Shut in and cut off?

An exploration of internal and external relationship dynamics of adolescents and young adults who are socially withdrawn and isolated in their homes

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Abstract

The aim of this research was to learn more about adolescents and young adults who withdraw into their rooms, and who are isolated from society. I wanted to investigate whether 'Hikikomori', a phenomenon found in Japan of people shutting themselves away in their rooms for months and years, without attending education, training or work, was relevant in Britain.

Data was gathered by a two-staged method: an audit conducted at a young people's mental health clinic, and semi-structured interviews with child psychotherapists and a psychiatrist who had clinical experience of working with severely withdrawn young people.

The audit was analysed using descriptive statistics. The key findings of the audit were that 16% of overall referrals showed Hikikomori presentations of being shut away in their room for several months or more, and a further 13% were social isolated and at risk of Hikikomori. The audit further showed that such withdrawn young people showed a higher engagement in psychotherapy compared to overall referrals. It also showed there are some characteristics that are common amongst the withdrawn group, in particular excessive computer use, experiences of bullying, and fears that others would attack, control or humiliate them.

The interviews were analysed using Thematic Analysis, which identified four overarching themes of 'being stuck', 'relationship to the outside world', 'boundaries' and 'therapy, change and endings'. Their subordinate themes are explored within psychoanalytic theories on adolescence, and concepts such as 'psychic retreats' and 'pathological defence systems', as well as psychoanalytic investigations of the impact of the internet, leading to a consideration of the internal objects and the inter-relationship dynamics present within severe withdrawn states.

The findings of the audit and the interview study were compared with each other and put in the context of other research findings. The implications of the findings are considered and recommendations made.

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Glossary

NEET: Not in education, employment or training

EET: Education, employment or training

CAMHS: Child and Adolescent Mental Health Service

Hikikomori: A person who has socially withdrawn to such an extent that they do not, or only very rarely, leave their room, and this has lasted more than six months. Hikikomori also refers to the state/ condition of such withdrawal.

Introduction

Background and context

The term Hikikomori was first introduced by Saito (1998) to describe a a phenomenon that became an issue in Japan in the 1990s, where young people were withdrawing from social contact for long periods of time, sometimes for years, and shutting themselves away in their rooms, with an almost complete lack of interest in school or work. The most commonly used definition of Hikikomori is a person who by their early twenties has stayed in their home for more than six months, and who does not have a psychiatric diagnosis (Saito, 1998; Lee et al, 2013). Hikikomori was introduced in 2010 in the Oxford English dictionary. The term combines the stem of the Japanese word *hiku,* 'to pull, draw, retreat', and *komoru*, 'to shut oneself up, stay inside'. Adamski (2018) added that *komoru* can mean to be in a castle and protecting yourself, to stay in the temple and pray, or to enter and hide.[1]

According to a number of research studies (Hattori, 2006; Teo,2010a; Koyama et al,2010) and a report by Japanese government (Gov of Japan Cabinet Office, 2010), Hikikomori in Japan is seen as reaching huge proportions. In the English media, *The Guardian Weekly* reported on the Hikikomori phenomenon in 2012, and the *BBC World News* reported on it in 2013. Both focused on Hikikimori as a Japanese phenomenon, though the Guardian article was based on a *Le Monde* article and included a presentation of a French study. *The Lancet* reported on the issue in 2002 (Watts, 2002), and again in 2011, where it warned that Hikikomori and what is dubbed 'modern-type depression' may not just be Japanese phenomena, but may "be indicators of a pandemic of psychological problems that the global internet-connected society will have to face in the near future" (Takahiro et al, 2011).

[1] *Interestingly, there seems to be a correlation with the culture of marketing. In 1981, Faith Popcorn, a trend forecaster and marketing consultant, coined the term cocooning whereby people stay inside their homes insulated from perceived outside danger (https://en.wikipedia.org/wiki/Cocooning). From a marketing point of view, internet shopping, Netflix, and other products to be used in the comfort of one's home are being promoted.*

Many of those in a Hikikomori state spend their time on the internet or playing videogames, often sleeping during the day and staying up all night. Psychologist Claudia Hammond (Hockings, 2013), who has spoken to Japanese young men living in a Hikikomori state, believes that sometimes depression is an underlying condition, and some people then seem to develop a social phobia because they have been inside for so long. The sufferers described their withdrawal as a response to pressures in society to adhere to a predefined time schedule for life (education, work, marriage). French psychiatrist Serge Tisseron (Gozlan, 2012) believes that Hikikomori "could be a form of withdrawal behaviour enabling adolescents to cope unconsciously with emotions and anxiety about the future, avoiding a full-blown psychiatric pathology, such as a nervous breakdown or the development of a phobia".

What sparked my interest in researching this phenomenon was clinical work with a patient who described himself as a Hikikomori. Since leaving school three years previously he had shut himself in his room in his parental home. He spoke to me of other people he had met through social anxiety internet forums, who like him had withdrawn into their rooms, who lived in the UK and in the USA. From this incidental report I hypothesized that severe withdrawal like this is not limited to Japan. Indeed, research on incidental reports of similarly shut-away young people living in other countries indicates that this is not an exclusively Japanese occurrence (Kato and Tateno, 2012).

From my own clinical practice within CAMHS and other mental health services for young people, as well as incidental reports from other clinicians working in such services, over the last decade or so there seems to have been an increase in referrals of young people who have stopped attending school and who have retreated to their homes. Sadly it can be difficult for services to reach these young people if they are unable to come to the clinics, unless the service has the resources to visit them at home.

In a recent *Dispatches* programme (*Dispatches*, 2019) the Children's Commissioner for England, Anne Longfield, reported that the number of home-schooled children has more than doubled over the last five years, reaching the record number of around 60,000. In 2018 alone, according to the Ofsted annual report, an estimated 9,700 children aged 14-16 dropped out of school. Anne Longfield stated that while reasons

for home educating are varied, for many of these families home education has not been a planned choice but a situation forced upon them as their children could not cope in school. Equally, the school could not provide them with the support to keep them in school, or needed to 'off-roll' them in order to keep their league table standard. As there is no legal duty on councils to monitor home-educated children, and as councils often do not have the resources to do so, these children can become invisible (ADCS Home Education Survey 2018 states that 87% of councils said they don't have the resources to support the increasing numbers of home-educated children).

In my experience of working in a CAMHS clinic, the following trajectory is not uncommon: unable to cope with school – reduced attendance – dropping out of school to be home educated – decreased social life – increased time spent at home – increasing low mood and anxiety particular in relation to re-joining the social educational world. Anne Longfield (*Dispatches*, 2019) stated that "[d]ata on future outcomes of home-educated children is inconclusive, but evidence given to one parliamentary review showed they are four times as likely to be classed as NEET[2] once turned sixteen".

Figures from the Higher Education Statistics Agency have also shown an increase in the number of students dropping out within the first year of higher education, for three years running (Wealy S, 2018), and this is higher for students from low-income families (Busby, 2019).

A report by the Bow Group, using figures from official documents, estimated that in 2005, 15,000 children in their GCSE year were missing from school registers, and there has been an average of 5,000 children dropping off the school roll each year. Only a small proportion of these are pupils who leave school to be home-schooled. They describe an increase of 44% from 2001 to 2006 in young people (16-24 year olds) who are NEET. As there is no national database, and as councils are not required to track those not on a school roll, some young people do just 'disappear' in the minds of society. Being interviewed by *The Guardian*, Skidmore, one of the authors of the report, stated that "[t]here are certain groups in society who have

[2] Not in Education, Employment or Training

fallen so far below the radar that politicians are not aware they exist"(Asthana and Revill, 2007).

Becoming invisible to society is a serious issue. Young people might come to harm without anyone noticing.

A recent epidemiological study conducted in Japan indicates that young people who have dropped out of the education system, school or university, are more likely to become Hikikomori compared to those who have not dropped out (Yong and Komura, 2019). There are a variety of reasons for young people to drop out of school and/ or become NEET. Many of them continue to engage in the social world in some way. However, they are vulnerable to getting involved with alcohol, drugs and the criminal world. They are also vulnerable to becoming reclusive and hidden away at home. Special Educational Needs, disabilities or illnesses, bullying, high levels of anxiety, and being a carer are all areas mentioned by the *Dispatches* programme and the Bow Group report. Some of those in these categories may become withdrawn once they stop engaging with the EET world. This is the group of young people that the present study focuses on.

I believe that a combination of factors contributes to the development and maintenance of such a withdrawn state, factors that are psychological, familial, social, and cultural, and that represent the impact on the individual of socio-economic realities. An external relationship characteristic, for example, could be the lack of authentic communication with parents, or a reaction against intrusive dynamics from parents or peers. A socio-economic factor could be the lack of job prospects, contributing to a nihilistic outlook on life.

In this study I focus on intra-psychic processes and inter-relational processes, and how these can interrelate and be a reflection of each other. An intra-psychic feature, for example, could be a 'psychic retreat' type of defence mechanism against awareness of painful reality (Steiner, 1993). I wanted to learn more about the phenomenology of such a reclusive state of mind, and what its psychic meanings and functions may be. As a subsidiary question, I wanted to enquire whether the use of the internet features in a young person's withdrawal and, if it does, in what way.

As I approached the question of the most appropriate and feasible form of data collection and methods of analysis, I postulated that whatever led to the

development of a withdrawn state, once established it becomes a vicious circle. Having less contact with others, a withdrawn person becomes 'de-skilled' in relating to others. In addition, for someone anxious about relating, doing less of it is likely to increase the fear of social contact. This makes it more and more difficult for the person to come out of his/her retreat. The point where someone in the young person's life is concerned enough to instigate a referral to psychological services constitutes a moment of opportunity to intervene in this vicious circle.

Psychotherapy, with its focus on exploring relationship patterns through the exploration of transference/countertransference dynamics, seems in a good position to start a process of change. The point where a withdrawn young person actually engages with a psychotherapist is a moment of opportunity to engage in contact, a moment where the withdrawn person might step out of his/her reclusive state. With this postulation in mind I decided to focus my study on moments of contact between a psychotherapist and a severely withdrawn young person. I did this through two aspects of the investigation: a broader exploration through an audit of referrals to a young person's mental health clinic; and a more in-depth study interviewing psychotherapeutic clinicians about their work with severely withdrawn young people. It is hoped that my study will increase understanding of withdrawn young people and how services can be helpful to this client group.

Need for study and anticipated benefits

Although there have been several studies looking at different aspects of Hikikomori in Japan, which I will detail in my literature search, the studies on such extreme withdrawal outside of Japan are limited. A number of people have called for research on Hikikomori internationally (Kato & Tateno, 2012; Takahiro et al, 2011; Teo, 2010a), including whether Hikikomori meets criteria for a new DSM psychiatric disorder (Gaw and Teo, 2010; Lee et al, 2013), or is a particular sociocultural manifestation of established diagnoses such as prodromal psychosis or internet addiction (Stip et al, 2016).

A Japanese study on school refusal called for further investigation of the characterological comparisons of school refusal in Japan, the USA and Europe (Honjo et al, 2001). Furthermore, research into predictors and consequences of

social withdrawal, and the influence of internalising difficulties in children and adolescents has been recommended (Kingery et al, 2010; Wonjung et al 2007). We need to increase our clinical knowledge of withdrawn young people, including their attitude towards seeking help in order to find treatments (Lee et al, 2013; Ranieri et al, 2015; Yong and Kaneko, 2016). One of the recommendations of the *Improving Mood with Psychoanalytical and Cognitive Therapies (IMPACT)* study was to examine the characteristics of adolescent depression that index the risk for non-response to short-term treatment (Goodyer et al, 2017), and it might be that withdrawal accompanying the depression is one of those risk factors.

My study is thus a timely response to an under-examined phenomenon. The extent of the problem in the UK is not known, but, considering the context of people dropping out of school and university, which I discussed earlier, it might be pronounced and increasing. I believe it is vital that we take note and research the spread and the depth of this issue.

As a society we have only recently begun to examine more closely the impact of the internet and other new technologies on today's young generation. I am not aware, however, of any closer examination of the phenomenon of young people withdrawing into their rooms, which may be a particular form of psychological distress within today's world. As Rustin (2000) states: "The kinds of mental and emotional ill-being to which psychoanalysis has responded have evolved during its history, probably reflecting changes in socially-constructed kinds of typical individual experience" (p.43). I believe that this research constitutes one response to such developments.

Aims of study

The general aim of this study is to learn more about young people who withdraw into their rooms, and to facilitate understanding on how to best help such withdrawn young people. Specifically, the questions I wanted to examine in the audit are whether withdrawn young people come to the attention of psychological services, and, if so, whether such young people engage with psychotherapeutic treatment, and whether there are common characteristics of young people who shut themselves away in their rooms. The aim of the interview study was to learn about withdrawn

young people’s object relationship dynamics, via talking to clinicians who have worked with them, and through this to find out more about the phenomenology and potential psychic meanings and functions of such a reclusive state of mind.

Details of study

For this investigation the age range focused on is 13-25 years. The reason for this particular age range is that it includes the period of leaving school, a period where young people are expected to transition into work or further education or training. It may be that this is a particularly risky period for a young person who is vulnerable to becoming isolated. The disappearance of the structure of school, together with an inability (for example, due to lack of opportunity or due to high levels of anxiety) to go into further education, training or work may become the point at which a young person stops leaving the house.

The method of investigation involves a quantitative and a qualitative element, an audit and an interview study.

For the audit I looked at referrals to a mental health clinic which specialises in working with the adolescent and young adult age group. I retrospectively examined files of those referred within a given time period of six months. I wanted to find out whether there were any referrals of young people who showed characteristics of Hikikomori. The questions the audit addresses are:

> Are withdrawn young people being referred to psychological services?
>
> If there are such referrals, what are the outcomes of such referrals?

A positive answer to the first question would provide an indication that there are young people in England who show characteristics of Hikikomori, and that such withdrawn young people do get referred to a mental health clinic. The second question might give an indication about engagement. For someone who does not leave his or her house, coming to a service would be particularly challenging. Furthermore, in case there were several such referrals, I wanted to look for patterns in terms of gender, age, and accompanying symptoms, as well as treatment offered and the outcome of this.

For the second part of the investigation I interviewed seven child and adolescent psychotherapists, and one consultant psychiatrist specialising in adolescents and young adults. The aim of this was to find out about their understanding of withdrawn young people and how they have engaged with them. What did they think helped or hindered engaging the young person? What was their understanding of what contributed to the young person becoming isolated and withdrawn from contact, and what made it difficult to come out of their withdrawn state? How has the experience of being with the young person in the therapy room shaped the clinician's understanding? Has there been a change over time in how the young person related to the clinician, and how does the clinician understand any such change? I analysed the interviews using Thematic Analysis to elicit themes which, explored and drawn together, brought me closer to understanding withdrawn states.

Access and ethical considerations and permissions

To initiate the audit, I spoke with the then chief executive of the clinic and the lead of the adolescent and young adult service, who both expressed support for the research proposal generally and the audit specifically. To start the process of going through the formal application, I met with the governance and risk manager of the clinic who expressed great interest in my research proposal. My formal application to conduct the audit was granted approval in June 2014.

The data from the audit was analysed using descriptive statistics and, as such, consists of aggregated data with no personal details. The audit cases were not linked with the interview study, except as they provide a general descriptive context to the information gathered by the interviews. The original information about referrals, which included names, was immediately put into my own numerical form and kept separate from any material that formed the analysis of the data. I only used these numerical codes to refer to, and describe, the further analysis. The data was kept in a locked filing cabinet, and information stored electronically was accessed only via a password. Regarding the interview study, I provided the participants with written information about my research and gained their written consent[3]. In this information,

[3] See appendices C and D

given verbally and in writing, it was made clear that the interviews would be audio-recorded on physical tapes and hence non-digitally. Participants were anonymised and their places of work disguised, to ensure that the interview subjects were not traceable. I explained that anonymised quotations and/ or understanding gained from the interviews might be used in my thesis, and might be disseminated via presentation at professional conferences or published in peer reviewed journals. I explained that I would not ask for detailed case histories of any patients discussed, and would only ask for particular biographical information about the patients which related to my research questions (for example: at what point in their lives did they start shutting themselves away?). I was vigilant about disguising any information about patients, or about treatments, that might make them identifiable.

I was mindful that interview subjects might find it anxiety provoking to reflect on their work, and on their feelings in relation to their patients, in particular due to the tape recording, as they might feel their work was under scrutiny. The interviews were conducted in a relaxed and neutral atmosphere. The style and content within the interviews was a process the participants were familiar with. The clinicians interviewed were used to reflecting on their work in clinical supervision, peer supervision groups and case presentations within their respective work teams. I hoped that the interviews might be interesting and valuable for the clinicians, as the analysts who were interviewed by Hamilton had reported (Hamilton, 1996). In fact, all my participants told me afterwards that they found the interview helpful and interesting, by reflecting on their clinical work.

Tape recordings and transcripts of interviews will be destroyed when the research is completed, to protect the subjects from later inadvertent disclosure. The data has been in a locked filing cabinet, and information stored electronically was accessed only via a password.

Both aspects of the study were given ethical approval by UEL's University Research Ethics Committee in January 2015 (Ref no. UREC_1415_19; see Appendix E).

Outline of thesis

This thesis consists of four chapters. In the first chapter I explain my search methods and then give a literature review outlining previous research on Hikikomori and

related studies. This is divided into prevalence, other presenting issues associated with Hikikomori such as problematic internet use, and more qualitative orientated studies dealing with psychosocial issues. As part of this I discuss the disagreement within the research community as to whether Hikikomori is cultural specific to Japan. I then chart conceptual and theoretical ideas, which might be helpful to understand severe withdrawal, within the psychoanalytic literature as well as from Saito's book (Saito, 1998). Saito, a psychiatrist in Japan, initiated the term of Hikikomori, and his book is based on his vast experience of trying to support people in Hikikomori, and their families.

I need to mention here that the outline of this thesis does not follow the chronological order in which I conducted my research. While I had some ideas about which psychoanalytic concepts might be relevant, in particular Steiner's concept of the 'psychic retreat' (Steiner, 1993), I had left the conceptual and qualitative literature search until after I had analysed my data and collected them into themes. I did this in order to minimise my preconceptions about this subject, which might have impacted on my responses within the interviews and my analysis. Hence the conceptual and theoretical literature review refers to material which I have found useful in thinking about my findings, and features in the discussions within my findings chapters.

The second chapter discusses the audit part of my research. I describe the rationale for, and my process of conducting, the audit and how I collected the data, as well as the format of ordering the data and the methodology used to analyse them. I then outline and discuss the findings, and include sections on age and gender distribution, referral sources, engagement and presenting issues.

The third, and largest, chapter deals with the interview study. It starts with a general introduction to qualitative and psychoanalytic research, examining more closely psychoanalytic research methods and how these relate to my research. I then discuss the potential impact of a researcher interviewing professional peers about their perspectives on their clinical work with withdrawn patients, and explore the complex layers of subjectivity this creates. This chapter also includes an extensive section on potential benefits and challenges when interviewing one's peers, and my thoughts on how this might have impacted on my interview study. I then give a rationale of my chosen methodology, as well as a detailed outline of how I

conducted the interview study, including selection of participants and the structure of the interviews. I describe the process, and discuss the methodology used, for analysing the interview study data, and my rationale for using this methodology. I then introduce the participants, and give a context of the work they spoke about, before moving onto the findings of the interview study. The findings are separated into four overarching themes of 'being stuck', 'relationship to the outside world', 'boundaries' and 'change and endings'. The first three of these themes have several sub-themes exploring more detailed aspects.

The fourth chapter, the discussion and synthesis, will compare the findings of the audit with those of the interviews, and compare these to other research. I then gather together the interview sub-themes, to chart a potential process of a young person becoming withdrawn and getting increasingly stuck. I also provide a more in-depth exploration of some sub-themes, referring to psychoanalytic theories and comparing this with Saito's (1998) experiences. After a section on evaluation of my methodology and its limitations, I then outline a final conclusion and give recommendations.

Definitions

In this research I examine the kind of withdrawal that is so severe that it would fall under the Hikikomori definition. I will use the term Hikikomori, as it used in the literature, to refer to both the Hikikomori state and a person who has withdrawn to such an extent as to meet the definition of a Hikikomori. As this term is not well known in the UK, it is unlikely that a withdrawn young person would identify themselves as a Hikikomori in the way that people in Japan do. I will use the original definition of Hikikomori for the state where the young person has socially withdrawn to such an extent that they do not, or only very rarely, leave their room, this has lasted more than six months, and there is no psychiatric disorder (Saito, 1998; Lee et al, 2013). For simplicity I will use 'Hikikomori' or 'withdrawn' interchangeably. In the audit study, however, I make a distinction between 'severely withdrawn' cases, which match the Hikikomori definition, and less severely withdrawn cases where I use the term 'socially isolated'.

I will use the term ‘young people’ to refer to adolescents and young adults. The specific age range of my research is 13-25.

When speaking of psychotherapist or therapist in this thesis, I am referring to psychoanalytically-trained psychotherapists or psychoanalysts. During my discussion of the interview study, therapist will refer specifically to the Child psychotherapists who I have interviewed.

Within psychoanalytical literature, there are different ways in which the concept of countertransference is used, in particular in terms of the extent to which countertransference stems from the therapist’s emotional response being influenced (for example by the process of projection) by their patient (Baum, 1969; Spillius et al, 2011). I will use the term transference to mean the patient’s conscious and unconscious emotional responses to the therapist, within the frame of psychoanalytic psychotherapy or psychoanalysis. I will use the term countertransference to mean the therapist’s conscious and unconscious emotional responses to the patient. A continuous examination of these processes, and trying to work out how far these responses stem from the therapist’s own internal world being triggered by the dynamics of the encounter, and how much they are an expression of a feeling that was evoked by the patient’s emotional demeanour, and what, if anything, these responses might mean in terms of the patient’s transference, is very much part of a psychotherapist’s work.

Chapter 1: Hikikomori reviewed

Introduction

In this chapter I will outline first how I conducted the literature review, and then outline the finding of the review, separated in sections dealing with different aspects of Hikikomori within the research literature. This is followed by an exploration of literature which provided conceptual and theoretical models that I have used to help me understand my findings.

Methodology of the literature review

I conducted my literature search in two stages. At the time of writing my proposal in 2013 I had conducted a literature search using PsycINFO, as well as a general ‘google scholar’ search to get a sense of what had been researched about Hikikomori, and where the gaps were. I had searched the following keywords: Hikikomori; severely/ prolonged/ acute withdrawn AND young/ youth/ adolescent; school AND refusal/ drop-out/ absenteeism. Once I had some of the most-cited and relevant research papers on the subject, I used their references to further my search. At this point in time there was a dearth of papers on Hikikomori from outside of Japan, and several recommendations to research this subject area in other countries. I then searched for studies on depression in adolescence, and social anxiety, though this subject area was too vast for a comprehensive review, so I only took out some examples which looked most relevant to my research. The *IMPACT* study (Goodyer et al, 2017) at that point was still in process.

I then conducted a second literature search in 2018, after I had analysed and written up my data from the audit and interview studies. For this search I used the ‘EBSCO Discovery’ search engine, restricting it in date to anything published after my previous search in 2013. Interestingly, the research on Hikikomori had increased significantly in the five years since, and included both some qualitative studies as well as more studies from outside Japan. It showed that awareness of this issue has

increased globally. I did a final search just before completion, in summer 2019, and in fact found another important research study.

I conducted further searches within specific journals, notably the *Journal of Child Psychotherapy, Psychoanalytic Review*, *International Journal of Psychoanalysis, Psychoanalytic Psychotherapy, and the Journal of Infant, Child and Adolescent Psychotherapy.* I searched for case studies which had features of the topic being researched. I entered keywords of withdrawal/ withdrawn; psychic retreat; socially isolated. I also did a search in these journals on internet/ techno-culture/ cyber-world, as my analysis of the audit and interviews showed a strong association between young people who are withdrawn in their rooms and those who spend a lot of time on videogames and/or the internet.

In terms of conceptual and theoretical models that might help understand this phenomenon, I had some ideas of which psychoanalytic concepts might be helpful, in particular Steiner's "Psychic Retreat" (Steiner, 1993). However, I purposely left any further search until after I had analysed my audit and interview study data, in order to limit preconceptions that might influence the analysis. I then used the same keywords, and checked the indices of key psychoanalytic books, followed by using material that these papers or books referred to, and then searched for models of understanding particular aspects within my findings, referring to psychoanalytic literature. In my final discussion and conclusion chapter I compare my audit and interview findings with those of the studies referred to in my literature review.

Prevalence

According to Hattori (2006) and Teo (2010b), Hikikomori in Japan has been seen as reaching huge proportions. An epidemiological study suggested 1.2% of adults in Japan had experienced Hikikomori (Koyama et al, 2010). The Japanese government found 236,000 people withdrew to the extent of either never leaving their room, or at times leaving their room but never their house, or staying at home mostly, but occasionally going to their local shop (Gov of Japan Cabinet Office, 2010). A cross-sectional study in Japan (ages 15-39 years) found a prevalence rate of 1.8% (Yong and Nomura, 2019), and one conducted in Hong Kong found 1.9% of young people

(12 – 29 years) surveyed by telephone had withdrawn in their home for more than six months (Wong et al, 2015).

In terms of gender, studies on Hikikomori showed at least three times as many males as females (Lee et al, 2013; Saito, 1998; Teo, 2010a). However, a more recent population study (Yong & Nomura, 2019) showed a less dramatic gender difference, with 65.5% males in the Hikikomori group compared to 47.3% males in the non-Hikikomori group. In terms of social class, this study found no differences in prevalence according to social class.

When I first developed this project in 2014, this kind of withdrawal was well known in Japan, although it had not been reviewed in the English medical literature (Teo, 2010a) apart from one published case in the US (Teo, 2010b) and in Oman (Sakamoto et al, 2005). However, in recent years the incidental reports of similarly shut-away young people living in other countries indicates that this is not an exclusively Japanese occurrence, and there are published cases from Brazil, Canada, India, Italy, Korea, Oman, Poland, USA (Adamski, 2018; Chong & Chan, 2012; Gondim et al, 2017; Lee et al, 2013; Ranieri, 2015; Sakamoto et al, 2005; Stip et al, 2016; Teo, 2010b; Teo et al, 2015).

A survey of 124 psychiatrists in international countries outside of Japan, although not including the UK, revealed the existence of Hikikomori syndrome in all countries examined, and especially in urban areas (Kato & Tateno 2012), and the authors argue that it is an emerging psychiatric disorder (Tateno et al, 2012). It is interesting to note that several new studies have been done within the last three years, and several of them state that Hikikomori has become a global problem (Adamski, 2018).

The impact of withdrawal can be severe and longstanding on health, wellbeing and economic prosperity. The sedentary indoor lifestyle of Hikikomori is found to be causing increasing health problems such as obesity, hypertension, and heart disease associated with vitamin B1 deficiency (Tanabe et al 2018; Yuen et al, 2018). Due to adolescence being such a critical period for trying out interpersonal relationships, withdrawing during adolescence creates the risk of future problems such as becoming a NEET or a 'Parasite Single'/'Twixter' (staying with parents far into adulthood) (Lee et al, 2013; Yong and Nomura, 2019).

Comorbidity

Problematic internet use

Problematic internet use and addiction is sometimes associated with Hikikomori, although it is not clear whether it is a primary reason for social withdrawal or a secondary result of social withdrawal (Cerniglia et al, 2017; Furlong, 2008; Teo, 2010a; Sakamoto, 2005; Shirasaka, 2016; Lee et al, 2013). Some researchers make a direct link between the rise of, and our dependence on, technology and the increasing problem worldwide of Hikikomori (Adamski, 2018; Watts, 2002). However, Stip et al (2016) suggest that chronological development, when looking at individual cases, will indicate which 'triggered' which.

When Saito first raised concerns about withdrawn young people, in the last decade of last century, widespread internet use did not exist, and he also does not refer to the use of computer games in his study. Hikikomori was a problem before the arrival of widespread access to the internet, which suggests that problematic computer use is secondary to problematic withdrawal.

Adamski (2018) believes problematic use is due to the internet giving people the opportunity to relate to other people without having to leave their home. Yong and Kaneko's (2016) qualitative study found that the respondents did not naturally prefer the computer to communicate, but it allowed them more controlled social interaction where they could stay anonymous. They found interaction over the internet helped to build confidence, form identity and to recognise their own thoughts. However, by (partially) fulfilling their natural need to communicate, internet communication kept the status quo, a comfort zone the respondents did not dare to move beyond.

Excessive use of virtual reality is associated with loneliness (Engelberg & Sjoberg 2004; Nalwa & Anand, 2003; Lavin et al 2004; Shirasake et al, 2016; Whang et al, 2003), low self-esteem (Yang & Tung, 2007), depressed mood (Ybarra et al, 2005; Wang et al 2003) and anxiety (Zochil, 2015), and, for adolescent boys, insecure peer attachment (Reiner et al, 2017; Wartberg et al, 2017). Shyness was predictive of internet addiction and dependence (Chak & Leung, 2004; Lawin et al 2004). However, in a study of how people use the internet, Scealy et al (2002) did not find shyness or anxiety linked to the use of email or chatrooms, although they found that shy males were more likely to use the internet for recreational searches. Smahel et al

(2012) found a correlation between internet addiction and an approach to friendship where there is a preference to seek online friends.

Wang et al (2003) also found compulsivity, and social dysfunctional behaviour such as ‘ to escape reality’ associated with heavy internet use. Geyer et al (2017) in a study of students on how, and in which context, they use the internet, concluded that the constructs of ‘escape from problems’ and ‘loss of control’ showed the risk of problematic internet use. Nalwa and Anand (2003) found that people with internet addiction would delay other activities to spend time online, lose sleep due to time online, and feel that life would be boring without the internet. Adherence to idiosyncratic values, and lack of emotional and social skills, were associated with heavy internet usage (Engelberg & Sjoberg, 2004).

In a study of 13,588 internet users in Korea, Whang et al (2003) found that the 3.5% of the sample who had been diagnosed with internet addiction (and 18.4% as possibly addicted) had a higher correlation to dysfunctional social behaviours than the non-addicts group. The addicted group were more likely to use the internet to escape from reality, and to use it when they felt stressed or depressed. In addition, the addicted group showed unusually close feelings for strangers, which the authors stated might put them at higher risk of interpersonal dangers.

In a study of young adults, Evren et al (2018) showed an association between severity of internet addiction and ADHD, as well as emotion regulation difficulties and depression. A longitudinal study found a direct statistical link between unbalanced emotion regulation in infancy and internet addiction in adolescence (Cimino and Cerniglia, 2018). Additionally, a large-scale study of 23,533 adults (Andreassen et al, 2016) found a significant correlation between addictive technology use and mental disorders of ADHD, OCD, anxiety and depression.

Fontana et al (2018), in a study of 269 adolescents, found that Rejection Sensitivity (a tendency to expect, perceive and overreact to interpersonal rejection) was associated with internet addiction. An association between high social anxiety and higher rejection sensitivity, as well as higher online self-disclosures was found in a sample of Iranian students (Molavi et al 2018).

Depression

It is not clear whether there is a link between withdrawal and depression. Saito (1998) found 59% of his Hikikomori respondents experienced depressive mood, if mild forms are included, and more often felt empty and bored, or had feelings of despair. 43% had stated suicidal thoughts and 14% had harmed themselves, which Saito states as worrying but still being a much lower rate than in other psychological problems.

Honjo et al (2001) found that school refusal is associated with somatic complaints such as headache and gastrointestinal problems, rather than depression, although they conclude that it is likely that they don't feel depressed due to their emotional conflicts having been somatised. A published case in Canada (Stip et al, 2016) showed no evidence of depression. Koyama et al (2010) found that above 50% of adults having experienced Hikikomori had also experienced a mood disorder in their lifetime, but these were mild to moderate rather than severe.

Lee et al (2013) conducted a study in Korea specifically on youth, defining hikikomori/ socially withdrawn youth as anyone under 25 years old who has not left their room for at least three months, excluding those with a psychiatric diagnosis. Their study of a short home visiting programme had 41 participants (31 male, 10 female, with a mean age of 15) and a control group. Using a number of psychiatric scales, they found significantly higher levels of depression, anxiety, social anxiety and risk of internet addiction compared to the control group. It is interesting that not all Hikikomori youth in their sample were shown to suffer from depressive mood. Uchida and Norasakkunkit (2015) state that "most severely depressed people in Japan are not Hikikomori, nor are most Hikikomori severely depressed" (p.9).

Examining literature on Hikikomori, Sarchione et al. (2015) conclude suicide risk was not prevalent amongst Hikikomori sufferers. A recent population study did show a significantly higher prevalence of psychiatric conditions amongst the Hikikomori group compared to the non-Hikikomori group, including self-harming behaviours (Yong & Nomura, 2019). However, once they controlled for a history of psychiatric treatment, suicide risk was not found to be significantly higher. As there is very limited examination of Hikikomori presentations within western research literature, I looked at some studies on depression to see whether severe withdrawal states feature within their findings.

There is a large and often contradictory research literature on depression (Angold 1988). In a meta-analysis of epidemiological studies, Costello et al (2006) found no evidence for an increased prevalence of child and adolescent depression over the preceding 30 years. Public perception of a rise is likely to be due to heightened awareness and previous under-diagnosis. Looking at the abstracts of various studies examining depression in young people, I have not come across any specific information on withdrawn features (Angold & Rutter, 1992; Dunn & Goodyer, 2006; Goodyer, 1996; Goodyer & Altham, 1991; Halperin et al, 2010; Harrington & Dubicka, 2001; Kendler et al, 1999; Lewinsohn et al, 1999; Rudolf & Klein, 2009; Wilkinson et al, 2013).

In contrast, Berney et al (1991), in their study of childhood depression, did find a higher incidence of school refusal in the depressed group than the control group. In the childhood depression study of Trowell et al (2011), several children presented as feeling stuck, emotionally still functioning like younger children, struggling with the basic question of whether they had a right to exist, retreating into the safety of childhood dependence, and some being held in oedipal partner roles with their parents, which locked them into their homes.

The most recent IMPACT study (Goodyer et al 2017) investigated whether the specialised psychological treatments of CBT and Short Term Psychoanalytic Therapy, and a brief psychosocial intervention, reduced the risk of relapse in adolescents with moderate to severe depression. They found that, with all three treatments, 70% of adolescents had improved substantially. It would be interesting to investigate whether within their sample included severely withdrawn adolescents, and, if so, whether they showed responsiveness to treatment.

Fleming et at (1989) and Kennedy et al (1989) found an association between the severity of a young person's depression and peer rejection. This brings me to another issue often present in withdrawal.

Social anxiety

Nagata et al (2013) found 19% of 141 patients diagnosed with Social Anxiety Disorder fulfilled the criteria for Hikikomori. These patients also had an earlier onset, and lower treatment response rate, than those with SAD alone. As social anxiety seems to be a feature in withdrawn states, I then searched for studies on depression also including anxiety. A frequent co-morbidity of anxiety with depression has been found (Angold & Costello, 1993). Mitchell et al (1988) found that children with co-morbidity of depression and anxiety, particular separation anxiety, tend to be more disturbed than those who are only depressed. Campbell notes the co-morbidity of anxiety present in some depressed children, and that depression is often preceded by anxiety in children, whereas the reverse is not the case, and isolation can be a feature of this co-morbidity (Campbell, 2011).

Saito (1998) believes that while prolonged withdrawal increases difficulties of relating and fear of others, social anxiety, or an inability to relate, is not what causes withdrawal.

Gazelle and Rudolph (2004) found that anxious solitary youth, who were excluded by their peers, showed a longer-term trajectory of social avoidance and depression, although they did find some positive shift if the environmental attitude became more inclusive of the young person. In a longitudinal study in New Zealand, early anxiety and withdrawal were associated with increased risk of later social phobia, panic/agoraphobia, and major depression during adolescence and young adulthood (Goodwin et al, 2004; Jakobsen et al 2012).

Having outlined its prevalence and some associated disorders, I will now examine qualitative studies focusing on psychosocial and cultural features and factors.

Psychological, cultural and socioeconomic aspects

The literature is divided over the question of whether this phenomenon is specific to Japan. There are those who believe Hikikomori to be a response to a particular combination of cultural, economic and social pressures existing in Japan (Hockings, 2013; Nae, 2018; Saito, 1998). Saito (1998) found a significant common feature among Hikikomori was being a firstborn male child. He concludes that this shows there is a problem with Japanese society and its pressure on the firstborn male.

Affluence and technology, the pressure to conform, and an ageing population, have all been linked to Hikikomori in Japan (Watts, 2002). Overell (2018) concludes that Hikikomori are actively rejecting mainstream society. Toivonnen et al (2011) believe that this 'subgroup' of Japanese society is an outcome of labour market changes rather than psychopathology. Rubenstein (2016) argues that parents of Hikikomori found it helpful to contextualise their children's behaviours as an alternative to, and a critique of, the Japanese post-war socioeconomic situation of prosperity followed by recession, and the breakdown of traditional social ties. A conflict between individualistic society and collectivistic tradition as a root cause for Hikikomori is also argued by Sanchez Rojo (2017).

On the other hand, the fact that more recent studies show a high prevalence of withdrawn young people occurring in other countries shows the specific Japanese cultural and socioeconomic contexts cannot be just to blame. Saito, who was the first to raise concern about withdrawn youth in Japan, had emailed psychiatrists in other countries to ask whether they see this problem. The responses were that this symptomology would be treated under other psychiatric conditions, such as social phobia or avoidant personality disorder. So it might be that the same phenomenon exists in other developed countries, but is not specifically defined as Hikikomori.

In addition, there are socioeconomic aspects of other countries which are similar to the Japanese situation. For example, the Japanese cultural attitude of children living with their parents well into adulthood is seen as linked to the Hikikomori phenomenon (Saito, 1998). There is an economic correlation with present-day Britain, and its very high housing costs, which in the last decade has also resulted in many adult children still living with their parents.

A recent report by the thinktank Civitas states there has been a dramatic increase in young adults (20-29 year olds) living with their parents. As the increase is highest in areas of expensive housing, this trend has been blamed on the housing crisis (Bentley & MacCallum, 2019).

As another example, Sanchez Rojo (2017) argues that the conflict between collectivism and individualism, seen as one reason for Hikikomori in Japan, is now also happening in the western world through the collectivist ideals of the internet.

Li and Wong (2015) propose a theoretical framework that views extreme withdrawal of young people as a result of the interplay between psychological, social and behavioural factors. For example, Stip et al (2016) propose that societal and economic changes "may lead to disengagement or dissociation from society in predisposed individuals as a psychic response to painful emotions" (p.3).

There are some studies that focus on psychological and interpersonal characteristics. A case study of 35 clients in Japan found an inability to trust and relate to others, loss of secure attachment, emotional neglect, absence of parent-child communication, and inhibition of self-expression as common features of Hikikomori (Hattori, 2006). Yong and Nomura (2019) found that the most significant indicator for Hikikomori was interpersonal difficulties, which included not feeling able to fit into a group, and feeling anxious about interacting with others, including those they are familiar with. Young et al's Korean study (2013) found 50% of participants had passive or indifferent relationships with peers and parents in their early life. They found school bullying to be present in 56% of their cases. This is mirrored by other studies which found a high incidence of ambivalent attachment, parental or peer rejection, and experiences of bullying amongst Hikikomori (Bierman & Wargo, 1995; Fleming et al, 1989; Kennedy et al, 1989; Krieg & Dickie, 2013; Lee et al, 2013; Wonjung et al, 2007).

Yong and Kaneko (2016) conducted a qualitative study examining the in-depth experience of a non-clinical sample of Hikikomori sufferers and people close to them. Using grounded theory they analysed non-structured interviews with eight informants, three of them being family members of a Hikikomori. Some of the informants were living outside of Japan. Although at the point of the study the ages of the Hikikomori sufferers were between 21 and 38 years, all but one had started withdrawing into their room in their childhood or teens. Their findings were complemented by examining online observations of bulletin boards and chatrooms. The themes the study found were: a sense of helplessness and failure; not being able to deliver what the world demands of them; withdrawing in response to disappointment or perceived failure in relating to others, with a preference of being alone rather than having to cope with people, and risk rejection, disapproval and challenges to their belief systems; a sense of inevitability of not fitting in with the world of work and people; and a world which is felt to be a battlefield.

The study concluded that Hikikomori is a response to a situation that the young adult felt powerless to change, and from which they could see no way out. As a result of conflicting demands they felt stuck and unable to move forward. The study argues against those who see Hikikomori as an active choice of rejecting mainstream values. In contrast, they argue that it is not culturally specific, but more likely a passive way of coping with contemporary competitive society and human relationships, where hiding away is seen as the only solution. Prolonged withdrawal makes it increasingly difficult to come out of, as the person's social skills become weakened and their fear of the outside increases with an anticipation-anxiety.

Not feeling able to control their life events is also mentioned by another study, exploring Hikikomori identified young people in Finland (Husu and Valimaki, 2017). They also found a sense of inadequacy and of failure, and a lack of self-efficacy, to be common themes. They concluded that such withdrawn young adults find external society demanding, and consider themselves as lacking resources (education, social network, personality type) that they see as valued in society and essential to survival. DeLuca (2017), investigating the literature on Hikikomori, believes it corresponds to the DSM5 category 'cultural idiom', as an expression of distress linked to the difficulties of the transition from adolescence to adulthood, where the confrontation with a demanding ideal is met with a lapse into passivity. Sarchione et al. (2015), examining literature, conclude that withdrawal is a way to preserve themselves from the risk of being ashamed by their own inadequacy. They note the low rate of suicidality among Hikikomori adolescents, and believe that the internet forms a sort of emergency exit.

Another qualitative study involving interviews with 30 socially withdrawn young people found three main themes: private status, a de-friending spiral, and suspension of experiences. What they found helpful was: rebalancing one's ideal self with reality, reconnecting with tuned-in people, and regaining momentum in life (Li et al, 2018).

Uchida and Norasakkunkit (2015) argue for the use of a spectrum approach to help identify those at risk of being marginalised in society. Their study found particular psychological tendencies of Hikikomori and to a lesser degree people who are NEET, such as lack of self-competence and unclear ambitions for the future.

I will now turn to looking at the kind of help that studies have proposed for Hikikomori sufferers.

Intervention

Saito (1998), who has extensive experience of working with Hikikomori sufferers and their families, emphasises the importance of intervention, and warns that without such interventions they are unlikely to improve. He also states that the family needs to be involved, for treatment to be successful, and recommends working with the whole family to try change the way family members communicate with each other. He advocates a mixture of psychological, family and interpersonal interventions. Ranieri (2015 & 2018) also advocates an adaptive multiple-approach support structure, which integrates clinical and rehabilitative interventions, and which promotes the resources of the individual, their family and social context.

Having concluded that interpersonal difficulties are the main problem for Hikikomori, Yong and Nomura (2019) advocate helping them to improve their communication skills and to become more integrated in their community.

