him and he was ostracized because of stuttering habit. After entering high school, he socialized with his friends but he suddenly lost his father because of an acute physical illness. He spent more time with his friends and rarely studied his lessons. After graduating from high school, he entered a university as easy to enter as his friends did. He rarely attended classes and dropped out of school in his second year. He started to work at a shop as an assistant in his 20s. When he reached his 30s he quitted the job because he wanted to work at a full time job. He started to look for a job as he wished, but he couldn't find any and lost his own confidence in time. He stopped looking for a job and withdrew from his family, staying in his room and playing video games. His daily routines were irregular, and he was playing games until midnight in a 5-year period. He had arguments with his sister and mother because of his failure to work and have a marriage. After learning that one of his friends committed suicide, he started to worry about himself. He applied to Hikikomori Support Center with his worried mother. He started to attend psychodynamic group therapies.

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6. Intervention Methods and Multidimensional Approach

Researches about hikikomori suggest a multidimensional approach to cure Hikikomori syndrome. Because the patient with hikikomori syndrome may need individual or group therapies in order to overcome his past injuries, there is a need for psychotherapy. Because the family affects the patient, in turn they are also affected by the situation, so the family also needs counselling and therapy. Different methods like physical activities also are found out to be effective in managing symptoms. Family therapy and counselling: Studies suggest that factors like family psychiatric history, dysfunctional family dynamics, family maltreatment history and single parent family might have an effect in the emergence of symptoms of hikikomori syndrome. If a parent has psychotic disorder, it affects the child's coping mechanism, affects regulation and socialization. In addition, if parents' expectations from the child are too high, when the child fails, he feels a lack of self-confidence and withdraws from school. If one of the parents is overprotective, the child may not be able to improve coping strategies when faced with challenges in daily life. So, it is important to have counselling with families about what hikikomori is, how to behave to their child with hikikomori syndrome and how to support their hikikomori child.

Psychotherapy sessions: Patients might have a history that causes hikikomori. For example, the patient may be ostracized because of any physical deficiency or any individual differences from classmates. That situation might cause the child to feel insecure and have difficulty with socialization. That's why weekly psychotherapy sessions are important for patients to overcome past injuries. Different therapeutic strategies like cognitive behavioural therapy, psychodynamic therapy or group therapies might be useful in overcoming hikikomori syndrome.

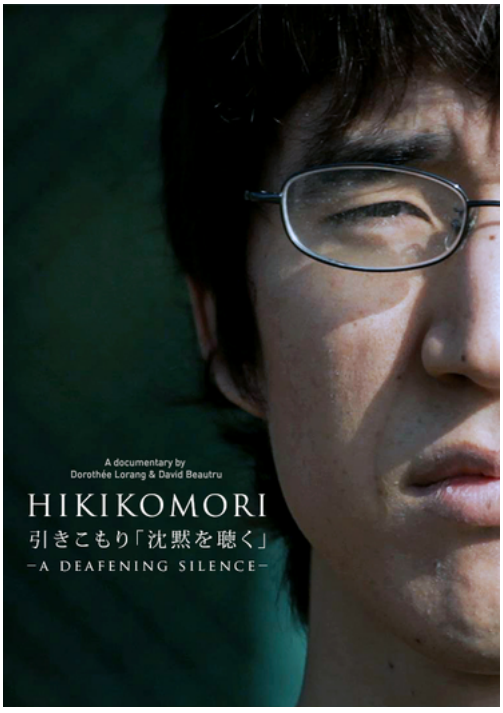
Physical Activities: A research study done by Keiko Yokoyama, Tadaaki Furuhashi, Yuji Yamamoto, Maki Rooksby and Hamish J. McLeod suggests a different approach called HMC program (Human movement consultation) Because sports are effective in improving mental health as well as cardiopulmonary functioning, quality of life and well-being, they offer people with hikikomori two types of physical activities which are outdoor workouts and interpersonal sports. Patients have homework like walking, running or cycling in outdoor activities. They are also directed to do interpersonal sports like table tennis, badminton or tennis because these activities require face to face interaction.