When Yong and Kaneko (2016) conducted online interviews with their respondents, they discovered that these interviews had an activating impact on some. Hence, they recommend talking sessions to facilitate the withdrawn person's ability to express themselves freely, to help self-reflection, which in turn might promote motivation to change. Lee et al (2013) found some improvements in anxiety levels and social activities in their home visiting counselling programme, despite this being of short duration. Psychotherapeutic approaches with possible adjacent use of medication are advocated for school refusers (Honjo et al, 2001), and psychotherapy is stated to be the treatment of choice, though engaging the person is often a problem (Lee et al, 2013; Stip et al, 2016). Teo et al (2015), interviewing 36 individuals across four countries who were shut in their rooms, found that 78% of them desired treatment, with a significantly higher preference for psychotherapy over pharmacotherapy, in-person over online, and mental health specialist over primary care providers.

Malagon-Amor et al (2018) found that those Hikikomori who also have high levels of anxiety, even though initially they seemed less severe than Hikikomori with other types of comorbidity, were more likely to disengage from medical reviews and

relapse, if not followed up intensively. This suggests that, particularly for the anxiety group, intensive treatments are more effective. Ranieri (2018) discusses the challenges of supporting a shut-away young person, concluding that interventions are likely to take a very long time, with many pitfalls along the way. She states that "[t]he establishment of a contact may present the final aim of many months of intervention" (p.627). In terms of psychoanalytic therapy she recommends an approach that takes a middle way, between interpreting and mirroring without interpreting. She advocates helping the patient understand their inner world while at the same time not pushing the patient to leave the protection of their retreat.

One of the problems that hinders access to treatment is that the person's isolation and, within the Japanese context, the sense of shame families feel, makes identification difficult (Stip et al, 2016). So the question of which treatment to use needs to firstly address the issue of how to identify those struggling with withdrawal, and how to facilitate their access to help.

Having charted the literature researching the prevalence and characteristics of the Hikikomori phenomenon, including some of its divergences, I will now present theoretical models that are useful to help understanding this issue.

Conceptual and theoretical models for understanding withdrawal states

In order to find ways of understanding my findings, in particular to explore the themes that arose interviewing clinicians who have experienced the inter-relational dynamic with a young person who is severely withdrawn, I have utilised psychoanalytical models of understanding to make inferences about what might be going on in the internal world of such withdrawn young people. Specifically, I have applied psychoanalytic approaches based on the Kleinian tradition, as this has been my own training. Below is an outline of the psychoanalytic literature which I have drawn on.

The psychoanalytic concept most relevant to my research is that of a pathological organisation, which Ranieri (2018) equates to the laws regulating life in the Hikikomori's room. A pathological organisation describes a set of tightly-knit defences that attempt to avoid being overwhelmed by anxieties, by avoiding

emotional contact with others and with internal and external reality (Spillius et al, 2011). Various authors have written about such an organisation of defences. Unlike defences which are transient and part of normal development, such an interlocking organisation of defences is a fixed formation in response to overwhelming anxiety aroused by development (O'Shaughnessy, 1981).

One such concept of a pathological organisation is Rosenfeld's (1964) idea of a 'narcissistic organisation', describing a dynamic whereby the self incorporates, and then becomes identified with, the object, denying any separate identity or boundaries between self and object, and thus avoiding feelings of dependence and need. In further papers he expands on this, and distinguishes between libidinal and destructive narcissism. In the latter, destructive parts of the self become idealised (Rosenfeld, 1971 & 1987). The omnipotent organisation acts like an internal gang, destroying any links between self and object and attacking the loving dependent part. Like an internal gang, false promises, particularly of protection, are made, and lure the healthy parts into this delusional world, making them dependent or even addicted. A deadly force (resembling Freud's death instinct, Freud, 1920 &1923) inside the patient becomes more threatening when the patient turns towards life and any progress, and development or contact triggers a severe, negative therapeutic reaction.

Speaking about external gangs as well as 'gang states of mind', Canham (2002) emphasises how in gangs, in contrast to groups, difference cannot be tolerated. In fact one of the gang's lures is its obliteration of difference, and thus all the difficulties and pains associated with acknowledging difference.

Meltzer (1973), discussing clinical material from a patient in the throes of a narcissistic organisation, believes terror to be at the core of such a psychic structure, and that it is the "dread of loss of the illusory protection against terror" which makes parts of the self submit to the narcissistic organisation to the point of becoming addicted to bad parts of the self (p.106).

O'Shaughnessy (1981) argues that sometimes a defensive organisation is helpful in giving the patient a refuge from overwhelming anxiety, and a chance to strengthen their ego. She describes work with a patient who at times seemed to use the defensive organisation as defensive, and at other times as a way of gratifying a cruel

part. Any feeling and thought was disowned by her patient, and O'Shaughnessy felt driven to despair by both; despair projected into her by the patient, as well as despair arising from the failure of the therapy to engender any change, which left her questioning whether there was any point in continuing the therapy.

John Steiner (1987 & 1993) found that a group of patients whose therapies were stuck and repetitive used a particular mechanism in order to avoid feeling pain and anxiety. These patients seem to retreat out of contact with their analysts into spatially experienced hiding places, which Steiner refers to as 'psychic retreats'. He describes these patients as being in the throes of an internal pathological organisation; a highly structured system of defences and of object relationships, whose function was to avoid contact with reality and other people, in an attempt to avoid pain and anxiety. He presents clinical material that shows these retreats are unconsciously experienced spatially, for example as a cave, house, or deserted island. On a deeper fantasy level, psychic retreats show themselves as spaces inside objects or part objects such as the womb, anus or breast.

Steiner, as with Meltzer and Rosenfeld, also compares this internal organisation with a gang, which offers itself as a protector. Steiner conceptualises that the psychic retreat functions as a third position, to the depressive or paranoid-schizoid position (Klein, 1946), avoiding the anxieties of either. The person stays in an equilibrium state, relatively free from anxiety, while completely stuck in his/her development. Progress in therapy is usually followed by a retreat and a negative therapeutic reaction. The patient feels threatened by any possibility of change, and may respond to any challenge to this with more severe withdrawal. There is a risk of the therapist becoming part of the defensive structure of the psychic retreat.

Another writer who has written about a tightly-knit system of defences is Williams (2000). Exploring the psychic structure of patients with eating disorders, and others difficult to reach, she formulates the 'no-entry' defensive system where any input is blocked and nothing is allowed to come inside. The patients are terrified, as, in their minds, any access is perceived as access to intruding persecutors.

Joseph (1971) describes therapy with patients who present as needing the analysis, and who attend regularly, yet don't make any use of it, keeping the therapy empty and flat. Joseph gave clinical material of a patient who, in identification with a

crestfallen mother, seems to be able to only tolerate a dead relationship. Joseph concludes that these patients' passivity is not only defensive, but also destructive, and that, in order to progress, the patient needs to become aware of their aggressiveness that is hidden underneath the passivity.

In another paper (Joseph, 1975) she further explores the technical difficulties of working with patients who are difficult to reach, either due to apathy or to keeping the needy part of the personality split off. Here she gives an example of a patient, where any pushing for contact by the analyst would confirm to the patient that no object is desirable enough to attract the patient sufficiently for him to seek the object out. She stresses the importance of observing closely from moment to moment within the session. In her "Addiction to near-death" paper (Joseph, 1982) she describes a group of patients who get pulled into a passive paralysed state, and seem to obtain masochistic satisfaction from a destruction of the self. Despair is projected into the analyst. The analyst has to be the one holding any striving for development, change, life and contact, as this is all split off within the patient.

McDougall (1984) similarly describes a group of patients who present as lifeless and unaffected, and whose therapies are stagnant for long periods of time, yet who "clung to [their] analysis like a drowning man to a life vest" (p.386). McDougall describes her countertransference when working with these patients as feeling tired, bored, despairing and paralysed in her analytical functioning, unable to either help them to become more alive, or help them to leave analysis. The lack of progress made her feel guilty. Sessions were repetitive, and she felt herself fighting against a pull of deathlike forces. She found an underlying gap between emotions and their mental presentations, and a tendency to discharge emotions rather than feeling them in order to avoid becoming overwhelmed. This discharge could happen through inappropriate behaviours such as addictions, or into the body where emotions become somatised.

She describes one patient, where deeper exploration uncovered a terror of contact with others, and with his own psychic reality, as this contact was felt to threaten his very existence by implosion or explosion. Fearing annihilation, melting into the other, or disintegration, any link that brought him closer into contact had to be attacked in the name of psychic survival. McDougall found that her countertransference was a communication of the infant's feeling that communication

is useless, and a desire for an affective relationship hopeless. She states that these kind of patients need a lot of 'holding' and managing one's countertransference, while waiting for the birth of a desire for contact in the patient.

Reconstructing the childhood of such unaffected patients, McDougall found a common feature of a paradoxical mother-child relationship, whereby the mother was out of touch with the infant's emotional needs, while controlling the child's thoughts and stifling any spontaneous gesture. Waddell (1998) describes this process of a mother focused on 'doing' and not being emotionally attuned with her infant. A repeated experience of not being understood confronts the infant with a mismatch between his internal experience and what is happening outside, for example 'feeling tired' and then being fed rather than helped to sleep. Such an infant will struggle with having no sense of coherence between internal and external experiences, and will be left with an experience of not being understood.

Exploring the types of fears and terrors which might lie underneath a person's psychological need to develop such tight defences, that were described by the writers above, Symington (1985) advises therapists to be sensitive to primitive terrors like those described by Bick.

Using material from infant observation, Bick (1968 &1986) formulates that in young infanthood the skin is felt to hold the parts of the personality together, and that the containing object is concretely experienced as skin. The infant needs to introject a containing object. Disturbances to this, engender the infant being faced with primitive terrors such as falling into outer space, liquefying, breaking into pieces. Bick describes how the infant has to defend against such primitive terrors, by what she calls second skin formations, and adhesive sticking to surfaces, to plug any gaps. Not having developed a sense of internal space means that the introjective-projective processes needed for development cannot happen, and instead a mode of relating to others by sticking to them in a two-dimensional way is fostered. Without a sense of an internal space, the other is also assumed to not have an internal space where thoughts and feelings could be received. Meltzer (1975) and Wittenberg (1975) elaborated this into their formulation of adhesive identification.

Symington (1985) says that it is such primitive terrors which are likely to be underneath narcissistic omnipotent structures. The patient's turning away from

contact might be from fear of disintegration, and hence in the service of survival. Emanuel (2001) elaborates on the psychic retreat concepts, suggesting that a prime motivator for going into such shut-off spaces is to avoid contact with 'the void'. The void resembles primitive anxieties described by Bick, it is a state that feels worse than death, a dimensionless space like black holes, which suck in and destroy any approaching object, or terror of non-being. Emanuel suggests that living inside the object, inside the claustrum as defined by Meltzer (1992), is one of the defences against experiencing the void. Being cocooned inside offers containment, structure to one's existence and identity, restores psychic equilibrium, and gives the illusion of no gap between self and object.

Having outlined some psychoanalytic theories which are helpful in understanding withdrawal states, I will now focus on psychoanalytic investigations relating to the cyber-world, as some of the Hikikomori research literature has found an association between the two.

Retreat into the internet conceptualised

I have branched out my conceptual literature search into material dealing with the internet and its potential impact on internal and external object relations. There are several reasons for doing so. As stated in the research literature review, Hikikomori states and a preoccupation with gaming or other internet activities are often linked, albeit that cyber-technology overuse is likely to be a problem secondary to the withdrawal. Furthermore, some case studies within the psychoanalytic literature do apply Steiner's psychic retreat concept to understand a patient's retreat into the cyber-world.

There are some who argue that cyber-space offers young people of today vast opportunities to try out different personas, and aspects of themselves, including sexuality, aspects that might otherwise stay inaccessible and encapsulated in social prescriptions (Lingiardi, 2011), or that are conflictual (Lemma, 2015), and that it provides a space for experimentation in a relatively consequence-free and commitment-free manner (Turkle, 2004, Kantrowitz, 2009), and is the 'hang-out' space for today's adolescents (Singer, 2013). However, cyber-space can become a refuge from the demands of reality, including the reality of our corporal existence with all its messiness, which can be a particular issue for adolescents who are faced

with the demands made on the mind by the physical changes in their body (Lemma, 2014 & 2015). Young people might retreat to the safety of the online world to avoid anxiety, confusion or perceived persecutory feelings that face-to-face interaction evokes in them (Gibbs, 2007).

Immediately retrievable answers to internet searches forgo our having to go through a more laborious and painful process of finding answers to our questions. In cyber-space we can acquire selves that can use skills without the slow and painful process of having to learn them (Lemma, 2014 and 2015), and ,going through levels within a game for example, offers the promise that we can become perfect (Turkle, 2004). The internet provides opportunities where the gap between a wish and its fulfilment is bridged (Malater, 2007). On the internet we feel in control of when to enter into, and exit from, contact, and we can feel protected from a painful reality and can avoid the work of separation and mourning (Gibbs, 2007; Lemma 2014 & 2015). The 'screen mother' is always available and can be turned on and off at will, unless it crashes, which, as Lemma (2015) points out, exposes our helpless dependency underneath the illusion of control.

Some relationalist psychoanalysts have argued that we need to revise the concept that we need to mourn our infantile wish for infinite access, and through this come to terms with loss and limit, and adapt to psycho-social reality, as well as having to temporarily accept 'unpleasure' (Freud, 1920) and postpone pleasure. Instead they advocate infinite access and multiple identities as today's tools towards self-discovery and meaning (Hartman, 2011a & 2011b; Turkle, 2005). Hartman (2011a & 2011b) also says that what appears to be a psychic retreat to nonreality, might, in the new frame of reference, become "a mode of psychic advance in a new kind of reality" (p.470), as a 'suspended animation' space where repair can happen. Lemma (2014 & 2015) warns of potential far reaching consequences of this collective sustained experience of immediate gratification, where there is no gap between anticipation and gratification, a gap she sees as necessary to represent our experience, and where thinking develops.

Weinberg (2014), examining the potential of internet forums from a group analytic perspective, advocates the internet as the answer to the economically driven reality of human isolation and alienation of modern society. He argues that the negotiation of boundaries, so important for one's sense of individuality and differentiation, is

easier on the internet, as the person feels more in control over their interaction. He believes that our conflicting needs to express our individual identity, and to feel belonging to a group, are easier to negotiate on the internet. Interaction without seeing the other can facilitate expression, as, without the 'look', less shame is evoked, as for someone who had felt oppressed by the other's look. On the other hand, lack of visual clues might be experienced as persecutory.

Lemma (2015) argues that we "have to move beyond the binary logic of virtual and real" (p.571). Considering that the real is always filtered through object relations, we cannot posit the virtual as in opposition to the real. Experience in cyber-worlds such as Second Life[4] are neither entirely virtual nor real. Internal and external worlds are linked, not equated and not split off from each other. With the lack of contextual referents, such as one's embodiment, and by offering the illusion of what is real, cyber-space can confuse the boundaries, and alter that relationship between internal and external, where the projected internal world within virtual space becomes seen to correspond to external reality.

Several writers (Carpi et al, 2018; Grayson, 2013; Lovegrove, 2013) give clinical case examples of young people where the patient's technology use has been helpful in illuminating unconscious conflicts and transference feelings. Gibbs (2007) gives an example in her work with adults, of a patient who seems to try to maintain a pre-oedipal transference, through their hours spent on the computer, as a way to keep a constant tie to the 'internet analyst'. She did think this constituted a psychic retreat, but as these processes were thought about in the therapy, and linked to the transference, they also had containing and transformative functions. In another case, she thought her patient's obsessively looking at images of women on the internet was a concretisation of his transference fantasy of the 'always waiting' and never abandoning analyst. Other writers also provide examples whereby technology seemed to be used to 'bridge the gap of sessions' (Lingiardi, 2008) or in an attempt to 'freeze time' (Malater, 2007). For some this can feel like a merging with another

[4] Second Life is a virtual world in which users can create their own characters, called avatars, and through these avatars interact with objects and other people, via their avatars, inside this virtual world.

being (Turkle, 2004), which Malater (2007) described as a swinging between separation anxiety and intrusion anxiety, between wishing and fearing to merge.

One of Gibbs' (2007) case vignettes involves a patient who would excessively play computer games, and read novels, fantasising about romantic involvements. In the session, Gibbs felt the patient wasn't relating to her as a separate person but was using autistic defences to ward off any triadic relatedness. Gibbs in turn felt more and more depleted, sleepy and doubting the value of the work. She describes this as the "numbing experience of being related to as a part-object, or a fused self-object, or, indeed, no object at all" (p.23), and warns that this can lead to ignoring the 'internet analyst' the patient has created. Not seeing the analyst as separate, the patient never felt any anger towards her, and when anger arose in the session this became a turning point.

Lingiardi (2008) describes her work with a patient who used cyber-space like a psychic retreat. "Stepping into these retreats, Louis stepped into peace and immobility, as if in a trance: life came to a halt, in a state of 'suspended animation'" (p.116). In the retreat, "being in a nowhere land where nobody can reach you", he was in a state between sleeping and waking, detached from the pain of reality of loss and dependence. Instead, he seemed to have entrusted containment of his self to the substitute internet object which felt to be under his omnipotent control. When he withdrew in the sessions, his therapist felt alone and useless. Lingiardi often felt in competition with the computer. She coped with this by holding on to her knowledge that a computer cannot feel pain and is thus incapable of reverie, incapable of transforming projected emotions.

However, Lingiardi, referring to Winnicot (1958), does wonder whether the computer world of sensations, enveloping her patient like an autistic encapsulation, did give him a sense of cohesion and a containing envelope for his skin. Phenomenologically, Lingiardi, referring to Odgen (1989), thought Louis lived in a sphere of experience between a sensory-based autistic world and an "inner object relationships outside time" (p124). Lingiardi believes that such a cyber retreat can represent a 'pause', a helpful transitional safe space. However, there is a risk of such a fantasy world becoming more preferable to the real world, and the retreat becoming a way of life. Lemma (2015) refers to that risk as inhabiting "a personal world of one […] in a narcissistic state characterised by complete omnipotence

where the laws of the reality principle no longer apply" (p.577). The danger, of course, is that exclusive relating to others over the internet leads to us losing the ability to communicate face-to-face (Toronto, 2009).

Carpi et al (2018), in a rare exploration within the *Journal of Child Psychotherapy* of the impact of techno-culture on our work, present three case vignettes of child patients who seem to live a parallel life in the internet and games. This parallel world provided them with a space where they could function on an infantile level, without having to recognise differences of gender or generation, or without being required to experience empathy or differentiate reality from fantasy. Giorgio (14yrs) is described as using the computer as a refuge from anxieties around pubertal changes, and drives towards separateness. The computer was like an always-present mother who reflected back an idealised image of himself, circumventing any paternal functions of giving meaning and boundaries to reality. Giorgio was socially distant and hostile towards reality, avoiding any frustrations. His therapist felt excluded and unable to reach him. Sensitive to any awareness of separateness, which triggered enforced withdrawal, his therapist struggled to find ways to talk with him. Another patient, Luigi (9yrs), was often absorbed in repetitive, destructive games by himself, turning the computer into an autistic object. Capri et al describe him as adhesively identified with the computer, living in a narcissistically omnipotent state. As with Giorgio, in this state of fusion he would not accept any third position.

Lemma (2014) emphasises the body as the starting point of mental functioning, and the site where we meet the other. In puberty we need to construe a new representation of the body, to accommodate the changing body. Adolescents have to integrate the reality of the mature sexual body into their sense of identity, which can trigger resurgence of primitive anxieties around separation and dependency.

Lemma gives a case example of a 17-year-old girl who hated her appearance and used cyber-space to create an idealised body. The computer provided her with an alternative to the demands of reality. She loved the way the mouse felt, and when playing on Nintendo it seemed to mould into her body, as if in a fantasy of fusion with an idealised maternal object. Online she entered a state of mind completely disconnected from reality, time ceased to matter, and others ceased to exist. Sometimes she would forget sessions because she was so immersed in a game. When so immersed, she would rage against anyone who intruded into this space for

pulling her back into reality. In sessions Lemma often felt redundant and rejected. Any brief moments of thinking together were followed by protracted periods where the patient shut her out. The patient told of her wish to be plugged onto a life-support machine, which the computer seemed to represent to her. Relationship to the computer, and the space it gives access to, Lemma says, parallels wishes for a pre-oedipal relationship to a receptive, desiring maternal body that can be fully known and controlled. The responsive computer gives access to a good 'screen mother' that is always there. Cyber-space provided her patient with an extension of the psychotic space that she retreated to in her mind, where reality of the painful real world was disavowed.

When bringing the patient's internet involvement into the analytic relationship, and its meaning, are explored, Lingiardi (2007) argues the experience can become transformative. In a later paper (2011) she refers to her patient using cyber-space as "a space to make the initial steps into a world inhabited by others but contained in a box that he himself controls" (p. 488).

Lingiardi advocates our need to examine the nature of the retreat at any one time, and whether it is used as a self-regulatory private state where we come out feeling more secure, and able to tackle the conflict, or whether it becomes a one-way place.

The way time is put on hold and broken up is mentioned by several authors. Lingiardi (2007), in her case study, describes how her patient's internet use left him with "fragments of incomplete experiences 'frozen' in operative units" (p.117). Toronto (2009) discusses how excessive internet use may become sequestered outside of time, an isolated space where experiences are disconnected from thoughts and feelings, disrupting one's biographical narrative. She brings two case examples of a child and an adult, who, in order to protect a fragile self, used the internet as a repository of projected thoughts and feelings which are disconnected from their real life experience.

The child withdrew into the virtual world of Toon Town in an attempt to escape the unpredictability of his life. Dissociated from their real life experience and their personal biographical narrative, these unlinked 'time out of mind' states are inaccessible to healthy modification and integration. Toronto compares this with theories on trauma, where intolerable affect and memories become split off.

Referring to Ogden (1990), she wonders about its impact on the ability for symbolic thinking, where fantasy and reality become concretised, losing its 'as if' quality, where one no longer informs the other. Some writers (Hartman, 2011a & 2011b; Turkle, 2004) raise the question whether this dissociation of different aspects of self should still be seen as pathological, or whether in our current techno-culture this has become normative and adaptive.

Conclusion

Since Saito's initial awareness-raising about an increasing number of young people shutting themselves away in their rooms, there has been increasing interest and research in Japan and other east Asian countries in this subject, and concern about this problem reaching epidemic proportions. In the last few years there has been some acknowledgment of this problem elsewhere. Despite the differences in opinion about whether the Hikikomori phenomenon is a culturally specific to Japan, it is clear that there are young people withdrawn into their rooms in other developed countries, although they might not use the Hikikomori term. Research on this subject has increased over recent years, and hopefully will continue to do so.

Various studies have found other psychological issues at time present with Hikikomori, specifically problematic computer/ internet use, mild depression, social anxiety, experiences of bullying, peer rejection, and a sense of inadequacy, failure and powerlessness. There is a disagreement on whether withdrawal is due to cultural and socioeconomic factors particular to Japan, and I have shown the likelihood that different cultural contexts can produce similar presentations. In terms of trying to understand such severe withdrawal states from a psychological perspective, I have shown that there are psychoanalytic concepts and explorations that can be applied to this phenomenon, such as Steiner's 'psychic retreat' and Rosenfeld's 'narcissistic organisation'. Conceptualisation of the cyber-world, its psychological functions and its impact on our internal world, have also been shown as helpful models in understanding withdrawal sates.

In my next chapter I will discuss the process and findings of the audit part of my research.

Chapter 2: Withdrawn states – how common are they?

Introduction

Treatment access is stated to be the most difficult problem in treating socially withdrawn youth (Lee et al, 2013). The aim of this audit study was to investigate whether withdrawn young people are being referred to psychological services, and are evident among the referrals received by one particular psychotherapy clinic. For any such cases found, the aim was to establish the patterns of referrals, engagement and treatment, and to describe the referred cohort in terms of their symptoms, gender and age. This audit provides a quantitative element within the overall doctoral study. It was hoped that the information generated from the audit could complement that of the interview study.

The research question for the audit was thus: are there adolescents or young adults who are being referred with issues of social withdrawal? If so, how do they differ from the total cohort of referred cases, if at all? Secondary questions were: If there are such cases, do they share any common characteristics? If there are such cases, did the referral proceed to the assessment or treatment stage, and how did the patient engage with this?

I conducted the audit within a psychotherapy clinic specialising in adolescents and young adults up to the age of 25 years. Due to most CAMHS services having an age limit of 18 years, this psychotherapy clinic received a lot of referrals of adolescents on the cusp of adulthood. This was ideal for my audit, as this age range matched my research interest. One of the services within this clinic provides a specific model of four consultation appointments for 16-30 year olds, which I shall name the short-term consultation model (SCM). I decided to include the SCM data, with the proviso of being mindful that it potentially includes data from young adults who are slightly older than those of my study. Data were taken retrospectively from the referral information, and the information contained in the case files.

Process of conducting audit study

After going through the formal procedure of applying to conduct an audit, and receiving permission from the institution, I obtained a list of all referrals to the clinic within a given six-month period, between January and June 2014. I then obtained the matching records of all those on this list. The data I used came from referral information, such as letter by referrer, documentation from assessments (assessment reports, case notes), and, where relevant, information from case files. At the time, the clinic still used paper records, so I sourced files from the archive where the case was closed, and from the 'live' filing system where the case was still open during the time of my investigation, which was May to July 2015. The audit data was recorded manually, using a spreadsheet format, and analysed using first order descriptive statistics.

In the first instance, I examined all the referrals made. I read the referral letters and, where relevant, assessment reports, and recorded age, gender, presenting issues, and the outcome of referral of all cases. I identified cases in which social withdrawal seemed to be a part of the presenting issue, by looking out for words such as: isolated, no friends, always at home, school refusal, long periods in their room, long periods on computer, depression, no interests in anything, social anxiety, agoraphobia, fear of people. Where there were such indications, I made more detailed notes from these records. I looked for common characteristics of the population of patients referred, whether an assessment process was offered and engaged with, what recommendations were made, length and type of any treatment received, and outcomes if known.

Using a numeric coding system, I took information from the notes I made from the files and recorded the following data manually into a spreadsheet: gender; age; pathway/ team allocated; whether referral was rejected and why; how many assessment appointments were offered and attended; presenting issues described by referrer and, where relevant, by assessor; whether, and what type of, previous psychological help was given; what recommendations were made; and, where treatment was offered, what the outcome of this was.

Findings of audit study

During this six month time period, the clinic received 167 referrals. Of these 29 had been referred on to a specific project outside the clinic, three were referred on to an adult service, and three to another specialised clinic within the service These referrals were excluded from my study. Of the remaining 132 referrals, I could not locate 21 of the case files. On examination I also discovered four cases to be duplicates. Overall I was left with 107 files to be examined. Of these 107 files, 88 were closed and 19 files were still open at the time of investigation (June 2015).

I examined the referral letters for words and phrases that might indicate social withdrawal, and where social withdrawal was an issue I examined assessment and treatment reports. I found several such cases, and, on examining, decided to separate them into two categories which I shall refer to as ‘socially isolated’ and ‘severe withdrawal’. There were 15 ‘socially isolated’ cases and 16 ‘severely withdrawn’ cases.[5]

The first category, ‘socially isolated’, consisted of cases where some indication of withdrawal was present. The person seemed socially isolated but not to the extent of being stuck inside their room for months. In this category I placed referrals that used descriptions such as: school refusal: socially isolated, panic attacks when leaving home, and avoiding contact with outside world, in addition to the more generally stated presenting issues such as: low mood/ depressed or severe anxiety or socially anxious. In this category I also included one referral where ‘staying in bed and not coming out of his room’ for several weeks at a time was a cyclical pattern, but the young person had periods where he was able to function. I also included referrals where the person spent most of their time in their room but was still able to go to school or work occasionally, or where the more severe withdrawal was in the past. My hypothesis was that this category of patients could be at risk of deteriorating into a more severe withdrawal state. Six of the 15 cases in this category were also referred to as using their computer all the time and only relating to others online.

To my surprise, there were 16 cases of ‘severely withdrawn’, that is, where the description within the referral letter fitted a Hikikomori presentation of the young

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[5] see appendices A and B for descriptive tables of these cases

person being shut away in their room for months. In this more severe category I placed referrals which included descriptions of: dropping out of school/ college/ university and spending all their time in their room, rarely leaving their bed, and unable to leave the house, in addition to social anxiety or low mood. The referrals I included in this category all spoke of the person as being shut away inside their room for at least several months. Five of the 16 cases were also referred to as having a reversed sleep/wake cycle or other disturbed sleep patterns (for example, one was described as sleeping sometimes three and other times 20 hours a night), and two were mentioned as spending a lot of time online. Three further cases (making five in total) also included retreating into an online world or being addicted to computer games.

Five of the 16 had dropped out of school several years ago and were still out of education or work at the time of the audit, while two had previously been home schooled. This raises the question of whether dropping out of school and/or being home schooled could make it more difficult later on to re-integrate into the outside world.

It is interesting to note that five of the 16 had commenced college or university, but then dropped out within the first year, and had retreated ever since. Of these five, only one had also dropped out of school when younger. Assuming that the other four college dropouts did go to school, it would be helpful to discover what made it so difficult for these young people to be unable to manage this step towards an independent adult life (beyond economic conditions such as unable to afford student accommodation or unable to get a job).

Gender and age distribution

Overall, 33 males and 74 females had been referred. The age categories I have chosen are for reasons of alignment with educational and training structures. Gender distribution is indicated within brackets. I will make use of percentages in order to facilitate comparisons within my tables and figures.

Age	Socially isolated		Severely withdrawn		Total referred sample	
	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)
Total	15		16		107	
	6 (40%)	9 (60%)	8 (50%)	8 (50%)	74 (69%)	33 (31%)
under 16	2		2		9	
	1 (50%)	1 (50%)	2 (100%)	0	7 (78%)	2 (22%)
16-18yrs	7		5		40	
	4 (57%)	3 (43%)	3 (60%)	2(40%)	27 (66%)	13 (34%)
19-21yrs	5		4		25	
	1 (20%)	4 (80%)	1 (25%)	3 (75%)	19 (76%)	6 (24%)
22-24yrs	1		5		22	
	0	1 (100%)	2 (40%)	3 (60%)	12 (54%)	10 (46%)
25-29yrs	0		0		11	
					9 (82%)	2 (18%))

Table 1: age and gender distribution within socially isolated and severely withdrawn category compared to total sample of referrals

In the severely withdrawn category half the cohort was female, compared to 40% in the less severe category. Considering that overall there was more than double the number of young women than young men referred (females: 69%), there were proportionally less females within the socially isolated/ withdrawn sample.

Examining the gender distribution within the total referred sample, against the various age categories, we can see that up to the age of 18 years there is a reasonably steady tendency for females to make up the majority of referrals: 66% and 78% in these two categories, which is similar to the overall average of 69%. The percentage

is higher for the short-term consultation model. Considering that this is a service where the young person has to self-refer, it might indicate that females are generally more likely to refer themselves than males. Comparing this overall gender and age distribution with the socially isolated and severely withdrawn samples, there is a marked difference within the 19-21year age group: there are significantly more males than females in these two sub-groups, while in overall referrals females predominate. In the 22-24 years sample, the gender distribution of overall referrals is almost half and half, whereas the withdrawn sample in this age group is predominantly male.

There are no cases of above 25 years within the isolated or withdrawn sample. This shows that none of the SCM referrals within the time period of my audit mentioned social withdrawal as an issue. Considering that the SCM service only takes self-referrals, might this indicate that withdrawn young adults are less likely to refer themselves to services?

Referral sources and previous input by services

I wanted to examine the question of visibility, and whether withdrawn young people might fall below the radar of services once they are no longer of compulsory school age. To do so I looked at sources of referrals, and whether the young person had previously been having input from mental health, or social services, or specialised educational services.

Referral	Socially isolated n=15	Severely withdrawn n=16	Total sample n=107
GP	6 (40%)	6 (37.5%)	49 (45.8%)
Other health provider	5 (33.3%)	8 (50%)	36 (33.6%)
Education provider	1 (6.7%)	0	3 (2.8%)
Self or parent/carer	3 (20%)	2 (12.5%)	30 (28%)
Social services provider	0	0	7 (6.5%)

Table 2: sources of referrals

Where the referral was made by social services, or by ‘other health provider’ (which mostly consisted of people referred at 18 years by a CAMHS service), we know that the young person was already known to statutory services. As such they are likely to have already been on their radar before the young person reached the end of compulsory school age.

In the less severe group, six were referred by their GP, one by education, and three self-referred or their parent referred, but one of the three who self-referred had been in an in-patient unit before. Five had been referred by ‘other health clinic’ though we do not know which this refers to. Excluding those who had previously been under mental health services or a specialist educational service, and considering that ‘other health provider’ might be CAMHS or another mental health service, this still leaves us with 9 out of 15 in the less severe group who had been newly identified by services as needing help or had self-referred (excluding the self-referred who had been in inpatient unit before). Excluding the one referred by education, three of these were 16 or under, and five over sixteen years old, and as such past compulsory school age.

In the more severe category, six were referred by their GP and two self-referred but one of the GP-referred patients had previously been in an in-patient unit, another used to attend an EBD school[6], and a third had previous CAMHS input. Out of the eight referred by ‘other health provider’, one had been in an inpatient unit before and two had previous CAMHS input. These two, plus two further within those referred by ‘other health provider’ were 17 or 18 years old and it is likely that they were referred to the clinic by CAMHS because they had reached the age limit for CAMHS provision. The remaining three were over the age of 20 and we do not know which health provider had referred them. Assuming that ‘other health provider’ might be another mental health service, this leaves us with a definite five out of 16 who had been newly identified or self-referred, of which four were older than 16 and hence past compulsory school age.

These figures are somewhat encouraging, as they show that even where young people had not been referred into services while younger, they are still being

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[6] Special school for children with ‘emotional and behavioural difficulties’

identified at a time when they are shut away from public life and beyond the legal obligation to be in education. However, these figures are lower in the more severe group, which indicates that the more severely withdrawn young people are less likely to be identified by services if they had no previous input. As a further point, it is encouraging that three in the less severe, and two in the more severe, group had self-referred (which unlike in the SCM service includes referrals made by families) showing that there was an acknowledgement by the withdrawn young person, or by someone in their immediate family, that they had a problem needing support.

Engagement with service

In order to address my research question of whether young people who have withdrawn from contact can be engaged within therapeutic interventions, I examined the audit data in relation to what happened to a referral.

	Socially isolated (n=15) n (%)	**Severe social withdrawal (n=16) n (%)**	**Total sample (n=107) n (%)**
Referred to other service at intake[1]	1 (6.7%)	2 (12.5%)	11 (10.3%)
Did not opt in or withdrew[2]	2 (13.3%)	0	16 (15%)
Disengaged after one assessment appointment	5 (33.3%)	2 (12.5%)	13 (12.1%)
Referred to other service after assessment[3]	1 (6.7%)	2 (12.5%)	6 (5.6%)
Disengaged after assessment	2 (13.3%)	2 (12.5%)	13 (12.1%)
Engaged in therapy following assessment[4]	4 (26.7%)	8 (50%)	25 (23.4%)
Completed short-term intervention (SCM)	0	0	14 (13.1%)
Other/unknown[5]	0	0	9 (8.4%)

Table 3: referral flow

1) Mental health or complex needs teams, or social care, or to lower tier service.
2) Includes cases who did not attend or contact the clinic.

3) Mental health or complex needs team, or occupational health or social care.
4) Psychoanalytical psychotherapy, psychiatric reviews, or therapy offered by psychologists.
5) Includes referrals that were rejected due to funding issues.

Of the 107 referrals, 20 were not taken on by the clinic at intake and were hence not offered any appointments (first row, those referred to other services and last row, those not taken on for funding or other reasons). Of the remaining 87, 16 did not opt in, withdrew their referral or did not make contact or attend the first appointment. A further 13 young people (or, in the case of two, their parents) disengaged after attending one appointment, although they were offered more appointments (to either continue assessment or as part of the SCM service). We do not know why they disengaged, whether for example they felt they did not receive what they expected, or whether they felt helped enough by just one appointment. So 29 of the 87 overall referrals who were taken on by the clinic did not engage at all, or dropped out after one appointment.

Compare this to the socially isolated group. Taking out those who were not offered any appointments leaves us with 14, of which seven did not engage at all or dropped out after one appointment. In the severely withdrawn group we have 14 who were offered appointments, of which two did not engage at all or dropped out after one appointment. This means that of those offered appointments: 1/3 in the overall referrals did not engage or dropped out after one appointment, as did 1/2 in the less severe isolated group, and 1/7 within the severe group. This is surprising as it seems to indicate that the severely withdrawn group has a much higher engagement level than overall referrals, and the less severely withdrawn group had the least engagement level.

Excluding those who were referred to other services, either at intake or after a completed assessment, and excluding those of the ‘other’ category, we have 39 out of 81 referrals who either completed a course of SCM or therapy, or at the time of investigation were still engaging in therapy. Within the socially isolated group, out of the 13 who were offered appointments after the assessment stage there were four who engaged in further therapy. Within the severely withdrawn group, eight engaged in further therapy out of the 12 that were offered this.

This is a very surprising result, as it seems to indicate that contrary to expectations the severely withdrawn young people have a lower dropout rate when referred, and a higher engagement in ongoing therapeutic work than the general clinical population. The less severe socially isolated group had a much higher dropout rate and lower engagement in ongoing therapy compared to the general clinical population.

Outcome of therapeutic input

I then looked more closely at the outcome of those who engaged in therapy within the clinic, which could either be offered by a child and adolescent psychoanalytic psychotherapist, or a clinical psychologist, or a psychiatrist. The information was sketchy, as I had to rely on review reports or ending reports.

Of the four within the isolated sample who engaged in therapy: one had successfully completed psychotherapy and had improved so much that he was able to go to university, two were still in therapy, with no update reports available, and there was no further information on the fourth.

Of the eight within the severely withdrawn sample: one had engaged for three months, while the rest were in ongoing therapy. The patient who ended the treatment after three months is described as reporting that he only attends to please his parents and that he is fine. Of the seven ongoing cases, there were no review reports for four, including one where the treatment consisted of work with parents only. For the remaining three, their review reports described improvements which included: cessation of self-harming, improvement of physical symptom (IBS), improvement of mood, less retreating, and more able to socialise. One of these managed to get a part-time job. Out of the five cases where the young person engaged in therapy, and where an update report of their therapy was available, four showed improvement, some of it significant, and only one did not (and this patient denied that there was an issue to improve).

It is also noteworthy that one of the cases who completed the four session assessment, but then did not take up the offer for therapy, gave their reason as feeling better and having met up with friends.

Co-morbidity and clinical characteristics

I wanted to examine the socially isolated and severe withdrawal groups more closely, to see whether there were any similar characteristics described in the different referral letters or assessment reports. High levels of anxiety and depressed mood are presentations which are mentioned in most referrals, and hence might be part of the withdrawal state rather than a separate issue. As shown in my literature review, social anxiety in particular is likely to be an integral aspect of social withdrawal. Thus I looked at what other issues might be associated with withdrawal states. I have categorised those of the other presentations described by the referrer or assessor which appeared in more than one of the isolated and withdrawn samples.

	Socially isolated N=15 (%)	**Severely withdrawn N=16 (%)**
Spending hours on the computer	5 (33.3%)	5 (31.3%)
Bullied at school	3 (20%)	4 (25%)
Past physical or sexual abuse	1 (6.7%)	3 (18.8%)
Question of PTSD	0	2 (12.5%)
Excessive fears of others attacking or controlling or humiliating or OCD fears of contamination	3 (20%)	3 (18.8%)
Self-harm	5 (33.3%)	2 (12.5%)
Previous suicide attempt/s	3 (20%)	1 (6.3%)
Eating problems	2 (13.3%)	2 (12.5%)
Past violent behaviour	0	3 (18.8%)
Previous mental health inpatient admission	0	2 (12.5%)
Visual and auditory disturbances	1 (6.7%)	1 (6.3%)
Physical symptoms	2 (13.3%)	5 (31.3%)

Drug or alcohol problematic use	0	3 (18.8%)
Gender issues	1 (6.7%)	1 (6.3%)
Immigrated to the UK	3 (20%)	1 (6.3%)
Struggling with bereavement	1 (6.7%)	2 (12.5%)
Described as overclose relationship with mum	0	3 (18.8%)

Table 4: Clinical characteristics and co-morbidity within isolated and withdrawn samples

There are several issues which more than one of the cases within the isolated and withdrawn sample were referred for, in addition to presentations of isolation. As some of this information was taken from assessment or treatment reports, I have not been able to replicate this with the overall sample of referrals to the service as a whole. Hence I have not been able to compare whether the features mentioned here are as widely distributed amongst the overall referrals to the clinic.

The data have shown a high percentage of excessive computer use within both the less and more severe categories. There is also a high percentage in both categories of experiences of being bullied at school. In the severely withdrawn sample, two (12.5%) referred to PTSD symptoms, in one case stemming from a mugging and the other from a car crash. Excessive fears of others attacking or controlling or humiliating, or OCD fears of contamination, were mentioned in six (out of 31, i.e. 19.4%) of the less and more severely withdrawn samples combined. For one of these, the referral described the patient as being so worried that he was keeping weapons at his bedside.

Three of the severely withdrawn sample (18.8%), though none of the less severe sample, mentioned alcohol or drug misuse. Two of the socially isolated, and one of the severely withdrawn sample, within the audit were restricting food, and a further person had a different type of eating issue which was the hoarding of food.

Four within the isolated/withdrawn samples combined had previously attempted suicide, and seven were self-harming, although interestingly the numbers of self-harm and suicide attempts are significantly higher in the less severe ‘socially

isolated', where five presented with issues of self-harm and three had attempted suicide. Three within the severely withdrawn group had been acting out violent behaviour when they were younger, but were not any longer.

There is a high incidence of physical symptoms. Five within the more severe, and two in the less severe, group had physical problems, and apart from one, all these symptoms were either medically unexplained or could be due to stress and/or somatisation of psychological issues. Out of these seven, three suffered from abdominal pain that was either classed as 'medically unexplained' or diagnosed as IBS. Two suffered from chronic fatigue, and one from 'medically unexplained dizziness'. One of the withdrawn patients who had current chronic abdominal pains had several hospital admissions when younger, although it is not clear what for.

Three of the severely withdrawn samples, though none in the isolated sample, were judged by the referrer and/or assessors as 'overclose' or 'enmeshed' with their mother.

Two patients in the audit data presented with questioning their gender, with both of these assigned female at birth.

In three cases, across both samples, significant bereavements were specifically mentioned. In one of these cases, the ending report for the therapy states that the therapy focused on processing this loss, and the patient improved and started to socialise again.

Several patients within both categories had immigrated to the UK. One in the severe group, and three in the less severe group, had come to the UK in their teens, and one had parents who had immigrated.

Discussion and Conclusions

The audit has answered my research question of whether there are young people presenting with severe withdrawal who are being referred to a young people's mental health clinic. Young people in the 'socially isolated' and 'severely withdrawn' categories thus together made up 29% of the total number of referrals presented, the more severe category on its own making up 16%. This is a large number considering that the clinic takes referrals for all kinds of emotional problems. On a positive note it indicates that my hypothesis and concern that shut-

away young people might become invisible to services once they are beyond compulsory school age of 16 was incorrect. Young adults who are withdrawn *do* get referred. This audit cannot, however, provide data on the incidence of severe social withdrawal in the population as a whole, as it does not provide any information on young people meeting this description who were *not* referred.

It is likely that there is an over-representation of young adults being referred to this particular clinic, due to most CAMHS having a cut-off of 18years. If it is true that the transition into adulthood is a particularly difficult stumbling block, that can trigger withdrawal, (and the figure of nearly a third of my severe category having withdrawn following dropping out of first-year college seems to confirm this), then it is likely that a clinic offering services beyond 18 would have higher proportion of referrals of withdrawn young people compared to services that have a cut-off of 18years. It shows the importance of the provision of adolescent-to-adult transitional services.

In many respects the audit has thrown up some surprising findings, with16% of overall referrals describing presentations that would fit a Hikikomori category of being shut inside the room for months at a time. Where a more exact timeframe was indicated (for example by how many months between date of referral and when the young person dropped out of college and withdrew), the withdrawal had been for six months or more. This indicates that Hikikomori presentations are a significant problem amongst a clinical population of adolescent and young adults referred to a mental health service in the UK. On the positive side, contrary to my expectation, the audit data indicates that young people who are severely withdrawn, and shut in their rooms, do come to the attention of services even if they have reached the end of compulsory school age. Furthermore the audit showed that severely withdrawn young people can be engaged wit in therapeutic services. In fact, in comparison to overall referrals, those within the severely withdrawn group showed a lower dropout and higher longer-term engagement rate than the overall clinical population.

While, within the overall referrals, almost double the amount of women compared to men were referred (female 69%), there were more males than females referred within the less severely withdrawn group (females 40%) and as many men as women (50%) were referred within the more severe group. Within the 19-21year age group there were a lot more men than women referred in both the less, and more,

severe groups (females 20% and 25% respectively), whereas in the overall referrals within this age group there are more than three times as many females compared to males (females 76%). Why this gender distribution difference in the withdrawn sample, compared to referrals overall, is so significantly pronounced within the 19-21 year age group is an interesting question. This is a time of major transition into formal adulthood, where one is expected to either move into further education, training or employment. It might be that these expectations are gendered, and that men in particular are expected to go out there and be productive in the world of work, and it is this pressure that some young males react to by withdrawing.

While there are proportionally more men than women referred within the withdrawn categories, compared to the overall referrals, the actual number of females within the withdrawn sample is nevertheless a surprising result. The Hikikomori phenomenon in Japan is seen as an almost exclusively male problem, and most published cases are of males (Stip et al, 2016; Teo, 2010). The data from this audit did not mirror this. It would be interesting to research this more closely, as to why there is such a striking difference in gender distribution of shut-away people between the Hikikomori studies in Japan and my own investigation, and whether other studies in the UK would bear similar figures.

There were several other issues that were present in some cases of withdrawn young people, apart from social anxiety or depressed mood. There was a high incidence of computer overuse and of a (potentially related) reversed sleep/ wake pattern, which mirrored the research literature. Other issues included previous experience of abuse, bullying or traumatic incidences; and present perception of the outside being a frightening place; and high incidences of physical problems that are medically unexplained or could be due to somatising or stress; eating problems; and a background of having immigrated to the UK in adolescence.

In this chapter I gave an outline of the audit part of my research, the process from the initial idea to its execution. I have given the findings of the audit, and discussed these in terms of the literature review, with comparison to the interview findings deferred to a later exploration. As shown, the audit has answered my research questions that, yes, withdrawn young people are being referred to a mental health clinic, and, yes, they do engage in psychotherapeutic services. I have shown some

features that occurred more than once within the withdrawn samples. I will now turn to the qualitative part of my research in my next chapter.

Chapter 3: Experiencing withdrawal states – professional perspectives

Introduction

What is it like to work with, and try to engage with, a young person who has withdrawn from contact outside their home? In this chapter I will discuss the interview study, whose aim was to find out about psychotherapists' understanding of withdrawn young people they have worked with. It was hoped, through the analysis of the interviews, to elicit themes, and by exploring these to develop understandings of withdrawn states and how clinicians have worked with them. A subsidiary question related to how the use of the internet features in a young person's withdrawal and, if it does, in what way.

This chapter is organised in several sections. Firstly I will deal with methodological concerns. Within this I give a general overview of qualitative and psychotherapy research, discuss the ontological and epistemological positions underpinning my research, and explore issues of subjectivity. As my interview participants were professional colleagues, one section of this chapter explores the benefits, challenges and potential impact on the study of interviewing one's peers. I will then describe the design, process and methodologies of the interview study. After introducing the participants I will then review the key thematic findings of my study.

Psychoanalytic research and qualitative methodology

The psychoanalytical method has been described as moving "between the phenomenological details of what patients say, as these are understood and interpreted by their analysts, and more generalised concepts and classifications of states of mind" (Rustin 2000, p.39). By listening to psychotherapists' narratives of their understanding of the relationship dynamics in the therapy with a withdrawn young person, where they use their psychoanalytic training of examining

transference/counter-transference dynamics, and then examining the themes of these narratives through the lens of the psychoanalytic body of knowledge, I hoped to further our understanding about withdrawn mental states in young people. In order to conduct such an in-depth exploration I chose qualitative research methods for the interview part of my study.

Qualitative research has the potential to produce rich, context-specific and complex data, and is particularly apt at exploring meanings and understandings of the social world (Mason, 2014). However, as "[t]he laboratory of the qualitative researcher is everyday life and cannot be contained in a test tube, started, stopped, manipulated, or washed down the sink", and as it doesn't have defined procedures, it relies on processes such as inference (Morse, 1994, p.1).

There are many different methods within qualitative research, but Mason (2014) outlines three elements common to such research: an 'interpretative' philosophical stance that is concerned with how the social world is experienced, understood or constituted; methods of data generation which are sensitive and adapted to the social context rather than standardised or abstracted; and methods of analysis which take into account the richness, complexity and context of the generated data.

There have been different types of psychoanalytic research, including descriptive studies of processes within psychotherapy, outcome studies, development of psychoanalytic theory and technique, and studies connecting with other disciplines such as film, neuroscience, and sociology (Midgley, 2010; Rustin, 2010). However, the majority of psychoanalytic research has come from adult psychotherapy, and Reid (1997) suggests that child psychotherapists are in a unique position to conduct research, as they see the early stages of development of psychological problems, as well as seeing the child in the context of their family, and the interrelationship of the external and internal worlds.

Ontological view

My ontological view is that people's perspectives on reality are informed by their internal assumptions, beliefs and motivations, which are partly not conscious. My view of humans is that we are shaped by a complex interrelationship between innate personality traits, environment, bodily/ neurological make-up and experiences. I take

a psychoanalytical view that early experiences with caregivers, and how these are perceived by the infant, are particularly significant in shaping how we feel, think and perceive the world, which in turn forms how we relate to ourselves, others and the world around us. I believe that these internal experiences of the individual are inextricably linked with the external, with other people, society, and the physical environment, and, as such, my view is close to the 'psychosocial' research tradition (Holloway & Jefferson; Clarke, 2008; Holloway, 2008).

My theoretical perspective underpinning this research is objects relation theory, which has its origins with Melanie Klein. Images of people and events are internalised and coloured with fantasy and personalised perception, and become 'internal objects' which exert an unconscious influence on how we expect the world to be. Aspects of these internal objects are expressed through processes of transference and projection. Transference and projection are processes whereby another person is imbued with characteristics, attitudes or emotions that belong to our own emotional world. I will use these theoretical constructs of internal objects, and processes of transference and projection, to examine features of the intrapsychic and inter-relational dynamics present in a withdrawn state of mind, through looking at relationship dynamics perceived through the eyes of therapists working with them.

Studying unconscious processes

Psychoanalysis has a long history of trying to study unconscious phenomena. In psychoanalytic treatment, the frame is kept constant (same therapist, same room, same time/s each week, start and end to a session kept exact to the minute). This reliable frame is needed for clinical reasons to provide reliability and stability, and also functions as a kind of 'laboratory' condition, facilitating unconscious processes being seen more easily (Rustin, 1997 & 2001). Over the course of its history, key ideas within psychoanalysis have helped the individual practitioner to give meaning to clinical phenomena. Where existing key ideas cannot give meaning to clinical phenomena, a new hypothesis is made, which then becomes tested in clinical experiences, and, if proven to be useful, in whichever specific conditions of application, may become a new idea. There are many instances where an anomaly of an existing theory is re-examined through the description of clinical case material

not seeming to fit into this theory. The body of psychoanalytic knowledge includes various ‘key papers’ which mark a theoretical turn from previous concepts, or point towards a gap in theory, and then new concepts become more differentiated and fine-grained through testing in a multiplicity of clinical instances (Rustin, 2001, 2009 & 2019).

For the qualitative part of my research, I decided to interview psychoanalytically-trained child and adolescent psychotherapists. Psychoanalytic psychotherapists are specifically trained to examine processes which are unconscious and hence resistant to measurement and standardisation (Rustin, 2003).

[Psychoanalysts] have learned to recognise, categorise, name and discriminate between [unconscious phenomena found in the consulting room]. They then learned to make the conditions of the consulting room more rigorous, defining a temporal and spatial frame within which unconscious phenomena – in particular, those of the transference - could be made more clearly visible. Rustin, 1997, p. 532

One of the pre-requisites of child psychotherapy training is to observe an infant weekly over two years, and a young child over one year, in their natural environment. Brown (2007) says this constitutes “a practice in reflexivity par excellence” (p.189) as students are encouraged to observe, and then to write up in detail, what is happening, as well as their own thoughts and emotional responses to what they are observing, but to avoid any premature interpretations of meaning. The students also have to undergo their own psychoanalysis, to facilitate becoming aware of their own emotional response patterns and unconscious thought process.

In their clinical work, psychotherapists observe closely the relational dynamics, and their minute shifts over the course of a therapy session and over the course of the therapy treatment. Psychoanalytic psychotherapists observe both the content of what is being said, as well as tone of voice, body language, how the patient responds to something the therapist has said, the emotional atmosphere in the room at any particular time, and the emotional quality of silences. They also examine their own emotional responses and thought processes in relation to the patient and what is happening in the session.

They reflect on these observations, within and outside the therapy encounter, and think about how these observations relate to previous observations, and what the

therapist understands about the patient. At times these observations are explored with another psychotherapist, in clinical supervision. Through this reflection the psychotherapist makes inferences about what might be going on for the patient and aspects of their internal world, which the patient might not be conscious of, inferences which are then 'checked out' through appropriately timed 'interpretations'.

Hinselwood (2010) advocates that clinical material can be used as research data in a way comparable to the rigour of the natural sciences. A hypothesis about a patient becomes falsified or not each time the psychotherapist makes an interpretation, based on this hypothesis, of the patient, depending on whether the interpretation evokes some change within the here-and-now movement in relatedness within the session, and the patient's capacity to think and feel (Rustin, 2019). The therapist observes closely the transference/ countertransference dynamics (the 'clinical facts' (O'Shaughnessy, 1994)), examining the connections, and testing evidence of this, within one observation and from one observation to another (Brown, 2007; Reid, 1997; Rustin, 2019). In analytical treatment there are many opportunities to test conjectures about the patient's mind (Rustin, 2019).

While my research is not based on process notes of clinical sessions, my argument here relates to showing that the process of psychoanalytical therapy sessions has an inherent scientific aspect to it, of making hypotheses and ongoing checking and re-evaluating of these.

Freud (1912) described how the analyst uses themselves as an instrument by turning their "own unconscious like a receptive organ towards the transmitting unconscious of the patient" (p.115). An important aspect of psychoanalytic investigations, and which is different to natural sciences, is that the field of study (the patient's mind) and the instrument used to observe this (the therapist's mind) are subjective (Hinselwood, 2010). In fact one could argue that we need a subjective instrument to study subjective processes. Psychoanalytic psychotherapists deliberately use their subjectivity as an instrument of researching unconscious processes and how these might be expressed within inter-relational dynamics. As O' Shaughnessy (1994) states: "the analyst's mind is the instrument investigating the mind of the patient" (p. 943).

Subjectivity

My research methods are close to those of the psychosocial tradition (Holloway & Jefferson; Clarke, 2008; Holloway, 2008) which argues against dualistic ideas, and believes that the internal and the external, the individualist and the societal are inextricably linked. As a research method a psychosocial approach makes use of constructivist and psychoanalytic paradigms, and takes into account the subjectivity of the researcher, and the research subject; how the interviewee and participant are positioned towards the other; and the potential unconscious dynamics within an interview.

In the interviews I tried to approach the participants as partners, having a conversation, a 'wandering with' (the original Latin meaning of 'conversation' as Kvale points out) where meaning and knowledge are constructed, rather than assumed to be there to be mined (Kvale, 2007). In terms of outcome, my intention was to be 'equipoise' i.e. to be neutral and impartial to what themes I was going to find within my interview data, and of how the figures of my audit would answer my research questions (Taylor, 2010). Having said that, it is clear that the design, data collection, and analysis were all in some way influenced by my subjectivity.

While I tried to stay reflexive, and open to each interview encounter, and accepting of any understanding gained in an interview as provisional (Elliot et al, 2012), my own experience of clinical work with a young person who shut himself away in his room, and who identified as a Hikikomori, will have influenced how I responded within an interview, and what questions I asked. In the main this meant that I at times identified with the interviewee. For example, when an interviewee spoke about their frustration about the therapy work not seeming to move, I empathised, as I knew how that felt. In addition, as the interviews were conducted over five months, it is likely that subsequent interviews were influenced by what I had learnt in previous interviews.

Platt (1981) wondered whether the people whom she interviewed at a later stage were being influenced by talk within the community about her research study. She wondered if this had affected the content of what was said within the interview. With my research, I am certain that 'community knowledge' did influence people's decisions to volunteer to be interviewed, as well as how they approached the

interview. I had presented at an annual child psychotherapy conference, and subsequent smaller professional events, the clinical case study of a patient who had withdrawn into his room. My interest in the Hikikomori phenomenon was known within my clinical work circles, and within the wider professional community through my presentations. This was advantageous as it helped with finding participants, who selected themselves to be part of my study, because an aspect of their clinical work resonated with my speaking about the topic.

Considering that Hikikomori is not widely known about within the general population in the UK, or within the specialist child psychotherapy profession, it could be argued that participants self-selected on the grounds of narrowly defined similarities in their work, with what I was speaking about. On the one hand this gave me exactly the right characteristics in the sample that I was looking for, and nobody had to be excluded due to not meeting the criteria. On the other hand, it could be argued that this might have been too narrow and only gave me homogenous data. In actuality the clinical cases that the interviewees spoke about were quite varied in terms of background characteristics.

Within the psychotherapeutic profession, we are familiar with discussing our clinical work with colleagues within clinical supervision, training work discussion groups, or case discussions within our work teams. Due to projective processes, sometimes the interpersonal dynamics within such clinical case discussion groups mirror the intra- and inter-relationship dynamics of the patient/ family discussed. I tried to be open to the possibility of this happening within the research interviews. While transcribing, I included comments about the flow of the interview, for example when I interrupted the interviewee, and reflected on this at the analysis stage, and what might have been going on.

As researchers we have to be mindful of how our own beliefs, thoughts and feelings might influence how we perceive and interpret the data. Holloway and Jefferson (2000) have warned that even when trying to conduct a reflective practice within qualitative research, by examining and stating one's own assumptions and how this might affect the interview process, the researcher is likely to still have blind spots. For example, when something affects the researcher on a deep emotional level but they unconsciously defend against this by blocking this awareness. This they call the 'defended interviewer'. Child psychotherapists, through their training, as described

above, are skilled in staying with their feelings even when this is uncomfortable, and thus have a good standing in being able to provide reflective practice (Brown, 2007). Of course, while their training, way of practising, and clinical supervisory processes, do mitigate against their own assumptions influencing the interpretation of meanings, it does not completely exclude it.

Within my research there are several layers of subjectivity present. There are the therapists whom I interviewed and their perspectives on what might be going on for their patient. In the interviews, the therapists spoke about their experience of the therapy sessions with their patients, as well as what the therapists thought might be going on internally for their patients. There are two aspects to this, the hypothesis that the therapist might have made before, and checked and evaluated in subsequent encounters with their patients, and there might also be thoughts and hypotheses which arose within the conversation of our interview.

There is also my subjectivity, and how I experienced the interview, and my thoughts about what the therapists were saying. My methodological approach hence wove back and forth between the therapists' thoughts about their patients, seen through the lens of their experiences of being in the room with them, and my thoughts about the therapists' accounts. This approach adds layers of subjectivity, and hence makes analysis more complex, as the object of study passes through different paths of 'translation'. I think this is a strength of the approach.

The field of study, inter-relational dynamics, is being examined via the instrument of the therapist's mind, with hypotheses being made about what these dynamics might be a reflection of in terms of the patients' internal object relations, and then continuously evaluated within the psychotherapy work. Within the interviews, the descriptions of these dynamics and the accompanying hypotheses are looked at within another inter-relational encounter, potentially developing further hypotheses.

In terms of analysing the interview transcript, I am mindful that my assumptions are likely to have influenced in some way how I 'heard' the data. For example, Clarke (2008) warns of treating a transcript at face value, and gives an example of an interview he conducted where analysing the transcript without knowing the context of the interview encounter would have led to a completely different interpretation of the material. Unfortunately, due to time constraints and not realising its importance

at the time, I did not write field notes after each interview. In hindsight, it would have been helpful to have reflective notes. When I came to transcribe the interviews, quite some time had passed and some valuable reflections, in particular of my counter-transference within the interview, were lost.

My discussion of the data analysis of the interviews does make inferences about what might be going on in the patient's mind. These are hypotheses made on the basis of my analysis of the interviews, consisting of the therapists' descriptions of their experiences and hypothesis. It also needs to be noted that only a couple of the therapists spoke about intensive psychotherapy, the others referred to weekly psychoanalytic psychotherapy. This also limits how much one can make inferences about unconscious phantasy, as to do so would require not only the rigorous boundaries of the 'laboratory' of the consulting room (Brown, 2007) but also the high frequency of sessions of psychoanalysis. I cannot claim to have discovered unconscious phantasies. I would hence say that I am trying to find out about inter-relational dynamics and states of mind which are partly outside of awareness. These might point towards what might be going on in deeper layers of unconscious phantasy, but to really investigate these, single-case-study research of several-times-a week psychoanalytic treatment is recommended.

Interviewing one's peers

In orthodox research there used to be an assumption that an interviewer and interviewee would be unknown to each other before the interview, and would never meet again, and that the research roles could be segregated from all other roles, and power differentials in terms of status and class were common between interviewer and interviewee (Platt, 1981). I was interviewing colleagues from my own profession, plus someone from a closely related profession. The interviewees in my study were not anonymous to me. The extent to which I knew the interviewees ranged from belonging to the same team, sharing clinical meetings and social chats in the tea room, to people whom I did not know but whose faces I recognised from professional community gatherings. Some of the interviewees were senior to me (albeit with no direct line management responsibilities). In various senses one's peers could be seen as one's equals; for example in relation to social background and roles, and as sharing the same background knowledge and subcultural

understandings (Platt, 1981). Oakley (2016), talking about class, states that 'cultural homogeneity' between researcher and researched might reduce distance, but it doesn't take away the power imbalance between the researcher and the researched.

Interviewing within one's professional community, and being able to speak with a shared language, norms and theoretical assumptions, might enable getting clear and explicit data without the need for detailed explanations of basic terminology, which leads to rich and intuitive responses (Chew-Graham et al, 2001; Coar and Sim, 2006; Platt, 1981). "As an insider, the interviewer can gain potentially rich insights by capitalizing on a shared culture and a common stock of technical knowledge, as well as feelings of collegial trust" (Coar and Sim, 2006, p.255).

However, there is the danger that interviewing one's professional colleagues might inhibit the questioning of shared assumptions and lead to carelessness and 'shared conceptual blindness' and prevent new insights during data analysis (Platt, 1981; Chew-Graham et al, 2001; Coar and Sim, 2006). Interviews by fellow professionals can thus be both selective and restrictive on the one hand, and facilitate more open and detailed responses on the other (Chew-Graham et al, 2001).

Interviewing professional colleagues runs the risk of the interview being approached within professional roles, rather than research roles, and professional status differences might operate in addition to the structural differences such as age and gender (Chew-Graham et al, 2001; Coar and Sim, 2006; Platt, 1981). I found that (apart from the interview with the psychiatrist) the interviews felt similar to peer clinical supervision or discussion, a model familiar to both the researcher and the interviewee, and a model that includes the exploration of transference dynamics. It could be argued that it altered the fact that this was information collection for research and not a case discussion. However, viewed through the lens of the psychosocial interview approach, and considering the topic under investigation involved interpersonal and transference dynamics, I think the role of one therapist presenting clinical work to another therapist enhanced, and did not clash with, collection of in-depth data relevant to my research topic.

Interviewing professional colleagues did make the power differentials more complex. At the time I conducted the interviews I was still in training. I interviewed both other psychotherapists, in various stages of their training, as well as qualified

clinicians of varied seniority. This will have impacted on the relational dynamics of the interviews. In the case of a trainee interviewing another trainee, there might have been an identification between us, or, conversely, feelings relating to being at different stages of the training. In the case of me as a trainee interviewing senior staff, what Kvale referred to as an 'elite interviewee', the power asymmetry that traditional interviewing approaches have been criticised for, may have been cancelled out (Hollway & Jefferson, 2000; Kvale, 2007).

However, Platt (1981) warns that interviewing someone more senior might make it difficult for the researcher to not give an honest account of the rationale and purpose of one's study to such respondents, which then might bias the interview and also goes against the 'textbook' advice of concealing one's hypothesis. Interestingly, this did happen in my interview with the psychiatrist. He asked questions about what I had discovered in relation to the subject, and I found myself discussing my findings as they were at that stage in time. The interview from the outset was different to the others as it aimed to get an overview rather than details of specific therapist/ patient dynamics. There were power differentials, me a trainee, he a consultant and from a profession that is sometimes seen as higher in status. It might be that his asking me questions, and me readily answering them, was an (unconscious) attempt to redress the power differentials of researcher/ researched. The question that I am left unable to answer is whether, and how, it would have affected the data had I been less open about my thoughts.

Shared community membership can affect both interviewer and interviewee. Platt (1981) describes how several of her respondents expressed embarrassment at revealing things about themselves. Coar and Sim (2006) as well as Chew-Graham et al (2001), both exploring methodological issues within studies involving interviewing fellow GPs, found that some of the interviewed GPs felt that the interview was a test of knowledge or competence. Some aligned themselves with the interviewer with expressions of camaraderie (Coar and Sim, 2006) and, felt less threatened when treating the interviewer like a confidante who 'knows the problem' (Chew-Graham et al, 2001).

I do think the participants of my study treated me as a colleague who 'knows the problem', and this allowed them to feel more comfortable in speaking about difficulties within their therapeutic practice that they might not have shared with

someone from outside the profession. Some of my respondents did question themselves in terms of how good they were as a therapist, which might indicate an aspect where they saw me as someone judging their professional performance. There were moments when I seemed to have been positioned as a critical supervisor who perceived them as failing as a therapist, or as judging commissioner who perceives a lack of results and hence the therapy profession as not deserving continued funding. This is difficult to disentangle, as the feeling of failing as a therapist was a common theme of the interviews. Both trainees and those senior to me spoke of feeling like a failure, the difference being that where a trainee doubted their practice, having less experience to compare it with, the senior therapists were clearer that this was related to this particular patient.

Having outlined how interviewing professional peers might have impacted on my interview study, I will now turn to discuss my methodology.

Interview study methodology

The main part of this investigation was based on interviewing seven child psychotherapists about their experience of working with a young person who has withdrawn into their room. I have included a further interview with a psychiatrist who had been involved in developing a service for young people who are hard to reach and out of education, work or training.

Recruitment and selection of participants

In order to gain the specific data I was looking for, my sample was not randomly selected. Instead I looked for interview partners who had particular knowledge and experience that this investigation needed (Flick et al, eds, 2004). The criteria for this were: an interest in thinking about the issue of extreme social withdrawal in adolescents/ young adults, and experience of working with a patient/ patients for whom withdrawal is or was an issue. As one of my research questions related to engagement, I was interested in including clinicians who have engaged a withdrawn patient through creative or indirect ways, for example via phone/internet or through parents.

Prior to selection, I had met with two senior clinicians, one child psychotherapist and one paediatric and adolescent psychiatrist, for a focused conversation about this issue of withdrawn young people. Albeit not part of the formal data collection, these conversations informed my thoughts about developing the study.

After ethical clearance, I searched for potential interviewees through the structures of an NHS trust which has a large adolescent and young adult clinic (up to the age of 25). I advertised through word-of-mouth, enquired at triage and team meetings, and asked clinicians in a supervisory capacity if they knew of therapists who are working, or have worked, with a patient who has withdrawn into their rooms. In my recruitment search, I included both senior psychotherapists as well as clinicians still in training who may have relevant experience from recent intensive cases. In order to limit variation in relation to theoretical assumptions and working model, the sample was drawn from Tavistock-trained child psychotherapists. I intended to include one or two psychoanalytically-minded psychiatrists who might have the advantage of an overview of cases. I found a paediatric and adolescent psychiatrist with very relevant service development and delivery experience.

I provided interested clinicians with an outline of my research, and made clear that the interviews were to be tape recorded. Those who agreed to participate were given an ethical consent form to sign.[7] To my surprise, it was not difficult to find clinicians with this specific clinical experience. Even after I had already got eight clinicians who were committed to the study, I came across other clinicians who could have become involved. I believe this is a further indication that this is a prevalent issue.

Structure and process of interviews

Before the interviews 'proper', I conducted a pilot interview with a child psychotherapist who had relevant experience of working with someone severely withdrawn. The data of this interview could not have been used for my research as the work involved an older patient. The purpose of the pilot was to give myself a 'practice run' including how to position myself as a researcher viz-a-viz a professional colleague, to assess whether this method was going to meet my

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[7] See appendices C and D for copy of information sheet and consent form.

objectives, and whether I needed to change anything such as the structure, how directive to be, and the style and wording of questions.

The interviews were semi-structured. I chose this method in order to combine a high level of openness and non-directedness with a high level of concreteness, and to avoid a prescriptive pre-formulated approach that a more directed interview entails (Flick et al, 2004). I approached the interviews with the same method of exploration as the professional context of psychotherapy itself: to have the minimum amount of structure in order to elicit a narrative configured according to the principles of free association (Hollway & Jefferson, 2000).

Mason (2014) advises trying to make the interview as contextual as possible by trying to conjure up the experiences or processes the researcher is interested in exploring. Merton and Kendall (in Flick, 2004) cite one method as the 'focused interview' where a topic of conversation becomes determined in advance and consists of a film, article or experience of a social situation. This is seen to provide a stimulus for personal recollections and feelings, and to elicit perspectives that were not anticipated. Flick states as one of its advantages is:

> [t]he possibility of combining a reserved, non-directive management of a conversation with an interest in very specific information and the opportunity for an object-related explanation of meanings
>
> Flick, 2004, p.206

In order to provide such a stimulus I started each interview by showing an evocative YouTube clip of somebody who had withdrawn into their room ('The Harris', 2009). This five-minute clip was produced by a Japanese organisation that supports people who have withdrawn into a Hikikomori state. The animation features a man who lives in his room. A female person, probably his mother, puts food in front of the door. The man inside his room is shown spending his time eating and playing on computer games. He is awake throughout the night. An outside perspective is then shown which features his window as the only one lit up in an urban landscape of darkness. The man looks disturbed by the outside light entering through the window and he uses Gaffer tape to increasingly block up the window, more each night. When only one small square of light is left, the man hesitates, then tapes up this last bit, effectively completely blocking him off from the outside world.

By showing this animated clip, I hoped to stimulate an evocative frame of mind and to potentially elicit unconscious realisations of themes within the therapies that the interviewee intended to speak about. None of the interviewees had come across the Hikikomori phenomenon before my initial presentations. Without using any words, the film clip summed up what I was trying to study.

Using the filmclip at the beginning of each interview worked very well. After watching the clip, I started each interview with a 'narrative-generating question' by asking what the clip made the interviewee think of in relation to their clinical practice. This stimulated a spontaneous narrative and framed the interviews as a whole (Flick et al, 2004). In one case the interviewee, on seeing the clip, changed his mind regarding the patient who he had intended to talk about. In two interviews the therapist felt that the clip did not completely represent their patient, as in both these cases the patient did manage to go out of their rooms occasionally, though they both felt worried that their patient could become increasingly trapped in the room.

All interviewees said that the clip reminded them of their work with a withdrawn patient, or in the case of the psychiatrist, a group of patients, that they then spoke about in the interview. The scene of the man taping up the window seemed particularly evocative to the interviewees, referring to how "all lights go out and only one is left on" (Andrea, p.1),[8] with "the square of light left decreasing by each day: bit by bit the connection to the world is severed" (Mike, p.1), and "taping up the window destroying rhythm of day and night" (Steven, p.1).

The rest of the interview did not have a uniform structure. My subsequent questions evolved from the flow of each interview, and were for clarification, follow-up or steering towards more specific examples or depth.[9] In my mind I had prepared the topic guide of questions below, which I hoped the interview would address, to be used if the free-flowing discussion had not already evolved into this area (Sternberg, 2012):

- How has the clinician engaged with the withdrawn young person? What does s/he think has facilitated engagement?

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[8] All the names of the participants are pseudo-names.

[9] See appendix E for interview schedule.

- What is the clinician's view about how the young person came to become socially withdrawn? What is the clinician's view of what factors hindered the young person coming out of their reclusion?
- What are the transference/ countertransference dynamics of the relationship between the clinician and the patient, and has that changed over time? How has the clinician understood this in relation to the young person's internal and external object relationships?
- What, in the clinician's view, has been helpful to the withdrawn young person, or what may be helpful?

In the interviews, many of these questions were addressed without my directly asking them. The last question, about their thoughts of what was, or could be, helpful, including other service input, I did ask directly in most interviews. Furthermore, in the cases where the therapies had ended, I asked questions about how the therapist felt about the ending and afterwards.

Originally, the plan was for interviews to last 1.5 hours. The feedback from the interviewee of the pilot interview was that it had felt too long, so I gave an estimated timeframe of an hour for the subsequent interviews. However, several of the interviews went beyond that, and the eight interviews lasted between 50min and 1 hr 40min. It is notable that all the interviews were difficult to end. Where the respondent had a subsequent appointment, the interview had a strict time boundary. Others abruptly ended when both the interviewee and I were made aware of the time, by the click of the tape coming to the end of its recording. In others where there wasn't such a strict time boundary, we just continued talking. This might be relevant in terms of the possibility that the interviews mirrored the theme of a sense of 'time without boundaries' within the patient's material, for example existing inside a sense of timelessness where the passing of time is ignored. I will discuss this further in the findings sections.

Method and process of data analysis

Having considered Interpretative Phenomenological Analysis (IPA), Grounded Theory and Thematic Analysis as potential methods to analyse the data, I chose to use Thematic Analysis. Thematic Analysis (TA) is commonly used to analyse

textual material from more than one piece of text and, as such, is well suited to analysing several interviews (Howitt & Cramer, 2008). The interviews of my study are not first-hand accounts, which IPA, with its focus on personal meaning and sense-making, is seen as most appropriate for (Larkin et al, 2006; Smith et al, 2009). I also decided against Grounded Theory as it has a focus on generating theory (Glaser & Strauss, 1968), and seemed to require detailed theoretical and techno-logical knowledge and a large set of data (Braun & Clarke, 2006; Smith et al, 2009).

More in line with TA, my main aim was to understand the data, and identify a limited number of themes which adequately reflected the data (Howitt & Cramer, 2008), while any subsequent theory development was secondary. Furthermore, I believe that Thematic Analysis was the most appropriate tool for analysing the data, as it does not adhere to one theoretical framework. I am interested in a phenomenological approach, of describing the experiences, meanings and reality of the subject of the research (the withdrawn young person), as well as exploring how these realities and meanings have been constructed through their unique personal intra-psychic and relational experiences, and within the cultural, techno-cultural and socio-economic context. It needs to be noted that these experiences and meanings are mediated through the subjectivity of the clinician working with them; and further mediated through an inter-subjective process of the interviews, and a further subjective process of my analysing the transcript data.

I believe that Thematic Analysis has given me the flexibility to work within these complex layers, as well as the rigour of identifying, coding and analysing the data to find themes/ repeated patterns, both within the data set of the interviews and the data corpus of all data collected for this research project. I will now give an outline of the process of my data analysis, which was based on: Braun and Clarke's (2006) approach of using a six-phase process that at times weaves back and forth between different phases.

The interviews were recorded on tapes, with a tape recorder. To familiarise myself with the data (phase one) I had, I transcribed all the interviews myself. In order to make the data as concrete as possible, and increase the findings' reliability, my transcriptions included pauses, 'uhms', changes in speed or volume, and overlaps, and I used verbatim quotes throughout my findings chapters (Silverman, 2014). Using a psychoanalytic approach, I believe that such pauses and slips are relevant,

and may express unconscious thoughts. While transcribing I also made a note of any subjective response to listening to the interview, to tap into my own emotional responses to the auditory observation of the interview. As mentioned before, I wished I had made reflective notes straight after each interview. A lot of time had passed between the interviews and my transcribing them, and while listening to the tapes I re-remembered aspects of them. Regrettably, one of the interviews had such sound interference on the tape that parts of the transcript were inaudible. I have made a note of this where I have quoted from this interview.

For phase two, 'generating initial codes', I printed the transcripts, leaving space on the side of the paper, read through them and made notes on the side describing in summary what is happening in a section of the text. Sometimes this summarised a sentence, other times a paragraph, depending on when a theme seemed to change. Over the course of coding chunks of the text in such a way, some topics re-emerged. I then went back and made a note of this with different coloured pens, for example where the interviewee spoke about their countertransference.[10]

For phase three, 'searching for themes', I then wrote all the coded extracts into a new word document, with references to interview and page numbers, and started ordering them into sections of themes. As I was going through the data set, I reshuffled these groupings, or created new ones, where data did not fit into groupings. I then had groupings such as: 'activities/interests/ how spend time', 'background/ past experiences', 'attachments/ identifications', 'social life/ relationships with others and the outside world', 'countertransference responses', 'transferee responses', and 'perception of internal and external reality'.[11]

Many of the individual coded extracts related thematically to extracts of other sections, and I needed to review the themes (phase four). To order the vast amounts of codes within the sections, and then to group them together into themes and sub-themes, I developed several mind maps, starting with categories of: 'self-identification', 'computer world', 'psychic retreat', and 'countertransference', and

[10] See appendix F for sample page of coded transcript.

[11] See appendix G for sample page of gathering of codes.

branching out into various aspects and sub-aspects using the coded extracts.[12] From these mind maps evolved the sub-themes that I then grouped together into themes which became phase five 'defining and naming themes'.

For the last phase of writing, the findings chapters, I had to make choices of where to order which sub-theme, as a lot of the sub-themes could have been placed in different themes. For example, the sense of timelessness, which has been placed under 'boundaries', could have also been placed under 'being stuck' or 'relationship to outside world'. In fact, the different themes could be seen to describe different layers moving from a concrete reality to a more subjective intra-psychic reality. While writing up my findings I moved back and forth between the codings, my mind-maps and the original text to review and adjust the themes and sub-themes.

From the analysis of the audit and the interview data, and the themes that have been elicited through the Thematic Analysis, I then examined and thought about the material and particular aspects of it with the help of existing psychoanalytic theory. I further examined both interviews and the audit study in the light of qualitative research studies, and published case studies which have similar features.

Introducing the participants

Eight clinicians were interviewed, seven child and adolescent psychotherapists (four of whom were in training, and three consultant psychotherapists) and one consultant psychiatrist. The psychotherapists spoke about their perceptions and feelings about their therapeutic work with patients who were severally withdrawn and shut away. The psychiatrist was chosen to be interviewed to give a more overview perspective. He had been instrumental in setting up a new service for 16-25 year olds who were on the fringes of society, and one of the client groups worked with was adolescents and young adults who are withdrawn and not in education, work or training.

In terms of gender, the sample consisted of three female therapists working with a male patient, two male therapists working with a female patient, and two female therapists working with a female patient. As Hikikomori in Japan is seen as a mainly

[12] See appendix H for sample of mind-maps.

male problem, I was surprised to have as many female patients being spoken about as males.

In terms of age, the therapists spoke about work with patients who were between 13-20 years old. Age of the patients is relevant in terms of what, in their present lives, they were dropping out of, and hence the response of services to this. Two of the therapists spoke about patients who were still at an age where being in education is a legal requirement, with potential sanctions for their parents if they are not attending school.

Four out of the seven therapists spoke of work with a patient who, before their therapy, had in some cases quite substantial previous psychological input through school counselling or CAMHS. The patients were referred to the psychotherapy service as it was felt that previous input had not managed to engage the patient or shift their difficulties.

The length and frequency of the therapies ranged from one year of weekly therapy (two interviews), two years of weekly therapy (two interviews), four years of weekly therapy (one interview), three-times weekly therapy over one year, and continuing at time of interview (one interview), and three-times weekly for three years (one interview). The time from the end of the therapy, the interviewees spoke about, ranged from: one still in the middle of a therapeutic process, one who had finished with the patient one week prior to the interview, three who had finished a few months prior to the interview, and two where the therapy had finished one, and several years prior to interview. The timing of the interviews viz-a-viz the ending of the therapies had an impact, in that it influenced how the therapist reflected on the work in terms of the distance their minds were to the process, and how digested the therapists' views on the therapeutic process were.

I had deliberately not asked the interviewers about the family backgrounds or histories of their patients, mainly due to providing anonymity, although occasionally background information emerged within the flow of our conversations. I had not intended to compare background information. However, analysing the data, there are some themes within their backgrounds which appeared in more than two of the interviews. Most of the interviewees mentioned that their patient had no contact with their father, and there seemed a lack of a male presence within the household.

Several interviewees spoke about a fear of the outside, not only in the patient but in their parents or grandparents. Several interviewees spoke about their patients having a carer's role within the family, due to maternal health or mental health issues, and several interviewees spoke about their patients themselves having had past or present physical illness and/or surgeries. I will discuss this data and other common characteristics, as well as comparing this with the audit data, in the discussion chapter.

Having introduced the participants to the interview study, I will now turn to the themes that arose through the analysing the interview data.

Interview study findings

I will now present and explore the themes and sub-themes of the interviews. Within the first theme I will explore different layers of the overarching sense of stuckness, both internally, externally and within the therapy, and what this evoked in the therapists. My second theme deals with the relationship between the space of retreat and the external world. From the withdrawn state, the outside world tends to be perceived as full of dangers, pressures and demands. I explore how the cyber-world, as well as the therapy, can be drawn into the psychic retreat, while also offering contact with other people. I look at the therapists' perceptions, and how these seem to indicate that a fear of contact, leading to a defensive denial that contact is needed, might underlie the tendency to withdraw. In my third theme I explore the issue of boundaries in various aspects, boundaries of space, time, and between people, and explore of what this might say about the withdrawal state. In my last theme I will discuss what the therapists have said in relation to changes in therapies, what was helpful, and the impact of endings.

Theme One: Being stuck

> "She was stuck in her flat and stuck in her mind, unwilling to move".
> Paula's interview, p.3 [13]

A theme that ran through all the interviews related to a sense of stuckness. The patients of the interviewees were stuck inside their rooms and stuck in their lives without any movement. The sub-themes of this chapter will explore the different ways that this stuckness was expressed within the therapies, and the impact this had on the therapist.

Firstly, however, I would like to give the context of the therapies and outline the timeframe that the patients had been stuck in their rooms.

At the start of the therapy of the two patients who were still of compulsory school age (under 16), Sharon's patient had been stuck inside his room for three years, while Marion's patient was still managing to go to school, reluctantly, but did not leave his room otherwise. Of the over 16s: Paula's patient had been withdrawn into her room for months after having left school, and there had been previous periods of several months where she refused to go to school. Mike's patient had various periods of school refusal from the age of eight, until ceasing to attend altogether. Julia's patient had previous periods of not leaving her house, and at the point of her therapy she managed to leave the house for a once-weekly volunteer job. Andrea's patient was stuck at home with no work or training, and Steven's patient had not left her house for nearly a year before starting therapy. Apart from Marion's patient, and, to a limited extent, Julia's patient, the young people did not engage in activities appropriate to their ages, be it school, college, training, work. They did not engage in social or leisure activities outside their home.

<u>Endless repetition</u>

Being withdrawn inside their rooms, their lives mainly evolved around the same activities, day in and day out, stuck inside a status quo of not changing.

> "I felt he was very stuck, but then there was just... just his sense of things not changing… They hadn't changed previously, so maybe there was no

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[13] Names of interviewees are pseudo names.

expectation of change".

Marion, p.9

The stuckness in their lives appears to have been mirrored in the therapies. Interviewees reported the therapies as feeling stuck for long periods and "not going anywhere" (Julia, p.5). The therapists described often feeling bored, feeling drowsy, having difficulty focusing, difficulty keeping awake, a sense of heaviness and the work requiring lots of stamina and effort. Andrea speaks of her frustration:

> "I often felt quite bored…and quite lonely, quite frustrated and hopeless feeling: 'no, you're not going anywhere', you know, really this thing came to my mind, 'is there any hope, are we ever going to go forward *(laughs*)?', hm… Really frustrating, really difficult. At times I was feeling quite claustrophobic as well… Because I think (*talks slower)* the way he describes things he would go around and around and around".
>
> Andrea, p.2

Andrea said she felt claustrophobic at times. This arose from the endless repetition and lack of movement bringing up a fear of being stuck inside a non-changing moment-in-time. Several interviewees referred to a sense of timelessness and the feeling of claustrophobia, which I will examine more closely in a later section. All the therapists in my study described feeling frustrated with the apparent lack of movement in the therapy.

> "It was just a kind of opening up and talking and then closing everything and then back to square one. […] I began to say: Look, we can't go on like this, this is a cycle repeating itself over and over again".
>
> Paula, p.2

Paula felt that the therapy was going in circles:

> "She used the therapy as a way of opening the bubble and talking about all her difficulties and her fears and.. um… but then closed the bubble again on going home, and reversed back to square one".
>
> Paula, p.1

Paula felt worn down by, and stuck in, repetitive cycles where each session felt like a repetition of the previous session. Further into the therapy the patient herself brought the image of how she experienced the therapy as an unpacking of a car boot,

showing the therapist the items inside, only to then put them all back again until the next session.