Case A from the study is an undergraduate student who was 19 years old. When he was first accepted into the program, he had withdrawn from school, his daily life cycle had been reversed, and he spent most of his time in his room playing video games. He was also attending psychiatric consultation bi-weekly at that time. Case A did some activities during treatment such as walking, running, cycling, table tennis, badminton, and catch-a-ball game. At first, he had a lack of confidence in choosing which activities to attend. Afterwards, he felt unsure and worried whether he could do it successfully. As he continued to exercise, his self-confidence increased and he felt better both physically and psychologically. He was more willing to engage in interpersonal sports with different members. At the end of the process, he decided to return to university.

Documentaries, Films and Videos

Movies and documentaries can powerfully express social phenomena by combining visual, emotional and narrative elements. This provides viewers with an entertaining experience and allows them to think, empathise, speak and take action on social issues. Therefore, we would like to give you some suggestions regarding the hikikomori phenomenon:

1. **Hikikomori, a deafening silence**



A calm, empathetic documentary film about hikikomori - mostly young, male social recluses in Japan - and their way back into society through the help of institutions.

2. Japan: The Age Of Social Withdrawal | 101 East

Documentary in which Al Jazeera English Channel interviews hikikomori individuals.

3. Hikikomori: Japan's Vanishing People

Hikikomori describes a Japanese psychopathological and sociological phenomenon affecting up to 2 million people who withdraw from society, hiding in their rooms for months to years at a time.

Director: Mandana Mofidi (2017).

4. Film: Tokyo Sonata

It describes the changing family structure when the father of the family loses his job. Although the elements of the hikikomori phenomenon are not seen clearly, the way in which a male individual experiencing economic difficulties in a traditional patriarchal structure is defined by society is conveyed very well in the film. It is a good movie that shows why hikikomori is in high numbers in a sociological context, especially in Japan.

7. List of useful organizations

Italy

- Hikikomori Italia (*https://www.hikikomoriitalia.it/*)
- Amahikikomori (*https://www.amahikikomori.it/*)
- Associazione Italiana per la Salute Sentale AISME (*http://aisme.info/*)
- Associazione Italiana Tutela Salute Mentale AITSAM (0422 710926) (*https://www.aitsam.it/*)
- Telefono Amico Italia (*https://www.telefonoamico.it/*)
- SOS Psiche (*https://www.sospsiche.it/salute-mentale/volontari.html*)
- Telefono verde salute mentale (800.833.833)
- Emilia Romagna, Hikikomori Italia Genitori ONLUS (emiliaromagna@hikikomoriitalia.it), (*https://www.hikikomoriitalia.it/p/gruppo-genitori.html; https://www.informafamiglie.it/unione-terre-acqua-casa-isora/servizi-alle-famiglie/corsi-e-gruppi-per-genitori/gruppo-per-genitori-associazione-hikikomori-italia-genitori-onlus*)
- Linee di indirizzo su ritiro sociale Emilia-Romagna. Prevenzione, rilevazione precoce ed attivazione di interventi di primo e secondo livello (*https://www.regione.emilia-romagna.it/notizie/2022/giugno/adolescenza-le-linee-guida-della-regione-contro-disagio-e-ritiro-sociale-formazione-prevenzione-monitoraggio/linee-di-indirizzo-su-ritiro-sociale-rer-1.pdf*)
- Bologna, Associazione Senza Fili (*https://centrosenzafili.it/adolescenti-e-preadolescenti/*)
- Bologna, Nessuno Resti Indietro (348 5660573)
- Progetto Spazio ed Amicizia ODV: spazioamicizia@gmail.com
- Bologna, Cercareoltre Sinergie per la Salute Mentale (0516753917)
- Bologna, Villaggio del Fanciullo (giovanni.mengoli@dehoniani.it) (051 343754, 051 345834)
- Short documentary in Italian, by Hikikomori Italia: (*https://www.youtube.com/watch?v=Q6GjaYwsrlk&pp=ygUTaGlraWtvbW9yaSBmYW5ucGFnZQ%3D%3D*)
- Milano, Centro Hikikomori (02 36 74 27 58), (hikikomori.coop@gmail.com)
- Toscana, Rete Cedro: documentazione sulle dipendenze patologiche (*http://www.retecedro.net/contatti-3/*)
- Centro studi Gruppo Abele (011 3841050), (*http://centrostudi.gruppoabele.org/*)
- Attiva-Mente (*https://www.ciai.it/progetto/attiva-mente/*)

Turkiye

- **112 Line**

In Türkiye, there is a telephone hotline 112 for all emergencies and counselling services. People can call this number if they have a condition related to Hikikomori or if they are mentally or physically unable to cope. They will be supported with emergency counselling.