It is noticeable that the young people did not seem to consciously experience any frustration about their situation or any wish for it to change. On the contrary, the interviewees reported their patients presenting as feeling comfortable in their situation, unable or unwilling to change, and experiencing any change as frightening.

> "He wanted to continue with what he is doing now [at home playing computer games] for the rest of his life".
> Marion, p.8

While the patient appears happy to stay where they are, the therapists felt frustrated and at times hopeless and despairing. We could hypothesise that the therapists feel the frustration that the patients themselves did not consciously feel. Saito (1998) emphasises that what to others might look like being comfortable and contented inside their room, the withdrawn person is in fact highly anxious underneath. To be fully aware of the implications of their withdrawn life could lead to despair.

> “I had got very worried, felt totally stuck, that I would just be seeing her forever, this would be endless, just giving me enough to feel I couldn't justify not seeing her, but feeling really quite despairing. And I think that despairing feeling that she would never get better, that she was stuck, was what it felt in the countertransference”.
> Julia, p.4

Looking at this through a psychoanalytical concept of projective processes, I think that one way of understanding the therapists’ feelings of despair might be as a projected communication of an emotional situation which is too unbearable to be aware of (Joseph, 1982; McDougall, 1984; O’Shaughnessy, 1981). In this framework it would also make sense that the patients, according to the therapist’s perception, seem to believe themselves to be comfortable in this stuck place; this belief could be understood as a protection against painful awareness.

The apparent lack of change within the therapy led some of the therapists to feel stuck themselves, stuck with a patient they can’t get rid of, with an accompanying sense of being stuck there forever.

"It's accumulative, so the more, the longer I saw her the more difficult it would be, but then also the feeling that I could not possibly let go of her, and that's where the team would help me".
Paula, p.6

As with many of the patients, Paula's patient presented herself with feeling comfortable about being stuck, while Paula got increasingly frustrated. The therapist who I interviewed for the pilot described how initially her patient left her feeling unmoved, but over time she became increasingly frustrated and worried about her patient's stuckness. Rather than a regression, as Paula feels, one could conceive this as a progression within the therapeutic process. That before the patient related to others in adhesive identification, without a sense of having an internal space or of others not having an internal space, and hence assuming that the therapist would not be able to receive any thought or feelings from him (Bick, 1968 &1986; Meltzer et al, 1975). Looking at it through this theoretical model, Paula's frustration could be understood as an indication that her patient had an increasing impact on her, and projected the feeling of fear and frustration about being stuck. We could see this as the patient, having developed an idea that Paula has an internal space that can receive projected feelings, started to communicate with her therapist emotionally. It is also interesting that Paula asked for help from her team, the need of an (oedipal) third to break the stuck-together couple (Britton, 2004*)* which I will discuss further within the theme of boundaries.

Cyclical dynamics

Several interviewees spoke about the ongoing cyclical dynamics, where any slight change or engagement was followed by a regression and withdrawal. Mike describes: "There was a getting a little bit of drawing you in, and then when one gets caught by that, she would push you away" (Mike, p.1). Mike understood this as his patient's way of coping with the fear of being rejected. Mike thought that when his patient felt in contact with an other this would trigger her fear of losing this contact. By being the first one to withdraw, Mike thought that his patient protected herself from a fear of being left.

The psychiatrist, in his interview, also refers to a dynamic where a patient got better, re-kindling the hope in the therapist, only to then become more regressed again, and

the difficulties this can create in trying to support a young person. This ongoing to and fro dynamic engendered in Andrea a doubt that any improvement would be sustained.

> "So any step forward I was wondering: is it a solid step, or is he going to step back again? Is it progress, or is it just a moment? Is he going to sustain it or not?".
>
> Andrea, p.6

Each rekindling of hope was followed by disappointment, leaving the therapist unsure whether any contact made, or change witnessed, was going to be sustained or was just another moment in a repetitive cycle. When I interviewed Andrea she had just finished the work with this patient. At that point she believed that the patient had made progress over the course of the therapy, but in her mind this progress felt very fragile, and she worried that after the end of the therapy he would just go right back into his retreat.

Sharon had a slightly different perspective. She did not see the alternating contact/withdrawal dynamic as cyclical, but more as a moment-by-moment result of falling one way or the other. In the interview, Sharon strongly related to the scene at the end of the YouTube clip where the withdrawn young man receives a message from a support organisation. The clip ends at the point where he holds the computer cursor poised between the 'reply' and the 'delete' button. Sharon stated:

> "It felt like he was always poised on a place: will he press the delete button or does he press the reply button and it felt often that I was kept on an edge.
> *Whether he would engage in that moment or not?*
> Yes, whether he would engage or, and my thoughts about the silence, um, or his movements in the chair, or, feeling more comfortable than others, and the times when it felt more like this was a withdrawal into a place where I just wasn't allowed access, and this was hugely familiar to him".
>
> Sharon, p.2

Sharon had a particular difficulty in that, for a year, the patient did not engage in any talking and had his back turned to her, and when he did start to talk, there were periods where he would withdraw into silence again. Sharon thought her patient was left poised between engagement and withdrawal. Within the micro-level of the

moment-to-moment within each session, as well as on the wider level of the process of the therapy over time, Sharon had to focus intently on the non-verbal and unconscious communications and her countertransference.

Julia felt tantalised by the repetitive dynamics of moments of improvements being followed by renewed regression.

> "I also felt that she was trying to manipulate, put on a trick. That she would just.., that she had all this potential, and we would have some great conversations […]. And then (*louder*), if you had a bit of success, she would have to slap it down".
> Julia, p.5

Julia described how every time there was a change, her patient would respond with attacking the therapy. "Like she made you feel that she was getting better and then it would turn into an attack" (Julia, p.6). Julia's sense of being attacked might be understood as an indication that there indeed is something destructive going on, where any progress or link made feels so threatening to a part within the patient that this has to be destroyed (Bion, 1959).

Joseph (1971), in exploring the dynamic with patients who appear passive and flat, describes how, when the patient gets in touch with some aliveness and progress, he cannot bear the accompanying feelings of jealousy and envy and then has to destroy the experience. Rosenfeld (1987) also describes how when working with patients in the throes of narcissistic defence organisation, any progress is followed by a severe negative therapeutic reaction. At moments of emotional contact, moments where the patient has come out of the withdrawal state and out of the place of stasis into movement, like someone inside a gang reaching out for help, a challenge has been made to the illusion created by the gang of not needing anyone outside. The idea of losing this illusory protection feels terrifying (Meltzer, 1973). In any turning towards life, the destructive part feels threatened and exerts its power more strongly. Steiner (1993) also describes this dynamic whereby any change, which is felt so threatening, triggers a more severe withdrawal. This brings me to my next sub-theme of change provoking huge fears within the withdrawn patients.

Fear of change

A recurrent theme that the interviewees referred to was a sense of their patients experiencing change, movement and development as frightening and unsettling. As Andrea said:

> "if there was any change he was all over the place and could not find a peaceful place to be, even in his room, nowhere. And then he would forget appointments, miss letters, would become quite annoyed about things, would be quite chaotic, sense of chaos around, when things happen to others, not necessarily him, it really affected him"
> Andrea, p.11

Andrea describes her patient as being so disturbed by any change that the structure of his life, and we could think about this as the structure of his retreat, seems to break down. It might be that withdrawing to a place where everything stayed the same was partly in response to experiencing movement and change as overwhelming. It might also be that over time the person becomes 'institutionalised' within their room and change becomes more frightening. Several interviewees spoke about their struggles to challenge their patients in any way, or "having a different view" (Steven, p.3), this being perceived by the patient "like the end of the world" (Paula, p.4).

Saito (1998) says that Hikikomori people, stuck in a closed-off and fixed system of relating, are often very sensitive and afraid of change. Steiner (1993) also refers to change being felt as threatening inside a psychic retreat. The therapists struggled to bring any difference into the therapy room; any challenges to the patient's thinking were blocked off (different patients using different 'tactics' to block these off) creating huge technical difficulties and making the therapy feel quite stagnant a lot of the time. As if under the throes of an internal gang which has to obliterate any differences within it (Canham, 2002), the person becomes locked into a fixed thought system that could not be disturbed.

Julia described how any slight movement in a therapy session could trigger in her a fear that her patient would run and never return. Her frequent worry about "having lost the patient" (Julia, p.4), with the accompanying guilt of having done something to make the patient run away, is voiced also by Steven.

> "One interesting countertransference is, every other week or so I keep thinking that I have lost her, that she might never come back, because she is too cross with me or because I have taken up something too directly, even though in that I have been quite careful".
> Steven, p.3

Steven and Julia's countertransference might point towards an indication that underneath the patient's panic about change, lies a fear of loss which has been projected into the therapist. In this framework we could think of change as being acutely felt as a separation.

Identification with being incapable

Several interviewees described their patient's fear of potency, and how their patients seemed to be holding on to an identification of being sick or old, impotent, and not able to do things. Julia said that her patient: "had this idea that she had no energy, and the fact that 'no energy' therefore meant that she couldn't get out of the house" (Julia, p.3), and Andrea said that her patient wanted a justification for wanting to be sick.

> "When you look at him he does at times come across as a disabled old man, when in many ways he is not, but he does produce this sort of experience of being old (*switches into quoting him*): 'I'm tired, too fearful, too vulnerable, too impotent'"
> Andrea, p.8

It is of note here that on the surface these patients' presentations appear like a limited ability, yet these patients were not disabled. The psychiatrist thought that maybe autism spectrum disorders might feature within this patient group, but this was not borne out in my study. Sharon for example specifically mentioned that her patient was not on the spectrum. The interviewees at various points all commented on the capacity of their patient which made it so much more difficult to understand why they appeared so disabled in their functioning. Mike said: "That was the sadness about it really, she was bright, she was very articulate, yet she was a person who was completely withdrawn" (Mike, p.3), and Julia said of her patient that "she was intelligent, compassionate; she'd sit in her room not really being able to do anything" (Julia, p.6).

How much the patient's stuckness was based on inability ('can't') or refusal to try ('won't') was an ongoing question in some of the therapists' minds. The psychiatrist said that these withdrawn young people evoked an emotional response of frustration and thinking "just grow up, pull yourself together, surely you can overcome these anxieties" (psychiatrist, p.5). This is mirrored by Julia when she states: "Why is she making so much fuss? Which is what she accused all the professionals of saying: ' come on, make an effort, just make an effort'" (Julia, p.6). Julia then reflected on this:

> "And it really came across to me how difficult it is for someone to give up on their helplessness, because rationally nothing was stopping her from that […] but obviously there was another part in her that very strongly didn't allow it […]. And I think she didn't like the fact that ultimately that what she had to do, she had to decide, nobody could take the decision for her. […] What was really hard was that I'm not sure how much she wanted to get better actually. It was always the fear that that was what people were saying to her that it was her fault that she doesn't get better."
>
> Julia, p.6

How much a patient is able to change at a particular point in time is a question that therapists ask with any patient, but with therapy that seems to be in an ongoing impasse the question of barriers to change is likely to be the most pertinent question of all. A further quote by Julia might give us a clue.

> "So you know she can either embroil herself in all that, and be depleted, because she feels that if she really gets going against her mother she would smash everything up. So she would rather be a bit depleted and a bit chronic-fatigued, it is quite useful for her actually. Because otherwise I think she is really worried about what will happen".
>
> Julia, p.6

Medically, there was a question whether or not this patient had chronic fatigue. The above quote suggests that rage might underlie the inertia, keeping a passive non-moving state in order to prevent aggressive feelings from rising to the surface; a fear of what might happen if she got in touch with feelings of anger or rage.

Paula felt that "there was something aggressive about [the patient] wanting to come, refusing to conceive an ending and not changing at the same time" (Paula, p.3). She described her patient right from the go expressing that she couldn't bear it if therapy were to stop. The patient seemed to be clinging to the therapy like a life vest (McDougall, 1984), yet Paula is left feeling that the therapy is not helping her. At another point in the interview Paula described "there was something very stubborn in her not wanting to, there was no progress there was no, you know, kind of small steps, it was always the same step" (Paula, p.5).

Feeling identified with someone sick, old and disabled, for someone in the midst of adolescence and young adulthood, is incongruent to their developmental stage. Interestingly, Andrea, who described her patient presenting like a disabled old man, was not the only interviewee who felt her patient's presentation as being incongruent with their chronological age. Paula also described her patient like this. "It was like being with a 50-year-old woman; there was no adolescent at all" (Paula, p.6). Had the adolescent processes come to a halt? Had the patients stopped their development or literally skipped over the adolescent development, a period marked by a drive forward, immense changes and an increase in potency? Which brings me to the next sub-theme.

<u>Fear of development</u>

> "Development feels scary as it entails living in the world (and not the computer)".
> Steven, p.3

Having dropped out of school, or never having made the transition from school into work, training or further education, nor having any (face-to-face) social or romantic relationships, the development of these patients along ordinary life trajectories had come to a halt. Two out of the three adult patients in this study had to be brought to their therapy sessions by a parent, despite there not being any transport issues, as if they were children. Clinging to an identification of being incapable, as discussed in the previous section, keeps the person stuck developmentally.

> "I think development is a very scary process for her […]. It is very difficult for her to have to take on the part that she plays in keeping herself in this position, to accept that she does have some capacities, that she could do stuff.

Um, I think it quickly just becomes terrifying really, um, that she would be forgotten or something like that".

Steven, p.3

Steven continued to say that his patient would get very angry whenever he tried to refer to her capabilities. At those times he worried about losing her, and thought that he would miss her if she did not come back. What the patient seems to hold on to is an idea of being incapable. The therapist's countertransferential response might indicate that there is a fear of loss in the sense of 'if I develop I will be abandoned'. Any stage of development forward brings with it the loss of what has been (Waddell, 2018). To avoid such loss, maybe it feels safer staying stuck at an earlier developmental stage.

Sharon thought that her patient's constant hesitation in engaging, stemmed from a fear of development.

"[…] his real fears about the future, about growing up and whether he'd be able to sustain that. […] this wasn't a person who fought with his parents, he didn't argue, he did not show the sort of adolescent desire to break free, to challenge his parents in any way. And instead it felt as if he became locked inside more and more".

Sharon, p.2

Forming one's identity, independent from one's parents, is one of the tasks of adolescence, which here seems to have halted. To find one's identity necessitates a certain pushing forward of one's own ideas in order to find where the boundaries lie to other people and their ideas. Sharon told me that her patient had extensively researched about psychotherapy. However, to my question whether she thought her patient had googled her name, she responded in the negative.

"He was so inhibited, any sense of potency of gaining access or entry, that was part of his withdrawal though, he was so terrified of.., I think of being male, being potent, so that 'wanting to get inside' didn't, didn't, I didn't experience that with him".

Sharon, p.4

There seems to be a lack of drive, curiosity, a lack of pushing forward to meet with the world and other people, which was mirrored in the dynamics within the therapy.

Waddell described how increased mental and bodily ability makes the adolescent literally be able to act on their “feelings, urges and fantasies […] - to impregnate or to have babies, to harm or kill themselves, to inflict actual damage on others, on their parents, and on their surroundings” (Waddell, 2018, p.51). Increased potency can bring up fear as well as excitement. We could speculate that the withdrawn young person’s fear of what they could do was so terrifying that all feelings had to be dampened down.

Interestingly, several interviewees spoke about their patient’s lack of drive in relation to sex and aggression. Andrea said that:

> “He was very inhibited sexually, he never had a sexual relationship with anyone, he is terrified of sex, of his own body, of intimacy. And when he talks about it, it's in a very fantasised way, it's like a fairy tale (*Laughs*), a bit like a fantasy of intimacy, he really struggled to think about it and talk about it. So the way he managed it was by conceiving sex as something dangerous, wrong, dirty. There is only one sort of way, that he is a virgin and he wants to be with someone who is a virgin and they would be together for ever.. (*Laughs*) […] And I think he's always afraid of being aggressive, to be like his father, he is terrified of the things that being potent means being destructive and how difficult for him to disconnect from this image of his father who was so destructive”.
> Andrea, p.9

Andrea describing her patient as having the wishful fantasy of virgins being intimate together without being ‘dirtied’ by sex, could be seen as a pre-genital version of sexuality, the ‘happy forever after’ of fairytales, while the reality of relationships and adult sexuality is blocked off. Using psychoanalytic theory one could also think about this as an idyllic infant/ mother merging before the oedipal father interrupted their union. Steven stated that his young adult patient:

> “She describes herself as asexual, and her own description of asexual is that she does not have any sexual desires, actual feelings in her body. […] when she was at school, they wanted to watch [a teenage romantic vampire movie], and she was disgusted, she wanted to watch Harry Potter, where there is less of overtly sexual. […] she talked about Hermione, I think she identified with,

> and Hermione did have a relationship but not an overtly sexual one”.
> Steven, p.7

Both Andrea and Steven said that their patients were terrified of sex. Whereas Andrea’s patient associates it with fairytales’ idea of early childhood, Steven’s patient seems identified with a pre-teen latency movie character. Steven thinks that the patient’s adolescent sexual development was delayed. He also described how his patient was horrified when he used the word ‘intimacy’, horrified there could be any suggestion of there being any intimacy between them.

Over the course of the therapy this changed. Steven said that his patient came to recognise that intimacy can be more than just sex. Steven felt this was a huge development for her. Interestingly, his patient created online an avatar which Steven believes was a sexualised character. His patient complained how other avatars would be after her avatar, promising sex. Steven told me how his patient was aghast about this, yet had provoked it, as if desire was being projected ‘out there’ into others.

Marion’s patient was still in his early adolescence when his therapy started. Marion described how in the early period of their work her patient seemed to forget that she was there in the room, and she struggled to keep awake against an overwhelming feeling of sleepy boredom. This changed over time.

> “He became more interesting because he became more interested in having a relationship in the therapy room. I think initially he wanted to simply forget that I was there or somehow close me off, or trying to make me disappear or put me to sleep… so, yes I think he became more interested, and I think partly as a change in becoming more adolescent. Um, he was very open about the changes in his body and becoming, um, waking up”.
> Marion, p.5

Marion believed that a process of ‘waking up’ to the other person in the therapy room was inter-related to her patient’s physical pubertal changes, which occurred in the same time period. In the above quote there is a pushing forward towards the other person with interest, which in turn makes him more interesting to the other. This example counters Steven’s patient’s apparent fear of being forgotten about if she developed. Aggression experienced as a vital energy coming into the room was also described by Mike.

> "It [the therapy] was like plodding (..*inaudibl*e..). And then she got cross with me (*laughs*), they really were the best sessions, she got really cross with me (*smiling energetically*) she really did get mad at me
>
> *So she engaged in the crossness?*
>
> Yeah, she engaged when she was cross!"
> Mike, p.5

Mike's eyes lit up when he told me this. In the crossness, there was an engaging, an interest, so markedly different to the usual 'plodding'. The pubertal push forward, and the moving forward to make contact with another, seemed to enliven a process which had often felt stagnant.

It is noteworthy that there did seem to be a move in terms of development over the course of the therapies described. In fact, taking steps towards independence was an area that was frequently cited by the interviewees. For example, the adult patients who were brought to the sessions by their parents, starting coming by themselves. Other moves towards independence such as improvement in self-care and starting volunteer work, I will discuss in subsequent sections.

I would now like to turn to the impact that the repetitive, cyclical dynamics, which the patients' apparent fear of change and development engenders, has on the therapists.

Doubting the value of their work

The repetitive cycles, the slowness or even stuckness of the work took its toll on the therapists. All the interviewees said that they at times felt hopeless in the face of this non-movement and repetitiveness. Most also mentioned times where they doubted themselves and their work, even to the point of questioning psychotherapy as a helpful approach.

To my question of whether anything had changed over the course of the therapy, Paula responded:

> "I think that things got worse. Because of the stuckness. There is only so much you can take feeling stuck, and also the frustration, that I couldn't really do my job. Yes, I could do it, but it wouldn't really lead to anything […]. I

> was asking myself: is this wasting a resource…um…what am I doing here?"
> Paula, p.6

Paula was questioning her ability to do her job, which then moved to questioning whether there is any point in doing her job with this patient, and whether she wasting resources. At several points during the interview Paula said the work was 'difficult', 'challenging', 'unrewarding and hard'. These phrases were echoed by several of the other interviewees.

Sharon talked about the stamina required working with this kind of patient. "I realised very quickly I needed a balance, a rest in the afternoon, the afternoon before I saw him, because often I would just be absolutely drained" (Sharon, p.9). Unlike some of the other therapists she did not feel that she could not carry on, although it is interesting that at the outset she thought she'd be working with this patient for a year, and didn't imagine that she would end up working with him for four years.

The huge effort required, without the reward of seeing this effort as being helpful and changing things for the better for the patient, led to doubts in several of the therapists.

> "It was really hard actually, really hard (*inaudible*). I was somebody who had worked in CAMHS for about 10 years or so (*pause*).Yes, I had conversations with her but, was it therapy? In some ways I was making a huge effort trying to keep this young person engaged because we were concerned about her".
> Mike, p.1

Mike refers to his longstanding experience at CAMHS, yet this patient and her lack of engagement leaves Mike doubting whether what he was doing was therapy. Doubting the value of the work, and their own skills as therapists, was particularly difficult for those interviewees who were still in training, and who did not have a vast amount of experience behind them to compare this work with.

> "[...] always questioning our work, 'am I on the right track?' (*laughs*) you know (*laughs*) 'what should I do?' you know, 'is it the normal process.. is it the nature of this specific work?.. should I have seen more progress by now?'; all these things I was asking myself, and in supervision as well…".
> Andrea, p.6

Without the confidence gained from experience, Andrea questions her work. Yet there was no difference between the trainees and the consultant psychotherapists in terms of doubting themselves and their work. There was something particular in the dynamic with the severely withdrawn young person that seems to engender this doubt.

Looking at this through Rosenfeld's (1987) model of a defensive organisation, we could understand these dynamics as the destructive part within the patient, like a gang leader, destroying any meaning by repetitive behaviours and devaluing the therapy by showing it up as failing. Another way of thinking about this is the therapist picking up on what it might feel like for the withdrawn young person, doubting the value of their work and a sense of failure. Several Hikikomori studies have referred to the withdrawn person feeling they have failed in their role as a productive member of society (DeLuca, 2017; Husu and Valimaki, 2017; Yong and Kaneko, 2016).

While left with doubt about their ability to help the withdrawn patient, the therapists are left with concerns about their patient never moving forward but staying stuck forever. I will explore this in the next sub-theme.

<u>Therapists' concerns about their patients' futures</u>

> "I had this kind of fantasy about thinking in 10 years' time where he would be [in his thirties] and I always had this very dreadful image of somebody really lonely, overweight, on the computer, eating, depressive, compulsively eating. What is he going to be like in 10 years' time, this was always on my mind". Andrea, p.6

Andrea's worry was echoed by other interviewees. For some of the therapists it was this worry that kept them going, in a process that so often felt so difficult: the worry about what might happen to their patient were they to be left to their own devices; the worry that their patient would be stuck where they were forever, without any development. Where interviewees had themselves not referred to this, I asked them about how they imagine their patients to be in the long-term future if they were not receiving any input that would help them to change. All gave similar answers, which were summed up by the psychiatrist when he gave this image:

> "He would be 30 years old, housebound, depressed, is depressed already, but then he would have a psychiatric diagnosis and then he would not have any resilience to draw on to have a meaningful life. That he would have retreated so far that he would not have a job, he would not have a relationship, he would be feeling depressed, hopeless, and ultimately I suppose there would be risk of substance misuse, risk of alcohol I suppose, sort of get down to the corner shop, and suicide would be a vulnerability with a young man with nothing to live for".
>
> Psychiatrist, p.2

This worrying picture puts emphasis on how vital it is to not lose these young people, to not let them drop out of our collective minds.

Judging by Saito's experience of trying to help Hikikomori sufferers, there is a real risk of deterioration into a chronic state whereby the person has, over time, increasingly withdrawn from contact, first from the outside, then also from the people living in his house, becoming fearful of contact.

> When withdrawal reaches this extreme state, then Hikikomori patients often are unable to do anything for themselves, spending the entire day in an absent-minded state, wrapped in a blanket, and letting time go by pointlessly.
>
> Saito, 1998, p.43

This state might be compared with 'pervasive refusal' where a child withdraws completely, physically and psychically, from contact with life. Magagna (2002) describes this as the use of primitive protections to completely barricade against external life for fear of annihilation, where anything coming in is perceived as a threat.

Sadly, judging by the Hikikomori phenomenon in Japan, the therapists' fears for the patients' future is well founded. Once withdrawn in their room for a prolonged period of time, it becomes increasingly difficult to re-engage with the outside world, and, without any help, people in a state of Hikikomori tend to stay stuck there, for years and years (Saito, 1998). I will discuss this in more detail within the Discussion and Synthesis chapter.

In this theme chapter I focused on the stuckness within the therapies and the external lives of the patients. I have explored how an identification with being incapable, and

the fear of change and development seem to produce this stuckness. I have looked at the impact on the therapist that these dynamics engender, leaving the therapists to doubting themselves and the potential of therapy to help the withdrawn person, and to believe that their patients might stay chronically stuck. In my next chapter I will focus on the relationship to the outside world.

Theme Two: Relationship to the outside world

In this section I would like to explore the various aspects of relating to the outside world which have come out as themes within the interview data. The therapists spoke about their patients being perceived, and perceiving themselves, as outside of their peer group. Experiences of bullying and other attacks were used as justifications to withdraw, and the outside world seems to have become perceived as dangerous and as putting too many demands and pressures which are experienced as overwhelming. The withdrawal state becomes a protection against the outside world. For some, the cyber world seems to have become part of the retreat and I will explore in this chapter the role that the computer and internet seem to play. I will describe how some of the therapists felt excluded by their patient's immersion in the cyber world, and at times the therapy itself seems to have been drawn into the psychic retreat. I will look at how underneath this need for the retreat seems to be a terrible fear of contact. A way of dealing with this seems to be a denial that contact is needed or wished for.

Being outside the group

A theme running through the interviews related to the sense of being different, of being outside of peer relationships, being perceived as odd and looking different. Mike for example said that his patient was seen by others as "a strange girl" (Mike, p.3). It is unclear how much it was the patients who isolated themselves by presenting themselves as different in order to avoid social relationships. Marion for example thought her patient was comfortable with being strange and actively presenting himself as such.

> "He attends school but was considered quite a strange boy by lots of the other pupils. The fact that he seemed quite comfortable about being strange tends to make them leave him alone".
>
> Marion, p.1

At another point in the interview Marion said that her patient was teased at school, and it is likely that his more deliberate presentation of being different is both a reaction to being ostracised as well as encouraging it. Her patient also did not fit into stereotypical gendered activities, which again made it more difficult to be part of the peer group.

Paula said her patient "couldn't bear being amongst her peers" and that:

> "simply going to school was really very difficult.
> *Because of being with other people?*
> (*Interrupts me*) Because she felt like a fish out of water, it is like being aged 50 and going to year 11, A-levels. So she felt completely like a fish out of water". Paula, p.7

Paula's use of the expression 'like a fish out of water' is interesting, conjuring the idea of her living in a world which is very different to the world other people live in, and that she cannot breathe in this 'other' world. Throughout the interview Paula used the phrase of 'bubble', a bubble that her patient was living inside of and which she feared stepping out of, a bubble of her own creation, a space she withdrew into.

Several of the interviewees said their patients had no friends. Marion and Julia said their patients had online friends, albeit no friends they met face to face. However, not having any friends, or only online friends, did not feature in all of the interviews. Mike for example said that his patient's friends were making a great effort to get into contact with the patient, but were ignored. Again this brings up the question that I discussed in the context of the 'identification with being incapable' sub-theme, of how much this is an *inability* and how much an *unwillingness*. We cannot see this in a binary way. In this instance, being 'unwilling' to engage with friends might be a protection against being (or feeling) 'unable' to socialise or against fearing rejection.

Whatever the reason, the interviewees' patients seemed outside of their peer group and at times presented themselves as different. This in turn could make them a target for bullying, to which I will now turn my focus.

<u>Outside equated with danger and pressure</u>

The psychiatrist thought that bullying frequently featured in withdrawn young people's narratives, and he thought that bullying was one factor leading to the

withdrawal in the first place. He gave an example of one patient who had retreated into an online world to escape bullying in the offline world, only "then he started to be bullied online, so now he doesn't even interact with anyone online" (psychiatrist, p.1). Bullying was mentioned by several interviewees; for example, Andrea described how her patient had suffered abuse at home and then:

> "things became much worse in secondary school where he was really badly bullied, and when moving to college he was badly attacked, … that's when he really became much more withdrawn, secluded".
> Andrea, p.8

At another point in the interview Andrea reflects:

> "He went through horrible experiences, so, he would sometimes sort of justify why he lives that way because the world simply isn't safe, that's why you need to stay at home at the computer world and, you know, he is afraid of going out, and it is all very reasonable".
> Andrea, p.3

Actual experiences of abuse and attacks fed into a perception of the outside world as dangerous and then were used as a justification for withdrawing. Marion's patient had been attacked. Marion said that her patient had already been afraid to go out before this incident and she thought that the attack wasn't severe, but "this attack was used by him as another reason why he should not go out" (Marion, p.4).

The outside world, and other people, not only seemed to be perceived as dangerous, but also as pressurising and demanding. Several interviewees spoke about their patients' inability to cope with everyday demands. Steven said of his patient:

> "Other people are scaring her in all sorts of ways, making demands on her, to have to go out and work, or to play a part, and they might have sexual demands, or demands on her feelings".
> Steven, p.8

Interestingly, this particular patient was described as being a feisty girl in her latency years, who fought against gangs on her estate and protected younger children. Steven said that this changed in the patient's adolescence when she started to have panic attacks. Her parents responded to this by taking her to hospital, leaving her

anxiety uncontained and amplified. Her panic of the outside deteriorated to such an extent that she stopped leaving the house. Before she started the therapy she had not left the house for nearly a year, and her self-neglect was so severe that services were close to admitting her to an inpatient unit.

The YouTube clip that I showed the interviewees portrays a scene where the person tapes up his window with Gaffer tape, more and more, until only a small gap to the outside is left. After a hesitation he tapes that up too, closing him in completely. During the interview, Mike refers to this scene.

> "When I was watching the video I was thinking of her, in the clip when the lad was putting paper on the wall and there was increasingly less of the world. That's what she did; there was a bit in her that was in the world, and that bit is severed, that bit *she* severed a bit at a time, bit by bit".
> Mike, p.3

Mike's patient had been in an inpatient unit before the start of the therapy. She had several spells where she refused to go to school. The most recent time she was at school, she could not cope with the demands of school and got her timetable reduced. Still unable to cope, it was reduced further, bit by bit, until "nobody [was] telling her that she needed to go" and she stopped going to school altogether (Mike, p.3).

Steven and Mike's patients are good examples of what Saito (1998) referred to as a vicious cycle, where the increased isolation due to their withdrawal made the outside world a more unknown place, which in turn increased the fear of the outside world leading to further withdrawal.

Anxiety over doing things, and a limited ability to cope with everyday tasks, was another factor mentioned by the interviewees. Steven described his patient as not able to cope with more than one thing each day, like going to the shop, or going to the therapy session, each activity filled up her whole day preparing for it and recovering from it. Furthermore, Steven thought his patient was not able to hold two things in mind. He realised that when he would use 'on one hand… on other hand' types of interpretations, his patient would only hear the first part. Andrea also spoke about how her patient felt pressurised by any social interaction or everyday

activities. Andrea was often worried that she might be perceived as too demanding on him.

> "The concern I had, that I always have in my mind; one of them was: am I actually pressurising him, as he says? Should I be a bit, am I putting some of my anxiety into him? By wanting him to move on, to move forward, as I was always thinking about that, and another side that was always present in my mind, is he ever going to manage to, to move on a little bit, get out of his house, to connect?"
> Andrea, p.6

Andrea is questioning her wish for her patient to move forward and whether she is pressuring him. Her patient seems to perceive this wish as an expectation and pressure. Anyone trying to help someone with this fear, be it a parent, teacher or therapist, would be in a tricky situation, as any help is likely to be perceived as a pressure to change and to do something different. Paula described how any time she approached the subject of thinking about work or training, it triggered such anxiety in her patient that any further thinking became blocked.

Interestingly, there were some differences in terms of the patients' attitudes towards the realities of the external world: some interviewees reported that their patients had no realistic evaluation of the future, and the limits of being provided for by parents, while existing in a room not doing anything towards sustaining themselves. It seems as if their minds have become closed to the external. Other interviewees reported that their patients did appreciate the necessities of the external world, for example the reality of needing of a job, but felt paralysed by their perceptions of the external world's pressures and demands. Perceiving the outside world as risky, and as making demands that the withdrawn person feels they cannot live up to, is a theme that is referred to in several studies on Hikikomori (Hockings, 2013; Husu & Valimaki, 2017; Nae, 2018; Saito, 1998; Yong & Kaneko, 2016).

Feeling unable to cope with these perceived pressures of the outside and the social world, the young person withdraws into the safety and predictable space of their room. As Paula said: "Home was like a cocoon to her" (Paula, p.1). I would now like to focus on a particular place that some of the interviewee's patients retreated to: the cyber world.

Retreat into perceived safety of the cyber world

Unable to cope with the outside world, with its perceived everyday demands and dangers, which had become a justification for retreating into their own four walls, for several of the patients the computer offered a seemingly perfect vehicle to realise the wish for a retreat into a safe and predictable world. Out of the seven therapists, five reported that their patients immersed themselves in computer activities. Marion described her patient as “addicted to computer games for a very long time” (Marion, p.1), and Mike said that his patient would be in her room and “smoke, eat rubbish, play music and play on the PlayStation” (Mike, p.6).

The man portrayed in the YouTube clip spends his days asleep and his nights awake, playing games on the computer. I asked whether this resonated with the interviewees. Many of the interviewees referred back to this clip at various points during the interviews.

> “When you see (in the film clip) all the lights going off in the night, with only one light one, it really made me think of him, because he used to swap day for night. He really struggled generally with having a sense of a routine, um, and he would spend a lot of time in front of the computer, and I think that during the day there were more demands, household demands, demands of his family […]. So I think he used to spend the night withdrawn into the computering *(sic)* world”.
> Andrea, p.1

Another therapist, Steven, also associated with the film clip:

> “The link I have in my mind was sleeping during the day and taping up his windows in the film and sort of destroys the rhythm of day and night. And this young lady who I see, one of her complaints is that she has difficulty sleeping and there is a part of her that is aware, but she doesn't help herself with basic sleep hygiene, like not playing on the computer just before she goes to bed, but she just can't, has not found a way how to stop. She'd play all night”.
> Steven, p.1

The psychiatrist described this group of socially isolated patients as retreating from the daytime world with a reversed sleep pattern (psychiatrist, p.1). The reversed

sleep-wake cycle creates another vicious circle. As Saito (1998) explains, the combination of the physiological effects of daytime relaxing (disturbances in the balance of the autonomous nervous system, including insomnia, lack of exposure to sunlight, and disturbance of the body clock),and psychological reasons (low self-esteem, and feeling bad about spending another pointless day) makes them want to hide away from other waking people. It is important to note that Saito's study found a high incidence of a reversed sleep-wake cycle amongst Hikikomori people, and this is before the widespread use of the internet. It indicates that using the computer in the night is not the primary motivation underlying this phenomenon. I wonder if the unconscious motivation is about sleeping through the daylight hours, with daytime being associated with the world of people, of work and expectation and demands. Daytime is the time when other family members are awake and might be demanding engagement.

To what extent the computer is a vehicle to assist retreat, and how much it is a vehicle for contact, is an important question, and one that cannot be answered straightforwardly. Using the computer will have different meanings to different people and at different times. Interchanges on the computer can provide a first step out of withdrawal, trying out social interactions in a space relatively free from commitments and consequences of their actions (Turkle, 2004; Kantrowitz, 2009). Julia for example describes her patient as depending on the computer for staying in contact with other people.

> "Totally dependent on email and the whole of the internet, specifically getting messages. One of the things that I've noticed about her when I started working with her was how much it really felt like that was her one contact with the world".
>
> Julia, p.1

It is not clear how Julia's patient would get the contact details of people she has not personally met. However, direct messaging implies some form of an ongoing connection, a to and fro of interchanges with another person, which I would say is closer to relating than other forms of internet activity, such as gaming or browsing. Maybe the patient felt more in control of, and hence less anxious about, social contact on the computer in contrast with the more unpredictable face-to-face interaction (Gibbs, 2007). Julia said that her patient was "aware of how limited her

controlling is once she goes into the world of reality" (Julia, p.4), and makes the point that, compared to the unpredictability of the world and of people, "if you are staying in and I'm not coming out at least you know where you are" (Julia, p.5). Interestingly, this quote could mean two things, depending on whether the 'you' is a personal or generic pronoun. Staying in, one knows where one is. If the 'you' and the 'I' in this quote denote two different people, it means: 'If you are staying in, I know where you are', which could continue: 'and therefore I know that you have not left me'. In either case, the staying-in-world conjures up feelings of safety and security, where everything including the object is controlled. This self-created world is felt to be predictable. You know where you are.

Unlike relationships with people, the computer can be controlled. You can create your own world and in your avatar can recreate 'your self'. Everything is available at the click of a button, giving you immediate gratification. You don't have to wait. As Steven said:

> "[…] she has created a world with as minimum frustration as possible. All this gratification, and the games […]".
> Steven, p.3

Due to its global reach, if you want to communicate or game with someone, someone somewhere is always available. Like a breast that never stops giving, the screen mother is always available, can be turned on and off, and gives the illusion of control over the other that loss can be evaded (Gibbs, 2007; Lemma, 2014 and2015; Malater, 2007). (Until it crashes!).

The therapists described how their patients felt comfortable in this world. Julia for example said that the patient felt admired and valued in the online gaming world.

> "…so for her it's a lifestyle, and the trouble with it is that it's got too much, it is actually ..it's too good, too appealing. I mean if you'd have to choose between an exciting, beautiful, very well done computer game, the opportunity to speak to someone all over the world […]. It's all, better then real life, and more comfortable, if you want to talk to someone, someone will always be available somewhere".
> Julia, p.9

On the internet, Julia's patient could immerse herself in a beautifully created world, engage and disengage with other people immediately, and create a self that is admired by others. Here, there is no challenge and no difference to rub up against.[14]

One of the first versions of a virtual world where people could create their own characters (avatars) to inhabit a virtual world, and engage with other avatars, was aptly called 'Second Life'. As discussed in the previous theme, most interviewees had described their patient's fear of potency and intimacy, and a holding on to an identification of being sick, impotent, and not able to do things. To a person inside a withdrawal state, the cyber world could indeed provide a second life, a chance to be someone different, someone potent, and someone not afraid to interact, and a refuge from their bodily existence (Lemma, 2014).

Some of the patients involved themselves in the world of animees, following particular characters and the stories of these characters. Animee is a style of hand-drawn and computer animation originating in Japan. There are different genres of animee, consisting of artistic drawings, storytelling, series and films. Fan clubs have evolved around particular characters of animee. For example, for Marion's patient the animee world offered him a world without aggression, a world with ordinary friendships, friendships he himself did not have.

> "[the online cartoon videos are about] how to deal with situations and friendships and the people are nice to each other in these cartoons, they don't behave in the way that people do out on the street and in school; that's what he tells me".
> Marion, p.2

While identifying with this animee, patients could experience a life and a world that wasn't threatening. In primary school, Marion's patient played Minecraft, a computer game involving building things. As he got older he proceeded to post online horror stories he wrote, though Marion did not know the extent of this or

[14] I would like to mention here that Paula's patient, one of the two patients who did not engage in the computer world, had another idealised world that she retreated into: she would obsessively read romantic fiction, and then imbued the real world with this fictional world, where she would obsessively fantasise about people she barely knew and whom she believed were in love with her.

whether he was interested in how other people perceived his stories. He then got involved in a fan club of a particular animee genre, involving a character adapted from a young children's comic.

> "He describes it as a community on the internet, all they talk about it, some of them actually meet up, he is aware of this but he would never do this […]. He just enjoys watching the videos, and the story lines, and the kinds of comments that people make about the series. It's quite idealised.
>
> *So then he would follow other people's comments?*
>
> Yes photos and people's comments about it […] I think infers a great deal from other people's comments online, and he makes judgements about their personalities, and the kind of people that they are, and what they may be like to socialise with. So he has in mind that some of these people that he could be friends with, even though he doesn't actively pursue that, communicate that.
>
> *So does he do that in fantasy?*
>
> Yes I think he does… um… But then he does have people he communicates with whilst they are playing games online. He seems to think that is enough for him because he enjoys it. He does recognise that if he spends all his time doing that, he never does any homework, and you might not get a good job and that is something that he wants.
>
> *He wants a good job?*
>
> He wants a good job because he wants to be comfortably off so he can do what he wants to do.
> *Which is?*
> Which is to play computer games (*laughs*)".
> Marion, p.8

It is clear that this patient is actively engaged with other people, albeit through the internet. He builds worlds out of blocks in Minecraft, he posts his own stories online and he watches and reads other people's creations and their opinions about others' creations. He is finding out about people and relationships, an important part of adolescent development, in an indirect way. He is involved in a fan club that seems to provide him with a sense of belonging to a community. Weinberg (2014) argues

that our conflicting need to express our individual identity and to feel belonging to a group is easier to negotiate on the internet. Interestingly, the fan club Marion refers to revolves around a children's comic adapted to adult audiences. Maybe there is a part of a negotiation of adolescence here, with its yearning for a childhood lost. The stories of this animee are idealised versions of reality, like an escape into a Peter Pan world without the pirates (aggression).

The cyber world also might be seen as a simpler compared to the complexity of the real world and real world relationships. Steven's patient, who struggled with keeping more than one thing in mind, would create avatars for computer games which could only be made with one characteristic at a time. Unlike the complexity of humans and their relationships "there can't be two traits at once, they can't co-exist" (Steven, p.5), effectively getting rid of ambivalence or mixed feelings.

However, the repeated experience of immediate gratification of need does not allow for learning to tolerate the inevitable frustration of life and relationships. Being immersed in this non-real world without being challenged by the real world, there is a danger that over time the fictional world comes to be felt as the real world. As Julia said of her patient, who had a whole network of friends on the internet: "she felt that this was a world that was valid" (Julia, p.1).

Learning to bear a gap between wanting something and its gratification is vital for development of thinking (O'Shaughnessy, 1964). We need this gap for our experience to be represented, a place to think about what isn't there at that moment, and, as Lemma (2014) warns, sustained experiences of immediate gratification might have far reaching consequences. Although Sharon was not aware of her patient being involved in the cyber world, her quote below nevertheless outlines what happens if one is shut away from the world.

> "I think part of his difficulty was identity. [...] If he were a teenager in the outside world he would be testing out some of these identities he was forming, experimenting, um, and this was a young person who was trapped in his room, so there wasn't anything from the outside world to challenge those thoughts he was having about himself and others".
> Sharon, p.4

As discussed in the 'fear of changes' section, the therapists struggled to challenge their patients even in the most gentle ways. The withdrawn state is fortified to such an extent, it disallows any challenges. Isolated from others, no alternate perspectives can enter the withdrawn system and there are no challenges to fixed thoughts. No real-life social interaction can be practised. This seems to be reflected by, as well as recreated in, the patients' use of the computer.

While in the longer term being immersed in the cyber world might increase withdrawal, in the short term the internet provided the patients with a sense of belonging to a community. Playing online with a group of people not known in non-virtual life does often engage a feeling of belonging, as many young people and adult gamers will tell you. Maybe for our patient group this kind of contact felt manageable, and prevented complete isolation; contact that indeed became a lifeline. "And I think it probably did save her from committing suicide, she wouldn't have been able to cope without it" (Julia, p.9).

In their meta-analysis, Sarchione et al. (2015) argue that the internet forms a sort of 'emergency exit' that prevents Hikikomori from becoming suicidal. Saito (1998), speaking in the context of the early period of internet use, advocates a positive view of the withdrawn person's obsessive and singular interest in screens, stating that maintaining an interest in society, even if that is via a television or computer screen, keeps some link with society.

In the longer run, however, there is a real risk that the retreat into the cyber world increases the withdrawal state. This seems reflected by a process that seems to be happening in some of the therapies whereby the therapy itself became drawn into the withdrawal system.

<u>Therapy becomes psychic retreat</u>

Several interviewees described how they, at times, questioned whether the therapy itself had become drawn into the withdrawal system of the patient. For example, Andrea described how her patient's obsession with the computer world made her feel so shut out, that the therapy itself seems to have succumbed to a retreat inside the computer world.

> "I often felt he tried to reproduce this solitude in the room with me and sometimes he related to me as if he was by himself with the computer […].

> He would just go on and on and on, ten, twenty minutes talking about computer things, using a very technical computer language. I told him that I'm not acquainted with this language and I asked him to explain initially […], but after a while I realised it was not really the meaning of the words; it was more a way to disconnect.
>
> *So the way he communicated was to block you out?*
>
> Yes to block me out and to (*tries to find the words..*) really (*blows out*) you know, to really (*blows out as if frustrated*), to continue to be isolated in a way, to stop the possibility to engage in any way in relation to me. Um, and in the initial period of the treatment I felt that this was really his anxiety, anxiety of being in the room with someone else. […] But as he became more used to me I think he was getting more comfortable, but he would still from time to time resort to this sort of, this sort of: this place of his own, his own mind, really disconnecting, and going on talking for hours about computer games, or some (*blows out*) using some technical terms in creating computer games and things such as these. And I often found that thinking about the symbolic meaning behind this story that he was creating was not really the point, not really helpful, it was more a way of communicating these states of… isolation".
>
> Andrea, p.1

Andrea became increasingly frustrated while she told me this. I wonder if this sense of frustration originated from a feeling of exclusion. Here she is, trying every effort to engage with this person, to understand what he is talking about, while his mind instead is linked with the computer, using technical language the therapist doesn't understand, effectively excluding her. Lingiardi (2008), working with a patient who used cyberspace like a psychic retreat, describes how she used to feel in competition with the computer and had to tell herself that a computer cannot feel pain and thus is incapable of reverie, of transforming projected emotions. Looking at this through a framework of projective processes, Andrea's frustration here could be thought of as a holding and transforming projected emotions that the patient had communicated: feelings of exclusion, disconnection and isolation.

The sense that the therapy has become another form of retreat had become one factor in Andrea's decision (in discussion with her supervisor) to end the treatment (after three years).

> "I think he… coming here to see me, became an end of itself (*laughs*). Not a bridge to help him connect with others around. As if coming to see me was fulfilling and he didn't need anything else, as if this was something that could go on for ever, as if I could replace all of his relationships, as if I had become a very good friend, an inseparable friend who would always be there for him, all this sort of fantasies I think were around, and we were exploring together. And this actually was one of the reasons why I decided to end the treatment, because I think there was a risk that his therapy would just become this isolated experience rather than a bridge".
> Andrea, p.5

By deciding to end the treatment, Andrea had in fact emphasised a boundary, a message that the status quo cannot continue endlessly. Unlike the gaming world that he was immersed in, real-time contact with a real person cannot be had on tap endlessly. In reality there are boundaries. By providing a boundary she was trying to reach the patient, to remind him of the reality of the world.

Paula was also considering providing a boundary and ending the therapy. Her patient regularly attended the session yet did not seem to use it in a meaningful way. I asked Paula what she thinks motivated her patient to come to the sessions.

> "I think that, I had asked her many times, I think that, there was this, that was the unloading bit, a sense of relief, it was a bit, it was a bit predictive *(corrects herself:)* addictive. Addicted to the sessions, and that was part of the problem. That she was, there was an element of self-soothing, which wasn't terribly helpful, but self-soothing within which she then couldn't continue, it wasn't kind of self-soothing which was long-lasting, just…(*interviewer: In the moment).* In the moment, yeah, and also it was the place where to go. […] It was like an outing!"
> Paula, p.9

At another point in the interview, Paula spoke about her questioning of how much longer the therapy should continue while there seemed to be so little shift, and she

stated “this bubble, this therapy bubble couldn't go on and on” (Paula, p.5). She is wondering whether the therapy itself has become part of the patient’s retreat, a self-soothing activity, like a pleasant outing.

Having outlined the type of relationship to the world these withdrawn patients seem to have, and the retreats they use, I will now look at what might be underneath.

Fear of contact

> “He wouldn’t dare to come into contact with other people’s minds”.
> Sharon, p.5

The external world equates to other people, and just as the external world was perceived as unsafe, so did any contact with another. The fear of contact was a theme that ran throughout the therapies. Contact with another person, another mind, was experienced as extremely painful.

> “Anything that vaguely moved would generate terrible pain [in her leg]. I think that’s, I think that’s what I felt ‘thinking’ was doing to her, or talking, that it was as though...it was just unbearable.[…] the sessions were like, using the image of the leg, it was like being around the leg without touching it”.
> Paula, p.7

It is interesting how the description of physical pain was also very relevant on a psychic level. As with others, this patient could not bear any movement, any changes. Paula felt the sessions were repetitive cycles (the metaphor of unpacking and repacking the car boot) without any sense of anything moving. It is interesting that the patient complained of pain in her legs - the legs are what make our bodies able to move. It might be that this patient’s whole body mind system was expressing a fear of movement. Relationships are also based on movement - we move towards an Other to make contact. Touch being experienced as extremely painful by her patient, Paula had to move around her without touching her.

How much contact was felt as bearable also had a bearing on the frame of the therapy. One of the therapists in this study had to adapt the frame of the therapy to having phone sessions. This was the only way that the patient could bear the therapeutic contact. It is interesting to note here that while phone contact might provide one with more control, as it is more distant, there is also something more

intimate about it, as the therapist's voice is literally transported into the patient's room and the patient's ear. Another difference is that phone sessions were initiated by the therapist i.e. the therapist is calling the patient, rather than the patient coming to see the therapist.

Another therapist, Sharon, reflected that once-weekly sessions were about as much contact as the patient could bear. "Anything more frequent would have been dangerous" (Sharon, p.7). This reflection had followed a conversation about Sharon's fear that she might cause harm to the patient. In Sharon's description of the therapy, there was a sense of intrusion being associated with the contact with another mind. Sharon described how sometimes ill-timed interpretations made the patient flinch, as if in pain from a sudden unexpected intrusion.

> "And sometimes it felt as if my words were penetrating into his barrier of his mind or skin, or wherever the unconscious can get in there, and really disturb him".
>
> Sharon, p.6

Sharon expressed the importance of her own analysis, to mitigate the potential of an unconscious retaliation towards the patient which she felt possible within this transference/ countertransference dynamic. "[I]t's that toxic", she felt (Sharon, p.6).

Steven also expressed a sense that the patient experienced words and contact as an intrusion, and as 'being done to'.

> "It's like my thinking is not how we might think of as thinking.. to her, it is like doing something to her, is very bad, or sexual, not the kind of thing that it'd be me thinking about her. I think with two minds in the room it'd be very difficult".
>
> Steven, p.8

The above described how the therapists thought that their patients' perception of contact was something extremely painful, as risking stirring toxic disturbance or as bad sexual intrusion. If this is the case, such a severe perception of what contact/ being touched by another person meant, it would not be surprising that extreme ways are needed to cope with this. One of these ways (defences) seems to be a denial of a need for others. Shutting yourself away in a room and not engaging with others and the outside world could be seen as a statement of: I don't need you.

Denial of need for others

> "I think initially he wanted to simply forget that I was there and somehow closed me off, or trying to make me disappear or put me to sleep".
> Marion, p.5

The patient's retreat offered a predictable, safe, secure and comfortable way of being (and with those patients who used the computer world, this was also recreated there). There seemed to be a denial of the need for others[15].

Julia described how her patient was often left alone at home when she was a child, and that now as a young adult her patient was recreating this situation.

> "I can understand how she is somehow repeating something, which is about being stuck by herself but she has twisted and turned it into: 'I don't need the outside world anyway'".
> Julia, p.2

Protecting herself against the hurt of her childhood experiences of neglect, Julia's patient seems to have developed a defensive attitude of not needing anyone.

All therapists stated how they often felt isolated and shut out by their patients. The therapists' feelings in the sessions were frequently described with words such as: feeling sleepy, drowsy, heavy, bored, and draining. I wonder if the difficulty with keeping alert and awake may have to do with not feeling emotionally engaged with the patient. In some cases, the therapists felt shut out to such an extent they felt that in the sessions their very existence was being denied by their patient. For example, Steven described how he felt he had to make a conscious effort to stay alive inside the patient's mind.

> "I get a somatic transference sometimes where I want to yawn in the room. When she has left the room, nine times out of ten, I always stand up and yawn and stretch. There is something that shuts down. And it's hard to stay alive. ..(*Pause*)…I think in her parents' mind she's been killed off".
> Steven, p.8

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[15] *In some of the patients, there was a family member they seemed merged with, to the exclusion of anyone else, which I will discuss in the next them.*

Steven had to actively keep his mind alive and thinking, and struggled to keep the patient alive inside his own mind, to avoid 'getting killed off' which he thinks may have happened to his patient inside her parents' mind. Similarly, Sharon described how she felt that her very existence felt denied, how she felt formless to the patient and at times in the countertransference to herself, and one of the main markers of change within the therapy was that she had "become a real presence" to the patient. I would like to quote at length.

> *"What do you feel you were you to him, and how did that change over time?*
>
> Um, what was I to him?… I think to begin with, I don't really think I had much of an identity actually. From his perspective, what was I to him, that is very difficult to answer because in the beginning I think he… I think I lacked colour. At one point in these early months I felt I almost lacked form. As if I did not have a (*laughs nervously*) skeletal structure, as if I was just (*speeds up)* kind of something there (*almost taken over by the next words)*, but I think there must have been something about, there must have been some hope that something was there, otherwise he would not have come to treatment, and then in time he filled me up to be a real presence in the room, and a presence in the room that helped him to make sense of some of the bizarre and strange thoughts and passions that he had. And I think it helped him. It was interesting, it felt as though he became more conscious of his own body as we went on, and that is because I think he became more conscious of my presence... (*pause)*…as a woman […], and so he started to notice what I was wearing, how I was dressed".
>
> Sharon, p.5

This is an apt description of a development from a nebulous unformed and bland 'something there', to an awareness of another person with a separate body and mind. Bick (1968) describes how in the young baby the skin is felt to hold all the parts of the personality together. Without such a 'psychic skin' the baby is left with such primal terrors such as fragmenting, liquefying, and falling into space without a spacesuit. Applying Bick's concept to Sharon's description of her patient, we could speculate that her patient hadn't fully developed a 'psychic skin', providing structure, form and boundaries to his mind, and used his retreat as something to cling to like a second skin (Bick, 1968 & 1986).

At another point Sharon spoke of the challenge of having to hold on to one's own sense of identity in the therapy room.

> "I think one of the things that these children do, particularly when so withdrawn and not speaking, um, [what one has to do] is actually holding on to your own sense of identity and as a clinician, and a sense of capacity that you can work with this patient".
> Sharon, p.4

I wonder if this gives us a clue about one of the factors underlying this fear of contact and the need to deny the other's existence. One way of understanding the blocking out of the other could be as an attempt to hold on to one's sense of being, and identity, in the face of the primal fear of one's existence being wiped out (McDougall, 1984; Symington, 1985; Emanuel, 2001).

Marion spoke about long periods within the therapy where she felt desperately stuck and felt:

> "this hideous drowsiness, that would come over me when I come into the room and I tried… I tried to stop him to draw so much because that was kind of a way of closing me out".
> Marion, p.10

Marion felt that his talking and drawings were not in the service of communication, but more to exclude Marion.

> "He tells me about the things he's interested in, and has not been particularly interested whether I be interested in them, it is very much his interest and him choosing to talk about it or not".
> Marion, p.7

Marion felt that over time this changed. He started to feel proud of his drawings "for their artistic value and (has become) more interested in other people seeing his work" (Marion, p.4). Marion did not feel drowsy anymore, but interested. Her patient had become more aware of others' interests, awareness of how other people see his drawings with a more objective artistic eye. The drawings initially seemed a way to shut out the awareness of the presence of the other, and over time seemed to become a medium that could serve as a bridge to engage with others, an interest in how others might perceive something he has created, and be interested in it.

Several of the other therapists had also mentioned that over the course of the therapy the patients developed an increased awareness of themselves, of the therapist in the room with them and of other people. Becoming more conscious of the other and feeling more interesting to the other could become a motivation for looking after oneself more.

Having explored various aspects of the theme of relating to the outside world, I will now turn to the next theme.

Theme Three: Boundaries

Boundaries has been a theme that appeared in various different forms. The withdrawal state itself can be seen as forming a boundary between the person and whatever, and whoever, the person is withdrawing from. In other instances it is the lack of a boundary that seems significant. I will explore the sub-theme of there not seeming to be a sense that time has a boundary, but just goes on and on. Relating to this is boundaries and the lack of them, in terms of the physical space, being discussed. Further there are the boundaries between people, and again the lack of them, where the person seems merged with another. The lack of care for oneself also relates to personal space and how that is being perceived. Feeling trapped inside a tight space or feeling encroached by the intrusion of another person's space is discussed in claustrophobia.

Sense of timelessness

In several of the interviews, at points where it felt relevant, I had asked about how the therapist experienced *time* in the sessions, and if that changed. Several of the interviewees had already spoken about their patients' attitude towards time in relation to the boundary-less world of gaming and the internet. The sense of there being no boundary to time was also reflected in how the interviewees perceived the length of the therapy contract. This ranged from one therapist stating their patient "could stay in therapy forever" (Andrea, p.6), to another feeling the therapy "could go on and on" (Paula, p.3), to another who did not stick to the original plan to end but instead "the therapy just happened to continue" (Sharon, p.9).

A sense of drowsiness and sleepiness was mentioned by several of the interviewees, and potentially this may have been connected to the sense of being stuck in time.

> "And then this sort of malaise, sleep-like state, I think there was timelessness in that, um, the sense that time just wasn't passing […]. Well, I thought there was something I could do (*energetic*), to kind of shift this stuckness, and this, this hideous drowsiness, that would come over me when I come into the room". Marion, pp.9-10

The sense of 'forever' is likely to partially relate to how boundaries and separations were being experienced by the patients. Mike and Paula said that their patients, right from the beginning of the therapy, complained of having to end. This sense of separation being felt as catastrophic left the therapists feeling guilty when considering an ending. So the therapists seem to be in a situation where the sense of 'nothing changing' and 'being stuck in a moment of time' was accompanied by their patients' demand or desperate plea that the therapy should be unlimited.

Bartram (1999) described her work with an autistic boy who seemed to create a sense of timelessness by "fragmentation, so that moments are a series of dots which are not interlinked" or "by the endless repetition of an action" (p.141). This seems to be happening in the therapies here. Andrea expressed that whether the therapy was two or four years would have made no difference, that the extra time had no impact on the patient. The passing of time seems to have been rendered meaningless. Paula's description of "opening up and talking and then closing everything and then back to square one" (Paula, p.2), as discussed in the 'Being stuck' section, indicates another way of how timelessness seemed to be created in the dynamic of the therapy.

Andrea described how at times she experienced ten minutes like an eternity.

> "I think I was always very conscious of time and he did too (*laughs*). The clock was next to him and he would look at the clock quite often, and I think I did also look at it often.
>
> *You mean in the sense of: I can't wait to get this over? Or the sense of that there is not enough time left? Or…*
>
> Sometimes I can't wait to get it over and sometimes I'm really curious because it felt like an eternity when he was going around and around, and I wanted to know how long was it was going to take (*laughs*), how long did it last? Then I would say: wow, 10 minutes, that's really hard.

And it felt like a lot longer than that?

> A *lot* longer, and sometimes I would use the clock to measure how long is this likely to be happening, in some ways that's how I found ways to manage it. And I had these limits, after 20 mins I had to do something. I think I used to play around with the clock, like I would think: how long am I going to leave it, or: I observe how long he is going to go on with this, or: is he going to do something different? So in that sense I was quite aware of time (*at that point the tape cuts off*)".
> Andrea, pp.11-12

Andrea described how she used to cope with this by measuring time, to assure herself of the clock's hands moving forward, assuring herself that time was indeed passing and not stuck in one place. The clock is a tangible reminder that there are boundaries in place, reassuringly coming from the outside (and hence unable to be manipulated). Just like in the interview, Andrea and I are being reminded of the boundaries of time by the tape cutting off!

Sharon also experienced the sense of timelessness:

> "There were these subtle movements, whereby it felt as if he seems to have really started to notice me in the room, and everything became so magnified, (*laughs*), sometimes it felt like those 50 min, like we had always been there together. Just (*inaudible*), in terms of the sense of time, just the intensity of being with him during that time, and then there were other times when those 50 mins would go (*breath drawn out*) so (*drawn out*) we'd been there for a year in those 50 min".
> Sharon, pp.2-3

Sharon describes here two very different qualities of feelings of timelessness: the sense of time having stopped with no past or future, and all the senses magnified into the very present moment creating an intensity of contact. This was very different to other moments where time felt endlessly drawn out and not moving (which Sharon's manner of speaking at the end of this quote reflects). Both moments depict a sense of timelessness, the difference being in how the present moment was being felt: either engaged, and at one with the world, and contact with the person in

the room, or more of a lost, shutting out, state, being withdrawn from the world of contact.

Boundaries of time and space

At another point in the interview, Sharon described how her patient in the early phase of the work would face the clock-face rather than the therapist, and over time, little by little, moved towards facing the therapist. Boundaries of time and space are connected. One could speculate that her patient's orientation towards the clock rather than the other person in the room stemmed from a need to see the clock showing time moving minute by minute, and as such giving a structure to time and a boundary to the session. At another point in the interview Sharon described how her patient needed the physical boundaries of the room.

> "Those edges, where the ceiling meets the top of the wall, where the ceiling is, that was quite important, […] trying to find a ceiling to his thoughts, needing to know that he could trust that whatever it was in my mind, it contained these sense impressions, that these four walls would (*pause*) […] It was more about trying to see whether there were any gaps, did the ceiling meet the top of the wall and the wall go to the other wall.
>
> *Boundaries*
>
> Yeah, very straightforward boundaries".
> Sharon, p.6

At another point Sharon said: "What I had was the four walls and the clock (*laughs*), um, and the way he related to the four walls and the clock, that was what I worked with, that was my box" (Sharon, p.8). The boundaries to the physical space in the room were important, and the shifts in how the patient seemed to perceive these boundaries were meaningful and signified inter-relational dynamic shifts.

Sharon noticed that over the course of the therapy the sense of time came to be felt as more realistic, so that 50 minutes felt like 50 minutes. This coincided with the patient's use of space at home, in that he would now occasionally come out of his bedroom and go into the kitchen. Feeling more grounded in external reality and anchored to another mind, to other people, the patient was able to venture out from his four walls to a shared space associated with nourishment.

Marion similarly experienced her patient as, over time, becoming more engaged and living in real time. She planned an ending with her patient, a year ahead. It is interesting that when this boundary of time was set, something changed.

> "I had a sense that things would go very, very, very slowly… Yeah, there was a certain timelessness in the way he used the sessions, and as we worked towards an end we had to be very focused, each time we count down and he became very aware of the ending. And I think he did pick up a bit, the pace did begin to increase a little bit towards the end, so it might be that having a shorter duration would be helpful to him as it might actually encourage him to use it more actively. Just a sense of something running out, the awareness of things don't go on forever, might be helpful".
> Marion, p.9

The realisation of there being a gap between the ideal and the real, between what he wanted and what he can have, was a real development forward (Bartram, 1999). Both Marion and Sharon described a process whereby their patients seem to have moved from a denial of the reality of time passing, towards an awareness of boundaries of time and space, and this seem to activate an increased engagement.

<u>Interpersonal boundaries</u>

In my interview with the psychiatrist I had asked whether, from his experience of working with withdrawn young people, he could see any patterns. He thought that one pattern might be an enmeshed relationship with a parent. He gave an example of this.

> " So like in school refusal, mum might ring up and say that their child has a tummy ache, or headache, so rather than what I expect a more robust parent would say, like: he is perfectly fit but I can't get him to go, and that would go down as an unauthorised absence. Whereas a parent who is trying to keep them out of trouble, or might accommodate their child's wishes, would say: he can't come in because he's been sick or got a headache, so they go down as an authorised absence, and that can lead to trouble as things slowly develop".
> Psychiatrist, p.5

Whatever this parent's reasons were for lying to the school, and it might have been the fear of fines, it does show a difficulty with boundaries, both in terms of setting

limits as well as in terms of boundaries between the parent and the child as two separate people. It is interesting that the psychiatrists' thoughts were echoed by five of the interviewees, describing their patients as having a too-close or an enmeshed relationship to their mothers and/or siblings, even though I had not asked the interviewees about the family background of their patients. Speaking about a parent review, Marion said:

> "there is something almost more sibling-like about the way mum describes their relationship. He himself seems to think that at some point in the future he would grow out of the need to share a room with his mum".
> Marion, p.5

Earlier in the interview Marion spoke of her struggle to keep focused against a "heavy draining sleepiness" (Marion, p.4) that was induced in her, and at the point when she spoke about the patient changing, and becoming adolescent, Marion's energy during the interview changed, and she became more lively.[16] Within psychoanalytic theory one way of understanding this sleepiness could be as a way of projective identification induced in the therapist in an unconscious attempt to merge, in order to deny boundaries and avoid the realisation of separation and hence of loss (Gibbs, 2007; Rosenfeld, 1964).

Andrea spoke about how she experienced a dynamic in the therapy room that made her wonder, in the context of her experience of her patient, whether her patient unconsciously was wishing to merge. This patient had a close relationship with a sibling, and when the sibling moved on and became more independent from the family, the patient was left lost in aguish and despair.

> "He was always searching […] for someone with whom he could become *one* again, he used to say that, you know, that they were one, together, and now he is half, and he hates being half, and so very often I felt that if I was not present he would just be half a person (*laughs*) again, without a sort of (*laughs*) an engine, or… yeah, to move him forward, so I think in some ways this was played out in the dynamic".
> Andrea, p.7

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[16] Full quote discussed under Theme 4.

Andrea told me that she felt that her patient treated her as if she wasn’t a separate person in the room, and she believed he had a fantasy that she could replace his sibling. The way he talked to her in a monologue, about his computer interest, without seeming aware that she didn’t know this world, even though she repeatedly told him that she didn’t understand, might be an indication that indeed he did not see her as a separate person, but assumed that her thoughts, interest, and understanding would be the same as his own.

Within ‘Theme Two’ I quote Sharon’s description of a shift she saw in her patient’s view from a sense of himself and the world being formless, to really recognising Sharon as a separate person, as a woman. Below, she reflects on her sense that her patient struggled with a basic sense of boundaries:

> “I think what he was struggling with that there are normal, whatever normal means, filters that make a distinction between what is rising from the unconscious and conscious thoughts and actions. Those filters that we have that make a distinction between those different parts of mind, and where ideas and thoughts originate. I really think he didn't know, it didn't happen. Or that he becomes so engaged in his own world that there wasn't this coming up against the outside world, that he wouldn't dare to come into contact with, other people's minds etcetera. We started to see the boundaries between self and others”.
>
> Sharon, p.5

Sharon stated that one of the vital aspects that proved to be helpful to her patient, was a slowly sifting out of what was inside and what was outside. She tried to help the patient “to work out in his mind what was real and what wasn't, what was mostly imagination, and making those distinctions” (Sharon, p.3), that is to strengthen the boundary between his conscious and unconscious mind.

Over the course of the therapy, Sharon noted a shift in the patient’s sense of boundaries when he talked about a film.

> “I have seen the film, which was incredible. And it felt like it was kind of one of those moments of synchronicity, of suddenly we were in a place together, we had an understanding, although mine was quite different, but we nevertheless had a shared experience that was something to do with outside of

> the room. And then it opened up something else for him, that I possibly did things outside these 50 minutes and he did things outside these 50 minutes".
> Sharon, p.3

A third space seems to have opened up, allowing a separateness and boundary between them. With a shift towards acknowledging the reality of boundaries of time and space, and the containing structure this realisation provides, Sharon thought there seems to have been a parallel process of understanding that he is separate from other people, that what is inside his mind does not equate to what's out there, and in other people's minds, and that there is a differentiation between unconscious phantasy and more conscious purposeful thought and action. One could speculate that the withdrawal state was a way of having a protective wall around himself, against a sense of being lost in unlimited space and time, and the perceived threat of his mind merging with another.

Another aspect of interpersonal boundaries, and their lack, brings me to my next sub-theme, whereby the person doesn't appear to care about how they might be perceived by others, and their appearance and smell intrudes into the other's personal space.

Lack of self-care

> "She felt herself to be very unlovable, uninteresting to both of her parents. I think that comes into the session as well, her self-care can be very poor, she would wear tatty clothes, she makes herself unappealing".
> Julia, p.4

Five of the therapists described their patients as not looking after themselves, and, as the above quote from Julia described, presenting an unkempt appearance. Not looking after themselves might be an external expression of not feeling cared for internally. Julia thought that her patient's withdrawal was partly due to a re-enactment of childhood experiences of neglect.

> "[She was] so angry against her mother that she wrecked herself, and then ironically replicated, re-enacted the situation where she would be left to rot in her flat, but now it had become something that she had engineered".
> Julia, p.2

In a mechanism described by Anna Freud (1936) as identification with the aggressor, a powerless, passive state of being neglected as a child is turned into an active state of self-neglect. The neglectful object in reality has become internalised, and now as an internal object is exerting its influence. By making herself unappealing, Julia's patient is communicating how she feels inside - uncared for and neglected. Similarly, the psychiatrist described one of the young people he had worked with.

> "Other family members have got up and left, […] so he feels sort of stranded, and he feels that he is (*pause*), he actually said that he feels he is a repulsive lump that nobody cares about".
> Psychiatrist, p.3

Not feeling cared about, and with a neglectful internal object, as with Julia's patient, this young person seems to show to the world how uncared for he feels inside.

Steven's patient had frequent terrifying panic attacks. She, at times, would not come to the session, or would want to leave early, because she did not want Steven to witness her in such an anxiety state. Steven said that this made him think:

> "as if I wouldn't be able to be concerned about her, that I wouldn't have that kind of mental space, be able to look after her in that mental state".
> Steven, p.6

Steven thinks that his patient communicated a lack of faith that she could be looked after when in a vulnerable state. The lack of self-care affected how the patient was seen on a visual level, as well as how the patient was 'taking in' with the perception of smell. When I asked Steven how it is to be in the room with his patient, he responds:

> "The first thing you notice is the smell, part a pets smell, part of not washing and self-neglect, and it is extremely strong and it goes into my lungs immediately and… and…
>
> *What reaction do you have to the smell?*
>
> I want to breathe out and it feels quite disgusting sometimes, but it quickly goes and I don't notice it again, till she has left the room and I'm clearing up, and… Except there have been three or four times when I have smelt it in the

room with her from the beginning to the end, and it has just got right into my lungs all of the sudden, and it's been very interesting when that has happened, it reminds me that the smell is there all the time and…

So when do you think that has happened and it stayed the whole time?

I'm trying to think of an example. It's been particularly […] when she is very angry with me and she hasn't been able to communicate it, I think. I don't know whether this (*pause*). In many ways that makes absolute no sense because it's me who is either switching off or forgetting until those points. Because the smell is there all the time, objectively".
Steven, p.2

Steven thought there was a clear link between the unwashed smell and his patient being angry with him. The patient returning to a session in an unwashed state might be an expression of an accusation of being abandoned, of not being looked after, and being left to her own devices. Interestingly, Steven stops noticing the smell over the course of a session. Maybe the interest in her as a thinking being takes precedence over his perceptual experience. However, at times when the patient is angry, the smell continues to keep a grip on Steven. One way of understanding this would be within Bion's concept of 'attack on linking', where an unconscious dynamic is created of a kind of intrusion on the therapist's body and perceptual apparatus, and hence his mind, which distracts the therapist to such an extent that he momentarily loses his ability to think (Bion, 1959).

Saito (1998) has a quite different take on the Hikikomori's relationship to bodily care. He found that a lot of Hikikomori are overly concerned with cleanliness in terms of other people in the house, yet might live in rubbish inside their rooms. He thinks that it is because they are taking too much care about washing, and take so long in the bath, that it exhausts them to such an extent, that they don't bath often. He also describes that some Hikikomori do not go to the toilet, but use bottles in the room, in order to avoid others in the house.

When I asked the interviewees about changes over the course of the therapy, Julia, Andrea and Steven all reported that their patients' improved in appearance and self-care. It seems that through the regular contact with the therapist, maybe with the

experience of being held and looked-after in mind, the patient's sense of being worthy to be cared for increased, strengthening an internal caring object.

However, one of the therapists described his patient as worsening in her self-care. When Mike still saw the patient in clinic, she looked well cared for. After the first therapy break his patient felt unable to return to the clinic, and they continued the therapy with phone appointments. After several months, towards the ending of the therapy, the patient came to the clinic again. Mike was shocked by her appearance. She looked unkempt, "like someone never leaving the house, not really exercising" (Mike, p.5). And yet at that latter meeting, the patient expressed her appreciation of Mike for being there for her, an appreciation that Mike did not expect to hear, as so often she had told him that "she hated my guts" (Mike, p.5).

It is interesting that the one therapist who reported a worsening in self-care over the course of the therapy, had been having phone appointments. One could speculate that the therapist not visually seeing the patient might have influenced this. Winnicott (1967) speaks of the mirroring containment of the mother: when the infant looks at the mother's face "what the baby sees is himself or herself" (p.112). Mike's patient did experience Mike as reflecting herself back to her, through his engagement with the phone calls and thinking about her, which over the course of the therapy she was able to appreciate. However, Mike did not in fact visually see her, and she could not see herself reflected back in the therapist's *eyes*. One could speculate that the other patients presented themselves as more looked-after in their appearance for the therapists' eyes, while Mike's patient had no interest in her appearance. It might be that on their face-to-face meeting close to their planned ending, she needed to let Mike know the state he was leaving her in.

I would now like to turn to a dynamic which can feature as an aspect of lack of self-care, to investigate what Steve hinted at when he described the patient's unwashed smell going into his lungs, and Steve trying to breathe it out, i.e. the sense of feeling trapped within an enclosed space.

<u>Claustrophobia</u>

All the interviewees had referred to a sense of feeling stuck, both in relation to their clinical work with a withdrawn patient, as well as in relation to how their withdrawn patient seemed to be stuck in their room and in their life. Two of the therapists

referred to a stronger and more viscerally-felt sense of stuckness: feeling claustrophobic.

Andrea describes a persistent sense of claustrophobia engendered within her when in the presence of her patient, and the unwashed smell contributed to this.

> "At times I was feeling quite claustrophobic as well… Because I think (*talks slower*) the way he describes things he would go around and around and around, the same things, a lot of repetition, hum, I remember feeling quite, um, quite, (*blows out as if frustrated for not finding words*), yeah, sometimes quite claustrophobic, like, there's not much air. Adding to the fact that he didn't have a shower every day, had lots of issues with his hygiene so, his presence in the room was felt (*laughs*), in lots of sorts of ways, I often make sure I opened a window before he came into the room because that gave me more of a sense of space.
>
> *So was he smelling? (I talked a bit over interviewee here)*
>
> Yeah…
>
> *...And the smell closed you in as well?*
>
> Yeah. And I think the sense of claustrophobia became very much when I felt, like when there was a window open, some possibility of getting out of this place, and then he would go and cut it, would find some way to corrupt whatever possibility was there to come out of that place, that lonely and repetitive place. Not all the time, but this was like the worse experience I had of him".
>
> Andrea, p.10

The open window seems to alleviate the therapist's claustrophobic feeling by representing an idea of a way out of the repetitive place, as well as a way for the unpleasant smell to leave and a route for fresh external air to come into the room. At another point in the interview, Andrea spoke of how her patient described feeling claustrophobic himself.

> "Whenever there was that extra demand on him, if that day wasn't a good day, […] if something in the [family] dynamic changed, he would feel completely claustrophobic in that place. That's how he would describe it, not having one

> place [for himself], not having anything, quite anxious".
> Andrea, p.10

Andrea's patient experienced demands concretely, as things or people occupying space and crowding him out, and any relational changes leave him feeling claustrophobic. Subsequent to the above excerpt, I asked Andrea whether she had ever thought that her patient was feeling claustrophobic in the therapy room. Andrea did not think that he ever was, though my questions led to a further association of her patient being thrown into a complete state of disorientation and chaos when faced with any slight change in others.

The other therapist who had specifically referred to claustrophobia was Paula. She described the house that her patient was living in with several family members.

> "So it was a very… well, I thought it was a very claustrophobic space […] but whenever I tried to, well, kind of challenge her a bit, well, to address the stuckness in the sessions, it was like the end of the world and… and…
>
> *Did you feel claustrophobic when with her?*
>
> Yes. When I brought it to the team meeting, and the team commenting that she reminded them of the woman in Misery. I actually saw the movie, one of them is terrifying, it was a terrifying movie.
>
> *(Interrupting) The woman in movie is obsessive…*
>
> (*talks over me, as if we are both speaking at the same time*). She gets completely obsessed and she… Well, talking about being secluded, not leaving a space, this man has an accident and ends up in the middle of Canada. And she rescues him, and takes him to her lodge in the middle of nowhere, and she is a nurse, but instead of curing him and helping him, well first she does, and then she becomes obsessed and he can't leave, and she is a big butch woman, and I remember the team's comments and they were completely spot on".
> Paula, p.4

Interestingly, in this excerpt we were talking over each other and didn't give each other any space. Paula thought her patient was living inside a claustrophobic space at home, and Paula felt trapped within a therapy that was stuck and not going

anywhere. Like McDougall's (1984) description of a group of patients who appear not moved by the therapeutic work, and whose therapies are stagnant for long periods yet "clung to [their] analysis like a drowning man to a life vest" (p.386), Paula felt that her patient clung to her. At the same time she felt ineffectual in helping her, and felt cruel when challenging her patient, which created such immense anxieties. This engendered a feeling of being trapped, and considering the association to the film Misery, like she was being held down and controlled, with a sense of there being no way out.

The sense of being stuck, that all the therapists spoke about, relates both to the temporal as well as the spatial realm; not developing forward with time, as well as being stuck at a place and not moving out of that place. Claustrophobia is experienced on a bodily level, and accompanied by feelings of panic of not being able to breathe. Hikikomori is manifested in a very spatial way; the people have withdrawn into a confined space.

Having described themes and sub-themes that arose from my analysis of the interview data, I will now explore in more detail an area that I have touched on throughout my explorations of the sub-themes: changes over the course of the therapies, endings, and what the therapists thought was, or could be, helpful for the withdrawn young person they worked with.

Theme Four: Therapy, change and endings

Strictly speaking, changes and endings are not themes that arose from the data analysis as such. However, as a lack of movement and of boundaries are features common to the states under exploration, I felt it was important to address these by examining discussions of change and endings as they arose in the interviews. Changes over time, in particular in terms of how the therapists felt towards their patients, was a question I asked all the therapists, if they had not already referred to it. How endings were considered, and how they happened, where relevant, was another area that all the therapists referred to. A discussion around endings needs to consider that the therapies were at very different stages, ranging from having finished several years ago, to having finished a week prior to the interview, to still being ongoing.

Marion spoke about how the therapy seemed to have accelerated as they were approaching the ending, with her patient becoming more talkative and reflecting on how it would feel not coming to see the therapist anymore.

> "I think there was a kind of regret, actually, he had never used the adult dolls, and I had the sense that there was some regret about the possibility that he had not taken up. Quite hard really the last session (*interviewee choked up a bit, tearful).* We talked about him having more therapy in the future, and whether he wanted me to leave his box intact, and he decided that he didn't want it to be, but he wanted other children to use those things. I don't know whether this was because he felt he had outgrown it. Yeah, it was quite sad, and at the end, he said goodbye (*clears throat*) and thank you very formally […]. It was quite a sad ending. I feel as though I have abandoned him".
> Marion, p.10

This therapy had ended a few months prior to the interview, and it is clear that Marion still felt the impact of the goodbye and she is left feeling that she had abandoned him. Interestingly, at that very point in the interview the tape had suddenly stopped, bringing the interview to an abrupt end. Neither the interviewee nor I had been aware of the time. Might the ending have felt abrupt to Marion and her patient, even though this was an ending that had been prepared for?

At the ending, Marion's patient was in touch with regrets of what he hasn't used, maybe a realisation of the 'unused' (wasted) time while shutting himself off from the world. Marion also had a sense of him having outgrown the toys. This was a patient who was obsessed with specific comic characters, as if holding on to an earlier time. Marion then spoke about how over the course of the therapy he had become more interesting to her, and he became more interested, developing a wish for contact with other people. At the ending, letting go of the toys and letting other children have them might indicate that he had matured, had moved forward in his development and towards a more separated (and Kleinian depressive) position. At another point in the interview Marion said:

> "In the last year, that [the heavy and draining feeling Marion used to feel] seems to have gone and there is something more adolescent, *he* is a lot more adolescent […]. Yeah much more lively, much more present and he was more

able to think a lot more about his relationship with peers, and little bit about the relationship with his [family].

So what do you think has helped to make that change?

I think he… he uses the therapy… a bit… to some extent… I think there is a recognition in him that his life was becoming very limited by his interest and that he couldn't completely close himself off completely".
Marion, p.4

Whereas in the early phases, Marion was overcome with heaviness and feeling drained, it is clear at the end of the work that her patient had left 'an emotional mark' inside of Marion's mind, indicating that an emotional link had been made. Over the course of the therapy the patient, so afraid of contact initially, had allowed himself to make a connection.

My interview with Sharon had also felt cut short at the end. There was so much more to talk about, but we had to end. Sharon had described the ending of the therapy as being full with sorrow and her patient as coming to terms with losses in his life.

"[I]n how it ended, it felt like he was poised to go into the world, um... not without difficulties, but I think there was the appreciation that this path of difficulties could be borne, and that he certainly now had more of a sense of who he was, a sense of identity, a greater sense of actually being in his body. And importantly, his mind had more of a structure to it. Because before there had been a dissociation with his body, because of this very early trauma, there were disconnects in his mind, and in relation to his body, and also his mind in relation to me, whereas now being conscious of being ready, what we might think of his social capacity, social engagement.

Sounds like a huge shift.

It was a huge shift. But he left treatment still vulnerable, and of course that is exactly how it is, but I would dare to say what he'd gained. So he recognised his vulnerabilities, he recognised something about his tendency to shut up and shut down and withdraw, and I think he'd recognise how that arrested his development. [Speaks about being stuck in his room for several years]. I am just thinking now (*laughing)* at an appointment he told me that he'd left the

house and walked around the harbour, and he told me about the tide coming in, it was just so much, you know talking about..

The outside world…

Yes, and he was saying to me [about things he was struck by] and it really helped us to think about how he outlined his prison... The associations we had with it! We were talking about some of the videos [they previously discussed] and we talked about some of his dreams, it really told me that he was on the way of engaging, in an *altogether* kind of way".
Sharon, p.10

Sharon's patient had been moving towards an engagement with the world, and with other people. He was still vulnerable, and he still hardly left his house, but the shifts within the therapy were immense. He was having a conversation about things he had seen, and what this reminded him of, and was able to use metaphors to describe his inner experience. This is in striking contrast to the beginning of the therapy, when for over a year the patient sat in silence. Very slowly there had been some changes. For example the patient starting to nod when Sharon was musing, and changing his body position slightly from facing the clock to facing the therapist, then moving towards occasional eye contact, and eventually to an engagement that is of 'an altogether kind'. Reflecting on what she thought was helpful to her patient, Sharon said:

"I think what helped was someone [was] interested in his mind, who understood that there was actually quite a lot of mental activity going on. I started to speak about how he was trying to work out in his mind what was real, and what wasn't, what was mostly imagination, and I think he slowly started to making those distinctions. It sounds so simple *(laughs)*, but it took a long time for him to be able to hear that, to hear that there was a mind trying to connect with his and for him to find a way of being".
Sharon, p.3

This was a long and slow process. As described in a previous section, Sharon felt that over the course of the therapy the sense of time within the session felt more realistic. At home, the patient's spatial movements increased and included the

kitchen, to venturing outside on rare occasions, to starting a part-time college course towards the end of the therapy.

Mike expressed surprise in the interview about how much he still thinks about his patient, even though the therapy had finished over a year prior. During the therapy, it felt important to Mike to continue to give the message to his patient that he had not forgotten her. To my question of what he thinks was helpful, he responded:

> "I don't know, I don't know. I think with her, when she feels so helpless and hopeless and nobody would.. And just how easy it'd be for her to be terrified to go out, and then never talk to anybody. So then for me to say: 'I am thinking about you, I have not forgotten about you, even I know you don't want me to talk to you', I think that was the message that I kept giving her".
> Mike, p.6

As with Sharon, Mike had to stay with long periods of silence, during which Mike was left wondering whether she had put the phone on the side, whether she had gone to sleep, whether she was still there. Mike felt this 'being there' over time engendered change.

> "I think she accepted that there was somebody who would think about her (..*inaudible*..), that I had managed to continue. […] there was a message at the end of that, isn't there: that somebody *does* care, even if you yourself don't. Even if you think you don't deserve. She could value the fact that I was there each week".
> Mike, p.7

Mike wished the therapy could have continued. They had to stop due to her reaching the age limit of the service, although she did have social service input after the therapy.