- **183 Line**

Through 183 telephone hotline Anti-Violence Hotline, one of the Call Centres of the Ministry of Family and Social Services, calls regarding services for family, women, children, disabled, elderly and their relatives are evaluated and guidance and counselling services are provided. It operates on a 7 days 24 hours a day basis. Although this telephone line was initially established as a violence line, the Ministry's psychological support services can be learnt by calling this telephone line.

- **CİMER**

There is a platform called CIMER that allows access to all public institutions in Turkey. Each individual can write the service they need on this platform. Accordingly, information that will help him/her will be provided to him/her.

Social Service Centres (SSCs)

- **Individual Counselling:**

In Social Service Centres (SSCs), individual counselling in psychosocial service areas is carried out by the appropriate professional staff according to the client's problem area. Psychological assessment is carried out by a psychologist, social and economic assessment by a social worker, and developmental assessments by a child development specialist. During individual counselling, problems that fall within the field of other psychosocial support staff at the SSC, concern other units within the SSC, require diagnosis and treatment and/or concern other institutions and organizations must be referred to the relevant person or institutions. Cases referred to the relevant persons or institutions and the procedures initiated there can continue to be interviewed by the counsellor upon their request. Cases referred for psychiatric diagnosis and treatment may continue to meet with the counsellor at the SSC after the diagnosis is made and the treatment is arranged (if possible, the counsellor may continue to communicate with the physician).

For contact information of the centres in each district in Istanbul:
https://www.aile.gov.tr/istanbul/kuruluslarimiz/

- **Family interviews:**

All psychosocial support staff (psychologists, social workers and child development specialists) can conduct family interviews in cases that fall within the psychosocial service areas of SHMs and where the family should be handled as a system. The main point in these interviews is that each professional handles the family from his/her own professional perspective. In cases where the family needs to be handled systemically, it is more appropriate for personnel trained and equipped in family counselling to see the family. In case of individual psychological problems that may prevent the family counselling, the social worker and child development specialist should refer the case to a psychologist, and if there is a suspicion of psychopathology after the psychological evaluation by the psychologist, the case should be referred to a psychiatrist. According to the results of the psychological evaluation and psychiatrist examination, the psychologist and other professional staff should decide how to manage individual and/or family interviews together with the approval of the clients.
https://www.aile.gov.tr/istanbul/kuruluslarimiz/

- **Psychological support units affiliated to Istanbul Metropolitan Municipality**

Psychometry, child-adolescent psychotherapy and counselling, adult psychotherapy and counselling, couple and family psychotherapy and psychiatric counselling services are carried out in the units affiliated to the Istanbul Metropolitan Municipality for the purposes of solving the problems of individuals, increasing the quality of their daily lives, individual development and maintaining their social cohesion.
In Istanbul, 28 Psychological Counselling Centres provide services to citizens between the ages of 3-65.
You can find contact information from this link:
https://saglik.ibb.istanbul/psikolojik-danismanlik-merkezleri-pdm/

- **Guidance and Research Centres (GRCs)**

Guidance and Research Centres are affiliated to the Ministry of National Education. It carries out studies for the effective implementation of guidance and psychological counselling services in educational institutions and is responsible for carrying out educational assessment, diagnosis and guidance services for individuals requiring special education.
https://orgm.meb.gov.tr/www/rehberlik-ve-arastirma-merkezi-ram/icerik/1929

- **Guidance Services of Schools**

Every school has a counselling service. Psychological counsellors take part in this service. Every young person can get support from counsellors.