> "There was an overlap of me finishing and them coming in. And they were giving some practical support. But it wasn't about that. It was about somebody being there for her, keeping an eye on her, that was the experience that she got something from, and she would always say: 'It's a waste of time, why are they [social services] coming around here'".
> Mike, p.7

It was this message of: ‘I will come to you even if you say you don’t want me to’ which seems particularly pertinent for this patient group. Contact is such a struggle, that initiating it is a great challenge to overcome. Mike’s patient was not able to do the initiating that is required every time one comes to the clinic to attend an appointment. By setting up phone appointments each week, Mike was the one initiating the contact. Sometimes the patient did not pick up the phone, but nevertheless the phone ringing at the arranged time gave a concrete sign that he was thinking about her and was trying to make contact with her.

Andrea was left feeling worried about the patient after the ending of the therapy, and worried that all the work might just collapse once their contact had stopped.

> “It [the ending] was difficult, he was very much on my mind, I was feeling myself responsible, I would find myself thinking about the treatment, different phases of the treatment, and wondering if I should have done something differently?, was it helpful at all?, I feel quite responsible… um..
>
> *Responsible for?*
>
> Um, Maybe this was something that was projected into me, I don't know, I just felt in some ways.. um..
>
> *Like responsible for his wellbeing? Or his life or (interviewee breathes out/ sighs) improvement..?*
>
> For him... his capacity to sustain the improvement, I think I'd feel devastated if he'd left and everything collapsed, and this is a risk, this is something that is a risk. He might sustain it and he might not. But I did feel almost as if I had to do something miraculous (*laughs*), something that would make sure he could sustain ah, whatever was helpful for him, for his life.
>
> *As if the responsibility was on you?*
>
> Yes, as if it is was on me (*very definite voice*) yes, as if the responsibility that he should take, and have, about his life, as if I was carrying it”.
> Andrea, p.7

The interview was held a week after they had their last session, and Andrea was left with doubts over the patient’s ability to sustain the work, and she was feeling responsible for him. She felt unable to trust that the patient would cope, and unsure

whether the therapy had been helpful and robust enough not to crumble. She felt that she had to do something miraculous. There seems a sense that without the concrete contact, everything would just collapse. If this was something that was projected into Andrea, it might indicate that the patient struggled with keeping the object in mind, and a sense of catastrophic collapse when not actually seeing the object anymore. At another point in the interview Andrea said that she believed the therapy was like a trial relationship.

> "But then he was much more comfortable about coming to the clinic. Um, and I think all the anxiety about being with someone, starting a relationship, which he had experienced with me, and then I think which shifted over the months. And I think this possibly became a sort of, a different way of relating. I would use *'us'* as an example for him, for example when there was a possibility of meeting somebody, he would come up with all the excuses and anxiety around it, and I would say: 'oh, that is exactly what you said how you felt when you first came to see me'".
> Andrea, pp.4-5

For someone frightened of relating with others, the therapeutic space offered an opportunity to 'trying out' relating to another person. Like Sharon said, a working out what is in one's own mind and how this is differentiated from another mind, checking out one's fears about the other with the other, realising the boundaries between self and the other which in turn makes relating to another a less scary endeavour. This seemed indeed helpful for Andrea's patient. There were also some external changes which showed improvement: her patient had allowed himself to be supported by a charity, support he would have previously rejected, his self-care and hygiene improved, and he even managed to start some volunteer work.

Steven's patient, despite often complaining of the therapy not being helpful, hardly ever missed a session. Discussing this, Steven explains:

> "For an adolescent her attendance is really high.
>
> *Particularly for an adolescent who shuts themselves away in her room. So what do you think makes her able to come?*
>
> I think this is a very difficult question (*laughs*)...(*pause*). Um…the first thought I had is that what makes her come, or what she would say makes her

> come, that'd be two different things, I think. I think she comes because it probably does provide her with some regularity and consistency that she had lost. Well, consistency that is kind of a limited resource if you like, there are boundaries to each session, it's not like the computer game which is accessible all the time, so there is that consistency. And also she gets in contact with a real live person that she can see, that she can see *feeling*".
> Steven, pp.1-2

What he believed his patient, on some level, realised and appreciated, was having contact with a real-life person with feelings, a mind which can be touched by another mind. The therapy provided her with emotional contact together with consistency, reliability and boundaries.

Paula, like Andrea, was left in doubt whether the improvements her patient had made would be sustained after the ending. She said she thought that not much had moved over the course of the therapy. She felt that after every session they had gone back again to square one. Yet there were external shifts: after a few months the patient started coming to the clinic by herself, instead of with a family member. In the middle phase the patient started volunteer work, which she sustained and which turned out to be a real developmental push for her. Towards the end of the therapy the patient also managed to finish her exams, and started to make friends and at times go out with them. Paula reflected that the one-to-one of the therapy was too intense for her patient, although a group would have been just the same. She thought what was helpful was:

> "[…] practical, I think that was what she responded to. Because I have just, I did a bit of thinking and a bit of practical, and I think that's what I have managed to do with her. Sometimes some patients are in the way almost not treatable, which is part of the tenacity of the pain; that that is just part of the way she is. I don't think that things have changed a great deal for her, this is terrible to say".
> Paula, p.8

I wonder if it was the combination of thinking about meaning, and thinking about practical solutions which might have been what was helpful. It is questionable whether 'practical' on its own would have helped. This patient did have social

services input, someone coming to her house to help with practical day-to-day tasks, but she did not engage with this. I think this sense of ‘can’t do’ was overwhelming both the patient and her therapist; being so worn down by a feeling of stuckness and repetition that it became hard to see the movements that have in fact taken place.

Julia also described a difficulty of connecting to a competent side. Her patient had brief periods where she was able to go out and do something that involved socialising, and unfamiliar things like travelling to a new town for the day, and yet when stuck inside her room it was as if this never happened. Julia describes, as one of the changes:

> “I challenge her more, she is more able to be challenged, and it does begin to feel like things are shifting. But [speaks about patient’s family and an upcoming change], well, she is trapped, if something changes, I think she finds it quite frightening, because… You know, she is very controlling, but she is aware of how limited her controlling is once, when she goes into the world of reality. It is only now that I am able to remind her of, that she does have a side that is very competent and how can you use and mobilise that”. Julia, p.4

I wonder if the experience of Julia, reliably continuing to be there, and thinking about her patient, lessened the need to be ‘incapable’ in order to summon support, that her patient had increased confidence in the object’s availability, and hence was more able to connect to her competent side. Her improvement in her self-care also indicates an increase in feeling cared for, and a shift towards independently looking after herself. Other changes that Julia mentioned were a lessening of the appeal of the computer world, and “much less having to defend against that she also wants real friends” (Julia, p.9).

> “I think having the time, um, and I think working with a lot of time, trying to understand, really trying. […..] and about wondering, you know, to what extent their early experience has fed into why it is so hard for her to move on. Um, so, taking it up in quite a straightforward way […] trying to make a link with that [between past and present] because she doesn't like links, but anyway, what happened to her and is still reverberating, so the more she was able to see that, I think that has helped her. (*Louder:*) It has helped me,

> because there's this thing about, at the outset, I found her such a pain and now I really like her.
>
> (*Surprised*:) *Gosh, your feelings really have changed.*
>
> Yeah, which is probably, could be a...
>
> *Change.*
>
> Change, oh, there is quite a.., I mean, in some ways there is no change. […] there is increasingly the idea of limiting the amount of time we spend with adolescents, and this is somebody who I don't think you could shortcut, but I think it's very hard to prove that it is all going to be worthwhile, because objectively she still is pretty ill, still hasn't gone back to school, she is still quite trapped, she doesn't go out, she still spoils things for herself".
> Julia, p.8

Again, while the therapist struggled to hold on to improvement made, it is clear that there are shifts. Julia's feelings towards her patient drastically changed over time. The patient became likable, and Julia was more able to connect to the patient's vulnerability. This change of feeling towards the patient is an indication of something also having shifted inside the patient. During the interview, Julia was put in mind how the decision to get well is complicated for "someone who is very ambivalent about getting well" (Julia, p.3)

When looking at improvements, we need to remember the immense hurdles that are in the way, including the person's ambivalence about getting better. The psychiatrist described trying to engage a withdrawn young person by going to his home. The young person had requested help and they had made a plan to take him out.

> "But four weeks later he still has not left the house, so in fact he was regressing. So this very talented assistant psychologist would say 'come on, today is the day we agreed that we would go out' and he would just lie on the sofa with the duvet over his head and refusing to go out. We finally got him out of the house last week, but his mum had to come too. So the next step is that maybe we go out without his mum. So it's just little steps. I suppose what the film maybe didn't… - you would have to think a bit harder to think how it might be like for someone like that to step out outside again, and how

frightened he would be".

Psychiatrist, p.1

When discussing outcomes for these worrying patients, we do indeed need to remember the possible outcome if no treatment had been given. In the previous section I explored how the interviewees imagined their patients' future had the patients not been supported. The interviewees thought the long term prognosis would be bleak. For example, both Julia and Steven specifically mentioned that they strongly believed the therapy had put their patient on a different life trajectory. They believed that without it their patients would have gone back to not leaving the house, and likely to have been admitted to inpatient units.

In summary, the changes over the course of therapy included improvements in self-care, becoming more interested in the world and interesting to others, becoming more adolescent (and as such moving on from the developmental stuckness), increased ability to have a two-way conversation and to see the other person as separate. The therapists also referred to their patients realising their retreat is a prison (Sharon) and regrets over wasted time (Marion). Most importantly, the impact that the patients had left on their therapist shows that they have made an emotional connection with another person.

What the therapists felt was helpful was the reliability and consistency of the contact, giving the message that they are thinking about their patient even at time when the patient rejects them, showing that they are interested in the patient's inner world, helping to distinguish internal and external, and the psychological boundaries between self and other, the opportunity to 'try out' relating and to, as Steven commented, relating to a real life person who one can see feeling.

This concludes my findings chapter, and I will now turn to gathering together the findings of the interview and audit, compare them with other literature and follow up on some themes with a more in-depth discussion.

Chapter 4: Discussion and synthesis

Introduction

In this section I shall firstly review the findings of the audit study, and compare these with the findings of the interview study and with other research literature. Within this I will discuss gender distribution, and then explore particular presenting issues (additional to withdrawal) which featured prominently in both samples (the less severe group which I referred to as "isolated", and the more severe sample which I called "severely withdrawn"). I will then focus on the findings of the interview study. I will chart the progression from triggers to withdrawal, to the continuation and maintenance of a withdrawal state, which includes outlining several interwoven layers which keep the withdrawal state static. Within this I will discuss my findings and compare this to other literature, in particular Saito (1998), who coined the term Hikikomori and initiated awareness-raising on the subject. Some areas of exploration, which I touched on within the individual sub-themes sections, I will reflect on in more depth, with the help of psychoanalytic theory. I then will refer to strengths and limitations of the research's methods, discuss the implications of my findings for intervention and improvement, and give recommendations. To end my thesis, I will put this investigation into the context of our today's world, and the pressures and insecurities that the present generation of young people in Britain are faced with.

Is it a male problem and what else do Hikikomori sufferers struggle with?

In this section I will revisit the findings of the audit and compare these with the findings of the interview and with other research.

Gender

Discussions within the research literature and the media have portrayed Hikikomori in Japan as predominately a male problem. For example, studies show a gender difference of at least three times as many males as females (Lee et al, 2013; Saito, 1998; Teo 2010). In my audit study, the gender distribution within the under-18 year olds is similar in the withdrawn sample and the overall referrals to the service, where more females than males are being referred. Interestingly, in the post-18 age group this drastically changes. In the 19-21 group, while there are three times as many females referred to the clinic overall, there are significantly more males than females in the socially isolated and severely withdrawn samples combined. The 22-25 group continues to have more males referred in the withdrawn samples, while the overall referrals in this age group are about even in terms of gender.

These findings in the post-18 group bear out existing research. Saito (1998) gives as one explanation to the majority of Hikikomori being male, that there is a high expectation in Japanese society that men will participate in society in some form once they reach adulthood. One could explain the post-18 change in gender distribution in my audit with similar reasons: that gendered expectations become more relevant at the point of transitioning into adulthood, where more pressure is placed on males to go out and be productive in the world of work, and it is this pressure that some young males react to by withdrawing.

In my interview study, out of the seven psychotherapists, four spoke about a male patient and three about a female patient. The presence of so many females in both my interview study, and the younger age group in my audit, surprised me, as, judging by the literature on Hikikomori, I assumed this to be a mainly male issue. This would merit further exploration, which might explain, for example, whether there is a difference in gender distribution between different cultural contexts, or whether there is an increase in young women withdrawing today, compared to earlier studies, or whether there are gender differences in terms of the visibility of withdrawn young people.

Real and perceived danger of the outside

Within my audit data, the number of those who were bullied at school was high in the isolated, and the more severely withdrawn, samples. These findings are correlated in both my interview study, where several of the therapist said their

patients had been bullied, as well as other research quoting high incidences of past experiences of bullying amongst people withdrawn in Hikikomori (Krieg and Dickie, 2013; Lee et al, 2013). Correspondingly, in the severely withdrawn sample in the audit, two (out of 16) referred to PTSD symptoms, in one case stemming from a mugging and the other from a car crash. Excessive fears of others attacking, or controlling, or humiliating, or OCD-style fears of contamination, were mentioned in six (out of 31) of the less and more severely withdrawn samples combined. One referral letter described the patient as being so worried that he was keeping weapons at his bedside. PTSD had been one of the characteristics found as present amongst Hikikomori in Lee et al's study (2013). While not specifically mentioning PTSD in my interview study, two of the seven therapists' patients gave a past non-familial attack as the reason of seeing the outside world as unsafe.

As my interview findings showed, and as I discussed in the 'outside equated with danger and pressure' sub-theme, being bullied, or abused, or traumatised by an external event, might lead to a perception that the outside world is a dangerous place and might become one factor in a tendency to withdraw from the outside. Withdrawal away from the pressures of the outside world has also been suggested as a leading cause for Hikikomori by several research studies (Hockings, 2013; Kaneko, 2016; Nae, 2018, Tamaki, 1993).

Uchida and Norasakkunkit (2015) identified low self-competence as one of three risk factors of Hikikomori. They explained that low self-competence is associated with high levels of anxiety when encountering anything challenging, leading to an avoidance of activities such as looking for work or dealing with interpersonal differences.

Cyber world

In terms of retreating into the perceived safety of the cyber world, both my audit and interviews show a high proportion of the withdrawn young people to be overusing the computer. Five of the seven therapists reported an overuse of internet activity. This is mirrored by research studies showing a strong association between social withdrawal and excessive computer use, as discussed in my literature review. So my subsidiary research question can be answered, that the internet is indeed a feature in withdrawal states in significant cases. What role it plays in terms of facilitating

contact, or increasing withdrawal, cannot be straightforwardly answered, as it seems to be doing both.

From the themes of the interviews, we have seen how the outside world has been perceived as full of dangers and pressures, and the cyber world seems to be used as one place to retreat to. But during the time inside this retreat, the internet does offer an opportunity for the withdrawn person to engage with others, for example Julia's patient interacting with people from all over the world via her avatar, and Marion's patient feeling part of an online animee community.

Interchanges on the computer can provide a first step out of withdrawal, trying out social interactions in a space relatively free from commitments and the consequences of their actions (Turkle, 2004; Kantrowitz, 2009). It raises the question to what extent contact via the internet is an authentic contact with a separate other, or an illusion of contact, more like a narcissistic self-object (Turkle, 2004) Being immersed in the sensation-rich cyber world can function like an autistic envelope, while also providing a needed sense of cohesion and a sense of being held together inside his/her skin (Lingiardi, 2008 referring to Winnicott, 1958). For some, like Julia's patient, it can be a lifeline.

The themes from the interviews have not provided any definite answers to this question, but have illustrated how videogames and the cyber world can be used by withdrawn young people. They can be a place where they feel in control, a predictable world that is a safe way to make contact with the outside, while also furthering the withdrawal state where the person is so preoccupied and immersed that s/he loses sight of there being another relational world.

Risk

I would now like to discuss risk. Research on Hikikomori seems to suggest a low rate of suicidality (Sarchione et al. 2015; Stip et al, 2016). Where suicidal risk was present in Hikikomori, this was seen as associated with previous psychiatric conditions rather than the Hikikomori condition itself (Yong & Nomura, 2019).

Within my isolated/withdrawn samples, four had previously attempted suicide, and seven were self-harming, although interestingly the numbers of self-harm and suicide attempts were significantly higher in the less severe 'socially isolated' group.

This puts the referrals into context, as it might have been the self-harm that was the worrying behaviour rather than the withdrawal itself.

In contrast, only one of my interviewees spoke of their patient having self-harmed, and this was in the past, when younger. No interviewee referred to previous suicide attempts, although several spoke about their concerns for their patients becoming suicidal during treatment. As I had not asked about backgrounds of their patients, it is possible that it was not foregrounded sufficiently to be mentioned by the interviewees. Another possibility might be that the withdrawal state itself, by its numbing effect, protects from more actively self-destructive impulses of self-harm and suicide. This could explain the therapists' worries when their patients were further on in the treatment, maybe as the young person was coming out from their retreat, and being faced with the effects that the retreat has protected them from (Steiner, 1993). A numbing effect of a withdrawal state might also explain why, within the audit, the self-harm and suicide attempts are so much higher within the less severe withdrawn group.

Regarding violent behaviours, in my audit three of the severely withdrawn group used to act violently when they were younger, but not any longer. Past aggressive acting out, in contrast to their present passive demeanour, had also been mentioned by two of my interviewees. In the present time the patients were described by the interviewees as not being in touch with their anger. Again this might indicate that the retreat serves as a protection against aggressive feelings.

One of my interviewees, in fact, had said how he liked it when the patient became angry with him, as at these points it felt as though they were in contact. This is consistent with Yong and Nomura's (2019) finding that Hikikomori was not associated with externalising violent behaviour, but rather with violence directed at the self in the form of self-harm. Interestingly, it contrasts with Saito (1998), who found outbursts of violence, or of chronic aggression, of the Hikikomori person towards the family, particularly the mother, as a frequent secondary problem. The difference to Saito's study might be explained by there being an element of culturally specific ideas about the role of a mother, in Japanese society, which facilitates such behaviour.

Numbing and blocking from contact

Two of the socially isolated, and one of the severely withdrawn, sample within the audit were restricting food. This differed from my interviews, where food was only referred to in terms of eating unhealthily and not caring about their body. However, one could speculate that a 'no-entry' type of presentation (Williams, 2000) which is discussed as an underlying dynamic in food restricting, is similar to that in Hikikomori. The therapists of my interviews spoke of their patients' fear of anything different and 'other' to come in, both in terms of challenges to their thought system as well as being touched emotionally. The therapists felt blocked off by their patients, and some felt like an intruding object in the countertransference (see for example Sharon's fear of causing damage).

Thinking about numbing, and ways of blocking emotional contact, it is interesting to note that alcohol or drug misuse, which was mentioned in three of the severely withdrawn sample within my audit, and which could be seen as another way of blocking from awareness painful emotions, did not feature at all as an issue within the interviews, nor could I find any reference to this in the research literature. A larger study is needed to ascertain whether or not there is any association.

Physical complaints

The audit data shows a high incidence of physical symptoms amongst the isolated and withdrawn samples. Five in the more severe, and two in the less severe, group had physical problems, and, apart from one, all these symptoms were either medically unexplained or could be due to stress and/or somatisation of psychological issues. One of the withdrawn patients who had current chronic abdominal pains had several hospital admissions when younger, although it is not clear what for. This correlates with my interview data, where there was also a high incidence of physical problems. Three of the therapists spoke about their patients' physical problems, one with current (potentially somatised) symptoms and two with past illness that involved medical interventions at a young age.

It would be interesting to further investigate whether hospital admissions, and medical intervention at an early age, might impact on psychological health in adolescence and young adulthood, and whether it might make a person more vulnerable to later withdrawal. Regarding current physical symptoms, which might be a somatised expression of psychological un-wellness, I believe that this might be

forming another part of the retreat system, protecting the person from overwhelming psychological malaise or pain. This correlates to Honjo et al's (2001) study of school refusal, which concluded that rather than feeling depressed, their emotional conflicts had been somatised, and are being expressed via physical symptoms, in particular headache and gastro problems.

Loss

Another associated presenting issue shown in the audit data relates to bereavement and loss. Struggling with bereavement, which three audit cases described, might indicate a sensitivity towards loss, where a person has not 'successfully grieved' a loved one and then protects themselves from this grief by shunning contact. In fact, with one of these cases who did engage in further therapy, the ending report on this therapy states that it focused on processing this loss, and the patient improved and started to socialise again. Within my interviews, several therapists had spoken about their fear at points in the therapy that the patient would leave and drop out, while the patients themselves, on a conscious level, did not seem bothered about coming or not coming to see the therapist. I believe that the fear of abandonment is likely to be part of the picture, which the retreat is defending against.

Something which surprised me when I examined the audit data, which had not appeared as a factor in the interviews, was that several of the patients within the withdrawn categories had immigrated to the UK. One in the severe group, and three in the less severe group, had come to the UK in their teens, and one further had parents who had immigrated. Immigration brings with it significant losses, and it might be that being uprooted from one's country and culture, and the potential accompanying experience of being different from one's peers and isolated, might increase one's vulnerability to withdrawing. These are very small numbers, and this question would need to be investigated in larger research studies.

Boundaries

Relating to my interview data theme of boundaries, three of the referrers or assessors, within the audit isolated/withdrawn samples, described the patient as seemingly 'overclose' or 'enmeshed' with their mother. Five of my interviewees, including the psychiatrist, also referred to an overclose relationship with mothers or

siblings. The psychiatrist thought that 'enmeshed relationships with mother' was a pattern in this group of patients.

The interview data showed a sub-theme of 'merging' within the inter-relationship dynamics of the therapy; the sense that the patient, unconsciously, was either in a merged identification with an internal object, represented by for example their room, the computer, or an obsessional fantasy,- with the therapist feeling excluded, and as if not existing in the patient's mind; or a sense of the patient wanting to merge with the therapist, again the therapist not feeling allowed a separate mind.

One of the interviewees, Paula, described how she asked for her team's reflections, to gain an outside perspective and help decide how to proceed. We could see this as a need for finding the third position from which the object relation could be observed (Britton, 2004), an object-relating that was characterised by either an adhesive sticking or by a sense of being merged.

Saito (1998) states that people in withdrawal tend to see their families not as a differentiated 'other' but as an extension of themselves, as part of their bodies. This in turn prevents any real communication from happening, just as talking to oneself is not real communication. He sees a frequent pattern of a co-dependent relationship between mother and child, and the importance of the therapist driving a wedge between them.

Relating to boundaries, two patients in the audit data presented with gender confusions. In the interviews, while not directly speaking about gender identity issues, some of the therapists referred to their patients as presenting as not defined or formed in their identity. This did seem to be more relevant to the male patients, where the therapist felt there was a lack of potency, sexuality, masculinity. Within the audit, by contrast, both the patients who were questioning their gender were female by birth. This would be an interesting subject to examine further.

I would now like to move on to summarising my findings by gathering them into my thoughts on how a common course of withdrawal state from triggers to continuation to stuckness might look like.

Charting withdrawal: from triggers to solidified state

The patients described in the interviews were all very different from each other, and so were the therapists. Yet, all the therapists described similar dynamics of a sense of failure, of nothing shifting, of stagnation and repetitiveness. The therapists perceive the therapy with their withdrawn patient as stuck, which in turn seems to mirror their patients being stuck both externally in their rooms, their lives stagnant and not moving, and internally being stuck in states of mind where they are frightened to open up to the influence of another.

Their backgrounds and early experiences might have been very different across this patient group, but what unites them is their developmental stage. The interviewees' patients are adolescents and young adults, yet their development seems to have halted. All the therapists in my study spoke about their patients being stuck in their development. Two of my interviewees describe their patients as presenting themselves as middle-aged and old. It seems as if the turbulence of adolescence, and the acquiring of responsibilities, and independence of the young adult, had been bypassed.

Saito has titled his book *Hikikomori: Adolescence without end*. From my interviewees' descriptions I think that the withdrawn young people they describe have become stuck or regressed to a pre-adolescent state. In Saito's study, more than a third of his respondents demonstrated 'reliance on parents and infantile behaviour'. Saito believes this regression to a childlike state is caused by the withdrawal, and reliance on others, just as someone hospitalised for a long period would display a more regressed state.

The turbulence of adolescence and growing into adulthood is a challenging process. Everything is in flux, the adolescent is changing on all levels, endocrinologically, physically, psychologically and neurologically, all in the context of wider social and cultural pressures (Waddell, 2018).

Each developmental transition involves the loss of what was previous, and adolescence brings many losses, including the safety and certainty of childhood. The adolescent has to enter a stage of uncertainty, the unknown and confusion with the

world around them, as well as their internal world and sense of identity, constantly shifting (Waddell, 2018). The adolescent has to integrate the reality of their mature sexual body into their sense of identity, which can trigger a resurgence of infantile anxieties (Lemma, 2014). In fact, Hoxter (1964) believes that it is the fear of being overwhelmed by uncontrolled expression of infantile fantasies which now, due to physical maturity, the adolescent is capable of enacting in reality, which lies underneath the fear of growing up. Rustin (2014) refers to infantile feelings of rage and envy being particular frightening.

On an external level, there is the pressure of having to make decisions, which can have far-reaching consequences, with new responsibilities, while having to find one's identity and giving up childhood comforts (Brenman-Pick, 1988). In addition, our current school system, with its emphasis on testing, and having to choose particular academic routes, and cross hurdles to the next stage at an ever increasingly younger age, causes huge pressures to succeed, and encourages a feeling of being written off for those who fail.

It might be that the turbulence and pressures of the adolescent period, and its task of developing into adulthood, has been experienced as too difficult. For someone who is already emotionally vulnerable (for example due to lack of sufficient containment as infants, early traumas or a constitution that make them less resilient to the ups and downs of life), adolescence might be a trigger point for shutting down. Severe withdrawal could be seen as one particular form of psychological protection against difficulties which are felt to be too overwhelming.

Perceiving the external world as pressuring and demanding has been a sub-theme in my interviews. Yong and Kaneko (2016) found one of the main themes of their qualitative study to be the withdrawn person's sense of failure viz a viz society, with a perspective that sees the world like a battleground whose demands they cannot deliver, and where they don't fit in. This sub-theme of finding the outside world as demanding, and themselves as lacking the resources valued in society, was echoed in a study conducted in Finland (Husu & Valimaki, 2017). The themes and sub-themes from my interviews seem to mirror this on a more internal level. The therapists spoke of worrying that they were putting too much pressure on their withdrawn patients, and that their attempts to try to relate seem to be perceived as demand.

Nae (2018), discussing Hikikomori in Japan, describes a Japanese concept of 'ibasho', a place where one belongs, "a place in which the individual establishes social connections with others, a place in which the individual's existence is validated, and in which one identifies with one's self" (pp.22-23). Nae describes how, due to economic and societal changes in Japan, these connections rapidly disintegrated, leading to a kind of social death. He argues that his patient group have lost or never gained such a place of belonging, of social connections. Several therapists within my study described their patients as looking odd and not fitting in with their peer group, and both Marion and Julia's patients seem to try to find a virtual community to get a sense of belonging.

Being withdrawn from contact, there is little opportunity to have one's identity validated. In fact, I would say, as we are speaking of adolescents and young adults, have they even taken the step onto the road of the adolescent task of developing a sense of one's identity? One needs to be able to bounce off other people, separating from parents, and trying out different versions of oneself through one's peers. Being withdrawn, they do not have that opportunity, or, if connected via the internet, only a limited opportunity.

Toivonon et al (2011) who believe that the Hikikomori phenomenon in Japan is an outcome of the labour market changes in Japan, rather than psychopathology, describe how the Hikikomori 'sub-group' as unable to conform, while also unwilling to rebel. The authors also class this sub-group as causing a problem to the mainstream Japanese society. Overell (2018) argues that the Hikikomori's apparent wilfulness produces them as "subjects who are out of place and pace with the dominant heteronormative, masculinist culture of contemporary Japan" (p.206).

One could say that identifying as a Hikikomori, and being part of a subculture, in itself could be seen as a rebellion, while providing a sense of belonging to a group and identity. This is very different to this study's patient group who live in a culturally different context and who do not have such an identity. However, one might propose that they, too, are unable to conform and unable to rebel. The sub-themes within the interviews of being outside their peer group, of not feeling they belong, and being withdrawn from the external world, demonstrate they are unable to conform. The sub-themes of lack of aggression and potency, as well as a sense of lacking defined boundaries, dynamics of merging, and a sense of formlessness is not

conducive to the idea of rebelling. One needs some sense of an identity to be able to rebel.

Saito (1998) believes there is a vicious circle going on in all three areas of the individual, family and society, each area affecting the others negatively and shutting them down. He argues that, while in other types of mental illness a person has the opportunity to interact with people outside unhealthy family dynamics, for the withdrawn person, the routes from individual to family or from individual to society are shut down. He argues that the vicious cycles in each of these areas become stabilised over time, and become a single interdependent system, what he calls the 'hikikomori system'. In a healthy system, the point of contact, and hence channels of communication, between the three areas are open, and affect each other. In the hikikomori system, mutually receptive communication is completely blocked.

Once established the withdrawal system becomes chronic and stuck on several levels, which I will discuss below.

Saito compares the vicious circle to addictions, whereby the person feels ashamed and a failure because of his withdrawal, which in turn increases their self-hatred, making the withdrawal worse. As with an alcoholic, the withdrawn person needs outside help in order to get out of this cycle. The family is then caught in another vicious cycle whereby they get irritated by the withdrawn person's behaviour, and try to get her/him to change, which the young person experiences as pressure, leading to more withdrawal.

The therapists in my study felt frustrated with their patients for not changing, or felt frustrated that efforts to engage with their patient were then blocked or the patients retreated. The withdrawn young person evokes this response in their objects.

The themes within my study seem to point towards this 'fixed system' happening on an intrapsychic level. Fear of development, fear of change, fear of contact and the outside, being equated with unsafe and pressures - all of which are found within the main themes – keeps the person inside their withdrawal state. The withdrawal state keeps the person protected from what s/he is afraid of, by staying at a static place that is familiar, known, and not threatening. Any threat to this static place seems to be experienced with huge panic.

Under the sub-theme of cyclical dynamics, I explored how any movement, challenge and change seems to be experienced as another demand that is too overwhelming, and triggers a negative therapeutic reaction of renewed withdrawal. Looking at the immense fear of contact, and panic about any change that these patients seem to have, these strong reactions are not surprising. The terrors that some of the interviewees got a glimpse of, at points of contact or change, give us an indication of the reason for the persistence of the withdrawal state. It seems that making contact is perceived as a threat to one's very existence (Emanuel, 2001; McDougall 1984; Symington, 1985). The psychic retreat keeps these fears at bay by keeping a state of equilibrium (Steiner, 1987, 1993) while any threat to this (illusory) protective structure is dreaded (Meltzer, 1973).

One way for the withdrawal system to be kept static is through endless repetition and suspension of time - a sense of timelessness. For some, the world of videogames and the cyber world both mirror this repetitive and timeless world, while also providing the only safe way of being in contact with the outside world. I will now explore our sense of time through a developmental perspective and how something going astray in this process might impact on how we experience time.

It is an essential tenet of psychoanalytic theories of development that time away from the caregiver is developmentally necessary. Winnicot (1967) describes a process whereby a baby has to deal with its caregiver's absence in progressively increasing intervals. Correspondingly, the baby's ability to hold the caregiver's image in mind to cope with these absences increases. This develops the ability to symbolise, and forms a transition from the baby's sense of being merged with the caregiver to feeling being separate. Time away provides a spur to the development of thought; through tolerating frustration the infant can start to think and to gain a perspective on the experiences he had with the caregiver (O'Shaughnessy, 1964).

This process helps with awareness of reality, breaks off omnipotent fantasies and prevents symbiosis. A third person, the father, comes into the relationship between mother and baby and, as such, regulates the length of the exclusive contact and signifies "time to move on" (Canham, 1999, p.161). Without this sense of 'Father time'/ 'Grandfather clock' providing a boundary, we end up, as Blomberg (2005) speaking about children with severe autism describes, "liv[ing] entirely in an unbroken *present tense*" (p.32), without any space between self and other, without

any distance to one's own experience, and without "an assurance that there exists a life outside and ahead of the present" i.e. the future (p.42). It is not surprising that the sense of living in timelessness can bring forth both blissful, as well as terrifying, states depending on how the present tense is being felt.

Arlow (1984) states that how the present moment is experienced, is determined by past experiences and fantasies, and future anticipations. Each new perception falls into place in terms of the three coordinates of time: past, present, future. Any alteration in the sense of self is likely to also alter how time is experienced. The passing of time (like Canham's 'time to move on') is on some level associated with going towards death. We can experience a sense of timelessness when immersed in the joy of the moment, without being aware of ourselves, losing all sense of time, for example when being lost in a piece of music. Fusion with the object can create feelings of timelessness. Maybe in that moment there is a feeling of immortality, the sense of being outside of time, in eternity.

> If time could be made to stand still, nothing would ever change. There would be no advance toward death; life would be one perpetual pleasant afternoon.
> Arlow, 1984, p.30

Arlow gives an example of a patient who treated time as if he had unlimited amounts of it. He wanted to stay a child forever, dropping out from college and from time, and thus mastering death. The patient experienced timelessness with a sense of nostalgic longing; he was yearning for a distant past, and the distant future, both felt as a blissful union with mother, the present represented reality.

As discussed in the 'fear of change' sub-theme, we saw that underneath the panic evoked by change might lie a fear of loss. We could think of the sense of timelessness, which the interviewees were experiencing within the therapies with withdrawn young people, as connected to a fear of moving towards death. In timelessness, there is no beginning or end and maybe an unconscious way "to eliminate any notion of space between the objects" (Blomberg, 2005, p.30). While merged with the other, no gap needs to be felt, no abandonment, no 'death' inside the mind of the other. Instead a seemingly 'perpetual pleasant afternoon' seems to have been created inside the retreat. The illusion of this, however, is indicated by the terrors the patients seem to be in touch with whenever this space is challenged: the

tight grasping, for example by Paula's patient, or the search for coordinates of time and space, that Sharon's example illustrates. These expose the disorientation and terrors that might lie beneath the need for creating such a retreat.

On a spatial level, the thought of being stuck, and not moving from one place, for many would conjure up a sense of being trapped. Claustrophobia was mentioned in some of the interviews. In both Paula and Andrea's cases, it was the therapist who was feeling claustrophobic. Paula thought that her patient's living situation was 'claustrophobic', but it is not obvious that her patient herself ever said that. It is interesting that in both cases the therapist-patient couples are like two sides of a coin: the enclosed space and the lack of movement seems to feel safe to the patients while triggering feelings of claustrophobia in the therapist, while any changes or challenges to the stagnant enclosed place trigger panic and, as Andrea thinks, claustrophobic feelings in the patient.

Feeling claustrophobic when coming out of an enclosed space seems paradoxical. This sort of paradox has been explored by Zizek (2004) in relation to being faced with an excess of choice on the internet, creating a feeling of being trapped inside infinite space. We could speculate that what lies beneath this panic are the primitive terrors described by Bick (1968' 1986), memorably described as like falling into space without a spacesuit.

One psychoanalytic model that is used to understand claustrophobic feelings is Meltzer's 'The claustrum' (1992). His explanation would be that the person in unconscious fantasy has entered into the object, as a way to control the other from the inside, and then finds themselves trapped inside the object. We could theorise that a withdrawal into a 'small space' constitutes a way of feeling safe and secure inside a familiar space, which is perceived as being under one's total control, and anything outside of that is associated with terrors of not being in control. This absolute need to control brings up feeling of being trapped in the other person, a claustrophobic panic which mirrors the panic feelings the withdrawn person feels whenever there is a threat to the controlled familiar space. The question arises whether, over the process of coming out of withdrawal, there comes a point when the person gets in touch with feeling trapped inside his or her enclosed space.

The chronicity of the withdrawal system extended its reach into the space of the therapies. The therapists felt this tendency towards stasis when they felt trapped inside a stuck (non-) process, with the therapy itself drawn into this impasse. Steiner (1987, 1993) has warned of the tendency of a psychic retreat to draw the relational environment into its defensive structure. In the sub-theme of therapy becoming a psychic retreat I refer to several interviews pointing towards this dynamic, whereby the therapist felt that the therapy got stuck, and became what Andrea described as part of the 'bubble', a comforting and soothing activity where any change-promoting challenges were blocked off. This is what led some of the therapists to decide to introduce an ending. Maybe in psychotherapy cases such as these, not having a set ending runs the risk "of the treatment inhibiting itself" (Freud, 1937, p.217). By setting an ending the therapists were giving a boundary and as such standing up for the reality of time passing.

On an interpersonal level there is another vicious circle, as while being shut away one also loses the opportunity for practising social skills, and for meaningful contact with others, including healing interactions such as those that might have triggered the withdrawal, such as conflicts with friends or bullying at school (Saito, 1998; Yong & Kaneko, 2016). While Saito refers to actual people that the Hikikomori person might need closure for, I believe this is also happening on an intra-psychic level, whereby the person through lack of contact with external people is unable to heal the disrupted internal object relations. Unable to recuperate from such disrupted relationships, unable to find peace between their internal objects, the person continues to be bombarded with persecutory feelings and as such the withdrawal state in itself, as Saito states, is traumatic (Saito, 1998).

As shown, the themes of my interview study confirm how tenacious the withdrawal state is. The therapists and the psychiatrist in my interview study all gave a bleak picture of an imagined future, had the withdrawn young people they worked with not received any help from services. Their fears for their patient's future are well-founded. As Saito (1998) states: "When one is dealing with long-term withdrawal, there are limits to the efforts that both the individual and the family can make, no matter how hard they try" (p.94). In his years of working with Hikikomori people, Saito concludes that without treatment the Hikikomori will stay withdrawn and not improve. Several other studies also indicate that withdrawal and social isolation in

adolescence show a long term trajectory of social avoidance or phobia, and major depression, as well as problems such as staying a NEET or 'Twixter' (staying with parents way into adulthood) (Gazelle & Rudolph, 2004; Goodwin et al, 2012; Jakobsen et al, 2012; Lee et al, 2013).

With support, however, withdrawn young people can be helped to come out of their retreat, and engage with other people. Within my audit study, where available, review or ending of therapy reports describe slow to significant improvements in four out of the five cases, including less withdrawal and moving on to university or part-time work. The last theme of my interview study explored the changes within the therapies and showed that there were improvements, both intra-psychic, as well as from an external point of view. Interestingly, where change could be particularly seen was in the interviews of the therapists for whom a longer time period had lapsed since the therapy they were describing had finished. The therapists who were still working with the withdrawn patient, or those who had recently finished, were generally more doubtful about how much has improved. This difference might indicate that the latter therapists are still in the throes of countertransferential feelings such as failure. The improvements these patients made, might on the surface look small, and as having taken a long time, however, in the context of where the patients were to start with, and the tenacity of the withdrawal state, I would argue the improvements were significant.

For someone who has an image of the other as frightening, the experience and the healing power of a supportive relationship can help to acquire a more realistic view of others (Saito, 1998). This view of the other as frightening has also become stuck, and small (and hence bearable), but persisting, challenges to this view help the person to acquire a more accurate view of the other. What seems to contribute to this, then, is the regular contact with a therapist, another mind who is interested in them and who persistently provides an openness to contact, while sensitive to the patients' fear of contact. This is someone who validates the need for protective defences, while at the same time standing up against destructive forces. Someone who can sit with all the frustrations and disturbing thoughts and feelings that the person might need to have communicated, and continues to be present, patient and to provide a necessary structure, while advocating for reality in the form of boundaries to external and internal space and time.

Evaluating methods and limitations

One of the strengths of my research has been the combination of quantitative and qualitative elements, as it allowed a certain level of comparison, as shown in this discussion in terms of associated characteristics. What it has mainly effected though is a more holistic picture i.e. what can be seen externally (prevalence, comorbidity, behaviours) and internally (thoughts, feelings, object dynamics). Descriptive analysis and thematic analysis have proved to be suitable and effective methods to analyse the audit, and interview study, and to answer my research questions.

The movement between the therapists' accounts of their experiences of working with a withdrawn young person, and their hypotheses about the object relation dynamics, and my thoughts on these accounts, created a kind of tapestry of translation between the young person, the therapist and the researcher. While these layers of subjectivity added complexity, I think it strengthened the analysis and hypotheses made, in particular as the field of study in itself is subjective.

It needs to be emphasised that this study has provided an outline of themes which are potentially present within Hikikomori states. Both audit and interviews constitute a snapshot of the Hikikomori issue, as manifested during a particular timeframe at one young people's mental health clinic in the present-day UK, and as experiences through clinical work by eight clinicians. In this study, both depth and breadth are limited. To increase depth i.e. to explore potential unconscious phantasy present in withdrawal states, and issues of psychoanalytic techniques in relation to working with this patient group, I advocate single case studies of psychoanalytic treatments. To increase breadth would warrant much a larger sample size.

Most importantly, in order to develop a more holistic picture of Hikikomori in young people in today's Britain, we would need to hear the direct voices of withdrawn young people and their families.

Where should we go from here? Conclusions and recommendations

The audit has shown that Hikikomori type states are one of the presenting issues that lead young people to be referred to a mental health clinic. With 16% of referrals,

within a given time period, meeting the Hikikomori definition, and a further 13% at risk of such severe withdrawal, this is a high number for a condition that in the UK has not yet been defined. Judging by episodic reports from other CAMHS, and other adolescent or young adult mental health services, the increase of pupils dropping out of school, and a concurrent trend of new technologies decreasing face-to-face personal interaction, this is an issue that should not be ignored.

While my audit showed that young people beyond compulsory school age, who are severely withdrawn, do get noticed by services, it is likely that many young people who are withdrawn are not being identified due to the nature of the problem. The audit was conducted in a clinic that specialised in working with adolescents and young adults up to the age of 25. Most adolescent services have an age limit of 18, and it is not known how adult mental health services may be resourced to pick up on the specific needs of this group. Yet the audit and interview study conducted here, along with the literature on Hikikomori, all seem to suggest that it is this transition to an adulthood developmental stage that can trigger or solidify withdrawal. As the psychiatrist of my study said:

> "The 16 to 24 are one of those critical periods, a bit like the nought to two […] it is also crucial time period when moving away from school. While when at school and missing school it'd be noted, and there would be a motivation to go to school when one is forced to go to school, but then at 16 that finishes. It's giving people a few more choices and be led by them, which is a developmental stage […] you're not quite an adult yet, the new age for adulthood is 25, so it makes sense to have a bit more support, you can't be expected to sort everything out yourselves yet".
> Psychiatrist, p.5.

The transition to adulthood could be seen as a succinct developmental stage, as Arnett (2000) has named 'emerging adulthood'. Arnett argued that within Western developed societies the ages from 18 to 25 are a particular developmental phase, with specific challenges and needs different from both adolescence and adulthood. I would agree, but extend this age range to 16 to 25 in order to capture the end of compulsory school.

> "For me [they are] a priority group, in particular after the age of 18, services just disappear. We have an adult mental health service who has this idea of over-18s being help-seeking and motivated, and would turn up to appointments on time, and if you didn't do any of those things, unless you actually had psychosis, serious mental illness, you were not of any concern to the mental health services, they just leave you be. […] I don't know if there are young people out there we just do not know about, who are in this situation, there might be I suppose, if their parents did not raise the alarm. At school age they are being flagged up, but post-16 they sort of go off the radar".
>
> Psychiatrist, p.3

The clinic in which I conducted my research does provide a mental health services to adolescents and young adults up to the age of 25. However, there are not many services that do. I would hence recommend extending the age limit of present CAMHS and similar services, so that young people accessing those services are not dropped or dismissed at an age when compulsory education ceases, and they are particularly vulnerable to dropping out of society.

My study has shown the tenacity of a withdrawal state, and the difficulty and immense effort and persistence it takes to move out of such withdrawal. Saito (1998) states that the longer someone has been withdrawn, the more difficult it is to emerge. This brings an urgency to get these young people help as early as possible, and before their withdrawal becomes chronic and before they 'drop off the radar'. Preventative services are vital, as the psychiatrist of my study said "at this age it might prevent serious mental health problems later on so it is a good idea for the local borough to invest" (p.5)

This would involve help at a stage when a young person is at risk of dropping out of school. Yong and Nomura (2019) found that those who have dropped out of the education system have a higher risk of becoming Hikikomori. The example of Mike's patient struggling to attend school, having her timetable increasingly reduced until "nobody [was] telling her that she needed to go" and she dropped out completely (Mike, p.3), is sadly a story I am familiar with in my work at a CAMHS service liaising with schools. Saito (1998) warns against going along with a child's wishes to drop out of school. He thinks that having a place officially still waiting for

them is helpful for a withdrawn person. In his experience, even though a withdrawn person wants to quickly cut ties in order to feel better, when they actually do quit, “the reality of not having any place in society becomes that much heavier and difficult to bear” (p.137). He found that once the official procedures to quit school or work had been completed, the young person suddenly loses more energy and becomes more despondent.

In terms of what type of support to give those who are already withdrawn, a combination of psychotherapy, help with interpersonal communication, family work, and rehabilitative interventions are advocated (Ranieri, 2015 & 2018; Saito, 1998; Yong & Nomura, 2019). The psychiatrist of my study also felt that a multi-agency approach was needed “to help them holistically with their development” (p.3) offering help with whatever the young person needs, for example apprenticeships, education, support activities, and to try engage the young person meeting in social space, cafes, as well as doing home visits and doing things such as taking the young person out for pizza. He also said services should have a presence on the internet, so the young person can find them.

My interview and audit study have shown that severely withdrawn young people can and do engage in psychotherapy, and can be helped, albeit slowly, in that way. This suggests that such services should be provided, and that will require more resources which are so stretched at present in the provision of mental health services to all groups. In a trend away from longer-term and more intensive treatment, it is likely that the kind of withdrawn young people in this study would not benefit as they could. Some balance is required to enable the continuing provision of intensive and long-term work.

In terms of a mental health service specifically targeted for Hikikomori presentations, I would not advocate this, but that withdrawn young people are helped within a generic adolescent and young adult service. The reason for this recommendation is to take into account the particular difficulties that this patient group evokes in the therapists working with them, specifically dealing with the countertransferential responses such as failure and despair, and dealing with periods of impasse, cyclical dynamics, and very slow progress. I think psychotherapists working with such severe withdrawal states would need the variety of working with patients with other types of presenting issues.

Whether there is an increase in young people becoming isolated from society is an important issue. A study conducted in 2018 by the Office for National Statistics, on loneliness, found that 10% of 16-24 year olds described themselves as suffering from loneliness, and this was a higher proportion than any other age group (Coughlan, 2018). We need to have services for adolescents and emerging adults, both in terms of mental health as well as services that offer advocacy and socialising opportunities, such as youth services, where socially anxious young people are helped to socialise with others. Different types of services need to work together to provide holistic care.

As a society, we need to keep in our collective minds those who have withdrawn behind a protective wall and are unable to reach out, of their own volition. This is so in relation to the provision of services, alertness to the manifest aspects of withdrawn states, and to further research in the UK context in terms of prevalence, characteristics, prevention and intervention.

The present context

Saito spoke of people withdrawn into Hikikomori at a particular period in time, and in a particular cultural and socio-economic context. To end my thesis I would like to focus on the context of today's Britain. For the young people who shut themselves in their rooms in today's Britain, what kind of world are they withdrawing from? The youth of today is dealing with a very particular socio-economic and technological context, and we live in times which are marked by huge insecurities. Today's young people are faced with these insecurities and pressures permeating all levels of their lives.

The economic situation in Britain has put a lot of pressures on families. Following the economic crash of 2008, and after a decade of austerity measures, there has been a rise in inequalities in wealth and power, and an increase in poverty including child poverty (Child Poverty Action Group, 2017), with the number of people using foodbanks increasing year on year and reaching 1.6 million foodparcels given out in 2019 (The Trussel Trust, 2019). The impact of this has been far reaching, with many parents having to work longer hours to make ends meet, affecting their stress levels

and the time they have to spend with their children, which in turn impacts negatively on children's mental health (Ryan, 2016).

In addition, an overheated housing market has pushed home ownership out of reach for many, and left others in crippling debt, while private tenants are charged extortionate rents and have little legal security. Cuts to local government spending meant a decrease in community projects, which is likely to have negatively impacted on social cohesion and increased the isolation of families. The negative messages of Brexit over the last three years have further divided people, and the constant change and uncertainties have fostered heightened levels of anxiety and insecurity within the population.

A recent report by the British Psychological Society warned of the impact of austerity on children's mental health (Puffet, 2018). The briefing paper by a group of psychologists identified a set of particular experiences which they called 'austerity ailments'. These are: humiliation and shame, fear and mistrust, instability and insecurity, isolation and loneliness, and feeling trapped and powerless. The similarities to some of my themes are interesting.

Today's young people are under immense pressures during their educational lives. Changes in the education system, with its school performance measures and focus on testing, have had a negative impact on pupils' mental wellbeing. Teachers, parents and pupils have all reported greatly increasing levels of stress, anxiety, panic attacks, depression, and fear of academic failure amongst both primary and secondary students within the last few years, due to the pressurised assessment regime (Busby 2019a; Rashid, 2019; Weale, 2017; YouGov, 2019).

On a social level, peer-group relations have become so much more complex to negotiate due to technology and social media. The rapid growth of social media and its permeation throughout society, in particular of young people, has been suggested to have negatively impacted on young people's mental health, for example by increasing levels of anxiety, loneliness and the fear of missing out (for example: Edmunds, 2019)

On leaving school, and entering work or further education, young people are faced with further stressors. While statistics indicate a decrease in youth unemployment, there are now more young people who are economically inactive i.e. not activity

looking for work due to caring responsibilities, illness or disability. Recent statistics show 800,000 young people (16-24 year olds) who are NEET, which is 11.6% of all young people (Office for National Statistics, 2019a).

The percentage of young people (16-24 year olds) in employment who are on zero-hours contracts has been rising since 2013, and is now at its highest ever level, with 330,000 young people on zero-hours contracts, that is 8.8% of all young people who are employed (Office for National Statistics, 2019b). Not knowing whether you have an income the next day, and the stress of the potential short-notice cancellation of arranged shifts, creates huge insecurity and stress. Those people with insecure jobs, such as those n zero-hours contracts, are more at risk of physical and mental ill health (Centre for longitudinal studies UCL ,2017).

For those going on to further education, the tripling of university fees in 2010 meant that graduates now start their working lives with a burden of huge debts. It has also led to lowered aspirations to an university education amongst 10-15 year olds (Anderberg et al, 2019).

Referrals to CAMHS services, and admissions to hospital of young people who have harmed themselves, have been rising over recent years, while at the same time services have stagnated and been cut. Figures in 2017 suggested that more than 338,000 people were referred to CAMHS, but less than a third of these received any treatment within the year (Local Government Association, 2019). The demand for services is a reflection of a rise in children's mental health problems, with figures for 2017 suggesting that one in eight children had a diagnosable mental health disorder (YoungMinds 2018). So at the same time that mental health problems in young people have been increasing, mental health services for children and adolescents have been cut. There have been decreases in the numbers of qualified staff, and of specialist services, as well as the treatment time per patient, alongside increases in treatment thresholds, meaning many children fail to receive the care and treatment that they need (Association of Child Psychotherapists, 2018). Services are stretched to breaking point, and a report by the Children's Society estimated that 110,000 children referred to CAMHS in 2017 were not treated because thresholds were so high (Bulman, 2019).

I would like to speak a bit about how the way time is experienced has changed on a collective level. Baraister (2017) describes how zero-hours contracts, job insecurity, low pay, and the "unemployed who are kept permanently busy being assessed for dwindling benefits", all create an experience of time whereby "the present is experienced as time that is both relentlessly driven and yet refuses to flow", a sense of constantly being charged up but without anywhere to use this energy (p. 9).

There seems to be a general sense of time speeding up over recent years. The speed of change of technological advances, 24/7 markets, a global infrastructure that focuses on continuous work and consumption, high-speed management styles, ever-faster implementations of new structures in organisations, and short-term focus has led to an increased pace of life which has been termed 'social acceleration' (Hartmut, 2005; Hsu & Elliot, 2014). There is both a work ethic, as well as a social obligation of being always available, contactable and responding.

In order to keep pace with these changes, we constantly have to readapt. In a fast-paced economy, where objects become obsolete at an ever-increasing rate, is there a danger of people becoming 'obsolete', that because they are unable to keep pace, they feel they have no value to society? Even to just maintain one's position, one has to move, adapt, improve oneself. Hartmund (2005) describes how the increase in the speed of change leaves us with a sense of the present time being compressed. Hsu & Elliot (2014) elaborate that when change happens so quickly and constantly, one loses the sense of where one is going, in addition to struggling to keep an identity, when this identity is constantly being put in question. There is a risk that meaning and identity are being lost, and a risk of people becoming overwhelmed and giving up, leading to depression and detachment.

Considering, for example, the testing regime of today's schools, it seems that children are no longer allowed to 'linger', or to experiment without consequences, but are instead expected to perform as adults are.

In the background of all this, and in the foreground for many people, we are in a crisis globally. Climate change impacts negatively on mental health, with children and teenagers more likely to be effected (Burke et al, 2018; Kowalski, 2019), partly due to their immaturity and developing coping capacities (Majeed & Lee, 2017), and partly because it is the young generation that will be most impacted in the future.

Not surprisingly, the young generation blames the older generations for not having taken action, which causes anger, resentment, fear, frustration and being overwhelmed (Kowalski, 2019). Witnessing directly or indirectly through news reports and social media the impact of climate change, and the knowledge there is more to come, creates huge fears. Now being defined as ‘eco-anxiety’, many people are experiencing stress and worry at increasing levels, about climate change (Fawbert, 2019), which, it is suggested, might lead to an increase in depression within the population (Majeed & Lee, 2017). A survey in the US commissioned by the Washington Post and the Kaiser Foundation found that the majority of the youth surveyed expressed belief that climate change will cause a moderate to great deal of harm to their generation, and many reported feeling afraid (Palinkas et al, 2019).

Just within the last few months, we have seen deforestation through logging and fire within South America, melting of the ice caps, accelerating species destruction, and the fires in Australia. Put into the context of the sense of time, the impact of climate change is getting rid of our connection to the past while foreclosing the sense of our present moment continuing into the future. This leaves us on a collective level with a break in our sense of ’continuity-of -being (Winnicott, 1960).

All of the factors discussed above are likely to have contributed to a general decline in how happy young people feel. This decline was starkly illustrated by the 2018 International student assessment survey (Pisa), conducted by the OECD, of 15-year-olds in 72 countries. This found a steep decline in life satisfaction in all countries (compared to its 2015 survey), and Britain having the steepest decline of all (Adams & Barr, 2019; OECD, 2018). Nearly half of those surveyed in Britain reported they were dissatisfied with their lives, and Britain ranked 69th out of the 72 countries surveyed in terms of life satisfaction.

When asked whether their life “has meaning or purpose”, the British youngsters scored next to last of the countries surveyed, and Britain was the only European country where more than half reported feeling sad regularly.

In the context of the immense pressures and insecurities of today’s world, withdrawing and shutting out the world might be one way that some young people cope with the uncertainty and pressures of today’s reality.

Bibliography

Adams R. and Barr C. (2019) 'Many UK children feel their lives have no meaning, survey finds', *The Guardian Newspaper*, published on 4th Dec. https://www.theguardian.com/education/2019/dec/03/british-schoolchildren-among-least-satisfied-with-their-lives-says-oecd-report

Adamski, D. (2018) 'The influence of new technologies on the social withdrawal (Hikikomori Syndrome) among developed communities, including Poland'. *Social Communication*, 1: 58-63.

Arlow. (1984) 'Disturbances of the Sense of Time – with special reference to the experience of timelessness'. *Psychoanalytic Quarterly*, 53: 13-37.

Association of Child Psychotherapists (2018), ''Silent Catastrophe', responding to the danger signs of children and adolescent mental health services in trouble'. https://childpsychotherapy.org.uk/acp-report-silent-catastrophe

Arnett, J.J. (2000) 'Emerging Adulthood: A theory of development from the late teens through the Twenties'. *American Psychological Association Inc*, 55 (5): 469-480. https://doi: 10.1037//0003-066X55.5.469

Anastasopoloulos, D., Laylou-Lignos, E., and Waddell, M. (eds) (1999) *Psychoanalytic Psychotherapy of the Severely Disturbed Adolescent*. Karnac Books Ltd, London,UK.

Anderberg D., Chevalier A., Luermann M., Pavan R. (2019) 'Tuition fee rises mean children are less likely to aspire to go to university', *Royal Holloway University of London*, July www.nuffieldfoundation.org/wp-content/uploads/2019/07/anderberg-42242-educationreport7.pdf

Andreassen, C. S., Billieux, J., Griffiths, M. D., Kuss, D. J., Demetrovics, Z., Mazzoni, E. and Pallesen, S. (2016) 'The relationship between addictive use of social media and video games and symptoms of psychiatric disorders: A large-scale cross-sectional study'. *Psychology of Addictive Behaviors*, 30 (2): 252–262. https://doi.org/10.1037/adb0000160

Angold, A. and Rutter, M. (1992) 'Effects of age and pubertal status on depression in a large clinical sample'. *Development and Psychopathology*, 4 (1): 5-28.

Angold, A. (1988). 'Childhood and adolescent depression: I. Epidemiological and aetiological aspects'. *British Journal of Psychiatry*, 152: 601-617.

Angold, A. and Costello, E.J. (1993) ‘Depressive co-morbidity in children and adolescents: Empirical, theoretical, and methodological issues’, *American Journal of Psychiatry*, 150: 1779-1791.

Alvarez, A. and Reid, S. (1999) *Autism and Personality*. Routledge, Sussex, UK.

Asthana, A. and Revill, J (2007) ‘Revealed: Britain's 100,000 'invisible' teenage dropouts’. https://www.theguardian.com/uk/2007/may/06/children.politics

Baraister L. (2017) ‘*Enduring Time’*. Bloomsbury Publishing Plc, London, UK

Bartram, P. (1999) ‘Sean. From solitary invulnerability to the beginnings of reciprocity at very early infantile levels’. In Alvarez and Reid (eds) ibid

Baum O. (1969) ‘Countertransference’. Psychoanalytic Review, 56D (4), 621-638

BBC (2013) ‘*BBC World News’*. https://youtu.be/dr5yliP9TfU

Bentley, D. and MacCallum, A. (2019) ‘*Rise and Fall: the shift in household growth rates since the 1990s*’. Report by Civitas, Feb2019. Reported on in https://www.theguardian.com/society/2019/feb/08/million-more-young-adults-live-parents-uk-housing and https://www.bbc.co.uk/news/education-47162010

Berney, T., Bhate, S., Kolvin, I., Famuyiwa, O., Barrett, M. and Fundudis, T. (1991) ‘The context of Childhood Depression’. *British Journal of Psychiatry*, 159 (11): 28-35.

Bertolini, R. and Nissim, S. (2002) ‘Video games and children’s imagination’. *Journal of Child Psychotherapy*, 28 (3): 305-325.

Bick, E. (1968) ‘The experience of the skin in early objects relations’. In Briggs, A. (2002) *Surviving Space*. Karnac Books Ltd, London, UK.

Bick, E. (1986) ‘Further considerations on the function of the skin in early object relations’. In Briggs, A. (2002) ibid

Bierman, K.L. and Wargo, J.B. (1995) ‘Predicting the longitudinal course associated with aggressive-rejected, aggressive (nonrejected), and rejected (nonaggressive) status’. *Development and Psychopathology*, 7 (4): 669-682. https://dx.doi.org/10.1017/S0954579400006775

Bion, W.R. (1959) ‘Attacks on Linking’. *International Journal of Psycho-Analysis*, 43: 306-310, reprinted in ‘Second Thoughts’, 93-109.

Bion, W.R. (1962), reprinted 1984, *Learning from Experience*. Karnac Books Ltd, London, UK.

Bion, W.R. (1967) *Second Thoughts*. Karnac Books Ltd, London, UK.

Blomberg, B. (2005) ‘Time, space, and the mind: psychotherapy with children with autism’. In Houzel, D. and Rhode, M. (eds) *Invisible Boundaries. Psychosis and autism in children and adolescents*. Karnac Books Ltd, London, UK.

Brady, M. T. (2017) '"Sleeping beauties": succession problems of adolescence'. *Journal of Child Psychotherapy*, 43 (1): 55–65.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology'. *Qualitative Research in Psychology*, 3: 77-101.

Brenman-Pick. (1988) 'Adolescence: its impact on patient and analyst'. *International Review of Psycho-Analysis*, 15: 187-195.

Briggs, A. (2002) *Surviving Space*. Karnac Books Ltd, London, UK.

Britton, R. (2004) 'The missing link: parental sexuality in the Oedipus complex'. In Britton, R., Feldman, M. and Shaugnessy, E. *The Oedipus Complex today*, revised edition. Karnac Books Ltd, London, UK.

Bulman M (2019) 'More than 100,000 children denied mental health treatment each year, figures suggest. Tens of thousands of 10-17 year olds seeking help turned away from NHS trusts because problems not deemed 'serious' enough, warns Children's Society'. *The Independent*, 17th June. https://www.independent.co.uk/news/uk/home-news/child-mental-health-services-children-cuts-nhs-camhs-report-a8960736.html

Burke, S., Sanson, A. & Hoorn, J. (2018) 'The Psychological Effects of Climate Change on Children'. *Current Psychiatry Reports* 20 (35) https://doi.org/10.1007/s11920-018-0896-9

Busby E. (2019a) 'Majority of parents say exam pressure is affecting children's mental health, poll finds. Children have lost sleep and sought healthcare advice over stress related to tests, survey says'. *The Independent*, 14th May. https://www.independent.co.uk/news/education/education-news/parents-exams-mental-health-children-gcses-a-levels-sats-mumsnet-a8913406.html

Busby, E. (2019b) 'Poorer students now even more likely to drop out of university than richer peers'. The Independent, 7th March. https://www.independent.co.uk/news/education/education-news/university-dropout-rates-students-rich-poor-education-a8812526.html

Campbell. (2011) 'Co-morbidity: childhood depression and anxiety in family therapy'.In Trowel. (ed) ibid.

Canham, H. (1999) 'The Development of the Concept of Time in Fostered and Adopted Children'. *Psychoanalytic Inquiry*, 9 (2): 160-171.

Canham, H. (2002) 'Group and gang states of mind'. *Journal of Child Psychotherapy*, 28 (2): 113-127.

Caparotta, L. (2013) 'Digital technology is here to stay and the psychoanalytic community should grapple with it'. *Psychoanalytic Psychotherapy*, 27 (4): 296-305.

Carpi Lapi, S., Fattirolli, E. and Pini, M. G. (2018) 'The internet and psychotherapy with adolescents and preadolescents: some thoughts about the countertransference'. *Journal of Child Psychotherapy*, 44 (2): 221–242.

Cerniglia, L., Zoratto, F., Cimino, S., Laviola, G., Ammaniti M. and Adriani, W. (2017) 'Internet addiction in adolescence: Neurobiological, psychosocial and clinical issues'. *Neuroscience and Biobehavioral Reviews*, 76 (Part A): 174–184. https://doi.org/10.1016/j.neubiorev.2016.12.024

Centre for longitudinal studies UCL (2017) 'Being on a zero-hours contract is bad for your health, new study reveals', 5th July. https://cls.ucl.ac.uk/being-on-a-zero-hours-contract-is-bad-for-your-health-new-study-reveals/

Chak, K. and Leung, L. (2004) 'Shyness and locus of control as predictors of internet addiction and internet use'. *CyberPsychology and Behavior*, 7 (5): 559-70.

Chew-Graham, C.A., May, C.R. and Perry, M.S. (2002) 'Qualitative research and the problem of judgement: lessons from interviewing fellow professionals'. *Family Practice*, 19 (3).

Child Poverty Action Group (2017) 'The austerity Generation: the impact of a decade of cuts on family incomes and child poverty'. Report published 17th Nov. https://cpag.org.uk/child-poverty/child-poverty-facts-and-figures

Chong, S.S. and Chan, K. (2012) 'A case study of a Chinese 'Hikikomorian' in Canada – Theorising the process of Hikikomorization'. *Journal of Special Education and Rehabilitation*, 13 (3-4):99-114. https//doi: 10.2478/v10215-011-0028-0

Cimino, S. and Cerniglia, L. (2018) 'A longitudinal study for the empirical validation of an etiopathogenetic model of internet addiction in adolescence based on early emotion regulation'. *BioMed Research International*, Article ID 4038541 https://doi.org/10.1155/2018/4038541

Clarke, S. (2008) 'Psychosocial research: relating self, identity, and otherness'. In Clarke, S., Hahn, H. and Hoggett, P. (2008) *Object Relations and Social Relations*. Karnac Books Ltd, London, UK.

Coar, L. and Sim, J. (2009) 'Interviewing one's peers: methodological issues in a study of health professionals'. *Scandinavian Journal of Primary Health Care*, 24 (4): 251-256.

Copley, B. (1993) *The world of adolescence*. Free Association Books, London, UK.

Costello, J.E., Erkanli, A. and Angold, A. (2006) 'Is there an epidemic of child or adolescent depression?'. *Journal of Child Psychology and Psychiatry*, 47 (12): 1263-1271.

Coughlan, S. (2018) *'Loneliness more likely to affect young people'*. BBC news website 10th April 2018, accessed 31/05/2019 at https://www.bbc.co.uk/news/education-43711606

De Luca, M. (2017) 'Hikikomori: 'Cultural idiom or present-day expression of the distress engendered by the transition from adolescence to adulthood'. *Evolution Psychiatrique*, 82 (1): 1-15.

Dispatches. (2019) 'Invisible Kids'. Channel 4, broadcasted on 4.2.2019.

Dunn, V. and Goodyer, I.M. (2006) 'Longitudinal investigation into childhood- and adolescence-onset depression: psychiatric outcome in early adulthood.' *British Journal of Psychiatry*, 188: 216-222.

Edmunds R. (2019) 'Anxiety, loneliness and Fear of Missing Out: The impact of social media on young people's mental health ' *Centre for Mental Health*, Briefing 53, 19th Dec. https://www.centreformentalhealth.org.uk/blog/centre-mental-health-blog/anxiety-loneliness-fear-missing-out-social-media

Edwards, J. (2001) *Being Alive. Building on the work of Anne Alvarez*. Brunner Routledge, Sussex, UK.

Elliot, H., Ryan, J. and Holloway, W. (2012) 'Research encounters, reflexivity and supervision'. *International Journal of Social Research Methodology*, 15 (5): 433-444.

Emanuel (2001): 'A-Void – an exploration of defences against sensing nothingness'. *International Journal of Psychoanalysis*, 82: 1069 -1084.

Engelberg, E. and Sjöberg, L. (2004) 'Internet Use, Social Skills, and Adjustment'. *CyberPsychology, Behavior and Social Networking* https://doi:10.1089/109493104322820101

Evren, B., Evren, C., Dalbudak, E., Topcu, M. and Kutlu, N. (2018) 'Relationship of internet addiction severity with probable ADHD and difficulties in emotion regulation among young adults'. *Psychiatry Research*, 269: 494–500. https://doi.org/10.1016/j.psychres.2018.08.

Fawbert D. (2019) 'Eco-anxiety': how to spot it and what to do about it'. *BBC Three*, 27 March. https://www.bbc.co.uk/bbcthree/article/b2e7ee32-ad28-4ec4-89aa-a8b8c98f95a5

Fleming, J.E., Offord, D.R. and Boylle, M.H. (1989) 'Prevalence of childhood and adolescent depression in the community'. *The British Journal of Psychiatry*, 155: 647-654.

Flick, U., von Kardorff, E. and Steinke, I. (2004) *Qualitative Research*. SAGE Publications Ltd, London, UK. Originally published by Rowohlt Taschenbuch Verlag GmbH, Hamburg, Germany.

Fontana, A., Callea, A., Casini, E. and Curti, V. (2018) 'Rejection sensitivity and internet addiction in Adolescence: Exploring the mediating role of emerging personality disorders'. *Clinical Neuropsychiatry: Journal of Treatment Evaluation*, 15 (4): 206–214.

Freud, A. (1936) [1993] *The ego and the mechanisms of defence*. Routledge, London, UK.

Freud, S. (1912) *Recommendations to physicians practising psychoanalysis*. Standard Edition, 12, 111-120, Hogart Press Ltd.

Freud, S. (1920) *Beyond the Pleasure Principle*. Standard Edition, 18, 3-64.

Freud, S. (1923) *The Ego and the Id*. Standard Edition, 19, 1-66.

Freud, S. (1937) *Analysis Terminable and Interminable*. Standard Edition, 23, 211-252.

Furlong, A. (2008) 'The Japanese hikikomori phenomenon: acute social withdrawal among young people'. *The Sociological Review*, 56: 309–325.

Gazelle, H. and Rudolph, K. (2004) 'Moving toward and away from the world: Social approach and avoidance trajectories in anxious solitary youth'. *Child Development*, 75 (3): 829-849.

Gaw, A. and Teo, A. R. (2010) 'Hikikomori, a Japanese Culture-Bound Syndrome of Social Withdrawal?: A Proposal for DSM-5'. *Journal of Nervous & Mental Disease*, 198 (6): 444-449. doi:10.1097/NMD.0b013e3181e086b1

Geyer, L. S., le Roux, M. P., Hall, H and Crafford, G. (2017) 'Internet use among university students: A reason for concern?'. *Perspectives in Education*, 35(1): 66–80. https://doi.org/10.18820/2519593X/pie.v35i1.6

Gibbs, P.L. (2007) 'Reality in Cyberspace: Analysands' Use of the Internet and Ordinary Everyday Psychosis'. *Psychoanalytic Review*, 94: 11-38.

Glaser, B. and Strauss, A. (1968) *The Discovery of Grounded Theory*. Weidenfeld and Nicolson, London, UK.

Gondim, F.A., Aragao, A.P., Holanda, F.J. and Messias, E.L. (2017) 'Hikikomori in Brazil: 29 years of voluntary social withdrawal'. *Asian Journal of Psychiatry*, 30: 163-164.

Goodwin, R.D., Fergusson, D.M. and Horwood L.J. (2004) 'Early anxious/ withdrawn behaviours predict later internalising disorders'. *Journal of Child Psychology and Psychiatry*, 45 (4): 874-883.

Goodyer, I. M. (1996) 'Recent undesirable life events: Their influence on subsequent psychopathology'. *European Child & Adolescent Psychiatry*, 5(Suppl 1): 33-37.

Goodyer, I. M. and Altham, P. M. (1991) 'Lifetime exit events and recent social and family adversities in anxious and depressed school-age children and adolescents: I'. *Journal Of Affective Disorders*, 21(4): 219-228. https//doi:10.1016/0165-0327(91)90001-9

Goodyer et al (2017) 'Cognitive-behavioural therapy and short-term psychoanalytic psychotherapy versus brief psychosocial intervention in adolescents with unipolar major depression (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled trial'. *Health Technology Assessment*, 21 (12).

Government of Japan Cabinet Office (2010) 'Children and Young White Paper. Section2: young, unemployed, part-time worker, and withdrawal'.

https://www8.cao.go.jp/youth/kenkyu/hikikomori/pdf_index.html. Accessed on 11.4.2014; translation by Google Translator.

Gozlan, M. (2012) 'The growing band of young people living a reclusive life'. *Guardian Weekly*, 17.7.2012. https://www.theguardian.com/world/2012/jul/17/growing-band-young-people-reclusive-life

Grayson, C. (2013) 'Some clinical benefits of Digital Technology in Adolescent Psychotherapy'. *Journal of Infant, Child and Adolescent Psychotherapy*, 12: 38-44.

Guardian Weekly. (17.7.2012) Based on article in *La Monde*.

Guignard, F.(2014) 'Psychic development in a virtual world'. In Alessandra Lemma and Luigi Caparrotta (eds), 2014, ibid.

Halperin, J.M., Rucklidge, J.J., Powers, R.L., Miller, C.J. and Newcorn, J.H. (2010) 'Childhood CBCL bipolar profile and adolescent/young adult personality disorders: A 9-year follow-up'. *Journal of Affective Disorders*, 2010 (130): 155-161.

Hamilton, V. (1996) *The Analyst's Preconscious*. The Analytic Press Inc., NJ, USA.

Harrington, R. and Dubicka, B. (2001) 'Natural history of mood disorders in children and adolescents'. In *The depressed child and adolescent*. Edited by Goodyer, I. Cambridge University Press, Cambridge, UK.

Hartmut R. (2005) [2013] *Social Acceleration: A new Theory of Modernity* translated and introduced by J. Trejo-Mathys, Columbia University Press, USA

Hattori, Y. (2006) 'Social Withdrawal in Japanese Youth. A Case Study of Thirty-Five Hikikomori Clients'. *Journal of Trauma Practice*, 4 (3-4): 181-201.

Hartman, S. (2011a) 'Reality 2.0: 'When Loss is Lost'. *Psychoanalytic Dialogues*, 21: 468-482.

Hartman, S. (2011b) 'Reality Bytes: Reply to Commentaries'. *Psychoanalytic Dialogues*, 21: 508-514.

Hinshelwood, R.D. (1994) *Clinical Klein*. Free Association Books, London, UK.

Hockings, L. (presenter). *BBC World News*, 3.7.2013. http://youtu.be/dr5y1iP9TfU

Holloway, W. (2008) 'The importance of relational thinking in the practice of psychosocial research: ontology, epistemology, methodology, and ethics'. In Clarke, S., Hahn, H. and Hoggett. P. (2008) *Object Relations and Social Relations*. Karnac Books Ltd, London, UK.

Hollway, W. and Jefferson, T. (2000) *Doing qualitative research differently*. SAGE Publications Ltd, London, UK.

Honjo, S., Nishide, T., Niwa, S., Sasaki, Y., Kaneko, H., Inoko, K. and Nishide, Y. (2001) 'School refusal and depression with school inattendance in children and

adolescents: Comparative assessment between the Children's Depression Inventory and somatic complaints'. *Psychiatry and Clinical Neurosciences*, 55: 629–634. https//doi: 10.1046/j.1440-1819.2001.00916.x

Houzel, D. and Rhode, M. (2005) *Invisible Boundaries. Psychosis and Autism in Children and Adolescents*. Karnac Books, London, UK.

Howitt, D. and Cramer, D. (2008) *Introduction to Research Methods in Psychology*. Pearsons Education Limited.

Hoxter, S. (1964) 'The experience of puberty'. *Journal of Child Psychotherapy*, 1 (2): 13-25, reprinted in *Journal of Child Psychotherapy*, 43 (1): 96-107.

Hsu E.L. and Elliot A. (2014) 'Social Acceleration Theory and the Self'. *Journal for the Theory of Social Behaviour* 45 (4) . DOI:10.1111/jtsb.12072

Husu, H. and Välimäki, V. (2017) 'Staying inside: social withdrawal of the young, Finnish 'Hikikomori'. *Journal of Youth Studies*, 20 (5): 605-621. https//doi: 10.1080/13676261.2016.1254167

Jakobsen, I.S., Horwood, L.J. and Fergusson, D.M. (2012) 'Childhood Anxiety/ Withdrawal, Adolescent Parent-Child attachment and Later Risk of Depression and Anxiety Disorder'. *Journal of Child and Family Studies*, 21(2): 303-310.

Joseph, B. (1971) [1989] 'On passivity and aggression: their interrelationship'. In Feldman, M. and Spillius, E.B. (1989) '*Psychic Equilibrium and Psychic Change – Selected Papers of Betty Joseph*'. Routledge, East Sussex, UK.

Joseph, B. (1975) [1989] 'The patient who is difficult to reach'. In Feldman, M. and Spillius, E.B. (1989) '*Psychic Equilibrium and Psychic Change – Selected Papers of Betty Joseph*'. Routledge, East Sussex, UK.

Josep,h B. (1982) [1989] 'Addiction to near-death'. In Feldman, M. and Spillius, E.B. (1989) '*Psychic Equilibrium and Psychic Change – Selected Papers of Betty Joseph'.* Routledge, East Sussex, UK.

Kaneko, S. (2006). 'Japan's "Socially Withdrawn Youths" and Time Constraints in Japanese Society: Management and conceptualization of time in a support group for "hikikomori"'. *Time & Society*, 15(2–3): 233–249. https://doi.org/10.1177/0961463X06067034

Kantrowitz, J. (2009) 'Internet Interaction: The effects on patients' Lives and Analytic Process'. *Journal of the American Psychoanalytic Association*, 57 (4): 979-989.

Kato, T.A. and Tateno, M. (2010) 'Does the "hikikomori" syndrome of social withdrawal exist outside Japan? A preliminary international investigation'. *Social Psychiatry and Psychiatric Epidemiology*, 47 (7): 1061-1075.

Kato, T. (2016) 'Hikikomori and modern-type depression in Japan'. *European Psychiatry*, 33: S23-S23. https//doi:10.1016/j.eurpsy.2016.01.835

Kowalski K. (2019) ‘Climate change poses mental health risks to children and teens’. *Science News for students. Health and Medicine*, 2nd May. https://www.sciencenewsforstudents.org/article/climate-change-poses-mental-health-risks-children-and-teens

Kendler, K.S., Karkowski, L.M. and Prescott, C.A. (1999) ‘Causal relationship between stressful life events and the onset of major depression’. *American Journal of Psychiatry*, 56 (6): 837-41.

Kennedy, E., Spence, S.H. and Hensley, R. (1989) ‘An examination of the relationship between childhood depression and social competence amongst primary school children’. *Journal of Child Psychiatry*, 30 (4): 561-573.

Kingery, J.K., Erdley, C., Marshall, K., Whitaker, K.G. and Reuter, T. (2010) ‘Peer Experiences of Anxious and Socially Withdrawn Youth: An Integrative Review of the Developmental and Clinical Literature’. *Clinical Child and Family Psychology Rev*, 13: 1-128.

Klein, M. (1946) [1997] ‘Notes on Some Schizoid Mechanisms’. In *Envy and Gratitude* and other works (1946-1963). Vintage, London.

Klein, M. (1997) *The Psycho-Analysis of Children*. Vintage, London.

Klein, M. (1998) *Love, Guilt and Reparation* and other works (1921-1945). Vintage, London.

Kowalski K. (2019) ‘Climate change poses mental health risks to children and teens’, *Science News for students. Health and Medicine*. 2nd May. https://www.sciencenewsforstudents.org/article/climate-change-poses-mental-health-risks-children-and-teens

Krieg, A. and Dickie, J. (2013) ‘Attachment and hikikomori: A psychosocial developmental model’. *International Journal of Social Psychiatry*, 59 (1): 61-72.

Kvale, S. (2007) *Doing interviews*. SAGE Publications Ltd, London, UK.

Laufer, M. (1968) ‘The Body Image, the Function of Masturbation and Adolescence: Problems of Ownership of the Body’. *Psychoanalytic Study of the Child*, 23: 114-137.

Laufer (ed) (1985) *The suicidal adolescent*. Karnac Books Ltd, London, UK.

Lavin, M.J., Yuen, C.N., Weinman, M. and Kozak, K. (2004) ‘Internet dependence in the collegiate population: the role of shyness’. *Cyberpsychology and Behavior*, 7 (4): 379-83.

Lee, Y.S., Lee, J.Y., Choi, T.Y. and Choi, J.T. (2013) ‘Home visitation program for detecting, evaluating and treating socially withdrawn youth in Korea’. *Psychiatry and Clinical Neurosciences*, 67 (4): 193-202. https//doi:10.1111/pcn.12043

Lepisto, B.L. (2013) ‘All Wired Up: Tweens, Teens, Technology and Treatment’. *Journal of Infant, Child and Adolescent Psychotherapy*, 12: 34-37.

Lemma, A. (2014) ‘An order of pure decision. Growing up in a virtual world and the adolescent’s experience of the body’. In Lemma, A. and Caparrotta, L. (eds) (2014) ‘*Psychoanalysis in the Technoculture Era*’. Routledge, East Sussex, UK.

Lemma, A. (2015) ‘Psychoanalysis in times of technoculture: Some reflections on the fate of the body in virtual space’. *International Journal of Psychoanalysis*, 96: 569-582.

Leuzinger-Bohleber, M. and Target, M. (eds) *Outcomes of Psychoanalytic Treatment. Perspectives for Therapists and researchers*. Whurr publishers Ltd, London, UK and Philadelphia, USA.

Lewinsohn, P.M., Allen, N.B., Seeley, J.R. and Gotlib, I.H. (1999) ‘First onset versus recurrence of depression: Differential processes of psychosocial risk’. *Journal of Abnormal Psychology*, 108: 483-489.

Li, T.M. and Wong, P.W. (2015) ‘Youth social withdrawal behavior (hikikomori): A systematic review of qualitative and quantitative studies’. *The Australian and New Zealand Journal Of Psychiatry*, 49 (7): 595-609.

Li, T.M., Liu, L. and Wong, P.W. (2018) ‘Withdrawal experience and possible way-outs from withdrawal behavior in young people’. *Qualitative Social Work*, 17 (4): 537-555. https://doi.org/10.1177/1473325016688369

Lingiardi, V. (2008) ‘Playing with Unreality: Transference and computer’. *International Journal of Psychoanalysis*, 89: 111-126.

Lingiardi, V. (2011) ‘Realities in Dialogue: Commentary on Paper by Stephen Hartman’. *Psychoanalytic Dialogues*, 21: 483-495.

Local Government Association (2020) ‘CAMHS – Facts and Figure’. https://www.local.gov.uk/about/campaigns/bright-futures/bright-futures-camhs/child-and-adolescent-mental-health-and

Lovegrove, L. B. (2013) ‘All Wired Up: Tweens, Teens, Technology and Treatment’. *Journal of Infant, Child and Adolescent Psychotherapy*, 12: 34-37.

Magagna, J. (2002) ‘Mrs Bick’s contribution to the understanding of severe feeding difficulties and pervasive refusal’. In Briggs, A. *Surviving Space*. Karnac Books Ltd, London, UK.

Majeed H. & Lee J. (2017) ‘The impact of climate change on youth depression and mental health’. *The Lancet planetary Health*, 1 (3) https://doi.org/10.1016/S2542-5196(17)30045-1

Malagón-Amor, A. et al (2018) ‘A 12-month study of the hikikomori syndrome of social withdrawal: Clinical characterization and different subtypes proposal’. *Psychiatry Research* https//doi:10.1016/j.psychres.2018.03.060

Malater, E. (2007) ‘Caught in the Web’. *Psychoanalytic Review*, 94 (1): 151-169.

Masataka, N. (2002) ‘Low anger-aggression and anxiety-withdrawal characteristic to preschoolers in Japanese society with 'hikikomori' is becoming a major social problem’. *Early Education and Development*, 13(2).

Mason, J. (2014) *Qualitative Researching*. Sage Publications Ltd, London.

McDougall, J. (1984) ‘The “Dis-Affected” Patient: Reflections on Affect Pathology’. *Psychoanalytic Quarterly*, 53: 386-409.

McGrath L., Griffin V., Mundy E. (2016) ‘The psychological impact of austerity’. *Educational Psychology Research and Practice*, 1st Dec https://www.researchgate.net/publication/322918554_The_Psychological_Impact_of_Austerity_A_Briefing_Paper

Meltzer, D. (1973) ‘Terror, Persecution, Dread’. In *Sexual States of Mind*. Karnac Books Ltd, London, UK.

Metlzer, D. (1975) ‘*Dimensionality in Mental Functioning’.* In Meltzer et al ibid.

Meltzer, D. 1992 (2008) *The Claustrum.* Karnac Books Ltd, London, UK.

Meltzer, D., Brenner, J., Hoxter, S., Weddell, D. and Wittenberg, I. (1975) *Explorations in Autism*. Clunie Press for Roland Harris Trust, UK,

Midgley, N. (2006) ‘The inseparable bond between cure and research: clinical case study as a method of psychoanalytical inquiry’. *Journal of Child Psychotherapy*, 32 (2): 122-147.

Midgley, N. (2010) ‘Research in child and adolescent psychotherapy: an overview’. In Horne and Lanyado *The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches*. Routledge, London, UK.

Mitchell, J., McCauley, Bruke, P.M. and Moss, S.J. (1988) ‘Phenomenology of depression in children and adolescents’. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27: 12-20.

Molavi, P., Mikaeili, N., Ghaseminejad, M. A., Kazemi, Z. and Pourdonya, M. (2018) Social anxiety and benign and toxic online self-disclosures: An investigation into the role of rejection sensitivity, self-regulation, and Internet addiction in college students. *Journal of Nervous and Mental Disease*, 206 (8): 598–605.

Mooney, R. (2016). ‘“It’s silly these doors don’t open”: a six-year-old girl emerges from a chronic state of emotional withdrawal’. *Journal of Child Psychotherapy*, 42 (2): 163–178.

Morse, J. (1994) ‘Qualitative Research: Fact or Fantasy? In Morse J, ed, *Critical Issues in Qualitative Research Methods*. SAGE Publications Inc, California, USA.

Mueller, K., Janikian, M., Dreier, M., Wölfling, K., Beutel, M., Tzavara, C. and Tsitsika, A. (2015) ‘Regular gaming behavior and internet gaming disorder in European adolescents: results from a cross-national representative survey of

prevalence, predictors, and psychopathological correlates'. *European Child & Adolescent Psychiatry*, 24(5): 565–574. https://doi.org/10.1007/s00787-014-0611-2

Nagata, T., Yamada, H., Teo, A., Yoshimura, C. and Nakajima, T. (2013) 'Comorbid social withdrawal (hikikomori) in outpatients with social anxiety disorder: Clinical characteristics and treatment response in a case series'. *International Journal Social Psychiatry*, 59 (1): 73-78.