Bosnia and Herzegovina

Menssana Association - 061 629 591 - Menssana is the first Association in Bosnia and Herzegovina who participated in the project dedicated to phenomena of Hikikomori with the team of credible persons who went throughout a training to be competent to help and guide people with Hikikomori.

The Blue Phone - 080 050 305 - is an advisory line for anonymous and free help to young people and children in Bosnia and Herzegovina. The most common reasons why children turn to them are related to mental health, violence or abuse.

The SOS red line - 033 222 000 - is a phone number that allows citizens of Sarajevo Canton and beyond to report any form of domestic violence: physical, psychological, sexual and economic violence.

Mental health centres in health centres in the Federation of Bosnia and Herzegovina adapted their work to the new situation and made themselves available to citizens for psychological support **by telephone** during and after working hours, and those centres that were able to organize this support 24 hours and on weekends.

Federal Ministry of Health - "Please contact us, the contact numbers of mental health centres for the FBiH area are available to you and are published on the website of the **Crisis Staff of the Federal Ministry of Health** and **Association XY**. If you see that a certain crisis is affecting your mental health, seek help, seek advice, it's just a small professional conversation", said Irina Puvača, underlining how the Centres for Mental Health have made themselves available online, through all their lines.

ALBANIA

It's worth noting that various organizations have undertaken distinct initiatives to promote mental health awareness among young people. Additionally, the concept of Hikikomori has been recently introduced in Albania and the Western Balkans.

People in Focus Albania NGO - PiF is the first Association in Albania who participated in the project dedicated to phenomena of Hikikomori, raising awareness and building capacities of Psycho-social professional and teacher on how to identify and help and guide young people with severe social isolation.

Alo 116 Phone Line - The National Advisory Line for Children in Albania focuses on children and young people by taking in account and referring their requests according to the needs they convey to ALO 116. It is available to all children throughout the country, 24 hours 7 days a week and every day of the year. *https://alo116.al/*

Counselling Line for Girls and Women 116 117 - Line for Girls and Women provides telephone counseling as well as face-to-face counseling for women and girl. This line offers free psychological and legal counseling aimed at empowering and supporting women who are victims of violence. *https://hotlinealbania.org/.* Additionally, a Counselling Line for Boys and Men is founded. *https://www.clmb.al/*

Public Health Institute - The mission of PHI, as the National Center in the field of public health, consists in the development, prevention and control of diseases, injuries, disabilities, and environmental health-damaging factors, and the development and of health promotion campaigns in close cooperation with national and international agencies and organizations.

Psycho-social Services of Schools - Every school has a counselling service. Psychological counsellors take part in this service. Every young person can get support from counsellors.

Individual Counselling - In Albania, a variety of private counseling clinics are available to individuals seeking support for their mental health. These clinics serve as accessible and welcoming spaces where individuals can seek professional assistance to address their psychological well-being.

NB. If you see that a certain crisis is affecting your mental health, seek help, seek advice, it's just a small professional conversation.

8. Final Reflection

Youthful Pain as a Message to the World: At Hikikomori's School

• *The rebellion, and the failure of the required tasks, and the consequent protective distance that the boys trigger with respect to the system, seems to ask, albeit in dysfunctional ways, to open a solitary space to stop the demands of the social machine, and to search within oneself their own personal values and one's own personal path.*

•*Young people, with their puzzling behaviours, stage what the adult society removes. In this case the Hikikomori are spokesmen, and they take on an existential depression that adults don't allow, all busy with their innumerable commitments, and that the more sensitive boys, who do not yet have a stable position in the companies they intercept.*

• *Perception of an internal void, within which the essential questions of the human being: What do I want? Where do I want to go? What meaning does my life have? How can I contribute to the improvement of society? What's the point of all the evil in the world? What is love? What about friendship? And the war?*

• *Far from being able to find univocal answers to these questions, however, they need a development time, and a participatory research together with someone who wants to be together with them in the exploration, without saturating the thought immediately with advice and straight ways.*

•*Are we still able to narrate rather than explain? We are still able to complicate rather than to label and simplify?*

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