Nae and Niculina (2018) 'Quo Vadis? Japanese Youth and the Burden of Living'. *Euromentor Journal*, 9 (2)

Nalwa, K. and Anand, A. (2003) 'Internet addiction in students: a cause of concern'. *CyberPsychology and Behavior*, 6 (6): 653. https//doi:10.1089/109493103322725441

Oakley, A. (2016) 'Interviewing Women Again: Power, Time and the Gift'. *Sociology*, 50 (1): 195-213.

Odgen, T. (1989) *The primitive edge of experience*. Karnac Books Ltd, London, UK.

OECD (2018) *Programme for International Student Assessment Results 2018*. https://www.oecd.org/pisa/publications/pisa-2018-results.htm

Office for National Statistics (2019a), 'Young people not in education, employment or training (NEET), UK: November 2019'. https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/bulletins/youngpeoplenotineducationemploymentortrainingneet/november2019

Office for National Statistics (2019b) 'People in Employment on zero hours contracts'. https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/emp17peopleinemploymentonzerohourscontracts

O'Shaughnessy, E. (1964) 'The Absent Object'. *Journal of Child Psychotherapy*, 1 (2): 34-43.

O'Shaughnessy, E. (1981) 'A Clinical Study of a Defensive Organization'. *International Journal of Psycho-Analysis*, 62: 359-370.

O'Shaughnessy, E. (1994) 'What is a Clinical Fact'. *International Journal of Psycho-Analysis,* 75: 939-948.

Overell, R. (2018) 'Queer Will: hikikomori as wilful subjects'. *Inter-Asia Cultural Studies*, 19 (2): 206-219.

Palinkas A. (2019) 'Ecoanxiety. Ecoparalysis. Solastalgia. Call it what you want—when it comes to climate change and mental health, the future is now'. *Environmental Health News* 2nd Dec. https://www.ehn.org/how-climate-change-affects-mental-health-2641458829.html?rebelltitem=1

Petry, N. M., Rehbein, F., Gentile, D. A., Lemmens, J. S., Rumpf, H.J. and Mößle, (2014) 'An international consensus for assessing internet gaming disorder using the

new DSM-5 approach’. *Addiction*, 109 (9): 1399–1406. https://doi.org/10.1111/add.12457

Platt, J. (1981) ‘On interviewing one’s peers’. *British Journal of Sociology*, 32 (1)

Puffet, N.(2018) 'Austerity to blame' for many children's mental health problems’. *Children and Young People Now*, March 6th. https://www.cypnow.co.uk/news/article/austerity-to-blame-for-many-children-s-mental-health-problems

Ranieri, F. (2015) ‘When social withdrawal in adolescence becomes extreme: the hikikomori phenomenon in Italy’. *Psychiat Psychol Klin* 15 (3): 148-151. https//doi:10.15557/pipk.2015.0023

Ranieri, F. (2018) ‘Psychoanalytic psychotherapy for hikikomori young adults and adolescents’. *British Journal of Psychotherapy*, 34 (4): 623-642.

Ranieri, F., Andreali, M., Bellagamba, E., Franchi, E., Mancini, F., Pitti, L., Sfameni S. and Stoppielli, M. (2015) ‘Early Adolescence in Social Withdrawal: Two Hikikomori in Treatment’. *European Psychiatry*, 30 (1): 1198. https//doi.org/10.1016/S0924-9338(15)30941-X

Rashid I. (2019) ‘Primary school SATs create too much pressure for teachers and pupils says survey. YouGov poll suggests school leaders believe the exams lead to a narrowing of the curriculum being taught’. *Sky News*, 19th March. https://news.sky.com/story/primary-school-sats-create-too-much-pressure-for-teachers-and-pupils-says-survey-11669830

Reid, S. (1997) ‘The generation of Psychoanalytic knowledge: Sociological and Clinical Perspectives. Part two: Projective Identification – the other side of the Equation.’ *British Journal of Psychotherapy*, 13 (4).

Reiner, I., Tibubos, A., Hardt, J., Müller, K., Wölfling, K. and Beutel, M. (2017) ‘Peer attachment, specific patterns of internet use and problematic internet use in male and female adolescents’. *European Child & Adolescent Psychiatry*, 26 (10): 1257–1268. https://doi.org/10.1007/s00787-017-0984-

Rhode, M. (2011) ‘Some reflections on the individual therapy: themes and interventions’. In Trowel, J. (ed) *Childhood Depression*, Karnac Books Ltd, London, UK.

Rosenfeld, H. (1964) ‘On the Psychopathology of Narcissism: A clinical Approach’. In Rosenfeld, H. *Psychotic States*. Karnac Books Ltd, London, UK.

Rosenfeld, H. (1971) ‘A clinical approach to the psycho-analytical theory of the life and death instinct.’ *Int. Journal of Psycho-Analysis*, 52: 396-400.

Rosenfeld, H. (1987) ‘Destructive Narcissism and the death instinct’. In Rosenfeld, H. *Impasse and Interpretation*. New Library of Psychoanalysis, Routledge, London, UK.

Rubenstein, E. (2016) ‘Emplotting Hikikomori: Japanese Parents’ Narratives of Social Withdrawal’. *Culture, Medicine and Psychiatry*, 40: 641-663.

Rudolf, K. and Klein, D.N. (2009) ‘Exploring depressive personality traits in youth: Origins, correlates, and developmental consequences’. *Development and Psychopathology*, 21 (4): 1155-1180.

Rustin, M (1997) ‘The generation of Psychoanalytic knowledge: Sociological and Clinical Perspectives. Part One: Give me a Consulting Room…. The Generation of Psychoanalytic Knowledge’. *British Journal of Psychotherapy*, 13 (4).

Rustin, M. (2000) ‘Reflections on the biographical turn in social sciences’. In Chamberlayne, P.M., Bornat, J. and Wengraf, T. (eds) *The turn to Biographical Methods in Social Sciences*. Taylor Francis/ Routledge, London, UK.

Rustin M. (2001) ‘Research, evidence and psychotherapy’ in Mace C., Stirling M. & Roberts B. (eds) *Evidence in the Psychological Therapies. A critical guide for practitioners*. Brunner-Routledge, Hove, UK

Rustin, M. (2003) ‘Research in the Consulting Room’. *Journal of Child Psychotherapy* 29 (2): 137-146.

Rustin, Margaret (2009) ‘The psychology of depression in young adolescents: A psychoanalytic view of origins, inner workings and implications’. *Psychoanalytic Psychotherapy*, 23 (3): 213-224. https//doi:10.1080/02668730903226596

Rustin, Michel (2009) ‘What do Child psychotherapists know?’. In Midley, N., Anderson, J., Grainger, E., Nesic-Vuckovic, T. and Urwin, C. (2009) *Child Psychotherapy and Research*. Routledge, East Sussex, UK.

Rustin, M. (2010) ‘Varieties of psychoanalytic research’. *Psychoanalytic Psychotherapy*, 24 (4): 380-397.

Rustin M. (2019) ‘Researching the Unconscious. Principles of psychoanalytic method’. Routledge, Oxon, UK

Ryan F. (2016) ‘Our children’s mental health crisis is shocking. But so is the Tory silence’. *The Guardian, 19 May 2016 08.01 BST* https://www.theguardian.com/commentisfree/2016/may/19/children-mental-health-crisis-tory-silence-austerity-natasha-devon-axed

Saito Tamaki (1998) ‘Hikikomori. Adolescence without End’. Original publication in Japan by PHP Institude, Inc. English translation copyright 2013 by University of Minnesota Press, Minneapolis, USA

Sanchez Rojo (2017) ‘The “hikikomori” phenomenon: tradition, education and information and communication technologies (ICT)’. *Arbor: Ciencia, Pensamiento y Cultura*, 193 (785): 405 https// 10.3989/arbor.2017.785n3010

Sakamoto N., Martin R.G., Kumano, H., Kuboki T. and Al-Adawi, S. (2005) ‘Hikikomori, is it a cultural-reactive or culture-bound syndrome? Nidotherapy and a

clinical vignette from Oman.' *The International Journal of Psychiatry in Medicine*, 35 (2): 191-198.

Sarchione, F. et al. (2015) 'Hikikomori: Clinical and Psychopathological Issues'. *European Psychiatry*, 30: 1288. https//doi:10.1016/S0924-9338(15)31007-5

Scealy, M., Phillips, J.G. and Stevenson R. (2002) 'Shyness and Anxiety as Predictors of Patterns of Internet Usage'. *CyberPsychology & Behavior*, 5 (6) https//doi.org/10.1089/109493102321018141

Segal, H. (1957) [1986] 'Notes on Symbol Formation'. In Hanna Segal *Delusion and artistic creativity and other psychoanalytic essays*. Free Association Books, London, UK.

Segal, H. (1997) 'On the clinical usefulness of the concept of the death instinct'. In J. Steiner (ed) *Phantasy, Literature and War. Papers 1973-1995*. Routledge, London, UK.

Shirasaka, T., Tateno, M., Tayama, M., Tsuneta, M., Kimura, H. and Saito, T. (2016) 'Survey of the relationship between internet addiction and social withdrawal (HIKIKOMORI) in Japan'. *Japanese Journal Of Alcohol Studies & Drug Dependence*, 51 (5): 275–282. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=cmedm&AN=30462389&authtype=shib&site=eds-live

Silverman, D. (2014) *Interpreting Qualitative Data.* Sage Publications Ltd, London, UK.

Singer (2013) 'Discussion of Presentations by Barry Dauphin, Charles Grayson, and Brenda Lovegrove Lepisto for the Panel "All Wired Up: Tweens, Teens, Technology and Treatment"'. *Journal if Infant, Child and Adolescent Psychotherapy*, 12: 51-57.

Skidmore, C., Cuff, N. and Leslie, C. (2007) *Invisible Children*. Report by the Bow Group. https://www.bowgroup.org/sites/bowgroup.uat.pleasetest.co.uk/files/Invisible%2520Children%2520-%252024.05.07.pdf

Smahel, D., Brown, B. B. and Blinka, L. (2012) 'Associations between online friendship and Internet addiction among adolescents and emerging adults'. *Developmental Psychology*, 48 (2): 381–388. https://doi.org/10.1037/a0027025

Smith, J., Flowers, P. and Larkin, M. (2009) *Interpretative Phenomenological Analysis*. SAGE Publications Ltd, London, UK.

Spillius, B., Milton, J., Garvey, P., Couve, C and Steiner, D (2011) *The New Dictionary of Kleinian Thought*. Routledge, East Sussex, UK.

Steiner (1987) 'The interplay between pathological organisations and the paranoid-schizoid and depressive positions'. *International Journal of Psycho-Analysis*, 12: 161-172.

Steiner, J. (1993) *Psychic Retreats*. Routledge, London, UK.

Stip, E., Thibault, A., Beauchamp-Chatel, A. and Kisley, S. (2016) 'Internet Addiction, Hikikomori Syndrome, and the Prodromal Phase of Psychosis'. *Frontiers in Psychiatry*, 7 (6). https//doi:10.3389/fpsyt.2016.00006

Symington, J. (1985) 'The Survival Function of Primitive Omnipotence'. *International Journal of Psycho-Analysis*, 66: 481-488.

Tamaki, S. (1998) *Hikikomori. Adolescence without End*. English Translation: 2013, Regents of the University of Minnesota Press, USA.

Tanabe, N., Hiraoka, E., Kataoka, J., Naito, T., Matsumoto, K., Arai, J. and .Norisue, Y. (2018) 'Wet Beriberi Associated with Hikikomori Syndrome'. *Journal of General Internal Medicine*, 33 (3): 384-387.

Tateno, M., Park, T.W., Kato, T.A., Umene-Nakano, W and Saito, T. (2012) 'Hikikomori as a possible clinical term in psychiatry: a questionnaire survey'. *BMC Psychiatry*, 12:169. https//doi:10.1186/1471-244X-12-169

Takahiro, K.A., Shigenobu, K. and Teo, A. (2018) 'Hikikomori: Experience in Japan and international relevance'. *World Psychiatry*, 17 (1): 105-106.

Takahiro, K.A., Naotaka, S., Norman, S. and Shigenobu, K. (2011) 'Are Japan's hikikomori and depression in young people spreading abroad?'. *The Lancet*, 378: 1070. https://doi.org/10.1016/S0140-6736(11)61475-X

Taylor, D. (2010) 'Psychoanalytic Approaches and outcome research: negative capability or irritable reaching after fact and fiction'. *Psychoanalytic Psychotherapy*, 24 (4): 398-416.

Teo, A.R. (2010a) 'A New Form of Social Withdrawal in Japan: a Review of Hikikomori'. *Int J Soc Psychiatry,* 56: 178-185.

Teo, A. (2010b) 'Social isolation associated with depression: A case report of hikikomori'. *International Journal of Social Psychiatry*, 56: 178-185.

Teo, A.R., Fetters, M.D., Stufflebam, K., Tateno, M., Balhara, Y., Choi, T.Y. et al (2015) 'Identification of the hikikomori syndrome of social withdrawal: psychosocial features and treatment preferences in four countries'. *Int. J Soc. Psychiatry* 61 (10): 64-72. https//doi:10.1177/0020764014535758

TheHarris, J. (2009) *Hikikomori* http://youtu.be/50Y7R5zP0wc

The Trussel Trust (2019) 'Record 1.6m food bank parcels given to people in past year as the Trussell Trust calls for end to Universal Credit five week wait', 25th April.
https://www.trusselltrust.org/2019/04/25/record-1-6m-food-bank-parcels/

Toivonon T., Norasakkumkit, V. and Uchida, Y. (2011) 'Unable to conform, unwilling to rebel? Youth, culture, and motivation in globalising Japan'. *Frontiers in Psychology*, (2) https//doi: 10.3389/fpsyg.2011.00207

Toronto, E. (2009) ‘Time out of Mind: Dissociation in the Virtual World’. *Psychoanalytic Psychology*, 2: 117-133.

Trowel, J. (eds) (2011) *Childhood Depression. A Place for Psychotherapy.* Karnac Books, London, UK.

Turkle, S. (2004) ‘Whiter Psychoanalysis in Computer Culture?’. *Psychoanalytic Psychotherapy*, 21 (1): 16-30.

Turkle, S. (2005) *The Second Self: Computers and the Human Spirit*. Cambridge: MIT Press.

Uchida, Y. and Norasakkunkit, V. (2015) ‘The NEET and Hikikomori spectrum: Assessing the risk and consequences of becoming culturally marginalized’. *Frontiers in Psychology*, 6 (1117); https//doi: 10.3369/psyg.2015.01117

Waddell, M. (2002) *Inside Lives*. Karnac Books Ltd, London, UK.

Waddell, M. (2018) *On Adolescence. Inside Stories.* Routledge, Oxon, UK.

Wartberg, L., Kriston, L. and Kammerl, R. (2017). ‘Associations of Social Support, Friends Only Known Through the Internet, and Health-Related Quality of Life with Internet Gaming Disorder in Adolescence’. *CyberPsychology, Behavior & Social Networking*, 20 (7): 436–441. https://doi.org/10.1089/cyber.2016.0535

Watts, J. (2002) ‘Public Health experts concerned about “hikikomori”’. *The Lancet*, 359 (9312). https//doi:10.1016/S0140-6736(02)08186-2

Weale S. (2017) ‘More primary school children suffering stress from Sats, survey finds’, The Guardian, 1st May. https://www.theguardian.com/education/2017/may/01/sats-primary-school-children-suffering-stress-exam-time

Weale, S. (2018) ‘University drop-out rates in UK rise for third successive year’. https://www.theguardian.com/education/2018/mar/08/university-drop-out-rates-uk-rise-third-year

Weinberg (2014) *The Paradox of Internet Groups. Alone in the Presence of Virtual Others*. Karnac Books Ltd, London, UK.

Whang, L. et al (2003) ‘Internet Overuses Psychological Profile: A Behavior Sampling Analysis of Internet Addiction’. *Cyberpsychology and Behavior*, 6: 143-150.

Wilkinson, P. O., Harris, C., Kelvin, R., Dubicka, B. and Goodyer, I. M. (2013). ‘Associations between adolescent depression and parental mental health, before and after treatment of adolescent depression’. *European Child & Adolescent Psychiatry*, 22 (1): 3-11. https//doi:10.1007/s00787-012-0310-9

Williams, G. (2000) *Internal Landscapes and Foreign Bodies*. Gerald Duckworth, London, UK.

Winnicott D.W. (1960) [1990] 'The Theory of the Parent-Infant Relationship'. *The Maturational Processes and the Facilitating Environment*, H. Karnac (Books) Ltd, London, UK

Winnicott, D. W. (1963) *Struggling through the Doldrums*. Winnicott, C., Shepherd, R. and Davis, M. eds (2012) Winnicott, D.W. *Deprivation and Delinquency*. Routledge Classics, London and New York.

Winnicott, D. W. (1967) 'The Location of Cultural Experience'. *International Journal of Psycho-Analysis*, 48: 368–372.

Winnicott (1958) [1992] *Through Paediatrics to Psychoanalysis*. H. Karnac (Books) Ltd., London, UK, London, UK.

Winnicott (1989) *Playing and Reality*. Routledge, London, UK.

Wittenberg, I. (1975) *Primal Depression in Autism – John*. In Meltzer et al ibid.

Wong, V. (2009) 'Youth Locked in Time and Space? Defining Features of Social Withdrawal and Practice Implications'. *Journal of Social Work Practice*, 23 (3): 337-352.

Wong, P.W., Li, T.M., Chan, M., Law, Y.W., Chau, M., Cheng, C., Fu, K.W., Bacon-Shone, J. and Yip, P.S. (2015) 'The prevalence and correlates of severe social withdrawal (hikikomori) in Hong Kong: A cross-sectional telephone-based survey study'. 61 (4): 330-342. https//doi: 10.1177/0020764014543711

Wonjung O., Rubin, K.H., Bowker, J.C., Booth-LaForce, C., Rose-Krasnor, L. and Laursen, B. (2007) 'Trajectories of Social Withdrawn from Middle Childhood to Early Adolescence'. *Journal of Abnormal Child Psychology* https//doi10.1007/s10802-007-9199-z

Yang, S. and Tung, C. (2007) 'Comparison of Internet Addicts and Non-Addicts in Haiwanese High School'. *Computers in Human Behavior*, 23: 79-96.

Ybarra, M. et al (2005) 'Depressive Symptomatology, Use, Internet Use and On-Line In reaction: A National Survey'. *Journal of Adolescence Health*, 36: 9-18.

Yong, R. and Kaneko, Y. (2016) 'Hikikomori, a Phenomenon of Social Withdrawal and Isolation in Young Adults Marked by an Anomic Response to Coping Difficulties: A Qualitative Study Exploring Individual Experiences from First- and Second-Person Perspectives'. *Open Journal of Preventive Medicine*, 6: 1-20. http://dx.doi.org/10.4236/ojpm.2016.61001

Yong, R. and Nomura, K. (2019) 'Hikikomori is most associated with interpersonal relationships, followed by suicide risk: a secondary analysis of a national cross-sectional study'. *Frontiers in Psychiatry*, 10 (247). https//doi:10.3339/fpsyt.2019.00247

YouGov (2019) 'Primary school leaders deliver damning verdict on high-pressure testing'. 18th March.

https://www.morethanascore.org.uk/primary-school-leaders-deliver-damning-verdict-on-high-pressure-testing/

YoungMinds (2018) ‘New Figures Show A Rise In Young People's Mental Health Problems Since 2004’. 23rd Nov. https://youngminds.org.uk/blog/new-figures-show-a-rise-in-young-peoples-mental-health-problems-since-2004/

Yuen, J., Yan, Y., Wong, V., Tam, W., So, K-W. and Chien, W-T. (2018) ‘A comprehensive health profile of Youths living a “hikikomori” lifestyle’. *International Journal of Environmental Research and Public Health*, 15: 315. https//doi:10.1177/0020764011423184

Zizek, S.L. (2004) ‘What can Psychoanalysis Tell us About Cyberspace?’. *The Psychoanalytic Review*, 91: 801-830.

Zochil, M. L. (2015). ‘A Literature Review of Internet Addiction with a Focus on University Students’. *Journal of the Australian & New Zealand Student Services Association*, (46), 13–19. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=eue&AN=112085198&authtype=shib&site=eds-live

Appendix A : Descriptive table of referrals within audit with less severe socially isolated presentation

No	Ref by	Age/ gen der	Description of isolation (socially isolated but not shut away completely)	Other presentations/ info	Outcome of referral
120	Other clinic	24/ m	Only having online relationships, which he clings to, lonely, feels invisible	Suicide attempt, bullied at school, porn	Did not opt in
98	Other clinic	17/f	Referrer mentioned severe anxiety, including social anxiety in the past, but that had improved	Self-harm, suicidal ideation, restricting food, alcohol and drugs, art degree	Withdrew referral
157	Self	17/ m	Not wanting to do anything, not talking to anyone, not caring about anything	Was mugged and bullied at secondary school, fears of being controlled/ humiliated, and thus won't get close	Disengaged after one appt. Previous family therapy which was perceived as not making any difference
167	Educ ation	18/f	Described as feeling invisible and being very isolated with no friends	Self-harm, eating issues (restricting), body image issues, fear of being rejected	Attended. four assess appts, referred to MH service as too risky
88	GP	16/ m	Addicted to computer games, social anxiety issues and low school attendance	Physical deformity	Parent only attended one appt
51	Self	19/ m	Solitary activities and internet overuse, difficulty making friends	Immigrant (as teen), abused by person in authority as child in home country, DV	Referred to therapy elsewhere
30	GP	20/ m	When not at work spends all his time in his bedroom, isolates himself and avoids contact with outside world	Stuck in development, bereavement (dad)	Psychotherapy, improved and able to go to uni
115	GP	15/ m	Depressed, no friends, staying in his room a lot of the time, only communicating with other people on the internet, does still attend school	Confused about sexual identity, depressed since 12yrs	Disengaged after attendin one assessment session
69	Other clinic	19/f	Very lonely, abandoned, depressed	Self-harm, at 12yrs came to UK while parents went back to homeland, is now at Uni	Weekly therapy, open

129	GP	16/f	Problem going to school, anxiety socialising	Panic attacks, medically unexplained physical symptoms, gender issues	Psychotherapy, open
132	Other clinic	15/f	Fluctuates withdrawn-engaged, therapy seen as respite to unrelenting demanding world, depressed	Panic attacks, suicide attempts, therapist seen as intrusive	Psychotherapy, open
59	Self	18/f	Withdrawn, social isolation, fear of unfamiliar people, anxiety going out	Self-harm, anxiety, suicide attempts, immigrated here at 14yrs, visual and auditory disturbances *previous inpatient unit*	Did not engage after attending one session
68	GP	20/m	Panic attacks before leaving home, depressed, social phobia, prefers contact online as can present himself in different light	Very self-conscious, thinks people looking and laughing at him, family are immigrants and isolated	Attended all four assessment sessions then declined offer of therapy
82	GP	18/m	Can't get off his chair and turn off computer game, doesn't like people, lethargic	Despairing, holds weapons at his bedside	Parent attended one session only
119	Other clinic	19/m	About every two/three months he stops being able to function and can't get out of bed for two-three weeks at a time, dropped out of uni	Was bullied as child for being fat, says he had girlfriends but no friends, self-harm	Referred to complex care team (but did not respond to them)

Appendix B : Descriptive table of referrals within audit with severely withdrawn presentation

No	Referred by	Age/ gender	Description of isolation (withdrawn in room)	Other presentations/ information Previous mental health service input	Outcome of referral
97	GP	22/ m	Dropped out of college due to depression, social withdrawal, reversed wake/sleep cycle. This had improved after previous psychotherapy and he returned to college but then relapsed after 3 yrs	Depression, suicide attempt, question of PTSD (mugged), suicide attempt, hating himself and others, cannabis use *previous inpatient unit*	Referred to complex needs at intake
139	GP	19/ m	Housebound for a year and rarely leaving his bedroom or bed, with a reversed sleep/ waking cycle	Cannabis use, friends would come and watch him sleep, close relationship with mum, violent behaviour when younger, bereavements *in EBD primary*	Referred to mental health services at intake
124	GP	17/ m	Refusing school before, and now out of education or work, high levels of social anxiety, only messages people he met online, no other contact, spending his time at home and sleeping up to 20 hours at a time, only having left the house twice in preceding four months to go to shop for food, extremely isolated	Previous therapy for PTSD due to car crash, previously bullied, questions around chronic fatigue	Attended the four assessment sessions, felt better and even met with friends, but then disengaged after the assessment
90	GP	15/ f	Dropped out of school and was being home schooled by mum. She was described as unable to leave the house	OCD and chronic abdominal pain, several admissions to hospital as child (whooping cough and others), described as 'enmeshed with mum' *previous CAMHS offered but not engaged with*	Disengaged after one assessment appt
101	Other clinic	21/ m	Assessor described patient as stuck at home, unable to engage with anything and escaping into a sci-fi world. referrer mentioned social anxiety and depression	Suicidal, general anxiety disorder, worried about how others see him, bullying, previous alcohol problems, 'wants to be taken care of in residential home'. *previous inpatient unit*	After four attended assessment sessions, was referred to complex needs team as seen as too unsettled for outpatient therapy

112	Other clinic	17/ m	Not attending school, home schooled, addicted to computer games and sleep/ wake reversed pattern, communicates with friends via skype	Suffering from chronic abdominal pain. Bereavement (grandma) Discusses himself in third person Visual and auditory disturbances Enmeshed with mum In sessions withdraws once more meaningful explorations Feels bored Says things are fine and only attends to please parents *previous CAMHS*	Attended eight out of 13 sessions
126	GP	15/ f	Extreme social anxiety, no friends, shut inside room	Eating issue, denying there is a problem, trichotillomania	Parents attended two appts but then disengaged
70	GP	21/ m	Social anxiety since young age, solitary, dropped out of Uni, returned and 'shut down' in his room since	Would store food for fear of disaster (psychiatric assessed as not psychotic), bullied by sibling and at school, angry outbursts at school	Psychotherapy, open
93	Other clinic	23/ f	Dropped out of uni after first year, eight months prior, and has taken to her bed refusing to see anyone since	Sexually abused by stranger in homeland, bullied in primary, immigrated to UK after 16yrs, medically unexplained physical symptoms (dizziness, inner ear probs), mother physical illness, family secretive	Parent work, open
100	Other clinic	20/ f	Out of school for three yrs, then dropped out of uni and stays home, social anxiety, disconnected from others, depressed	Obsessional, perfectionistic, mother anorexic, somatising, question of ME	Psychotherapy, open
138	Other clinic	22/ m	Dropped out of college after first year. Social withdrawal, depressed, Retreats from everyday life into a world within his room and online, poor sleep patterns	Severe anxiety, lonely as child, fears about parents expectations, criticised as lazy,	Therapy and psychiatric input, open
141	Self	23/ f	Out of work or education, stays at home bored, little	Gender issues, has boyfriend, self-	CBT therapy, deteriorated,

			relating with family, shut-down, depressed	destructive, in therapy becomes silent, withdrawn and dejected when feels misunderstood	referred to BP service
158	Other clinic	18/ f	Fearful of leaving home, and stopped attending school (missed three years), feels stuck	Physical symptoms (IBS) made her stopped leaving house, panic attacks As child was carer Self-harm to manage anger, feels not seen by family. Continues to withdraw when physical symptoms better	Psychotherapy, open No more self-harm and improvement in IBS
166	Other clinic	18/ f	Dropped out of school at 14yrs, isolated at home, housebound. Retreats into world of comics and computer, real world feels too dangerous. Does not have a friend	Phobias (contamination fears), cut off emotionally, Panic attacks, high IQ, abused as child, maternal MH issue. Lonely as child, felt different, but did have friends as child	Psychotherapy, open Slow improvement in mood and less retreating
58	Other clinic	18/ f	Unable to leave house, not socialising, withdrawn into herself	Self-harm, Previous school attendance poor but still high achieving. Selective mute as child *Previous CAMHS*	Anti-depressants and parent work. Mood improved and over time able to socialise a bit and has part-time job
80	self	23/ m	Dropped out of Uni due to severe anxiety. After a violent clash with mate, he isolates himself inside his room. anxious e.g. panics when phone rings, hides phone	Lonely as child Gets too close, clingy to others	Only attended one out of four sessions (YPCS)

Appendix C: Information sheet given to participants

<u>Information sheet for interested participants in the research study</u>

Shut in and cut off?

An exploration of internal and external relationship dynamics of adolescents and young adults who are socially withdrawn and isolated in their homes

How does a young person come to be withdrawn to the extent of shutting themselves away from the social outside world and shut themselves away inside their homes for long periods at a time? What contributes to a young person becoming withdrawn and what makes it difficult to come out of their withdrawn state?

How can we engage with someone who has dis-engaged from contact? What are the particular challenges for the clinician in trying to make contact with them?

These are the questions I would like to explore in this research study. It is hoped that this study will contribute towards understanding of the 'psychic retreat' state and towards increasing services' ability to help young people who are withdrawn.

I am looking for psychotherapists and psychiatrists working at the Tavistock who are interested in exploring these issues, and would like to think more about work they have done with a withdrawn young person (15- 25yrs) or with his/her family.

Involvement in this study will consist of a 1 hour tape-recorded interview.

Further information about the researcher and the research:

Petra Mohr is a trainee Child and Adolescent Psychotherapist placed at xxx. This study is part of my Professional Doctorate.

I have a particular interest in withdrawal states and in the Hikikomori phenomena, and have given presentations of a case study at the ACP (Association of Child psychotherapists) 2014 annual conference, and at forums of the BPS (British Psychoanalytic Society) and of the SAP (Society of Analytic Psychology).

Please contact me on xxx for any further information

UEL is the sponsor of this research.

Data gained in this study will be kept secure and confidential to the researcher and her supervisors, subject to legal limitations.

Participants' names or place of work will not be given to ensure that the participants are not identifiable.

I will not ask for detailed case-histories of the patients you may discuss, and only ask for particular biographical information about the patients which relate to my research question (for example: at what point in their lives did they start shutting themselves away?). Any more detailed biographical information about a patient that may arise in the course of the interview will not be used in the written material research. I will be vigilant to disguise any information about the patient or about the treatment to ensure that it is not identifiable.

The researcher's dissertation and any subsequent dissemination in presentation at professional conferences or publications in peer reviewed journals of the research may include anonymised data extracts from the interview.

This research has been given formal approval from UREC, the Ethics Committee of the University for East London. Data generated in the course of the research will be retained in accordance with the University's Data Protection Policy. Confidentiality of information provided is subject to legal limitations.

Involvement in the project is voluntary and participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

Any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, should be addressed to researchethics@uel.ac.uk.

Appendix D: Consent Form for participants

Consent for participation in the Research Study:

"Shut in and cut off?-An exploration of internal and external relationship dynamics of adolescents and young adults who are socially withdrawn and isolated in their homes"

I give my consent in participating in a tape-recorded interview for this research study.

I give my consent for anonymous material relating to this interview at the Tavistock and Portman NHS Foundation Trust to be used for presentation at professional conferences or publication in journals relating to psychotherapy.

I understand the following:

- This study is a research project as part of a Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy undertaken by the researcher, Petra Mohr.
- Participation in this study will involve an audio-recorded interview. The interviews will take place at the Tavistock and Portman NHS Trust.
- Anonymised quotations and/ or understanding gained from this interview may be described within the researcher's dissertation, and may be disseminated via presentation at professional conferences or published in peer reviewed journals.
- Data gained in this study will be kept confidential. Participants' names and place of work will be anonymised in the research dissertation and in any dissemination of the research.

- The researcher/ interviewer will not ask for detailed case-histories of any patients. Any more detailed biographical information about a patient that may arise in the course of the interview will not be used in the written material research. Information about patients or about the treatment will be disguised and not identifiable.
- Arrangements for the secure management, storage and destruction of data will be adhered to.
- This research has been given formal approval from UREC. Data generated in the course of the research will be retained in accordance with the University's Data Protection Policy. Confidentiality of information provided is subject to legal limitations.
- UEL is the sponsor of this research. SAMHS (Specialist Adult and Adolescent Mental Health Services) at the Tavistock and Portman NHS Trust supports this research.
- Involvement in the project is voluntary and participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.
- I have been offered an opportunity to raise any questions or concerns I might have about this – and to have these answered to my satisfaction.

Name (please print): ……………………………………

Signed: …………………………………………………

Date: ……………………………………………………

Appendix E: Interview Guide

- Can you tell me what this movie clip makes you think of in relation to your clinical practice?
- Could you tell me a bit about your work with a withdrawn young person?
- How did you manage to engage with him/ her?
- What was particularly difficult working with him/her?
- What was it like being in the room with (or, where work isn't face-to-face: working with) him/her? Tell me a bit about the feelings that were invoked in you. Did these feelings change over time?

- How do you see the transference dynamics between you? Have they changed over time? How do you understand these dynamics in relation to the young person's internal and external object relationships?

- What in your view contributed to the young person becoming socially isolated, and what hindered them to come out of their reclusion?
- What do you think has been helpful for the young person? Or what do you think might have been helpful (including other types of input)?

Appendix F: Sample of initial coding

4

p.3

know, she felt a little bit more connected with her peers. so instead of being home all the time, like a..like a girl, like a child really, she would have a few moments where she would go out, with a friend, or do something, in the beginning it was with her grandmother and grandmother's friends. So, it went from that to her being able to have a few friends. She did go to the there was a kind of end of year party end of six form party at school and she did go to that. So, are you know, there were a few external, there are a few more movements but

developmentally stuck like child

small movement to going out

How did you feel towards her ..(inaudible as she speaks over me and my voice hesitant)

It was very difficult, it was, it was hard work, hard work... Very unrewarding work. And there was something quite, something quite aggressive

therapist: unrewarding hard work

sth aggressive

About her not changing?

Yes about her not changing, and about her wanting (emphasised) to come at the same time. Definitely very aggressive when I started talking about ending, that we have to end, and it was very difficult to even conceive that I could end with this girl. it really felt that we would go on and on. And then I brought her to a team meeting, I discussed her and that help me get permission to end. Clinicians were saying to me you have to end with this girl, that she can't continue the same way, and that you have done what you could do. She was furious with me, and she threatened all sorts of things and she would make a complaint. There was something quite clever about that her. she wanted to look at her file. None of that really happened, and at the end there was no complaint. But...ahm..We stopped, I gave a lot of warning, a few months. And then she saw another clinician a few times. This clinician had the same feeling, how am I going to see to discharge the girl like this. And then she came with her mother. And then the other clinicians saw them, her and her mother, not regularly but on and off, so her and another for a few months. And then the mother said that said she's okay now, she doesn't need this, she needs to concentrate on the pain in her leg and then they left.So it wasn't very successful intervention. I honk that probably without therapy it would have been worse. I think part of the problem was that she was stuck in a place in her mind, and in her flat with her mother. She didn't want to move

wanting to come, refusing to conceive an ending and not changing at the same time

feeling we could go on and on

ending perceived as catastrophic

therapist feels treatment was unsuccessful but it would have been worse without it

stuck in her mind, her flat, unwilling to move

Do you think that was the same stuckness in the therapy?

Yeah yeah. Four example it was very difficult for her to hear any comments about her sister and how she, my patient, was really being sisters' mother, taking responsibilities, caring for this five year old in a way that wasn't helpful and wasn't healthy at all,, so it took a while to be able to hear that comment. She would be very kind of defensive, and saying nothing is wrong with that, this is how I lead my life. She would be completely in her bubble, so, challenging or removing this bubble..., I think she remained in a bubble. So any movement, she just wouldn't really

patient blocking off any challenge to her thinking

Appendix G: Sample of gathering codings into categories

<u>Patient's perception of Retreat/ perception of external reality/ internal vrs external/ attitude to development</u>

External/ outside world perceived as threat/ not safe 1-4 (Interview No1 page 4), 2-3, world outside 'bubble' (physical and psychic retreat) feel frightening 4-7; Staying shut-off feels comfortable 1-4; While trapped in room there is no testing or challenges to his thoughts about himself or others 8-4; Development feels scary as it entails living in the world (not computer) 7-3

This group of patients does recognise difference between real-world and internet relationship. Internet seen as safe place to retreat to 5-1; Home is like a cocoon 4-1; Wants to continue with what he is doing now (playing computer games) for rest of his life 1-8

Staying in feels predictable and safe "if you are staying in and I am not coming out at least you know who (where) you are" 6-5 Being stuck in room while telling herself 'don't need the outside world anyway' 6-2

Has an idea of the reality of needing a job 1-8; Difficulty even thinking about future (job/ training) 4-7; Was able to work and focus on the external 4-4 It's unclear how much he is making realistic evaluation or a fantastical one about future 1-8 Belief that change is possible 1-9

Sees pet cat and later sister's baby with fondness as well as often annoyed with mess, taking up space, burdening him 2-10

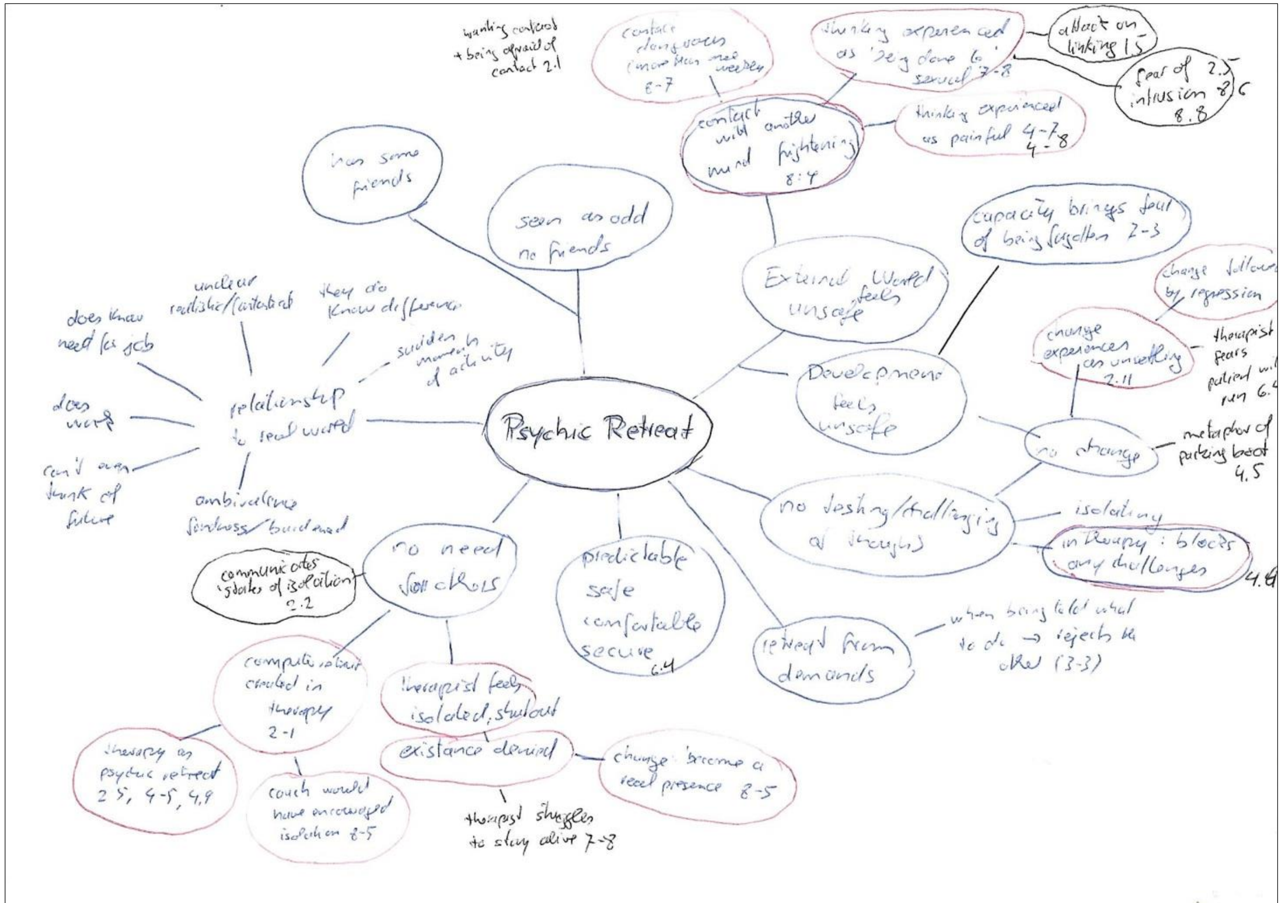
<u>Counter transference responses</u>

Nearly falling asleep, sleep-like state 1-4, 1-9; Difficult to focus, drowsiness 1-4, 1-9; After each session therapist needs to stretch, something had shut down 7-8 ; Draining 1-4; Heavy 1-4; Stamina needed, sessions leave therapist drained 8-9; Boredom 2-2,

Sense of timelessness 1-9, 1-9; Sense of time shifts between intense eternal moment to drawn out where 50 min feel like a year 8-3

Sense of *nothing changing* 1-9, Sense of stuckness 1-9, 4-6, not going anywhere 2-2, therapist feels stuck in repetitive cycles where each session felt like a repetition of the previous session 4-2, image patient brings about therapy dynamics: unpacking boot of the car, show the items inside, then put them all back again 4-5, impasse 4-5, long periods in therapy felt stuck 6-5, frustrated, feeling 'just needs to make an effort, what's the fuss', minimising problems of patient, just as other professionals had done 6-6, therapist believe patient did not want to get better but couldn't take this up for fear of being perceived as blaming 6-7, [...]

Appendix H: samples of mind maps



Appendix E : UREC Approval letter

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
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Quality Assurance and Enhancement

04 February 2015

Dear Petra,

Project Title:	**Shut in and cut off? An exploration of internal and external relationship dynamics of adolescents and young adults who are socially withdrawn and isolated in their homes.**
Researcher(s):	**Petra Mohr**
Principal Investigator:	**Professor Barbara Harrison and Dr Jocelyn Catty**
Reference Number:	**UREC_1415_19**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered at the meeting on **Wednesday 21st January 2015**.

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Tavistock Centre, London NW3 5BA	Professor Barbara Harrison and Dr Jocelyn Catty

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC Application Form	1.0	14 October 2014
Participant Information Sheet	1.0	14 October 2014

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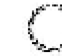

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
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Quality Assurance and Enhancement

Consent Form	1.0	14 October 2014
Interview Topic Guide	1.0	14 October 2014
Approval letter from Tavistock	1.0	04 February 2015

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Rosalind Eccles
University Research Ethics Committee (UREC)
UREC Servicing Officer
Email: researchethics@uel.ac.uk

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